Indiana Department of Health (IDH) HIV Services Program Frequently Asked Questions

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Division of
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Programmatic Questions

1. **What is the HIV Services Program (HSP)?**
   HSP provides eligible people living with HIV (PLWH) in Indiana access to antiretroviral medications and services. HSP refers to the overall program at IDH that administers access to HIV care, services, medications and health insurance. To receive these wide range of services, PLWH must enroll with Non-Medical Case Management (NMCM) organizations across Indiana. More information can be found here: http://www.state.in.us/IDH/17740.htm.

2. **What is the Medical Services Program (MSP)?**
   MSP is a program under HSP that provides eligible PLWH in Indiana with access to medications and insurance, as well as limited care services for uninsured enrollees.

Eligibility

3. **What is the eligibility application process for clients? Is this process only available through certain agencies?**
   In order to be eligible to receive services through HSP (including services and MSP), clients must complete the eligibility determination process, including semi-annual recertification, through a Non-Medical Case Management (NMCM) site. Documentation of Ryan White eligibility may be obtained from the client's Non-Medical Case Manager, or through HIVe if you are a HIVe-participating site. Please feel free to contact your Ryan White Services Specialist for questions related to eligibility.

4. **What are the current eligibility requirements for HSP?**
   All applicants and clients seeking services to be provided by Indiana HSP (including services and MSP):

   1. *Be diagnosed as HIV positive*
   2. *Be a resident of Indiana*
   3. *Have an individual or household income at or below 300% of the federal poverty level (FPL)*
   4. *Be assessed for all other insurance or health care coverage (including Medicaid and Medicare)*

   Please refer to IDH HSP Policy #18-01 "Ryan White HIV/AIDS Program (RWHAP) Part B Eligibility Policy for detailed requirements.

5. **How can a client's enrollment be reactivated once they are terminated from the HSP?**
   Once a client is terminated from HSP, they are allowed a 21-day period to appeal their termination. During that appeal period, if the client (or the client's Non-Medical Case Manager) provides all outstanding documentation/justification to remain on the program, his/her coverage can be reactivated. If he/she (or the client's Non-Medical Case Manager) does not provide the necessary documentation/justification and his/her coverage is terminated following the appeal period, the individual's Non-Medical Case Manager may submit a new application for services.

6. **Do we need to have eligibility documentation in the file for every client we serve?**
Yes. Current eligibility is required for all services provided within the scope of services funded by RWHAP Part B. You may obtain documentation of a client's RWHAP eligibility from the client's Non-Medical Case Manager, or through HIVe if you are a HIVe-participating site. Please refer to IDH HSP Policy #18-01 "Ryan White HIV/AIDS Program (RWHAP) Part B Eligibility Policy" (Documentation section) or contact your Ryan White Services Specialist with any questions about eligibility.

7. **What is the referral form that is needed from other agencies to document that the client is eligible for RWHAP Part B?**
A referral form is not required for a client to receive services. A client may request services or may be referred to services through an agency's normal process. All clients must have an active and current eligibility determination for services to be paid for with RWHAP funds. Please contact your Ryan White Services Specialist with any questions.

8. **Can referral and eligibility documentation information be faxed or emailed to us from other agencies?**
Evidence of client eligibility may be exchanged securely between agencies according to normal subrecipient agency practice, ensuring the confidentiality of the client. Additionally, agencies can search for clients in HIVe to confirm eligibility and should do so prior to providing a service. In cases where there are questions about the eligibility status of a client, sites should reach out to the enrollment site or IDH.

9. **If required information on referred clients is not sent by the referring AIDS Service Organization (ASO) and the client refuses to provide it, can we proceed with our intake/transferring back into care?**
Services can only be paid for with RWHAP funds if a client is determined eligible and that eligibility documentation is current. If you are providing services to clients who are being reengaged in care, you can check on eligibility status through HIVe if you are a HIVe-participating site. If the client is new to care, or the eligibility has expired, you should continue to work with the client to engage in services and assist with completing eligibility determination.

10. **Can Medical Case Managers complete the initial eligibility determination and update every six months, or will the client have to go through an agency funded for Non-Medical Case Management?**
Clients must complete the eligibility determination process, including semi-annual recertification, through a Non-Medical Case Management site. Documentation of RWHAP eligibility may be obtained from the client's Non-Medical Case Manager, or through HIVe if you are a HIVe-participating site. Please contact your Ryan White Services Specialist with any questions related to eligibility.

11. **What payor of last resort status documentation is required for Food Bank services before a client can access RWHAP Part B funded services?**
Food bank services are not usually reimbursable under other third-party payors. Therefore, "Payor of last resort" does not apply. Subrecipients are expected to assess whether other sources of assistance are available in the community so that Ryan White funds can serve the most clients possible. Please refer to the "IDH HSP Food Bank/Home-Delivered Meals Service Standard" for additional information.

