MEMORANDUM OF UNDERSTANDING

Between

HIV Health & Human Services Planning Council of New York

hereafter referred to as "Council"

and

NYC Department of Health & Mental Hygiene

Bureau of HIV/AIDS Prevention & Control

hereafter referred to as "Grantee"

Approved by the HIV Planning Council, April 26, 2012

Signed June 7, 2012

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 (NYCDOHMH)/Bureau of HIV/AIDS Prevention and Control (Grantee).

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

- Create a shared understanding of the relationship between the Council and Grantee;
- Delineate the roles and responsibilities of each entity; and
- Encourage a mutually beneficial relationship between these important partners.

Under Ryan White legislation, the Grantee and the Planning Council are independent bodies with both shared and complementary responsibilities. This MOU is a dynamic tool to help the stakeholders avert conflict. The underlying foundation of the memorandum is the principle of mutual respect. Mutual respect is created through open communication, active listening, seeking understanding, and

acknowledging our mutual goals. This document is built upon the understanding that the Council and the Grantee are equal stakeholders in the Ryan White process with the mutual goal of helping individuals and families living with HIV/AIDS obtain the highest quality and most appropriate Ryan White HIV/AIDS Treatment Extension Act Part A eligible services.

This document is intended to reflect legislative requirements and Health Resources and Services Administration-HIV/AIDS Bureau (HRSA/HAB) guidance. It is not meant to supersede or contradict any Federal, State or Local or departmental governances (such as laws, regulations, ordinances, Mayoral Executive Orders, or policies). In such cases where this MOU contradicts/is inconsistent with any Federal, State or Local or departmental governances, such Federal, State or Local or departmental governances shall have precedence over the guidance in this MOU. The MOU shall be revised to be in accordance with such governances. In addition, this MOU shall not contradict the bylaws of the HIV Planning Council.

Both the Council and the Grantee share the goal of maintaining a comprehensive system of care for people living with HIV/AIDS (PLWHA) that is accessible to all, provides high quality care, and improves the health and quality of life for low income, uninsured, and underinsured PLWHA. The Council and the Grantee are both dedicated to the vision that all PLWHA 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 controlling the HIV epidemic. The values of access, compassion and respect, excellence, partnership, integration, informed choice, and equity are shared by the Council and the Grantee and inform this MOU.

Roles and Responsibilities

Roles and Responsibilities of the Planning Council

The Planning Council is solely responsible for the following tasks as specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009:

1. **Priority Setting and Resource Allocation:** The Council is responsible for setting priorities among service categories, allocating funds to those service categories, and providing directives to the Grantee on how best 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:

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

b. The process is data-based and meets federal guidelines and sound practices with regard to service categories, allocation of funds to core medical versus support services, directives, and the decision-making process.

c. The Grantee 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 levels for the next fiscal year.

e. The Grantee 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 Grantee may make proposals for the use of unexpended or unobligated funds to the Council at the 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 of each year. It specifies the amount of funding that can be moved and to which service categories. When the Grantee does implement the reprogramming of funds, the Grantee will provide the Planning Council's Finance Committee brief reasons why funds were unexpended or unobligated and a report on the service categories from which these unexpended funds originated.

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

e. The Grantee informs the Council of the amount and type of unobligated 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 Grantee 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 Planning Council is responsible for evaluating how quickly and efficiently the Grantee contracts with service providers and how long the Grantee takes to pay the contracted providers. The Planning Council also determines whether the Grantee used service funds as specified in the Council's priorities and allocations The Finance 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 Grantee 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 Grantee by June of each year for use in the Part A application.

c. The Grantee develops a response to the assessment of the administrative mechanism, including an action plan as needed.

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

   a. Planning 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.

