RWHAP TA Webinar

Indiana State Department of Health

January 23, 2018

10:30 am – 12:00 pm

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zoom

- Please enter the agency name and list all participants in the ”chat” room

Helpful Hints

- Press esc to exit full screen
- Hover over the top to change “view” options
- Place yourselves on “mute” until you’re ready to pose a question or make a comment
- Use the “chat” room to pose questions and make comments
- Meeting will be recorded and available for sharing after the meeting

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Agenda

- Introductions
- Overview of Part B Supplemental Award
- Invoicing & Contracts
- Eligibility
- Data Requirements
- Communication
- Next Steps

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An Equal Opportunity Employer

Organizational Ideas

Consultants

- Thomas Bartenbach
- Michael Wallace

About you

- AIDS Ministries/AIDS Assist
- AIDS Resource Group
- Aspire Indiana Health
- Brother's United
- Clark County Health Department
- Community Health Foundation
- The Damien Center
- Damien Cares
- The Damien Center (VMS)
- Health and Hospital Corp. (Eskenazi)
- ISDH (Prevention & STD)
- IU Health LifeCare
- Matthew 25
- Meals on Wheels
- Meridian Health Services
- IU Health Bloomington Positive Link
- Positive Resource Connection
- Scott County Health Dept.
- Step-Up, Inc.
- Volunteers of America

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Ryan White Part B Funds

- Part B funds are awarded to States and Territories by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB)
  - Part A funds are awarded to cities
  - Part C funds are awarded to clinics
  - Rules vary by Part
- Ryan White Part B funds must be:
  - Used for HIV-related services for HIV-positive people
  - Provided to eligible low-income people
    - States define low-income
  - Used for specific services
    - HRSA provides clarification in Policy Clarification Notice #16-02, "Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds"
    - Usually some of the awards fund HIV services, and some of the awards fund medication access including insurance assistance

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- ISDH manages Part B funds through the HIV Services Program (HSP)
  - Historically, HSP used all Part B funds for the HIV Medical Services Program:
    - Medication access and medical care for uninsured people
    - Insurance support
  - HSP has received additional "Part B Supplemental" funds
    - Funds will support additional services statewide through agreements with agencies
    - Funded service providers are called "sub-recipients"
- HSP is developing the infrastructure needed to fund more services
  - We appreciate your collaboration, support and patience as we create these systems

Description of Service Provider Grantor Relationship

(45 CFR 75.351)

Recipient

- The entity that receives the RWHAP award directly from HRSA
- Many RWHAP recipients (recipient or sub-recipients) are also “pass-through” entities
- A pass-through entity is an entity that provides a sub-award to a sub-recipient to carry out part of the RWHAP activity

Sub-recipient

- The entity that receives a sub-award from a pass-through entity to carry out part of the RWHAP programmatic activity (e.g., RWHAP provider)
- Is responsible for adherence to applicable Federal RWHAP program requirements
- Has its performance measured in relation to whether objectives of the RWHAP were met
- Uses Federal funds to carry out the RWHAP Program for a public purpose as specified in authorizing statute

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Uses of Funds

Ryan White HIV/AIDS Treatment Extension 2009

SEC. 2612. USE OF AMOUNTS.

- *(a) Requirements- The Secretary may not make a grant under section 2601(a) to the chief elected official of an eligible area unless such political subdivision agrees that—*
  - *(1) subject to paragraph (2), the allocation of funds and services within the eligible area will be made in accordance with the priorities established, pursuant to section 2602(b)(4)(C), by the HIV health services planning council that serves such eligible area;*
  - *(2) funds provided under section 2601 will be expended only for—*
    - *(A) core medical services described in subsection (c);*
    - *(B) support services described in subsection (d); and*
    - *(C) administrative expenses described in subsection (h); and*
  - *(3) the use of such funds will comply with the requirements of this section.*

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Payor of Last Resort

Activities

- Allocation of Expenses Among Funding Sources
- Grantees Receive Multiple RW Funding
- Grantees Receive Other Sources Of Funding
- Billing Medicaid, Medicare and other payors

