MEMORANDUM OF AGREEMENT

Between

HIV Health & Human Services Planning Council of New York

hereafter referred to as “Council”

and

NYC Department of Health & Mental Hygiene

Bureau of Hepatitis, HIV and Sexually Transmitted Infections

HIV Care and Treatment Program

hereafter referred to as “Recipient”

Approved by the HIV Planning Council, 10/26/2023

Signed 10/30/2023

Section I: Purpose and Introduction

The mission of the Eligible Metropolitan Area (EMA) is to ensure that people with HIV (PWH) have access to and maintain appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life. This is a Memorandum of Agreement (MOA) 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 Hepatitis, HIV, and Sexually Transmitted Infections (BHHS)/HIV Care and Treatment Program (Recipient). “Council” refers to the body made up of Mayorally appointed members of the HIV Health and Human Services Planning Council of New York as per Mayoral Executive Order 162. For the Council, the designated liaison is the Council Director. For the Recipient, the designated liaison is the Director of the HIV Care and Treatment Program.

The purposes of this Memorandum of Agreement (MOA) are to:

- Create a shared understanding of the relationship between the Council and the 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 MOA is a tool to help the stakeholders establish norms of cooperation and collaboration. The underlying objective of the MOA 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 optimizing the impact of Ryan White funding.

This document is intended to reflect legislative requirements of the Ryan White HIV/AIDS Treatment Extension Act while detailing roles and responsibilities among Council and Recipient staff. 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).

Both the Council and the Recipient share the goal of maintaining a comprehensive system of care for PWH that is accessible to all, provides high quality care, and improves the health and quality of life of low income, uninsured, and underinsured PWH. The Council and the Recipient are both dedicated to ensuring that all PWH residing in the New York Eligible Metropolitan Area (NY EMA) will have equitable 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.

Section II. Roles and Responsibilities

1. Priority Setting and Resource Allocation (PSRA): The Council is responsible for a data-driven process to set priorities for the Ryan White Part A (RWPA) program, rank those priorities, allocate funds to RWPA service categories that comply with Federal law and regulations, and provide 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. PSRA is an important legislative responsibility of a planning council, and greatly influences the system of HIV care in the EMA. [2602(b)(4)(C)] and 2602(d)(1)]

Annual Priority Setting and Resource Allocation Process:

a. The Council carries out the PSRA process with support from the Recipient on a timeline that adheres to the Part A grant schedule and expected application deadline.
b. The Recipient supports the Council’s PSRA process, including the provision of mutually agreed upon data,

and deliverables specified in the chart in the Information/Document Sharing Section, pp. 11-14.

c. The Council engages subject matter experts, research and testimony external to the RWPA service system to assess the RWHAP payor of last resort requirement.

d. The Council annually develops spending scenarios to account for possible funding increases or decreases. The Recipient implements Council approved priorities, allocations, and service guidance, and provides reports and presentations, as requested, to support the informed and timely submission of legislatively mandated deliverables in accordance with the dates outlined in Table B on page 12 of this document.

Reallocation/Reprogramming:

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

b. 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 to identified service categories.

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

d. When appropriate and of interest for the care of PWH, the Recipient is encouraged to make proposals to the Council beyond what is outlined in the reprogramming plan for the use of unexpended or unobligated funds at mutually agreed upon scheduled times or as necessary to ensure full expenditure and appropriate use of service dollars.

e. The Recipient informs the Council of the amount and type of unobligated funds available for carry-over. The Council develops and approves a plan for use of the carry-over funds prior to the submission of the carry-over request to HRSA. The Recipient reports the carryover approval and final use of carryover funds once approved by HRSA.

f. The Recipient will inform the Council, in a timely manner, if there is a change to a service category due to the termination of a subrecipient or other contingency that affects the delivery of the services as outlined in the Council's directives and allocation plans.