12. **If someone is already enrolled in Indiana Ryan White Part B or the Marion County RWHAP Part A program, do we have to re-enroll them in a Part B program enrollment?**
Clients must be determined to be "eligible" for the RWHAP Part B Program to receive services paid for with federal RWHAP Part B funds issued by the Indiana State Department of Health (IDH), per RWHAP legislation. Eligible clients may qualify to enroll in several HIV service and medication assistance programs available across the state. Enrollment criteria for various programs may vary, and eligibility does not guarantee enrollment. Programs conduct intakes and assessments to determine those services and assistance programs for which a client may qualify for enrollment. The Part B program is a part of HSP. The IDH eligibility application is for all Part B services, including those funded through HSP. Currently, the Part A Transitional Grant Area (TGA) and IDH have different eligibility determination procedures and policies, so a client must complete eligibility for both. However, IDH and the TGA are working toward combining this process.

13. **What are the differences between eligibility for Part A and Part B?**
There are just a few differences, although both Parts A and B must ensure clients are HIV-positive and low-income (less than 300% of the Federal Poverty Level). Part B (IDH) must verify that clients are residents of the state, whereas Part A (Marion County) must verify that clients reside only within a specific geographic area within the state called the "Transitional Grant Area", or TGA. Parts B and A calculate client income slightly differently, due to efforts to align Part B eligibility with certain insurance eligibility requirements through the Affordable Care Act (ACA). Both Parts B and A require clients to recertify their eligibility at least every 6 months, and to do a full reapplication for eligibility annually. IDH and Marion County are working together to combine the eligibility process so that the requirements and procedures are alike. This will reduce administrative burden to both clients and providers (including Non-Medical Case Managers).

14. **Does every client have to be active on RWHAP Part B before they can get services from staff persons funded by RWHAP Part B? If so, does this mean that staff person can't provide any services or do any documenting for that client until their RWHAP Part B is active?**
Clients must be determined to be "eligible" for the RWHAP Part B Program to receive services paid for with federal RWHAP Part B funds issued by IDH, per RWHAP legislation. Service providers should work with clients to help engage them and complete an eligibility determination through a Non-Medical Case Manager. If a client does not complete an eligibility determination (or is found to be ineligible), then services must be paid for with other funding.

15. **During intake with a Non-Medical Case Manager, if a client declines to provide demographic data used for eligibility (birth date, name, proof of HIV status, residency, etc.), what are my options?**
To engage in the Non-Medical Case Management program, you must have documentation of Indiana residency and HIV status to be eligible for the program. An intake can still be done with a client working to get the required eligibility documentation, and the Non-Medical Case Management program will work to help eliminate barriers for the client. There are many resources that can help clients obtain those documents. If the client declines to provide documentation or work to obtain

required documents, then they would not qualify for the Non-Medical Case Management program.

16. **Will clients receive a confirmation letter of eligibility in the mail?**
    No. All HSP services eligibility is processed through HIVe and agencies should print or take a screen shot of the HIVe client verification from the system to document eligibility.

17. **Who can I contact to get technical assistance (TA) on HIVe?**
    Please reach out to the program staff within your area, for RW Services please reach out to the hsprogram@ISDH.in.gov email or for NMCM please reach out to supportivesevices@ISDH.in.gov.

Medication Access

18. **Will clients receive a confirmation letter of eligibility in the mail?**
    Yes. For clients receiving medication services through MSP, the client and their Non-Medical Case Managers will receive an eligibility confirmation letter by mail, called a "Welcome Letter". You can also confirm a client's eligibility through HIVe if you are a HIVe-participating site.

19. **What program(s) can a person needing medications gain access to?**
    MSP is comprised of five programs designed to work together to provide PLWH who meet program eligibility criteria with access to HIV medications. The five programs are:

    a. ***AIDS Drug Assistance Program (ADAP):*** *ADAP functions as a temporary medication assistance program. It provides a limited array of Food and Drug Administration (FDA)-approved medications for the treatment of HIV and related conditions. MSP pays 100% for the prescription medications listed on the formulary of ADAP Covered Pharmaceuticals. Payment for any non-formulary medication is the client's responsibility.*

       In addition to enrollment in ADAP, an uninsured client is dually enrolled in the Early Intervention Program (EIP) that provides ADAP clients access to services via fee-for-service model.

    b. ***Health insurance assistance program:*** *The health insurance assistance program (HIAP) is the primary assistance program within the HIV MSP. It coordinates health coverage for clients that are eligible for a comprehensive insurance plan through the Marketplace. MSP pays 100% of the client's premium, deductible, co-insurance, and/or co-payment. Applicants with Medicare Part D are* ***not*** *eligible for HIAP.*

    c. ***Medicare Part D Assistance Program:*** *Medicare Part D Assistance Plan (MDAP) emerged from the federal Medicare Part D prescription drug coverage legislation. It coordinates health care coverage with a variety of participating providers under the Medicaid Part D prescription drug plan. MDAP is utilized when an eligible individual is aged 65 or older or has a qualifying disability and is enrolled in a participating Medicare Part D plan.*