   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 and HIV/AIDS Bureau requirements are met.

   c. The Mayor retains sole responsibility for appointment of all members to the Planning 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 Planning Council operates as an independent partner of the Grantee, the Grantee 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 Planning Council is appointed by the Commissioner of the NYC Department of Health and Mental Hygiene.

e. Committee members who are not Planning Council members are vetted by the Membership Committee and selected by the two Co-Chairs and the Finance Officer.

Roles and Responsibilities of the Grantee

The Grantee is responsible for the following:

1. **Procurement and Contracting:** The Grantee 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 and its members play no role in procurement or contracting.

2. **Contract Monitoring:** The Grantee, 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 Grantee informs the Council of expenditures by service category on a quarterly basis and identifies the need for reprogramming of funds during the grant year based on service category expenditures.

3. Technical Assistance to the Service Providers: The Grantee provides technical assistance to service providers on an as-needed basis to build capacity and to improve contract compliance and service delivery.

4. **Clinical Quality Management:** The Grantee 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 and to enhance health and supportive service access and delivery and continuously improve systems of care. This involves design and implementation of a Quality Management plan in accordance with HRSA requirements.

a. The Planning 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 Grantee 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 Grantee and Planning Council 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 HIV/AIDS Bureau expectations and overseeing its implementation. The Grantee assists with the design of the needs assessment and overall process, providing the Planning Council information such as epidemiologic data, service utilization data, and expenditures by service category.

   a. Through the Needs Assessment Committee and the Planning Council support 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. Grantee 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 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 Grantee to arrange key outside researchers and program staff on subjects being reviewed by the Council.

e. The Grantee produces an annual presentation for the Council on the size and demographics of the epidemic and other data needed for planning purposes, in coordination with the Needs Assessment Committee.

2. **Comprehensive Planning:** The Council and the Grantee work together to develop a Comprehensive Plan for the organization and delivery of health and support services within the EMA. The Plan is developed every three years or as specified by the HIV/AIDS Bureau, and is developed and structured to meet all specifications in the guidance provided by the HIV/AIDS Bureau.

   a. Both Planning Council and Grantee identify goals, objectives, tasks, and timelines for the Comprehensive Plan work plan.

   b. Both the Grantee and the Planning 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 Grantee in maintaining and refining the system of care.

   d. The Council reviews the plan each year and uses it in development of an annual plan.

   e. The Grantee 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.

f. The Grantee and Council jointly ensure that the comprehensive plan is compatible with the New York State DOH AIDS Institute Statewide Coordinated Statement of Need (SCSN).

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 Grantee, the Planning 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 Grantee 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 Planning Council works with the Grantee 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 on performance measures and evaluation studies.

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

   b. The Planning Council may identify and request service effectiveness data that will be provided by the grantee, based on the availability of data.

   c. The Planning Council has the option of evaluating service effectiveness.

5. **Maintenance and Improvement of a System of Care:** The Planning Council and Grantee share responsibility for the development, maintenance, and continuous improvement of a system of care for the EMA. The Planning Council

carries out this responsibility through such activities as priority setting and resource allocation, directives on how best to meet these priorities, identification of service models, and development and approval of standards of care for funded service categories. Through needs assessment and comprehensive planning, it works with the Grantee to review, assess, and refine the system of care based on sound data. The Grantee carries out this responsibility through its engagement 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 Planning 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, developed with the input of both clinicians and people living with HIV and AIDS for applicable service categories. The Planning Council provides input to these processes through participation of Planning Council members. The EMA can adopt available standards of care or indicators such as those developed by New York State.

c. The EMA develops its own Service/Program Standards, and the Planning Council takes the lead in this effort, through the Integration of Care Committee, with extensive Grantee involvement. The Planning Council systematically reviews standards of care as an aspect of improving the system of care.

