

Alternate Payment Models for Ryan White HIV/AIDS Program Funded Services: Strategies Used by Nine Grantees

Prepared for the District of Columbia HIV/AIDS, Hepatitis, STD and TB Administration

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Introduction

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) offers Ryan White HIV/AIDS Program (RWHAP) Part A and Part B grantees some flexibility in determining the method used for paying subgrantees for core medical and support services. Many Part A and Part B grantees use a traditional “cost-based reimbursement” approach, in which subgrantees submit budgets that include personnel costs, other direct costs related to the provision of funded services, and capped indirect costs (IDCs). Some grantees, however, have developed alternative reimbursement models for core medical and/or support services.

This report summarizes the reimbursement approaches taken by nine RWHAP grantees. While not an exhaustive list, the seven Part A and two Part B grantees demonstrate a range of payment methods that might provide ideas for other grantees.

This report utilizes the following terms to describe various reimbursement concepts:

- *Cost-based reimbursement and full-time equivalent (FTE) coverage:* Generally defined as paying allowable costs incurred, up to a set limit. Most grantee staff interviewed use “cost-based reimbursement” to refer to the “traditional” reimbursement model of paying for line item personnel costs, including FTEs, as well as other direct costs.
- *Fee-for-service (FFS):* A FFS approach involves paying a specific, agreed-upon amount for each unit of service provided. As discussed in greater detail below, the fees may be set by the grantee, negotiated based on accounting data provided by subgrantees, or benchmarked using other fee schedules such as Medicaid or Medicare.
- *Unit cost reimbursement:* Unit cost reimbursement can be considered a type of FFS, in that payment is made for each “unit” of service provided. The units are clearly defined (e.g., an x-ray conducted during a dental visit, a 15-minute unit of a face-to-face medical case manager visit, a bag of food, or a mile driven for medical transportation); and the “unit cost” is the aggregate cost of inputs associated with providing a given unit of service. The cost may be calculated by dividing all subgrantee costs by the number of units provided. A grantee could choose to calculate a standard unit cost based on the average costs of inputs across subgrantees; build on benchmark unit cost payment systems used by Medicaid or Medicare; or apply a blended approach.
- *Performance-based payment:* Also sometimes known as “pay for performance” (P4P), performance-based systems are based on a requirement that subgrantees meet certain standards set prior to the contract period. While several grantees reported using “performance-based” payments to describe a broad range of payment models, it appears that of the interviewees, only LA County has already implemented a system with payments that are linked to subgrantee performance.

In general, there are two ways a Ryan White grantee could implement performance-based payments: In one model, grantees could set aside a percentage of funds allocated to that service category (a “withhold”) throughout the grant year. At the end of the grant year, grantees would then distribute the withheld funds across subgrantees that met performance benchmarks. Alternatively, grantees could adjust future payment rates based on past year performance. Either way, payment levels would be linked to meeting certain performance criteria. Enhanced payment could be based on meeting certain thresholds for performance (e.g., testing at least X% of clients for TB in a given year) or could be scaled based on how well a subgrantee performs beyond the threshold level. In theory, a Ryan White grantee could also base performance-based payments on patient outcomes, such as a certain percentage of clients having undetectable viral load.

It is important to note that GW staff found in our assessment that grantees applied different terms for the payment models that are used. Therefore, throughout this report we attempt to make clear both what a grantee defines as its payment system and how the system is actually operationalized.

Because HAB refers to the recipients of grantee funding as subgrantees, that term is used throughout this report, even where providers are technically not subgrantees but contractors.

Methodology

This analysis is based on a purposeful sample of grantees. GW staff contacted staff at HAB and at the National Association of State and Territorial AIDS Directors (NASTAD) to

request a list of Part A and Part B grantees that use, or are considering, nontraditional payment models for one or more RWHAP service categories. HAB staff recommended four Part A grantees, while NASTAD recommended four Part B grantees. Through internal conversations, GW staff added three additional Part A grantees to the list.

GW staff emailed contacts at each agency to request information about their payment models. GW staff received responses from six Part A grantees and three Part B grantees. In the course of the interviews, GW determined that one additional Part A grantee should be contacted, and chose to include two of the three Part B grantees in the report. GW conducted phone interviews with representatives of the nine grantees identified in Table 1.¹

Table 1: RWHAP Grantees Participating in the Assessment	
Part A Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs)	Part B States
Fort Lauderdale/Broward County, FL (EMA) Los Angeles County, CA (EMA) Miami-Dade County, FL (EMA) New York City, NY (EMA) Orange County, CA (TGA) San Diego, CA (EMA) St. Louis, MO (TGA)	New York Washington

Telephone interviews were guided by a semi-structured interview tool. Interviews ranged from 30-60 minutes. All interviews were conducted with one or more staff implementing the RWHAP in that jurisdiction. In some cases, grantee contractor staff also participated in the interviews. Some grantees provided supplemental documentation, with a subset of materials included in the report appendices as noted, and others are available from GW.

Staff from each grantee were asked to review their respective draft profiles for accuracy.

Edits or concurrences were received from all grantees but St. Louis.

¹ GW spoke with Dawn Fukuda in Massachusetts, but did not include Massachusetts in the report at this time.

Key Findings

We summarize key findings in this section. Full profiles of each grantee's payment model can be found starting on p. 16.