MSP pays for the client's deductible and co-payments for charges allowed by the approved Medicare Part D plan. MSP will not cover the following costs:

- *Medicare Part D plan premiums;*
- *Non-covered pharmaceuticals as determined by the participating Medicare Part D plan;*
- *Balances remaining for pharmaceuticals billed at more than the "usual and customary" rate;*
- *Balances remaining for pharmaceuticals billed at an "out-of-network" rate;*
- *Pharmaceuticals dispensed prior to an application's approval; or*
- *Pharmaceuticals dispensed after termination from the plan.*

The costs to the enrollee are dependent upon the participant's income and which plan is chosen. MDAP will pay for the allowed Medicare Part D co-payments and annual deductible. The enrollee should not have any out-of-pocket expense for covered services other than the premium amount itself.

Extra Help, also called the low-income subsidy (LIS), is a Medicare program designed to help lower-income Medicare Part D enrollees afford the Medicare Part D coverage. MDAP enrollees who apply and are approved for Extra Help will realize lower or no premium costs, do not experience a coverage gap, and have no late enrollment penalty.

d. ***Health Indiana Plan (HIP) Basic:*** *The Healthy Indiana Plan is the state of Indiana's Medicaid health coverage program for non-disabled people living in Indiana ages 19-64. HIP Basic provides benefits include medical and pharmacy. MSP pays 100% of the client's deductibles and co-payments for medications on the Medicaid formulary. Payment for any non-formulary medication is the client's responsibility. Applicants with Medicare Part D are **not** eligible for HIP Basic.*

e. ***Health Indiana Plan (HIP) Plus:*** *The Healthy Indiana Plan is the state of Indiana's Medicaid health coverage program for non-disabled people living in Indiana ages 19-64. HIP Plus provides comprehensive benefits including medical, pharmacy, vision, dental, and chiropractic services. The client pays the first month (or any previous balance) POWER Account contribution in full, after which MSP pays 100% of the client's POWER Account contribution to ensure the client's coverage stays active. Applicants with Medicare Part D are **not** eligible for HIP Plus.*

Service Standards

20. What are Service Standards?

Service Standards establish minimum expectations for providing a service. Some examples of activities included in Service Standards are what elements assessments should include, time frames between intakes and initial appointments, educational/background requirements for staff providing a particular service, and key activities that should occur with clients under a service. Service Standards help ensure clients receive the same basic elements of a service no matter where they obtain that service or who provides that service.

21. **When will the Service Standards be released?**
Service Standards for every funded service category are available on the IDH website at: https://www.in.gov/isdh/27827.htm. Service Standards were developed with subrecipient and provider input and will continue to be reviewed every year to ensure they remain current. Please contact your Ryan White Services Specialist if you have any questions about Service Standards.

22. **What is the difference between service standards and service units?**
These two concepts are related and tie together but are distinct. Service Standards describe how services should be provided at a minimum and are very detailed. Service units are a simple measurable categorization of types of services provided to clients. Service Standards for all funded service categories can be found at: https://www.in.gov/isdh/27827.htm.

Subrecipient Monitoring

23. **What is Subrecipient Monitoring?**
Subrecipient monitoring refers to all activities that IDH performs to make sure subrecipients remain compliant with federal policies and regulations, as well as contractual terms. This includes monthly subrecipient progress reports describing successes and challenges with delivering funded services, invoice review and expenditure tracking, data review and annual administrative and fiscal site visits.

24. **What are "National Monitoring Standards"?**
The Ryan White National Monitoring Standards are three sets of guidance that explain general administrative, programmatic and fiscal requirements for administering RWHAP funded services and are put forth by HRSA's HIV/AIDS Bureau. The National Monitoring Standards outline the compliance requirements that all recipients and subrecipients must follow according to federal policies and laws. Annual monitoring site visits review how well subrecipients are meeting the various compliance requirements referenced in the National Monitoring Standards.

25. **When will the annual site visits start?**
Annual site visits are being scheduled, and you will be notified by your Ryan White Services Specialist once your agency is scheduled for a visit.

26. **Where can I find the monthly progress report form?**
The fillable PDF form can be accessed at this link here.

27. **When is the monthly progress report due and what time frame does it cover?**
In alignment with your invoice submission, the monthly progress report is due 20 days after each month ending and covers each full calendar month. For example, the monthly progress report for June will cover June 1-30 and is due to IDH no later than July 20. The monthly progress report for July will cover July 1-31 and is due to IDH no later than August 20. Monthly reports should be submitted with the invoice for the month being addressed.

