

CALIFORNIA SECTION 1115 DEMONSTRATION AMENDMENT PROPOSAL
DSRIP CATEGORY 5 HIV TRANSITION PROJECTS
Version June 18, 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 has stated that Ryan White Act Sections A, B, C, and D, including ADAP, must be considered payer of last resort, so these programs cannot pay for any services covered by the LIHP for a person who is eligible for and enrolled in the local 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, and align Category 5 projects to the priorities in local Ryan White plans.

The proposal is undergoing further refinement of the metrics for the DSRIP Category 5 projects. The approved final version of the proposal will serve as the basis for supplements to Attachment P, “Reserved DSRIP Metrics”, and Attachment Q, “Delivery System Reform Incentive Payments (DSRIP) Metrics”, of the STCs.

Eligibility – Any DPH system with an approved DSRIP 5 year plan as of July 1, 2011, which is located within a County operating a LIHP, and is a participating provider thereof, 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.

Reporting – DPHs will report progress on their HIV Incentive Plan according to Attachment P of the Standard Terms and Conditions that governs reporting for Categories 1-4 of the DSRIP.

Payments – Coinciding with the term of the LIHP component of the Demonstration, a total of \$110 million in DSRIP Category 5 HIV Transition project payments (total computable) will be available for SFY 2012-13, and \$55 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. DPH systems must ensure the projects proposed are consistent with nationally recognized/accredited standards of HIV 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 should help to better coordinate and integrate health care services and improve the quality of care delivered for persons with HIV through, for example, building physical and IT infrastructure, promoting innovation in the way care is delivered, and building the skills and capabilities of staff serving patients with HIV. 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 with an emphasis on ensuring efficient coordination of services among providers.
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 the projects and associated milestones that may be selected within each category. These projects and milestones are not meant to be adopted by every DPH system, but rather 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. Listed below are seven projects of which each participating DPH must select three, allowing each DPHs' proposed plan to be tailored to their system's needs. For each selected project, each DPH must complete all associated milestones listed below unless the DPH indicates in their plan proposal that a particular milestone is not relevant/applicable, provides suitable rationale, and proposes an alternative milestone as a substitute. DPHs are responsible for determining the timeline along which they will achieve each Category 5a milestone; however each DPH must have milestones

that are achieved in the first six months of the Incentive Program and milestones that are achieved in the final twelve months of the Incentive Program.

Category 5a Projects:

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
6. Launch electronic consultation system between HIV primary care medical homes and specialty care providers
7. Ensure access to Ryan White wrap-around services for new LIHP enrollees

Further detail and milestones of these 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. Specific milestones related to this project are listed below.

- 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. Specific milestones related to this project are listed below.

- 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 clinician 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. Specific milestones related to this project are listed below.

- 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. Specific milestones related to this project are listed below.

- 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. Specific milestones related to this project are listed below.

- 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

Launch electronic consultation system between HIV primary care medical homes and specialty care providers: Implementation of an electronic consultation (eConsult) system will permit secure web-based dialog between referring HIV primary care providers and selected specialists on a specific patient requiring specialty services. eConsult has been demonstrated in other county health systems to reduce unnecessary face-to-face specialty visits, improve the effectiveness of visits when they are necessary, enhance primary care provider satisfaction with patient care, and meet standards for timely access to specialty care. Electronic consultation improves coordination of care between specialists and primary care providers, which reduces redundant, inappropriate, and over use of specialty services, and enhances the timeliness and effectiveness of specialty care delivery. This system also fundamentally transforms the relationship between specialists and primary care providers such that they see themselves as part of the same, as opposed to different, patient care teams. This transformation in relationship and documentation of communication is expected to reduce medical-legal liability and improve provider morale. Moreover, electronic consultation will greatly enhance the efficiency of the specialists' time and effort. Specific milestones related to this project are listed below.

