

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRSA

Health Resources & Services Administration

HIV/AIDS Bureau
Division of State HIV/AIDS Programs

***Ryan White HIV/AIDS Program
HIV Care Grant Program – Part B States/Territories Formula and AIDS
Drug Assistance Program Formula and ADAP Supplemental Awards***

**Funding Opportunity Number: HRSA-22-033
Funding Opportunity Type(s): Non-Competing Continuation
Assistance Listings (CFDA) Number: 93.917**

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2022

Application Due Date: November 8, 2021

***Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!
HRSA will not approve deadline extensions for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to 1 month to complete.***

Issuance Date: July 23, 2021

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Authority: 42 USC §§ 300ff-21 to 331b and 300ff-121 (sections 2611-2623 and 2693 of the Public Health Service (PHS) Act).

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA) is accepting applications for the Ryan White HIV/AIDS Program Part B Base, AIDS Drug Assistance Program (ADAP) Base, ADAP Supplemental, Minority AIDS Initiative, and Emerging Communities program. The purpose of this program is to assist states and territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income people with HIV. It supports the HIV National Strategic Plan goals to prevent new HIV infections, improve HIV-related health outcomes of people with HIV, reduce HIV-related disparities and health inequities, and achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders.

Funding Opportunity Title:	HIV Care Grant Program - Part B States/Territories Formula and AIDS Drug Assistance Program Formula and ADAP Supplemental Awards
Funding Opportunity Number:	HRSA-22-033
Due Date for Applications:	November 8, 2021
Anticipated Total Annual Available Funding:	\$1,340,000,000
Estimated Number and Type of Award(s):	Up to 59 Grants
Estimated Award Amount:	Varies- formula calculation
Cost Sharing/Match Required:	Yes for Part B Formula/Base, Emerging Communities and ADAP Supplemental when applicable to specific states
Period of Performance:	April 1, 2022 through March 31, 2027 (five years)
Eligible Applicants:	In addition to the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau may apply. [See Section III. 1 of this notice of funding opportunity (NOFO) for complete eligibility information.]

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at <http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf>, except where instructed in this Notice of Funding Opportunity (NOFO) to do otherwise.

Technical Assistance

HRSA has scheduled the following technical assistance:

Webinar

Day and Date: Wednesday, August 25, 2021
Time: 02:30 - 04:00 pm

Join ZoomGov Meeting

<https://hrsa-gov.zoomgov.com/j/16041483625?pwd=am1jaHdvRDI5eWt3UWIUNzAxTnRQUT09>

Meeting ID: 160 4148 3625

Passcode: FY22X07TA

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833 568 8864 US Toll-free

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Passcode: 809110554

Find your local number: <https://hrsa-gov.zoomgov.com/u/az33IRjaq>

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Join by H.323

161.199.138.10 (US West)

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Meeting ID: 160 4148 3625

Passcode: 809110554

The recorded webinar will be available on the [TargetHIV website](#)

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I. Program Funding Opportunity Description

1. Purpose

This notice announces the opportunity to apply for funding under the Ryan White HIV/AIDS Program (RWHAP) Part B Base, AIDS Drug Assistance Program (ADAP) Base, ADAP Supplemental, Minority AIDS Initiative (MAI), and Emerging Communities (EC) program. The purpose of this program is to assist states and territories in developing and/or enhancing access to a comprehensive continuum of high quality HIV care and treatment for low-income people with HIV. For the purposes of this program, “states/territories” include the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

A comprehensive system of HIV care includes the 13 core medical services specified in the Public Health Service (PHS) Act, Section 2612(b)(3) [42 U.S.C. 300ff-21(b)(3)]. Comprehensive HIV care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV to access and remain in primary medical care to improve their medical outcomes. These core and support services assist people with HIV in accessing treatment for HIV infection that is consistent with the [Department of Health and Human Services \(HHS\) Treatment Guidelines](#) (see <http://www.aidsinfo.nih.gov>).

The RWHAP Part B/ADAP recipients must use grant funds to support, develop and expand systems of care to meet the needs of people with HIV. The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) requires that the RWHAP Part B/ADAP Programs conduct needs assessments and use needs assessment data to make decisions on services needed to eliminate barriers faced by people with HIV in accessing and remaining in medical care.

In June 2015, HRSA HAB and the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention (DHAP) released a joint guidance for the Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for RWHAP Part A and B recipients. This guidance was set forth for health departments and HIV planning groups funded by DHAP and HAB for the development of an Integrated HIV Prevention and Care Plan and allowed jurisdictions to submit one Integrated HIV Prevention and Care Plan, including the SCSN, to CDC and HRSA. As HRSA views integrated prevention and care planning as the most appropriate mechanism to fully plan HIV services, CDC DHAP and HRSA HAB have issued joint guidance for the development of the HIV Prevention and Care Plan to cover calendar years 2022 – 2026. Submission of the Integrated HIV Prevention and Care Plan not only meets the legislative and programmatic requirements of CDC and HRSA, but also serves as a jurisdictional HIV/AIDS strategy or roadmap. **Important Notes:**

- **Multi-Year Funding:** HRSA HAB transitioned the RWHAP Part B/ADAP from an annual application program to a five-year funded program effective in FY 2017. HRSA HAB will continue the five-year period of performance that will cover FY 2022-FY 2026. In this next five-year period of performance, eligible applicants will

submit an application in the first year (FY 2022), and non-competing continuation (NCC) progress reports will be submitted for years 2 through 5 (FY 2023 through FY 2026, respectively).

- **Unmet Need:** HRSA HAB updated the estimation methodology used to determine unmet need for HIV-related services. Eligible applicants will need to provide estimates using the new [Unmet Need Framework](#) with their applications. See the Demonstrated Need section for additional detail, and reference the [TargetHIV](#) website for training materials and tools related to estimating and reporting Unmet Need.
- **Work Plan:** The Implementation Plan is comprised of two components, the Implementation Plan Table and the Implementation Plan Narrative. You will only be required to submit an Implementation Plan Narrative with this funding announcement. The Implementation Plan Table will not be submitted with this application. You will provide the Implementation Plan Table with your Program Terms Report.
- **Needs Assessment:** You will need to submit a brief HIV/AIDS epidemiological data profile and narrative, and a brief outline of the needs assessment with this application. A more in depth epidemiological data profile and narrative and outline of the needs assessment will be submitted with the Integrated HIV Prevention and Care Plan to be submitted in December 2022.
- **Quality Management Plan:** You will be required to submit an updated Quality Management Plan as a reporting requirement with the Program Terms Report, ninety (90) days after the award is made.

The following information will assist you in understanding and completing your FY 2022 grant application:

- RWHAP Part B funds, including ADAP, are subject to Section 2612(b)(1) of the PHS Act, which requires that not less than 75 percent of the award (minus amounts for administration, planning/evaluation and clinical quality management) be used to provide core medical services. Support services allowed under RWHAP Part B are limited to services that are needed for people with HIV to achieve their medical outcomes. The service definitions can be found in Policy Clarification Notice (PCN) 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.
- Applicants seeking a waiver to the core medical services requirement must submit a waiver request either with this application, or up to four (4) months after the budget period start date. Submission should be in accordance with PCN 13-07 Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts A, B, and C, and sample letters can all be found at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>. A core medical services waiver request should be included as **Attachment 8 if it is submitted with the application.**
- The Agreements and Compliance Assurances required for this NOFO are found in **Appendix A**, and require the signature of the Chief Elected Official (CEO), or the CEO's designee. The Agreements and Compliance Assurances should be included as **Attachment 7.**

2. Background

This program is authorized by the PHS Act, Sections 2611 - 23 and 2693 [42 U.S.C. 300ff-21-300ff-31b and 300ff-121]. HHS administers the RWHAP Part B/ADAP through the HRSA, HAB, Division of State HIV/AIDS Programs (DSHAP). All 59 eligible entities receive RWHAP Part B Base and ADAP Base funding through this program. For more information regarding the RWHAP, please visit the HRSA website: <http://hab.hrsa.gov/>.

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV. The program funds grants to states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

The RWHAP has five statutorily defined Parts (Parts A, B, C, D and F) that provide funding for core medical, support services, and medications; technical assistance; clinical training; and the development of innovative models of care to meet the needs of different communities and populations affected by HIV.

An important framework in the RWHAP is the HIV care continuum, which depicts the series of stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication to achieve viral suppression. Supporting people with HIV to reach viral suppression not only increases their own quality of life and lifespan, it also prevents sexual transmission to an HIV-negative partner.

The HIV care continuum framework allows recipients and planning groups to measure progress and to direct HIV resources most effectively. RWHAP recipients are encouraged to assess the outcomes of their programs and should work with their community and public health partners to improve outcomes across the HIV care continuum. HRSA encourages recipients to use the [performance measures](#) developed for the RWHAP at their local level to assess the efficacy of their programs and to analyze and improve the gaps along the HIV care continuum.

Strategic Frameworks and National Objectives

National objectives and strategic frameworks like the Healthy People 2030, the HIV National Strategic Plan: A Roadmap to End the HIV Epidemic (2021 – 2025); the Sexually Transmitted Infections National Strategic Plan for the United States (2021 – 2025); and the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021 – 2025) are crucial to addressing key public health challenges facing low-income people with HIV. These strategies detail the principles, priorities, and actions to guide the national public health response and provides a blueprint for collective action across the federal government and other sectors. The RWHAP supports the implementation of these strategies and recipients should align their organization's efforts, within the parameters of the RWHAP statute and program guidance, with these strategies to extent possible.

Expanding the Effort: Ending the HIV Epidemic in the U.S.

According to recent data from the [2019 Ryan White Services Report \(RSR\)](#), the RWHAP has made tremendous progress toward ending the HIV epidemic in the United States. From 2015 to 2019, HIV viral suppression among RWHAP patients who have had one or more medical visits during the calendar year and at least one viral load with a result of <200 copies/mL reported, has increased from 83.4 percent to 88.1 percent. Additionally, racial/ethnic, age-based, and regional disparities reflected in viral suppression rates have significantly decreased.¹ For example, the disparities in viral suppression rates between Black/African Americans and white clients have decreased since 2010.² These improved outcomes mean more people with HIV in the United States will live near normal lifespans and have a reduced risk of transmitting HIV to others.³

In February 2019, the [Ending the HIV Epidemic in the U.S.](#) (EHE) initiative was launched to further expand federal efforts to reduce HIV infections. This 10-year initiative seeks to achieve the important goal of reducing new HIV infections in the United States to fewer than 3,000 per year by 2030. The initiative promotes and implements four strategies to substantially reduce HIV transmissions – Diagnose, Treat, Prevent, and Respond. The initiative is a collaborative effort among key HHS agencies, primarily HRSA, the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

For the RWHAP, the EHE initiative expands the program’s ability to meet the needs of clients specifically focusing on linking people with HIV who are either newly diagnosed, diagnosed but currently not in care, or are diagnosed in care but not yet virally suppressed to the essential HIV care and treatment and support services needed to help them achieve viral suppression.

Using Data Effectively: Integrated Data Sharing and Use

HRSA and CDC’s Division of HIV/AIDS Prevention support integrated data sharing, analysis, and utilization for the purposes of program planning, conducting needs assessments, determining unmet need estimates, reporting, quality improvement, enhancing the HIV care continuum, and public health action. HRSA strongly encourages RWHAP recipients to:

- Follow the principles and standards in the [Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action](#).
- Establish data sharing agreements between surveillance and HIV programs to ensure clarity about the process and purpose of the data sharing and utilization.

¹ Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019. <http://hab.hrsa.gov/data/data-reports>. Published December 2020. Accessed December 2, 2020.

² Black/African American clients went from 79.4 percent viral suppression in 2015 to 85.2 percent in 2019, while 88.3 percent of white clients were virally suppressed in 2015 and 91.8 percent in 2019

³ National Institute of Allergy and Infectious Diseases (NIAID). Preventing Sexual Transmission of HIV with Anti-HIV Drugs. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2016 Mar 29]. Available from: <https://clinicaltrials.gov/> NCT00074581 NLM Identifier: NCT00074581.

Integrated data sharing, analysis, and utilization of HIV data by state and territorial health departments can help further progress toward reaching the HIV National Strategic Plan goals and improve outcomes on the HIV care continuum.

HRSA strongly encourages complete CD4, viral load (VL) and HIV nucleotide sequence reporting to the state and territorial health departments' HIV surveillance systems to benefit fully from integrated data sharing, analysis, and utilization. State health departments may use CD4, VL, and nucleotide sequence data to identify cases, stage of HIV disease at diagnosis, and monitor disease progression. These data can also be used to evaluate HIV testing and prevention efforts, determine entry into and retention in HIV care, measure viral suppression, monitor prevalence of antiretroviral drug resistance, detect transmission clusters and understand transmission patterns, and assess unmet health care needs. Analyses at the national level to monitor progress toward ending the HIV epidemic in the U.S. can only occur if all HIV-related CD4, VL, and HIV nucleotide sequence test results are reported by all jurisdictions. CDC requires the reporting to the National HIV Surveillance System (NHSS) all HIV-related CD4 results (counts and percentages), all VL results (undetectable and specific values), and HIV nucleotide sequences.

Program Resources and Innovative Models

HRSA has a number of projects and resources that may assist RWHAP recipients with program implementation. These include a variety of HRSA HAB cooperative agreements, contracts, and grants focused on specific technical assistance (TA), evaluation, and intervention activities. A list of these resources is available on [TargetHIV](#). Recipients should be familiar with these resources and are encouraged to use them as needed to support their program implementation.

An important technical assistance resource is the [RWHAP Recipient Compilation of Best Practices Intervention Strategies](#) (Best Practices Compilation). The Best Practices Compilation is currently under development, but will present strategies that have been implemented in real world settings and that improve outcomes along the HIV care continuum. The RWHAP Best Practices Compilation will be an easily searchable resource to support recipients' work and the needs of the people served by the RWHAP.

In addition, many RWHAP Special Projects of National Significance (SPNS) projects have demonstrated promising new approaches for linking and retaining priority populations into care. As resources permit, RWHAP recipients are encouraged to review and integrate these tools within their HIV system of care in accordance with the allowable service categories defined in [PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds](#). Examples of these resources include:

- [E2i: Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV](#)
E2i uses an implementation science approach to evaluate and understand existing and new intervention strategies that can be used in RWHAP provider settings. Once interventions or strategies are demonstrated and evaluated using implementation science, manuals, guides, interactive online tools, publications, and instructional materials are

developed and disseminated for replication and integration into RWHAP provider settings.