28. **When will I receive feedback on the monthly progress report I submit and what will it look like?**
You will receive feedback from IDH on your monthly progress report submission by the 15th day after the due date. For example, the monthly progress report for June is due on July 20 and you will receive feedback from IDH by August 15. The monthly progress report for July is due on August 20 and you will receive feedback from IDH by September 15. Feedback may request you submit additional information or clarification in subsequent progress reports.

29. **Will I ever have to resubmit a progress report based on something I forgot to include or didn't provide enough detail on?**
No. Because you are submitting progress reports every month, you would provide additional detail and substance around key activities in following monthly reports.

Other Programmatic Questions

30. **Do People with HIV (PLWH) with insurance currently receiving mental health services from licensed clinicians in an HIV Community Based Organization (CBO) that is unable to bill insurance need to transfer to an agency able to bill insurances?**
Our intent is continuity of care, not disruption. These situations are best handled on a case-by-case basis to allow for the greatest flexibility to meet need while still ensuring overall compliance. To meet federal requirements, our funded services will target providers who are Medicaid certified and are credentialed by a client's insurer. For groups that do accept insurance or unable to bill an insurance plan, we must be aware of their competency, comfort, and experience in serving individuals from key groups most in need across Indiana. Please contact your Ryan White Services Specialist when these situations arise, and you may reference IDH HSP Procedure #18-10 "Payor of Last Resort Policy Exception: Procedure to Appeal for Exception to IDH HSP Policy #18-02 Payor of Last Resort Policy" for further information.

31. **Are providers required to be Medicaid certified?**
Yes. Any provider supported with RWHAP funds who provides services covered by Medicaid must be a Medicaid provider. If a provider is not currently certified by Medicaid, then that provider should immediately initiate an application if they plan to continue to provide RWHAP-funded services. Again, the intent is continuity of care, not disruption. Please contact your Ryan White Services Specialist so that any situations may be resolved on a case by case basis.

32. **Are we able to provide Syringe Exchange Programs with HSP funding?**
IDH has determination of need within the state and there is limited prevention funding being directed toward syringe exchange programs. Funds may be used to support staff and supplies (absent the purchase of syringes). Relevant service categories include Health Education (HE) and Risk Reduction (RR), Outreach and Psychosocial Services.

Fiscal Questions

33. **Where do I find the fiscal Policies and Procedures that I need to follow?**

All fiscal policies can be found at the following location on the website: https://www.in.gov/isdh/27828.htm

34. Do I send all HIV/STD/VH invoices to the same place?
NO, you will send them to your designated email inbox listed below:
- *Prevention: hivprev@ISDH.in.gov*
- *HIV SERVICES Program: HSProgram@ISDH.in.gov*
- *DIS: STD@ISDH.in.gov*

35. Do I have to submit my invoices in monthly order?
Yes, each month builds on the next in the invoice template. To have your summary sheet give you accurate balances, percentage spent, etc. you must submit the invoices in order. Submit your current month's expenses by the 20th day of the following month.

36. How do I know if I have entered the correct invoice date?
Your invoice date should always be the current date you are submitting your invoice to IDH.

37. Is there a correct way to title the subject line of my email when I am sending an invoice to IDH?
Agency name SCM# (12345) Invoice number (FEB12345HIV20) and any short identifier can follow this, such as "invoice". It is vital that the SCM number has a space on either side of it in the
SAMPLE: AGENCY 12345 FEB12345HIV20 INV

38. I have negative numbers showing up on my invoice template, what does this mean?
You have overspent a line or service category. The amount that is listed on your template for any category is all you are supposed to spend in that category. If you attempt to spend more that you have been allotted, you'll see negative figures. You should talk with your Ryan White Services Specialist and determine whether a Request for Budget Change (RBC) should be submitted. Please see: Procedure 18-06 Subrecipient Request for Budget Change

39. What is required as "supporting documentation" to accompany our invoices? Do we need to send copies of our receipts?
Currently, IDH HSP requires submission of supporting documentation with every invoice effective with contracts beginning September 2020. Supporting documentation means documentation that justifies every expenditure on that invoice, such as payroll expenditures, paid receipts for supplies or other items, and travel vouchers paid for staff travel. See Policy 18-05: Procedures for Subrecipient Invoice Submittal by Service Category and Documentation Approval.

40. I am not spending as much money in a certain category on my budget as I predicted. Can I use that money for something else?
Usually, Yes. But you must obtain written authorization from IDH HSP first. You will want to go to HIV/STD/VH website and obtain the Request for Budget Change template, IDH HSP Procedure #18-06 "External Request for Budget Change Procedure" and send the completed RBC Template to the designated email inbox. At times there

might be reasons which will not allow you to reallocate funds, but we will do everything we can to help you do so.