- Establish Specialty – Primary Care workgroups for priority specialties to develop shared approaches, including referral protocols and guidelines for management of specific conditions, to common and important medical conditions for patients with HIV
- Develop and implement Electronic Data Interface for e-Consultations between primary care medical homes for patients with HIV and select sub-specialties
- Develop mechanism to track referral volume, demand, and appropriateness of referrals over time

Ensure access to Ryan White wrap-around services for new LIHP enrollees: HIV ancillary services will continue to be available for RW-eligible clients regardless of the payer of their medical care. Referrals for new LIHP enrollees will be coordinated through the initial eligibility screening process, and services may be promoted through existing service sites, through outreach programs, and through electronic media to expand client awareness of available programs. Care coordination services comprised of multidisciplinary teams located within the medical home have been shown to improve access and retention, while addressing other factors that may create barriers to continued, effective engagement in medical care, such as housing, mental health services, substance use treatment, treatment adherence counseling,

transportation, and oral health services. Specific milestones related to this project are listed below.

- Establish a mechanism such as an MOU between the DPH and LIHP with the local Ryan White system of care to ensure that transitioned HIV patients are assessed for wrap-around services
- Ensure care coordination within each medical clinic designated as a medical home for patients with HIV. Care coordination staff will work with the primary care team to assess patient need, develop care plans to promote engagement and retention in medical care, and address cofactors that may create barriers to such care

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.

All DPH systems will be required to report data on six HRSA HAB HIV Core Clinical Performance Measures; DPHs will also select four additional Core Clinical Performance Measures on which they will report data. Lists of required measures and the menu of optional measures are listed below.

Required Performance Measures – DPHs to report on each of the following:

- CD4 T-Cell Count (July 2008)
- HAART (July 2008)
- Medical Visits (July 2008)
- PCP Prophylaxis (July 2008)
- Viral Load Monitoring (November 2011)
- Viral Load Suppression (November 2011)

Additional Performance Measures – DPHs to report on two additional metrics from Group A and two additional metrics from Group B:

Group A	Group B
Version August 2008 unless otherwise noted	Version April 2009 unless otherwise noted
<ul style="list-style-type: none"> • Adherence Assessment and Counseling • Cervical Cancer Screening • Hepatitis B Vaccination • Hepatitis C Screening • HIV Risk Counseling • Lipid Screening • Oral Exam 	<ul style="list-style-type: none"> • Hepatitis B Screening (November 2011) • Chlamydia Screening • Gonorrhea Screening • Hepatitis/HIV Alcohol Counseling • Influenza Vaccination • MAC Prophylaxis • Mental Health Screening

<ul style="list-style-type: none"> • Syphilis Screening • TB Screening • Medical Case Management: Care Plan (November 2009) • Medical Case Management: Medical Visits (November 2009) 	<ul style="list-style-type: none"> • Pneumococcal Vaccination • Substance Use Screening • Tobacco Cessation Counseling • Toxoplasma Screening
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For each metric, DPH systems will measure and report their baseline performance within the first six months of the transition plan. After the baseline data is collected, each DPH system will be responsible for achieving a performance improvement target by the end of the transition program in order to receive the incentive funding associated with each measure, with “x” being determined by the DPH after taking into account input from DHCS and CMS. Wherever possible, DPHs’ will tie their performance improvement target to National Goals, Targets, or Benchmarks for Comparison, as defined in each HAB HIV Performance Measure.

Funding Allocation

Within each Demonstration Year, each DPH’s allotment of funding will be allocated equally between Category 5a and Category 5b, with each project carrying equal weight, regardless of the number of associated milestones. Funding will be allocated to each milestone within a project equally.

Other Required Category 5 Plan Elements

Each Transition Plan must also develop and 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 in which the DPH system participates, 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 must 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 possible, milestones must be aligned with nationally recognized/accredited standards of HIV care and, where relevant, must 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
- Description of how achievement of the proposed milestone will improve coordination and integration of services for patients with HIV, and align with the continuum of Ryan White supported programs in the locality.
- 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.