RWHAP Service Categories Included in Payment Models

There is significant variation in the extent to which grantees incorporate nontraditional payment models into their RWHAP programs (see Table 2 for details). At one end of the spectrum, Miami-Dade County and Ft. Lauderdale/Broward County Part A grantees use FFS and unit cost reimbursement for almost all service categories. At the other end, the Orange County Part A grantee uses a FFS model for specialty medical care only. Los Angeles (LA) County was the only grantee interviewed that has already implemented a performance-based payment model, as discussed in greater detail below. The New York City (NYC) and Ft. Lauderdale/Broward County grantees reported that they are considering adopting elements of a performance-based model.

Fee Setting

As Table 2 summarizes, grantees use a variety of FFS approaches to reimburse subgrantees for outpatient/ambulatory medical care (OAMC) and dental services. The most common approach is to link fees to either Medicare or Medicaid rates, with or without an additional rate enhancement. For example, New York State bases its FFS payments for OAMC on the Medicaid fee schedule; Orange County negotiates specialty care reimbursement within a range of 110-130% of Medicare rates. LA County took a different approach, developing a single

per-visit rate for OAMC visits, whether conducted by a physician, nurse practitioner, or physician assistant. LA County funded a consulting firm (Mercer) to develop the rates, based on market research, subgrantee input, and Bureau of Labor Statistics (BLS) data for the region (see Appendix 2 for the Mercer rate study and the LA County profile for further detail).

LA County also was the only grantee interviewed that has specific plans to incorporate performance-based elements into reimbursement within the next two years, with rate changes and bonuses for subgrantees that meet thresholds on a specified set of performance indicators (see Appendix 1 for a description of the incentive payment system). Ft. Lauderdale/Broward County and NYC both reported that they are considering adding such elements in the future. Currently in NYC, subgrantees that “over-perform” by offering more services than planned may receive bonus payments toward the end of the grant year, if funds are available.

For unit cost reimbursement of service categories other than OAMC and dental, Ft. Lauderdale/Broward and Miami-Dade County base their rates for unit cost reimbursement on market research, including comparisons with other grantees. Appendix 3 summarizes Miami-Dade County’s payments by service category. NYC uses FFS for a majority of services and developed rates based on a range of calculations described in Appendix 4.

All grantees interviewed with FFS or unit cost reimbursement place some form of monthly and/or annual caps on payment per subgrantee per service category. Reallocations (referred to commonly as “sweeps”) among subgrantees and across service categories throughout the grant fiscal year allow for resources to follow the needs of the clients and to be targeted to the actual services used.

Table 2: Summary of Reimbursement and Fee Setting Methods Used by RWHAP Grantees

Grantee	Payment for OAMC and Dental Services	Payment for Other Services
Ft. Lauderdale/ Broward County	FFS, based on Medicaid rate when available	For all other service categories, unit cost reimbursement, with price structure based on comparison with other local EMAs
Los Angeles County	For primary medical care, single rate model for visit with physician, NP, or PA (currently \$330.12), with plans to incorporate performance-based adjustments in future years. Rate based on extensive consultation, BLS data, and third party rate study	Cost-based reimbursement
Miami-Dade County	Medical: FFS fees are based on the Medicare rate, with a 1.5 multiplier for evaluation and management only (office visits) Dental: multiplier applied to Medicaid dental rates	Unit cost reimbursement based on market research for all service categories other than outreach (which is line-item budget reimbursement of actual costs)
New York City	Some Part A funding supports the state’s FFS uninsured care program (see summary below)	FFS for most service categories; medical case management paid daily and adjusted for intensity; legal services paid hourly
Orange County	FFS for specialty medical care only; negotiated at 110-130% of Medicare rates Dental services included under master agreement. One mental health provider is also on a FFS contract	Cost-based reimbursement
San Diego County	Primary medical care: Federally Qualified Health Centers (FQHCs) reimbursed on FFS basis at FQHC Medicaid rate; University of California San Diego reimbursed at rate negotiated earlier with the County for low-income health program Medical specialty services: FFS, rates negotiated with subgrantees Dental: FFS, based on 130% of rates in an earlier Medicaid program, but planning to switch to current Denti-Cal rates	Cost-based reimbursement, but considering shift to FFS for mental health services
St. Louis	Primary care and dental reimbursed on FFS basis; rates based on Medicaid	Cost-based reimbursement
New York State	FFS for primary care, based on Medicaid fee schedule	Cost-based reimbursement
Washington State	OAMC and dental reimbursed on FFS basis, based on 125% (OAMC) and 133% (dental) of Medicaid rate.	Cost-based reimbursement for medical case management and several related service categories, but with incorporation of “performance-based” elements.

Staffing and Data Systems

Most grantees interviewed reported that FFS or unit cost reimbursement require staffing and data systems that differ significantly from those needed in a more traditional payment model.

Staffing

Several grantees reported that FFS reimbursement is administratively simpler than cost-based reimbursement. While subgrantees generally still must respond to an RFP or otherwise provide documentation of eligibility for funding, reimbursement involves fairly straightforward invoicing and payment. However, a FFS model does require fiscal staff to process claims and track spending to ensure that funding is targeted to the right service categories and reallocated on a timely basis as needed. In addition, grantees noted the importance of extensive desk and onsite monitoring to ensure that client records substantiate that the claimed services were actually provided at the levels reported.

