

**NYS Department of Health (DOH)
AIDS Institute, Division of HIV Health Care
Bureau of HIV Ambulatory Care Services, Family and Youth Services Section (FAYS)**

**Request for Applications (RFA):
Family-Focused HIV Health Care for Women
and
HIV Health Care and Related Services for Adolescents and Young Adults**

RFA #09-0006/FAU #1003121025

Questions and Answers

*All questions are stated as received by the deadline announced in the RFA.
The NYSDOH is not responsible for any errors or misinterpretation of any
questions received.*

The responses to questions included herein are the official responses by the State to questions posted by potential bidders and are hereby incorporated into the RFA #09-0006/FAU# 1003121025. In the event of any conflict between the RFA and these responses, the requirements or information contained in these responses will prevail.

GENERAL AND TECHNICAL QUESTIONS AND ANSWERS

Question 1:

What is the deadline for submitting the Letter of Interest? It was NOT noted on the cover sheet of the RFA as stated within the RFA?

Answer 1:

Letters of Interest are due **by 5:00 pm on October 14, 2010**. As stated on page 30 of the RFA, NYSDOH encourages, but does not require, prospective applicants to submit a Letter of Interest.

Question 2:

What is the email address and/or fax number of Ms. Valerie J. White, to whom the Letter of Interest must be directed.

Answer 2:

As stated on page 30 of the RFA, "If you are submitting a Letter of Interest to Apply", please submit to:

Valerie J. White
Deputy Director, Administration and Data Systems
New York State Department of Health AIDS Institute
ESP, Corning Tower Room 478
Albany, New York 12237

Question 3:

Please clarify regarding Administrative Costs (Page 43 Bullet 'H'), in past AIDS Institute budgets, we have had line items for telecommunication, space and audit costs in addition to our administrative overhead line. Are we still allowed to cover these items in addition to the 10% administrative overhead line?

Answer 3:

Yes, however, none of the costs used to support the administrative cost rate can be directly billed to the contract. For example, if the budget includes space costs, then space cannot be included as part of the administrative cost rate. Costs being reimbursed from the administrative cost line cannot be budgeted on any other line of the contract.

Question 4:

Can in-kind staff whose participation is vital to the program be listed on the budget without any monetary amount charged to the grant?

Answer 4:

In-kind staff person(s), whose participation is vital to the program, may be listed on the personal services page of the budget, with a brief position description included that relates to proposed program services.

Question 5:

If applying for more than one component must we submit separate applications?

Answer 5:

As stated on page 5 of the RFA: "Agencies may apply for funding for each component; however separate applications must be submitted for each."

Question 6:

If two distinct programs from the same institution apply for the RFA, are they considered separate agencies that are eligible for funding, or must programs submit an application collaboratively?

Answer 6:

As stated on page 5, first paragraph. "An agency may submit only one application per component." Therefore, an application for the same component from an agency must be a collaborative application. Two distinct programs from the same agency could submit distinct applications for different components.

Question 7:

Regarding Scope of Program Services for all Components: On page 13, Section B it states, "1) Core Services must be provided on-site and are eligible for grant funding and 2) Required

linkage services must be in place to provide a continuum of care services. However, linkage (referral) services are not fundable under these grant awards.” Historically we have used a consulting physician from another institution to provide some clinical services on our own site, and have used a social service agency consultant to provide support services on our site. These services have been paid under the "Subcontracts/Consultants" budget category. Are we still able to do that, or has something changed?

Answer 7:

Yes, that is allowable. An agency may choose to subcontract with one or more agencies to provide core services on site that are currently not provided by the applicant agency (e.g., a psychiatrist, a community navigator). Clinicians identified as subcontracts/consultants must be included in the “40 percent full time effort” cap for clinical services.

Question 8:

On page 13 of the RFA, under the notes in Scope of Program Services, it is noted that "all budgeted clinician time may not exceed 40 percent full time effort". Is a Licensed Clinical Social Worker (LCSW or LMSW) considered clinical staff and, therefore, be included in the 40 percent full time effort cap?

Answer 8:

Medicaid will reimburse for mental health counseling for LCSWs and LMSWs to children and adolescents up to 21 years of age and pregnant women up to 60 days post partum. This includes hospital outpatient departments and diagnostic and treatment centers; however, a facility must have a psychiatry or psychology certification on its operating certificate. In such cases, grant support is limited as defined above. Please review pages 26 and 27 of the RFA. If the facility does not have psychiatry or psychology certification on its operating certificate, then LSCW and LMSW staff would **not** be included in the cap total of 40 percent FTE.

Therefore, if there is no third party reimbursement for mental health counseling provided by a LCSWs and/or a LMSWs grant support is allowed and not included in the 40% cap.

Question 9:

Regarding Project Narrative, Section B - Scope of Program Services (page 13), “Grant funding may support up to 25 percent of a clinician's time to provide program oversight.... Other clinical staff may be included on the budget, but **all** clinician time may not exceed 40 percent full time effort.”

Please explain:

- a) Does the 40 percent limitation apply to funding for **each** clinician included on the budget?
- OR
- b) Does the 40 percent limitation mean that **all** of the percentages of multiple clinicians included on the budget cannot exceed 40 percent?