Legislation

- the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—
  - (i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or
  - (ii) by an entity that provides health services on a prepaid basis *(except for a program administered by or providing the services of the Indian Health Service)*; and [NB: section 204(c)(3) probably should have been added to (i)]

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ALLOWABLE SERVICES

CORE MEDICAL SERVICES

- AIDS Drug Assistance Program Treatments
- AIDS Pharmaceutical Assistance
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services
- Home Health Care
- Hospice Services
- Medical Case Management, including Treatment Adherence Services
- Medical Nutrition Therapy
- Mental Health
- Oral Health
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient
- Child Care Services

SUPPORT SERVICESS

- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management
- Other Professional Services
- Outreach Services
- Psychosocial Support Services
- Referral for Health Care and Support Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services (residential)

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Key Fiscal Words

- **Legislation:** The exercise of the power and function of making rules that have the force of authority.
- **The Code of Federal Regulations:** General and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
- **Policy**: High-level overall plan embracing the general goals and acceptable procedures of a governmental body.
- **Requirement:** A compulsory or required item; a necessary condition.
- **Allocable Cost:** Process of assigning/distributing a cost, or a group of costs, to one or more cost objective(s).
- **Allowable Cost:** Costs that are necessary and relevant to the delivery of a particular service.
- **Reasonable Cost:** When the cost, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time, the decision was made to incur the cost.
- **Compliance:** Meeting federal legislative and programmatic requirement.
- **Disallowed cost***:* Charges to a Federal award that the Federal awarding agency or pass-through entity determines to be unallowable, or not in compliance with the applicable Federal statutes, regulations, or the terms and conditions of the Federal award.

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Invoice Process

Policy: Provides guidance related to the documentation and data that are required to approve invoices and in determining whether the cost of a service is reasonable, allowable and allocable.

- **Submission of Sub-recipient Invoices**
  - Each month, sub-recipients will submit completed invoices for their Ryan White Part B expenditures by the 20th of the month.
  - The invoices will include: a summary total expenses by service category, required documentation, and the necessary data to support the reasonableness of services.

- **Evaluation of Sub-recipient Invoices will be done by Service Category**

- **Reimbursement Methodology -** Direct cost/categorical line-item methodology.

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Invoice Process

- **Documentation by line item:**
  - **Personnel –** Time sheets and payroll reports that show allocations for positions divided among different funding sources or services.
  - **Benefits –** Schedule of benefits with list of actual expenditures. Documentation can be provided by the sub-recipient per employee or in the aggregate for all employees. The verification of the expenditures for employee benefits should be reviewed during the annual sub-recipient fiscal monitoring site visit.
  - **Phone/Supplies/Travel and Other Personnel Related Expenditures** – Supporting documentation will consist of properly paid invoices. If bill is distributed among several services or funding sources, show allocations.
  - **Food cost for meals---**actual cost of food per meals provided
  - **Equipment –** The sub-recipient should provide copies of invoices for all purchases of equipment or for all other special purchases.

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Invoice Process

- **Professional services such as diagnostic & laboratory tests; specialty medical or vision services rendered by licensed providers-**Invoice of cost of service per patient (no patient name).

- **Data Support –** Visits, clients, meals, whatever is the appropriate unit for the service reimbursed.
  - Unit of service to be defined at a later date

- **Evaluation of Reasonable Cost by Service Category**

  The total cost of the service divided by the expected number of units equals to cost per unit. The goal is not to make decisions based on lowest cost. Is to make decisions base what is the reasonable cost for the agency, the geographical location the service is been provided and other circumstances prevailing at the time the unit cost was evaluated.

- **Evaluation of Allowability of Cost by Service Category**

  The verification of service allowability will be reviewed during the annual sub-recipient fiscal monitoring site visit.

➢ **Payment Policy:** 30 working days after receipt of a completed invoice.

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Sub-recipient Contracts

- All sub-recipients have received initial contracts
  - This allows services to be provided and invoicing/payment to occur
  - Contracts specify which services you can provide and your budget parameters
- Contract modifications will be issued in the near future
  - Additional language will clarify:
    - Sub-recipient requirements
    - ISDH's role and expectations
    - Federal requirements
- Additional contract language will be covered on a future webinar

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What's "In The Works"?

