Grantee and Planning Council Roles and Responsibilities under Part A of the Ryan White HIV/AIDS Treatment Extension Act

Based on the Legislation as of the December 2009 Reauthorization and the 2013 Updates of the Part A and Part B Manuals

Note on Recent Reauthorizations and Planning Councils: The 2009 Ryan White HIV/AIDS Treatment Extension Act made relatively limited changes in the roles and responsibilities of Part A Planning Councils. More significant changes were made in the 2006 reauthorization, which divided Part A grantees into two groups based on number of new AIDS cases: Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). Both EMAs and TGAs that are former EMAs are required to have Planning Councils, which have the same roles and responsibilities they had under previous legislation. However, the 2006 Act led to the establishment of five new TGAs, which were not required to have a Planning Council. The Act did require the Chief Elected Official (CEO) of the TGA to provide documentation to HRSA/HAB that “…details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds from the grant…” [Section 2609(d)(1)(A)]. It also required that the application demonstrate “the inclusiveness of affected communities and individuals with HIV/AIDS” [Section 2603(b)(1)(f)]. Three of the new TGAs chose to have Planning Councils, which are bound by the same legislative requirements and HRSA expectations as other Planning Councils. Few changes in Planning Council operations were made in the 2009 Amendments, except for the addition of responsibility for estimating, assessing, developing a strategy for addressing the HIV-positive/unaware population. However, the legislative requirement for TGAs that are former EMAs to maintain Planning Councils ended in fiscal year 2013.

Sources of HRSA/HAB Expectations and Sound Practice: Sources of information on HRSA/HAB Expectations and Sound Practice include several documents, among them policies and program letters from HRSA, the Part A Manual, and the Planning Council Primer. All are available online. In addition, the National Monitoring Standards include updated service category definitions. They became available online in April 2011 and can be found at http://hab.hrsa.gov/manageyourgrant/granteebasics.html. Other documents and sources include the following:

- Policies and program letters are available online at http://hab.hrsa.gov/manageyourgrant/policiesletters.html.

Quotations describing HRSA expectations come from the Part A Manual unless otherwise noted.

* Updated by Emily Gantz McKay and Hila Berl of EGM Consulting, LLC in September 2014. Originally developed by Emily for Mosaica, under the Ryan White TAC, reviewed by HRSA/HAB, and updated several times. Current update not supported by public funds.

EGM Consulting, LLC and Mosaica
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| • Support needs assessment efforts  
  - If consultants are used, manage the procurement process to hire the vendor, ensuring that the Council plays the lead role in selection while municipal procedures are followed  
  - Have a staff member with relevant knowledge and skills attend meetings of the needs assessment Committee  
  - Provide information to support the needs assessment process, such as service utilization and cost data  
  - Help arrange access to information from other governmental units or provider agencies – such as epidemiologic data, in user-friendly formats or provider participation in PLWH surveys  
  - Where the grantee has staff with appropriate skills, provide advice and assistance in the process  
  - Where appropriate, | • Take primary responsibility for needs assessment  
  - Choose a committee to take primary responsibility  
  - Design and plan the needs assessment, in collaboration with the committee responsible for ensuring use of the data for decision making (usually Priorities and Allocations)  
  - Conduct or oversee the needs assessment process (can be done directly or through consultants)  
  - If consultants are to be used, work with the grantee to select consultants using approved municipal process  
  - Ensure that information is presented in user-friendly formats  
  - Present this information to the Planning Council and to the committee that oversees priority setting and resource allocations and provide explanation and interpretation as needed | • Section 2602(b)(4) of the Ryan White legislation requires Part A Planning Councils to conduct needs assessments that: “determine the size and demographics of the population of individuals with HIV/AIDS”; “determine the needs of such populations, with particular attention to: (i) individuals with HIV/AIDS who know their HIV status and are not receiving HIV-related services; (ii) disparities in access and services among affected subpopulations and historically underserved communities; and [as of 2009] (iii) individuals with HIV/AIDS who do not know their HIV status.”  
• Section 2602(b)(4)(G) requires the Part A Planning Council to “establish methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels.”  
• Section 2603(b)(1) specifies that in seeking supplemental funding, the EMA or TGA is | • The Planning Council plays the lead role, but needs assessment is a partnership activity of the Planning Council, grantee, and community.  
• The needs assessment can be managed by the Planning Council, Planning Council staff, a needs assessment committee, a consultant, or some combination of volunteers and paid staff. Whatever process is used, the Planning Council needs to develop “ownership” of the needs assessment process. If consultants or staff are used, they should be seen as the Planning Council’s representatives.  
• Grantee needs to be involved in and supportive of the needs assessment process, be familiar and comfortable with the findings, and review results to identify issues involving grantee responsibilities.  
HRSA/HAB recommends a multi-year needs assessment cycle that over a period of 3 years includes the following five components:  
• An epi profile (to be updated annually)  
• An assessment of service gaps  
• An estimate and assessment of unmet need [the unmet need for primary medical care for PLWH who know they are HIV+ but are not receiving HIV-related medical care – to be updated at least every 2 years] and of the HIV+/unaware population  
• A provider inventory  
• An assessment of provider capacity and capability  
The Part A Manual provides summary information on these, and the Needs Assessment Guide provides detailed guidance on how to plan and implement each component. |
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<td>address issues identified in the needs assessment that involve grantee responsibilities such as quality of care</td>
<td>expected to provide information that “demonstrates the need in such area, on an objective and quantified basis, for supplemental financial assistance to combat the HIV epidemic.”</td>
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### Comprehensive Planning