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 who are selected by the Recipient to deliver services for PWH pursuant to the Ryan White Part A grant ("Subrecipients") and how long the Recipient takes to pay the funded subrecipients. 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 fiscal 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 agreed upon timeframe and facilitates any needed collection of information from funded service providers, so that the Council can implement an independent assessment.

b. The Recipient will provide information for the assessment of the administrative mechanism to inform the Council's assessment of timeliness of contract executions and payments.

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

d. The Council may conduct a survey of subrecipients triennially. The Recipient will share an updated list of subrecipients for survey distribution.

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

a. Council staff are DOHMH employees. 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. Council members are appointed by the Mayor and must reflect the demographics of the population of individuals with HIV in the jurisdiction. 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. Committee members who are not Council members are vetted by the Rules and Membership Committee and selected by the Governmental Co-Chair, in consultation with the Community Co-Chair and the Finance Officer.

4. 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) Subrecipients during the procurement and contracting process. The Council and its staff play no role in procurement or contracting, except as outlined in the section on Subrecipient Procurement (see page 8). All federal fiscal reporting and required audits are the responsibility of the Recipient.

5. Contract Monitoring: The Recipient, directly and through its administrative agency, monitors contracts with Subrecipients to be sure that providers are meeting their legal responsibilities in compliance with established service directives. The Council sees contract monitoring and expenditure data, by service category, not by individual service provider.

6. 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 deliver and continuously improve systems of care. This involves design and implementation of a Quality Management (QM) plan in accordance with HRSA requirements.

a. The Council shares responsibility with the Recipient for establishing service standards which are used as part of quality management (as described in shared responsibilities below).

b. The Council participates in the NY EMA QM committee, which is managed by the Recipient, and provides input on QM activities as a stakeholder of the QM program. This committee addresses quality challenges and coordinates activities to ensure that QM/Quality Improvement is being used to improve client health outcomes and address health disparities.

c. The Recipient reports to the Council on an annual basis on the components and outcomes of QM across the RWPA portfolio or by service category, for its use in planning.

d. Council members will be invited by the Recipient to all QM trainings, but with priority given to RWPA subrecipients and PWH who receive services from RWPA programs.

e. The Council is not engaged in the implementation of QM program activities beyond input into the development of the QM plan.

f. The CHAIN Technical Review Team will include the Council staff liaison to the Needs Assessment committee, two Consumers Committee members, a Tri-County representative, the Director of the Council or designee and any additional Council member as agreed by the Council Director and the TRT leadership.

7. Needs Assessment: The Council has primary responsibility for needs assessment, which includes designing a comprehensive multi-year needs assessment that meets legislative requirements. 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. Data and information requested for the Needs Assessment should be submitted as outlined in table 2 on page 12 of this document.

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. Council staff coordinate trainings for Council members on epidemiological data and other needs assessment, cost, and utilization data.

8. Comprehensive Planning: The Council and the Recipient work together through a process led by the NY State Department of Health, and which includes BHHS, the NYC HIV Prevention Program, other NYS HIV Prevention and Care Planning Bodies, and other responsible parties to develop a comprehensive plan (currently known as 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 in accordance with guidelines from the HRSA HIV/AIDS Bureau and the Centers for Disease Control and Prevention.

a. Both the Council and Recipient identify the EMA's goals, objectives, tasks, and timelines for the Integrated Plan.

b. Both the Recipient and the Council approve the Integrated Plan before submission to HRSA/CDC.

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

d. The Recipient implements the Integrated Plan as applicable to Ryan White Part A funded services in the NY EMA and reports annually to the Council on its role in implementation of the Integrated Plan.

9. Early Identification of Individuals with HIV and AIDS (EIIHA). 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, 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 the strategy in time for inclusion in the Part A funding application.

10. Program Evaluation: The Council and Recipient assess the effectiveness of the services offered in meeting the identified needs, based on aggregate data on performance measures. Outcome measures are included in service directives for this purpose and will be developed collaboratively based on availability of data from the Recipient.

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, for use in the planning process.