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

1. **Grantee and Planning Council Support Staff**: The Planning Council support staff is responsible for coordinating and supporting the work of the Planning Council and its committees, to enable the Council to meet its legislative responsibilities. Supervision and management of Planning Council support staff are kept separate from Grantee staff management and supervision in order to ensure that the Planning Council operates as an independent body.
   a. Grantee staff members are supervised by the Bureau of HIV Prevention and Control.
   b. The Planning Council Director is supervised by the Deputy Commissioner for Policy and External Affairs but is expected on a day-to-day basis to meet the needs of the Planning Council.
   c. When the Planning Council Director is hired, the Planning 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. Grantee staff are not involved in the hiring of Planning Council support staff, in order to maintain the independence of the two entities.
   e. The Planning Council Director has primary responsibility for selecting and supervising other Planning Council support staff members, within the local personnel system.
   f. The Council, through the Community Co-Chair, will provide feedback on the performance of the Planning Council Director.

2. **Budgeting and Fiscal Management of Planning Council Support Funds:** Each year, the Planning Council negotiates the amount of the Planning Council support budget with the Grantee, since that budget is a part of the administrative budget

for the EMA. The Planning Council controls its budget once the amount has been determined.

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

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

c. The Planning Council approves the budget and also approves any budget modifications during the program year.

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

3. **Contracting for Planning Council Consultants or Services:** The Grantee provides contracting services when the Planning Council needs to hire consultants or other contractors to carry out work funded through its budget.

a. The Planning Council through its committee structure determines the need for consultants or other experts that can not be filled by existing Council or grantee resources to help conduct its business, and the Council staff drafts the scope of work and required qualifications. Contracting must meet local procurement requirements as well as Ryan White guidelines.

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

4. **Annual Application Process:** The Grantee has primary responsibility for preparation and submission of the Part A application and for responding to Conditions of Award (COA). The Planning Council is responsible for providing information related to its legislative responsibilities.
    a. The Planning Council through its support staff provides information for the application sections related to Planning 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 whether the Grantee has expended funds in accordance with Planning Council priorities, allocations, and directives.
    c. Council members may review the draft grant application narrative before it is submitted.
    d. Council Co-Chairs write and sign letters to fulfill Conditions of Award as required and submit them to the Grantee 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 Grantee or by HRSA.

5. **Provider RFP:** Procurement is the Grantee's responsibility. The Grantee ensures that contracts provide for the services described in the RFP and services are consistent with the Planning Council's service priorities, directives and standards of care.

Communications

Communications Procedures

Both the Grantee and the Planning 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 Planning Council standing committee has a Grantee 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 Grantee for that committee and is responsible for all regular communications and information requests related to that committee. The Grantee is represented by at least one staff member at other *ad hoc* Council meetings as requested by the Council, with two weeks notice required for participation.

3. The Grantee and Planning 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 Planning Council, the designated liaison is the Planning Council Director. For the Grantee, it is the Director of HIV Care, Treatment, and Housing 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). This means, for example, that a Committee Chair who needs information from the Grantee requests it either through the assigned Grantee staff member during the meetings or through Planning Council support staff. For information beyond normal reports and information as specified in the chart in this MOU, it is the responsibility of the Planning Council Director and the Director of HIV Care, Treatment, and Housing or designee to determine whether the Grantee is the appropriate source for this information and whether the information is available and can be provided within the Grantee's resources. Where the Grantee feels it cannot meet the request, the Director of HIV Care, Treatment, and Housing or designee consults with the Planning Council Director and with the Council Co-Chairs as necessary.

5. Staff of both entities and Planning Council members take care to avoid inappropriate communication requests or channels. This means not asking for information from individuals other than the designated individuals, using and not bypassing established communication channels, and maintaining the confidentiality of information that should not be shared outside the Part A program.

6. 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.

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

8. Planning Council members and staff do not use in meetings or decision making any information about individual providers, even if it is available to members as individuals. Planning Council members refrain from requesting information about individual providers through the [local or state Public Records or Freedom of Information] law in their capacity as Planning Council members.

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

10. The Planning Council does not become involved in consumer complaints about services. If the Planning 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 own complaints process. Planning Council or support staff may also refer them to the Grantee.