- [**Integrating HIV Innovative Practices \(IHIP\)**](#)
Resources on the IHIP website include easy-to-use training manuals, curricula, case studies, pocket guides, monographs, and handbooks, as well as informational handouts and infographics about SPNS generally. IHIP also hosts TA training webinars designed to provide a more interactive experience with experts, and a TA help desk exists for you to submit additional questions and share your own lessons learned.
- [**Replication Resources from the SPNS Systems Linkages and Access to Care**](#)
There are intervention manuals for patient navigation, care coordination, state bridge counselors, data to care, and other interventions developed for use at the state and regional levels to address specific HIV care continuum outcomes among hard-to-reach people with HIV.
- [**Dissemination of Evidence Informed Interventions**](#)
The Dissemination of Evidence-Informed Interventions initiative ran from 2015-2020 and disseminated four adapted linkage and retention interventions from prior SPNS and the Minority HIV/AIDS Funds (MHAF) from the HHS Secretary's Office initiatives to improve health outcomes along the HIV care continuum. The initiative produced four evidence-informed care and treatment interventions (CATIs) that are replicable, cost-effective, capable of producing optimal HIV care continuum outcomes, and easily adaptable to the changing health care environment. Manuals are currently available at the link provided and will be updated on an ongoing basis.

HRSA HAB also recognizes the importance of addressing emerging issues, as well as supporting the needs of special populations. To help recipients in responding to these critical issues, HRSA HAB funds projects to provide technical assistance and resources for recipients. Examples of projects include:

- [**Building Futures: Supporting Youth Living with HIV**](#)
- [**The Center for Engaging Black MSM Across the Care Continuum \(CEBACC\)**](#)
- [**Using Community Health Workers to Improve Linkage and Retention in Care**](#)

II. Award Information

1. Type of Application and Award

Type of applications sought: Non-Competing Continuation

HRSA will provide funding in the form of a grant.

2. Summary of Funding

HRSA estimates approximately \$1,340,000,000 to be available annually to fund 59 recipients. The actual amount available will not be determined until enactment of the final

fiscal year FY 2022 federal appropriation. This program notice is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, HRSA can process applications and award funds appropriately. The period of performance is April 01, 2021 through March 31, 2022 (5 years). Funding beyond the first year may be awarded through a modified non-competing continuation in order to reduce the administrative burden on recipients. Funding beyond the first year is subject to the availability of appropriated funds for the RWHAP Part B/ADAP Program in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government. Notification of awards will be sent to the CEO or to the delegated administrative agency responsible for dispersing RWHAP Part B/ADAP funds.

HRSA HAB has transitioned the RWHAP Part B/ADAP from an annual non-competitive funded program to a multi-year funded program, effective FY 2017. The period of performance is five years (April 1, 2022 through March 31, 2027). A non-competitive application will be submitted for FY 2022, and Non-Competing Continuation (NCC) Progress Reports will be submitted annually for FY 2023 through FY 2026.

RWHAP Part B Base, ADAP Base, and EC formula awards are based on the number of reported living cases of HIV in the state or territory in the most recent calendar year as confirmed by CDC and submitted to HRSA. Similarly, for recipients applying for MAI formula funds, awards are based on the number of reported living minority HIV cases for the most recent calendar year as confirmed by CDC and submitted to HRSA. For subsequent budget periods, annual award amounts for these portions will be adjusted based on updated case counts. ADAP Supplemental grants are awarded by the same formula as ADAP Base to states which meet any of the criteria listed in that section of the NOFO and choose to apply; annual eligibility for ADAP Supplemental in subsequent budget periods will be announced through the NCC process.

Please note that the HHS Secretary (Secretary) may reduce the amounts of grants under the RWHAP Part B/ADAP to a state/territory or political subdivision of a state/territory for a FY if, with respect to such grants for the second preceding FY, the state/territory or subdivision fails to prepare audits in accordance with the procedures of Section 7502 of Title 31, United States Code. See Section 2682(a) of the PHS Act.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at [45 CFR part 75](#).

Please see [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D](#) along with the [FAQs](#) for information regarding the statutory 10 percent limitation on administrative costs.

III. Eligibility Information

1. Eligible Applicants

In addition to the 50 states, the District of Columbia, the Commonwealth of Puerto Rico,

the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau are eligible to apply for RWHAP Part B Base, ADAP Base, and MAI funding.

RWHAP Part B/ADAP applicants must designate a lead state/territory agency that will be responsible for administering all assistance received; conducting a needs assessment and preparing a state/territory comprehensive plan; preparing all applications and reports; receiving notices regarding programs; and collecting and submitting to the HHS Secretary every two years all audits from recipients within the state/territory, including an audit regarding funds expended.

ADAP Supplemental funding: States and territories are eligible to apply for ADAP Supplemental funding if they meet at least one of the following criteria, as reported by the state or territory on the most recent ADAP Data Report (ADR):

- a) Financial requirement of Federal Poverty Level (FPL) = or <200percent;
- b) Limited formulary compositions for all core classes of antiretroviral medications;
- c) Waiting list, capped enrollment, or capped expenditures;
- d) An unanticipated increase of eligible individuals with HIV.

Even if a state/territory meets one of the eligibility criteria listed, it will be deemed **ineligible** for ADAP Supplemental funds if the state/territory did not obligate 75 percent of its previous FY RWHAP Part B/ADAP award within 120 days of the budget period start date, as reported on the previous FY Interim Federal Financial Report (FFR) within 150 days of the budget period start date.

Note: The Coronavirus Disease 2019 (COVID-19) public health emergency has posed significant challenges for RWHAP recipients, providers, and clients to provide and access care. On February 23, 2021, HRSA HAB released a [letter](#) that waived certain statutory penalties and administrative requirements for FY 2020 and 2021 in accordance with the Consolidated Appropriations Act, 2021, Pub. L. 116- 260, Division M, § 307. The requirement to obligate 75 percent of FY 2021 RWHAP Part B/ADAP award within 120 days of the budget period start date has been waived for FY 2021. Therefore, no states/territories will be deemed ineligible if they did not obligate 75 percent of their FY2021 award within 120 days of the budget period start date.

This requirement has only been waived for FY 2020 and FY 2021. Failure to obligate 75 percent of RWHAP Part B/ADAP in FY 2022 or future budget periods will result in penalties assessed to future budget years of the period of performance. ADAP Supplemental funding is determined on an annual basis; receipt of funding in one year does not guarantee funding in any subsequent year.

Eligibility for EC formula awards depends in part on the number of confirmed AIDS cases within a statutorily specified “metropolitan area.” The Secretary uses the Office of Management and Budget’s (OMB’s) census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area, including an EC. HHS relies on the OMB geographic boundaries that were in effect when a jurisdiction was initially funded as an EC. For all newly eligible areas, the boundaries are based on current OMB MSA boundary definitions.

An EC must have between 500-999 cumulative AIDS cases during the most recent five years. Cumulative AIDS cases are reported and confirmed by the Director of the CDC as of December 31 of the most recent calendar year. States with jurisdictions classified as an EC are eligible to apply for these funds. ECs continue their eligibility for these funds as long as the statutory incidence requirements during the most recent period of five calendar years and prevalence level for three consecutive years have been met. Areas are notified by letter when they are at risk of losing eligibility.

The following states are eligible to apply for EC formula awards and they are responsible for applying for the eligible MSAs below:

States	Emerging Communities*
Alabama	Birmingham-Hoover, AL MSA
California	Bakersfield, CA MSA
Delaware	Philadelphia-Camden - Wilmington, PA-NJ-DE-MD MSA
Florida	Lakeland-Winter Haven, FL MSA Port St. Lucie, FL MSA North Port-Bradenton-Sarasota, FL MSA
Georgia	Augusta-Richmond County, GA-SC MSA
Kentucky	Louisville/Jefferson County, KY-IN MSA
Mississippi	Jackson, MS MSA
New York	Albany-Schenectady-Troy, NY MSA Buffalo-Cheektowaga-Niagara Falls, NY MSA Rochester, NY MSA
North Carolina	Raleigh, NC MSA
Ohio	Cincinnati, OH-KY-IN MSA
Oklahoma	Oklahoma City, OK MSA
Pennsylvania	Pittsburgh, PA MSA
Rhode Island	Providence-Warwick, RI-MA MSA
South Carolina	Columbia, SC MSA Charleston-North Charleston, SC MSA
Virginia	Richmond, VA MSA
Wisconsin	Milwaukee-Waukesha-West Allis, WI MSA
Total: 16 States	Total: 21 Emerging Communities

*The list of RWHAP Part B ECs uses the most recent MSA names pursuant to OMB Bulletin 20-01. Only the EC MSA names have been updated; the MSA codes and boundaries remain the same. Source: <https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf>. The AIDS cases for determining eligibility have been reported to and confirmed by the director of the CDC, based on the boundaries that were in effect when the EC first received funding.

2. Cost Sharing/Matching

Cost sharing/matching is required for this program as described below.

Section 2617(d)(3) of the PHS Act indicates that matching funds are required from states

with more than one percent of the total HIV cases reported to the CDC during the previous two FYs (i.e., 2020 and 2021). A state can meet its match requirement through non-federal cash or in-kind resources, which can be provided either directly or through donations to the state from public or private entities, in proportion to the RWHAP Part B/ADAP funding. The same eligible funds can be used to meet both a recipient's state match requirement and the Maintenance of Effort (MOE) requirement. The match begins at \$1 in non-federal funds for every \$5 in federal funds and increases to \$1 in non-federal funds for every \$2 in federal funds in later years (Section 2617(d)(1) of the PHS Act). If required, the state match, inclusive of the rate of the match, is listed on the Notice of Award (NOA). A state/territory may request a reduction in the award amount if unable to meet the match requirement.

State/territory matching funds for ADAP Supplemental awards are required in an amount equal to \$1 for each \$4 of federal funds provided in the supplemental grant award (Section 2618(a)(2)(F)(ii)(III) of the PHS Act). A state/territory is eligible for a waiver from the match requirement for ADAP Supplemental funding if it also has a state match requirement for the RWHAP Part B Formula/ADAP Base funding, and has met that match requirement. A state/territory may also request a reduction in the ADAP Supplemental award amount if unable to meet the match requirement.

The RWHAP Part B MAI awards are exempt from the matching requirements. EC funds are not exempt from matching requirements.

3. Other

HRSA will consider any application that exceeds the ceiling amount non-responsive and will not consider it for funding under this notice.

HRSA will consider any application that fails to satisfy the deadline requirements referenced in [Section IV.4](#) non-responsive and will not consider it for funding under this notice.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates), an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

Maintenance of Effort

The RWHAP Part B/ADAP funds are not intended to be the sole source of support for HIV care and treatment services in the states and territories. Grant funds shall not be used to take the place of current funding for activities described in the application. By signing the 2022 Agreements and Assurances (Appendix A) and the SF-424 application, the recipient agrees to maintain non-federal funding for HIV-related activities at a level which is not less than expenditures for such activities during the FY prior to receiving the award (as authorized by Section 2617(b)(7)(E) of the PHS Act). The Maintenance of Effort (MOE) requirement is important in ensuring that RWHAP funds are used to supplement existing state expenditures for HIV-related care and treatment services and to prevent RWHAP

Part B/ADAP funds from being used to offset specific HIV-related budget reductions at the state level. Agreements and Assurances for subsequent years will be provided through the non-competing continuation process.

To demonstrate compliance with the MOE provision, states and territories must maintain adequate systems for consistently tracking and reporting on HIV-related expenditure data from year to year. The system must define the methodology used, be written and auditable, and must ensure that federal funds do not supplant state spending, but instead expand and enrich HIV-related activities. Complete the MOE information and submit as **Attachment 5**.

HRSA will consider any application that fails to satisfy the requirement to provide MOE information non-responsive and will not consider it for funding under this notice.

Note: Multiple applications are not allowable.

HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA **requires** you to apply electronically. HRSA encourages you to apply through [Grants.gov](https://www.grants.gov) using the SF-424 workspace application package associated with this notice of funding opportunity (NOFO) following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

The NOFO is also known as “Instructions” on Grants.gov. You must select “Subscribe” and provide your email address for each NOFO you are reviewing or preparing in the workspace application package in order to receive notifications including modifications, clarifications, and/or republications of the NOFO on Grants.gov. You will also receive notifications of documents placed in the RELATED DOCUMENTS tab on Grants.gov that may affect the NOFO and your application. *You are ultimately responsible for reviewing the [For Applicants](#) page for all information relevant to this NOFO.*

2. Content and Form of Application Submission

Section 4 of HRSA’s [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, etc. You must submit the information outlined in the Application Guide in addition to the program specific information below. You are responsible for reading and complying with the instructions included in HRSA’s [SF-424 Application Guide](#) except where instructed in the NOFO to do otherwise. You must submit the application in the English language and in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit

The total size of all uploaded files included in the page limit shall not exceed the equivalent of **90 pages** when printed by HRSA. The page limit includes the project and budget narratives, some attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form "Project Abstract Summary." Standard OMB-approved forms that are included in the workspace application package do not count in the page limit. Note: If you use an OMB-approved form that is not included in the workspace application package for HRSA-22-033, it may count against the page limit. Therefore, we strongly recommend you only use Grants.gov workspace forms associated with this NOFO to avoid exceeding the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **It is therefore important to take appropriate measures to ensure the application does not exceed the specified page limit. Any application exceeding the page limit of 90 will not be read, evaluated, or considered for funding.**

Applications must be complete, within the maximum specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

- 1) You certify on behalf of the applicant organization, by submission of this proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3321).
 - c. Where you are unable to attest to the statements in this certification, an explanation shall be included in **Attachments 10-12: Other Relevant Documents**.

See Section 4.1 viii of HRSA's [SF-424 Application Guide](#) for additional information on this and other certifications.

Temporary Reassignment of State and Local Personnel during a Public Health Emergency

Section 319(e) of the PHS Act provides the Secretary of HHS with discretion upon request by a state or tribal organization to authorize the temporary reassignment of state, tribal, and local personnel during a declared federal public health emergency. The temporary reassignment provision is applicable to state, tribal, and local public health department or agency personnel whose positions are funded, in full or part, under PHS programs and allows such personnel to immediately respond to the public health emergency in the affected jurisdiction. Funds provided under the award may be used to support personnel who are temporarily reassigned in accordance with § 319(e). Please reference detailed

information available on the HHS Office of the Assistant Secretary for Preparedness (ASPR) website via <http://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx>.

Program-Specific Instructions

In addition to application requirements and instructions in Section 4 of HRSA's [SF-424 Application Guide](#) (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract

Use the Standard OMB-approved Project Abstract Summary Form 2.0 that is included in the workspace application package. Do not upload the abstract as an attachment. For information content required in the Project Abstract Summary Form, see Section 4.1.ix of HRSA's [SF-424 Application Guide](#).

In addition, the abstract should include the following information:

- A general overview of the HIV epidemiology in the state/territory including demographics and the geography of the epidemic;
- A general description of the HIV service delivery system in the state/territory, including what services are available, where those are located, and how clients access those services; and

A general description of the ADAP, including number of clients served, medication and health care coverage assistance program models, and any program limitations currently in place or anticipated in the upcoming budget period.

As noted in the SF-424 Application Guide, the project abstract must be single-spaced and limited to one page.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well-organized so that reviewers can understand the proposed project.

Successful applications will contain the information below. Please use the following section headers for the narrative:

- (A) FY 2022 [Part B Base](#) Grant Application
- (B) FY 2022 [ADAP Base](#) Grant Application
- (C) FY 2022 [ADAP Supplemental](#) Grant Application
- (D) FY 2022 [Emerging Community \(EC\)](#) Grant Application.