11. Maintenance and Improvement of a System of Care: The Council and Recipient share responsibility for the development, maintenance, and continuous improvement of the NY EMA's system of care.

a. 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 service standards for funded service categories. Through needs assessment, comprehensive planning, and participation in the development of the QM plan, the Council works with the Recipient to review, assess, and refine the system of care based on data.

b. 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, QM, 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 service standards.

c. The Council and Recipient jointly develop service standards for all Part A service categories other than ADAP. Service standards, though a work product of the NY EMA and a shared responsibility, will be initiated by the Recipient and edited by a workgroup comprised of Council members and staff and Recipient staff. Service standards 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 program implementation.

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

e. The Council develops and approves service directives for Part A categories other than ADAP, through the Integration of Care Committee and with support from the Recipient. The service directives describe the goal of the service category, how the service relates to the objectives of the Integrated Plan, the service model and service elements, and client and agency eligibility. The service directives are used as the guiding document for the Recipient's RFPs.

12. 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 are 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 to ensure that the Council operates as an independent body.

    a. Recipient staff members are DOHMH employees within BHHS.

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

    c. When a new 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. Both the Recipient and Council staff are employees of DOHMH but are hired and supervised by different reporting entities. In order to maintain the independence of the two entities, Recipient staff are not involved in the final hiring decisions of the Council Director and support staff and

Council staff are not involved in the final hiring decisions of the Recipient and its staff, but may participate in the interview process when requested.

e. The Council Director has primary responsibility for hiring and supervising other Council support staff, within the NYC DOHMH personnel system.

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

2. Separation of Planning Council and Recipient Roles:

a. A separation of Council and Recipient roles is necessary to avoid conflicts of interest. The legislation prohibits Council public deliberations to be "chaired solely by an employee of the grantee." [2602 (7)(A)].

b. According to the legislation, a Recipient representative whose position is funded with RWHAP Part A funds, or who provides in-kind services, or who has significant involvement in the RWHAP Part A grant, shall not occupy a seat on the Council, nor have a vote in the deliberations of the Council.

3. **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 and is responsible for spending down funds.

a. Negotiation on the Council support budget will be undertaken by the co-chairs and finance officer of the Council and the Recipient. Negotiations must be completed, and the budget ratified by the Executive Committee, within 30 days of the Notice of full Grant Award.

b. In the event of a partial award, the Council's support budget will continue at the previous year's amount until the final award is received.

c. Funds provided must be sufficient to ensure that the Council can fulfill its legislative mandates and responsibilities.

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

e. Council budget modifications during the program year shall be reported to the Recipient and the Executive Committee. DOHMH manages the Council budget, but the Council and its staff control it. Specifically, 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, Finance Officer, and the Executive Committee share responsibility for monitoring Council expenditures, based on reports provided to the Council.

4. **Contracting for Council Consultants or Vendors:**

a. The Council, through its committee structure, determines its need for consultants or vendors that cannot be filled by existing Council or Recipient resources to help conduct business. 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. These processes, including oversight of contracted deliverables, are managed by Council support staff.

c. The Recipient provides support and advice to the Council regarding the procurement and contracting processes only. The Recipient does not carry out negotiations with consultants or contractors, make budgetary decisions, or in any way make material decisions related to the Council's consultants or vendors.

13. Grant and Non-Competing Continuation Application Process: The Recipient has primary responsibility for preparation and submission of the Part A grant application and for responding to reporting requirements. The Council is responsible for providing information for the application 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 to the Recipient on a mutually agreeable timeframe.

b. The Co-Chairs sign a letter of assurance to accompany the application that indicates that the application was developed in accordance with Council priorities, allocations, and directives.

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

14. Reporting Requirements:

a. Council Co-Chairs sign letters to fulfill reporting requirements as required by HRSA and outlined in Notice of Awards and submit them to the Recipient in time to be sent to HRSA before the deadline. Copies are shared with the Council.

b. The Council takes any other actions needed to fulfill reporting requirements as notified by the Recipient or by HRSA.

