

**SECTION 1115 DEMONSTRATION AMENDMENT PROPOSAL**  
**DSRIP CATEGORY 5 HIV TRANSITION PROJECTS**  
**Submitted April 11, 2012**

***Context***

Ryan White-eligible persons with HIV have been enrolled in coordinated systems of care in California since 1991. People with HIV living in California have received coordinated medical outpatient care (primary and specialty) through Ryan White Parts A, B, C and D, with pharmaceuticals provided largely from the California AIDS Drug Assistance Program (ADAP), funded by Ryan White Part B, State general funds and rebates. In addition, persons with HIV have received case management, and a variety of other Ryan White services, including, but not limited to, dental, substance abuse treatment or counseling, home health, and mental health services.

As part of California's Bridge to Reform Section 1115 Medicaid Demonstration (Demonstration), California counties are implementing the Low Income Health Program (LIHP), as one of the few adopters in the country of the early Medicaid expansion available under the Affordable Care Act. In the summer of 2011, HRSA provided guidance to California regarding the Ryan White statutory "payer of last resort" requirement in relationship to the LIHP. Specifically, HRSA stated that Ryan White funded services under Sections A, B, C, and D, including ADAP, can no longer be available to individuals once they become eligible for and enrolled in a LIHP. Additionally, such low-income persons with HIV who otherwise meet LIHP eligibility standards may not be excluded by the LIHP. This means that low-income persons with HIV previously covered by a Ryan White system of care, will, upon enrollment in an LIHP, be required to receive their outpatient medical care, pharmaceuticals, and mental health services from providers within their County LIHP network. All other remaining services not covered by the LIHP could continue to be provided through Ryan White, where available. Beginning January 1, 2014, these low-income persons with HIV will be served through a combination of Medi-Cal (Medicaid expansion) or California Health Benefits Exchange, and Ryan White.

HIV care is complex, and if transitions in coverage and care provision are not managed carefully, poor patient outcomes and increased health system costs can result. As a result, it is critical that Designated Public Hospital (DPH) systems, as a primary provider of care to LIHP enrollees, focus delivery system reforms so as to secure the infrastructure needed to optimally coordinate services for this vulnerable population. Incentivizing such investments will help support the ongoing transformation of ambulatory care services, including an emphasis on prevention and continuity of care, within the DPH systems.

***Proposed Section 1115 Demonstration Amendment – DSRIP Category 5 HIV Transition Projects***

The proposed Section 1115 Demonstration amendment will assure that persons with HIV make the transitions of coverage from Ryan White to California's LIHPs without loss of core medical or other critical services. The proposal would enable DPH systems with approved 5 year

Delivery System Reform Incentive Pool (DSRIP) plans under the Demonstration to establish “Category 5” HIV Transition projects to develop programs of activity that support efforts to provide continual access to high-quality, coordinated, integrated care to patients with HIV, particularly those LIHP enrollees who previously received services under the Ryan White program.

As a core element of the DSRIP Category 5 projects, participating DPH systems would develop individualized HIV Transition Plans that are specifically designed to strengthen the ability of their directly-operated health care delivery systems to serve persons with HIV, with a particular focus on outpatient medical services. This Category 5 HIV Transition Project would provide funding for incentives for delivery system reform and is not intended to provide direct payment for services. Regardless of the current participation in the Ryan White program, delivery system reforms, including the example initiatives proposed below, are needed across the diverse set of DPH system providers in California. Through careful development of individualized plans, DPHs can intentionally tailor their proposed Category 5 projects to align with the most pressing needs within their system of care for patients with HIV.

**Eligibility** – Any DPH system with an approved DSRIP 5 year plan as of July 1, 2011, and located within a County operating a LIHP may propose a Category 5 HIV Transition project.

**Relationship to DSRIP** – Participating DPH systems will amend their existing DSRIP 5 year plans to include Category 5 HIV Transition projects.

**Payments** – Coinciding with the term of the LIHP component of the Demonstration, a total of \$150 million in DSRIP Category 5 HIV Transition project payments (total computable) will be available for SFY 2012-13, and \$75 million (total computable) will be available for the July 1, 2013-December 31, 2013, six month period. The total available payments will be consistent with the Demonstration budget neutrality limit. Total payment amounts will be allocated to each participating DPH system on the basis of its approved proposal. Payment amounts will be disbursed in equal semi-annual payments.