Answer 9:

Yes, all clinician effort IN TOTAL may not exceed 40 percent full time effort. Your interpretation in b) is correct. Please refer to page 13 of the RFA. Also, as stated on pages 26 and 27 of the RFA, VI. General Program Requirements, **Limits on Grant Funding for Clinicians for Components A and B:** “Other clinician staff may be included on the budget, but all budgeted clinician time may not exceed a total of 40 percent full time effort (FTE). For example, if the clinical designee is included on the budget for 20 percent FTE, up to 20 percent FTE may be allocated for other clinicians”. As noted on page 12, however, “This policy *may* be waived for **Component C**, Youth Access Program, if the care provided by the clinician cannot be reimbursed through third party billing”.

Question 10:

Regarding Section VI, General Program Requirements, Limits of Grant Funding for Clinicians, page 26, #3. “Each program should have a designated clinician to provide oversight; grant funding may support up to 25 percent of this clinician's time for administrative and clinical oversight. Other clinical staff may be included, but all time may not exceed a total of 40 percent full time effort ...if clinical designee is included for 20 percent, up to 20 percent may be allocated for other clinicians.”

- a) Please clarify what the percentages of clinician time represent. Do the percentages represent a portion of the budget?
- b) If a clinical designee is funded at 25 percent of FTE, an HIV specialist funded at 10 percent, and a psychologist at 10 percent is this over the limit per guidelines (as the clinical staff percentages add up to 45 percent)?
- c) Are social work staff included in the 40 percent limitation, or can they be funded in addition to "clinical" (medical) staff?
- d) Does the 40 percent limitation only apply to clinicians who can bill and generate third party revenue?

Answer 10:

- a) No. The 40 percent full time equivalent effort represents the proportion of clinician time that may be supported by this grant funding. It does not represent up to 40 percent of the grant funding that may be budgeted for clinical services. For example, if one clinician is included on the budget for 15 percent effort, up to 25 percent effort may be allocated for another clinician(s). This scenario represents clinicians who are 100 percent full time.
- b) Yes, this exceeds the limit of 40 percent full time effort.
- c) Medicaid will reimburse for mental health counseling by LCSWs and LMSWs to children and adolescents up to 21 years of age and pregnant women up to 60 days post partum. This includes hospital outpatient departments and diagnostic and treatment centers; however, a facility must have a psychiatry or psychology certification on its operating certificate. In

such cases, grant support is limited as defined above. Please review pages 26 and 27 of the RFA. If the facility does not have psychiatry or psychology certification on its operating certificate, then LSCW and LMSW staff would **not** be included in the cap total of 40 percent FTE.

- d) The 40 percent limitation applies to clinicians who can bill and generate third party revenue. Please note: reimbursable HIV primary care and mental health care are not directly funded services under this application (please refer to page 13 under Notes: third bullet of the RFA). Funding of clinician's effort provides for wrap around services to include case conferencing, care coordination, quality improvement activities and other activities which are not billable through Medicaid/other insurance, but which are necessitated by the program model.

Question 11:

If we apply for one region but are able and willing to service another region as well, do we count the total number of those clients in the 2 regions that we serve in our “proposed number of clients served”?

Answer 11:

If proposing to serve more than one region, the total should be the number projected to be served in both regions. The location with the higher caseload would determine the primary region. The program in the primary region would need to meet eligibility requirements, as stated on page 10 of the RFA. The applicant would be competing with applicants in the primary region identified for the funding award

Question 12:

On page 27 of the RFA under the Note: it states, "If mental health services are provided by an Article 28 facility with an operating certificate that includes "Mental Health Services" and these services are provided by staff eligible to bill under third party reimbursement, grant support is limited as defined above." At my Article 28 institution, we are not eligible to bill for mental health services under third party reimbursement. Therefore, I want to clarify if our mental health professional salaries are still part of the 40 percent clinician cap or not?

Answer 12:

As stated on page 27 of the RFA, "If mental health services are provided by an Article 28 facility with an operating certificate that includes "Mental Health Services" and these services are provided by staff eligible to bill under third party reimbursement, grant support is limited..." and is to be included in the 40 percent clinician cap.

Therefore, if a program is not eligible to bill for Mental Health Services, then this position(s) is not included in the cap. Mental Health Services provided must meet AIDS Institute standards.

Question 13:

In previous years the phrase "family-centered case management" was used to define the type of case management services that are mandated by this grant. In the current RFA, the term "medical case management" is used instead. The two terms imply slightly different activities. Has something changed or is this merely semantics?

Answer 13:

The "family-centered case management model" is not applicable to this RFA. To encourage the effective and efficient utilization of case management resources, Component A and Component B require medical case management as a core service. Medical case management is intended to address the needs of HIV-positive individuals in ambulatory care settings to coordinate all medical related care and services, diminish barriers to medical care and facilitate referrals and receipt of supportive services needed to maintain optimal health. Clients that require family-centered and/or intensive case management should be referred to community-based case management programs, such as the COBRA Community Follow-up Program. Collaboration between medical and community-based case management is essential. For further information, please refer to the definition of medical case management on page 24 of the RFA.