11. The Grantee is responsible for communication with HRSA on all administrative activities and on issues related to the grant application and COA process. The Planning Council Co-Chairs and the Planning Council Director may communicate

directly with the HRSA Project Officer on matters related to the Planning Council's legislative responsibilities.

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 Grantee staff outside of regular Council meeting times.
2. The Grantee 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, Treatment, and Housing or designee and the Planning Council Director are responsible for resolving the situation.

Information/Document Sharing and Reports/Deliverables

Overview

It is the intent of this MOU to encourage regular sharing of information and materials throughout the year. 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 reasons of sensitivity or confidentiality.

Information to be Provided by the Planning Council to the Grantee

The Planning Council will provide the Part A Grantee or designee with the following information and materials:

Information/Material to be Provided by the Planning Council to the Grantee	Timing
1. A dated list of Planning 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 Planning Council's monthly meetings, retreats, orientation and training sessions, and other Planning	At the same time notification goes to Planning Council members

Information/Material to be Provided by the Planning Council to the Grantee	Timing
Council events	
3. Planning Council staff meets with the grantee to plan for data needs in advance of development of the meeting agenda	On a mutually agreed upon time frame
4. The meeting notice, agenda, and information package for each Planning Council meeting	At the same time this information is provided to Planning 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 Planning Council approval
6. Annual reprogramming plan showing ranked service priorities, funding allocations and any guidance related to reprogramming	Within 5 business days after the Planning Council has approved the plan in June
7. Guidance on how best to meet these priorities	Within 5 business days after Planning 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 Planning Council approval
9. Information for the Part A application	Mutually agreed upon time frame based on grantee 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 grantee

Information to be Provided by the Grantee to the Planning Council

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

Information/Reports to be Provided to the Planning Council by the Grantee	Timing
1. Copies of: – The annual grant award notice including Conditions of Award – Any approved carryover request – Other official communications from HRSA/HAB that directly involve the Planning Council	Within [5] business days after they are received from the funding agency; more quickly when a response involves the Planning Council and is time-sensitive
2. Written quarterly 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	Quarterly, at least 5 business days before the meetings of the Finance Committee
3. Data by service category on client waiting lists and wait times	On a mutually agreed upon time frame
4. Service category score cards for overall base-funded services and MAI-funded serves as well as each service category showing three years of contract data. Reports will include: number of contracts, service category	August 30 for prior grant year for all categories June 15 for prior grant year for high priority categories, as determined

Information/Reports to be Provided to the Planning Council by the Grantee	Timing
allocation, carryover, modifications to the service category allocation, expenditures in dollars and percents, units of service, number of clients served, demographics of clients served, special populations served, number and type of contractor issues identified during the year and notes explaining data. [Include average cost per client per year.]	by the Council's annual plan
5. 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 [rather than YTD since this is the end-of-year report]	Within 120 days after the end of the grant year
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 Federal Financial Report and other end-of-year reports including the Final Implementation Plan and Final Allocations Report, as submitted to HRSA/HAB in the final	Within 10 business days after submission to HRSA/HAB

Information/Reports to be Provided to the Planning Council by the Grantee	Timing
progress report each year, providing information on the number of individuals served and expenditures for each service category	
10. Epidemiologic data report and presentation specifically targeted to provide information needed for priority setting and resource allocation and for comprehensive planning, including size of the HIV/AIDS population, trends, and subpopulation data as mutually agreed upon	As mutually agreed, for use in needs assessment, comprehensive planning, priority setting and resource allocations
11. Needs assessment studies or analysis, as requested by the Needs Assessment Committee	As mutually agreed with the Needs Assessment Committee, to inform the planning process
12. Estimate of Unmet Need from most recent grant application	As mutually agreed, for use in priority setting and resource allocations
13. Best available data on cost effectiveness and/or outcomes by service category	As mutually agreed, for use in priority setting and resource allocations
14. An annual Quality Management report and a report on service category outcomes.	As mutually agreed, for use in priority setting and resource allocations
15. A report on the status of the comprehensive plan measures.	As mutually agreed, for use in priority setting and resource allocations
16. Data on Part A coordination with housing, prevention and other HIV/AIDS programs	As mutually agreed, for use in priority setting and resource allocations