41. **We did not receive a fiscal tracking sheet or an invoice spreadsheet. Who do we contact if we have questions about these forms?**
    Please contact your Ryan White Services Specialist if you have any questions about invoicing or your budget.

42. **If the grant is paying for an FTE (full-time equivalent), and a RWHAP Part B-eligible client has health insurance that pays for a service (i.e. for mental health), how do we account for that insurance billing, as it relates to the fully-funded FTE?**
    If IDH is paying for a full-time equivalent that generates income by billing insurance or other payers outside of RWHAP, that income is considered "program income" and must be invested back into the program that generated that income. In the example above, if HSP is funding a mental health provider at a clinic, and that mental health provider sees clients with insurance that can be billed, the insurance payments back to the clinic must be invested back into the clinic's RWHAP Part B programming. The clinic does not necessarily need to invest the program income back into mental health services but can be used to support any Part B funded activity. You must track this program income to document how it was expended, and you must make this documentation available to IDH HSP upon request and during annual site visits.

43. **Are Non-Medical Case Managers able to provide modest incentives to clients that are being brought in or back to care?**
    You may used RWHAP funds for incentives but must observe certain restrictions set by the federal governments. RWHAP funds may not be used to make direct cash payments to intended clients of RWHAP-funded services. However, store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are allowable as incentives for eligible program participants. Vouchers and store gift cards should be administered in a manner which assures that they cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. Please reference "IDH HSP Policy #18-06 "Gift Card Policy" for further information.

44. **Does an agency need a separate food pantry for RWHAP Part B eligible clients, or can it be one combined pantry open to all clients? Does food or other materials/resources for RWHAP eligible clients need to be kept separate and only made available to eligible and enrolled clients?**
    No, a separate inventory does not need to be maintained. The agency would need a methodology to align costs paid for with RWHAP funds with the food and products distributed to RWHAP eligible clients.

45. **How do subrecipients track costs for fiscal management when services are funded by multiple funding streams? Can they use an estimate or are they required to attach a cost to each of the items that clients receive? What would be considered a unit of service – each separate item or an overall actual or estimated cost of food distributed per visit?**
    If you are using multiple funding streams for services, you must have a documented budget that includes all those funding streams. You must track expenditures by each

funding stream to ensure those expenditures are allowable under that funding stream and ensure that the same expenditures are not duplicated between funding streams. You must have a methodology that shows how you assign costs by item or by proportionate costs to each funding stream, and that methodology must be consistently applied. IDH has defined service units for every funded service category, but this is for data collection purposes and not for invoicing. However, that data can help you determine the proportion of costs assigned to each funding stream.

For HIV programs funded from multiple sources subrecipients should create separate cost codes for each funding source to track how funds are budgeted and spent. For example, if you are in a larger, multipurpose organization your HIV program most likely has its own cost center. If your HIV program is funded from multiple sources – for example, Ryan White Part A, Part B, Part C and program income, each of these should be assigned a cost code. Your HIV program budget should reflect what components of your budget each of these sources supports and your accounting system should be able to track expenditures back to each of these sources. The IDH staff can provide budget worksheets that will help you budget funds from multiple sources.

46. **Are appliances, such as a freezer for a food pantry, allowable purchases? Is this part of the administration allocation?**
Under the Health Resources Services Administration (HRSA) HIV/AIDS Bureau (HAB) Policy Clarification Notice (PCN) #15-01, this is an allowable administration expense.

47. **If we do not use all our allocated funds by the end of the fiscal year, do we lose them?**
Yes. Subrecipients may not carry over any funding across budget years. It is important to communicate with your Ryan White Services Specialist about any under spending during the year so that IDH HSP can reallocate funds to other needed service expenditures. If you have unspent funds left at the end of the year, these funds may need to be returned to the federal government. If the amount of unexpended funds at the end of the year is too high, IDH may risk receiving a reduced federal award for the state in the future so it is very important to work closely with your Ryan White Services Specialist in this situation.

48. **Is Time and Effort reporting required?**
Time and Effort reporting is required when any part of salaries, wages or benefits (not contractors) are paid with federal funds. This is a federal requirement, not just a Ryan White Part B requirement.

49. **How do I "certify" Time and Effort?**
The subrecipient's financial manager should administer the Time and Effort reporting procedure, provide orientation and training and perform periodic reviews to ensure compliance. Managers/supervisors with first-hand knowledge of employees' work are responsible for certifying (verifying) that the employee's Time and Effort tracking and reporting is accurate and compliant. Managers/supervisors review employees' Time and Effort on a regular schedule (most often monthly), and sign a statement certifying the information is true and accurate. The subrecipient must have policies and procedures outlining this process and that identify sources of supporting documentation that can be used to reasonably assure accuracy. More detailed

information about Time and Effort is included in the November 2018 IDH subrecipient webinar and can be viewed with all TA webinars on the IDH webpage here.