DSRIP Category 5 project payments are intended to support and reward DPH systems for improvements in their delivery systems that meet the special needs of enrollees with HIV/AIDS. As such, the payments are not direct reimbursement for expenditures incurred by the DPH systems in implementing reforms, and are not reimbursement for health care services that are recognized under the Special Terms and Conditions or under the State Plan. The Category 5 project payments are not considered patient care revenue and should not be offset against the certified public expenditures incurred by DPH systems for health care services, DSH or administrative activities as defined under the STCs and/or under the State plan.

**Finance** – The non-federal share of the payments will be provided through intergovernmental transfers made by DPH systems electing to participate in the DSRIP Category 5 HIV Transition project component, or other local units of government.

**Stakeholder Input** – DHCS will convene an HIV Stakeholder Advisory Group who will have the opportunity to provide feedback on each proposed plan.

### ***DSRIP Category 5 Description***

Following is a description of the proposed HIV Transition project component structure within the DSRIP plans, and example projects that DPH systems may select. Category 5 Plans would highlight the infrastructure, programs, and services that must be put in place to ensure that persons with HIV can be cared for in an integrated and coordinated system of care. By ensuring that all providers serving patients with HIV have the necessary set of capabilities, the HIV Transition Project will provide essential support in the continued development of a robust, broad, and high-quality delivery system for patients with HIV, despite the effects of coverage shifts. In doing so, the HIV Transition Project is critical to sustaining a high level of service delivery for patients with HIV as they transition from Ryan White to the LIHP and ultimately to Medi-Cal in 2014.

Each participating DPH system would submit a Category 5 plan oriented to meet the goals of quality care, care continuity, care coordination and seamless coverage transition. Category 5 plans would include appropriate projects with milestones for each applicable Demonstration year (or portion thereof), i.e., Demonstration Year 8 and the first 6 months of Demonstration Year 9. Milestones could help to build physical and IT infrastructure, promote innovation in the way care is delivered and improve the quality of care delivered across broad populations. Based on the progress made toward achieving the milestones, DPH systems would receive DSRIP payments associated with that particular metric. Because each DPH system has distinct local needs and resources, plans would vary and identified milestones would likely differ.

Each plan would include projects and milestones for the following categories:

1. **Category 5a – Improvements in infrastructure and program design:** Each plan would include projects and milestones that are able to improve how care is delivered to HIV patients.
2. **Category 5b – Improvements in clinical and operational outcomes:** Each plan would also include projects and milestones that measure HIV patients' health and health care.

Additionally, each plan would include milestones related to **shared learning**, such as participating in learning collaboratives/initiatives, training and education, and identifying and communicating best practices so that effective interventions and models can be more rapidly and broadly disseminated.

Below are examples of projects and associated milestones that may be selected within each category. These sample projects and milestones are not meant to be adopted by every DPH system, but rather the example milestones serve to demonstrate a comprehensive array of potential improvement activities and metrics through which progress can be measured. Therefore, in designing their HIV Transition Plans, DPH systems may select from the milestones

included here or may propose other milestones that accomplish the Category 5 HIV Transition aims and are better suited to meet their particular needs. However, it is important to note that the overall undergirding of the projects (i.e., the models and constructs) would be similar across the DPH systems in that each HIV Transition plan must include activities under both categories as well as shared learning. Importantly, DPH systems may not propose projects that are to be performed as a part of Categories 1-4 of their existing DSRIP plan.

DPH systems would specify the Category 5 metrics to be used to measure progress in each reporting period in table format. While milestones may apply to more than one period, the Category 5 plans must uniquely specify the particular progressive improvement (and metric) for that period. Incentive funding would be allocated to each project and its associated milestone. Together, these plans, and the important transition work they describe, would better promote a seamless and continuous transition of coverage and care coordination for patients with HIV.

### ***Category 5a: Infrastructure & Program Design***

The infrastructure and programmatic efforts that are undertaken in this category are foundational. These activities would be designed to enhance the ability of DPH systems to provide care within patient-centered medical homes, an essential building block to ensuring delivery of high-quality medical care for patients with HIV. Some examples of projects under this category include:

1. Empanel patients into medical homes with HIV expertise
2. Roll-out a Disease Management Registry module suitable for managing patients with HIV
3. Build clinical decision support tools to allow for more effective management of patients with HIV
4. Develop Retention Programs for patients with HIV who inconsistently access care
5. Enhance data sharing between DPHs and County Departments of Public Health to allow for systematic monitoring of quality of care, disease progression, and patient and population level health outcomes

Further detail and milestones of these example projects is provided below.

