Department of Health

HIV/AIDS Subpopulation

Value-based Payment Recommendation Report

HIV/AIDS Clinical Advisory Group

May 2016

Introduction

Delivery System Reform Incentive Payment (DSRIP) Program and Value-based Payment (VBP) Overview

The New York State (NYS or the State) DSRIP program aims to fundamentally restructure New York State's healthcare delivery system, reducing avoidable hospital use by 25 percent, and improving the financial sustainability of New York State's safety net.

To further stimulate and sustain this delivery reform, at least 80 to 90 percent of all payments made from managed care organizations (MCOs) to providers will be captured within VBP arrangements by 2020. The goal of converting to VBP arrangements is to develop a sustainable system that incentivizes value over volume. The Centers for Medicare & Medicaid Services (CMS) has approved the State's multiyear VBP road map, which details the menu of options and different levels of VBP that the MCOs and providers can select.

HIV/AIDS Clinical Advisory Group (CAG)

CAG Overview

For many VBP arrangements, a subpopulation or defined set of conditions may be contracted on an episodic/bundle basis. Clinical Advisory Groups (CAGs) have been formed to review and facilitate the development of each subpopulation or bundle. Each CAG comprises leading experts and key stakeholders from throughout New York State, often including representatives from providers, universities, State agencies, medical societies, and clinical experts from health plans.

The HIV/AIDS CAG held a series of meetings throughout the State on the HIV/AIDS subpopulation. Specifically, the CAG discussed key components of the HIV/AIDS VBP arrangement, including subpopulation definition, risk adjustment, and the HIV/AIDS quality measures. For a full list of meeting dates, and an overview of discussions, please see Appendix A of the Quality Measure Summary.

Recommendation Report Overview and Components

The following report contains two key components:

1. **HIV/AIDS Playbook**

   The playbook provides a definition of the HIV/AIDS subpopulation and presents a selection of descriptive data views that were presented to the CAG.

2. **HIV/AIDS Quality Measure Summary**

   The quality measure summary provides a description of the criteria used to determine relevancy, categorization, and prioritization of quality measures and provides a listing of the recommended quality measures.

Contents

Introduction **2**
DSRIP and VBP Overview 2
HIV/AIDS Clinical Advisory Group (CAG) **2**
CAG Overview 2
Recommendation Report Overview and Components **2**
Playbook Overview – HIV/AIDS **5**
Definition of Subpopulation – HIV/AIDS **6**
Attachment A: Glossary **7**
Attachment B: Available Data Impression– Tentative Data, Validation Ongoing **8**
HIV/AIDS Clinical Advisory Group (CAG) Quality Measure Recommendations **11**
Introduction **11**
HIV/AIDS Subpopulation **11**
Selecting Quality Measures: Criteria Used to Consider Relevance **11**
Clinical relevance 11
Reliability and validity 12
Feasibility 12
Meaningful and actionable measures for provider improvement in general 12
Categorizing and Prioritizing Quality Measures **12**
Overview of CAG Quality Measure Discussion **13**
HIV/AIDS CAG Recommended Quality Measures – Category 1 and 2 ..... **14**
CAG Categorization and Discussion of Measures **15**
CAG Categorization and Discussion of Measures - Category 3 ..... **18**
Appendix A: Meeting Schedule **25**

HIV/AIDS Playbook

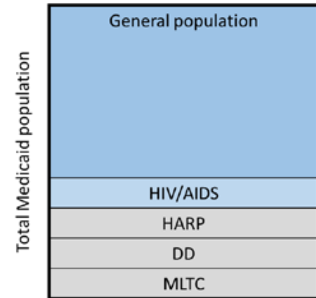
Definition of the HIV/AIDS Subpopulation

May 2016

Playbook Overview – HIV/AIDS

New York State's VBP Roadmap[1] describes how the State will transition 80 to 90 percent of all payments from MCOs to providers from fee for service (FFS) to value-based payments.

For this purpose, the total Medicaid population is split into five subpopulations:



- Members diagnosed with HIV/AIDS
- Members in health and recovery plans (HARP)
- Members with intellectual/developmental disabilities (I/DD)
- Members in managed long-term care plans (MLTC)
- All other members, the general population

This document will focus on the subpopulation of Medicaid members diagnosed with HIV/AIDS.

The table below gives an overview of the sections contained in this recommendation report.