50. **How do we report program income?**
    Subrecipients must have mechanisms in place to track program income, budget program income and report program income. Subrecipients must develop a comprehensive HIV program budget that shows not only how Part B funds are budgeted but also how program income is used as well as any other sources of funding that support their HIV program. To the extent possible program income funds should be expended prior to RWHAP federal funds. Documentation of program income and program income expenditures must be maintained and provided to IDH staff upon request and during every annual site visit. Further information about uses and limitations of program income can be found in the HRSA HAB Policy Clarification Notice (PCN) #15-03 "Clarifications Regarding the RWHAP and Program Income", and the accompanying FAQ located at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

51. **How do you determine whether the costs of services are "reasonable"?**
    Subrecipient invoices must be evaluated for reasonableness at least twice a year following a procedure that is compliant with 45 CFR 75 Subpart E. Please refer to IDH HSP Procedure #18-04 "Reasonable Cost Procedure" for guidance in determining reasonable cost.

52. **Can you clarify the distinction between "balance billing" and covering out of pocket expenses for clients?**
    It is NOT ok for funds to make up the difference between what a provider charges and what an insurance company pays for that service. This is an insurance regulation that requires providers to accept the contractually negotiated reimbursement rates from insurance companies. It is OK to have funds wrap-around out-of-pocket costs related to HIV care. For example, Pharmacy services where the pharmacy bills insurance, the copay is then billed to ADAP for PLWH enrolled in the program.

Administrative Questions

53. **What is meant by "there is no hierarchy across RWHAP Parts."**
    This means that there is no requirement to spend a particular RWHAP Part (A, B, C, etc.) before or after another Part. "Payor of last resort" does not apply between the various Ryan White Parts, as each Part must follow "payor of last resort" requirements.

54. **With our RWHAP Part B residential substance use dollars, if an Indiana resident is eligible for RWHAP Part B services but a treatment option has openings in another state, can we still pay for it?**
    RWHAP funds must be used for services for residents of the state, or of the catchment area of a Part (i.e., Part A TGA, Emerging Communities area, etc.). Funds may be used to pay for services to those residents that may be provided in another state or catchment area as long as the client maintains evidence of residency according to Indiana Department of Health (IDH) eligibility policy, especially if appropriate services are not available in the client's area of residence. It is recommended that the subrecipient put in place a contract or agreement with the service provider so the provider can be paid directly by the subrecipient. The provider should also agree to provide necessary client information needed to continue payment for those services, such as eligibility updates. If the client becomes a resident of another state or catchment area, then payment for services would be managed by the new area. When these situations arise, please contact your Ryan White Services Specialist to discuss.

55. **Are we going to receive slides for the monthly TA calls?**
    Yes! They are distributed to all subrecipients each month through the IDH website. Please see the following page for posted materials for all webinars:
    https://www.in.gov/isdh/27833.htm

56. **Where can I find quick contact information for additional questions and TA?**
    Please contact your Ryan White Services Specialist for all TA needs.

57. **Can subrecipients utilize administrative funds to support HIV staff training?**
    Yes. You can use administrative dollars from your contract to support staff training. If you may exceed the administrative budget line item, then contact your Ryan White Services Specialist.

58. **Our agency offers tuition remission to our employees in attendance at our university. Is it allowable to use part of our grant to cover the cost of tuition remission for budgeted staff?**
    IDH HSP can reimburse for some conferences and training but does not reimburse costs related to tuition.

59. **If an agency is providing psychosocial services and/or Health Education (HE)/Risk Reduction (RR) and they wish to bring in an expert presenter for one of their client sessions that would involve a cost, how should that be billed? This activity targets a group of clients that have the need for the presentation demonstrated in their treatment plan.**
    Honoraria for training of staff or clients is a budgeted expense tied to the service provided as defined in Policy Clarification Notice (PCN) 16-02. As such, it is not considered administration but part of providing a service as defined by the Health Services Resources Administration HIV/AIDS Bureau (HAB). The rationale for the expense must focus on how the training of staff or client enhance the service.

60. **As a prevention provider who is also funded under Ryan White, what parts of compliance with the RWHAP are applicable? Who will do our site visits?**
    Any subrecipient that receives any amount of Part B funding must be in compliance with all requirements of the RWHAP, including receiving an annual site visit. RWHAP Part B and CDC Prevention funds have different requirements due to differences in federal legislation and policies that govern those funding streams. HSP and HIV Prevention are working together to reduce administrative requirements that may be duplicative but must ensure compliance to both funding streams. The site visit schedule and process for reviewing agencies that receive both Part B and HIV Prevention funds are currently under review.

