MEMORANDUM OF UNDERSTANDING

Between

HIV Health & Human Services Planning Council of New York

hereafter referred to as "Council"[1]

and

NYC Department of Health & Mental Hygiene

Bureau of HIV/AIDS Prevention & Control

hereafter referred to as "Recipient"

Approved by the HIV Planning Council, May 30, 2019

Signed May 31, 2019

Purpose and Introduction

This is a memorandum of understanding (MOU) between the HIV Health and Human Services Planning Council of New York (Council) and the New York City Department of Health and Mental Hygiene (DOHMH)/Bureau of HIV/AIDS Prevention and Control (Recipient). The mission on the EMA is to ensure that people living with HIV (PLWH) have access to and maintain appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life.

The purposes of this Memorandum of Understanding (MOU) are to:

- Create a shared understanding of the relationship between the Council and Recipient;
- Delineate the roles and responsibilities of each entity; and
- Foster a mutually beneficial relationship between the Council and Recipient.

Under Ryan White legislation, the Recipient and the Council are independent bodies with both shared and complementary responsibilities. This MOU is a tool to help the

[1] "Council" refers to the body made up of Mayorally-appointed members of the HIV Planning Council as per Mayoral Executive Order 162

stakeholders establish norms of mutual cooperation. The underlying foundation of the memorandum is to promote open communication, foster active listening, build understanding, and acknowledge our shared goals. This document is built upon the understanding that the Council and the Recipient are equal stakeholders in the Ryan White process.

This document is intended to reflect legislative requirements of the Ryan White HIV/AIDS Treatment Extension Act. It is not meant to supersede or contradict any Federal, State, County, Local or departmental governances (such as laws, regulations, ordinances, Mayoral Executive Orders, or policies). The MOU shall be revised to be in accordance with such governances. In addition, this MOU shall not contradict the bylaws of the Council.

Both the Council and the Recipient share the goal of maintaining a comprehensive system of care for PLWH that is accessible to all, provides high quality care, and improves the health and quality of life for low income, uninsured, and underinsured PLWH. The Council and the Recipient are both dedicated to ensure that all PLWH residing in the New York Eligible Metropolitan Area (EMA) will have equal access to comprehensive health and social services in order to achieve optimal quality of life and health outcomes, which will contribute to ending the HIV epidemic.

Roles and Responsibilities

Roles and Responsibilities of the Council

The Council is responsible for the following:

1. **Priority Setting and Resource Allocation:** The Council is responsible for setting priorities among service categories, allocating funds to those service categories that comply with federal law and regulations, and providing directives to the Recipient on how to meet these priorities. This includes reallocation

(reprogramming) of funds as required during the program year and allocation of carryover funds for both Part A and MAI funds.

Annual Priority Setting and Resource Allocation Process:

a. The Council carries out priority setting and resource allocation by the deadline agreed upon with the Recipient, which is based on the Part A grant schedule and expected application deadline.

b. The process is data-driven in regard to service categories, allocation of funds to core medical and support services, directives, and the decision-making process.

c. The Recipient provides the Council with mutually agreed upon data and materials for use in priority setting and resource allocation, as specified in the chart in the Information/Document Sharing Section.

d. The Council develops spending scenarios to account for possible funding increases or decreases for the next fiscal year.

e. The Recipient implements Council priorities, allocations, and service guidance as approved by the Council, and reports on implementation to the appropriate committee(s) of the Council.

Reallocation/Reprogramming:

a. The Council is responsible for approving the reallocation or reprogramming of funds involving the transfer of funds from one service category to another during the program year and the use of carryover funds.

b. The Recipient may make proposals for the use of unexpended or unobligated funds to the Council at mutually agreed upon scheduled times or as necessary to ensure full expenditure and appropriate use of service dollars.

c. The Council develops and approves a reprogramming plan for the expenditure of unexpended or unobligated funds by June 1st of each year. It specifies the percentage and/or amount of funding that can be moved and to which service categories. When the Recipient does implement the reprogramming of funds, the Recipient will provide the Planning Council's Executive Committee with reasons why funds were unexpended or unobligated and a report on the service categories from which these unexpended funds originated.

d. The Recipient implements the Council's reprogramming plan for the expenditure of unexpended or unobligated funds.

e. The Recipient informs the Council of the amount and type ofunobligated funds available for carry-over, and the Council develops and approves a plan for use of the carry-over dollars prior to the submission of the carry-over request to HRSA.

f. The Recipient submits a proposal to HRSA for use of carry-over dollars before the deadline that is consistent with the approved Council plan and reports to the Council on the results.