Data Systems

Grantees using FFS or single rate systems reported that having specific claims-based data systems is instrumental to the success of their payment models. For example, Miami-Dade County uses CaseWatch Millennium [aka Service Delivery Information System (SDIS)], which meets the EMA's data management and federal reporting requirements, from Automated Case Management Systems (ACMS). This secure data system allows authorized subgrantee staff to enter and/or review client-level data on services provided, and maintains all program-related client eligibility, client demographic, health assessment, plan of care, service utilization,

adherence, and health outcome information in one centralized electronic record for each client. Access to client information is limited to appropriate staff according to the levels or components of the service category they work under. CaseWatch is also used to facilitate a certified referral process, so that documentation to support client eligibility is maintained on file at the client's medical care management site, thereby relieving the client from having to take copies of the same documents to each provider of service. CaseWatch is also used to facilitate the EMA's billing process for Part A and Minority AIDS Initiative (MAI) funding.

NYC's FFS reimbursement system for OAMC services uses eSHARE (Electronic System for HIV/AIDS Reporting and Evaluation), a data system developed specifically for the grantee. Subgrantees enter client-level data, and each billable service has an associated reimbursement rate. A "bridge" system links eSHARE to MAPS, a contract management system developed by Public Health Solutions, the City's RWHAP master contractor. If data entered by a subgrantee are inconsistent with agency payment policies (such as monthly limits on a given service per client), the system notifies the agency, and staff can contact the subgrantee to resolve the issue. MAPS can also be used to create reports for both the agency and subgrantees.

LA County uses CaseWatch, a client-level data system. One of its features is a link to eligibility verification, only permitting reimbursement of subgrantees that can show that a client is ineligible for public insurance and has no private coverage.

Ft. Lauderdale/ Broward County uses Provide Enterprise (PE) client-level data system to manage all reimbursement records, service utilization, and client demographic and eligibility data. All FFS claims are managed in PE, with paid and denied claims recorded in the system. Claims data are coded using Current Procedural Terminology (CPT) codes. PE interfaces with the Medicaid enrollment data system to disallow RWHAP payment for Medicaid enrollees. Part

A staff use PE to generate standardized expenditure, utilization, and other reports, as well as to project under- or over-expenditure per service category and to conduct quarterly sweeps.

For its FFS payment system for OAMC, New York State uses Emdeon, a third-party administrator.

Benefits and Challenges in Implementing Alternative Payment Models

Our interviews yielded several important considerations about the benefits and challenges of novel RWHAP payment mechanisms for grantees and subgrantees.

Benefits

Several interviewed grantees reported that, once in place, a FFS or unit cost reimbursement model is simpler to administer than a traditional cost-based reimbursement model based on a line-item budget. Ft. Lauderdale/ Broward County grantee staff called FFS and unit cost reimbursement a “cleaner process,” with common understanding and clear expectations among the grantee and subgrantees. Ft. Lauderdale/ Broward County staff also stated that oversight is somewhat easier, with the grantee conducting simpler, though still important, fiscal reviews and monitoring. Miami-Dade County staff also finds unit cost reimbursement to be simpler to administer, with less paperwork than cost-based reimbursement would entail, particularly given the large number of clients and high service utilization in the EMA. Grantees report that both FFS and unit cost reimbursement are easier for subgrantees, particularly medical subgrantees that already bill other payers on a similar basis.

A FFS or unit cost model can also be more flexible, allowing grantees to conduct reallocations, either among subgrantees or service categories, multiple times during the grant year to make funding follow client service utilization.

Another significant potential benefit is the incentive created for subgrantees. LA County staff noted that under a traditional cost-based reimbursement model, subgrantees had no incentive to increase their patient loads during a grant year, even when demand for HIV care would rise. A single-rate model per patient visit maintains an incentive for subgrantees to see more patients. In a related benefit, the model levels the playing field among subgrantees, which under a cost-based reimbursement system could be paid widely divergent amounts per patient visit. In NYC, subgrantees also have the potential to earn bonuses or increase their payment rates based on over-performing their target number of services. In a performance-based system such as LA County's, providers have the potential to earn more for achieving high standards on performance measures, with potential improvements to patient care and outcomes.

A FFS model, particularly for OAMC and dental services, also aligns RWHAP with the payment approach used by most third-party payers. Alignment ensures simpler administration for both grantees and subgrantees and can, in theory, allow for better integration. San Diego County is considering shifting to a FFS basis for mental health services, in part because it would improve integration by allowing subgrantees to have a care team that includes physical and mental health providers and to bill for all personnel on a FFS model. LA County also noted that because most other payers use FFS, traditional grants-based models facilitate "double dipping" or other concerning practices on the part of subgrantees.

Challenges

One of the most commonly cited challenges in a FFS or unit cost model is establishing payment rates and service unit definitions. For OAMC and dental services, as discussed above, a Medicaid or Medicare rate can be used as a benchmark. However, those rates may be unacceptable (or insufficient) to some or all subgrantees. LA County, which set a single per-visit rate independent of other payers' rates, noted that an additional barrier was the reluctance of some clinics to share "true cost" information that included Part C funding.

Outside the OAMC and dental services context, developing unit costs for other service categories can be challenging. NYC staff noted that there is no clear consensus on setting rates, and that it is difficult to match the rates to the real experience of all subgrantees. Additionally, rate setting is a time consuming and resource intensive process, resulting in rates only being updated every few years.