15. Subrecipient Procurement: Subrecipient procurement is wholly the Recipient's responsibility. The Recipient ensures that Ryan White Part A funded services are consistent with the Council's priorities, allocations, and directives.

a. Council staff will review a final draft of all Ryan White Part A-funded concept papers and RFPs before release to the public. The review will be limited to ensuring that RFPs are consistent with the Council's priorities, allocations, and directives.

b. For services procured through an MOU, the Recipient will send a draft scope of services from the MOU with a detailed written description of the program for review by Council staff to ensure consistency with the Council's priorities, allocations, and directives.

c. Council members have two weeks from the issuance of a concept paper or 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.

16. MOA Implementation:

a. The Director of the Council or a designee and the Director of HIV Care and Treatment Program/Project Director RWHAP Part A of the NY EMA or a designee will be jointly responsible for monitoring implementation of the MOA.

Section III. Communications

1. Communications Procedures: Both the Recipient and the Council recognize the importance of regular and open communication and of sharing information on a timely basis. Information needs to be received regularly and according to the agreed upon tables on pages 11-14. There must be clarity regarding what is to be communicated, when, and to whom. When problems or issues arise, a joint commitment to resolving them through established procedures is expected. Specifically, the parties commit themselves to the following procedures:

a. 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. Issues or problems should prompt communication with the other party, with the goal of clarifying the problem and jointly identifying an optimal solution.

b. The Director of the HIV Care and Treatment Program or their designee will attend all full Council meetings. 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 should be included in all regular communications and information requests related to that committee. At a minimum, the Director and Deputy Director of the Council and the Recipient and designee need to be copied on all written correspondence related to requests for information. Data requests, as defined below, need to go through a separate process between the Director of the Council and the Recipient.

c. The Recipient or its designee is represented by at least one staff member at other, non-committee Council meetings as requested by the Council, with 2-3 weeks' notice.

d. The Recipient and Council each have a designated liaison responsible for sharing and receiving information for all other communication requests outside those arising from committee work, and for disseminating information within entities. When questions or concerns arise, the designated liaison ensures that they are addressed in writing within five business days.

e. 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. The request is made in writing by the Council staff for the committee to the Recipient staff assigned to said committee copying the Director and Deputy Director of the Council and the Recipient and designee.

f. Policy and service information or data that is not within the scope of the Recipient will be requested directly from the Council and is not the responsibility of the Recipient staff. It is the responsibility of the Council staff to determine the appropriate source for such information. Where clarification is needed, the Council Director and Deputy Director will consult with the Recipient or designee.

    i. Council requests for information and data must be submitted to the Recipient as defined below in bullet b and c.

    ii. **Information requests** are Council requests that ask for advice or clarity on funded-program or service category requirements, procurement processes, legislative or regulatory requirements, grant rules and policies, and other local or federal administrative processes related to the grant. Information requests will be made 15 to 30 days in advance of the target date for delivery. The Recipient staff members who are assigned to the Council Committee making the information request shall be the staff member responsible for that request.

    iii. **Data requests** are Council requests of the Recipient that include quantitative or qualitative data including, but not limited to, epidemiological data, programmatic data, surveys or polls of provider or client experiences, and program implementation data. Data requests will be made at least 8 weeks in

advance of the target date for delivery. On a case-by-case basis, data requests on shorter turnarounds may be considered (e.g., requests for an update to a previous table or graph), but the standard for submission of new data requests is to allow at least 8 weeks from receipt to fulfillment. The Recipient will inform the Council of the range of data collected and available for use by the Council for planning purposes.

g. Council members will not have access to information about the performance or expenditures of individual providers but will receive such information by service category.

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

i. If either Recipient staff or Council support staff or members receive complaints about the other party, they will inform the Director of HIV Care and Treatment or the Director of the Council, as appropriate, maintaining appropriate protection of confidentiality.