- **Participate in Comprehensive Plan development** – usually by having a staff member on the responsible committee
  - If consultants are used, handle the vendor process to ensure that the Council has a strong voice in selection and municipal procedures are followed
  - Provide data for the Comprehensive Plan, such as epi, client cost and utilization, and available Quality Management and outcomes data
  - Develop goals and objectives related to grantee areas of responsibility, such as Quality Management
  - Help develop goals and objectives in areas of shared responsibility

- **Play the lead role in development of the Comprehensive Plan**
  - Develop a planning process and assign responsibility to a committee (e.g., Planning Committee)
  - Work with the grantee on hiring a consultant if needed, jointly agreeing on requirements and participating in the selection process
  - Set goals for the continuum of care and other areas of Planning Council responsibility (e.g., membership, consumer involvement) and help develop goals and objectives in areas of shared responsibility
  - Implement components of the Plan that involve Planning Council responsibilities

- **Section 2602 (b)(4)(D) of the Ryan White legislation requires EMAs and TGAs to “develop a comprehensive plan for the organization and delivery of health and support services” that addresses unmet need, is coordinated with HIV prevention and substance abuse treatment programs, is consistent with the Statewide Coordinated Statement of Need (SCSN), and [as of 2009] “includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in section 2604, with particular attention to reducing barriers to...”**

- **HRSA/HAB expects EMAs and TGAs to develop multi-year comprehensive plans that will:**
  - Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities
  - Establish and support an HIV care continuum
  - Coordinate resources among other Federal and local programs, and
  - Address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

On December 16, 2009, HRSA/HAB sent a letter to Part A grantees regarding the 2009 reauthorization requirements around HIV-positive/unaware individuals, including the PC’s responsibility for development of a strategy to address these provisions.

- It said that “Because the new requirements regarding early identification of persons who are unaware of their HIV status are closely linked to HIV prevention activities, supported by the Centers for Disease Control and Prevention (CDC).”
- HRSA “recommends that in those instances in which there are directly supported CDC-HIV community prevention groups, or similar local planning bodies, the PCs should work collaboratively with existing planning...”
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<td>(e.g., addressing unmet need)</td>
<td>• Monitor progress in implementing the Plan</td>
<td>routine testing and disparities in access and services among affected subpopulations and historically underserved communities.</td>
<td>bodies in the development of a strategy that will make these persons aware of their HIV status.</td>
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<td>• Implement components of the Plan that involve grantee responsibilities</td>
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<td>• Whenever possible, existing strategies should be strongly considered as the basis of this new Ryan White HIV/AIDS Program requirement.” Information on the PC’s strategy is now also requested in the Part A application.</td>
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<td>• Provide data to the Planning Council in a timely manner to help monitor progress on Plan goals and objectives, based on agreed upon data sharing</td>
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<td>HRSA/HAB currently requires each EMA and TGA to prepare and submit a comprehensive plan every three years. The last plan was due in May 2012 and covered the period 2012-2014.</td>
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### Priority Setting

- **No role in decision making on priorities**
- **Provide data to help with priority setting, such as service utilization data by service category**
- **Be present during the process to answer questions about grantee data and provide expert advice**

- **Set priorities**
  - Ensure a sound process and criteria for priority setting
  - Ensure that priorities are data-based
  - Ensure that priorities are reviewed annually, though sometimes there may be few changes in priorities

Section 2602(b)(4)(C) states that Part A Planning Councils are required to “establish priorities for the allocation of funds within the eligible area….”

- **Establishing service priorities means deciding, which HIV/AIDS services are the most needed and important for Ryan White-eligible PLWH in the EMA or TGA, and listing them in priority order. When setting service priorities, the Planning Council should consider only the relative importance of each service category for PLWH, not whether other funding streams are available.**
- **The Planning Council should use the HRSA/HAB service category definitions, since some service categories have been changed or eliminated following the 2006 reauthorization, which authorizes the Secretary of HHS to determine allowable support**
## Role of Grantee

- Develop its own budget for the use of grantee administrative funds and QM funds
- Provide data to support the allocations process, such as unit cost and other financial data and quality management data
- Help Planning Council in estimating costs of

## Role of Planning Council

- **Allocate resources to priority service categories**
  - Where appropriate, separately allocate funds to subcategories within a broader service category
  - Agree with the grantee on a budget for Planning Council Support, which is a part of the overall 10% of funding that may be used

## Legislative Authority

Section 2602(b)(4)(C) states that Part A Planning Councils are required to “establish priorities for the allocation of funds within the eligible area….”