Relatedly, several grantees reported that paying a fixed rate for services may result in over- or under-paying subgrantees. Subgrantees may complain if rates are not updated frequently. For example, in Ft. Lauderdale/ Broward County, the rate for medical case managers has not been adjusted, even for inflation, in ten years. However, grantee staff notes that a medical case manager can still generate enough reimbursed units to exceed payroll and related budget costs. In LA County, an initial proposed single rate payment level developed based on a detailed analysis by Mercer (Appendix 3) was rejected by subgrantees as too low.

LA County noted that some subgrantees have been resistant to the idea of performance-based payment methods. County staff noted that ultimately, some subgrantees may leave the program if they are unable or unwilling to meet performance goals.

In a straight FFS context, St. Louis staff cautioned that it can be relatively difficult to implement HIV-based quality improvement (QI), compared to a grants-based system, because

subgrantees do not receive funding for QI. Staff noted that clinics that also get RWHAP Part C or Part D funds may be able to engage in broader HIV care QI due to an earmarked QI budget. Subgrantees that do not get Part C or Part D funds may not.

Other grantees sounded a note of caution about the impact of new payment models on the subgrantee-patient relationship. NYC is also considering the use of performance and quality measures in 2015. However, staff pointed out the risk of entangling quality measures with reimbursement in a way that could incentivize subgrantees to cherry-pick patients. In Washington State, where medical case management is reimbursed on a traditional cost reimbursement basis (though with required performance reporting), staff felt that a FFS model could result in agencies trying to meet quotas at the end of each month instead of focusing on being generally available and responsive to their clients.

Conclusion

Several payment models offer alternatives to traditional cost-based reimbursement in the RWHAP Program. Depending on its goals, HAHSTA may want to consider assessing the feasibility of FFS or unit cost reimbursement for one or more service categories in the EMA, possibly eventually incorporating performance-based elements. As other grantees have done, HAHSTA might initially develop a payment system for core medical services for which units of service are easily defined using existing billing code systems, and for which Medicaid or Medicare payment rates are accepted by subgrantees. Such a strategy might also promote the transition of some core medical providers to public third-party payment systems as a growing number of HIV+ DC residents become insured. GW staff would be happy to engage in further research and discussions about this issue.

Grantee Profiles

All information in these profiles is from interviews with grantee staff, unless otherwise indicated.

Fort Lauderdale/Broward County

Fort Lauderdale/Broward County has a long-standing practice of using FFS and unit cost reimbursement for all medical and support services. The system is based on the model established previously by the Miami-Dade County Part A grantee. The Palm Beach County Part A grantee adopted the same system, resulting in a consistent payment system across South Florida.

FFS is used by the grantee to pay for medical and dental services. Reimbursement per procedure is generally based on Medicaid rates, where available for covered procedures. CPT codes are used to define specific units of service. For all other service categories, reimbursement is unit cost-based. When no Medicaid rate is available, the agency develops a price structure based on a cost comparison with other local EMAs, such as Miami-Dade County.

All subgrantee contracts include an annual maximum reimbursement per month. Between 80-85% of subgrantees meet their monthly maximum payment threshold. There are 12 participating subgrantees, with each covering about eight service categories. Administratively, the reimbursement system employs three contract staff and three fiscal staff. The grantee conducts reallocations several times per year.

The grantee has considered incorporating an element of performance-based contracting into the payment system, to “reward good subgrantees.” For example, subgrantees could receive 80-90% of their reimbursement from producing units, with the remainder predicated on meeting

certain performance indicators. The grantee is currently considering the feasibility of this approach, but notes that implementation, if it occurs, would be “years down the road.”

Grantee staff reports that FFS and unit cost reimbursement are a “cleaner process” than cost-based reimbursement was, with clear expectations and simple accountability. Oversight responsibilities are slightly easier, although the grantee fiscal staff review all submitted claims and track expenditures on at least a quarterly basis to ensure they are in line with projected drawdowns. This process requires detailed claims (including service date, CPT code, name of provider) to substantiate requests for reimbursement. Staff conduct reviews of randomly selected clients to ensure that units billed were for services that were in fact performed.

Subgrantees may complain about inadequate reimbursement, and that the medical case management rates in particular have not been adjusted for inflation in ten years. However, the grantee staff noted that what a medical case manager can generate in reimbursed units will exceed the payroll and related costs of individual medical case managers.

Los Angeles County

LA County has instituted a performance-based, FFS reimbursement approach for OAMC services. Early in the AIDS epidemic, the grantee used a cost-based reimbursement system, granting funds to a handful of large non-profit AIDS Service Organizations. Over time, several subgrantees approached the grantee to report that their volume of services was increasing but their funding was not. The grantee attempted to supplement grants as needed, but the process was haphazard, giving subgrantees no incentive to increase patient volume. In the meantime, other subgrantees experienced a shrinking patient population. As a result, per-visit payment to subgrantees varied wildly, from \$50 up to \$600. The single rate model was developed in order to

even the playing field and maintain an incentive for subgrantees to serve more patients if demand exists.

The grantee conducted a series of rate studies and consulted extensively with outside parties, including a subgrantee caucus and health economists. They specifically wanted to determine the cost of providing a unit of service, with the unit defined as an appointment with a physician, nurse practitioner, or physician assistant. The grantee commissioned a rate study from Mercer, which conducted a financial review of a subset of subgrantees.

The rate that was initially developed was \$167 per visit, fully loaded to reflect the costs of clinicians, ancillary staff, staff support, administration, and indirect costs. However, subgrantees felt that the proposed amount would be insufficient. Mercer then conducted further review of BLS data, as well as other relevant information on rates in the region.