Section	Short Description
Description of Subpopulation	Description of the HIV/AIDS subpopulation
Attachment A: Glossary	Listing of all important definitions
Attachment B: Impression of the Data Available	Data overview of the HIV/AIDS subpopulation

[1] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Definition of Subpopulation – HIV/AIDS

The HIV/AIDS subpopulation is a cohort of Medicaid members who are HIV-positive or who have AIDS, regardless of age or gender. It does not include members receiving both Medicaid and Medicare (dual eligible). The HIV/AIDS subpopulation accounts only for those who have been identified and diagnosed with HIV/AIDS and does not account for individuals who may test positive for HIV or have AIDS, but are undiagnosed or not linked to care.

Currently, there are approximately 49,500 Medicaid members[2] in the HIV/AIDS subpopulation. In 2014, the total Medicaid spend was $2.1 billion (4.5% of the total $47 billion annual Medicaid spend). The average Medicaid cost per Medicaid member with HIV/AIDS in 2012–2013 was approximately $42,500. The member population and associated dollar value and percentage represent the Medicaid only population, excluding patients who also receive care through Medicare.

To date, almost all Medicaid members within the HIV/AIDS subpopulation are either enrolled in a managed care plan or an HIV/AIDS special needs plan (SNP). The SNPs provide additional support to patients in adhering to medication regimens, addressing alcohol and substance abuse problems, and addressing family dynamics related to a patient's HIV/AIDS status. The SNP also cover the Medicaid member's eligible children, regardless of whether they have HIV/AIDS. 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.

[2] Identifies Medicaid eligible only individuals and does not account for Medicaid/Medicare dual eligible. This analysis is based on claims data. It may differ from other estimates of the volume of individuals diagnosed with HIV/AIDS.

Attachment A: Glossary

- **Delivery System Reform Incentive Payments (DSRIP):** A five-year program that reinvests up to $6.42 billion in Medicaid savings in New York State's healthcare organizations to reduce hospitalizations, reduce emergency room visits, and improve outcomes. The goal of DSRIP is to move provider Medicaid payments from "FFS" to "VBP".
- **Fee for Service (FFS):** The prevailing payment model where physicians are paid for each service rendered. Proven to incentivize volume over value.
- **Medicaid Redesign Team (MRT):** MRT is a State team organized by Governor Cuomo to find savings in the long term. The MRT generated $17 billion in federal Medicaid savings, which enabled the State to obtain an 1115 Waiver to reinvest half into delivery system reform programs.
- **Potentially Avoidable Complication (PAC):** PACs can occur as hospitalizations, emergency room visits, and professional services related to these hospitalizations, but they can also occur in outpatient settings. There are two types of PACs.
    - *PAC Type 1:* PACs related to the index condition (the episode being studied that the PACS directly relate to). They can happen during the index stay, look-forward period in a procedural and acute medical condition, or any time during the episode time window for acute and chronic medical conditions. Examples of this are emergency room visits due to diabetic coma in a diabetic patient, respiratory failure in a patient admitted with pneumonia, or readmissions for the same and related reasons as the initial admission and relevant to the patient's condition. These PACs are typically taken care of by the servicing physician.
    - *PAC Type 2:* PACs related to patient safety failures. These include inpatient-based PACs, which include HACs (CMS defined hospital-acquired conditions) and PSIs (Agency for Healthcare Research and Quality (AHRQ) defined patient safety indicators). Type 2 PACs go beyond these standard definitions and also encompass other situations related to patient safety such as adverse drug events, drug interactions, many kinds of avoidable infections, etc., which could best be avoided by process improvement.
- **Special Needs Program (SNP):** An HIV SNP is a special health plan for people on Medicaid living with HIV/AIDS and their eligible children, whether or not the children have HIV or AIDS. The doctors, nurses, and other care providers who participate in HIV SNPs understand the special needs facing people living with HIV/AIDS.[3]
- **Value-based Payment (VBP):** VBP is a sophisticated payment mechanism designed to incentivize physicians to provide more value and better outcomes while reducing costs.
- **VBP Roadmap:** To ensure the long-term sustainability of the improvements made possible by the DSRIP investments in the waiver, the Terms and Conditions (T&Cs) (§ 39) require the State to submit a multiyear roadmap for comprehensive Medicaid payment reform, including how the State will amend its contracts with Managed Care Organizations (MCOs.

[3] https://www.health.ny.gov/diseases/aids/general/resources/snps/#what

Attachment B: Available Data Impression– Tentative Data, Validation Ongoing

Subpopulation: HIV/AIDS (Medicaid-Only)

General Characteristics

Source: Medicaid Data Claims January 1st, 2012 - December 31st, 2013

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized.