Question 14:

Components A and B, page 26, Limits on Grant Funding for Clinicians: Please clarify the statements in the RFA "Other clinical staff may be included on the budget, but all budgeted clinician time may not exceed a total of 40 percent full time effort. These staff may include...training." My questions are:

- a) Does this clinical staff also include dieticians and licensed clinical social workers?
- b) For patients/adolescents who do not have insurance coverage for clinical assessments and counseling, can funds within the proposed budget be allocated to payment of those clinical services if needed?
- c) Are all psychological, psychiatric, nutritional, and social work assessments/counseling sessions to be billed to third party payers?
- d) If there are per diem clinical staff (who have no FTE designation) and who are funded specifically for the program, how do we calculate them into the 40 percent cap?

Answer 14:

- a) Medicaid will reimburse for mental health counseling by LCSWs and LMSWs to children and adolescents up to 21 years of age and pregnant women up to 60 days post partum. This includes hospital outpatient departments and diagnostic and treatment centers; however, a facility must have a psychiatry or psychology certification on its operating certificate. In such cases, grant support is limited as defined above. Please review pages 26 and 27 of the RFA. If the facility does not have psychiatry or psychology certification on its operating

certificate, then LCSW and LMSW staff would **not** be included in the cap total of 40 percent FTE. Clinical staff includes registered dietitians (see answer c below).

- b) Services for patients/adolescents without insurance should be provided while referral and advocacy for Medicaid, ADAP or other insurance coverage are occurring. In most cases, this should be for a short duration, with services being reimbursed retroactively. For programs serving youth who are homeless, runaway, etc., a clear justification for limited funding must be provided.
- c) If third party reimbursement is available, these services should be billed. "If mental health services are provided by an Article 28 facility with an operating certificate that includes 'Mental Health Services' and these services are provided by staff eligible to bill under third party reimbursement, grant support is limited..." and should be included in the 40 percent clinician cap. Mental health services provided must meet AIDS Institute standards. Please refer to the Medicaid policy for reimbursement of social work and psychological services, as well as pages 26 and 27 of the RFA.

Effective January 1, 2011, nutrition therapy will be a billable service without accompanying primary care services. Currently, a dietician cannot bill for nutritional services as a stand alone procedure on a Medicaid claim. However, when a patient visits their HIV provider and also sees the nutritionist, nutrition assessment and/or therapy should be billed as part of the APG. Since programs funded through this RFA are projected to start July 1, 2011, nutrition services, by a dietician, should be included in the budgeted 40 percent full time effort cap for clinical services.

- d) The applicant should review the percent of time that is being spent on non-billable activities as outlined on pages 13, 26 and 27 of the RFA, e.g., case conferences, QI activities, treatment adherence, etc., and utilize that percent of the per diem staff. You may wish to look at the number of hours worked and what percent of time is spent on these activities to determine the percent effort to be allowed on the proposed budget. For example, a 20 hour clinician might spend 5 hours a week on these activities. This would be 12.5 percent of a FTE.

Question 15:

- a) Will there be one funded program serving both the Western New York Region and Finger Lakes or can you apply to serve one of the regions? Please clarify the regional expectation.
- b) If you have a provider subcontract committed to your program 20 percent effort, is the allowance for this position 25 percent (for non-directs) of the 20 percent?
- c) Nurse Practitioners' are employees of the hospital and employed 20 hours per week by the program 100 percent time and effort. Is the allowance for this position 15 percent as long as it does not exceed the 40 percent maximum?

Answer 15:

- a) Although Western New York and the Finger Lakes are two geographic areas, for the purpose of this RFA, this is one region. For Component A (see Page 7), there may be up to 1 program funded for the Western New York/Finger Lakes regions. For Component B, it is expected that one program will be funded for the Western NY/Finger Lakes region (see page 8). Applicants may apply to serve both areas, but are not required to provide services in both geographic areas.
- b) **All clinician effort in total may not exceed 40 percent full time effort.** This includes clinical subcontractors in addition to clinicians on the personal services page. See pages 26-27 for further clarification. "Grant funding may be used to support up to 25 percent of a clinician's time for administrative and clinical oversight of the program including care coordination, continuous quality improvement activities, training, program development and management, and participation in case conferences." This determination should be made based on a job description and amount of time spent on non-billable activities. The percent for any one clinician cannot exceed 25 percent of any one full time equivalent. Therefore, based on this scenario, where the clinician is 20 percent effort, it needs to be determined what percent of time is non-billable and therefore how much of this 20 percent should be budgeted on the grant.
- c) No. The amount budgeted to this program for other clinical positions would determine how much could be budgeted to the remaining positions, again, recognizing that only 40 percent full time equivalent can be budgeted in total for clinicians' non billable activities for the proposed program.

Question 16:

Page 5 of the RFA states an agency may submit only one application per component. Since there are defined regions outside of NYC, there are questions related to this:

- a) If an agency/program currently serves clients in counties listed under 2 or 3 different regions (outside of NYC), can they continue to serve those clients?
- b) In situations where there are previously well established referral paths to the program, from providers in counties in more than one region, would program be able to serve new referrals from these counties if the county does not fall under the region under which RFA is submitted?

Answer 16:

- a) Yes. An applicant may serve a wider geographic area. However, the region the applicant is competing under should be the region with the larger number of consumers being served. The designated regions listed in the RFA are to enable a competitive process for funding. It is not to limit a facility's catchment area or the clients the facility serves.
- b) Yes. A funded agency can serve referrals from other geographic regions.