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

k. The Recipient is responsible for communication with HRSA on all administrative activities and on issues related to the grant application and the reporting requirements 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 and Council business. Individual Council members may contact the HRSA Project Officer to discuss Council-related issues at the Project Officer's invitation. The HRSA Project Officer convenes monthly monitoring meetings with Council and Recipient staff. Invitations to these meetings is at the discretion of the HRSA Project Officer.

l. Council and Recipient staff will communicate regularly to ensure seamless collaboration and coordination of activities related to the Ryan White Part A program, which may include monthly coordination meetings and other DOHMH meetings, presentations, distribution of quarterly updates to RWPA subrecipients, etc., as needed.

2. Implementing Communications Procedures

To facilitate communications and implement the communications procedures as outlined above, all parties agree to the following actions:

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

b. Recipient staff should be present at relevant Council committee planning calls, as requested, for coordination of work.

c. The Recipient and the Council will develop shared timelines to ensure coordinated and timely deliverables.

d. 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 reporting requirements, new or revised HRSA/HAB regulations or expectations, and the Part A program guidance – will be shared within two business days**.** Both parties commit to responding within five business days to any requests that involve meeting reporting requirements, satisfying other HRSA/HAB requirements or requests, and addressing other matters that may affect the EMA's Part A program.

e. Where no timeline exists for sharing of specific information or materials, a timeline mutually agreeable to both parties will be established. Timelines do not commence until both Council and Recipient staff agree on a final timeline. Any expected deviations from agreed upon timelines should be communicated to the Director and Deputy Director of the Council and the Director of the Recipient on a timely basis.

Section IV. Information/Document Sharing and Reports/Deliverables

Overview

This section specifies the standard sets of materials to be provided and information to be shared through meetings between the Recipient and the Council. Parties to the MOA 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 or those related to conflict of interest.

1. 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 Director or designee will ensure that the Recipient receives the following reports and information. 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 MOA.

Table A.

Information/Documents to be Provided by the Council to the Recipient	Submission Timeline
1. An annual planning schedule, timeline, and work plan for the full Council and all committee	Within two months of the first Council meeting of the planning cycle
2. A current list of Council members, their HRSA membership categories, their terms of office, and primary affiliations, as appropriate	Provided annually and updated during the year for the Program Terms Report
3. 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
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, service categories resource allocations, service directives, service standards, an approved preliminary spending plan for grant application and final spending plan for the full grant award, annual Reprogramming and Carryover Plans, Needs Assessments and other committee reports.	Within 5 business days after Council approval
6. Information for the Part A application and to meet HRSA reporting requirements	Mutually agreed upon time frame based on Recipient timeline and as required by HRSA

2. 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 by 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 MOA.

Table B.

Information/Reports to be Provided by the Recipient to the Council	Submission Timeline
1. Copies of: – Grant award notices – Reporting requirements – Approved carryover request(s) – Other official communications from HRSA/HAB that involve the Council	Within 3 business days after they are received by the Recipient from HRSA; more quickly when possible and when a time-sensitive response involves the Council.
2. Written 2nd and 3rd quarter commitment and expenditure report by service category, including approved spending plan, modified spending plan including reprogramming and carryover, 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 in December (2nd quarter) and March (3rd quarter).
3. Twelve-month (4th quarter) commitment 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 (“carryover”).	Within 90 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. Requests for data/information (such as fact sheets) to be used in the priority setting and resource allocations process, as agreed upon by the PSRA Committee and Recipient* *Currently this includes: 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.	As agreed upon by Recipient and Council support staff.