2. **Assessment of the Efficiency of the Administrative Mechanism:** The Council is responsible for evaluating how quickly and efficiently the Recipient contracts with service providers and how long the Recipient takes to pay the contracted providers. The Council also determines whether the Recipient used service funds as specified in the Council's priorities and allocations. The Executive Committee of the Council carries out an assessment of the efficiency of the administrative mechanism each year and provides a report on findings and recommendations to the full Council for review and approval.

a. The Recipient provides information needed for the assessment on a mutually agreeable timeframe, and facilitates any needed collection of information from funded service providers, so that the Council can implement an independent assessment.

b. The Council provides the report to the Recipient by July 31st of each year for use in the Part A application.

c. The Recipient will report within 90 days on a corrective action plan to address deficiencies identified in the assessment of the administrative mechanism.

3. **Planning Council Operations:** Council staff, under the Director, HIV Health & Human Services Planning Council of New York (hereinafter referred to as the Council Director), works with the Council to manage and support Council operations. The staff role is collaborative with but independent of the Recipient.

a. Council staff support all Council operations, primarily through working with the Council Co-Chairs and Committee Co-Chairs and staffing all Council and committee meetings. As DOHMH employees, Council staff may access, as appropriate and necessary to their role, information that Council members are not allowed to review as per the HRSA Ryan White Part A Manual.

b. The work of the Council is guided by its Bylaws and written policies and procedures, which are developed, reviewed, and updated under the leadership of the Rules and Membership Committee. Council staff help ensure that these policies and procedures are met.

c. The Mayor retains sole responsibility for appointment of all members to the Council. Nominations to the Mayor are made through an open nominations process that meets federal requirements and applicable Mayoral Executive Orders. To ensure that the Council operates as an independent partner of the Recipient, the Recipient does not play any role in Council member selection or recommendations, or in the selection of committee members.

d. The Governmental Co-Chair of the Council is appointed by the Commissioner of the NYC Department of Health and Mental Hygiene.

e. Committee members who are not Council members are vetted by the Rules & Membership Committee and selected by the Governmental Co-Chair, in consultation with the Community Co-Chair and the Finance Officer.

Roles and Responsibilities of the Recipient

The Recipient is responsible for the following:

1. Procurement and Contracting: The Recipient manages the process for awarding contracts to specific service providers, ensuring that funds are expended according to the priorities, allocations, and directives of the Council. The Council may not designate (or otherwise be involved in the selection of) particular entities as sub-recipients of the amount allocated. The Council and its staff play no role in procurement or contracting, except as outlined in the section on Shared Administrative Responsibilities/Provider RFP (see page 13, line 29).

2. Contract Monitoring: The Recipient, directly and through its administrative agency, monitors contracts to be sure that providers are meeting their legal responsibilities in compliance with established standards of care.

a. The Council sees contract monitoring and expenditure data, by service category, not by individual service provider.

b. The Recipient informs the Council of expenditures by service category as requested, but no more frequently than quarterly, and identifies the need for reprogramming of funds during the grant year based on service category expenditures as per the Deliverables section of this MOU.

3. Clinical Quality Management: The Recipient has responsibility for establishing and implementing a clinical quality management program to assess the extent to which HIV-related health services are consistent with Public Health Service guidelines, to enhance health and supportive service access, and to delivery and continuously improve systems of care. This involves design and

implementation of a Quality Management plan in accordance with HRSA requirements.

a. The Council is not engaged in the implementation of Quality Management, but has primary responsibility for establishing standards of care which are used as part of quality management (as described in shared responsibilities below). The Council participates in the Quality Management program, as determined by the Quality Management plan.

b. The Recipient reports to the Council on an annual basis on the components and outcomes of Quality Management by service category, for its use in decision making.