Annual Member Volume

46.8K

Annual HIV/AIDS Medicaid Costs

$1,670m

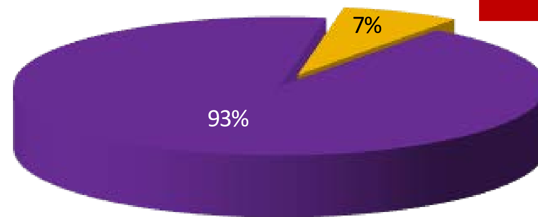
Average Annual Cost Per Member

$39,234

Annual HIV/AIDS Spending

Total Medicaid Costs: $23.1B

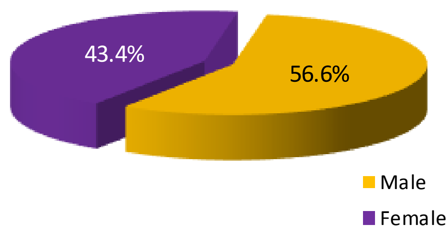
Data is tentative, validation is ongoing
Last updated November 2015



Care for HIV/AIDS Subpopulation*
All other Medicaid Care

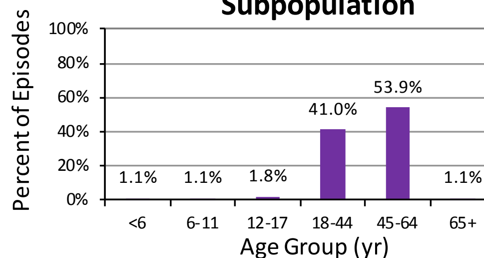
**Represents all Medicaid claims for healthcare services for patients with HIV/AIDS across all provider types.*

Gender Distribution of HIV/AIDS Subpopulation



Male
Female

Age Distribution of HIV/AIDS Subpopulation



Subpopulation: HIV/AIDS

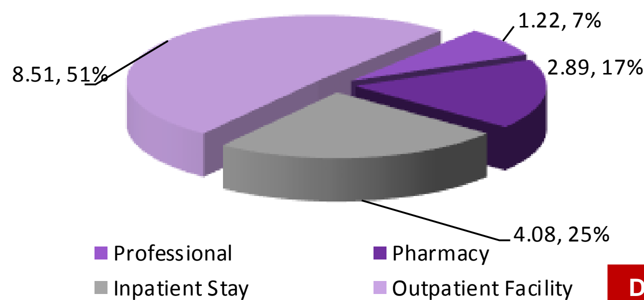
Cost Breakdown

Source: Medicaid Data Claims January 1st 2012 - December 31st 2013

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized.

Annual Dollar Allocation (in Millions)

Total Annual Amount: $3,154M



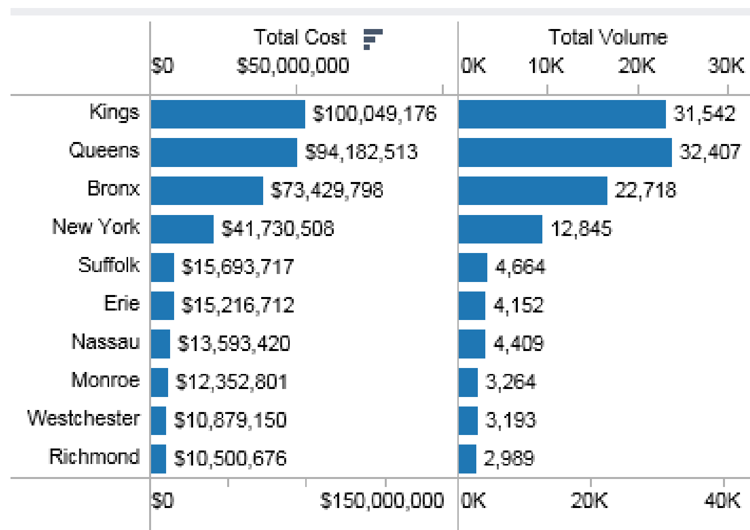
Data is tentative, validation is ongoing
Last updated November 2015

Variations in Costs per County

Source: Medicaid Data Claims January 1st 2012 - December 31st 2013

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized.

Costs and Volume 2013 per County for Top 10 Counties



HIV/AIDS Quality Measure Summary

May 2016

May 2016

NYS Medicaid Value-based Payment

HIV/AIDS Clinical Advisory Group (CAG) Quality Measure Recommendations

Introduction

Over the course of three meetings, the HIV/AIDS Clinical Advisory Group (CAG) has reviewed, discussed, and provided feedback on the analysis of the HIV/AIDS subpopulation to inform VBP contracting for Medicaid reimbursement for care attributed to the HIV/AIDS subpopulation.