61. **What do program/fiscal policies look like? How do we format them, and are there templates?**
    Each subrecipient is required to have policies and procedures that comply with RWHAP Part B administrative, program and fiscal requirements, but the format of those policies and procedures are up to the agency and are likely consistent with other policies and procedures within that agency. IDH does not mandate the format of policies and procedures. You are encouraged to network with other subrecipients if you are seeking examples. You may also contact your Ryan White Services Specialist for TA if you are unsure about RWHAP Part B compliance requirements.

Data Questions

Reporting Requirements

62. **Where can we go to learn more about required data and reporting frequency requirements?**
Effective September 30, 2020, data will be due 20 days after the end of the previous month in the IDH mandated data system. For example, the data for June will cover June 1-30 and is due to IDH no later than July 20. Refer to your Attachment A in your contractual agreement for additional information.

63. **When a client is seeking services through the HSP, what minimum data is required for service provision?**
Once a client is determined to be eligible, there is no additional self-reported data that the client must provide (such as race or ethnicity) that would preclude the client's ability to receive services. All other data will be collected and reported by the agency for each client that receives a RWHAP or RWHAP-related funded service. IDH has distributed documents to each agency regarding required data to be collected. These requirements are based on funded services that the client receives.

Agencies that have a local data system may use it for the purposes of collecting the required information, but agencies must have the ability to discern RWHAP eligible clients from other clients as well as RWHAP and RWHAP related funded services for the purposes of reporting data. Agencies must use the Excel template for local reporting requirements.

64. **Will TA be available for data reporting questions?**
IDH provides TA to all subrecipients regarding data reporting. Contact your Ryan White Services Specialist if you need TA on data reporting matters.

65. **What is the Ryan White Services Report (RSR) and am I required to do it?**
The RWHAP Services Report (RSR) is annual federal report that includes client-level report documenting the people served and services provided to RWHAP clients. All providers receiving RWHAP funding must complete the RSR. A new federal requirement is that providers receiving RWHAP-related funding (funding through rebates) will also have to complete the RSR in the future. IDH will be providing additional guidance to agencies regarding when this requirement will be implemented locally.

CAREWare

66. **What is CAREWare?**
CAREWare is a free, electronic health and social support services information system for HRSA's RWHAP recipients and providers. Currently, Marion County Public Health Department (MCPHD) administer a CAREWare network for Part A and C funded providers. IDH is collaborating with MCPHD to shared server so that all IDH and MCPHD RWHAP funded providers can use CAREWare.

67. **Will we be using CAREWare to facilitate tracking of service utilization?**
MCPHD funded providers are already using CAREWare. Implementation for IDH joining the shared CAREWare server is expected in Fall 2020. Additional information will be shared by IDH as it is available.

68. **When will the system to enter client data and service utilization be available**?

As noted above, the implementation for CAREWare is expected to begin in the Fall, 2020. In the interim, subrecipients must use the Excel table provided by IDH for the purposes of reporting data. Subrecipients may not use the Marion County CAREWare system. If you want to enter data into another data system such as an EHR, please contact IDH prior to entering data.

69. **Will we be able to set up the software/database system being used to capture/report performance measures?**
CAREWare has a performance measure module built into the software. In addition, custom reports can be developed as needed.

70. **Is it possible the excel data will be able to be imported into CAREWare?**
IDH is in the process of developing a transition plan for CAREWare implementation. IDH plans to import all data from September 30, 2019 to September 29, 2020. Data not submitted to IDH within this timeframe may not be included in the import and may be the responsibility of the subrecipient to manually enter data into CAREWare.

CaseManager

71. **Will CaseManager still be used as an IDH data collection system once CAREWare has been implemented?**
CaseManager will be live for case note entry only starting September 30, 2020. All client services will be required to be entered into CAREWare after this date. IDH is working on the transition from CaseManager to CAREWare but plans to have CaseManager inactive by January 2021.

Quality Management Questions

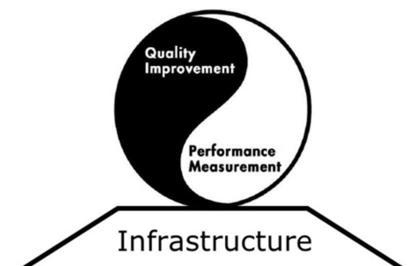
72. What guidance is there for subrecipients regarding Clinical Quality Management (CQM)?
Information for subrecipients related to CQM can be found at the following location: https://www.in.gov/isdh/27830.htm. You may also write to HIVQuality@ISDH.in.gov with specific questions for the IDH internal QM team.

73. Will subrecipients need to create their own quality management plans and convene their own quality management committees?
Yes, subrecipients are required to have their own QM Plans and Committees. Subrecipient contract language has been updated to reflect CQM requirements. Slight changes are expected year by year as the IDH program grows and matures. The IDH Internal QM team conducts statewide TA visits each fall and host the "Leading the Quality Effort" training each Spring. Additional TA and training is available by request by contacting HIVQuality@ISDH.in.gov.