Under Section 2604(h) of the 2006 Ryan White reauthorization, the grantee is permitted to use up to 10% of the grant award for allowable administrative costs


- Some suggested principles for priority setting from the *Part A Manual* include:
  1. Decisions must be based on documented needs.
  2. Services must be responsive to the epidemiology of HIV in this service area.
  3. Priorities should contribute to strengthening the agreed-upon continuum of care.
  4. Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
  5. Services must be culturally appropriate.
  6. Services should focus on the needs of low-income, underserved, and disproportionately impacted populations.
  7. Equitable access to services should be provided across geographic areas and subpopulations.
  8. Services should meet HHS Treatment guidelines and other standards of care and be of demonstrated quality and effectiveness.

### Resource Allocation (including Reallocation and Use of Any Carryover Funds)

**Overview:** The Planning Council must decide the amount or proportion of Part A program funds to be allocated to each of the service priorities it establishes.

**Allocations:** In addition to principles for priority setting, resource allocations should consider the following:

- The Ryan White legislation will be considered the funder of last resort.
- Part A will not be able to meet all identified needs.
- Allocations should be based on the best available...
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<td>bringing additional people into care</td>
<td>• Develop or approve all reallocations involving changes from Planning Council allocation decisions</td>
<td>(including Planning Council support activities), and another 5% or $3 million, whichever is less, for a clinical quality management program.</td>
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<td>• Prepare the final budget for the entire grant request, for submission to HRSA/HAB</td>
<td>• No role in determining the use of grantee administrative or QM funds</td>
<td>Section 2604(c)(3) requires that Part A programs allocate at least 75% of funds to “core medical services” – which now include:</td>
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<td>• Provide expenditure data to the Planning Council on a regular basis (usually monthly; not less than quarterly) throughout the year, so that Planning Council is aware of service categories that are under- or overspent</td>
<td>• If the grantee decides it cannot fully use administrative or QM funds, the Planning Council is responsible for reallocation of these funds</td>
<td>• Outpatient and ambulatory health services</td>
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<td>• Make recommendations to the Planning Council for reallocation of funds during the program year</td>
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<td>• AIDS Drug Assistance Program (ADAP) treatments</td>
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<td>• Provide data to support Planning Council decision making around carryover funds</td>
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<td>• AIDS pharmaceutical assistance</td>
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<td>• While carryover is permitted, prepare carryover request to HRSA/HAB, consistent with Planning Council decisions</td>
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<td>• Oral health care</td>
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<td>• Early intervention services</td>
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<td>• Health insurance premium and cost sharing assistance</td>
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<td>• Hospice services</td>
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<td>• Home and community-based health services</td>
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<td>• Mental health services.</td>
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<td>• Substance abuse outpatient care</td>
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<td>• Medical case management, including treatment adherence services</td>
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<td>data, not “passionate pleas” or anecdotal information.</td>
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<td>• The Council should consider to what extent these services are supported through other funding streams, and what additional need exists that cannot be met through the other funding sources.</td>
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<td>• Allocations should carefully consider the need to bring additional people into primary medical care and retain them in care.</td>
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<td>• The Council should use financial data such as average costs per client per year in allocating funds, so that it knows how many clients it can serve with its allocations.</td>
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<td>• Reallocations: The Planning Council must be informed of the changes to service priority allocations that result from any redistribution of program funds by the grantee. As with the initial disbursement of funds, the outcome of the redistribution must be consistent with the priorities and resource allocations of the Planning Council and meet the Ryan White requirement that 75% of program services funds be spent on core services. Any redistribution of funds by the grantee that is not consistent may lead to a grievance by the Planning Council.</td>
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<td>• Under the 2009 reauthorization, there are penalties for Part A grantees that do not spend at least 95% of their formula grant funds. Planning Councils need to work with their grantees to establish and implement rapid reallocations processes to ensure that at least 95% of these funds are expended.</td>
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<td>are needed for individuals with HIV/AIDS to achieve their medical outcomes” and are approved by the Secretary of Health and Human Services</td>
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**Directives**

- Use directives in procurement and contracting
- Monitor implementation of directives through contract monitoring and quality management
- **Provide directives to the grantee** to guide it in meeting Council-established priorities – usually related to populations to be served, geographic areas, and/or service models

Section 2602(b)(4)(C) requires Part A Planning Councils to “establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds…."

- Directives are instructions that the grantee must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care.

- The *Planning Council Primer* explains that “The planning council also has the right to provide directives” to the grantee on how best to meet the service priorities it has identified. It may direct the grantee to fund services in particular parts of the EMA or TGA (such as outlying counties), or to use specific service models. It may tell the grantee to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month). It may also require that services be appropriate for particular populations – for example, it may specify funding for primary care services that target gay men of color. However, the planning council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will quality. The planning council cannot be involved in any aspect of contractor selection (procurement) or in managing or monitoring Part A contract.”
**Role of Grantee** | **Role of Planning Council** | **Legislative Authority** | **HRSA/HAB Expectations and Sound Practice** (*Part A Manual, Policies and Guidance, and Project Officers*)
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| | | | • Directives are best developed collaboratively by the Planning Council and grantee. Grantees should work with the Council to understand its intent and help to craft language designed to address identified needs and attract eligible providers.