Question 17:

How should applications be delivered? Must they be hand-delivered or can they be mailed? Should Federal Express be used? Is fax or email definitely unacceptable?

Answer 17:

Applications can be mailed or hand-delivered. If mailing, applicants are encouraged, but not required, to use an express service. Applications will not be accepted via fax or email. Please see page 31 of the RFA.

Question 18:

If an application is received after 5:00 pm on October 28, 2010 will it be considered?

Answer 18:

It is the applicant's responsibility to see that applications are delivered to the address stated in the RFA prior to the date and time specified. Late applications due to a documentable delay by the carrier may be considered at the Department of Health's discretion but there are no guarantees. Applicants should make every effort to ensure that all applications are received before the deadline.

Question 19:

What is the address that applications should be mailed to?

Answer 19:

Applications should be mailed or hand-delivered to:

Valerie J. White
Deputy Director, Administration and Data Systems
New York State Department of Health AIDS Institute
ESP, Corning Tower Room 478
Albany, New York 12237

Question 20:

In looking over the budget forms, I am not finding a place to delineate our rent, utilities, phone, supplies, travel, postage, printing, etc. costs. I saw in the instructions to enter the total of such costs to the Summary Budget page on lines C, D, E, and F. I wonder, though, where to enter the breakdown of the total costs for each line?

Answer 20:

The budget forms provided for the RFA process do not include the "Other than Personal Services" (OTPS) detail pages. Please list dollar values for all OTPS items on the summary budget and provide a description of those items using the justification page(s).

Question 21:

Are the budget pages provided on the website in an Excel format?

Answer 21:

Yes, the budget pages are included on the website in an Excel format.

Question 22:

If we are already an AIDS Institute funded program, should we use the forms we already have? They include the information requested in Attachment 20.

Answer 22:

No. Applicants should complete the information requested on the forms provided as Attachment 20 of the RFA, regardless of whether or not they are currently funded by the AIDS Institute.

Question 23:

I cannot do a direct entry on the summary page as it is locked.

Answer 23:

The summary budget forms should be accessed through your internet browser at: <https://email.health.state.ny.us/go/www.health.state.ny.us/funding/rfa/1005131015/index.htm> and then saved to the hard drive of your computer. Once saved to your hard drive, open the document without updating the links. Some of the pages are protected so if you are having problems entering information you should unprotect the sheet by clicking on the tools button on your toolbar, click on "protection" and click on "unprotect sheet".

COMPONENT A QUESTIONS AND ANSWERS

Question 24:

Can two organizations partner together to apply for Component A of the RFA?

Answer 24:

Two agencies may partner together to apply for Component A. However, one agency (lead) must meet **all** of the eligibility requirements of Component A that are listed on page 10. The other agency would be considered a subcontract. Agencies must read the component description and fully comply with that component's requirements. All core services must be delivered by the applicant agency, as stated on page 17 of the RFA.

Question 25:

Does the lead agency have to provide services to all of the 150 clients stated on page 10 of the RFA for Component A?

Answer 25:

As stated on page 10 of the RFA under Section III. Who May Apply: Eligibility Requirements, for Component A, applicants must be licensed by the New York State Department of Health under Article 28 of the Public Health Law, and an applicant must be registered as a not-for-profit 501 (c) (3) health care organization. **“In addition, Component A applicants must: “Propose to provide clinical HIV services to at least 150 HIV-positive women annually age 25 and older if proposing services in New York City, or to at least 75 HIV-positive women annually age 25 and older if proposing services outside New York City”.**

Question 26:

If the Lead Agency does not have 150 clients but when partnering with another agency, we will meet the eligibility requirement of providing clinical HIV services to at least 150 HIV-positive women annually age 25 or older in New York City, can we still apply?

Answer 26:

No, it is not the intent of Component A to be a consortium approach to care. An agency may choose to subcontract with one or more agencies to provide services on site that are currently not provided by the applicant agency (e.g., a psychiatrist, a community navigator). The applicant must propose to provide HIV clinical services to at least 150 HIV-positive women annually age 25 and older at the applicant agency if proposing services in New York City.

Question 27:

Regarding Component A: page 10, 7th bullet of the RFA states, “that clinical HIV services must be provided for a minimum of 150 HIV-positive women age 25 and older if proposing services in New York City”. Must all of these women also receive case management services as well? (Some of them may be stable and not require case management.)

Answer 27:

As stated on pages 16 and 17 of the RFA, medical case management is a core service for Component A.

Medical case management is intended to address the needs of HIV-positive individuals in ambulatory care settings to coordinate all medical related care, diminish barriers to medical care and facilitate referrals to other supportive services to promote retention in care and improve health outcomes. Women who are clinically stable with no current medical/psychosocial issues only require a semi-annual face-to-face reassessment and case conference (sooner if medical circumstances change) to update the woman's status and review the service plan for changed circumstances. If resources for medical case management are available in your facility, utilization of these resources should occur and not be supplanted by funding for this application. However, it is expected that these services will be documented in the patient record. Women with dependent children requiring intensive case management should be referred to a community-based provider, such as a COBRA Community Follow-up Program. Refer to page 24 of the RFA.