Shared Responsibilities

The Recipient and Council (referred together as "the EMA") share the following legislative responsibilities, with one entity having the lead role for each, as stated below:

1. **Needs Assessment:** The Council has primary responsibility for needs assessment, which includes designing a comprehensive multi-year needs assessment that meets legislative requirements and oversees its implementation. The Recipient assists with the design of the needs assessment and overall process, providing the Council information such as epidemiologic data, service utilization data, and expenditures by service category.

a. Through the Needs Assessment Committee and the Council staff, the Council manages all required needs assessment activities, and ensures that other committees receive objective information in user-friendly formats for use in decision making.

b. Recipient staff assists with implementing various needs assessment data collection and analysis activities, based on the needs assessment plan developed and overseen by the Needs Assessment Committee.

c. The Council staff coordinates training for Council members on how to understand and use epidemiological data and other needs assessment, cost, and utilization data.

d. The Council works with its staff and the Recipient to arrange key outside researchers and program staff on subjects being reviewed by the Council.

e. The Recipient supports production of an annual presentation for the Council on the size and demographics of the epidemic and other data needed for planning purposes, in coordination with HIV Surveillance staff and the Needs Assessment Committee.

2. **Comprehensive Planning:** The Council and the Recipient work together with NY State and other responsible parties to develop a comprehensive plan (currently the Statewide Integrated HIV Prevention and Care Plan) for the organization and delivery of health and support services within the EMA. The plan is developed as specified by the HRSA HIV/AIDS Bureau, and is developed and structured to meet all specifications in the guidance provided by the HIV/AIDS Bureau.

a. Both the Council and Recipient develop a work plan to identify goals, objectives, tasks, and timelines for a comprehensive plan.

b. Both the Recipient and the Council approve the comprehensive plan before submission.

c. The comprehensive plan describes the goals and objectives of the EMA, and is used by both the Council and the Recipient in maintaining and refining the system of care.

d. The Council reviews the plan each year and uses it in planning.

e. The Recipient implements the comprehensive plan to the extent that resources are identified and available, and reports annually to the Council on its role in implementation of the comprehensive plan.

3. **Early Identification of Individuals with HIV and AIDS (EIIHA).** As specified in the 2009 Ryan White legislation, the EMA is required to develop and implement a plan for the early identification of individuals with HIV and AIDS who are unaware of their status. Working in collaboration with the Recipient, the Council develops a strategy for identifying individuals unaware of their HIV status by population subgroup, informing individuals of their HIV status, referring individuals to care, linking them to care, ensuring appropriate relationships, and attempting to overcome legal barriers.

   The Recipient estimates the number of HIV-positive/unaware individuals in the EMA, implements the EIIHA strategy, ensures documentation of EIIHA-related activities, and monitors and reports progress. The Council works with the Recipient to refine its strategy annually in time for inclusion in the Part A funding application.

4. **Evaluation:** The EMA assesses the effectiveness of the services offered in meeting the identified needs, based on aggregate data of performance measures and evaluation studies.

   a. The Recipient takes the lead on evaluation based on HRSA-specified performance measures.

   b. The Council receives data on service effectiveness, provided by the Recipient annually to conduct data analysis for use in the planning process.

5. **Maintenance and Improvement of a System of Care:** The Council and Recipient share responsibility for the development, maintenance, and continuous improvement of a system of care for the EMA. The Council carries out this responsibility through such activities as priority setting and resource allocation, directives on how best to meet these priorities, design of service models, and approval of standards of care for funded service categories. Through needs assessment and comprehensive planning, the Council works with the Recipient to review, assess, and refine the system of care based on sound data. The Recipient carries out this responsibility through its partnership with the Council in needs

assessment, comprehensive planning, and the design of service models, and its role in provider contracting, contract monitoring, Clinical Quality Management, and data gathering and analysis. The maintenance and improvement in the system of care must be consistent with the Council's service priorities, directives and standards of care.

a. Standards of care are used to establish minimum expectations for the delivery of services. They help define how services are structured and delivered, and guide quality management and contracting.

b. The EMA uses New York State Guidelines, Standards and Indicators for clinical services, developed with the input of both clinicians and people living with HIV and AIDS for applicable service categories. The Council provides input to these processes through participation of Council members. The EMA can adopt available standards of care or indicators such as those developed by New York State.

c. The Council develops its own service directives for Part A categories other than ADAP, through the Integration of Care Committee, with support from the Recipient. The directives describe the goal of the service category, how the service relates to the objectives of the comprehensive plan, the service model and service elements, and client and agency eligibility. The Council and Recipient jointly develop standards of care for all Part A service categories other than ADAP.