A key element of these discussions was the review of current, emerging, and new measures used to assess quality of care related to the HIV/AIDS subpopulation. This document summarizes the discussion of the CAG and its categorization of quality measures.[4]

HIV/AIDS Subpopulation

Medicaid members with HIV/AIDS represent a complex subpopulation, some of whom also suffer from comorbidities such as mental health and substance use disorders (SUD). While HIV status will be the primary criteria for the subpopulation inclusion, effectively treating this subpopulation means also screening for and treating other conditions that complicate the optimal treatment of HIV infection. These conditions add to the complexity of the care delivery and underscore the importance of providing coordinated, integrated care at appropriate points across the care continuum.

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 to End the AIDS Epidemic in New York State (EtE).[5] The HIV/AIDS VBP arrangement will include quality measures related to retaining individuals with HIV in the healthcare system and facilitating maximum viral load suppression. The CAG did not accept nor validate quality measures relating to Pre-Exposure Prophylaxis (PrEP) or to outreach and testing to high-risk populations. However, they did identify potential interventions to facilitate those prongs of the EtE plan. Throughout the pilot implementation of the HIV/AIDS VBP arrangement, quality measures related to identification of individuals with HIV or AIDS who are undiagnosed and the facilitation of PrEP for high-risk persons will be investigated and assessed for inclusion in the VBP arrangement.

In addition, potentially avoidable complications (PACs) related to the HIV/AIDS subpopulation will be assessed for inclusion in the HIV/AIDS VBP arrangement.[6] When a PAC code appears on a claim, costs for those services are accumulated. PACs could also be defined by rules such as avoidable readmissions. The percentage of total episode costs that are PACs is a useful measure to understand opportunities for improvement. PAC counts, can be considered clinically relevant and feasible outcome measures. Investigating PACs will continue throughout the 2016 and 2017 pilot and implementation phases of the HIV/AIDS VBP arrangement.

Selecting Quality Measures: Criteria Used to Consider Relevance[7]

In reviewing potential quality measures for utilization as part of a VBP arrangement, a number of key criteria have been applied across all Medicaid member subpopulations and disease bundles. These criteria, and examples of their specific implications for the HIV/AIDS subpopulation, are the following:

Clinical relevance

- Focused on key outcomes of integrated care process

  I.e., Outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e., the quality of one type of professional's care).

[4] The following sources were used to establish the list of measures to evaluate existing AIDS Institute quality measures; DSRIP/QARR measures; CMS Medicaid Core set measures; other existing statewide measures; NQF-endorsed measures/and measures suggested by the CAG.
[5] https://www.health.ny.gov/diseases/aids/ending_the_epidemic/
[6] See glossary in playbook for PAC definition.
[7] After the Measurement Evaluation Criteria established by the National Quality Forum (NQF), http://www.qualityforum.org/uploadedFiles/Quality_Forum/Measuring_Performance/Consensus_Development_Process%E2%80%99s_Principle/EvalCriteria2008-08-28Final.pdf

- For process measures: Measures represent crucial evidence-based steps in the integrated care process that may not be reflected in the patient outcomes measured.
- Reflects existing variability in performance and/or possibility for improvement

Reliability and validity

- Measure is well established by reputable organization.

  By focusing on established measures (owned by, e.g., NYS AIDS Institute Quality Program, NYS Office of Patient Quality and Safety (OQPS), endorsed by the National Quality Forum (NQF), Healthcare Effectiveness Data and Information Set (HEDIS) measures) and/or measures owned by organizations such as the National Committee for Quality Assurance.

- Outcome measures are adequately risk adjusted

  Measures without adequate risk adjustment make it impossible to compare outcomes between providers.

Feasibility

- Claims-based measures are preferred over non-claims-based measures (clinical data, surveys).

  I.e., Ease of data collection is important and measure information should not add unnecessary burden for data collection.

- When clinical data or surveys are required, existing sources must be available.

  I.e., The link between the Medicaid claims data and the clinical registry is already established.

- Data sources must be patient-level data.

  I.e., Measures that require random samples from patient records or patients are not preferred, because they do not allow drilling down to patient level and/or adequate risk adjustment.

- Data sources must be available without significant delay.

  I.e., Data sources should not have a lag longer than the claims-based measures (which have a lag of six months).