### Procurement

- **Carry out the procurement process** – prepare Requests for Proposals (RFPs), disseminate them widely, develop and implement a fair and impartial review process, select providers, and enter into contracts
  - Ensure that contracts reflect Planning Council allocations
  - Ensure that contracts require providers to meet standards of care set by the Planning Council

- **No role in procurement**

Section 2604(b)(2) permits contracting with public or nonprofit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area, including hospitals (which may include Department of Veterans Affairs facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, homeless health centers, substance abuse treatment programs, and mental health programs.

Section 2602(b)(5)(A) states that selection of those entities is the responsibility of the grantee, and “the Planning Council may not designate (or otherwise be involved in the selection of) particular entities as recipients of any of the amounts provided in the grant.”

- **Ryan White conflict-of-interest provisions reinforce the distinction between the Planning Council’s responsibility to set priorities and the grantee’s responsibility to procure particular services.** Planning Councils may not:
  - Name, recommend, or approve particular entities for funding
  - Be involved in the management of the contracts that govern the procurement of services, or
  - Participate or otherwise be involved in the review of funding applications or selection of providers of services.

- Grantee procurement is expected to meet both HRSA/HAB Part A policies for a fair and open process (as stated in the *Part A Manual* and summarized below) and regulations and municipal requirements.
  - The grantee is expected to widely disseminate its RFPs and to encourage applications from providers serving disproportionately impacted and traditionally underserved populations.
  - There should be an objective review process.
  - No one associated with the Planning Council should be involved in the process of reviewing applications.
  - Contracts should require compliance with standards of care and with HRSA/HAB and local client data, program, financial reporting, and key points of entry.
|----------------|--------------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------|
|                |                          |                       | requirements, as well as QM requirements.  
|                |                          |                       | • Grantee may contract with a for-profit provider only if there is no qualified nonprofit or public provider in the service area. In rare instances, grantee may have to contract with a provider headquartered outside the EMA or TGA if it is the only qualified entity available to provide the service. |
|                |                          |                       | **Contract Monitoring**  
|                |                          |                       | • **Carry out program and fiscal monitoring of all funded providers** to ensure that all contract requirements are met, established standard of care are met, and program and fiscal management and reporting meet grantee and HRSA/HAB requirements  
|                |                          |                       | • Conduct annual site visits to providers using standardized monitoring tools, including review of a sample of client charts, as well as review of provider reports  
|                |                          |                       | • Provide site reports to providers, including action required to resolve identified problems  
|                |                          |                       | • Link to Quality Management efforts to improve services  
|                |                          |                       | **No role in contract monitoring**  
|                |                          |                       | • Use summary data in decision making  
|                |                          |                       | Contract monitoring can serve as a primary mechanism for documenting grantee compliance with multiple Ryan White requirements, including the following:  
|                |                          |                       | • Priority for women, infants, children and youth, Section 2604(f)  
|                |                          |                       | • Administrative caps for first-line entities, Section 2604(h)(4)  
|                |                          |                       | • Imposition of charges for services, Section 2605(e)  
|                |                          |                       | • Payer of last resort, Section 2605(a)(6)  
|                |                          |                       | • Provision of outreach to low income individuals, Section 2605(a)(7)(c)  
|                |                          |                       | Section 2602(b)(5)(A) prohibits the Planning Council from being “directly involved in the administration of a grant” under Part A.  
|                |                          |                       | **As specified in the National Monitoring Standards, grantees must provide regular program and fiscal monitoring of all funded providers, using consistent tools and procedures.**  
|                |                          |                       | **Grantees should pay particular attention to the issues of improper payments and unallowable costs under the Part A program. These have received increased scrutiny under the most recent Office of Inspector General (OIG) Audits.**  
|                |                          |                       | **Grantees should prioritize monitoring of new providers and of providers that appear based on reports, utilization data, or cost data to be experiencing difficulties in meeting contract requirements.**  
|                |                          |                       | **“Planning Councils should request that the grantee or administrative agency provide them with aggregate summary reports by service category of the information collected” during monitoring visits, to help them evaluate the expenditure patterns of the EMA or TGA as a whole, as well as service categories. If money is not being spent in an efficient manner, Planning Councils can know early on and reallocate funds to another service category or direct the grantee to reallocate on a dollar or percentage basis to other agencies within a particular service category.**  
|                |                          |                       | **“Grantees should not provide and planning councils should not have access to individual provider**
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<td>• Provide Planning Council summary reports by service category</td>
<td>• Provide and periodically update standards of care that can be used in QM</td>
<td>Section 2604(h)(5) of the 2006 Ryan White legislation requires that the chief elected official (CEO) “provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, 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.” A maximum of 5% of the grant award or $3 million, whichever is lower, can be used for clinical quality management.</td>
<td>According to the Part A Manual, the grantee is expected to: • Establish and implement a quality management plan with annual updates. • Establish processes for ensuring that services are provided in accordance with HHS treatment guidelines and standards of care. • Incorporate quality-related expectations into Requests for Proposals (RFPs) and EMA/TGA contracts, including at the sub-recipient level. A successful quality management program should: • Have identified leadership, accountability, and dedicated resources available to the program. • Use data and measurable outcomes to determine progress toward evidenced-based benchmarks. • Focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement. • Be adaptive to change and fit within the framework of other programmatic quality assurance and quality improvement activities (i.e., Joint Commission on the Accreditation of Healthcare Organizations [JCAHO], Medicaid, and other HRSA programs). • Ensure that data collected are fed back into the quality improvement process so that goals are accomplished and improved outcomes are realized. As described in the Planning Council Primer,</td>
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<td>• Quality Management</td>
<td>• Carry out clinical quality management (QM) – carry out analysis of provider performance based on QM criteria • Require development of provider QM plans and approve those plans • Report QM findings to funded providers and work with them on continuous quality improvement (CQI) • Prepare summary reports to the Planning Council on QM findings overall and by service category</td>
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<td>“Usually the planning council develops standards of care to guide providers in delivering services. The grantee uses these standards of care in monitoring contractors and in determining service quality, as part of its Clinical Quality Management function. Developing standards of care is usually a joint activity, but in most EMAs and TGAs, the Planning Council takes the lead. To do this, it works with the grantee, providers, consumers, and experts on particular service categories. (Note: These standards of care must be consistent with HHS guidelines on HIV/AIDS care and treatment as well as HRSA/HAB standards and performance measures.)”</td>
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## Cost and Outcomes Evaluation