Administrative Responsibilities: In addition to these legislative roles, the Recipient and Council have the following related or shared responsibilities with regard to Part A planning and management:

1. **Recipient and Council Support Staff**: The Council support staff is responsible for coordinating and supporting the work of the Council and its committees, to enable the Council to meet its legislative responsibilities. Supervision and

management of Council support staff are kept separate from Recipient staff management and supervision in order to ensure that the Council operates as an independent body.

a. Recipient staff members are DOHMH employees supervised by the Bureau of HIV Prevention and Control.

b. The Council support staff are DOHMH employees supervised by DOHMH staff, other than recipient staff, as determined by the Commissioner of Health, but are expected on a day-to-day basis to meet the needs of the Council.

c. When the Council Director is hired, the Council provides input regarding the job description, including expectations and qualifications. The Community Co-Chair is kept informed throughout the hiring process, in accordance with NYC hiring policies and procedures.

d. Recipient staff are not involved in the final hiring decisions of the Council Director and support staff, in order to maintain the independence of the two entities, but may participate in the interview process when requested.

e. The Council Director has primary responsibility for selecting and supervising other Council support staff members, within the local personnel system.

f. The Council, through the Community Co-Chair, will provide annual feedback through a formal evaluation mechanism on the performance of the Council Director.

2. **Budgeting and Fiscal Management of Council Support Funds:** Each year, the Council negotiates the amount of the Council support budget with the Recipient, since that budget is a part of the administrative budget for the EMA. The Council controls its budget once the amount has been determined.

a. The initial negotiation on the Council support budget will be undertaken by the co-chairs and finance officer of the Council and the Director of Care and Treatment and/or his/her designee. Negotiations must be completed and the

budget ratified by the Executive Committee within 30 days of the Notice of Grant Award.

~~b~~. Funds provided are sufficient to ensure that the Council can fulfill its legislative mandates and responsibilities.

~~c.~~ Once the amount has been agreed upon, the Council and its staff are responsible for working with DOHMH to determine how best to use these funds to carry out the Council's legislative responsibilities and manage Council operations.

d. The Executive Committee approves any budget modifications during the program year.

~~e.~~ DOHMH manages, but the Council and its staff control the Council budget. DOHMH provides fiscal management of Council support funds, ensuring that all expenditures meet Ryan White and general federal fiscal requirements as well as local financial management regulations. The Council support staff and Finance Officer, and the Executive Committee share responsibility for monitoring Council expenditures, based on reports provided to Council support staff.

3. **Contracting for Council Consultants or Vendors:** DOHMH provides contracting support when the Council needs to hire consultants or other vendors to carry out work funded through its budget.

a. The Council through its committee structure determines the need for consultants or vendors that cannot be filled by existing Council or Recipient resources to help conduct its business, and the Council staff drafts the scope of work and required qualifications and solicits consultants or vendors.

Contracting must meet local and federal procurement requirements as well as Ryan White guidelines.

b. The process, including oversight of deliverables, is managed by Council support staff.

4. **Annual Grant Application Process:** The Recipient has primary responsibility for preparation and submission of the Part A grant application and for responding to Conditions of Award (COA). The Council is responsible for providing information related to its legislative responsibilities.

   a. The Council through its support staff provides information for the application sections related to Council membership and responsibilities (such as, but not limited to, priority setting and resource allocations), and assists with preparation and review of the application. The Council provides information required for the grant application on a mutually agreeable timeframe.

   b. The Council approves action by the Co-Chairs to sign a letter accompanying the application that indicates that the application was developed in accordance with Council priorities, allocations, and directives.

   c. Council members may review the 2nd draft of the grant application narrative and any available attachments, with the exception of the line item budget.

   d. Council Co-Chairs (Governmental and Community Co-chairs) write and sign letters to fulfill Conditions of Award (COA) as required and submit them to the Recipient in time to be sent to HRSA before the deadline, and share copies with the Council.

   e. The Council takes any other actions needed to fulfill COA as notified by the Recipient or by HRSA.