Empanel patients into medical homes with HIV expertise: While all LIHPs must assign enrollees to medical homes, empanelment into medical homes specifically equipped to care for patients with HIV is a critical component of care provision for this population. Medical homes specifically suited to care for patients with HIV may differ from non-HIV medical homes in a number of ways, e.g.:

- Nurses in HIV-focused medical homes often take on additional roles, such as screening for medication adherence challenges
- Panel Management has a greater level of complexity and depth than is often the case for traditional medical homes. Panel managers must track and follow-up traditional HIV

disease indicators (e.g., CD4 counts, Viral Load, Lipids, LFTs, other STIs, vaccine status, etc.) as well as serve an expanded health coach role to include HIV transmission risk reduction strategies; such intensive services often requires a more intensive staffing models than in medical homes that do not focus on patients with HIV

- Retention programs, such as that described in the milestone below, may be a supplemental service offered within HIV-focused medical homes
- In cooperating with other stakeholders and funders, HIV-focused medical homes coordinate or directly provide a high-level of wrap-around services (e.g., nutrition support, pharmacy support, behavioral health/psychiatric support, substance abuse services, social work services, care navigation, wellness services) essential to patients with HIV

To adequately prepare for implementation of medical homes that are able to care for HIV patients, clinics will need to determine the optimal staffing model for provision of multi-disciplinary team-based care to optimize access, retention, and treatment adherence and improve health outcomes and self-management. Unique panel weighting / patient risk-adjustment methodologies could be developed for building panels of patients with HIV; such methodologies will necessarily differ from panel weighting methodology for non-HIV patients in traditional primary care medical homes. For example, patients may be weighted according to consideration of factors such as: 1) prior utilization patterns of HIV care services; 2) prior history of difficulty in adhering to treatment plans; 3) time since HIV diagnosis; and 4) persistently poor health status. Examples of specific milestones related to this project include:

- Select/develop optimal staffing model(s) for use in medical homes that care for patients with HIV
- Define the roles and responsibilities of team members
- Implement a staffing model appropriate for LIHP patients empaneled in a medical home with HIV expertise, including pharmacy and medication adherence services for patients with advanced disease and co-morbidities
- Develop patient weighting/ risk-adjustment algorithms for assigning patients with HIV to medical homes
- Empanel patients into medical homes

Roll-out a Disease Management Registry module suitable for managing patients with HIV:

Disease Management Registries (DMR) are able to track clinical quality and health outcomes for patients empaneled in medical homes. Many DMRs have optional HIV modules. These specialized clinical modules will allow HIV providers to effectively monitor and deliver key aspects of HIV care that are known to be associated with improved health outcomes among HIV-positive populations. HIV modules can be configured with the ability to track clinical performance measures that allow the HIV provider team to identify and focus intensive clinical services and interventions on those patients who are not meeting treatment goals. Examples of specific milestones related to this project include:

- Identify/develop HIV DMR module
- Pilot use of HIV DMR module in clinics
- Roll-out HIV DMR module in all clinics that serve as a medical home for HIV-positive patients
- Document ongoing evaluation of clinical performance measures and use of data for performance improvement activities

Build clinical decision support tools to allow for more effective management of patients with HIV: Clinical decision support tools allow clinicians to better manage HIV patient panels through the use of disease-specific rules and queries that allow providers to identify patients in the medical home who are not meeting a prioritized set of HIV care goals consistent with national treatment guidelines and standards of care. Rules will allow providers and the care team to identify patients who, for example, (1) are out of care or inconsistently/sub-optimally accessing care, (2) qualify for antiretroviral therapy (ART) but are not receiving it, (3) are on ART but not achieving viral suppression and full benefit of therapy, and (4) are in need of screening or treatment for other co-morbidities or preventive health services. After relevant patient populations are identified, specific tools will help guide the patient toward proper diagnostic or therapeutic decisions. Tools may be built into the DMR to facilitate appointment planning, reminders, and outreach services or care coordination. The use of these tools will result in achieving more timely, patient-responsive, and efficient delivery of care to empaneled HIV patients. Examples of specific milestones related to this project include:

- Define full set of clinical decision support tools that will be available
- Deploy Information Technology (IT) programming and resources to develop clinical decision support tools
- Pilot, refine, and fully implement clinical decision support tools within medical homes that care for patients with HIV
- Establish and implement protocols and procedures for tracking use of clinical decision support tools and evaluating impact on disease management, service provision, and clinical health outcomes