Meaningful and actionable measures for provider improvement in general

- Measures should not only be related to the goals of care, but also something the provider can influence or use to change care.

Categorizing and Prioritizing Quality Measures

Based on the criteria identified in the preceding and using them to select appropriate HIV/AIDS quality measures, the CAG discussed and categorized measures into three categories.

- **Category 1** – Category 1 comprises approved quality measures that are thought to be clinically relevant, reliable, valid, and feasible.
- **Category 2** – Category 2 quality measures that are thought to be clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These quality measures will likely be investigated during the 2016 or 2017 pilot, but will likely not be implementable in the immediate future.
- **Category 3** – Category 3 measures were thought to be insufficiently relevant, valid, reliable, and/or feasible.

Overview of CAG Quality Measure Discussion

The CAG discussed key factors in addressing HIV/AIDS and effectively ending the epidemic. Such as targeted interventions and improved quality measures that align with better care. In addition, they also reviewed a number of quality measures from several different sources. Recognizing the key role of New York State's AIDS Institute in addressing the HIV/AIDS epidemic in the State, the CAG prioritized measures identified by the Institute first and evaluated them for inclusion in the VBP arrangement. The CAG then assessed other sources for inclusion of additional measures. In total, the CAG assessed potential measures from the following sources:

- AIDS Institute Quality Program
- DSRIP Measure Specification Manual
- QARR/HEDIS (National Committee for Quality Assurance)
- Centers for Medicare & Medicaid Services
- NQF – National Quality Forum
- HAB – HIV/AIDS bureau

Given the volume of potential quality measures under consideration, the CAG collectively reviewed, each specific topic area related to effectively treating individuals with HIV/AIDS and identified those measures most suitable for the HIV/AIDS VBP arrangement based on clinical relevance and feasibility. Topic areas included outcomes of care, screening and assessment, access to and utilization of care, medication management and vaccinations, and planning of treatment and education. Complete lists of measures identified in each category are found in the tables to follow. In cases where the CAG chose not to include QARR/HEDIS measures in favor of alternative measures, the rationale is indicated in the table. In some cases, the CAG identified that although some quality measures were similar, the desired outcome is more effectively captured by one measure over another. For example, developing a medical care management plan and requiring a medical visit was preferred to only mandating yearly outpatient visits.

Through discussing these themes, a number of key conclusions emerged. The CAG unanimously agreed that the most important outcome measure to be included in the HIV/AIDS VBP arrangement was viral load suppression. Simultaneously, the CAG recognized that full viral load suppression could not be expected to reach 100 percent for any attributed HIV patient population, and that this should be taken into account in the development of the VBP arrangement.

HIV/AIDS CAG Recommended Quality Measures – Category 1 and 2

This table should be read in the light of the preceding paragraph (Overview of CAG Outcome Measures): The categorization below does not reflect the priorities of the CAG but primarily the fact that the most relevant measures will require additional attention during the pilot phase.

	No.	Measure	Measure Steward/Source
Category 1	**1**	HIV Viral Load Suppression	Health Resources and Services Administration
	2	Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Health Care Incentives Improvement Institute
	3	Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis	National Committee for Quality Assurance
	4	CD4 Cell Count or Percentage Performed	National Committee for Quality Assurance
	5	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Center for Medicaid Services
	6	Substance Use Screening	Health Resources and Services Administration
	7	HIV Medical Visit Frequency	Health Resources and Services Administration
	8	Linkage to HIV Medical Care	Health Resources and Services Administration
Category 2	**9**	Sexual History Taking: Anal, Oral, and Genital	NYSDOH AIDS Institute
	10	Diabetes Screening	NYSDOH AIDS Institute
	11	Hepatitis C Screening	Health Resources and Services Administration
	12	Housing Status	Health Resources and Services Administration
	13	Prescription of HIV Antiretroviral Therapy	Health Resources and Services Administration
	14	Medical Case Management: Care Plan	Health Resources and Services Administration