Provider RFP: Procurement is the Recipient's responsibility. The Recipient ensures that contracts provide for the services described in the RFP and services are consistent with the Council's priorities and directives.

   a. Council staff will review a final draft of the RFP. The review will be limited to ensuring that RFPs are consistent with the Council's priorities and directives on a mutually agreeable timeline.

   b. Council members have two weeks from the issuance of a concept paper and RFP to file a grievance with the Recipient regarding a deviation from the

Council's service directives via a process outlined in the Planning Council's Policies and Procedures.

Communications

Communications Procedures

Both the Recipient and the Council recognize the importance of regular and open communications and of sharing information on a timely basis. Information needs to be received regularly. There should be clarity regarding what is to be communicated, when, and to whom. When problems or issues arise, there should be a joint commitment to resolving them through established procedures. The parties commit themselves to the following procedures:

1. All parties take responsibility for establishing and maintaining open communications. This includes both sharing information on a timely basis and reviewing shared information once it has been received. If issues or problems arise, it means communicating with the other parties to clarify the situation and decide how best to address it.

2. Every Council standing committee has a Recipient staff member who is assigned to it and attends meetings regularly, with the exception of the Rules & Membership, Consumers and Policy Committees. That staff member serves as liaison to the Recipient for that committee and is responsible for all regular communications and information requests related to that committee. The Recipient is represented by at least one staff member at other Council meetings as requested by the Council, with two weeks notice required for participation.

3. The Recipient and Council each has a designated liaison responsible for sharing and receiving information for all other communication requests, and for disseminating information within his/her entity. When questions or concerns

arise, the designated liaison ensures that they are addressed in a timely manner. For the Council, the designated liaison is the Council Director. For the Recipient, it is the Director of HIV Care and Treatment or designee.

4. Both entities use designated liaisons and channels of communication. When a committee needs information or materials pertinent to the legislative responsibilities of the Council, but not included in the data or reports regularly shared, the committee requests the information through the designated liaison, and the request is made in writing (via e-mail or letter) to the Director or Deputy Director of Care and Treatment. For example, a Committee Chair who needs information from the Recipient requests it through the assigned Council staff liaison. The Council staff liaison will then transmit the request formally as described above. For information beyond routine reports and information, it is the responsibility of the Council Director and the Director of HIV Care and Treatment or designees to determine whether the Recipient is the appropriate source for such information and whether the information is available and can be provided within the Recipient's resources. Where the Recipient cannot meet the request, the Director of HIV Care and Treatment or designee consults with the Council Director and with the Council Co-Chairs to resolve the request.

5. When policies or procedures appear problematic, the parties work together to clarify and, if appropriate, refine them – while adhering to legislative requirements, HRSA/HAB guidance and expectations as stated in Part A-related manuals, policy statements, and guidance, and state and local statutes and policies.

Communications and problem solving are used to protect the separation of roles between the Planning Council and Recipient. For example, Council members will not have access to information about the performance or expenditures of individual providers; it should receive such information only by service category.

6. Council members do not use in meetings or decision making any information about individual providers, even if it is available to members as individuals.

7. If either Recipient staff or Council support staff or members receive complaints about the other party, they inform the other party, maintaining appropriate protection of confidentiality.

8. The Council does not become involved in consumer complaints about services. If the Council or its support staff receive consumer or provider concerns or complaints about a specific provider, they refer the individual expressing the concern to the individual provider for resolution through its established complaints/grievance processes. Council or support staff may also refer them to the Recipient.

9. The Recipient is responsible for communication with HRSA on all administrative activities and on issues related to the grant application and COA process. The Council Co-Chairs and the Council Director may communicate directly with the HRSA Project Officer on matters related to the Council's legislative responsibilities. Individual Council members may contact the HRSA Project Officer to discuss Council-related issues at the Project Officer's invitation.