Develop Retention Programs for patients with HIV who inconsistently access care: Patients with HIV must regularly access and engage with their medical homes in order to enjoy optimal health outcomes. Failure to engage in consistent HIV care is a significant challenge for many DPH systems and is associated with suboptimal adherence to ART, virologic treatment failure, increased rate of community viral resistance, increased secondary HIV transmission, and poorer survival rates. To address the need to successfully re-engage patients lost to HIV care and improve subsequent retention in consistent HIV care, DPH systems may implement clinic-based Retention Programs. Patients identified as being out of regular medical care including those who are recently diagnosed will be referred to the Program which will utilize investigative techniques to locate lost-to-care patients and offer them client-centered interventions to improve their linkage and retention in HIV medical care. Examples of specific milestones related to this project include:

- Define criteria for enrolling patients in Retention Program
- Identify staffing models for implementation of Retention Program
- Implement Retention Program in medical homes for patients with HIV
- Track effectiveness of Retention Program along pre-defined outcome metrics

Enhance data sharing between DPH system providers and the County Departments of Public Health: Improved health information exchange will allow for more systematic monitoring of quality of care, disease progression, and patient and population level health outcomes among HIV cohorts. This includes developing an electronic data interface (EDI) between the Designated Public Hospital systems and Department of Public Health data systems in order to facilitate collection of standardized performance measures and key utilization and health outcome data (e.g., HIV viral load, CD4 cell counts) across the population of individuals living with HIV in each County. As HIV patients transition from Ryan White to the LIHP and ultimately to Medicaid in 2014 under the ACA, robust data sharing and exchange are critical to ensuring that access and high-quality care remains uninterrupted and that all patients, regardless of payer, are cared for according to the same high standards and goals of care. Improved data sharing will also enhance public health efforts to track and improve population health, reduce morbidity and mortality, and reduce forward transmission in order to stem the local HIV epidemic. When possible, programs will use existing HIV databases to obtain clinical information to help develop clinically appropriate primary care plans for HIV patients. Examples of specific milestones related to this project include:

- Identify and map domains for data exchange
- Develop and implement Electronic Data Interface
- Establish and implement protocols and procedures for ongoing monitoring and use of data to improve quality of care and population health

***Category 5b: Clinical and Operational Outcomes***

Activities under this category would be designed to drive DPH systems to select and commit to achieving discrete patient outcomes across several clinical domains. In doing so, DPH systems can help assure they are making concrete gains in patient quality and operational effectiveness that will have lasting benefits for patients who choose to make DPH systems their permanent medical home. Proposed milestones will be considered across six project types:

1. Access to Care
2. Health Screening – Identify Treatment/Service needs
3. Preventive Health Measures
4. HIV-Specific Clinical Outcomes
5. Care Management
6. Client Satisfaction

DPH systems would be responsible for selecting milestones from each of the six types. For each proposed milestone DPH systems would measure and report their baseline performance within

the first six months of the transition plan and would then set a target for achievement by the end of the transition program. Example milestones are provided below, though DPH systems may also propose their own milestones that fit within each of the project types.

#### Access to Care

- Percent of clients who have not seen an HIV provider in the prior 6 months who will receive outreach to re-engage in care
- Percent of clients who have had at least 2 HIV primary medical care visits in the prior 12 months, at least 3 months apart
- Percent of clients diagnosed with HIV in the prior 12 months who are empaneled into a medical home with HIV expertise within 3 months of diagnosis

#### Health Screening – Identify Treatment/Service needs

- Percent of clients screened for an active psychiatric illness in the prior 12 months
- Percent of clients screened for active substance abuse and dependency problems using outpatient substance use indicators in the prior 12 months
- Percent of clients who are pre-screened for barriers to treatment adherence in the prior 12 months
- Percent of clients who are at risk for syphilis based on clinical indication have had a serologic test performed at least once in the prior 12 months
- Percent of female clients who were tested for cervical cancer at least once in the prior 12 months
- Percent of clients who have been tested for Hepatitis C at least once, and every 12 months if determined to be at ongoing risk by the patient's primary care provider
- Percent of clients who have been screened for Hepatitis B at least once
- Percent of clients who had lipid testing performed at least once in the prior 12 months when on ART
- Percent of clients who were tested for tuberculosis based on clinical indication at least once in the prior 12 months
- Percent of clients who were tested for chlamydia based on clinical indication at least once in the prior 12 months
- Percent of clients who were tested for gonorrhea based on clinical indication at least once in the prior 12 months
- Percent of clients using tobacco who have received tobacco cessation counseling at least once in the prior 12 months