- **Evaluate the cost-effectiveness of service strategies and models, including medical outcomes** (often part of QM)
  - Work with Planning Council in developing outcomes measures and evaluating program outcomes
  - Use results in Part A application in seeking supplemental funds
  - Include outcomes evaluation requirements in requests for proposals and contracts

- **Evaluate the effectiveness of funded services in meeting identified EMA or TGA needs (optional)** – preferably integrated with QM
  - Develop outcomes measures for service categories, for use in effectiveness evaluation

- **Section 2602(b)(4)(C) of the Ryan White legislation requires Part A Planning Councils to “establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant” based on factors that include:**
  - “(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available….”

- **Section 2602(b)(4)(E) states that the Planning Council may, at its discretion, take the following actions:**
  - Evaluate the effectiveness of funded services in meeting identified EMA or TGA needs
  - Develop outcomes measures for service categories, for use in effectiveness evaluation

- **Evaluation of how well services are being delivered by funded providers and the cost effectiveness of such services are to be undertaken under the leadership of the grantee, as a part of Quality Management.**
  - Part A grantees should be able to compare the relative costs of providing a specific service among different providers. This necessitates having service standards, service units, and unit costs for each service. Quality of service is also a factor in determining cost effectiveness and needs to be considered both in selecting providers and in monitoring Quality Management programs.
  - Planning Councils need cost-effectiveness data to determine how to prioritize services and allocate funds. This is closely tied to outcomes evaluation in that services with better outcomes may be more costly but nonetheless more cost effective when outcomes are considered. Also important to consider is the way services are provided. For example, bus passes may be cheaper than but not as effective in assuring access...
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<td>discretion, “assess the effectiveness, either directly or through contractual arrangements, of the services offered [in the EMA or TGA] in meeting the identified needs.” Section 2603(b)(1)(D) requires that supplemental grants be based on applications that, among other factors, demonstrate “the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective….” and maintenance in care as taxi vouchers.</td>
<td>The 2006 reauthorization allows EMAs and TGAs to fund support services only if they can show that they help clients to “achieve their medical outcomes.” This makes evaluation focusing on clinical outcomes especially important.</td>
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<td>Assessment of the Efficiency of the Administrative Mechanism</td>
<td>Provide information to Planning Council to support this assessment, including information on the procurement process, contracting, consistency of awards with Planning Council priorities and allocations, distribution of funds, and provider relationships. Indicate to the Planning Council what action will be taken to address identified problems or weaknesses. Provide information to the Planning Council.</td>
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<td>Carry out an annual assessment of the administrative mechanism to determine how efficiently the grantee procures services and disburses funds, monitors contracts, provides prompt reimbursements to providers, supports the Council’s planning process, and follows Council allocations. Do assessment directly (with Planning Council support staff assistance) or through a consultant. Assign responsibility for</td>
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<td>2602(b)(4)(E) requires Planning Councils to “assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area….”</td>
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<td>The Part A Manual says that the purpose of the assessment of the administrative mechanism is “to assure that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. The planning council should not be involved in how the administrative agency monitors providers.” “The planning council may also assess whether the services that have been procured by the grantee are consistent with stated planning council priorities, resource allocations, and instructions as to how to meet these priorities. However, assessing the administrative mechanism is not an evaluation of the grantee or individual service providers, which is a grantee responsibility.” In evaluating the administrative mechanism, communication between the grantee and Planning Council is essential so that information can be</td>
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| about actions taken | the process, usually to a committee  
  • Design appropriate tools for the assessment  
  • Obtain information from the grantee, funded providers, and Planning Council members  
  • Analyze data and provide a written report to the grantee, including any needed action | efficiently shared. The Planning Council and grantee should establish, before the procurement process begins, a memorandum of understanding outlining a process and timeline for sharing data necessary to evaluate the administrative mechanism. The grantee must communicate back to the Planning Council the results of its procurement process.  
  • “If the council finds that the existing mechanism is not working effectively, it is responsible for making formal recommendations for improvement and change.” The grantee or administrative agency then needs to respond to the Planning Council in writing, informing it of corrective actions to be taken to improve or change the system. The Planning Council also has the right to bring a formal grievance if the grantee’s disbursement of funds is inconsistent with the Planning Council’s priorities and resource allocations. |  

