



**Department
of Health**

HIV/AIDS Value Based Payment Arrangement

Measurement Year 2018 Fact Sheet



HIV/AIDS Value Based Payment Arrangement

This fact sheet has been prepared to assist payers and providers to more thoroughly understand New York State's Medicaid Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) Value Based Payment (VBP) Arrangement. It provides an overview of the Arrangement, including a summary of the categories of care covered by the Arrangement and the types of measures recommended for use in HIV/AIDS VBP Arrangements.

Introduction

As part of the plan to transition to VBP statewide New York State (NYS) has identified certain groups, called subpopulations, within the Medicaid population for whom highly specialized, intensive care is required. The goal for these subpopulation VBP arrangements is to improve care coordination across traditional provider siloes, ensuring all healthcare providers work together to meet the needs of the member. Medicaid members with HIV infection or AIDS represent a complex subpopulation, some of whom also suffer from comorbidities such as mental health and substance use disorders (SUD). While HIV or AIDS status will be the primary criterion for subpopulation inclusion, effectively treating this subpopulation also means screening for and treating other conditions that complicate the condition. These comorbidities add to the complexity of care delivery and underscore the importance of providing coordinated, integrated care at appropriate points across the care continuum.

HIV/AIDS VBP Arrangements include the total cost of care for the members in order to incentivize all care professionals, including behavioral health providers, community-based providers, medical specialists, and other health care professionals, to provide high quality care. By rewarding VBP Contractors based on quality and cost-effectiveness within a total cost of care budget, VBP Contractors¹ are encouraged to focus on care coordination and high-value, evidence-based practices across the care delivery spectrum. Savings in an HIV/AIDS VBP contract can be primarily achieved through providing appropriate interventions for HIV/AIDS and other comorbid conditions, leading to a reduction in acute medical events and treatment, and a lower total annual cost of care. Social determinants of health such as housing status and economic self-sufficiency are also important variables to address.

This fact sheet provides an overview of New York State's HIV/AIDS VBP Arrangement and is organized in two sections:

- Section 1 describes the care included in the HIV/AIDS Arrangement, the method used to define the attributed population, and the calculation of associated costs under the VBP Arrangement;
- Section 2 describes the quality measure selection process and the categories of measures recommended for use in HIV/AIDS VBP Arrangements.

Section 1: Defining the HIV/AIDS VBP Arrangement and Associated Costs

The HIV/AIDS VBP Arrangement addresses the total care and the associated costs of that care for the members attributed under the Arrangement, regardless of where, how, or for what reason the care was delivered. VBP Contractors assume responsibility for the quality and cost of care for all conditions and types of care for attributed members, including primary care, specialty care, emergency department visits,

¹ A VBP Contractor is an entity – a provider or group of providers – engaged in a VBP contract.



hospital admissions, and medications (with a cap for specialty, high-cost drugs).² The majority of Medicaid members within the HIV/AIDS subpopulation are either enrolled in a managed care plan or an HIV/AIDS Special Needs Plan (SNP). The HIV SNPs are a special type of Medicaid managed care plan that provides a network of experienced HIV-service providers, HIV specialist Primary Care Physicians (PCPs), and a comprehensive model of case management. SNPs are also required to promote access to essential support services such as treatment adherence and housing and nutrition assistance, and to reach multi-cultural/non-English speaking communities.

Constructing the HIV/AIDS VBP Arrangement: Time Window and Services

The HIV/AIDS VBP Arrangement encompasses all services provided to the attributed member population during the contract year. This includes preventive care, sick care, and care for all chronic conditions, including procedures and surgeries with a date of service or discharge date within the contract year. Members of the HIV/AIDS subpopulation may seek care through community health centers, Designated AIDS Centers (DACs) or other hospital-based programs, or their primary care physician.

Eligible Member Population

Medicaid members in a Medicaid Managed Care Organization (MCO) or SNP who are diagnosed with HIV/AIDS and who are not dually eligible for Medicare can be included in HIV/AIDS VBP Arrangements. Members who test positive for HIV, but have not been formally diagnosed by a care provider, are not eligible for inclusion because they are not able to be attributed to a specific provider or provider group.