6. Estimated unobligated balance request ("carryover") for submission of the carryover waiver request to HRSA at the end of the calendar year.	Prior to submission to HRSA at the end of December.
7. Estimated unobligated balance ("carryover") amount, along with recommendations for use of carryover funds, including rationale and supporting data.	Prior to submission to HRSA.
8. Copy of the carryover plan submitted to HRSA.	Within 5 business days after it is submitted or received.
9. Copy of the end-of-year progress report, as submitted to HRSA, with a presentation to the Council, if requested.	Within 5 business days to Council co-chairs, with full report included in the following Recipient Report to the Council after submission to HRSA; presentation within 30 days after, if requested.
10. Needs assessment analysis from DOHMH data sources (e.g., eSHARE, CHAIN), as requested by the Needs Assessment Committee.	As requested, 6-8 weeks from the time of a *finalized request* from the Needs Assessment Committee documented using a data request form. Following the submission of an initial data request, the Recipient and Council liaisons will meet to review the request to ensure agreement on the scope of a final request.
11. Presentation of a summary of the contents of the annual grant application, including unmet needs estimate and the EIIHA plan.	Within 60 days of the submission of the grant application.
12. Best available data from CHAIN on effectiveness and/or outcomes by service category, if available.	As requested, 6-8 weeks from the time of a *finalized request (see definition above)*, for use in needs assessment, integration of care, priority setting and resource allocations.
13. 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 (see definition above).* If new analyses are needed, then a data request form will be submitted by the Council.
14. 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	90 days prior to the July Council meeting.
15. The Recipient will report to the Council the results of all Requests for Proposals (RFPs), including subrecipient awardees, geographic distribution, and funding amounts.	Within 5 days of award notices to the subrecipients.
16. The Recipient will provide an update to the Council on the implementation of new service directives including enrollment, utilization, successes, and challenges.	Within six months after first anniversary of new program start date.

17.The Recipient will report to the Council on a corrective action plan to address areas of concern identified in the assessment of the administrative mechanism.	Within 90 days of receipt of corrective action plan.
18. *(To Council staff only)* Drafts of solicitations and agreements to procure Ryan White Part A-funded services (RFPs, MOU scopes of work), to review for consistency with Council priorities, allocations, 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.
19. An annual presentation reporting on the Quality Management plan, its components, activities, and outcomes for the entire EMA or by service category.	As requested, 6-8 weeks from the time of a finalized request.
20. Responses to written information requests.	15 to 30 days after the information request is made.
21. Data requests not described above must be submitted to the Director of the HIV Care and Treatment Program or designee in writing using the data request form.	A minimum of 8 weeks prior to the expected delivery date, or as agreed upon between Director of HIV Care and Treatment and Council Director. On a case-by-case basis, data requests on shorter turnarounds may be considered as described in section III.1.f.
22. The Recipient will make available an online, publicly accessible resource directory with a list of Ryan White Part A subrecipients. Provider-level information from the directory will not be used by the Council for planning decisions.	Within three months after the beginning of each fiscal year. The directory will be updated as needed (e.g., newly funded providers, updated contact information for referrals).
23. The Recipient will provide a report for each full Council meeting covering updates on the following sections: 1) News from HRSA & Other Federal Partners, 2) Ryan White HIV/AIDS Program Part A NY EMA Administration, 3) Clinical Quality Management, and 4) BHHS activities.	Within 5 days of scheduled meeting date.

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 at which the request was raised. 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 Recipient and/or to their designee. The best data available shall be provided at a mutually agreed-upon date.

Recipient presentations to the Council and committees will be submitted to Council staff at least 5 business days in advance of the meeting where the presentation is scheduled to ensure that the presentation is responsive to Council needs and appropriate for the Council's diverse membership.

3. Documents and Information that Will Not be Shared

In order to maintain the confidentiality of sensitive information, the following information will not be shared, except as required by law:

1. The Council will not share information on the HIV status of members of the Council whose status has not been otherwise publicly disclosed.

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. 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.

Section V. Settling Disputes or Conflicts

The Council has adopted rules for respectful engagement. These will serve as the foundation for addressing challenging issues between the Recipient and the Council. If conflicts or disputes arise with regard to the roles and responsibilities specified in this Memorandum of Agreement, 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 HIV Care and Treatment Program or their designee):

1. Begin with a face-to-face meeting between the parties to attempt to resolve the situation within five working days after the issue or dispute arises, if reasonably possible.
2. If the situation cannot be resolved by these parties, a follow-up meeting should be held with their supervisors to discuss the issue and reach resolution within ten working days after the initial meeting, if reasonably possible.
3. If the situation still cannot be resolved after the meeting with supervisors, a final meeting including representatives of the Recipient and Council, their supervisors, and the Chief Elected Official or their designee will be held. The decision of the CEO or their designee will be final.