Implementing these Procedures

To facilitate communications and implement these communications procedures, all parties agree to the following actions:

1. Council Co-Chairs and Council support staff will meet (either in person or by conference call) at least quarterly with Recipient staff outside of regular Council meeting times.

2. The Recipient and Council will cooperate on developing a shared timeline to ensure coordinated and timely activities.

3. When making special requests for information or materials, both parties agree to provide as much lead time as possible; when sharing information, both parties will do so as quickly as possible. Normally, information received by one entity but important to both – such as Conditions of Award, new or revised HRSA/HAB regulations or expectations, and the Part A Program Guidance – will be shared within three business days. Both parties commit themselves to responding rapidly to any requests that involve meeting Conditions of Award, satisfying other HRSA/HAB requirements or requests, and addressing other matters that may affect the EMA's Part A program.

4. Where no timeline exists for sharing of specific information or materials, a timeline mutually agreeable to both parties will be established.

5. If requested information is not received in a timely manner, the Director of HIV Care and Treatment or designee and the Council Director are responsible for resolving the situation.

Information/Document Sharing and Reports/Deliverables

Overview

This section specifies a set of materials to be provided and information to be shared through meetings. Parties to the MOU may meet to discuss and plan for data sharing throughout the year and may also request and receive additional materials or information, except for those that should not be shared for legal reasons.

Information to be Provided by the Council to the Recipient

The Council will provide the Recipient or designee with the following information and materials:

The Council will provide an annual planning schedule/timeline/work plan for the full Council and all committees within two months of the first Council meeting of the planning cycle.

Information/Documents to be Provided by the Council to the Recipient	Timing
1. A dated list of Council members and their terms of office, with primary affiliations as appropriate	Provided annually and updated during the year as membership changes
2. Notification of the Council's monthly meetings, retreats, orientation and training sessions, and other Council events	At the same time notification goes to Council members
3. Council staff meets with the Recipient staff to coordinate planning needs	On a monthly basis
4. The meeting notice, agenda, and information package for each Council meeting	At the same time this information is provided to Council members
5. Annual service priorities rankings, list of service categories and resource allocations, along with the process used to establish them; approval of a preliminary spending plan for grant application and final spending plan based on full grant award	Within 5 business days after Council approval

Information/Documents to be Provided by the Council to the Recipient	Timing
6. Annual reprogramming plan showing ranked service priorities, funding allocations and any guidance related to reprogramming	Within 5 business days after the Council has approved the plan
7. Guidance on how best to meet these priorities	Within 5 business days after Council approval
8. Copies of final planning documents, such as needs assessment reports and the comprehensive plan	Within 5 business days after their completion and Council approval
9. Information for the Part A application	Mutually agreed upon time frame based on Recipient timeline for completion of the grant application
10. Information to meet HRSA reporting requirements and Conditions of Award	Based on annual calendar of reporting requirements developed by Recipient

Information to be Provided by the Recipient to the Council

The Recipient or designee will ensure that the Council Director receives the following reports and information for the use of the Council. These will be the minimum requirements. Additional or different information needs will be discussed and agreed upon at monthly coordination meetings of the parties to this MOU.

Information/Reports to be Provided by the Recipient to the Council	Timing
1. Copies of: – The annual grant award notice including Conditions of Award – Any approved carryover request	Within [5] business days after they are received from the funding agency; more quickly when a response involves the Council and

Information/Reports to be Provided by the Recipient to the Council	Timing
– Other official communications from HRSA/HAB that involve the Council	is time-sensitive
2. Written 2nd and 3rd quarter commitment and expenditure report by service category, including approved spending plan, modified spending plan including reprogramming, funds committed, funds uncommitted, year-to-date expenditures, and year-to-date unexpended funds. Reasons for under-spending by service category will be provided.	At least 5 business days before the meetings of the Executive Committee. The 2nd quarter report should be delivered in December. The 3rd quarter report should be delivered in March. The 4th quarter close-out report should be delivered in June.
3. Twelve-month commitments and expenditure report after close-out of grant year, by service category, including approved spending plan, modified spending plan, funds committed, funds uncommitted, total expenditures, and amounts unexpended	Within 120 days after the end of the grant year
4. Data by service category on client waiting lists and wait times, where available	On the same schedule as the quarterly financial reports. The Council may make a special request for a specific service category, after which the recipient has 45-60 days to provide the data.
5. A document that provides data on overall base-funded services and MAI-funded services as well as each service category showing three years of contract data. Reports will include data agreed upon by the PSRA committee and Recipient, based on planning	November 30 for the most current grant year available for all categories