Policies and procedures to be developed in the next month

- Budgets by service categories
- Invoicing documentation and approval process
- Procurement
- Reimbursement
- Allocations methodologies – time & effort
- Definitions and treatment of Administrative limitations
- Allowable/unallowable expenses

- Additional training opportunities

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Ryan White Eligibility

- Clients must be:
  - HIV positive
  - Low income
    - At or below 300% of the Federal Poverty Level (FPL) in Indiana
  - Residents of Indiana
  - Screened for all other payors including Medicaid
    - Services must be billed to other coverage first
- Eligibility must be recertified every 6 months
  - Annual recertifications involve obtaining updated documents
  - Six-month recertifications are done through “self-attestation”
    - Clients attest to “no change” in eligibility status, or provide information about what has changed.

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Current Eligibility Practice

- Indiana already conducts eligibility determination and recertification for clients accessing the HIV Medical Services Program
  - AIDS Drug Assistance Program (ADAP)
  - Early Intervention Plan (EIP)
  - Health Insurance Assistance Plan (HIAP)
  - Medicare Part D Assistance Plan (MDAP)
- Clients start the eligibility process with a Care Coordinator
  - HSP reviews the application and approves eligibility
  - Eligibility Confirmation Letters are mailed to clients and Care Coordinators
- Recertification occurs every 6 months
  - Mid-year recert = self-attestation if no changes
  - Full year recert = submission of documentation

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How to Ensure Clients are Eligible for Services

- Clients actively eligible for the HIV Medical Services Program are already eligible for services
  - Most clients will already be enrolled in the HIV Medical Services Program
  - Clients are receiving letters from ISDH to inform them they are eligible for services.
  - Obtain Client Eligibility Confirmation Letter from Care Coordinators
- Clients not actively eligible for the HIV Medical Services Program must be referred to a Care Coordinator
  - Care Coordinators will begin the eligibility application as they do now
  - Eligibility will be effective to the first of the month in which the client applied
  - HSP staff will approve eligibility and send letters to the client and Care Coordinator
  - Obtain Client Eligibility Confirmation Letter from Care Coordinators
- Clients must be actively eligible for services to be paid
  - Please monitor the Start and End eligibility dates

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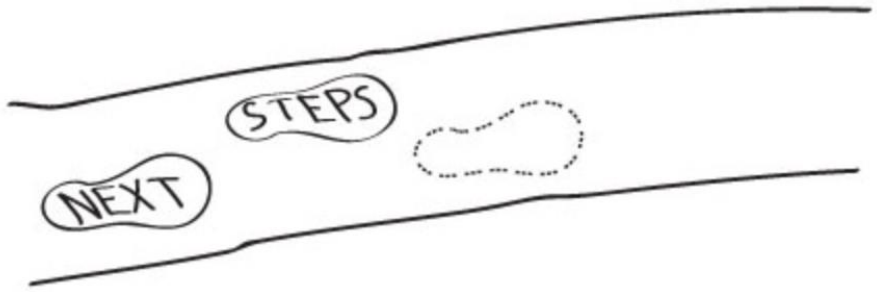
Next Steps of Eligibility Determination Process

- ISDH Information Technology (IT) systems are being updated
- Client Eligibility Confirmation Letter is being updated
- Eligibility Policy is being finalized and will be distributed
- Eligibility Determination Procedure is being finalized to help Care Coordinators and HSP staff
- Future plans include coordinating all eligibility determination across the state with other Ryan White Parts



Data Collection and Reporting Requirements

Code of Federal Regulations (CFR)

- “Explicitly states that grant recipients have a responsibility to monitor their funded subrecipients to ensure they are using their Federal grant program funds in accordance with program requirements”
  - CFR 74.47, 74.51,92.40

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What Does This Mean?