### Coordination of Services and Planning

- Describe in annual application how the implementation plan relates to and is consistent with the SCSN  
- Require that providers sign agreements with points of entry to identify and link PLWH into care  
- Ensure that providers help clients obtain other resources to support primary care and other services wherever possible, so that Part A is

- Ensure that priority setting and resource allocation consider other funding streams, especially HIV prevention, substance abuse prevention and treatment, Medicaid, and CHIP  
- Ensure that Council membership includes required representatives of other agencies, such as Medicaid, HIV prevention, substance abuse, mental health, and social services,

**Planning Council:**  
- Section 2602(b)(4)(H) requires the Planning Council to “coordinate with Federal grantees that provide HIV-related services within the eligible area.”  
- Section 2602(b)(4)(C) requires that priority setting and resource allocation consider coordination with HIV prevention and substance abuse treatment programs, and availability of other governmental and non-governmental resources

See Part A Manual, Section XII, Chapter 3. Grantees and Planning Councils are required to collaborate with other publicly funded programs in the planning, funding, and delivery of services. Chapter 7 provides guidance regarding coordination and collaboration with HIV Prevention.

The Ryan White Amendments of 2000 and 2006 expanded requirements for coordination with non-Ryan White legislation programs and payers from multiple sectors. Driving these changes is not only the funding represented by these entities (such as particularly Medicaid), but also the potential to coordinate planning and service delivery. The 2009 legislation further expanded the need for coordination,
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| the payer of last resort  
- Help the Planning Council in identifying other funding streams and share information about other available funding | including housing and homeless services  
- Collaborate with other publicly funded programs on needs assessment, estimation and assessment of unmet need, and development of the Comprehensive Plan, including strategies to coordinate services with HIV prevention and substance abuse prevention and treatment, including outreach and early intervention services | **Grantee assurances:** Section 2605(a)(3) requires the Part A application to include assurances adequate to ensure “that entities… that receive funds under a grant under this subpart will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV/AIDS.”  
The 2006 legislation includes provisions on Coordination in Part E. Section 2681(d) specifies “Integration by Local or Private Entities” and requires that to receive funds, “a local government or private nonprofit entity shall provide assurances to the Secretary that services funded…will be integrated with other such services, that 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.” | particularly with prevention and with points of entry, in order to meet the requirements for identification, testing, and linking to care of individuals who are HIV-positive but unaware of their status.  
On May 22, 2013, HRSA and CDC sent a joint letter to their grantees announcing their support of “integrated HIV prevention and care planning groups and activities… Activities to collaborate and/or develop a joint planning body are supported by both CDC and HRSA.” |

### Planning Council Operations

- Supports but does not direct the work of the Planning Council, nor  
- Develop and implement bylaws and policies to carry out its legislative  
Section 2602(b)(1) requires, that, “To be eligible for assistance under this subpart, the chief

**Independence of the Planning Council:**
- “The planning council is expected to be given full authority and support to carry out its roles and
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| does it carry out legislative duties assigned to the Council  
• Ensures that the Planning Council budget meets HRSA/HAB and municipal guidelines and fits within the 10% administrative cap  
• May hire Planning Council staff through grantee procedures, but does not supervise the work done by the PC staff | duties  
• In cooperation with the grantee, develop a budget for Planning Council support and monitor expenditure based on periodic fiscal reports from the grantee | elected official…shall establish or designate an HIV health services planning council ….”  
Under the 2006 Act, Planning Councils are required for all Part A programs that continue to qualify as eligible metropolitan areas (EMAs) – which means that they have had at least 2,000 new reported AIDS cases during the past five years and had at least 3,000 living cases of AIDS as of the end of the previous year.  
Former EMAs that do not meet this requirement, but have had 1,000 – 1,999 new cases of AIDS reported in the past five years and had at least 1,500 living cases of AIDS as of the end of the last calendar year, are now called Transitional Grant Areas (TGAs).  
New TGAs established as a result of the 2006 legislation are not required to have a Planning Council, but are required to carry out the same community planning activities and Section 2609(d)(1)(A) specifies that their application must detail “the process used to obtain community input (particularly from those with HIV) in the transitional area responsibilities. While the authority to appoint the planning council is clearly vested in the CEO, the planning council is not intended to be advisory in nature. It has legislatively provided authority to carry out its duties.”  
• While the CEO may designate a specific department within local government to administer the program, it is not appropriate for the grantee to perform duties related to the Planning Council’s legislative responsibilities. |
| Planning Council Support funds:  
The Part A Manual notes that: “The planning council needs funding to carry out its responsibilities. HAB/DMHAP refers to these funds as ‘planning council support.’ Planning Council Support funds are part of the 10 percent administrative funds available to the grantee for managing the Ryan White Part A program. The Planning Council must negotiate the size of the planning council support budget with the grantee and is then responsible for developing and managing that budget within the grantee's grants management structure.”  
Reasonable and necessary activities include both tasks directly related to legislative functions and the following costs that support multiple functions:  
• Staff support (professional and clerical)  
• Expenses of Planning Council members as a result of their participation  
• Activities publicizing the Planning Council’s activities for PLWH and efforts to substantively enhance community participation in Planning Council activities such as needs assessment and comprehensive... |
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<td>for formulating the overall plan for priority setting and allocating funds from the grant.”</td>
<td>planning • Developing and implementing Planning Council grievance procedures for decisions related to funding</td>
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<td>Section 2609(d)(1) of the 2009 legislation specifies that the CEO of a TGA may elect not to establish and maintain a Planning Council “if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds.” However, this option does not apply for fiscal years 2007 through 2013 if the TGA was already funded under Part A as of fiscal year 2006 – which includes TGAs that were formerly EMAs.</td>
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<td>On December 4, 2013, HRSA sent a letter to its grantees stating that HAB strongly recommends that the TGAs that previously received funding as EMAs “maintain the pre-existing structure in conformity with the Planning Council legislative requirements.”</td>
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<td>Section 2604(h)(3) of the 2006 Act specifies that one of the uses of the 10% administrative costs</td>
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**Section 2609(d)(1) of the 2009 legislation specifies that the CEO of a TGA may elect not to establish and maintain a Planning Council “if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds.” However, this option does not apply for fiscal years 2007 through 2013 if the TGA was already funded under Part A as of fiscal year 2006 – which includes TGAs that were formerly EMAs.**

