NEW YORK STATE OF OPPORTUNITY. Department of Health

HIV/AIDS Value Based Payment Arrangement

Fact Sheet

February 2024

NYS Medicaid Value Based Payment

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

New York State (NYS) has identified certain distinct populations within the Medicaid population for whom highly specialized, intensive care is required. The goal for these populations is to improve care coordination across traditional provider siloes, ensuring all healthcare providers work together to meet the needs of their patients. Medicaid patients with HIV infection or AIDS represent a complex population, some of whom also suffer from comorbidities such as mental health and/or substance use disorders (SUD). While HIV or AIDS status will be the primary criterion for inclusion, effectively treating this population 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 patients 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[1] based on quality and cost- effectiveness within a total cost of care budget, VBP Contractors 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 by 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 for HIV/AIDS patients.

This fact sheet provides an overview of NYS Medicaid's HIV/AIDS VBP Arrangement and is organized into 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 associated costs of that care for the patients 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 patients, including: primary care, specialty care, emergency department visits, hospital admissions, and medications (with an exclusion option for specialty, high-cost drugs).[2] The majority of Medicaid patients within the HIV/AIDS population 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

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

[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, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

that provides a network of experienced HIV service providers, HIV specialist Primary Care Practitioners (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 patient 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. Patients of the HIV/AIDS population may seek care through community health centers, Designated AIDS Centers (DACs), other hospital-based programs, or their PCP.

Eligible Patient Population

Medicaid patients 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. Patients who test positive for HIV but have not been formally diagnosed by a care provider are not eligible for inclusion as they are not able to be attributed to a specific provider or provider group.

Patient Attribution

Medicaid patient attribution defines the group of patients 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. For patient attribution to occur in any arrangement, a Medicaid-covered recipient must be enrolled for three or more consecutive months with a managed care plan. The NYS Roadmap[3] details attribution guidelines for VBP Contractors and Medicaid MCOs for each arrangement.

New York State's guidance for patient attribution in HIV/AIDS VBP Arrangements is to attribute patients based on the Medicaid MCO-assigned PCP. 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.

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 an exclusion option 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.

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

The HIV/AIDS Quality Measure Set is developed drawing on the work of the HIV/AIDS Clinical Advisory Group (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.[4] Based on this plan, 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.

[3] New York State Department of Health, Medicaid Redesign Team, Value Based Payment (VBP), VBP Roadmap. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm
[4] NYSDOH 2015 Blueprint on Ending the AIDS Epidemic

As the HIV/AIDS VBP Arrangement is a total cost of care population arrangement, a full complement of physical and behavioral health measures is included in the measure set to ensure patients with HIV/AIDS receive high quality general 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 Addictions Services and Supports (OASAS) for further feasibility review and, ultimately, to the VBP Workgroup responsible for overall VBP design and final approval.

Measure Classification

Each quality measure is designated by the State as Category 1, 2, or 3 according to the following criteria:

- **CATEGORY 1** – Approved quality measures that are deemed to be clinically relevant, reliable, valid, and feasible;
- **CATEGORY 2** – Measures that are clinically relevant, valid, and reliable but where the feasibility could be problematic; 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 (pay-for performance (P4P) or pay-for-reporting (P4R)) in their specific contracts. At least one Category 1 P4P race and ethnicity stratified measure must be included in any Medicaid HIV/AIDS VBP contract.[5]

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.

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. 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 patients 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 or vice versa through annual CAG and State review or as determined by the MCO and VBP Contractor.

Please see the Value Based Payment Reporting Requirements Technical Specifications Manual[6] for details as to which measures must be reported for the measurement year. This manual will be updated annually in line with the release of the final VBP measure set for the subsequent Measurement Year.

Categories 2 and 3

[5] The quality measure set can be found under the VBP Quality Measures section for the respective measurement year and arrangement. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

[6] VBP Reporting Requirements Technical Specifications Manual can be found under the VBP Quality Measures section for the respective measurement year. https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm

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.

Measures designated as Category 3 were deemed unfeasible. Reasons include concerns about valid use in small sample sizes of attributed patients at a VBP Contractor level or limited potential for performance improvement in areas where statewide performance is already near maximum expected levels.

Annual Measure Review

Measure sets and classifications are considered dynamic and will be reviewed annually. Updates will include additions, deletions, re-categorizations, and re-classification from P4R to P4P, or P4P to P4R, based on experience with measure implementation in the prior year.