For each header section listed above, use the following subheadings:

- Introduction
- Needs Assessment
- Methodology
- Work Plan
- Resolution of Challenges
- Evaluation
- Organization Information

(A) FY 2022 Part B Base Grant Application

The instructions for completing the Part B Base grant application are divided into two sections. Each applicant should only complete the applicable section. The sections are specific to the following two groups:

- The [50 states](#), the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands and Guam.
- The [Republic](#) of the Marshall Islands, Federated States of Micronesia, Republic of Palau, American Samoa and Commonwealth of the Northern Mariana Islands.

1. This Section is to be completed by the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands and Guam only.

▪ *INTRODUCTION --*

This section should briefly describe how the state/territory will utilize RWHAP Part B Base grant funds in support of a comprehensive continuum of high-quality care and treatment for people with HIV.

▪ *NEEDS ASSESSMENT*

- 1) **HIV/AIDS Epidemiology:** The purpose of this section is to briefly describe the HIV/AIDS epidemic in the state/territory. Section 2617(b)(2) of the PHS Act states that the application for RWHAP Part B Base funds shall contain a determination of the size and demographics of the population of people with HIV in the state.

Please note that both the Epidemiology table and narrative should be included as **Attachment 9**.

a) Table

Summarize in a table format the HIV (non-AIDS) and AIDS cases by age, sex, race/ ethnicity, and exposure category through December 31, 2020. Place the table in **Attachment 9** of the application and clearly label the data sources.

b) Narrative

Based on the most recent state/territory HIV/AIDS epidemiologic profile, provide a brief narrative description of any trends or changes in the age, sex, race/ethnicity, and exposure categories for prevalent cases and for cases newly diagnosed and reported in the previous two years for which data are available. Place the narrative in **Attachment 9** of the application.

- 2) **Needs Assessment and Public Advisory Planning Process:** The purpose of this section is to describe the Needs Assessment process and ensure that public health agencies receiving RWHAP Part B/ADAP grants have established a public advisory planning process that includes public hearings, as required by Section 2617(b)(7)(A) of the PHS Act.

a) Needs Assessment

- i) Briefly describe any current or planned needs assessment, including the geographic and population scope of the needs assessment, who participates in the process, and how participation from people with HIV.
- ii) Briefly describe how planned needs assessments will contribute to the Integrated HIV Prevention and Care Plan, including the SCSN due in December 2022.

b) Public Advisory Planning Process

- i) Describe the state/territory's HIV Public Advisory Planning process model (e.g., integrated care and prevention, statewide or regional, consortia). Please indicate the number and affiliations of the participating parties, including people with HIV, other RWHAP recipients, other HIV related programs, other general and local stakeholders, and community leaders.
- ii) If the RWHAP planning entity is not integrated with the CDC HIV Planning Group currently, please indicate what plans exist to integrate and/or what collaborative activities occur currently between the groups.

- 3) HIV Care Continuum:** The ultimate goal of HIV treatment is to achieve viral suppression. This is important for people with HIV to stay healthy, have improved quality of life, and live longer. People with HIV who maintain viral suppression have effectively no risk of passing HIV to others.

The HIV care continuum is a public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression. There are two approaches to monitor the HIV care continuum—the prevalence-based approach and the diagnosed-based approach. The prevalence-based HIV care continuum describes the number of people who are at each step of the continuum as a percentage of the total number of people with HIV (known as HIV prevalence). Prevalence includes both people whose infection has been diagnosed and those who have HIV but don't know it. The diagnosis-based HIV care continuum depicts each step as a percentage of the number of people with diagnosed HIV. For the purposes of this NOFO, a diagnosed-based HIV care continuum will be utilized. To be able to monitor progress across the HIV care continuum in a meaningful way, it is important to have standardized data elements that are both practical and feasibly implemented in RWHAP Part B/ADAP recipient jurisdictions. Each step of the diagnosed-based HIV care continuum outlined below includes specific definitions, including descriptions of the numerators and denominators, as described in the [CDC HIV Prevention Progress Report, 2019](#). Each step of the HIV Care Continuum is listed below:

- **Diagnosed:** Number of persons aged ≥ 13 years with HIV infection in the jurisdiction at the end of the calendar year.
- **Linked to Care:** Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.
 - Numerator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year who were

linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.

- Denominator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year.
- **Receipt of Care:** Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
- **Retained in Care:** Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
- **Viral Suppression:** Percentage of persons aged ≥ 13 years with HIV infection who had a viral load test result of < 200 copies/mL at the most recent viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed.
Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.

Note: Using the numerators and denominator descriptions above, provide a graphic depiction (i.e., bar chart) of the HIV care continuum for the jurisdiction.

- 4) **Unmet Need:** Unmet need is defined as the number of individuals with HIV in a jurisdiction who are aware of their HIV/AIDS status and are *not* in care. RWHAP legislation indicates that RWHAP Part B/ADAP recipients need to address unmet need by identifying, determining the needs, and facilitating interventions for individuals with unmet need.

HAB developed a new framework for recipients to report unmet need. This new Unmet Need Framework includes three components (late diagnosed, unmet need, and in care, but not virally suppressed) aimed at more broadly characterizing unmet need. In reporting estimates across each component of the unmet need framework, recipients must submit estimates using HIV surveillance data (the required method). In addition, recipients may submit estimates using RWHAP data (the enhanced method). Detailed information, training materials, and reporting tools, on the new unmet need framework are located on [TargetHIV](#).

The three components of the Unmet Need Framework are:

- a) Late Diagnosed:** (Required method only, HIV surveillance data) the number of late diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months after a new HIV diagnosis.
- b) Unmet Need:**
 - 1) (Required method, HIV surveillance data): Number/percent of people with HIV/aware with no CD4 or VL test in the most recent calendar year.
 - 2) (Enhanced method, RWHAP data): Number/percent of RWHAP clients with no CD4 or VL test or outpatient/ambulatory health services (OAHS) visit⁴ in the most recent calendar year.
- c) Not Virally Suppressed:**
 - 1) (Required method, HIV surveillance data): Number/percent of people with HIV/aware and in care that have a viral load ≥ 200 copies/mL at most recent test.
 - 2) (Enhanced method, RWHAP data): Number/percent of RWHAP clients in care that have a viral load ≥ 200 copies/mL at most recent test.

Submit Unmet Need Framework estimates as **Attachment 6** in your application. Tools developed to facilitate calculating and reporting the Unmet Need Framework estimates and the unmet need priority populations are located on [TargetHIV](#).

Based on the Unmet Need Framework estimates provided in **Attachment 6**, provide responses to the following:

- (a) Identify whether the enhanced method was utilized (in addition to the required method) to provide the Unmet Need Framework estimates. Describe any data system and/or other limitations that impacted your ability to provide these estimates.
- (b) Based on the estimates included in **Attachment 6**, describe the need(s) of the people in your jurisdiction who are 1) late-diagnosed, 2) have unmet need, and 3) are in care but not virally suppressed.

5) Co-occurring Conditions: Using the list below, provide the incidence and prevalence estimates describing the conditions co-occurring with HIV in the state/territory in a table format (submit as **Attachment 6**) and document the data sources used. Use most recently available data. If data are not available, provide a justification. The table must include:

- a) Hepatitis C virus**
- b) Sexually transmitted infection rates, including syphilis, gonorrhea, and chlamydia**
- c) Mental illness**
- d) Substance use disorder**
- e) Homeless/unstably housed**

⁴ Jurisdictions may choose to use other services to reflect HIV primary medical care. Any variation from the definitions should be clearly stated in documentation that accompanies the estimates.

f) Former incarceration

Note: You may include additional conditions unique to your jurisdiction, as applicable.

6) Complexities of Providing Care

- a) If the state/territory experienced a reduction in RWHAP Part B/ADAP formula funding last year (FY 2021), provide a narrative that addresses both the impact and response to the funding reduction, as outlined below. If not applicable, state “Not Applicable”.
 - i. Impact: The specific services that were eliminated or reduced, and by how much.
 - ii. Response: Any cost containment measures implemented (e.g., waiting lists, client cost-sharing, or other measures), stakeholder response to the reduction in funding, and any transitional plans implemented for clients who received services that were either eliminated or reduced.
- b) Provide, in a table format, current estimates on poverty and health care coverage status of people with HIV in your jurisdiction. Include the following information, as available:
 - i. The number and percentage of people with HIV who are enrolled in Medicaid, Medicare, and other health care coverage;
 - ii. The number and percentage of people with HIV who are uninsured, and;
 - iii. The number and percentage of people with HIV living at or below 138 percent and 400 percent of the FY 2021 FPL. Also, include the percentage of FPL used to determine RWHAP eligibility in the state/territory.
- c) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction.
 - i. Explain how coverage options in the jurisdiction negatively or positively influence access to direct health care services and health outcomes.
- d) Describe any relevant factors that limit access to health care including geographic variation, adequacy of health care coverage, language barriers, or other major social determinants of health, as applicable. If not applicable, state “Not applicable”.

7) Early Identification of Individuals with HIV/AIDS (EIIHA): The purpose of this section is to describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive. The goals of this initiative are to: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

Use the most current year’s data for persons at higher risk for infection to respond to the EIIHA plan section of the NOFO.

The CDC has published a series of statewide data sets reflecting the number of

people unaware of their HIV status. Use this data set reflecting the number of people unaware of their HIV status to develop your plan.

CDC Unaware State Tables

HIV Prevention Progress Report, 2019

(<https://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-preventionprogressreport.pdf>)

Describe the process for linking people identified in the EIIHA data to both prevention (for HIV negative clients) and care services (for HIV positive clients). Include a description of community partners and other resources utilized to provide these services and any major collaboration with other programs and agencies including HIV prevention and surveillance programs.

a) FY 2022 EIIHA Plan

The overarching goal of the EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and to ensure they are accessing HIV care and treatment.

- i. Describe the planned activities of the state/territory EIIHA Plan for FY 2022. Include the following information:
 - 1) The primary activities that will be undertaken, including system level interventions (e.g., routine testing in clinical settings, and expanding partner services);
 - 2) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs and the Ending the HIV Epidemic in the U.S. efforts in your state (if applicable); and
 - 3) The anticipated outcomes of the program's overall EIIHA strategy.
- ii. Describe how the proposed FY 2022 EIIHA Plan contributes to the goals of the [National HIV Strategic Plan 2021-2025](#) and the [Ending the HIV Epidemic in the U.S. initiative](#).
 - 1) List any innovative approaches that are used in the program's EIIHA plan to address barriers to assessing testing and treatment.
 - 2) List the collaborations being pursued within the program's EIIHA plan within the jurisdiction and with other public health stakeholders.
 - 3) Describe how the EIIHA data are used to analyze or address any gaps.
- iii. Describe how the Unmet Need estimate and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.
- iv. Describe how the EIIHA Plan for FY 2021 (e.g., process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2022.
- v. Describe any planned efforts to remove legal barriers, including state laws and regulations, to routine HIV testing.

- vi. Select three (3) distinct target populations for the FY 2022 EIIHA Plan. For each selected target population describe:
 - 1) Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
 - 2) The specific activities that will be undertaken with the target population;
 - 3) Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T. objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
 - 4) The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles; and
 - 5) Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.
- vii. Describe how efforts to impact the EIIHA population are evaluated in the state/territory.

▪ **METHODOLOGY**

- 1) **Third Party Reimbursement/Payor of Last Resort:** The RWHAP is the payor of last resort, and you must vigorously pursue alternate sources of payments. HRSA expects you to certify client eligibility every 12 months/annually and recertify eligibility at least every six (6) months (please see HAB PCNs 13-02, 13-03, 13-04, 14-01, and 18-01 at <https://hab.hrsa.gov/program-grants-management/policy-notice-and-program-letters>). You are required to use effective strategies to coordinate with third party payers that are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include, Medicaid, Children’s Health Insurance Programs (CHIP), Medicare, including Medicare Part D, basic health plans, and private insurance, including those purchased through the Health Insurance Marketplace. Subrecipients providing Medicaid eligible services must be Medicaid certified. Provide a narrative that describes the following:
 - a) The eligibility criteria for people with HIV who receive RWHAP Part B/ADAP funded services. Indicate the process for determining client eligibility for RWHAP Part B/ADAP at least every six (6) months.
 - b) How recipients/subrecipients document that people with HIV have been screened for and enrolled in eligible programs such as Medicare, Medicaid, private health insurance, the Marketplace plans, or other programs to ensure that RWHAP Part B/ADAP funds are the payor of last resort, as well as the frequency of this screening.
[Please see PCN 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements](#)
 - c) The process used by the state/territory to ensure that all recipients/subrecipients, including those funded through consortia or lead agencies, are

accessing, receiving, tracking and documenting third party reimbursement. Also describe the contract language or other mechanism(s) to ensure compliance (please see HAB PCNs 13-02, 13-03, 13-04, 14-01, and 18-01 at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>).

- 2) Consortia:** The RWHAP defines consortia as an entity or group of entities (public or private for-profit if such is the only available provider of quality HIV care in the area) that the RWHAP Part B/ADAP recipient funds to perform the following functions in a designated service area:
- Needs assessment, including identifying key populations and service delivery needs,
 - Planning, including alignment of developed plans with RWHAP Part B/ADAP recipient developed plans (e.g., Statewide Coordinated Statement of Need),
 - Delivery of comprehensive health and support services, either directly by the consortia or indirectly by subaward/contract,
 - Program and fiscal monitoring, including evaluation, and
 - Reporting, including required reports submitted to the RWHAP Part B/ADAP recipient and HRSA HAB.

All direct services to people with HIV provided by or through the consortia are considered support services and must be counted as part of the maximum 25 percent of funds that may be expended for such services. Please see 2613(f) of the PHS Act.

If the consortia is administering the RWHAP Part B award on behalf of the recipient (conducting planning, resource allocation, contracting, program and fiscal monitoring and required reporting), these expenditures would count toward the recipient's 10 percent limit on administrative expenses.

For states with consortia, please respond to the following:

- a)** List the funded consortia entities and the regional areas covered by the Consortia;
 - b)** Describe how the consortia conducts planning, resource allocation and contracting, program and fiscal monitoring, and required reporting;
 - c)** Provide a summary of the benefits of utilizing the consortia model for your state; and
 - d)** The state is fully accountable for activities within the consortia. Describe the policies in place to ensure that the state is fully providing fiscal and program monitoring.
- 3) Women, Infants, Children and Youth Proportionate Spending:** You are required to use a proportionate amount of your grant to provide services to women, infants, children and youth (WICY) living with HIV, unless a waiver is obtained. You demonstrate compliance with the WICY expenditure requirement in your annual progress report and may request a waiver as part of the annual progress report.

Describe the method used by the state/territory to document that it meets the legislative requirement for proportionate spending on services to WICY, or that it has obtained, or plans to obtain, a waiver.

- **WORK PLAN**

Describe the proposed activities of the RWHAP Part B. This should be presented in the form of an Implementation Plan Narrative, which is one component of the Implementation Plan. The other component of the Implementation Plan is the Implementation Plan Table.

You will only be required to submit an Implementation Plan Narrative with this NOFO application. The Implementation Plan Table will not be required at this time. You will provide the Implementation Plan Table with your Program Terms Report.