#### Preventive Health Measures

- Percent of clients with CD4 T-cell count < 200 cells/mm<sup>3</sup> who were prescribed PCP prophylaxis
- Percent of patients with CD4+count below 50 cells/mm<sup>3</sup> who were prescribed MAC prophylaxis



- Percent of clients who are not immune to or chronically infected with Hepatitis B who have received the Hepatitis B vaccination series
- Percent of clients who have received the Hepatitis A vaccination series
- Percent of clients who have received the pneumococcal vaccination series within the last five years
- Percent of clients who have received the influenza vaccination in the prior 12 months
- Percent of clients who are sexually active and received risk reduction assessment and if appropriate risk reduction counseling at least once in the prior 12 months

#### HIV-Specific Measures

- Percent of clients who had two or more viral load tests performed at least three months apart in the prior 12 months
- Percent clients with unsuppressed viral load who are on ART that receive at least one treatment adherence intervention in the prior 12 months
- Percent of pregnant clients who are on ART
- Percent of HIV-infected patients who had two or more CD4 T-cell counts performed at least three months apart in the prior 12 months
- Percent of HIV-infected patients with CD4 T-cell counts  $<500$  cells/mm<sup>3</sup> or an AIDS-defining condition who were prescribed an ART regimen in the prior 12 months
- Percent of clients taking HIV medications who have a suppressed viral load 6 months after enrollment (or if not on treatment at the time of enrollment, 6 months after initiation of treatment)

#### Care Management (CM)

- Percent of clients identified as in need of CM services who engage in and receive these services to assist with treatment adherence
- Percent of clients actively enrolled in CM who had a medical visit at least every 4 months in the prior 12 months
- Percent of clients receiving CM who had an assessment documented and updated once every 6 months in the prior 12 months

#### Client Satisfaction

- Percent of clients who receive an externally validated patient satisfaction survey (e.g., CG-CAHPS) in their medical home once every 12 months
- Percent of clients who report satisfaction (e.g., top 2 box score on CG-CAHPS) with overall care provided
- Percent of clients who report satisfaction (e.g., top 2 box score on CG-CAHPS) with specific patient satisfaction themes (e.g., established Section 1115 DSRIP CG-CAHPS themes: "Getting Timely Appointments, Care, and Information", "How Well Doctors Communicate With Patients", "Helpful, Courteous, and Respectful Office Staff", "Patients' Rating of the Doctor", "Shared Decision-making")

### ***Other Required Category 5 Plan Elements***

Each Transition Plan should also include milestones that promote shared learning. These may include the following actions:

- Participate in a collaborative
- Share learnings from implementing process improvements, e.g., through presentations and reporting
- Share data, promising practices, and/or findings with peer groups and/or a quality improvement entity to foster shared learning and/or to conduct benchmarking activities
- Collaborate in the dissemination/implementation of best practices with public HIV/AIDS agencies and health departments, LIHPs, or other public agencies

Other key elements of Category 5 project proposals will be developed and defined to provide the broader context and rationale for each plan, including the overall goal and the significance of that goal to HIV patients and the DPH, the reasons for selecting the milestones, metrics, improvements and targeted goals based on relevancy to the HIV population and circumstances, community need and priority, and DPH starting point. Such key elements will be developed and tailored to the individual DPH system in consultation with DHCS, and with input from stakeholders and frontline workers from the HIV/AIDS community. Examples of key elements which may be included are:

- Specific challenge(s) the Plan is seeking to address
- Solution(s) identified to address the challenge(s), including an explanation of how each proposed project would work to fill the gap/need or solve the issue
- Detailed description of proposed project and corresponding milestones by year
- Evidence-based (or other externally accepted) justification for the specific milestone or target selected (e.g., outcomes milestones set in accordance with published standards of HIV care); where relevant, milestones should be aligned with the Federal Implementation Plan of the National HIV/AIDS Strategy
- Starting point for each County related to each proposed project, such as a benchmark or baseline, if one is available
- Expected results of the plan and how those align with the Plan's goals
- Interrelationship of proposed project and milestones across the duration of the Transition Plan

### ***Review and Approval***

DPH systems would submit their DSRIP Category 5 Plans to DHCS for review. Each plan would address the two aforementioned categories and other required elements, and provide the rationale for focusing on the particular projects, milestones and metrics most relevant to its

population and circumstances. DHCS will review each proposal to verify that it conforms to the requirements for the categories.

The Department will approve each proposal and submit it to CMS for final review and approval. CMS will then review each Transition Plan as approved by DHCS. CMS' review will assess whether each plan includes projects that clearly identify goals, milestones and expected results, and their relationship to each other.