Medicaid members eligible for inclusion under a VBP subpopulation arrangement are *not* eligible for inclusion in other VBP arrangements. Subpopulation arrangement types include HIV/AIDS, Health and Recovery Plans (HARP), Managed Long Term Care (MLTC), and Intellectually/Developmentally Disabled (I/DD). Subpopulation arrangements are mutually exclusive; a member can only be enrolled in one or the other. MCOs and VBP Contractors can decide which subpopulation designation takes precedence for the member.³ Members included in subpopulation arrangements are also excluded from Total Care for the General Population (TCGP) and Integrated Primary Care (IPC) arrangements.

Member Attribution

Medicaid member attribution defines the group of members for which a VBP Contractor is responsible in terms of quality outcomes and costs. It becomes the basis for the aggregated total cost of care in a target budget for VBP. The NYS Roadmap details attribution guidelines for VBP Contractors and Medicaid MCOs for each arrangement.

New York State's guideline for member attribution in HIV/AIDS VBP Arrangements is to the Medicaid MCO-assigned PCP.⁴ However, an MCO and VBP Contractor may agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.

² The VBP Roadmap includes categories of costs that may be excluded from VBP arrangements, where appropriate. For more information see New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, June 2016: Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016, p. 72. ([Link](#))

³ Ibid. p. 15.

⁴ Ibid. p. 23.



Calculation of Total Cost for the Arrangement

The total cost for the attributed membership in HIV/AIDS VBP Arrangements includes all Medicaid-covered care provided during the contract year. The total cost of the HIV/AIDS VBP Arrangement is based on the cost of that care (defined as the total amount paid by the Medicaid MCO or SNP), including all costs associated with professional, inpatient, outpatient, pharmacy (with a cap for specialty, high-cost drugs), laboratory, radiology, ancillary, and behavioral health services aggregated to the attributed population level. The aggregate costs can be further analyzed to identify and understand sources of variation and opportunities for improvement in quality of care and resource use.⁵

Section 2: VBP Quality Measure Set for the HIV/AIDS Arrangement

The 2018 HIV/AIDS Quality Measure Set was developed drawing on the work of a number of stakeholder groups convened by the Department of Health (DOH) to solicit input from expert clinicians around the state. The HIV/AIDS Clinical Advisory Group, or CAG, convened specifically to make VBP quality measure recommendations. One of the key innovative aspects of the HIV/AIDS VBP arrangement is the incorporation of quality measures related to the goals outlined in New York State's three-point plan from the 2015 End the AIDS Epidemic Blueprint.⁶ The HIV/AIDS VBP arrangement will include quality measures related to retaining individuals with HIV/AIDS in the healthcare system and facilitating maximum viral load suppression.

Because the HIV/AIDS VBP Arrangement is a total cost of care subpopulation arrangement, a full complement of physical and behavioral health measures is included in the measure set to ensure members in care for HIV/AIDS receive high quality health care, in addition to specialty care for HIV/AIDS. The physical health measures were drawn from the measure sets developed by the Diabetes, Chronic Heart Disease, and Pulmonary CAGs and from the measures recommended for Advanced Primary Care (APC) by the Integrated Care Workgroup. Likewise, the behavioral health measures were drawn from the measure sets developed by the Behavioral Health CAG.

Measures recommended by the CAG were submitted to NYS DOH, the Office of Mental Health (OMH), and the Office of Alcoholism and Substance Abuse Services (OASAS) for further feasibility review and, ultimately, to the VBP Workgroup, the group responsible for overall VBP design and final approval for NYS Medicaid. During the final review process, the HIV/AIDS VBP measure set was aligned with existing Delivery System Reform Incentive Payment (DSRIP) Program and Quality Assurance Reporting Requirements (QARR) measures, and measures utilized by Medicare and Commercial programs in NYS, where appropriate. The measures were further categorized as Category 1, 2, or 3 based on reliability, validity, and feasibility, and by suggested use as either Pay-for-Reporting (P4R) or Pay-for-Performance (P4P).