This work plan applies to Part B Base, ADAP Base, and ADAP supplemental so please include ADAP funded services, including ADAP Supplemental, in the Implementation Plan Narrative. A separate ADAP work plan is not required.

1) FY 2022 Implementation Plan Narrative: The FY 2022 Implementation Plan indicates the core medical and support service categories that are prioritized and funded by the jurisdiction's RWHAP Part B/ADAP in order to impact progress on the HIV care continuum. The Implementation Plan Table contains objectives and outcomes which are related to the stages of the HIV care continuum, and demonstrates how funded services are implemented to achieve positive health outcomes and to promote access to high quality HIV care. The Implementation Plan Narrative should provide details on the activities listed in the Implementation Plan Table.

Provide a narrative that describes the following:

- a) How the activities described in the plan will be used to address gaps/barriers and improve outcomes along the HIV care continuum;
- b) How the HIV care continuum is currently or may be in the future utilized in planning, prioritizing, targeting and monitoring available resources in response to needs of people with HIV in the jurisdiction, and in improving engagement at each stage in the HIV care continuum;
- c) Any significant health disparities (related to race or ethnicity, gender, sexual identity, age, disability, socioeconomic status and geographic location) among populations within your jurisdiction's HIV care continuum, and current or planned activities targeted to address these disparities;
- d) How the activities in the plan address Unmet Need and reduce the number of persons out of care;
- e) How the activities described in the plan will ensure geographic parity in access to HIV services throughout the state or territory;
- f) How the activities described in the plan will address the needs of emerging populations;
- g) How proposed FY 2022 allocations address significant issues and core service needs identified in the Integrated HIV Prevention and Care Plan;

- h) How the resources of AIDS Education and Training Centers (AETC) will be used in the development and implementation of RWHAP Part B/ADAP;
- i) How the services and their goals and objectives relate to the goals of the [Healthy People 2030](#) initiative, particularly the objectives related to the HIV listing under the Topics and Objectives tab; and
- j) Outreach and enrollment activities to enroll RWHAP clients into the health care coverage.

2) FY 2022 Minority AIDS Initiative (MAI) Planning and Implementation: The purpose of this section is to provide a narrative description of the state/territory's planning for and implementation of an MAI program to increase racial and ethnic minority populations' participation in the ADAP through MAI-funded education and outreach services. Respond to the applicable questions below:

a) If eligible to receive MAI funds, do you plan to accept MAI funds in FY 2022? (Respond yes or no)

If the state/territory is planning to decline MAI funds, please provide a brief explanation for the declination.

b) If you plan to accept the MAI funding, please address the following:

- i) Provide a description of the FY 2022 MAI planning process in terms of:
 - (a) How program results and data generated from previous MAI-funded outreach/education and/or other RWHAP Part B/ADAP funded outreach activities informed the planning for the use of FY 2022 MAI funding; and
 - (b) How people with HIV, particularly targeted minority individuals, provided input into the MAI planning process.
- ii) Describe how the following have been taken into consideration and how they will be coordinated with RWHAP Part B MAI funds:
 - (a) Education and outreach services provided by other RWHAP recipients within the state/territory that are intended to increase access to ADAP; and
 - (b) Education and outreach services funded by other federal, state, and local resources, such as CDC HIV Prevention Services, Medicaid, Medicare Part D, and Substance Abuse and Mental Health Services Administration substance abuse and mental health treatment services.
- iii) MAI Plan Narrative and ADAP Capacity: Please provide a narrative description of the state's FY 2022 MAI Plan to increase racial and ethnic minority populations' participation in the ADAP through MAI-funded education and outreach services. Include a description of how education and ADAP outreach services will be provided, in terms of:
 - (c) Targeted audiences;
 - (d) Targeted activities;
 - (e) Traceable clients (i.e., how will the state know if a client provided MAI-funded outreach and education has been enrolled in ADAP or another medication assistance program);
 - (f) Geographic locations;
 - (g) Types of agencies and staff to provide services;
 - (h) Coordination with existing services and providers; and
 - (i) Involvement of targeted minority populations in implementation of plan.

3) AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program): This section must be completed by all states/territories that have included funding for a Local Pharmaceutical Assistance Program (LPAP) in the application. The purpose of this section is to describe the need for an LPAP, including a description of the systems and activities required to effectively operate an LPAP. When a jurisdiction determines there is a need for medication assistance and decides to allocate funds to the LPAP service category, it must demonstrate that the decision was based on information identified through a formal needs assessment process. The needs assessment must determine that the state's/territory's ADAP does not adequately address the medication assistance needs of clients in the states/territories (e.g., existence of an ADAP waiting list, restrictive ADAP financial eligibility criteria, or a limited ADAP formulary). The needs assessment should also demonstrate that other resources are inadequate to meet the medication needs of clients residing in the states/territories.

In August 2013, HRSA HAB provided guidance on the LPAP requirements <https://hab.hrsa.gov/sites/default/files/hab/Global/lpapletter.pdf>.

Implementation of an LPAP involves the development of a drug distribution system that includes, but is not limited to: client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum every six months; an LPAP advisory board; uniform benefits for all enrolled clients; compliance with RWHAP requirement of payor of last resort; and a drug formulary approved by the local advisory committee/board. An LPAP may not be used to provide short-term or emergency medication assistance.

If you plan to use funds for an LPAP, describe the following:

- a) The need for an LPAP in detail; include how the ADAP, other RWHAP funded service categories, and other resources (e.g., pharmaceutical assistance programs, patient assistance programs, local/state funded medication assistance programs) are failing to meet the state's/territory's medication needs;
- b) The component of the medication need that the LPAP will fill;
- c) How the LPAP will be coordinated with the ADAP;
- d) The client enrollment and eligibility process including how payor of last resort is ensured;
- e) The existing LPAP advisory board composition; if this is a new service category, describe the process and timeframe for development of the LPAP advisory board;
- f) How the recipient ensures that the LPAP follows the most recent HHS HIV/AIDS Treatment Guidelines; and
- g) The mechanism to ensure "best price" for medications (e.g., 340B Drug Pricing Program and/or Prime Vendor Program).

▪ *RESOLUTION OF CHALLENGES*

Please describe challenges you anticipate encountering for any applicable area below and describe what approaches you plan to use to resolve those challenges.

- 1) Needs Assessment and Public Advisory Planning Process
- 2) HIV Care Continuum
- 3) Unmet Need
- 4) Early Identification of Individuals with HIV/AIDS
- 5) Third Party Reimbursement/Payor of Last Resort
- 6) Women, Infants, Children, and Youth (WICY) Proportionate Spending
- 7) Implementation Plan
- 8) Minority AIDS Initiative (MAI) Planning and Implementation
- 9) AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program)
- 10) Other

▪ *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

- 1) Clinical Quality Management:** Section 2618(b)(3)(E) of the PHS Act requires the establishment of a clinical quality management (CQM) program to:
- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines (otherwise known as the HHS Guidelines) for the treatment of HIV disease and related opportunistic infections; and
 - Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

For this application, please describe:

- 1) What changes have been made to your current CQM program based on previous years' experience, outcomes, etc.
- 2) How CQM data improved patient care, health outcomes, patient satisfaction, and/or change service delivery in the jurisdiction, including strategic long-range service delivery planning.
- 3) What challenges you have or anticipate in implementing CQM activities.

ADAP should be included in this CQM description.

CQM Plan:

You will be required to submit an updated CQM Plan as a reporting requirement 90 (ninety) days after the award is made with the Program Terms Report. A CQM Plan describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and responsible parties, and evaluation of the CQM program.

More information about the HRSA RWHAP expectations for CQM programs is in:

- [PCN 15-02 Clinical Quality Management Policy Clarification Notice](#) and [Frequently Asked Questions](#)
- [HIV/AIDS Bureau Performance Measures](#)
- [HHS HIV/AIDS Clinical Guidelines](#)
- [HIV/AIDS Bureau Part B Monitoring Standards \(Part B specific, Universal Monitoring Standards, and Frequently Asked Questions\)](#)
- [HIV/AIDS Bureau Part B Manual](#)
- [HIV/AIDS Bureau ADAP Manual](#)

▪ *ORGANIZATIONAL INFORMATION*

1) Recipient Administration and Accountability: The purpose of this section is to demonstrate the extent to which the CEO in the state/territory has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure that the state/territory has complied with the RWHAP legislative mandates for payor of last resort, MOE, and the minimum expenditure requirement to provide services to women, infants, children, and youth.

a) Program Organization

Provide a description of how RWHAP Part B/ADAP funds are administered in the state/territory. This should reference positions described in the budget narrative and organizational chart, including the fiscal staff that are located outside of the RWHAP Part B/ADAP. Include an organizational chart in **Attachment 1**.

b) Fiscal and Program Monitoring

HRSA HAB holds recipients accountable for the expenditure of funds awarded under the RWHAP Part B/ADAP, and expects recipients to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV services in the state/territory, including contracts with consortia. You are also required to have on file a copy of each subrecipient's procurement documents (contracts), and fiscal and programmatic site visit reports. The requirements are outlined in the [Uniform Administrative Requirements, Cost Principles, and Audit Requirement for HHS Awards \(45 CFR part 75\)](#) - Subrecipient Monitoring and Management (45 CFR § 75.351 and 352) and [National Monitoring Standards](#).

Provide a narrative that describes the following:

- i) The roles and responsibilities of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of program expenditures and program revenue (including program income and medication rebates). Describe the process and coordination methods used by program and fiscal staff to ensure adequate and accurate tracking, reporting, and reconciliation of program expenditures and program revenue (including program income and medication rebates);

- ii) The process used to separately track RWHAP Part B Base, ADAP Base, ADAP Supplemental (if applicable), EC (if applicable) and MAI (if applicable) grant funds; medication rebates (if applicable); program income (if applicable); and the unobligated and carryover funds for each of these grant fund categories as applicable. Include information about the data system(s) utilized to track funds;
- iii) Process and mechanisms used to ensure that providers funded through multiple RWHAP parts (i.e., Parts A, B, C, D, or F) are able to accurately track clients and expenditures and avoid duplication of services;
- iv) The process used for fiscal and program monitoring, including the type and frequency of required reports;
- v) The process and timeline for corrective actions when a fiscal or program-related concern is identified;
- vi) The process, including a timeline, for receiving vouchers or invoices from providers/subrecipients; the process, including a timeline, for issuing payments to providers/subrecipients, from receipt of voucher/invoice to reimbursement;
- vii) If the state/territory has an approved annual site visit exemption, describe the state/territory's compliance with the terms of the exemption.
- viii) Provide the following information about the monitoring site visits that were performed:
 - (a) The total number of subrecipients, including consortia, funded in FY 2021;
 - (b) The total number and percentage of subrecipients that received a monitoring site visit in FY 2021;
 - (c) The total number of subrecipients expected to receive a monitoring site visit by the end of FY 2021;
 - (d) Whether each site visit included both fiscal and programmatic monitoring. If not, how the state/territory will ensure that both fiscal and programmatic site visit monitoring occurs for each subrecipient;
 - (e) The number of findings (including improper charges by subrecipients) identified in monitoring site visits in FY 2021. Identify the corrective actions planned or taken to resolve the findings identified;
 - (f) The number of subrecipients that received technical assistance (TA) during FY 2021, including the types, scope, and timeline of the TA provided.
 - (g) The number and percentage of eligible subrecipients compliant with audit requirements in 45 CFR Part 75, Subpart F. Indicate if there were any findings in subrecipients' single audit reports. Describe the measures taken by the recipient to ensure that subrecipients have taken appropriate corrective action.
 - (h) For those applicants with consortia, describe the state's monitoring requirements for consortia in relation to their subrecipients, including how those requirements and processes are compliant with the requirements outlined in the National Monitoring Standards.
- ix) Describe other monitoring practices if on-site visits did not occur.

2. Pacific Island Jurisdictions' FY 2022 Part B Base Grant Application

This Section is to be completed by the following applicants only:

- The Republic of the Marshall Islands
- The Federated States of Micronesia
- The Republic of Palau
- American Samoa
- The Commonwealth of the Northern Mariana Islands

Note: For those territories that are eligible to apply for the ADAP Supplemental, please refer to and complete the [FY 2022 ADAP Supplemental Grant Application Section](#).

▪ INTRODUCTION

This section should briefly describe how the territory will utilize RWHAP Part B Base grant funds in support of a comprehensive continuum of high-quality care and treatment for people with HIV.

▪ NEEDS ASSESSMENT

- 1) **The Territory's HIV/AIDS Epidemiology:** The purpose of this section is to briefly describe the HIV/AIDS epidemic in the territory. Section 2617 (b)(2) of the PHS Act states that the application for RWHAP Part B funds shall contain a determination of the size and demographics of the population of people with HIV in the territory.

Please note that both the Epidemiology Table and Narrative should be included as **Attachment 9**.

a) Table

Summarize in a table format the HIV (non-AIDS) and AIDS cases by age, race/ethnicity, and exposure category through December 31, 2020. Place the table in **Attachment 9** of the application and clearly label the data sources.

b) Narrative

Based on the most recent territory HIV/AIDS Epidemiologic Profile, provide a narrative description of trends in the age, race/ethnicity, and exposure categories for prevalent cases and for cases newly diagnosed and reported in the previous two years for which data are available. Place the narrative in **Attachment 9** of the application.

2) The Territory's Planning Process

- a) Identify the planning entity and mechanism the territory uses to make decisions about RWHAP Part B/ADAP funds. Discuss the participation of people with HIV in the planning process, including what the territory is doing to encourage and support their participation in this process.
- b) If the planning entity is not currently integrated with the CDC HIV Planning Group, please indicate if there are plans to integrate and/or what collaborative activities occur currently between the groups.

c) Discuss how allocation decisions are made between geographically or politically separate areas, and who is involved in making these decisions.

3) **HIV Care Continuum:** The ultimate goal of HIV treatment is to achieve viral suppression. This is important for people with HIV to stay healthy, have improved quality of life, and live longer. People with HIV who maintain viral suppression have effectively no risk of passing HIV to others.

The HIV care continuum is a public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression. There are two approaches to monitor the HIV care continuum—the prevalence-based approach and the diagnosed-based approach. The prevalence-based HIV care continuum describes the number of people who are at each step of the continuum as a percentage of the total number of people with HIV (known as HIV prevalence). Prevalence includes both people whose infection has been diagnosed and those who have HIV but don't know it. The diagnosis-based HIV care continuum depicts each step as a percentage of the number of people with diagnosed HIV. For the purposes of this NOFO, a diagnosed-based HIV care continuum will be utilized. To be able to monitor progress across the HIV care continuum in a meaningful way, it is important to have standardized data elements that are both practical and feasibly implemented in RWHAP Part B/ADAP recipient jurisdictions. Each step of the diagnosed-based HIV care continuum outlined below includes specific definitions, including descriptions of the numerators and denominators, as described in the [CDC HIV Prevention Progress Report, 2019](#). Each step of the HIV Care Continuum is listed below:

- **Diagnosed:** Number of persons aged ≥ 13 years with HIV infection in the jurisdiction at the end of the calendar year.
- **Linked to Care:** Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.
 - Numerator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with newly diagnosed HIV infection during the calendar year.
- **Receipt of Care:** Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
- **Retained in Care:** Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed

HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.

- Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.
- **Viral Suppression:** Percentage of persons aged ≥ 13 years with HIV infection who had a viral load test result of < 200 copies/mL at the most recent viral load test during the calendar year.
 - Numerator: Number of persons aged ≥ 13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed.
 - Denominator: Number of persons aged ≥ 13 years with HIV infection diagnosed by previous year-end and alive at year-end.

Note: Using the numerators and denominator descriptions above, provide a graphic depiction (i.e., bar chart) of the HIV care continuum for the jurisdiction.

4) Unmet Need

Describe the strategy for identifying people with HIV, what HIV resources are available, disparities in access and/or services, and what outreach efforts the territory plans for outreach and enrollment in care.

5) Complexities of Providing Care

Describe any relevant factors that limit access to health care including geographic variation, adequacy of health care coverage, language barriers, or other major social determinants of health, as applicable. If not applicable, state "Not applicable".

▪ *METHODOLOGY*

- 1) **The Territory's HIV/AIDS Care System:** Describe the territory's HIV system of care in 2022 (i.e., primary medical care, supportive services that enable people to access and remain in HIV primary care, and other health and supportive services that promote health and enhance quality of life). Include the following:
 - a) The strategy for identifying people with HIV who do not know their status, making such people aware of their status, and enabling such people to access services. Focus the response using the below guidelines.
 - b) The goals for the strategy. Describe how the strategy contributes to the goals of [HIV National Strategic Plan 2021 – 2025](#).
 - c) A timetable for achieving the goals and coordination with other community stakeholders.
 - d) A description of the current availability and limits of HIV resources and services to provide HIV care, including eligibility criteria.
 - e) A description of any plans to increase the availability of HIV care or to build capacity of HIV care in the territory.
 - f) A discussion of any disparities in access or services among affected sub-populations or communities.
 - g) A description of efforts to inform people with HIV about services and to engage people in HIV care.

- h) A description of how the Medicaid program, if applicable in the territory, provides services to people with HIV, including eligibility, and which HIV services are covered by Medicaid.
- i) A description of how HIV counseling and testing services are designed to help access to care for people testing positive for HIV. In addition, describe any other linkages with early intervention services.

- *WORK PLAN*

Describe the proposed activities of the RWHAP Part B. This should be presented in the form of an Implementation Plan Narrative, which is one component of the Implementation Plan. The other component of the Implementation Plan is the Implementation Plan Table.

You will only be required to submit an Implementation Plan Narrative with this NOFO application. The Implementation Plan Table will not be required at this time. You will provide the Implementation Plan Table with the Program Terms Report.

This work plan applies to Part B Base, ADAP Base, and ADAP supplemental, so please include ADAP funded services, including ADAP Supplemental, in the Implementation Plan Narrative. A separate ADAP work plan is not required.

FY 2022 Implementation Plan Narrative: The FY 2022 Implementation Plan indicates the core medical and support service categories that are prioritized and funded by the territory's RWHAP Part B in order to impact progress on the HIV care continuum. The Implementation Plan contains objectives and outcomes which are related to the stages of the HIV care continuum, and demonstrates how funded services are implemented to achieve positive health outcomes and to promote access to high quality HIV care.

Provide a narrative that describes the following:

- 1) How the activities described in the plan will be used to address gaps/barriers and improve outcomes along the HIV care continuum;
- 2) How the HIV care continuum is currently or may be in the future utilized in planning, prioritizing, targeting and monitoring available resources in response to needs of people with HIV in the territory, and in improving engagement at each stage in the HIV care continuum;
- 3) Any significant health disparities (related to race or ethnicity, gender, sexual identity, age, disability, socioeconomic status, and geographic location) among populations within your territory's HIV care continuum, and current or planned activities targeted to address these disparities;
- 4) How the activities in the plan address Unmet Need and reduce the number of people out of care;
- 5) How the activities described in the plan will ensure geographic parity in access to HIV services throughout the territory;
- 6) How the activities described in the plan will address the needs of emerging populations;
- 7) How proposed FY 2022 allocations address significant issues and core service

- needs identified in the Integrated HIV Prevention and Care Plan;
- 8) How the services and their goals and objectives relate to the goals of the [Healthy People 2030](#) initiative, particularly the objectives related to the HIV listing under the Topics and Objectives tab; and
 - 9) Outreach and enrollment activities to enroll RWHAP Part B clients into health care coverage.

▪ *RESOLUTION OF CHALLENGES*

The purpose of this section is to describe any challenges that may occur in implementing the proposed activities that are described in the Work Plan and the approaches that will be used to address these challenges.

▪ *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

- 1) **FY 2022 Implementation Plan:** Describe the data and process that will be used to monitor the Implementation Plan.
- 2) **Clinical Quality Management:** Section 2618(b)(3)(E) of the PHS Act requires the establishment of a CQM program to:
 - Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines (otherwise known as the HHS Guidelines) for the treatment of HIV disease and related opportunistic infections; and
 - Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

You will be required to submit an updated CQM plan 90 (ninety) days after the award is made, with the Program Terms Report.

For this application, please describe:

- 1) What changes have been made to your current CQM program based on previous years' experience, outcomes, etc.
- 2) How CQM data improved patient care, health outcomes, patient satisfaction, and/or change service delivery in the jurisdiction, including strategic long-range service delivery planning.

ADAP should be included in this CQM description.

CQM Plan:

You will be required to submit an updated CQM Plan as a reporting requirement 90 (ninety) days after the award is made, with the Program Terms Report. A CQM Plan describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and responsible parties, and evaluation of the CQM program.

More information about the HRSA RWHAP expectations for CQM programs is in:

- [PCN 15-02 Clinical Quality Management Policy Clarification Notice](#) and [Frequently Asked Questions](#)
- [HIV/AIDS Bureau Performance Measures](#)
- [HHS HIV/AIDS Clinical Guidelines](#)
- [HIV/AIDS Bureau Part B Monitoring Standards \(Part B specific, Universal Monitoring Standards, and Frequently Asked Questions\)](#)
- [HIV/AIDS Bureau Part B Manual](#)
- [HIV/AIDS Bureau ADAP Manual](#)

▪ **ORGANIZATIONAL INFORMATION**

This section should describe the organizational structure and resources that contribute to the administration of the territory's RWHAP in compliance with legislative requirements and program expectations.

1) The Territory's Organizational Structure: Within the territory's structure, identify the proposed entity or entities responsible for managing and administering Part B Programs, including health ministry or department, unit, staff, fiscal agents, and planning/advisory evaluation bodies. Highlight any changes that occurred over the past year or that are planned for the next year.

- a) Identify the entity responsible for financial management of the Part B Program, including health ministry or department.
- b) Describe how the fiscal and program entities work together to fulfill grant-related reporting and monitoring responsibilities.

2) The Territory's Ryan White HIV/AIDS Program Coordination of Planning and Services

a) **Coordination with other Federal Programs:**

- i) Describe how the Part B program coordinates HIV funding and service delivery with non-RWHAP programs.
Examples Include: Other HRSA funded programs (including Maternal and Child Health, Migrant Health Programs, and Community Health Clinics); CDC (Prevention, Surveillance, STD programs); Medicaid (including Medicaid managed care); Medicare; Veterans Affairs programs; territory funds; and other programs/initiatives (such as substance abuse prevention and treatment services or territory social and welfare services).
- ii) For those territories eligible for Global AIDS Funds, describe any ongoing or planned activities the territory is participating in through the Global AIDS Fund and how these activities are coordinated with the Part B program.

B) FY 2022 AIDS Drug Assistance Program (ADAP) Grant Application

This Section is to be completed by the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau.

The purpose of this section is to describe the state/territory's ADAP. ADAPs ensure access to medication to treat HIV for eligible clients through the direct purchase of medication and through covering the costs of health care coverage premiums, medication copays, and deductibles. ADAP eligibility is determined by the state or territory and includes verification of HIV status, financial eligibility, and residency eligibility criteria. Financial eligibility is usually determined as a percentage of the FPL. You are required to determine client eligibility on an annual/12 month basis and to recertify eligibility at least every six months.

There are instances when the steady growth in the number of eligible clients combined with rising costs of complex HIV treatments has resulted in states/territories experiencing greater demand for ADAP services than available resources can cover. As a last resort, a state/territory may implement an ADAP waiting list when adequate funding is not available to provide medications to all eligible persons requesting enrollment in their ADAP and after all other feasible cost-containment strategies have been utilized. HRSA HAB defines a waiting list as a register of individuals who have applied for and been deemed eligible for a state's/territory's ADAP, but who the state cannot immediately serve due to insufficient resources. ADAPs with waiting lists are required to verify program eligibility for all individuals on a waiting list and prioritize individuals by a pre-determined criterion. The ADAP manages the waiting list to bring clients into the program as funding becomes available.

Cost-containment strategies employed by ADAPs can include cost-cutting and cost-saving measures.

Examples of cost-cutting measures include:

- reductions in ADAP financial eligibility below 300 percent of the FPL;
- capped enrollment;
- formulary reductions with respect to antiretroviral and/or medications to treat opportunistic infections and complications of HIV disease; and/or
- restrictions with respect to ADAP health care coverage eligibility criteria.

Examples of cost-saving measures include:

- RWHAP Part B/ADAP structural or operational changes such as expanding health care coverage;
- strategies to increase enrollment in health care coverage;
- improved systems and procedures for collection of rebates and/or program income; and
- data-sharing agreements to facilitate coordination of benefits.

ADAPs are required to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds. As covered entities, ADAPs are eligible to participate in the 340B Drug Pricing Program under Section 340B of the PHS Act. Funds received as a result of participating in the 340B Drug Pricing Program must be returned to the state/territory RWHAP Part B/ADAP, with priority given to ADAP. You must ensure that you use rebates and program income consistent with RWHAP requirements. Please see the following PCNs for more information:

- [PCN 15-03: Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income](#)
- [PCN 15-04: Utilization and Reporting of Pharmaceutical Rebates](#)
- [Frequently Asked Questions for Policy Clarification Notices 15-03 and 15-04](#)

▪ *INTRODUCTION*

This section should briefly describe how the project will use grant funds to pay for ADAP-allowable services, including medication assistance, health care coverage assistance, and, through the Flexibility Policy, services that enhance access, adherence, and monitoring of medication treatment.

▪ *NEEDS ASSESSMENT*

This section should provide a detailed description of the need for funding for ADAP services in the state/territory, providing the information as requested below:

a) ADAP Enrollment and Utilization

- Discuss the driving factors for any significant increases or decreases in the ADAP enrollment and/or utilization in the past year (e.g., MAI Outreach, EIIHA activities, CDC testing initiatives, Health Insurance Marketplace enrollment, Medicaid expansion, increase in clients due to new diagnosis, re-engagement in care, loss of income, and/or loss of health care coverage), or any anticipated increases or decreases in FY 2022; and
- Provide a narrative that explains how ADAP services are equally and consistently available to all eligible enrolled individuals throughout the state/territory, including clients in outlying or rural areas.

b) ADAP Funding Resources

- Provide a table that lists all sources of funds for the ADAP Program (e.g., ADAP Base, state funds, other RWHAP funds, rebates, program income) for FY 2021 and those anticipated for FY 2022. The table should be included as **Attachment 4**.
- Provide a brief narrative that describes any changes to the funding from FY 2021 to FY 2022; and, if there are anticipated funding shortfalls for ADAP in FY 2022, the amount of and reason for the shortfall.

▪ *METHODOLOGY*

This section should describe the methods that you will use to address the need for ADAP medication and health care coverage assistance in the state/territory. Provide information as requested below:

1) Eligibility Determination and Recertification

Provide a brief description of each of the following:

- a) How the state/territory ensures that eligibility criteria are consistently applied across the state/territory;
- b) How the state/territory ensures the timeliness of eligibility determination, including the current timeframe from the receipt of a complete application to initial ADAP eligibility determination; and
- c) The state/territory's process for annual certification and six month recertification, including the level of documentation required for each. Include any changes that have been implemented as a response to the COVID-19 pandemic.

2) Formulary

Provide a brief description of each of the following:

- a) Whether the state/territory added or removed drugs from the formulary in the past year. If so, the reason for and the process followed for adding/ removing drugs; and
- b) If/how the state/territory utilizes an advisory body to inform decisions on ADAP formulary and operations.

3) Payor of Last Resort

Provide a description of each of the following:

- a) How the ADAP ensures it does not pay for any cost when there is another public or private payer available to cover the cost;
- b) How the ADAP ensures compliance with HRSA's mandate to vigorously pursue expeditious enrollment into health care coverage for which clients may be eligible, and how such efforts are documented;
- c) The process by which ADAP back-bills other payers (including Medicaid) when clients are determined to be eligible for other programs that provide prescription drugs; and
- d) Whether or not the ADAP has executed a data-sharing agreement with the Centers for Medicare & Medicaid Services. If yes, briefly describe any benefits and challenges of the data-sharing agreement. If no, explain why the ADAP has not executed a data-sharing agreement and any plans for executing an agreement.

4) Medication Assistance

ADAPs are required to use every means at their disposal to secure the best price available for all products on the ADAP formularies in order to achieve maximum results with these funds. Provide answers to each of the questions below:

a) Drug Pricing

- Does your ADAP participate in the 340B program?
 - If yes:

- How is the ADAP registered as a 340B covered entity status: Direct Purchase, Rebate, or both?
- Does the program participate in the 340B Prime Vendor Program?
- How does the ADAP ensure compliance (for itself and any contractors) with 340B program rules (e.g., prohibition on drug diversion, and duplicate discounts)?
- If no, how does the ADAP ensure it is receiving the best price available for medications?
- In addition to participation in the 340B program, describe the ADAP's current cost-saving practices, including participation with ADAP Crisis Task Force negotiated discounts.

b) Drug Distribution System

Provide a brief description of the drug distribution system used by the state/territory's ADAP. Include each of the following elements, as relevant:

- Provide the name of the wholesaler;
- Provide the name of the pharmacy benefits manager (PBM) and the services provided; and
- Describe the pharmacy/pharmacy network (e.g., national drug chain, mail order, state health department pharmacies, local pharmacies, university or disproportionate share hospital pharmacy), including the number of contract pharmacies.

c) ADAP-generated revenue

Provide a brief description of any revenue generated by the state/territory's ADAP. Include each of the following elements, as relevant:

- If the ADAP generates rebates, describe the mechanisms and timelines used by the state/territory to identify, request, track, and utilize rebates. Describe how the state/territory ensures that manufacturers' rebates are utilized consistent with [PCN 15-04 Utilization and Reporting of Pharmaceutical Rebates](#).
- If the ADAP generates program income, describe how the program income is generated, and the process used by the state/territory to track, utilize and report program income consistent with [PCN 15-03: Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income](#).