Question 28:

With the reconfiguration of the current Family Centered Care (FCC) and Centers of Excellence in Pediatric Care Programs (CEP),

- a) What will happen to the HIV-positive children who are under 13 years old and the exposed babies under 2 years old who are either in foster care or in the care of a relative other than their HIV-positive mother?
- b) How can we arrange for case management and supportive services for them?

Answer 28:

- a) As stated on page 15 of the RFA: The target populations for the Family-Focused HIV Health Care for Women model are: HIV-positive women with dependent children (HIV-positive and /or affected) living in the household, pregnant women diagnosed with HIV, and men living with HIV who are partners of the female index clients or are the designated primary caregivers of dependent children. HIV-positive children can be served through the Family-Focused Care Program with the mother as the index client. Medical case management may be provided for the family unit.

Infected children under 13 years of age should receive care by an HIV-experienced pediatric provider or by a pediatric provider in consultation with an HIV-experienced clinician. Pediatric medical care for both infected children and exposed infants is reimbursed through Medicaid and Third Party Insurance.

- b) The minimal care coordination needs of exposed infants would be expected to be provided as part of their medical care. Case management and supportive services for HIV-positive and HIV-exposed children are available if the HIV-infected mother is enrolled in the Family-Focused Care for Women Program. If the positive woman is not enrolled in this program, case management and support may occur through referral and linkage to COBRA Community Follow-up Programs (Medicaid reimbursed programs) and grant funded programs. HIV-infected children may also receive services via such programs. A directory of HIV-related services, inclusive of case management services, is available on the AIDS Institute's website: www.nyhealth.gov/diseases/aids.

Question 29:

When a new young adult presents for services who is HIV-positive and pregnant and between 21 and 25 years old, can they be served by an Adult Medical Provider or must it be a Pediatric Provider?

Answer 29:

A pregnant young adult woman who is HIV-infected is eligible to receive services from an adult provider, and may be served in the Family-Focused HIV Health Care for Women Program. However, there could be patients who may be better served by an adolescent medical provider. This is a clinical/multidisciplinary team decision.

Question 30:

When stating "co-located" Adult HIV, OB/GYN and Pediatric care.....:

- a) Do all of these services, or just some of these services like the adult HIV and pediatric care, or do any of the services, need to be occurring simultaneously in the same physical building?
- b) Or, can they be linked by being part of the same health care system or hospital?
- c) Or, can these services be occurring in close vicinity like a block or two away and shuttle service provided?

Answer 30:

- a, b) As stated on page 10 of the RFA, to be **eligible** to apply for Component A, applicants must provide "on-site" services for OB/GYN and adult HIV services. The intent of this requirement is to ensure optimal access for patient services. Therefore, if OB/GYN services are located at the same or an adjacent building to the HIV primary care clinic, this would meet the intent of "on-site". If a patient is required to walk a long distance or take a conveyance for transport, this would not be considered in the same or adjacent location. This would be assessed as a barrier to the receipt of service and likely result in missed opportunities for care.
- c) As noted on page 11 of the RFA, **preference** will be given to applicants that co-locate OB/GYN and adult services. As further noted on page 11 of the RFA, **preference** will also be give to applicants that co-locate adult services and pediatric care. Co-location is a *Guiding Principle of the RFA*, as defined on page 13, "co-location is an approach that offers needed client services in one location", facilitating the receipt of multiple services and the coordination of care.

Question 31:

Could you please clarify whether co-located services are required vs. strongly preferred? The RFA seems to be contradictory on this. For example, page 11 and page 39 state preference is given to applicants who provide co-located OB/GYN and Adult HIV Care as well as Adult HIV Care and Pediatric Care. Other parts of the RFA, including page 17 and page 38, indicate these co-located services are required. Could you clarify whether OB services, HIV pediatric services, services for HIV exposed infants, and adult HIV services must be offered at the same site?

Answer 31:

As stated on page 10 of the RFA, to be **eligible** to apply for Component A, applicants must provide "on-site" services for OB/GYN and adult HIV services. The intent of this requirement is to ensure optimal access for patient services. Therefore, if OB/GYN services are located at the same or an adjacent building to the HIV primary care clinic, this would meet the intent of "on-site". If a patient is required to walk a long distance or take a conveyance for transport, this

would not be considered in the same or adjacent location. This would be assessed as a barrier to the receipt of service and likely result in missed opportunities for care.

As noted on page 11 of the RFA, **preference** will be given to applicants that co-locate OB/GYN and adult HIV services. As further noted on page 11, **preference** will also be give to applicants that co-locate adult HIV services and pediatric care. Co-location is a *Guiding Principle of the RFA*, as defined on page 12, "co-location is an approach that offers needed client services in one location", facilitating the receipt of multiple services and the coordination of care.

The distinction is between on-site and co-located.

Question 32:

Given the eligibility requirement for Component A of at least 25 years of age, would exceptions be made for:

- a) patients who are already established in family services at the Adult HIV Program
- b) patients in need of family services (not yet enrolled), but already receiving their HIV services at the adult HIV program
- c) Would they be required to get case management and/or medical HIV services from the Component B programs or could they receive services from the Component A program?