CAG Categorization and Discussion of Measures

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required: Medicaid Claims Data	Data Required: Clinical Data	Quality Measure Categorization and Notes: Category	Quality Measure Categorization and Notes: Notes
Outcomes of Care	1	HIV viral load suppression***	Outcome	Health Resources and Services Administration	X			NO	YES	1	Suppression never reaches 100% of a patient population. Therefore, it is unrealistic to base the quality measure on the assumption that suppression can be achieved in all patients. It is important to distinguish between achieving complete viral load suppression for 100% of the patient population and achieving 100% viral load suppression for an individual patient, which is possible and desirable. In addition, consideration must be given to individuals who are diagnosed in the calendar year, but may not yet be exhibiting viral load suppression due to time needed for viral load suppression drugs to take effect. In part, this includes individuals initially diagnosed for whom initial steps might include linkage, initiation of ARV, and development of care plan.
Outcomes of Care	2	Proportion of patients with HIV/AIDS that have a potentially avoidable complication during a calendar year*	Outcome	Health Care Incentives Improvement Institute				YES	NO	1	Potentially avoidable complications have been identified through HCI3 methodology and stakeholder engagement sessions with a subgroup of the HIV/AIDS CAG.
Screening and Assessment	3	Sexually transmitted diseases – Screening for chlamydia, gonorrhea, and syphilis***	Process	National Committee for Quality Assurance	X	X	X	YES	YES	1	The CAG discussed the potential for this screening to identify a population at risk or high risk of HIV/AIDS infection and transmission.
Screening and Assessment	4	Sexual History Taking – Anal, Oral, and Genital**	Process	NYSDOH AIDS Institute				NO	YES	2	Protocol for taking a sexual history needs to be sufficiently comprehensive, in accordance with risk factors presented by individual members. Additional standards for extragenital testing (anal and oral) should be included as appropriate. STI testing protocol must account for and address the full spectrum of high-risk behavior, based on sexual activity and history of the patient, consistent with AIDS Institute guidelines.
Screening and Assessment	5	Diabetes Screening**	Process	NYSDOH AIDS Institute				NO	YES	2	The CAG recognized the importance of screening for diabetes while assessing the overall health of the HIV/AIDS subpopulation.

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required		Quality Measure Categorization and Notes	
								Medicaid Claims Data	Clinical Data	Category	Notes
Screening and Assessment	6	CD4 cell count or percentage performed*	Process	National Committee for Quality Assurance				NO	YES	1	This is an important measure of how healthy an individual's immune system is and how well it is fighting against HIV. CD4 cell counts are critical for assessing need for antimicrobial prophylaxis when below 500 cells/cmm, but it is less helpful for virally suppressed members when above 500 cells/cmm. Protocols for frequency of testing for those virally suppressed members whose CD4 cell counts are below 500 cells/cmm should be consistent with AIDS Institute testing guidelines.
Screening and Assessment	7	Hepatitis C Screening	Process	M3 Information LLC				NO	YES	2	This is a process measure based on data from an individual patient chart or record. Screening protocol should include HIV antibody test and where appropriate, Hepatitis C (HCV) viral load testing (consistent with AIDS Institute guidelines). Although the HCV antibody test should be administered to all patients, it may not accurately identify the presence of HCV infection due to the condition of the patient's immune system. Therefore, where appropriate, HCV viral load testing should be conducted.
Screening and Assessment	8	Multidimensional Mental Health Screening Assessment*	Process	Center for Medicaid Services				YES	YES	1	The CAG also identified mental health screening as a new process measure. For consistency across subpopulations where there is significant overlap, the HARP mental health screening quality measure is included here, as an HIV/AIDS subpopulation quality measure. This quality measure would be developed into more integrated measures that allows those with serious mental illness (SMI) to be screened for SUD and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process, executing the same approach for the HIV/AIDS subpopulation.
Screening and Assessment	9	Substance Use Screening	Process	Health Resources and Services Administratio n				YES	YES	1	Substance use screening is very important to HIV/AIDS subpopulation since it can identify the at risk/high risk for HIV/AIDS population. HARP quality measures include a similar measure. For HARP, the substance use screening quality measure steward is the American Society of Addiction Medicine.
Access to and Utilization of Care	1 0	HIV medical visit frequency ***	Process	Health Resources and Services Administratio n				YES	YES	1	Minimum standard for virally suppressed population should be one visit per year. The CAG discussed importance of needing additional visits for members who may suffer from comorbidities and other conditions.
Access to and Utilization of Care	1 1	Linkage to HIV Medical Care	Process	Health Resources and Services				YES	YES	1	This is a key component in addressing goals of EtE. Primarily linking and retaining persons diagnosed with HIV to healthcare will help maximize viral suppression so they remain healthy and prevent further transmission.