Section VI. Responsible Parties

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

The MOA and its terms continue to be in effect regardless of changes to the specific individuals in these positions. Their successors are expected to adhere to the MOA.

For the Recipient:

- Director of HIV Care and Treatment Program

For the Council:

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

Section VII. MOA Duration and Review

1. Effective Date

The MOA becomes effective upon HRSA approval and once it has been signed by all the authorized individuals representing the Recipient and the Council.

2. Duration

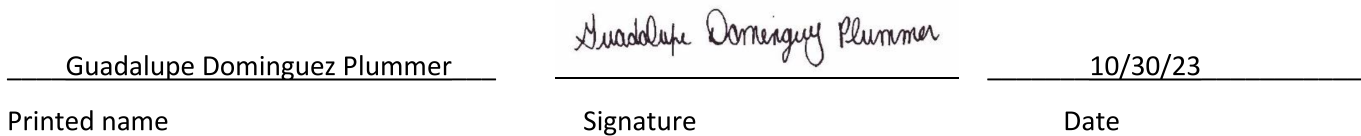
This MOA will remain in effect until the Ryan White Part A program ends or until the MOA is revoked by either party. Revocation requires a 30-day notice by either party. The Council may revoke the MOA by a vote of the full Council. The Department of Health and Mental Hygiene may revoke the MOA by written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

3. Process for Reviewing and Revising the MOA

The MOA will be revised every five years, with the involvement and approval of all parties, including HRSA. The MOA will be reviewed every three years 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 and inwriting. 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 Recipient may submit a request for changes and revisions at any time. A review of the MOA will be carried out within six months after each reauthorization or legislative revision of the Ryan White legislation, to ensure that the MOA remains fully appropriate, updated, and reflective of the Act. Once the MOA has been reviewed and revised, the amended version will be signed and dated by all parties. The revised version will become effective once signed.

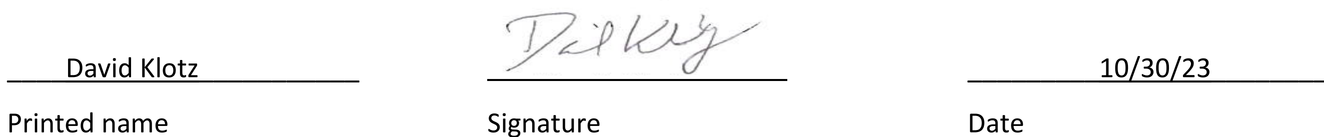
The Recipient and the Council hereby agree to comply to the terms of this memorandum of agreement.

Director of HIV Care and Treatment Program, Project Director of Ryan White Part A NY EMA (Recipient):



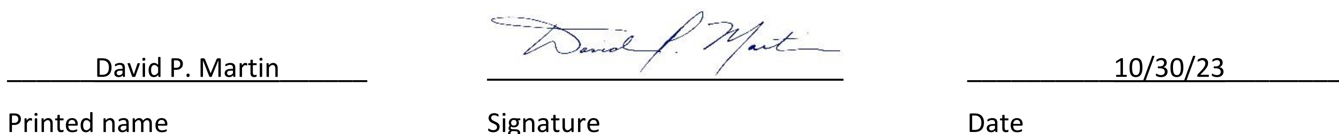
Guadalupe Dominguez Plummer		10/30/23
Printed name	Signature	Date

Council Director/Council Governmental Co-Chair:



David Klotz		10/30/23
Printed name	Signature	Date

Council Community Co-Chair:



David P. Martin		10/30/23
Printed name	Signature	Date