On December 4, 2013, HRSA sent a letter to its grantees stating that HAB strongly recommends that the TGAs that previously received funding as EMAs “maintain the pre-existing structure in conformity with the Planning Council legislative requirements.”

**Staffing:** The procedures to be used in hiring Planning Council support staff or contracting with consultants need to be agreed upon ahead of time with the grantee. Planning Council staff may be employed through the grantee’s payroll system, but measures must be taken to ensure that the Planning Council, not the grantee, directs the work of the Planning Council’s staff. HRSA/HAB discourages the practice of having a single staff person perform administrative work for the grantee and provide support to the Planning Council, where it can be avoided.

**Contracting for services:** While the legislation prohibits Planning Councils from participating or otherwise being involved in selecting particular entities for funding, “it can be involved with selecting entities and people to carry out activities directly related to planning council functioning and responsibilities” (e.g., hiring a consultant to help with needs assessment). The planning council “should be keenly attuned to potential conflicts of interest (real or perceived) in these hiring decisions.”
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<td>include “the activities carried out by the HIV health services planning council.”</td>
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### Planning Council Membership

- **No involvement in membership except if bylaws specify that a grantee representative shall be a member of the Council (voting or non-voting)**
- **Using an open nominations process, nominate people to serve as Planning Council members, and provide these nominations to the CEO for appointment**
- **Ensure that membership meets representation and reflectiveness requirements**
- **Monitor member involvement and recommend to the CEO removal of any members who do not meet bylaws requirements**
- **Monitor terms and follow the approved process for deciding whether to renominate individuals whose terms are ending (Renominations go through the same Planning Council recommendations and CEO approval process as new nominees)**
- **Ensure that recruitment**

Section 2602(b)(1) of the Act requires that the Planning Council “reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations.” The legislation specifies required categories of membership and indicates that “Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria.”

The 2006 Act maintains the same set of required membership categories as previous legislation, but adds two additional subcategories within “affected communities.” It now specifies “people with HIV/AIDS, members of a Federally recognized Indian tribe as CEOs in membership:** The chief elected official (CEO) within the EMA or TGA is ultimately responsible for ensuring that the Planning Council has an open nominations process. HRSA/HAB expects the following from the CEO:

- **The CEO will approve and/or appoint as Planning Council members only individuals who have gone through the open nominations process**
- **Appointments to the Planning Council will be made in a timely way, to ensure minimal disruption of Planning Council activities**
- **The CEO and the Planning Council will work together to develop and implement the nominations process and ensure that it is incorporated into the Planning Council’s bylaws.**
- **Requirements for an open nominations process do not eliminate or change the authority of the CEO to appoint members of the Planning Council. However, CEOs must use the established nominations committee and process to screen all nominees. The nominations committee selects candidates for appointment to the Planning Council, which submits a list of one or more candidates to the CEO. Some Planning Councils review and approve the candidates provided by the nominations committee. Others simply accept and forward the committee’s list. From this list the CEO appoints members.**
- **If the CEO does not wish to appoint a candidate put**
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<td>and nominations occur in a timely manner, to avoid vacancies occurring when terms end</td>
<td>represented in the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations.”</td>
<td>forward by the committee, and this decision will create or maintain a vacancy on the Planning Council, the established nominations process must begin again to identify other candidates. All candidates must go through the Planning Council’s open nominations process and be recommended to the CEO by the Planning Council.</td>
<td>• HRSA/HAB expects the CEO to appoint members expeditiously and not create or leave a vacancy on the Planning Council by rejecting a candidate without providing clear justification.</td>
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<td>Section 2602(b)(5)(C) states that no less than 33 percent of the members must be consumers who:</td>
<td>• “are receiving HIV-related services” from Part A-funded providers;</td>
<td>• HRSA/HAB expects the CEO to appoint members expeditiously and not create or leave a vacancy on the Planning Council by rejecting a candidate without providing clear justification.</td>
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<td>• “are not officers, employees, or consultants” to any providers receiving Part A funds, and “do not represent any such entity”; and</td>
<td>• “reflect the demographics of the population of individuals with HIV/AIDS” in the eligible metropolitan area (EMA).</td>
<td>• Conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. Conflict of interest occurs when a Planning Council member has a monetary, personal, or professional interest in a planning council decision or vote.</td>
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<td>• “reflect the demographics of the population of individuals with HIV/AIDS” in the eligible metropolitan area (EMA).</td>
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<td>• Funded providers have an obvious conflict of interest around decisions (such as priorities and allocations) that may affect their funding.</td>
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<td>Section 2602(b)(5)(A-B) of the Ryan White legislation includes provisions on conflict of interest that prohibit three types of activities:</td>
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<td>• Consumers are not considered to have a conflict of interest.</td>
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<td>• Planning Council involvement in the management of grant funds.</td>
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<td>• Planning Council participation in the selection of particular entities as recipients of those</td>
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<td>Conflict of Interest</td>
<td>• Establish and consistently implement and enforce a conflict of interest policy – including a disclosure form, announcement of conflicts of interest during meetings, and action to manage conflict of interest</td>
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<td>• Ensure that any grantee representative serving on the Planning Council follows conflict of interest policies</td>
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<td>funds. A financial or governance relationship with funded providers on the part of “unaligned” consumer members of the Planning Council.</td>
<td>interest based solely on the fact that they receive a particular category of services. Serving on the Board of Directors of a funded provider does create a conflict of interest. Planning councils should employ a variety of strategies to minimize conflict of interest and its potential adverse effects. Conflict of interest policies should include disclosure forms and verbal disclosure of potential conflicts by a Planning Council member. Generally, individuals with a conflict of interest are not allowed to vote on the issue involved. Often they are not allowed to participate in the discussion either – since discussion may involve efforts to influence how others vote. Most Planning Councils require disclosure of conflicts of interest involving a member’s close family members (such as a spouse or committed partner, parent, parent-in-law, child, or sibling). Because Planning Council members may include representatives of the Part A grantee, use of Ryan White funds by the grantee may pose conflict of interest issues. Use of Part A funds by the Part A grantee for delivery of particular services (e.g., medical care through a health department clinic) should be based on direction from the Planning Council and/or an objective review process. While local rules on procurement of services may allow the grantee to use funds it administers for its own services, HRSA/HAB expects that such use will be subject to a public process if other entities in the community could provide the same services. Such a process is in keeping with the spirit of the Ryan White legislation, which bases the appropriate and efficient use of scarce resources on input from community and organizational</td>
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<td>representatives who are directly affected by the HIV epidemic.</td>
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<td>If the grantee provides funds to a clinic or other provider that is part of the municipal government, this entity will be covered by the same rules and regulations as all other Part A service providers – fiscal and program reporting, fiscal and program monitoring, quality management reviews, etc. These requirements are clearly stated in the National Monitoring Standards.</td>
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### Grievances

- Establish grievance procedures related to grantee functions
  - Define and determine what kinds of actions are covered by the grantee grievance process, ensuring that legislative requirements are met
  - Develop and maintain a process for handling grievances
  - Provide clear information on what kinds of issues can and cannot be grieved to the grantee
  - Periodically review and refine the grantee grievance policy and process based on experience

- Establish grievance procedures related to Planning Council functions
  - Define and determine what kinds of actions are covered under the Planning Council grievance process
  - Develop and maintain a process for handling grievances
  - Provide clear information on what kinds of issues can and cannot be grieved to the Planning Council
  - Periodically review and refine the Planning Council grievance policy and process based on experience

Section 2602(b)(6) requires the Planning Council to “develop procedures for addressing grievances with respect to funding,” and to describe these procedures in its bylaws.

Section 2602(c)(2) requires the grantee to develop grievance procedures consistent with model procedures developed by the Secretary of Health and Human Services. They must include “a process for submitting grievances to binding arbitration.”

Both Part A Planning Councils and Part A grantees are required to establish procedures to address grievances related to funding. The following must be included:

**Grievances in relation to Planning Council actions (priority-setting and resource-allocation process)**

Grievance procedures must allow directly affected parties to grieve:

- Deviations from an established, written priority-setting or resource-allocation process (e.g., failure to follow established conflict of interest procedures).
- Deviations from an established, written process for any subsequent changes to priorities or allocations.

**Grievances in relation to grantee actions (procurement process)**

Grievance procedures must allow directly affected parties to grieve:

- Deviations from the established contracting and awards process (e.g., the selection of a particular provider in a manner inconsistent with the grantee’s established procurement process).
- Deviations from the established process for any
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| • Ensure that all providers have a client grievance process | | | subsequent changes to the selection of contractors or awards.  
*Grievance procedures must allow Planning Councils to grieve:*  
• Contracts and awards not consistent with priorities (including any language regarding how best to meet those priorities) and resource allocations made by the Planning Council.  
• Contract and award changes not consistent with priorities and resource allocations made by the Council. |