Answer 32:

- a) There is no **client** eligibility requirement that the client has to be 25 years of age, as per the target populations, page 15, HIV positive women (including young women) with dependent children, or who are pregnant and diagnosed with HIV are appropriate to be served under Component A. Age 25 was used a benchmark for **applicant** eligibility on page 10.
 - b) This is a new solicitation. Any patients who meet the target population are eligible to be included as potential clients for Component A.
 - c) Clients enrolled in Component A are required to receive clinical care and case management from that program.
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Question 33:

In response to one of our previous questions you noted that "HIV-positive children can be served through the Family-Focused Care Program with the mother as the index client. Medical case management may be provided through the program for the family unit." We are concerned about the HIV infected child under the age of 13 who is NOT cared for by an infected mother, but rather by an uninfected family member (e.g., grandmother, aunt) or is in foster care. In many instances the infected mother may have died or lost custody of the child for some reason. These infected children under the age of 13 and exposed children under 2 do not have an infected

parent in the program and therefore do not seem to have any entry into the program on their own account. What is your recommendation?

Answer 33:

Pediatric care for infected and exposed infants is reimbursed by Medicaid and other Third Party Insurers. Case management and supportive services for HIV-positive and HIV-exposed children are available if the HIV-infected mother is enrolled in the Family-Focused Care for Women Program. The Office of Children and Family Services ensures that children in foster care receive required health services as well as supportive services such as case management, (you may wish to refer to *Working Together, Health Services for Children in Foster Care* at www.ocfs.state.ny.us/main/sppd/health_services). Case management and supportive services for HIV-positive children are available through referral and linkage to COBRA Community Follow-up Programs (Medicaid reimbursed programs) and other grant funded programs. Other supportive service needs of exposed infants or family members can be met through other resources, such as community referrals.

Question 34:

Component A, page 15, target population lists HIV positive women 25 years plus with dependent children:

- a) Are HIV exposed infants/infected children under age 13 living in foster, adoptive or kinship foster families eligible for services under Component A?
- b) If a woman under age 25 with children is currently receiving services in a family care setting, would they be eligible to continue their services through a site funded through Component A?
- c) Can women under age 25, with dependent children, be referred to a Component A program?

Answer 34:

- a) Pediatric care for infected and exposed infants is reimbursed by Medicaid and other Third Party Insurers. The Office of Children and Family Services ensures that children in foster care receive required health services as well as supportive services such as case management. Supportive service needs of other family members should be met through other resources, such as community referrals.
 - b, c) Yes to both questions, as long as the woman is HIV-positive with dependent children or a pregnant HIV-positive woman of any age. There is no client eligibility requirement for a client to be 25 years of age. As per the target populations, page 15, HIV positive women with dependent children or who are pregnant and diagnosed with HIV are appropriate to be served under Component A.
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Question 35:

- a) In the eligibility section of the RFA for Component A, onsite services for 75 OB/GYN and adult HIV positive women age 25 and older outside of New York are targeted. The

eligibility does not specify women with children. Within the preferred categories, there are prenatal and family-centered care. In this new RFA initiative, can the 75 or more HIV-positive women over 25 be eligible if they do or do not have children in their care?

b) Does Component A support pediatric medical care?

Answer 35:

- a) As stated on page 15 of the RFA, the target populations for Component A are HIV-positive women who have dependent children living with them and pregnant women diagnosed with HIV. The program model is intended to provide HIV services in the context of family. The **applicant eligibility** criteria to serve 75 HIV-infected women annually (outside of New York City) was chosen to serve as a benchmark based on current number of women being served at Article 28 facilities. It is expected that during the first year, applicants funded for Component A will serve a caseload of 75 women living with HIV and their children. This number may also include young women less than 25 living with HIV who have children, and infected male adult caregivers of dependent children.
- b) Component A supports multidisciplinary care coordination with an HIV-experienced pediatric provider. It does not fund HIV pediatric medical care, which is funded through Medicaid and other Third Party Insurers.

Question 36:

Will HIV-positive children from 0-12 years old be grandfathered in to still receive services under this Family-Focused model of care? There are currently 30 HIV-positive children in this age group in the Hudson Valley, and 684 HIV-positive children in all 62 counties of New York State (2007 epi data). It is understandable that due to a decrease in positive births that funding must be cut going forward. However the fact remains that these children still require services that fall under Family-Focused HIV Care.

Answer 36:

HIV-positive children 0-12 years of age will not be "grandfathered in" to receive services under the Family-Focused model. As noted on page 4 of the RFA, due to the significant decline in perinatal HIV transmission, resources were redirected to increase support for adolescent services. Also noted in the RFA, the statewide estimate of children younger than age 13 living with HIV/AIDS in NYS in 2010 is 295. HIV programs who wish to consider serving the pediatric HIV population should consider how best to maximize third party revenue for clinical services and determine what program referrals are necessary to ensure children receive the services needed. Additionally, HIV-positive children can be served through the Family-Focused Care Program with the mother as the index client. Medical case management may be provided for the family unit.

COMPONENTS B AND C QUESTIONS AND ANSWERS

Question 37:

Is it possible that one agency can be awarded funding under both Component B and C?