The grantee ultimately selected a range-based rate, from approximately \$285 to approximately \$375 (this falls above Medicaid rates but below FQHC rates). The range permits implementation of performance improvement activities (See Appendix 1 for a detailed description of LA County's incentive payment system). The grantee will conduct an annual representative chart review to determine subgrantee performance for 24 indicators, such as viral load, CD4, TB screening, cervical cancer screening, and syphilis screening for men who have sex with men. These indicators were selected from among the HIVQUAL measures that LA County was already collecting. Subgrantees that meet all core performance benchmarks and reached all thresholds for compliance for supplemental measures will be eligible for rate increases and bonus payments. Some particularly important or complex performance measures, such as suppressed viral load, will be associated with higher bonuses than others.

The original thinking was that each subgrantee would receive \$285 per visit (regardless of clinician type), plus bonuses. However, the grantee decided instead to pay each subgrantee the midpoint of the range, or \$330.12 per visit, for the first year, in large part due to system changes and provider readiness issues as a result of preparation for and implementation of the Affordable Care Act. Staff will review a year's worth of data and conduct chart review to determine rates for the second and third years (though staff notes that they may continue with the \$330.12 rate for an additional year).

Approximately 10,000 clients in the EMA receive OAMC services reimbursed under the FFS model. Many are undocumented or otherwise ineligible for other health insurance coverage. The grantee reimburses 25 subgrantees that operate a total of 41 patient-centered medical home model sites.

LA County uses CaseWatch, a client-level data system. It is linked to eligibility verification records, so subgrantees are only paid if they can show that a client is ineligible for Medicaid and Medicare and doesn't have private insurance. The grantee conducts oversight that includes visits by contract program officers, with a sampling of charts or electronic health records reviewed each year. Staff notes that client-level data system compliance is not always optimal.

LA County has experienced several challenges in implementing the new payment system, including difficulty in establishing a rate that subgrantees perceive to be fair and commensurate with actual costs. A particular challenge that arises in this context may be subgrantee reluctance to share true cost data. Some subgrantees were willing to share Part A-related payroll and other related information, but would not share information on how they use Part C grants to

supplement their overall operations. LA County staff has discussed this challenge with their HAB project officer, as well as ways to coordinate the Part A and Part C grants.

The grantee also reported resistance among some subgrantees to the idea of performance monitoring. Grantee staff note that a critical mass of subgrantees is needed who understand the importance of the HAB core measures, and that some subgrantees who struggle with compliance may not remain in the Part A program. The grantee also notes that positive competition can be created by giving each subgrantee its own data, as well as the average rates of other subgrantees to allow comparison.

LA County staff suggest that strong performance measures are crucial for the continued investment of significant levels of federal RWHAP funds. In addition, they note that in a healthcare context with multiple funding streams, most third-party payers reimburse for services on a FFS basis. Mixing grant-based payment with FFS payers increases the risk of “double dipping” and other inappropriate uses of public funds.

Miami-Dade

Miami-Dade County uses a unit cost/FFS payment system for nearly all local RWHAP-funded service categories. The only exception is outreach, which is funded on a cost reimbursement basis because of challenges in identifying the appropriate “unit of service” and ensuring appropriate service delivery.

For OAMC services, fees are based on the Medicare rate, with a 1.5 multiplier for evaluation and management (E and M) medical office visits, and no multiplier for other program-allowable medical services. In FY 2013, a total of 5,788 uninsured and underinsured RWHAP clients received a combined total of 71,890 medical visits that were specifically

reimbursed by the grantee under the Part A and Minority AIDS Initiative funding. Basing reimbursement on the existing Medicare payment structure facilitated the billing process for the high number of clients who received Part A/MAI- funded medical care in the EMA.

For other services, unit costs are initially developed based on market research. As detailed in Appendix 3, unit costs vary significantly among service categories, and generally are sufficient to cover the percentage of salaries and fringe benefits, and other direct costs and administrative costs (up to 10% of the service category budget) charged to the Ryan White Program, as indicated on the corresponding budget and in accordance with time and effort reporting and fair share allocations.

Subgrantees are selected through a Request for Proposals (RFP) process every few years. Because the unit costs are non-negotiable, applicants must describe their anticipated units provided and how they will work within the budget corresponding to the defined units of service and planned number of clients to be served. There are currently 14 non-profit RWHAP subgrantees funded, each offering between 1 and 11 service categories; as well as 2 for-profit subgrantees for data system, planning council staff support, and quality management (QM) services.

Miami-Dade County uses CaseWatch as its centralized data system to track client eligibility, client demographic, health assessment, service utilization, and referral information. It also uses the system for billing service utilization analysis, and federal reporting. The CaseWatch vendor, ACMS, is based in Los Angeles, but has a local office that houses its program support staff and training office for Miami-Dade County operations. CaseWatch authorizes subgrantee staff in different service categories to view only certain data about their client's records in other categories (for example, mental health records can be viewed by only certain authorized

subgrantees). CaseWatch is also used to facilitate a certified referral process, so that documentation to support client eligibility is maintained on file at the client's medical care management site, thereby relieving the client from having to take copies of the same documents to each provider of service. The grantee reports that CaseWatch comes at a significant cost, but allows for an efficient tracking of client eligibility and services, processing of claims, and facilitation of the reporting process.