Information/Reports to be Provided by the Recipient to the Council	Timing
needs, and may include data such as number of contracts, service category allocation, carryover, modifications to the service category allocation, expenditures in dollars and percentages, units of service, number of clients served, demographics of clients served, special populations served, number and type of contractor issues identified during the year, systems-level considerations (e.g., payer of last resort analysis) and notes explaining data.	
6. Estimated carryover for submission of the carryover waiver request to HRSA/HAB at the end of the calendar year	Prior to submission to HRSA/HAB at the end of December
7. Actual carry-over based on the Federal Financial Report, along with recommendations for use of carry-over funds, including rationale and supporting data	Prior to submission to HRSA
8. Copy of the carryover plan submitted to HRSA/HAB, and the approved carryover plan	Within 5 business days after it is submitted or received
9. Copy of the end-of-year progress report , as submitted to HRSA/HAB, with a presentation to the Council if requested	Copy within 5 business days to Council co-chairs, with full report included in the following Recipient Report to the Council after submission to HRSA/HAB; presentation within 30 days after that if requested.
10. Epidemiologic data report and	As requested, within 30 days upon

Information/Reports to be Provided by the Recipient to the Council	Timing
presentation specifically targeted to provide information needed for planning, including size of the HIV population, trends, and subpopulation data as mutually agreed upon	request for use in needs assessment, comprehensive planning, priority setting and resource allocations
11. Needs assessment studies or analysis from DOHMH data sources (e.g., eShare, REU), as requested by the Needs Assessment Committee	As requested, 6-8 weeks from the time of a finalized request from the Needs Assessment Committee, to inform the planning process
12. Estimate of Unmet Need from most recent grant application	As requested, within 30 days upon request, for use in priority setting and resource allocations
13. Best available data from DOHMH data sources (e.g., eShare, REU) on cost effectiveness and/or outcomes by service category, if available	As requested, 6-8 weeks from the time of a finalized request , for use in priority setting and resource allocations
14. EIIHA (Early Identification of Individuals with HIV/AIDS) data report, providing information on the estimated number of individuals who are HIV+/unaware and the number who were: tested, found to be positive, informed of their status, not informed, referred to care, and linked to care, overall and by subpopulation – best available data	As requested, within 30 days upon request, for use in priority setting and resource allocations
15. Information, data, and proposed approaches from the Recipient necessary for the development of new service directives	6-8 weeks from the time of a finalized request and at least 5 business days before a committee or Council meeting at which they will be discussed or used for decision making

Information/Reports to be Provided by the Recipient to the Council	Timing
16. Information from the Recipient and administrative agency for completing the assessment of the efficiency of the administrative mechanism, including the procurement and grants award process and timing; statistics such as number of applications received, number of awards made; and reimbursement procedures and timelines. The recipient shall provide access to sub-recipient Part A contacts to conduct a survey of funded providers	30 days prior to the July Council meeting.
19. Drafts of the RFP (to Council staff only) to determine if it is consistent with Council priorities and directives.	Council staff will receive the final draft at the same time as all other reviewers of that draft. Council staff will have the same amount of time to review as other draft reviewers.
20. Quality improvement data aggregated by service category for planning purposes.	As requested, 6-8 weeks from the time of a finalized request

When the Council or a Committee requests special or additional information from the Recipient, the request will always be listed in the summary minutes of the meeting. In addition, Council support staff will provide a list of requests in a follow-up e-mail within two business days, with a copy to the Committee Chair and Council Co-Chairs, to the Director of Care and Treatment and/or to their designee. The best data available shall be provided at a mutually agreed-upon date.