Answer 37:

Yes, as noted on page 5 of the RFA, "Agencies may apply for funding for each component; however, separate applications must be submitted for each." Agencies would need to be successful in the competitive award process for each component to be awarded funding.

Question 38:

We would like to confirm that a hospital that has the capacity to serve two regions cannot apply for funding for both regions.

Answer 38:

See Page 5, first paragraph, "An agency may submit only one application per component." While an applicant may propose to serve two regions in one application, funding awards for Component B will not exceed \$341,000 in NYC and \$275,000 in the rest of the state (see page 7). To further clarify, the location with the higher caseload would determine the primary region and an applicant would be competing with applicants in that primary region identified for the funding award.

Question 39:

My institution currently receives funding under both the Adolescent/Young Adult HIV Specialized Care Centers (SCC) as well as the Centers for Excellence in Pediatrics (CEP). As the CEP funding stream has been phased out and available funds have been shifted into the SCC stream, I have been advised to fold my CEP program into the SCC funding stream, given that the vast majority of CEP patients are already above the age of 13 years.

Given that my current SCC funding is already close to the maximum allowable amount to ask for on this RFA, there is no additional funding to fold my CEP program into my SCC program. I am essentially being asked to absorb 85 HIV-positive patients from my CEP program into my SCC program without any ability to request more funding. What are the possibilities that the maximum amount of available funding to provide for these patients will be higher at some point?

Answer 39:

Page 6 Section II. Available Funding of the RFA states, "Sources and amount of funding for this RFA are subject to change." RFA funds are supported by appropriations from the New York State Legislature and by federal Ryan White HIV/AIDS Treatment Extension Act funds. Grant awards are subject to change based on the availability of funding, approval by the Office of the State Comptroller, and continued federal support for this initiative.

As noted on page 4, paragraph 2 of the RFA: There has been a significant change in the size of New York's pediatric HIV population. This is a result of the decline in perinatal transmission due to successful activities to prevent mother-to-child transmission and the aging of the pediatric HIV cohort. Due to the significant decrease in the pediatric HIV epidemic, resources formerly supporting Centers of Excellence in Pediatric HIV Care are being redirected in this RFA to

enhance services for older children, youth, women and families. Also noted on Page 4 in paragraph 2 of the RFA, the statewide estimate of children younger than age 13 living with HIV/AIDS in NYS by 2010 will be approximately 295.

Each program considering applying for funding will need to evaluate their caseload and determine which clients would be most appropriately served through the Adolescent/Young Adult HIV Specialized Care Center, and consider how best to maximize third party revenue for clinical services (refer to page 26 of the RFA). Young adults should be transitioned to adult care by age 24 or earlier as appropriate.

Question 40:

Section III, page 10, Component B has a requirement of a proposal to serve a caseload of 30 HIV-positive adolescents/young adults outside of New York City annually.

- a) Will agencies that currently serve fewer than 30 patients in this age group but provide program plans to increase those numbers be considered?
- b) Is the requirement for Component B that agencies are already serving that number of patients?

Answer 40:

- a) As stated on page 10 of the RFA, applicants for Component B must “Propose to serve a caseload of at least 50 HIV-positive adolescents/young adults in New York City annually *or* propose to serve a caseload of at least 30 HIV-positive adolescents/young adults outside of New York City annually”.
- b) If the current caseload does not meet the minimum eligibility requirements of 30, the applicant must demonstrate how this requirement will be met in the first year of the contract.

Question 41:

Regarding Section III, page 11, Component B, will applications from agencies proposing to collaborate with other agencies and/or utilize subcontracts or multiple sites for services be considered? As of December 31, 2008 there were 229 HIV-positive youth ages 13-24 years old in the Hudson Valley Region. The seven counties span over 4,000 miles. This is a very large area to be covered by only one agency in one location for medical, case management, mental health and nutritional services.

Answer 41:

It is not the intent of Component B to be a consortium approach to care. An agency may chose to subcontract with one or more agencies to provide services on site that are not currently provided by the applicant agency (e.g., a psychiatrist, a community navigator). The applicant agency must meet the eligibility requirements listed on page 10.

Question 42:

Regarding the program model for low threshold services, page 19 paragraph 3, are programs allowed to budget funds in order to cover uninsured persons who are not diagnosed as HIV-positive, but are high risk. These funds would be used to cover costs associated with STI testing, HIV testing, family planning etc.

Answer 42:

Limited funding may be requested on the budget to provide low threshold clinical services to **uninsured** high risk youth for **short term services** (no longer than 6 months). The goal of these services is to connect youth who are identified as HIV-positive to HIV care or if HIV negative/unknown to refer for ongoing medical and needed supportive services.

Question 43:

What materials, if any, would be acceptable to purchase as program promotional items under Component B and C?

Answer 43:

Limited funding may be approved for materials related to promoting the program services, e.g. a program brochure or client educational materials on HIV/STIs. Any educational materials to be developed or purchased using AIDS Institute funding would need to be approved by the AIDS Institute's Materials Review Committee consistent with the Guidance for Review of AIDS Institute Contractor Educational Materials, which may be accessed at www.nyhealth.gov/diseases/aids/standards/docs/contractor_review_guidance.pdf. The New York State Department of Health website has a wealth of free materials on HIV, STIs, and other major health issues.