Measure Classification

In May 2016, NYS published the initial recommendations of the HIV/AIDS CAG on measures for use in HIV/AIDS VBP Arrangements and included a review of the types of data needed for the recommended measures. Additionally, the report addressed other implementation details related to VBP arrangements. Upon receiving the CAG recommendations, the State conducted additional feasibility review and analysis to define a final list of measures for use during the 2017 VBP Measurement Year (MY). Each measure was designated by the State as Category 1, 2, or 3, according to the following criteria:

⁵ Additional information on total cost of the arrangement and use in contracting will be made available through other DOH materials in the future.

⁶ New York State Department of Health, New York State's Blueprint to End the AIDS Epidemic, 2015. ([Link](#))



- **CATEGORY 1** – Approved quality measures that are felt to be clinically relevant, reliable and valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures will be further investigated during the VBP Pilot program; and,
- **CATEGORY 3** – Measures that are insufficiently relevant, valid, reliable and/or feasible.

Note that measure classification is a State recommendation. Although Category 1 measures are required to be reported, Medicaid MCOs and VBP Contractors can choose the measures they want to link to payment and how they want to pay on them (P4P or P4R) in their specific contracts.

Category 1

Category 1 quality measures as identified by the CAGs and accepted by the State are to be reported by VBP Contractors. A subset of these measures is also intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.⁷

The State classified each Category 1 measure as either P4P or P4R:

- **P4P** measures are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.⁸ In other words, these are the measures on which payments in VBP contracts may be based. Measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors; and,
- **P4R** measures are intended to be used by the MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members under the VBP contract. Incentives for reporting should be based on timeliness, accuracy, and completeness of data. Measures can be reclassified from P4R to P4P through annual CAG and State review or as determined by the MCO and VBP Contractor.

Not all Category 1 measures will be reportable for Measurement Year 2018, as reporting on some of these measures will be phased in over the next 2 years. Please see the Value Based Payment Reporting Requirements Technical Specifications Manual⁹ for details as to which measures must be reported for the measurement year. This manual will be updated annually each fall, in line with the release of the final VBP measure set for the subsequent year.

Categories 2 and 3

Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability, but were flagged with concerns regarding implementation feasibility. These measures will be further investigated in the early stages of VBP implementation. The State requires that VBP Pilots select and report a minimum of one Category 2 measure per VBP arrangement for MY 2018 (or have a State and Plan approved alternative). VBP Pilot participants will be expected to share meaningful feedback on the feasibility of Category 2 measures when the CAGs reconvene during the Annual Measure Review.

⁷ New York State Department of Health, Medicaid Redesign Team, A Path toward Value Based Payment: Annual Update, June 2016; Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016, p. 34. ([Link](#))

⁸ Ibid.

⁹ 2018 Value Based Payment Reporting Requirements; Technical Specifications Manual, Nov 2017, File is located in the Quality Measures tab of the VBP Resource Library ([Link](#))



Measures designated as Category 3 were deemed unfeasible at this time for a number of reasons. These include concerns about valid use in small sample sizes of attributed members at a VBP contractor level and limited potential for performance improvement in areas where statewide performance is already near maximum expected levels. These Category 3 measures will not be tested in pilots or included in VBP arrangements in 2018.

Annual Measure Review

Measure sets and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, change in categorization, and reclassification from P4R to P4P or P4P to P4R based on experience with measure implementation in the prior year. The complete Category 1 and 2 measure set includes a subset of the IPC Measure Set determined relevant to the HIV/AIDS VBP Arrangement by the State.¹⁰ During 2018 the CAGs and the VBP Workgroup will reevaluate measures and provide recommendations for MY 2019. A full list of the MY 2018 HIV/AIDS VBP measures is included in the NYS VBP Resource Library on the DOH website.¹¹

¹⁰ The IPC measure set is the same set that will be used for the TCGP arrangement in 2018. Therefore, this is referred to as the TCGP/IPC measure set in other VBP-related documents.

¹¹ See the NYS Delivery System Reform Incentive Payment (DSRIP) - VBP Resource Library ([Link](#))