74. What are some examples of accepted Clinical Quality Improvement (CQI) methodology?
Accepted QI methods require practitioners to follow specific process and leverage specific tools and are well studied and based in evidence. Examples of accepted QI methodology include the Model for Improvement and Lean/Six-Sigma. The Model for Improvement is the most utilized methodology, because it is the simplest and easiest to understand. You can learn more about the Model for Improvement at the Center for Quality Improvement and Innovation website here: https://targethiv.org/cqii

75. Is client experience evaluation considered Quality Improvement (part of CQM) or Quality Assurance (part of compliance with administrative requirements)?
Client experience evaluation is a quality improvement activity that is part of a CQM program. Experience evaluation allows a provider organization to identify specific opportunities for improvement from the consumer perspective. Client experience evaluation is a way to tap into the clients you engage through delivery of your services in quality improvement. In addition to these engagements, you are required to involve consumers in your quality program to the extent you can through the creation of consumer advisory boards, adequate consumer involvement in your board of directors (>50% per the HRSA Bureau of Primary Health Care), consumer involvement on your agency's CQM committee, and other strategies. Using consumer involvement mechanisms to design and manage client experience evaluation is a gold standard in quality improvement.

76. What are the components of CQM?
Our Yin/Yang marble on a base is the most common way we think about quality management in the RWHAP. The RWHAP model is used across the Division, because RWHAP has been a national leader in quality improvement since its inception (more so than CDC, which is focused on evaluation and minimums). The component of CQM are Infrastructure, Performance Measurement, and Quality Improvement. For more information,



visit the Division's CQM Page: https://www.in.gov/IDH/27830.htm

77. **What should our CQM committee look like?**
    QM committees will differ by site, depending on the number of programs and populations served. Larger organizations will likely have larger committees than smaller organizations because they will need to include representatives and consumers from a larger number of programs and populations. Consumer representation should not only reflect populations that the organization currently serves, but also who they seek to increase service to. Committees choose how often they will meet and how they will meet (in-person, via phone conference, etc.).

78. **Can one CQM plan be used to meet the quality management requirements for all Ryan White parts.**
    Yes, IDH encourages sites to create one CQM plan that encompasses all programs and meets the requirements of each program's funding source.

79. **Should we include our agreed upon contract deliverables in our organization's CQM plan?**
    It is okay to include your contract deliverables in your CQM plans, but if you do, it is important to note that those deliverables are quality assurance goals. While quality assurance is a piece of quality management, your CQM plan exists for the purpose of performance measurement and quality improvement that happens outside the scope of contract deliverables you've agreed upon with your funders.

80. **We don't provide clinical services at our site. Why do we need a CQM plan?**
    Any organization that receives Ryan White funding is required to have a CQM plan per HRSA guidelines, regardless of whether they have any services that are clinical in nature. The term "clinical quality management" is used for congruency of language across all Ryan White recipient and subrecipients. See Policy Clarification Notice 15-02 update.

Resources

IDH HIV Services Program (HSP) Website

Addiction Technical Transfer Center

Center for Quality Improvement & Innovation

Health Resources and Services Administration HIV/AIDS Bureau (HAB) Policy Notices and Program Letters

Indiana State Department of Health (IDH) HIV Services Program (HSP) Video Center

MidWest AIDS Education & Training Center

National Monitoring Standards for Ryan White Part A and Part B Grantees

Ryan White Services Report (RSR) Technical Assistance (TA)

Ryan White Treatment Modernization Act Legislation

TARGET Center Website (HAB TA central dashboard)

Glossary

ACA..Affordable Care Act

ADAP...AIDS Drug Assistance Program

ASO..AIDS Service Organization

CBO..Community-Based Organization

CQM...Clinical Quality Management

CQI..Clinical Quality Improvement

FPL..Federal Poverty Level

FTE..Full Time Equivalent

HAB..Health Services Resources Administration HIV/AIDS Bureau

HE..Health Education (services)

HIAP...Health Insurance Assistance Program

HRSA...Health Resources and Services Administration

HSP...HIV Services Program

IDH...Indiana Department of Health

LIS...Low-Income Subsidy

MDAP...Medicare Part D Assistance Plan

MSP..Medical Services Program

NMCM...Non-Medical Case Management

PCN..Policy Clarification Notice

PLWH...People With HIV

RBC..Request for Budget Change

RFP...Request for Proposals

RR...Risk Reduction (services)

RSR...Ryan White Services Report

RWHAP .... Ryan White HIV/AIDS Program

TA .... Technical Assistance

TGA .... Transitional Grant Area

VA .... Veterans Affairs