- Data will be required to be collected and entered into an ISDH-required data system throughout the year
  - Data for each month must be entered by the 15th of the following month
  - Required data is based on the Ryan White services that the client receives
- Data are reported to HRSA/HAB in the Ryan White HIV/AIDS Program Services Report (RSR) annually
  - Federal due date is last Monday in March; first RSR is due March 2019
  - Recipient (ISDH) will establish earlier deadlines to assist with report completion

Data Collection Requirements

Core Medical Services	Support Services
Outpatient/Ambulatory Health Services	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Housing
Medical Case Management, including Treatment Adherence Services	Non-Medical Case Management
Medical Nutrition Therapy	Outreach Services
Mental Health	Substance Abuse Services (residential)
Substance Abuse Outpatient Care	

Data Collection Requirements-All Agencies

- First Name
- Last Name
- Full Data of Birth
- Race (including subgroups)
- Ethnicity (including subgroup)
- Gender
- Sex at Birth
- Services received

- Additional data elements are dependent on the services that the client receives

Additional Data Collection Requirements

Data Element: Medical Insurance	
Core Medical Services	**Support Services**
Outpatient/Ambulatory Health Services (OAHS)	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Housing
Medical Case Management, including Treatment Adherence Services (MCM)	Non-Medical Case Management (CM)
Medical Nutrition Therapy	Outreach Services
Mental Health	Substance Abuse Services (residential)
Substance Abuse Outpatient Care	

Additional Data Collection Requirements

Data Element: Housing Status	
Core Medical Services	**Support Services**
Outpatient/Ambulatory Health Services (OAHS)	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Housing
Medical Case Management, including Treatment Adherence Services (MCM)	Non-Medical Case Management (CM)
Medical Nutrition Therapy	Outreach Services
Mental Health	Substance Abuse Services (residential)
Substance Abuse Outpatient Care	

Additional Data Collection Requirements

Data Elements: Federal Poverty Level, HIV/AIDS Status, Client HIV Risk Factor, Enrollment Status, HIV Diagnosis Year	
Core Medical Services	**Support Services**
Outpatient/Ambulatory Health Services (OAHS)	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Housing
Medical Case Management, including Treatment Adherence Services (MCM)	Non-Medical Case Management (CM)
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Additional Data Collection Requirements-OAHS

- HIV Risk Screening Provided
- First Outpatient/Ambulatory Care Visit Date
- Outpatient/Ambulatory Care Visits
- CD4 Counts and Dates
- Viral Load Counts and Dates
- Prescribed PCP Prophylaxis
- Prescribed ART
- Screened for TB since HIV Diagnosis
- Screened for syphilis
- Screened for Hep B since Diagnosis
- Completed Hep B Vaccine Series
- Screened for Hep C since HIV Diagnosis
- Screened for Substance Abuse
- Screened for Mental Health
- Cervical Pap Smear
- Pregnant
- Date of First Positive HIV Test*
- First OAHS visit after first positive HIV Test*

*Only required for newly diagnosed clients

Feeling Like This?

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Current Activities

- Agency-specific TA materials that outline required data elements are being developed
- Interim data collection strategies are being explored
- Data systems that meet local needs and RSR requirements are being evaluated for use

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Next Steps

- ISDH and our TA experts will contact you to:
  - Provide guidance on specific data collection and reporting requirements based on funded services
  - Assess what information your agency currently collects and need for expansion to meet the requirements
  - Determine an interim data collection strategy for your agency until data system is chosen
- ISDH will finalize a data system for use
  - Training for use of the chosen system will be provided
- Additional training/technical assistance will be provided

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What's "In the Works"?

- Several items are being developed by HSP
  - A future eligibility determination process coordinated with Part A
  - Additional standard contract language
  - A Manual for providers (sub-recipients)
  - Service Standards for all funded services
  - A Site Visit and Monitoring Process for all funded providers (sub-recipients)
  - Policies and Procedures
- More Trainings and Webinars
  - Education about Ryan White requirements
  - Information about new policies and procedures
  - Technical assistance and support to help you implement these additional services

Communication

- Monthly TA calls
  - 3rd Tuesday of each month, 11-12 pm ET
- One e-mail for all general questions
- Point person for the respective areas
- Training
- Resources, materials and FAQs

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Mark Schwering
Ryan White Part B Program Director
317-233-7189
mschwering@isdh.in.gov

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