5) Health Care Coverage Assistance

The RWHAP allows state/territory ADAPs to purchase health care coverage and assist with medication co-payments, co-insurance and deductibles, as described in [PCN 18-01 Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance](#). Provide information as requested below:

a) Notification of Intent

Does the ADAP plan to utilize funds for health care coverage assistance in FY 2022? Respond yes or no.

- If yes, please specify which of the following components of health care coverage assistance will be provided: premium payment, medication co-payment assistance, medication co-insurance assistance, and/or medication deductible assistance.
- If no, please describe why the ADAP does not provide health care

coverage assistance, and whether the ADAP is planning to provide health care coverage assistance in the future; then skip to item 6.

b) Minimum Coverage Standards

Describe how the state/territory ensures that the health care coverage to be purchased includes at least one drug in each class of core antiretroviral therapeutics from the [HHS HIV/AIDS Clinical Guidelines](#) as well as appropriate primary care services.

c) Cost-Effectiveness

Provide the methodology used to determine that the purchase of health care coverage is cost effective compared to the cost of medications in the aggregate.

For more information please see the PCNs located at

<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>

6) Flexibility Policy as it Relates to Access, Adherence and Monitoring Services

The RWHAP legislation allows for a percentage of a recipient's ADAP award be used to "encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring." States may request to redirect up to five (5) percent of their ADAP base award for these services under this policy, and up to ten (10) percent in 'extraordinary circumstances.' The amount that a recipient can request to be redirected is in addition to the aggregate of 15 percent of ADAP funds allowed for administrative, planning and evaluation costs. In order to be eligible to utilize funds under the flexibility policy, the states/territories cannot have any program restrictions. Address each of the issues below:

a) Notification of Intent

Do you plan to utilize part of the ADAP award for access, adherence and/or monitoring services in FY 2022? Respond yes or no.

- If yes, what percentage (up to 5 percent, or 10 percent in 'extraordinary circumstances') of the ADAP base award do you plan to redirect to pay for the proposed services?
- If no, please skip to the next section.

b) Proposed Program

Provide a narrative description that includes:

- Proposed services to be funded (access, adherence, and/or monitoring) and the amount budgeted for each service area;
- The unit cost for each proposed service area (e.g., cost for billable hours for adherence and access services, lab services, etc.), and the methodology used to determine the cost; and
- The number of clients who will directly benefit from each of the proposed services.

c) 'Extraordinary Circumstances' Clause

If the recipient plans to redirect >five (5) percent and up to 10 percent of the ADAP base award under this policy, describe:

- Why the additional amount is essential to addressing access, adherence and/or monitoring within the state/territory's ADAP; and

- How the program ensures the redirection of funds does not diminish the availability of medication assistance for ADAP-eligible clients.

More information on the ADAP Flexibility Policy can be found in the [HIV/AIDS Bureau ADAP Manual](#).

- **WORK PLAN**

The intent of this section is to describe the activities proposed for ADAP in the Methodology section above. The Implementation Plan Narrative and CQM information provided in Section (A), the FY 2022 Part B Base Grant Application, applies to this ADAP section (i.e., all ADAP-funded services should be included in the Implementation Plan Narrative and CQM information). Therefore, **the submission of a separate ADAP work plan and CQM information is not needed.**

- **RESOLUTION OF CHALLENGES**

Provide answers to each of the issues below:

- 1) **Potential Challenges and Proposed Solutions**

Briefly discuss any challenges that may be encountered in the implementation of ADAP activities described above in the Work Plan and CQM Plan, and approaches that will be used to resolve such challenges.

- 2) **Waiting List**

Does the state/territory currently have a waiting list or anticipate implementing a waiting list in FY 2022? Respond yes or no. If no, skip to the following section. If yes, also respond to the following questions:

- a) Has the state/territory established written policies and procedures for the establishment and monitoring of a waiting list?
- b) What factors (e.g., state general fund cuts, increased enrollment, increased costs of medications or health care coverage premiums, etc.) contributed/are contributing to the decision to implement/maintain an ADAP waiting list?
- c) How have stakeholders (e.g., ADAP Advisory Body, people with HIV, providers) been involved in the decision to begin a waiting list?
- d) What is the process for communicating the implementation of a waiting list to stakeholders, providers, people with HIV, case managers and eligibility specialists?
- e) What preventative measures and cost containment measures have been/are being implemented prior to implementing a waiting list (e.g., formulary reduction, reducing income eligibility, cutting support or core medical services funding)?
- f) What mechanisms are being used to monitor status and adequacy of the ADAP (e.g. budget forecasting measures utilized, tracking of rebates and program income, submission of rebates to pharmaceutical companies, etc.)?
- g) What is the process the program for training and informing people with HIV, physicians, providers, eligibility specialists and case managers about the availability of medications through the Pharmaceutical Manufacturer Patient Assistance Programs (PAP)? If applicable, address any challenges clients, case managers, physicians, eligibility specialists and/or providers are facing in

enrolling clients on PAP; and any steps the program has taken to assist in meeting these challenges.

▪ *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

Describe the data and process that will be used to monitor the ADAP-specific objectives listed in the FY 2022 RWHAP Part B (X07) Implementation Plan.

▪ *ORGANIZATIONAL INFORMATION*

This section should describe the organizational structure and resources that contribute to the administration of the ADAP in compliance with legislative requirements and program expectations.

1) **Agency Oversight/Administration**

Provide a brief description of the management/administration structure of the ADAP. Include an organizational chart if the ADAP is administered by a different agency. Place this chart in **Attachment 1**.

2) **Contract Oversight**

Describe the state/territory mechanisms for monitoring ADAP-related contracts or subcontracts to ensure compliance with legislative requirements and program expectations.

C) FY 2022 ADAP Supplemental Award Application

Section 2618(a)(2)(F)(ii) of the PHS Act states that five percent of the ADAP appropriation will be reserved as supplemental funding to purchase medications for states and territories with demonstrated severe need. A state/territory must meet certain established criteria in order to be eligible to apply for an ADAP Supplemental Grant.

See [Section III. 1](#) of this NOFO for complete eligibility information for ADAP Supplemental Grant awards.

States/territories are eligible if they responded “YES” to any of the following questions on any of the following criteria **on the 2020 ADAP Data Report (ADR)**:

- a) Income Eligibility criteria equal to or less than 200 percent of Federal Poverty Level (FPL)(Question 2 of the ADR Recipient Report)
- b) Limited formulary compositions for all core classes of antiretroviral medications (Question 7a of the ADR Recipient Report);
- c) One or more of the following ADAP Limits: waiting list, capped enrollment, or capped expenditures (Question 1 of the ADR Recipient Report).

If you apply but are deemed ineligible, you will not receive supplemental funding.

Note: If you have any questions or concerns about your eligibility, please contact Susan Robilotto (srobilotto@hrsa.gov).

Use of ADAP Supplemental Grant Funds

States/territories must use ADAP Supplemental funds to provide HIV-related medications, health care coverage assistance, or the devices needed to administer the medications.

State Match Requirement for ADAP Supplemental Grant Funds

The ADAP Supplemental Grants require a state match of 25 percent (i.e., \$1 for each \$4 of federal funds provided), unless a waiver is requested and approved (Section 2618(a)(2)(F)(ii)(III) of the PHS Act). A state/territory is eligible for a waiver from the match requirement for ADAP Supplemental funding if it also has a state match requirement for the RWHAP Part B Formula/ADAP Base funding, and it meets that match requirement. If the state/territory is requesting a waiver to the match, please attach a waiver request letter as **Attachment 8**. Submit this request along with the other application information.

▪ *INTRODUCTION*

Provide the following information:

- c) A description of how the state/territory will use ADAP Supplemental funds for medication assistance in order to address one or more of the ADAP Supplemental eligibility criteria.
- d) ADAP Supplemental Grants require a state match of 25 percent, unless a waiver is requested and approved.
 - Is the state/territory submitting a state match waiver (as **Attachment 8**) with this application? Respond yes or no.
 - If yes, skip to the next section.
 - If no, please provide the maximum match dollar amount (and corresponding maximum grant dollar amount) the state/territory would be able to meet (e.g., the state can meet up to \$25,000 in state match, for a maximum grant award of \$100,000).

▪ *NEEDS ASSESSMENT*

This section should provide a description of the need for ADAP Supplemental funding in the state/territory, providing the information as requested below:

- 1) Describe the severity of need for ADAP Supplemental funds as framed by the following eligibility criteria. Specify if a criterion is not relevant to the need for ADAP supplemental funds.
 - a) Financial requirement of FPL = or <200 percent;
 - b) Limited formulary compositions for all core classes of antiretroviral medications;
 - c) Waiting list, capped enrollment, or capped expenditures; and
 - d) An unanticipated increase of eligible individuals with HIV.
- 2) Describe any other factors impacting the severity of need for ADAP Supplemental funds.

- **METHODOLOGY**

This section should describe the methods that you will use to address the need for ADAP Supplemental funding.

- **WORK PLAN**

The intent of this section is to describe the activities proposed for ADAP Supplemental funds in the Methodology section above. The Implementation Plan and CQM Plan information provided in Section (A) of this FY 2022 Part B Base Grant Application applies to this ADAP Supplemental section (i.e., all ADAP- funded services, including ADAP Supplemental, should be included in the Implementation Plan). Therefore, the submission of a separate ADAP Supplemental work plan is not required.

- **RESOLUTION OF CHALLENGES**

The responses provided to ‘Resolution of Challenges’ in the ADAP Base section of this FY 2022 Part B Base Grant Application apply to this section. No further information is required for this section.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

The responses provided to ‘Evaluation and Technical Support Capacity’ in the ADAP Base section of this FY 2022 Part B Base Grant Application apply to this section. No further information is required for this section.

- **ORGANIZATIONAL INFORMATION**

The responses provided to ‘Organizational Information’ in the ADAP Base section of this FY 2022 Part B Base Grant Application apply to this section. No further information is required for this section.

D) FY 2022 Emerging Communities (EC) Grant Application

This Section should be completed only by eligible applicants. *The following states are responsible for applying for the eligible Metropolitan Statistical Area (MSAs) below:*

States	Emerging Communities
Alabama	Birmingham-Hoover, AL MSA
California	Bakersfield, CA MSA
Delaware	Philadelphia-Camden-Wilmington, PA-NJ-DE-MD MSA
Florida	Lakeland-Winter Haven, FL MSA Port St. Lucie, FL MSA North Port-Sarasota-Bradenton, FL MSA
Georgia	Augusta-Richmond County, GA-SC MSA
Kentucky	Louisville/Jefferson County, KY-IN MSA
Mississippi	Jackson, MS MSA

New York	Albany-Schenectady-Troy, NY MSA Buffalo-Niagara Falls, NY MSA Rochester, NY MSA
North Carolina	Raleigh, NC MSA
Ohio	Cincinnati, OH-KY-IN MSA
Oklahoma	Oklahoma City, OK MSA
Pennsylvania	Pittsburgh, PA MSA
Rhode Island	Providence-Warwick, RI-MA MSA
South Carolina	Columbia, SC MSA Charleston-North Charleston, SC MSA
Virginia	Richmond, VA MSA
Wisconsin	Milwaukee-Waukesha-West Allis, WI MSA
Total: 16 States	Total: 21 Emerging Communities

*The list of RWHAP Part B ECs uses the most recent MSA names pursuant to OMB Bulletin 20-01. Only the EC MSA names have been updated; the MSA codes and boundaries remain the same. Source: <https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf>. The AIDS cases for determining eligibility have been reported to and confirmed by the Director of the CDC, based on the boundaries that were in effect when the EC first received funding.

EC formula awards are based on the number of reported living cases of AIDS within a specific MSA in the most recent calendar year as confirmed by CDC and submitted to HRSA.

Program Authority and Eligibility: The EC Supplemental Grant award is authorized under Section 2621 of the PHS Act. It is intended to enable states to supplement RWHAP Part B services in communities with emerging HIV epidemics within the state. A state receiving EC funding must ensure that the grant will be used only within the EC in the state.

See [Section III. 1](#) of this NOFO for complete eligibility information for EC Supplemental Grant awards.

▪ *INTRODUCTION*

The purpose of the EC Supplemental Funds under RWHAP Part B is to enhance a comprehensive array of RWHAP core and supportive services for communities in need within the MSAs that are not eligible to receive additional grants under RWHAP Part A. Please briefly describe how the EC funding will be used in the MSA.

▪ *NEEDS ASSESSMENT*

a) **Planned Services for Emerging Community Funds**

- Please describe how the planning process for the EC funds meets the following requirements. A state with multiple ECs should describe each EC planning process separately, if the process differs.
 - The allocation of the funds is based in accordance with the

local demographic incidence of HIV including appropriate allocations for services for infants, children, women and families with HIV;

- Affected communities and people with HIV are included in the planning process; and
- The proposed services are consistent with the local needs assessments and the Integrated HIV Prevention and Care Plan.

▪ *METHODOLOGY*

Please describe the following:

- 1) How the state disseminates/will disseminate EC funds within the MSA;
- 2) How the state will ensure that the current level of support for the activities in the EC is not supplanted by this funding;
- 3) How the state will utilize the funds in a manner that is responsive to the needs of the MSA, and is cost effective;
- 4) How the state will implement activities described in the plan to ensure geographic parity in access to HIV services throughout the EC;
- 5) How proposed FY 2022 allocations address significant issues and core service needs identified in the Integrated HIV Prevention and Care Plan; and
- 6) How the services and their goals and objectives relate to the goals of the Healthy People 2030 Initiative, particularly the objectives related to the HIV listing under the Topics and Objectives tab.

▪ *WORK PLAN*

Implementation Plan for EC funds: states with multiple ECs should describe the use of funds for each EC separately.

Please describe:

- 1) The services that will be provided in FY 2022;
- 2) The current or planned activities for addressing health disparities related to race, gender, sexual orientation and age among populations within the MSA's system of HIV care; and
- 3) The activities for addressing the needs of emerging populations.

▪ *RESOLUTION OF CHALLENGES*

The purpose of this section is to describe any challenges that may occur in implementing the proposed activities that are described in the work plan and approaches that will be used to address these challenges.

▪ *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

Describe the data and process that will be used to monitor the objectives in the FY 2022 EC Implementation Plan as provided above.

- **ORGANIZATIONAL INFORMATION**

The responses provided to the “Organizational Information” section in the FY 2022 RWHAP Part B Base Grant Application apply to this section. No further information is required for this section.

iii. Budget

The directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Follow the instructions in Section 4.1.iv of HRSA’s [SF-424 Application Guide](#) and the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if HRSA selects the application for funding, you will have a well-organized plan and, by carefully following the approved plan, may avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a HRSA- supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

In addition, the FY 2022 Ryan White HIV/AIDS Program Part B Base, Minority AIDS Initiative, AIDS Drug Assistance Program, ADAP Supplemental Awards, and Emerging Communities programs require completion of Sections A, B, E, and F of the SF-424A Budget Information – Non- Construction Programs form included with the application kit for the year of the budget period, and then a line item budget using Section B Object Class Categories of the SF-424A.