Documents and Information that Will Not be Shared

In order to maintain the confidentiality of sensitive information, the following information will not be shared:

1. The Council will not share information on the HIV status of members of the Council who are not publicly disclosed as people living with HIV.
2. The Recipient will not share information about individual applicants for service provider contracts or about the performance of individual contractors – information will be shared by service category only. In limited instances, such as for the purposes of assessment of the administrative mechanism or service directive development, Council staff may receive information regarding individual providers to carry out the Council's planning functions. Individual performance, spending, or contractual data will not be shared with the Council or Council Staff.
3. The Recipient will make available an updated resource directory with a list of Part A providers publicly accessible at the beginning of each fiscal year, but will not be used by the Council for planning decisions.
4. Information about the individual salaries of Recipient and Council staff will not be shared beyond those with a direct need to know. Except for the Governmental Co-Chair, the Council will receive staff salary data on Council support staff only in the aggregate. The Council will not have access to the Recipient's detailed budget or the Quality Management detailed budget other than the summary version (SF 424) submitted in the Part A Application.

Settling Disputes or Conflicts

If conflicts or disputes arise with regard to the roles and responsibilities specified in this Memorandum of Understanding, the parties will use the following procedures to resolve them (the Council will be represented by the governmental co-chair and community co-chair; the recipient will be represented by the Director of Care and Treatment or his/her designee):

1. Begin with a face-to-face meeting between the parties to attempt to resolve the situation, if reasonably possible within five working days after the issue or dispute arises.

2. If the situation cannot be resolved by these parties, hold a meeting of representatives of both parties (Council and Recipient as represented by the responsible parties as described below) and their supervisors, to discuss the issue and reach resolution if reasonably possible, within ten working days after the initial meeting.

3. If the situation still cannot be resolved, hold a meeting of representatives of the Recipient and Council and their two supervisors with the Chief Elected Official or his/her designee. The decision of the CEO or his/her designee will be final.

Responsible Parties

The following are the responsible parties to this MOU, which include the names of the individuals holding these positions at the time this MOU is adopted, and their contact information. These individuals should receive all communications related to this MOU.

The MOU continues in effect regardless of change to any of the individuals who hold these positions. Their successors are expected to adhere to the MOU.

For the Recipient**:**

- Director of HIV Care and Treatment
- Deputy Director of Care and Treatment

For the Council:

- Council Community Co-Chair
- Council Governmental Co-Chair
- Council Director

MOU Duration and Review

Effective Date

The MOU becomes effective once it has been signed by all the authorized individuals representing the Recipient, the Council, and HRSA/HAB.

Duration

This MOU will remain in effect until the Ryan White Part A program ends or until it is revoked by either party. Revocation requires a 30-day notice by either party. The Council may revoke the MOU by a vote of the full Council. The Department of Health and Mental Hygiene may revoke the MOU by written notice from the Commissioner of Health. Reasons for the revocation must be clearly stated and disclosed.

Process for Reviewing and Revising the MOU

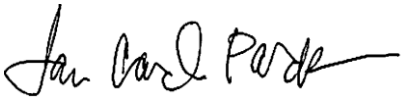
The MOU will be reviewed and revised periodically, with the involvement and approval of all parties, including HRSA/HAB. The MOU will be reviewed annually by the Recipient and the Rules & Membership Committee of the Council. Proposed changes or revisions may be developed by the Council and/or Recipient. All requested changes or revisions must be approved by both parties prior to

implementation. For the Council, the Rules & Membership Committee may recommend revisions at any time to the Executive Committee and then to the full Planning Council for approval. The Assistant Commissioner of the Bureau of HIV/AIDS Prevention and Control may submit a request for changes and revisions at any time. A review of the MOU will be carried out within six months after each reauthorization or legislative revision of the Ryan White legislation, to ensure that the MOU remains fully appropriate, updated, and reflective of the Act.

Once the MOU has been reviewed and revised, the amended version will be signed and dated by all parties. The revised version will become effective once signed.

Signatures

Graham Harriman, MA
Recipient Project Director



Jan Carl Park, MA, MPA
Council Governmental Co-Chair

Matthew Lesieur, MA
Council Community Co-Chair

Revised Memorandum of Understanding Approved by PC_5-30-2019