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required: Medicaid Claims Data	Data Required: Clinical Data	Quality Measure Categorization and Notes: Category	Quality Measure Categorization and Notes: Notes
				Administration							
Access to and Utilization of Care	12	Housing Status	Process	Health Resources and Services Administration				NO	YES	2	It is recognized that when individuals have stable or permanent housing, they receive better continuity and delivery of care; however, consistently measuring housing status is challenging.
Medication Management and Vaccinations	13	Prescription of HIV antiretroviral therapy***	Process	Health Resources and Services Administration				NO	YES	2	The CAG discussed the importance of adherence to medication as well as access to medication. However, ARV prescription is not readily available in Medicaid claims data and adherence to prescriptions is difficult to measure.
Planning of Treatment and Education	14	Medical Case Management: Care Plan	Process	Health Resources and Services Administration				NO	YES	2	The level of patient engagement and adherence to the plan are two key components in a patient's care plan. Plans and providers will engage in VBP contracts and will share, depending on the level of VBP, responsibility for effectively achieving quality measures to include prescription of a care plan as well as patient engagement.

CAG Categorization and Discussion of Measures - Category 3

The following quality measures were considered to be insufficiently relevant, valid, reliable, and/or feasible, and thus were not discussed at length.

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required		Quality Measure Categorization and Notes	
								Medicaid Claims Data	Clinical Data	Category	Notes
Outcomes of Care	15	HIV/AIDS: RNA Control for Patients with HIV	Outcome	Center for Medicaid Services				YES	YES	3	
Screening and Assessment	16	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Process	AMA Physician Consortium for Performance Improvement				YES	YES	3	
Screening and Assessment	17	Rectal Gonorrhea Testing Among MSM and MtF Transgender Patients**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	18	Rectal Chlamydia Testing Among MSM and MtF Transgender Patients**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	19	Pharyngeal Gonorrhea Testing Among MSM and MtF Transgender Patients**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	20	Hepatitis C (HCV) RNA Assay for Positives**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	21	Hepatitis C (HCV) Further Evaluation of RNA Positive Patients**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	22	Hepatitis C (HCV) Retest for Negatives, High Risk**	Process	NYSDOH AIDS Institute				NO	YES	3	

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required		Quality Measure Categorization and Notes	
								Medicaid Claims Data	Clinical Data	Category	Notes
Screening and Assessment	23	Gynecology Care – Pap Test**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	24	Digital Rectal Exam**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	25	Anal Pap Test**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	26	Colon Cancer Screening**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	27	Colon Cancer Screening Follow-Up**	Process	NYSDOH AIDS Institute				NO	YES	3	
Screening and Assessment	28	Cervical Cancer Screening	Process	National Committee for Quality Assurance	X	X	X	YES	YES	3	
Screening and Assessment	29	Hepatitis B Screening	Process	Health Resources and Services Administration				YES	YES	3	
Screening and Assessment	30	Lipids Screening	Process	Health Resources and Services Administration				NO	YES	3	
Screening and Assessment	31	HIV Positivity	Outcome	Health Resources and Services Administration				NO	YES	3	

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required		Quality Measure Categorization and Notes	
								Medicaid Claims Data	Clinical Data	Category	Notes
Screening and Assessment	32	HIV Drug Resistance Testing Before Initiation of Therapy	Process	Health Resources and Services Administration				YES	YES	3	
Screening and Assessment	33	System Level: HIV Test Results for PLWHA	Process	Health Resources and Services Administration				NO	YES	3	
Screening and Assessment	34	Tuberculosis (TB) Screening*	Process	National Committee for Quality Assurance				NO	YES	3	
Screening and Assessment	35	Late HIV Diagnosis	Outcome	Center for Disease Control				NO	YES	3	
Screening and Assessment	36	HIV/AIDS Comprehensive Care: Viral Load Monitoring	Process	New York State	X	X		YES	NO	3	The CAG discussed the viral load suppression as the key quality measure, recognizing that viral load suppression would require monitoring and at least one visit per year. See Measure 1 for more detail.
Screening and Assessment	37	Dental and Medical History	Process	Health Resources and Services Administration				YES	YES	3	
Screening and Assessment	38	Oral Exam	Process	Health Resources and Services Administration				NO	YES	3	
Screening and Assessment	39	Periodontal Screening or Examination	Process	Health Resources and Services Administration				YES	YES	3	