Miami-Dade County has a well-organized process for the reallocation of funds, which occurs three to four times during the grant year, to maximize the use of available funds. Subgrantees report unmet need to the grantee. The local planning council, the Miami-Dade HIV/AIDS Partnership, then receives information from the grantee regarding the expenditure rates for each service category and the unmet need by service category. The Partnership then determines the reallocation of funds. Staff notes that their fiscal administrator is extremely effective in overseeing this process, tracking reimbursements to the penny on a daily basis, and determining the schedule/timing for the reallocation processes.

One reported advantage of Miami-Dade County's unit cost reimbursement model is that it is a quicker and more expeditious way of disbursing funds to subgrantees than grant-based budgets. It requires far less paperwork for review by agency staff than would a grants-based system that requires subgrantees to detail their costs in a line-item budget with backup documentation submitted and reviewed monthly to support each line item billed to the program. The model is also administratively simpler for subgrantees. However, grantee staff notes that they do not conduct annual assessments of each rate, so it is possible that rates do not rise quickly enough to sufficiently reimburse subgrantees.

Staff recommend that other grantees considering a unit cost reimbursement model consider several factors. The high number of clients served in Miami-Dade County makes unit cost reimbursement much more efficient than cost reimbursement, but they note that the same may not be true for smaller grantees. They also emphasized the importance of a well-developed client-level data system in making reimbursement work promptly and effectively.

New York City

With approximately 17,000 PLWH receiving RWHAP services, the NYC EMA began to implement new reimbursement models for some service categories in 2006 in an effort to better align reimbursement with actual performance (see the New York City, “Performance-Based Reimbursement” document in Appendix 4). The New York EMA covers the five boroughs of NYC and three counties (Tri-County Region) north of NYC. NYC now uses per-client, per-day payment for care coordination, a medical case management model (21% of NYC’s grant budget); FFS payment for 41% of the grant budget, deliverables-based payments for 6% of the grant budget, and hourly payments for 4% of the grant budget. All contracts in the Tri-County Region (approximately 4.7% of the total grant) are paid exclusively using a traditional cost-based reimbursement methodology.

Table 3: New York City Service Categories With Alternative Payment Systems (Either FFS, Deliverables-Based, or Hourly)
<ul style="list-style-type: none"> • Legal Services (hourly) • Early Intervention services • Housing Placement Assistance • Harm Reduction (Substance Abuse Services- outpatient) • Medical Case Management • Mental Health Services (Some Performance-Based and Some Cost-Based) • Supportive Counseling and Family Stabilization (Psychosocial Support Services) • Food and Nutrition Services (Food Bank/Home-delivered Meals)
<p>“NYC Ryan White Part A Service Category Scorecards 2010-2012” in HIV Health and Human Services Planning Council of New York and New York City Department of Health and Mental Hygiene “Needs Assessment for HIV Services: New York</p>

For FFS payment rates, NYC initially gave applicants tools to calculate the actual cost of their services, with the cost proposal counting toward the total bid score. In later RFPs, NYC staff computed the rates they believe represented the costs necessary to conduct the work – taking a cue, staff noted, from Miami-Dade County – and published them in the RFPs. For most FFS categories, rates are based on outputs such as counseling sessions or meals served. Others are based on short-term outcomes, such as housing placement or linkage to care. Payment rates were calculated by taking into account expenses (such as salary, fringe, other than personal services or OTPS, and administration), service time (based on certain assumptions about productivity), and outcomes (such as linkage to care). Staff applied programmatic knowledge to account for variance in the time and staffing required (see Appendix 4 for additional information). Rates are intended to reflect the time required for data entry, chart notes, set-up and breakdown for group services, and a modest allowance for client no-shows. Grantee staff benchmark reimbursement rates when possible to ensure reasonableness.

To receive reimbursement, a subgrantee enters client-level data into eSHARE, a data system created and supported by the grantee. Every billable service has an associated reimbursement rate, and the system incorporates funding requirements. For example, a service such as group counseling might only be billable if at least three RWHAP clients participate. The system can also recognize caps on frequency of utilization per client, such as a ten service unit per month limit on mental health services. eSHARE is linked by a “bridge” system to a contract management system called MAPS, developed by the Part A administrative agent, Public Health Solutions. MAPS generates reports for subgrantees and for the grantee which itemize and summarize reported services. If the system identifies inconsistencies with billing requirements,

grantee staff can contact subgrantees to make payment decisions and to review any problems during fiscal monitoring site visits.

Administration of this reimbursement system required a change in staffing structure (note that part of the administration is contracted to Public Health Solutions, a non-profit corporation). Contract managers handle fiscal and programmatic responsibilities, including negotiation of budgets and service targets, and fiscal and administrative monitoring. Prior to the introduction of FFS reimbursement, Public Health Solutions assigned two staff members to each contract, one for fiscal oversight and one for program/administrative monitoring. The contract manager coordinates with Department of Health and Mental Hygiene (DOHMH) staff for programmatic assistance, and also helps contractors who are struggling to reach their targets.

As noted above, some service categories (including food and nutrition, emergency rental assistance, home care, and all 10 service categories funded in the Tri-County Region) are still paid via a traditional cost-based reimbursement model. Medical case management is paid at a capitated daily rate, based on the intensity of services required. Rate calculations for medical case management are included in Appendix 5. Daily rates require compliance with program requirements like minimum face-to-face contacts and outreach activities.