In Section B, the four required columns are:

- (1) **Administration** - This column should include all funds allocated to the following grant activities: recipient administration, planning and evaluation, and quality management;
- (2) **ADAP** - This column should include all funds allocated to ADAP (including medication and health care coverage assistance and ADAP Flex);
- (3) **Consortia/Emerging Communities** - This column should include all funds allocated to consortia and ECs; and
- (4) **Direct Services** - This column should include all funds allocated to the following grant activities: State Direct Services, Home and Community-Based Health Services, MAI, and the Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals.

The Consolidated Appropriations Act, 2021 (P.L. 116-260), Division H, § 202 (P.L. 116-260) states, “None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.” Please see Section 4.1.iv Budget – Salary Limitation of HRSA’s [SF-424 Application Guide](#) for additional information. Note that these or other salary limitations may apply in FY 2022, as required by law.

iv. Budget Narrative

See Section 4.1.v. of HRSA's [SF-424 Application Guide](#).

In addition, the FY 2022 Ryan White HIV/AIDS Program - Part B Base, Minority AIDS Initiative, AIDS Drug Assistance Program, ADAP Supplemental Awards, and Emerging Communities program requires a narrative that explains the amounts requested for each line in the budget. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the "other" category is justified. The budget narrative **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

The budget narrative format should explain the amounts requested for the following: RWHAP Part B Base, ADAP, ADAP Supplemental, Consortia, EC, and MAI, and the relevant RWHAP budget categories. The narrative should explain how the line items listed support the overall service delivery system and include justification for any applicable object class categories: Personnel, Fringe Benefits, Travel, Equipment, Supplies, Contractual, Construction, Other and Indirect Charges. For employees who are less than one (1) FTE on the grant, please identify all funding sources outside of RWHAP Part B funding for Personnel and Fringe Benefits costs.

Caps on Expenses: RWHAP Part B recipient administrative costs may not exceed 10 percent of the total grant award. Planning and evaluation costs may not exceed 10 percent of the total grant award. Collectively, recipient administrative costs and planning and evaluation costs may not exceed 15 percent of the total award. Recipients may allocate up to five percent of the total grant award or \$3,000,000 (whichever is less) for CQM.

Subrecipient administrative costs are capped at **10 percent in the aggregate**.

Subrecipient administrative activities include:

- Usual and recognized overhead activities, **including established indirect rates** for agencies;
- Management oversight of specific programs funded under the RWHAP; and
- Other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

If a RWHAP Part B grant recipient has contracted with an entity to provide statewide or regional RWHAP management and fiscal oversight (i.e., the entity has entered into a vendor or procurement relationship with the recipient, and is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's 10 percent administrative cap. Providers that have contracted to provide health care services for the lead agency are considered to be first-tier entities (subrecipients) of the recipient and are subject to the aggregate 10 percent administrative cap for subrecipients.

For further guidance on the treatment of costs under the 10 percent administrative limit, refer to [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Part A, B, C, and D.](#)

Payor of Last Resort: Charges that are billable to third party payers (e.g., private health insurance, prepaid health plans, Medicaid, Medicare, HUD, other RWHAP funding including ADAP) are unallowable. The RWHAP is the payor of last resort, and recipients must vigorously pursue alternate sources of payments. HRSA expects recipients to certify eligibility every 12 months/annually and recertify eligibility at least every six months (please see HAB PCNs 13-02, 13-03, 13-04, 14-01, and 18-01 at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>). Recipients are required to use effective strategies to coordinate with third party payers that are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include, Medicaid, Children's Health Insurance Programs (CHIP), Medicare, including Medicare Part D, basic health plans, and private insurance, including those purchased through the Health Insurance Marketplace. Subrecipients providing Medicaid eligible services must be Medicaid certified.

RWHAP Part B funds are subject to Section 2612(b) of the PHS Act, which requires that not less than 75 percent of the funds remaining after reserving funds for administration, planning and evaluation, and CQM be used to provide core medical services.

v. Attachments

Please provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Clearly label each attachment.**

Attachment 1: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the project.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section

4.1. of the HRSA's [SF-424 Application Guide](#))

Keep each job description to one page in length. Include the roles, responsibilities, and qualifications of proposed project staff. **This does not count toward the page limit.**

Attachment 3: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 2 that reflect changes since the last application, not to exceed 2 pages. **This does not count toward the page limit.**

Attachment 4: ADAP Funding Sources Table

Provide a table that lists all sources of funds for the ADAP Program (e.g., ADAP Base, state funds, other RWHAP funds, rebates) for FY 2021 and those anticipated for FY 2022.

Attachment 5: Maintenance of Effort (MOE) Documentation

Applicants must provide a baseline aggregate expenditure for their FY prior to the application deadline. Please provide a description of the non-RWHAP Part B/ADAP expenditures that count towards the MOE and methodologies for calculating MOE expenditures. Also, include a brief narrative explaining any changes in the data set where HIV-related expenditures have been reduced or where the purpose of an HIV-related expenditure has changed. HRSA will enforce statutory MOE requirements through all available mechanisms.

NON-FEDERAL EXPENDITURES	
FY Prior to Application (Actual)	Current FY of Application (Estimated)
Actual prior FY non-federal funds, including in-kind, expended for activities proposed in this application.	Estimated current FY non-federal funds, including in-kind, designated for activities proposed in this application.
Amount: \$ _____	Amount: \$ _____
_____ Recipient Budget (Fiscal) Officer	_____ Recipient Project Director

Attachment 6: Unmet Need Framework Table and Narrative

The table must include the values, all data sources, and calculations for Unmet Need. **A description of the information to include in the Unmet Need narrative is located in the Unmet Need Section of this NOFO under the Project Narrative.**

Attachment 7: Ryan White HIV/AIDS Program Part B Agreements and Compliance Assurances

The Ryan White HIV/AIDS Program Part B Agreements and Compliance Assurances are included ([Appendix](#)) with this NOFO, and require the signature of the CEO, or the CEO's designee.

Attachment 8: Core Medical Services, ADAP Supplemental Match and/or Annual Site Visit Exemption Waiver Request(s) and Justification

Please see below for information about waiver requirements and submission deadlines. If applicable, please include waiver requests for all of the following:

Core Medical Services

Applicants seeking a waiver of the core medical services requirement (Section 2612(b)(2) of the PHS Act) must submit a waiver request either with this application, any time up to the application submission, or up to four months after the grant award for FY 2022. Submission should be in accordance with HAB PCN 13-07, and may be found at <https://hab.hrsa.gov/program-grants-management/policy-notice-and-program-letters>.

If you are seeking a waiver of the core medical services requirement and you receive MAI funds, you must include the MAI funds in your waiver request. If you do not include the MAI funds in your waiver request, HRSA HAB will not consider the request.

ADAP Supplemental Match

The ADAP Supplemental Grants require a state match of 25 percent (i.e., \$1 for each \$4 of federal funds provided), unless a waiver is requested and approved (Section 2618(a)(2)(F)(ii)(III) of the PHS Act). A state/territory is eligible for a waiver from the match requirement for ADAP Supplemental funding if it also has a state match requirement for the RWHAP Part B Formula/ADAP Base funding, and it meets that match. If the state/territory is requesting a waiver to the match, please attach a waiver request letter. A state/territory may also request a reduction in the award amount if unable to meet the ADAP Supplemental match.

Annual Site Visit Exemption

You must submit a request for an exemption to the annual site visit requirement through the prior approval portal in EHBs within thirty (30) days after the submission of the application.

The annual site visit requirement was waived for FY 2021 due to the COVID-19 pandemic. That waiver is not in effect for FY 2022.

Attachment 9: HIV/AIDS Epidemiology Table and Narrative

Summarize in a table format the HIV (non-AIDS) and AIDS cases by age, race/ethnicity, and exposure category through December 31, 2020. Also include a brief narrative description of any trends or changes in the age, race/ethnicity, and exposure categories for prevalent cases and for cases newly diagnosed and reported in the previous two years for which data are available.

Attachments 10-12: Other Relevant Documents

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number Transition to the Unique Entity Identifier (UEI) and System for Award Management (SAM)

You must obtain a valid DUNS number, also known as the Unique Entity Identifier (UEI), and provide that number in the application. In April 2022, the *DUNS number will be replaced by the UEI, a “new, non-proprietary identifier” requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following webpages: [Planned UEI Updates in Grant Application Forms](#) and [General Service Administration’s UEI Update](#).

You must also register with SAM and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d)).

If you are chosen as a recipient, HRSA would not make an award until you have complied with all applicable DUNS (or UEI) and SAM requirements and, if you have not fully complied with the requirements by the time HRSA is ready to make an award, you may be deemed not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

*Currently, the Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://www.dnb.com/duns-number.html>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

[SAM.GOV](#) ALERT: For your SAM.gov registration, you must submit a [notarized letter](#) appointing the authorized Entity Administrator. The review process changed for the Federal Assistance community on June 11, 2018.

In accordance with the Federal Government's efforts to reduce reporting burden for recipients of federal financial assistance, the general certification and representation requirements contained in the Standard Form 424B (SF-424B) – Assurances – Non-Construction Programs, and the Standard Form 424D (SF-424D) – Assurances – Construction Programs, have been standardized federal-wide. Effective January 1, 2020, the forms themselves are no longer part of HRSA's application packages and the updated common certification and representation requirements will be stored and maintained within SAM. Organizations or individuals applying for federal financial assistance as of January 1, 2020, must validate the federally required common certifications and representations annually through SAM located at [SAM.gov](#).

If you fail to allow ample time to complete registration with SAM or Grants.gov, you will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date

The due date for applications under this NOFO is *November 8, 2021 at 11:59 p.m. ET*. HRSA suggests submitting applications to Grants.gov at least **3 calendar days before the deadline** to allow for any unforeseen circumstances. See Section 8.2.5 – Summary of emails from Grants.gov of HRSA's [SF-424 Application Guide](#) for additional information.

5. Intergovernmental Review

The Ryan White HIV/AIDS Program Part B Base, AIDS Drug Assistance Program (ADAP) Program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

See Section 4.1 ii of HRSA's [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

You may request funding for a budget period of up to one (1) year.

HRSA HAB will strictly enforce the RWHAP authorizing statute, which states: Section 2618(c)(1)--Expedited Distribution,-

- IN GENERAL, Section 2618(c)(1)(B)--Not less than 75 percent of the amounts received under a grant awarded to a state under Section 2611 shall be obligated to specific programs and projects and made available for expenditure not later than-
 - a) in the case of the first FY for which amounts are received, 150 days after the receipt of such amounts by the State; and
 - b) in the case of succeeding FYs, 120 days after receipt of such amounts by the State.

Section 2618(d)(2)--Reallocation-

- Any portion of a grant made to a State under Section 2611 for a FY that has not been obligated as described in subsection (c) ceases to be available to the state or territory and shall be made available by the Secretary for grants under Section 2620, in addition to amounts made available for such grants under Section 2623(b)(2).

In addition to the general Funding Restrictions included in Section 4.1 of the [SF-424 Application Guide](#), RWHAP Part B/ADAP funds **cannot** be used for:

- a) International travel;
- b) Construction (however, minor alterations and renovations to an existing facility to make it more suitable for the purpose of the grant program is allowable with prior HRSA approval);
- c) PrEP or Post-Exposure Prophylaxis (PEP);
- d) [Syringe Services Programs](#) (SSPs). Some aspects of SSPs are allowable with HRSA's prior approval and in compliance with HHS and HRSA policy;
- e) Cash payments to intended recipients of RWHAP services;

- f) Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service); and
- g) Development of materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Caps on Expenses: RWHAP Part B/ADAP recipient administrative costs may not exceed 10 percent of the total grant award. Planning and evaluation costs may not exceed 10 percent of the total grant award. Collectively, recipient administration, and planning and evaluation costs may not exceed 15 percent of the total award. You may allocate up to five percent of the total grant award or \$3,000,000 (whichever is less) for CQM.

Subrecipient administrative costs are capped at **10 percent in the aggregate**.

Subrecipient administrative activities include:

- usual and recognized overhead activities, **including established indirect rates** for agencies;
- management oversight of specific programs funded under the RWHAP; and
- other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

If a RWHAP Part B/ADAP grant recipient has contracted with an entity to provide statewide or regional RWHAP management and fiscal oversight (i.e., the entity has entered into a vendor or procurement relationship with the recipient, and is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's 10 percent administrative cap. Providers that have contracted to provide health care services for the lead agency are considered to be first-tier entities (subrecipients) of the recipient and are subject to the aggregate 10 percent administrative cap for subrecipients.

For further guidance on the treatment of costs under the 10 percent administrative limit, refer to [PCN 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Part A, B, C, and D](#).

The General Provisions in Division H of the Consolidated Appropriations Act, 2021 (P.L. 116-260) apply to this program. Please see Section 4.1 of HRSA's [SF-424 Application Guide](#) for additional information. Note that these or other restrictions will apply in following fiscal years, as required by law.

You are required to have the necessary policies, procedures, and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, executive salaries, gun control, abortion, etc. Like those for all other applicable grants requirements, the effectiveness of these policies, procedures, and controls is subject to audit.

Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the [HRSA Grants Policy Bulletin Number: 2021-01E](#).

Program Income: HHS Regulations require recipients and/or subrecipients to collect and report program income. Program income shall be monitored by the recipient, retained by the recipient (or subrecipient if earned at the subrecipient level), and used to provide RWHAP Part B services/ADAP services to eligible clients. Program income is gross income—earned by a recipient, subrecipient, or a contractor under a grant—directly generated by the grant-supported activity or earned as a result of the RWHAP Part B/ADAP award. Program income includes, but is not limited to, income from fees for services performed (e.g., direct payment, or reimbursements received from Medicaid, Medicare and third-party insurance). Direct payments include charges imposed by recipients and subrecipients for RWHAP Part B/ADAP services as required under Section 2617(c) of the PHS Act. You are responsible for ensuring that subrecipients have systems in place to account for program income, and for monitoring to ensure that subrecipients are tracking and using program income consistent with RWHAP Part B/ADAP requirements.

All program income generated as a result of awarded funds must be used for approved project-related activities. The program income alternative applied to the award(s) under the program will be the addition/additive alternative. You can find post-award requirements for program income at [45 CFR § 75.307](#).

All pharmaceutical rebates collected as a result of awarded funds must be used for approved project-related activities.

For more information, see the following:

- [PCN 15-03: Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income](#) and [45 CFR §75.307](#)
- [PCN 15-04: Utilization and Reporting of Pharmaceutical Rebates](#)
- [Frequently Asked Questions for Policy Clarification Notices 15-03 and 15-04](#)

V. Application Review Information

1. Review Criteria

The Ryan White HIV/AIDS Part B/ADAP Program is a formula-based program. HRSA has procedures for assessing the technical merit of applications and to assist you in understanding the standards against which your application will be reviewed. HRSA will review each application for completeness and eligibility, all required documents, and compliance with the requirements outlined in this NOFO. The Ryan White HIV/AIDS Part B/ADAP Program funds are distributed among eligible entities as formula-payment based awards according to data supplied in your application. HRSA will calculate FY 2022 award amounts based on the following:

- Project Organizational Chart
- Staffing Plan and Job Descriptions for Key Personnel

- Biographical Sketches of Key Personnel
- ADAP Funding Sources Table
- HIV/AIDS Epidemiology Narrative
- Implementation Plan (includes MAI, if applicable)
- Maintenance of Effort Documentation
- Unmet Need Framework and Narrative
- FY 2022 Core Medical Services Waiver Request (if applicable)
- State Match Information
- Ryan White HIV/AIDS Program Part B Agreements and Compliance Assurances
- ADAP Supplemental Match Waiver Request (if applicable)
- Grantee Administration and Accountability
- Early Identification of Individuals with HIV/AIDS
- Clinical Quality Management
- Women, Infants, Children, and Youth (WICY)

The RWHAP Part B/ADAP does not have funding priorities based on scoring because the funds are distributed according to a formula.