Topic	#	Quality Measure (*= NQF Endorsed) (**= eHIVQUAL) (***= Both)	Type of Measure	Measure Steward/ Source	DSRIP	QARR	HEDIS	Data Required		Quality Measure Categorization and Notes	
								Medicaid Claims Data	Clinical Data	Category	Notes
Screening and Assessment	40	Medical Assistance With Smoking and Tobacco Use Cessation	Process	National Committee for Quality Assurance	X	X	X	YES	NO	3	The CAG discussed the importance of screening for SUD an indicator of a population at risk or high risk for HIV/AIDS. Smoking tobacco was not regarded as a key quality indicator by itself.
Access to and Utilization of Care	41	New Patient Visit Frequency**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	42	Gonorrhea Treatment**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	43	Chlamydia Treatment**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	44	Syphilis – Treatment for Positives**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	45	Mental Health – Referral for Treatment Made**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	46	Mental Health – Appointment Kept**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	47	Substance Abuse Treatment for Current Users**	Process	NYSDOH AIDS Institute				NO	YES	3	

Department of Health

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								Medicaid Claims Data	Clinical Data	Category	Notes
Access to and Utilization of Care	48	Substance Abuse Treatment for Past Users**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	49	Mammography**	Process	NYSDOH AIDS Institute				YES	NO	3	
Access to and Utilization of Care	50	Diabetic Control Among Diabetic Patients**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	51	Diabetes Management – Serum Creatinine**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	52	Diabetes Management – Retinal Exam**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	53	Patient Involvement in Care Coordination Planning**	Process	NYSDOH AIDS Institute				NO	YES	3	
Access to and Utilization of Care	54	ADAP: Application Determination	Process	Health Resources and Services Administration				NO	YES	3	
Access to and Utilization of Care	55	ADAP: Eligibility Recertification	Process	Health Resources and Services Administration				NO	YES	3	

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								Medicaid Claims Data	Clinical Data	Category	Notes
Access to and Utilization of Care	56	Gap in HIV medical visits*	Process	Health Resources and Services Administration				YES	YES	3	
Access to and Utilization of Care	57	HIV/AIDS: Medical Visit	Process	National Committee for Quality Assurance				YES	YES	3	
Access to and Utilization of Care	58	HIV/AIDS Comprehensive Care	Process	New York State	X	X		YES	NO	3	The CAG considered quality measure # 13 as more appropriate in that it also measured patient engagement and involvement in the care plan. Unlike measure # 58, measure # 13 requires that a medical case management plan be developed or updated at least two times per measurement year or at the least, one medical case management encounter in the measurement year.
Access to and Utilization of Care	59	Waiting Time for Initial Access to Outpatient/Ambulatory Medical Care	Process	Health Resources and Services Administration				NO	NO	3	
Medication Management and Vaccinations	60	ADAP: Inappropriate Antiretroviral Regimen	Process	Health Resources and Services Administration				NO	YES	3	
Medication Management and Vaccinations	61	Hepatitis B Vaccination	Process	Health Resources and Services Administration				NO	YES	3	
Medication Management and Vaccinations	62	Influenza Vaccination	Process	AMA Physician Consortium for Performance Improvement				YES	YES	3	

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								Medicaid Claims Data	Clinical Data	Category	Notes
Medication Management and Vaccinations	63	PCP Prophylaxis	Process	National Committee for Quality Assurance				NO	YES	3	
Medication Management and Vaccinations	64	Pneumocystis jiroveci pneumonia (PCP) prophylaxis*	Process	National Committee for Quality Assurance				NO	YES	3	
Medication Management and Vaccinations	65	Pneumococcal Vaccination	Process	Health Resources and Services Administration				YES	YES	3	
Planning of Treatment and Education	66	ADAP: Formulary	Process	Health Resources and Services Administration				NO	YES	3	
Planning of Treatment and Education	67	HIV Risk Counseling	Process	Health Resources and Services Administration				NO	YES	3	
Planning of Treatment and Education	68	Dental Treatment Plan	Process	Health Resources and Services Administration				YES	YES	3	
Planning of Treatment and Education	69	Oral Health Education	Process	Health Resources and Services Administration				YES	YES	3	
Planning of Treatment and Education	70	Phase I Treatment Plan Completion	Process	Health Resources and Services Administration				YES	YES	3	

Appendix A: Meeting Schedule

Date		Agenda
CAG #1	9/3/2015	A. Clinical Advisory Group: Roles and Responsibilities B. Introduction to Value-based Payment C. Contracting Chronic Care: The Different Options D. Examples of VBP E. Introduction to Ending the Epidemic
CAG #2	10/1/2015	A. ACO Model Overview B. Introduction to the HIV/AIDS Business Case C. NYSDOH AIDS Institute – The New York State HIV Quality of Care Program D. Introduction to HIV/AIDS Quality Measures
CAG #3	10/13/2015	A. Interventions Discussion B. HIV/AIDS Quality Measures C. Introduction to HIV/AIDS Pilots