Most of the services reimbursed on a FFS basis are discrete outputs, such as counseling sessions or lab tests. Others, like linkage to care, are based on a “culminating event.” The grantee at one point used “milestone payments” when medical case management clients shifted from needing more intensive to less intensive services. However, because clients shifted back and forth between need levels (as opposed to proceeding linearly to less intensity), the grantee stopped using this type of payment. [Please note that Appendix 5 includes information about

these discontinued “milestone” payments as well as discontinued payments for Outpatient Bridge Medical Care.]

NYC EMA has slightly over 190 contracts, with 109 different subgrantees. Most subgrantees are multiply funded across service categories, with the largest numbers of subgrantees providing HIV testing and medical case management.

The grantee conducts a review of spending several times per year, and imposes contract takedowns when necessary for subgrantees that are not on track to spend their awards. “Takedown” funds are returned to the pool to redistribute. An appeals process for the takedown process is available for subgrantees. The grantee determines eligibility for enhancement funding (i.e. specific criteria for strong year-to-date spending contract awards, programmatic compliance). The local Planning Council has given the grantee the flexibility to reprogram original funding allocations for each service category. Toward the end of the grant year, the grantee determines which subgrantees have outperformed their targets and are, therefore, eligible for additional funds. Payment beyond initial targets is not guaranteed to subgrantees and is contingent on the availability of funds to due to underspending by other subgrantees. However, the subgrantee staff noted that the possibility of contract enhancement operates as a meaningful incentive for performance of a high volume of services.

In 2015, the grantee plans to increase the use of performance and quality measures. Staff stated that they are trying to avoid incentivizing subgrantees to look for clients likely to lead to “better” outcomes.

One challenge that NYC staff described is adjusting reimbursement rates in response to real experience of subgrantees. Rates are modified every few years, but there is no clear consensus on how to set rates, and the grantee tries to acknowledge the full costs of the program.

For example, there is a modest allowance made for clients who do not keep their appointments. While some rates have been increased, others have been decreased.

Orange County

The Orange County (California) TGA uses a FFS system for specialty medical care and with one mental health provider. Rates are negotiated and are generally set at 110% of the Medicare rate; they do not exceed 130%. In the past, RWHAP specialty medical care was provided by a single hospital subgrantee and reimbursed on a FFS basis. About eight or nine years ago, the grantee retained the FFS model, but shifted to a master agreement system in which subgrantees could apply to provide specialty services. Currently, at least 14 subgrantees have signed the master service agreement. Dental services are also included under the master agreement.

Participating Part A clients are generally uninsured. In 2013, 389 RWHAP clients used specialty medical services, compared to 765 in 2012. Staff attributes the decline to early implementation of the ACA in California, during which approximately one-half of their RWHAP patients became eligible for Medi-Cal (the California Medicaid program). Staff notes that the current patient pool is primarily people without legal residency status. The staff predicts that the number of clients will remain relatively stable, apart from newly identified HIV infections in people ineligible for other coverage.

Administrative staff includes one contract administrator (who only spends a portion of her time on contracts, including annual re-signing of the master agreement with each subgrantee). The sub grantee also has one specialty coordinator. The staff works with a third-party billing administrator to process reimbursement.

In a recent RFP for services categories other than specialty medical care, the grantee gave applicants the option of traditional cost-based reimbursement or proposing a FFS payment. For primary medical care, the grantee was curious about how the proposed rates would compare to those paid by Medicare. However, almost all subgrantees outside specialty medical care chose to continue to be paid on a cost-based reimbursement basis.

San Diego

The San Diego EMA uses a pooled services model, with FFS reimbursement for primary and specialty medical care and for primary and specialty dental care. Subgrantees join the “pool” by signing a master purchase agreement. This model was originally established by San Diego County to purchase healthcare for low-income people in general, and RWHAP was added later. Any willing and qualified subgrantee can sign the agreement and bill the grantee for treating RWHAP clients.

Most of the medical subgrantees are FQHCs, and they are reimbursed for OAMC at the FQHC Medicaid rate. The University of California San Diego also serves as a subgrantee, receiving reimbursement at a rate negotiated earlier with the County for its general low-income health program. Medical specialty services are carved out and negotiated, because it can be difficult to find subgrantees to provide these services. Dental fees are based on 130% of rates in an earlier Medicaid program, but the grantee is planning to switch to current Denti-Cal rates. The grantee uses a “not to exceed” clause to limit monthly billing per subgrantee.

Approximately 1,600 RWHAP clients are receiving OAMC, down from 2,400 before the State’s Medi-Cal expansion took effect. Approximately 2,200 patients receive dental services, with some overlap in these service populations.

Mental health services are still paid on a cost reimbursement basis. However, the grantee is considering shifting to FFS to allow better integration with other healthcare services.

Reimbursing mental health on a FFS basis would allow subgrantees to develop a team that includes OAMC, mental health, and medical case management subgrantees, and to bill for all services provided.

County staff notes that the FFS system for medical and dental care offers more flexibility than a cost-based reimbursement model. For example, in a traditional grants model, a staff member's departure from a subgrantee organization creates savings in the grantee's budget. In the FFS model, a grantee only pays for services provided, and funds can be more easily shifted where they are needed. In addition, because it receives bills as services are provided, the grantee is aware of over or under-performance compared to targets in real time, instead of learning about issues six or seven months into a contract year.