The RWHAP Part B Base, ADAP, and EC awards are based on the number of reported living cases of HIV in the state or territory in the most recent CY as confirmed by CDC data submitted to HRSA. Similarly, for recipients applying for MAI formula funds, awards are based on the number of reported and confirmed living minority cases of HIV for the most recent CY submitted to HRSA. The most recently completed CY ended December 31, 2020. ADAP Supplemental grants are awarded by formula to states meeting any of the criteria indicated in that section of the NOFO.

2. Review and Selection Process

Please see Section 5.3 of HRSA's [SF-424 Application Guide for more details](#).

The funds appropriated for the Ryan White HIV/AIDS Part B Program and ADAP are distributed among eligible recipients as a formula-based award. This program does not have any funding priorities, preferences or special considerations.

3. Assessment of Risk

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

HRSA is required to review and consider any information about your organization that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider your comments, in addition to other

information in [FAPIS](#) in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in [45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants](#).

HRSA will report to FAPIS a determination that an applicant is not qualified ([45 CFR § 75.212](#)).

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Awards (NOA) prior to the start date of April 1, 2022. See Section 5.4 of HRSA's [SF-424 Application Guide](#) for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's [SF-424 Application Guide](#).

If you are successful and receive a Notice of Award, in accepting the award, you agree that the award and any activities thereunder are subject to all provisions of 45 CFR part 75, currently in effect or implemented during the period of the award, other Department regulations and policies in effect at the time of the award, and applicable statutory provisions.

Accessibility Provisions and Non-Discrimination Requirements

Federal funding recipients must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity. For more information on recipient civil rights obligations, visit the HRSA Office of Civil Rights, Diversity, and Inclusion [website](#).

Requirements of Subawards

The terms and conditions in the NOA apply directly to the recipient of HRSA funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NOA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to subrecipients under awards, and it is the recipient's responsibility to monitor the compliance of all funded subrecipients. See [45 CFR § 75.101 Applicability](#) for more details.

Data Rights

All publications developed or purchased with funds awarded under this notice must be consistent with the requirements of the program. Pursuant to 45 CFR § 75.322(b), the recipient owns the copyright for materials that it develops under an award issued pursuant to this notice, and HHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use those materials for federal purposes, and to authorize others to do so. In addition, pursuant to 45 CFR § 75.322(d), the Federal Government has the right to obtain, reproduce, publish, or otherwise use data produced

under this award and has the right to authorize others to receive, reproduce, publish, or otherwise use such data for federal purposes, e.g., to make it available in government-sponsored databases for use by others. If applicable, the specific scope of HRSA rights with respect to a particular grant-supported effort will be addressed in the NOA. Data and copyright-protected works developed by a subrecipient also are subject to the Federal Government's copyright license and data rights.

3. Reporting

Award recipients must comply with Section 6 of HRSA's [SF-424 Application Guide](#) and the following reporting and review activities:

- a) **Program Terms Report.** You must submit a program terms report to HRSA 90 days after the award is made; further information will be provided in the NOA.
- b) **MAI Annual Plan and Report.** You must submit an annual plan on the proposed services provided with MAI funds, as well as an annual report on the outcomes of the services provided; further information will be provided in the NOA.
- c) **Interim Federal Financial Report.** You must submit an interim Federal Financial Report SF-425 (FFR) reflecting the amount of RWHAP Part B/ADAP funds obligated during the first 120 days of the budget period. Further information will be provided in the NOA.
- d) **Expenditure Report.** You must submit a RWHAP Expenditure Report; further information will be provided in the NOA.
- e) **Ryan White Part B/ADAP Unobligated Balance Estimate/Estimated Carryover Request.** You must submit a request for carryover of any estimated RWHAP Part B/ADAP Formula Unobligated Balance (UOB) to HRSA. If you fail to submit an estimated UOB and estimated carryover request to HRSA you will be ineligible to receive RWHAP Part B/ADAP Formula carryover funds. You may also request that HRSA deem that certain UOB funds be reduced by the amount of rebate funds actually expended.
- f) **Ryan White HIV/AIDS Program Services Report(s).** Acceptance of this award indicates that you assure that you will comply with data requirements of the RSR and that you will mandate compliance by each of your subrecipients. The RSR captures information necessary to demonstrate program performance and accountability. All RWHAP core service and support service providers are required to submit client level data for CY 2020. For additional information, please refer to the HIV/AIDS Program Client Level Data website at: <http://hab.hrsa.gov/manageyourgrant/clientleveldata.html> .
- g) **ADAP Data Report.** Acceptance of this award indicates that you assure that you will comply with data requirements of the ADR. The ADR is a reporting requirement for ADAPs to provide client level data on individuals served, services being delivered, and costs associated with these services. Further information can be found at: <http://hab.hrsa.gov/manageyourgrant/adr.html>.
Clinical Quality Management Plan. You must submit an updated CQM Plan describing all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and responsible parties, and evaluation of the CQM program to HRSA ninety (90) days after the award is made, with the Program Terms Report; further information

will be provided in the NOA. See PCN 15-02 Clinical Quality Management Policy Clarification Notice for more information:

<https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf>.

- h) **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

Please note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at [2 CFR § 200.340 - Termination](#) apply to all federal awards effective August 13, 2020.

VII. Agency Contacts

You may request additional information and/or technical assistance regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Marie Mehaffey
Grants Management Specialist
Division of Grants Management Operations, OFAM Health Resources and Services Administration 5600 Fishers Lane, Mailstop 10SWH03
Rockville, Maryland 20857
Telephone: (301) 945-3934
E-mail: Mmehaffey@hrsa.gov

You may request additional information related to the overall program issues and/or technical assistance related to this NOFO by contacting

Susan Robilotto
Director, Division of State HIV/AIDS Programs Attn: HIV/AIDS Bureau
Health Resources and Services Administration 5600 Fishers Lane, Room 09W52
Rockville, Maryland 20857
Telephone: (301) 443-6554
E-mail: srobilotto@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035) E-mail: support@grants.gov
Self-Service Knowledge Base: <https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For

assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET, excluding federal holidays at:

HRSA Contact Center Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

VIII. Other Information

1. Allowable Uses of Funds

For the most up-to-date listing of allowable uses of funds, refer to [HAB PCN 16-02: "Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds"](#).

These service definitions are effective for awards issued for Fiscal Year 2022.

2. National Monitoring Standards

You are required to have implemented the requirements as outlined in the RWHAP Part B NMS at the recipient and provider/subrecipient levels. HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the recipient, and provider staff. The NMSs can be found at: <https://hab.hrsa.gov/program-grants-management/ryan-white-hiv-aids-program-recipient-resources>.

3. Technical Assistance

HRSA has scheduled following technical assistance:

Webinar

Day and Date: Wednesday, August 25, 2021

Time: 02:30 - 04:00 pm

Join ZoomGov Meeting

<https://hrsa.gov.zoomgov.com/j/16041483625?pwd=am1jaHdvRDl5eWt3UWIUNzAxTnRQUT09>

Meeting ID: 160 4148 3625

Passcode: FY22X07TA

One tap mobile

+16692545252,,16041483625#,,,,*809110554# US (San Jose)

+16468287666,,16041483625#,,,,*809110554# US (New York)

Dial by your location

+1 669 254 5252 US (San Jose)

+1 646 828 7666 US (New York)

+1 669 216 1590 US (San Jose)

+1 551 285 1373 US

833 568 8864 US Toll-free

Meeting ID: 160 4148 3625

Passcode: 809110554

Find your local number: <https://hrsa-gov.zoomgov.com/join/az33IRjaq>

Join by SIP

16041483625@sip.zoomgov.com

Join by H.323

161.199.138.10 (US West)

161.199.136.10 (US East)

Meeting ID: 160 4148 3625

Passcode: 809110554

The recorded webinar will be available on the [TargetHIV website](#)

4. Tips for Writing a Strong Application:

See Section 4.7 of HRSA's [SF-424 Application Guide](#).

508 Compliance Disclaimer

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff above in [Section VII. Agency Contacts](#)

Appendix: FY 2022 AGREEMENTS AND ASSURANCES Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B/ADAP Grant Program

I, the Governor, or Authorized Designated Official, of the State or Territory of _____, hereinafter referred to as "State," assure that:

1. Pursuant to Section 2612¹

a) Section 2612(a)

Amounts provided will be expended on core medical services, support services, and administrative expenses only.

b) Section 2612(b)(1)

Unless a waiver is obtained, not less than 75 percent of the portion of the grant remaining after reserving amounts for administration, planning/evaluation and clinical quality management will be used to provide core medical services that are needed in the State for individuals with HIV who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

c) Section 2612(d)(2)

Entities providing Early Intervention Services (EIS) will ensure that the following conditions have been met:

1. Federal, State and local funds are otherwise inadequate for the EIS an entity proposes to provide; and,
2. The entity will supplement, not supplant, other funds available to the entity for the provision of providing EIS for the FY involved.

d) Section 2612(e)

For each of such populations in the eligible area, the State will use not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV to the general population in such area of individuals with HIV, unless a waiver is obtained from the Secretary.

e) Section 2612(f)

No amounts received under the grant will be used to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

¹ All statutory references are to the Public Health Service Act, unless otherwise specified.

2. Pursuant to Section 2613

Section 2613(b)

All required assurances will be obtained from applicants who apply to the State for assistance to provide consortia services.

3. Pursuant to Section 2615

Section 2615(b)

Assistance will not be used to pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools); or to pay any amount expended by a State under Title XIX of the Social Security Act.

4. Pursuant to Section 2616

a) Section 2616(c)(1)

The therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary are at a minimum the treatments provided by the State.

b) Section 2616(g)

Any drug rebates received on drugs purchased from funds provided under the grant are applied to activities supported under Part B, with priority given to AIDS Drug Assistance Program activities.

5. Pursuant to Section 2617

a) Section 2617(b)(4)

The State shall designate a lead State agency that will:

- 1) Administer all assistance received under Part B;
- 2) Conduct the needs assessment and prepare the State plan;
- 3) Prepare all applications for assistance under Part B;
- 4) Receive notices with respect to programs under Title XXVI;
- 5) Every two years, collect and submit to the Secretary all audits, consistent with 45 CFR Part 75 Subpart F, from recipients within the State, including audits regarding funds expended in accordance to Part B; and
- 6) Carry out any other duties determined appropriate by the Secretary to facilitate the coordination of programs under Title XXVI.

b) Section 2617(b)(6)

The public health agency that is administering the grant for the State periodically convenes a meeting that includes individuals with HIV, members of a federally recognized Indian tribe as represented in the State, representatives of recipients under each of the Ryan White HIV/AIDS Programs, providers, public agency representatives, and if applicable, entities on Part A Planning Councils, in developing the Statewide Coordinated Statement of Need (SCSN).

c) Section 2617(b)(7)(A)

The public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes

individuals with HIV, members of a federally recognized Indian tribe as represented in the State, representatives of recipients under each Part of Title XXVI of the Public Health Service Act, providers, public agency representatives, Part A Planning Councils (or other planning body), in developing the comprehensive plan and commenting on the implementation of such plan.

d) *Section 2617(b)(7)(B)(i)*

HIV-related health care and support services delivered pursuant to a program established with assistance provided under Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual living with HIV, to the maximum extent practicable.

e) *Section 2617(b)(7)(B)(ii)*

Such services will be provided in a setting that is accessible to low-income individuals living with HIV.

f) *Section 2617(b)(7)(B)(iii)*

Outreach to low-income individuals living with HIV will be provided to inform them of the services available under Part B.

g) *Section 2617(b)(7)(B)(iv)*

If using amounts provided under the grant for health care coverage, the State will submit a plan that assures that

- 1) such amounts will be targeted to individuals who would not otherwise be able to afford health care coverage; and
- 2) income, asset, and medical expense criteria will be established and applied by the State to identify those individuals who qualify for assistance under such a program; and that information concerning such criteria will be made available to the public.

h) *Section 2617(b)(7)(C)*

The State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Part B.

i) *Section 2617(b)(7)(D)*

The State will permit and cooperate with any Federal investigations undertaken regarding programs conducted under Part B.

j) *Section 2617(b)(7)(E)*

The State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the one-year period preceding the FY for which the State is applying to receive a grant under Part B.

k) *Section 2617(b)(7)(F)*

Grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with

respect to that item or service

- 1) under any State compensation program, insurance policy, Federal or State health benefits program; or
- 2) by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

l) Section 2617(b)(7)(G)

Entities within areas in which activities under the grant are carried out will maintain appropriate relationships with entities in the area serviced that constitute key points of access to the health care system for individuals with HIV (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, and homeless shelters) and other entities under Section 2612(c) and 2652(a) (eligible to apply for Part B Early Intervention Service Grants) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV and individuals knowledgeable of their HIV status but not in care.

m) Section 2617(b)(8)

The State will develop a comprehensive plan describing:

- 1) The estimated number of individuals within the State with HIV who do not know their status;
- 2) Activities undertaken by the State to find such individuals and to make them aware of their status;
- 3) The manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV; and
- 4) Efforts to remove legal barriers, including State laws and regulations, to routine testing.

n) Section 2617(c)

The State will comply with the statutory requirements regarding imposition of charges for services, for those providers who charge for services.

o) Section 2617(d)(1)

If subject to the matching requirement detailed in Section 2617(d), non-Federal contributions will be made available (either directly or through donations from public or private entities).

6. Pursuant to Section 2618

a) 2618(a)(2)(F)(ii)

States and Territories applying for ADAP Supplemental Treatment Drug Grants will make available non-Federal contributions (directly or through donations from public or private entities) in an amount equal to \$1 for each \$4 of Federal funds awarded, unless a waiver is obtained.

b) 2618(b)(3)(A-D)

The State will comply with the limitations of grant funds for administration planning and evaluation; and clinical quality management activities. In the case of subrecipients, the State will ensure that, of the aggregate amount so allocated, the

total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

c) 2618(b)(3)(E)(i)

The State will provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most recent Public Health Service guidelines for treatment of HIV and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV health services.

d) 2618(c)(1)

The State will ensure that 75 percent of Part B/ADAP funds will be obligated within 120 days of the start date of the grant award, and that if such funds are not obligated, they will be made available promptly to the Secretary for reallocation.

7. Pursuant to Section 2622

The State will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

8. Pursuant to Section 2681(d)

Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

9. Pursuant to Section 2684

No funds shall be used to develop materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

_____ Date _____ Signature

Title

Address