Question 44:

Under Components B and C, there is the mention of low threshold services, is it possible to budget the purchase of medications, i.e., antibiotics, emergency contraception and contraception, to provide these threshold services.

Answer 44:

Component B: To the extent possible, third party resources should be sought/utilized for needed medications, for HIV-positive adolescents/young adults, e.g., Medicaid, ADAP, Family Planning Benefit Program.

Component C: For high risk youth who are uninsured, limited funds may be budgeted for pharmaceuticals for acute illness, STIs or contraception. Please refer to page 23 of the RFA, Core Program Services Required On-Site, 10th bullet.

Question 45:

For adolescents who are uninsured and need pharmaceuticals, will necessary funds be allocated for this?

Answer 45:

For Component B, appropriate third party resources should be utilized for pharmaceuticals, e.g., Medicaid, ADAP, etc. For Component C, please refer to page 23 of the RFA, Core Program Services Required On-Site, 10th bullet: Immediate and limited access to pharmaceuticals to uninsured youth for acute illness, STDs or contraception" are required Core Program Services Required On-site, therefore, limited funds may be budgeted for this purpose only.

Question 46:

Under Component B can funds be allocated for expenses in running peer support groups and Consumer Advisory Boards (CAB)?

Answer 46:

It is expected that minimal funds might be needed for ongoing peer support groups and Consumer Advisory Board meetings. Nutritional supplements or Metro cards would be acceptable budgeted expenses.

Question 47:

Can money awarded under Component C be used to provide on-going medical services for HIV positive youth? (Page 22, Program Model Section, Paragraphs 1 and 2).

Answer 47:

No. The goal of the Youth Access Program is to reach HIV-positive adolescents/young adults whose status is unknown or who are not in care and connect them promptly to HIV /AIDS care. Youth Access Programs provide low threshold clinical services to **high risk** youth.

Question 48:

In regards to Component C, will preference be given to applicants who deliver services through a mobile outreach van?

Answer 48:

As noted on page 22 of the RFA, "Methods for implementing low threshold clinical services in community settings include but are not limited to:

- medically equipped vans
- part-time clinics in community-based settings
- mobile multidisciplinary teams."

Delivery of services via a mobile outreach van would be acceptable, provided it is medically equipped. It is not one of the preference factors listed on page 11 of the RFA.

Question 49:

Attachment 3, pages 4-5. This attachment states clearly that Part B funds **cannot** be used for: 1) HIV prevention/risk reduction for HIV-negative or at risk individuals and 2) HIV counseling and testing.

Both of these are required services to be provided under Component C, pages 19-20, Core Program Services. What required services specifically will be eligible for funding under Component C?

Answer 49:

As stated on page 9 of the RFA, Youth Access Program funding is through the New York State Budget, not Part B funds (Federal Ryan White Funds). Both HIV risk reduction services and HIV counseling and testing are required core program services targeted to high risk youth through the Youth Access Program.

Question 50:

Pg. 19, Program Model, 3rd paragraph, states that funded programs “may provide low threshold clinical services (up to 6 months) to high risk populations listed for Component C.” Does this only include partners of positive patients or any high risk adolescent population?

Answer 50:

Youth Access Program services should be targeted to high risk adolescents/young adults who fall under the target populations identified on pages 21-22 of the RFA. The last bullet of "Other young people for whom high risk can be documented..." would include partners of HIV-positive patients. However, this is not the only high risk population to be targeted.

Question 51:

Are funds going to be allocated for rapid HCV and pregnancy testing under Component C?

Answer 51:

Pregnancy tests would be an allowable budgeted expense under Component C. The HCV rapid test is not yet fully FDA-approved nor CLIA-waived. Therefore, it can only be used by laboratories with the appropriate certification. When full FDA-approval and CLIA waiver are obtained, a determination will be made.

Question 52:

Under component C, will funds be allocated for incentives?

Answer 52:

Very limited funds may be budgeted for certain items such as nutritional supplements or Metro cards for those adolescents/young adults that might not otherwise return for a needed service.

Question 53:

On page 25, Component C, Youth Access Programs, Core Program Services Required On-site, I want to know must all of the services listed be at the program site. If I am a CBO and I am collaborating with a community hospital, can the medical services, i.e. Pregnancy testing, screening for TB, Hepatitis A, B, C, and screening for STIs, can these services occur at the community hospital and the other core services be handled at my CBO?

Answer 53:

No. All core services, listed on page 23 of the RFA, must be rendered on site in accessible, community-based locations. The program model for Youth Access Programs is to provide low threshold clinical services and HIV/STD/pregnancy testing in the community and to facilitate entry into HIV care or other health care.

Question 54:

Page 41 of the RFA, under Section 5, Program Model, (h) states that applicants for Components A and B ONLY should describe the following: h) “The process for facilitating....”

If we are applying for Component B *and* C, do we need to respond to this question, or simply respond to h, i and j as applicable for Component C applicants?

Answer 54:

As stated on page 5 of the RFA, agencies may apply for funding for more than one component. However **separate applications must be submitted for each Component.**

If applying for Component B, Adolescent/Young Adult HIV Specialized Care Center, respond to Section 5, Question h.

If applying for Component C, Youth Access Program, a separate application must be submitted responding to Section 5, Questions h., i., and j.