Information/Reports to be Provided to the Planning Council by the Grantee	Timing
17. 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 mutually agreed, for use in priority setting and resource allocations
18. Description of current and proposed new service models, identifying the service category, comprehensive strategic plan goals and objectives, proposed elements of the service model, client and agency eligibility	At least 5 business days before a committee or Council meeting at which they will be discussed or used for decision making
19. Information from the Grantee and administrative agency as needed for completing the assessment of the efficiency of the administrative mechanism, to include the procurement and grants award process and timing; statistics such as number of applications received, number of awards made; and reimbursement procedures and timelines, plus contact information to permit a survey of funded providers	At a mutually agreed-upon date that enables the Council to complete the assessment by June
20. Reports, data, and materials to be used for review at Committee meetings and decision making at Planning Council meetings. This includes materials for review from the Tri-County Region.	5 business days before the meeting

When the Planning Council or a Committee requests special or additional information from the Grantee, the request will always be listed in the summary minutes of the meeting. In addition, Planning 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 Planning Council Co-Chairs and to the Director of Grant Administration and the Director of the Research and Evaluation Unit. 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 Planning Council will not share information on the HIV status of members of the Planning Council who are not publicly disclosed as people living with HIV/AIDS.
2. The Grantee 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.
3. Information about the individual salaries of Grantee and Planning Council staff will not be shared beyond those with a direct need to know. Except for the Governmental Co-Chair**,** the Planning Council will receive staff salary data on Planning Council support staff only in the aggregate. The Planning Council will not have access to the Grantee'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:

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 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 Grantee and Planning Council and their two supervisors with the Chief Elected Official or his/her designee. The decision of the CEO will be final.

Responsible Parties and Contact Information

Following are the responsible parties to this MOU, along with the names of the individuals in these positions at the time the MOU was adopted, and their contact information, including the individual within their office who should receive all communications related to this MOU and the Ryan White Part A program.

The MOU will continue in effect regardless of changes in the individuals who hold these positions. Their successors will be expected to follow the MOU pending the annual review.

For the Grantee:

- Assistant Commissioner of the Bureau of HIV/AIDS Prevention & Control
- Director of HIV Care, Treatment, and Housing

- Part A Grant Administrator

For the Planning Council:

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

MOU Duration and Review

Effective Date

The MOU becomes effective once it has been signed by all the authorized individuals representing the Grantee, Planning 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 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 through written notice from the Assistant Commissioner of the Bureau of HIV/AIDS Prevention and Control. Reasons for the revocation must be clearly stated and disclosed. If the MOU is revoked by either party, the Project Officer must be notified within 10 business days through the prior approval portal in the EHB.

Process for Reviewing and Revising the MOU

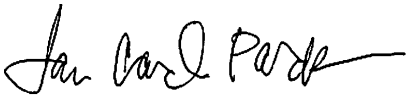
The MOU will be reviewed and revised periodically, with the involvement and approval of all parties, including HRSA/HAB. The MOU will be reviewed annually by the Grantee and the Rules & Membership Committee of the Council. Proposed changes or revisions may be developed by the Council and/or Grantee.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

requested changes or revisions must be approved by both parties prior to implementation. For the Planning Council, this means that the Rules & Membership Committee will recommend revisions 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.

All revisions and updates must be submitted to the Project Officer for prior approval via the EHB prior approval portal. When 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
Grantee



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

Dorella Walters, MPA
Planning Council Community Co-Chair

S: Memorandum of Understanding_6-7-2012_HRSA Revisions