The system is staffed by a principal administrative analyst and a fiscal manager. They conduct extensive forecasting based on historical data that accounts for seasonal variability, and can seek approval from the Planning Council when significant changes such as the Medicaid expansion occur. The grantee holds monthly meetings to review expenditures, and works with two administrative agents to develop data reports for the grantee.

St. Louis

The St. Louis TGA uses a FFS system for OAMC and dental care. Because the TGA spans two states, administration is somewhat complicated. At the grantee level, the program is administered by five people, including one contract person. Funds are contracted through two benefit/fiscal administrators, one for Missouri and one for Illinois.

In Missouri, the agency serving as fiscal administrator finances OAMC through FFS subcontracts with several private subgrantees and with two clinic subgrantees (Washington University and Saint Louis University Hope Clinic). In Illinois, the lead agency subcontracts with one clinic (Washington University) on a FFS basis. Grantee staff reports that the rates are based on the Medicaid fee schedule. Apart from OAMC and dental services, other categories such as medical case management, are funded on a traditional “salary plus fringe” basis.

In both states, the directly reimbursed OAMC services are for RWHAP clients who are uninsured. The number of uninsured clients is decreasing with implementation of the ACA, particularly in Illinois, where close to 95% of RWHAP clients are now insured. This year, the grantee plans to serve approximately 236 people with OAMC visits and 420 with labs tests.

Spending projections are based on the prior year’s data. When necessary, staff makes estimates based on significant changes. For example, subsequent to implementation of the ACA, the grantee reduced allocations for OAMC by 25%, allowing allocation of additional funds to serve more dental clients.

Staff states that the FFS system makes it relatively difficult to implement HIV-based QI, especially with the private subgrantees, who are only paid for specific services. The two university clinics also receive Part C funding, which allows them to do some HIV-specific clinical QM.

New York State

Since 1992, NY State has used a FFS system to reimburse subgrantees for OAMC offered to uninsured and underinsured RWHAP clients. Part B funds are supplemented with Part A funds to support a reimbursement pool.

The program currently serves approximately 23,000 clients, who are mostly uninsured. They are enrolled through a system integrated with the existing ADAP enrollment system. All enrollees receive a card that effectively functions as an insurance card for use in receiving services from enrolled primary care providers (subgrantees). In turn, the providers bill the State for reimbursement. Rates are based on Medicaid fee schedules.

For enrollees who are insured, the grantee determines whether the insurance is adequate and cost effective, and if the cost of the premium is a barrier to care. If the plan is adequate and cost effective but the premium is a barrier to care, the grantee pays the premium. Staff also determine if cost sharing would exceed 2% of the enrollee's gross income by analyzing cost sharing within the plan, assuming an average cost of care (including medications). If cost sharing would exceed that threshold, the client is enrolled in the state's program as underinsured.

For covered primary care services, the grantee uses a "pay and chase" model in which it directly reimburses primary care providers (subgrantees) for services, and then bills the client's insurer for reimbursement. This approach results in clients having no out-of-pocket costs for covered services.

Approximately 300 hospitals and clinics, 200 private clinicians and over 50 stand-alone laboratories participate as subgrantees. Staff report that subgrantees like the system because they are adequately reimbursed, it is administratively simple, and it assures reimbursement for services provided to uninsured individuals, helping to support the HIV service delivery infrastructure. Staff operate the HIV Uninsured Care Programs as part of the system for providing quality HIV care for uninsured and underinsured individuals living with HIV in New York State. For Primary care claims, the program uses a third-party administrator (Emdeon) to process most claims.

Washington State

Washington State reimburses OAMC and dental services on a FFS basis, both for uninsured and underinsured clients, and for insured clients who have yet to meet their deductibles. Their payment rate is set at 125% of the Medicaid rate for each CPT code, and at 133% of the Medicaid rate for dental services.

Washington State uses an FTE reimbursement model for medical case management services, but incorporates “performance-based payment” elements with extensive reporting and monitoring required. The grantee contracts with 14 agencies, all of which provide medical case management services. Some subgrantees provide additional services from four service categories, including food and transportation. Subgrantees are required to submit invoices with their FTEs allocated to provision of funded services, and must report quarterly on quality measures related to a statewide set of performance requirements for the service category. The grantee conducts monthly desk audits, as well as a quarterly review of clients served, and quarterly review of the QM and QI reporting. Subgrantees cannot receive reimbursement if they do not submit all required reports.

Five staff administer the program, including one field monitor, one contract coordinator, and one data person. Grantee staff conduct annual QM site visits at which they review 50% of charts for RWHAP patients who are not on Medicaid and 100% of charts for Medicaid patients. If a subgrantee has fewer than 50 RWHAP clients, the grantee reviews all RWHAP client charts, regardless of insurance status. Staff report that these site visits are staff intensive and time consuming but very important to the program.

At the end of each grant year, the grantee compiles data from each subgrantee and calculates a cost per service unit and cost per client. This information allows the grantee to compare agencies' services and performance, and to identify any problematic discrepancies. The grantee also provides each subgrantee with its own performance reports and with an average of other subgrantees' performance rates to allow de-identified comparisons and incentives for improvement. The grantee also sets aside some funding each year for situations such as unexpectedly high transportation costs in rural counties.

Grantee staff notes that in using FTE rather than a FFS approach, they are really paying for the medical case managers to be available to their RWHAP clients. One staff person previously worked in a state that used FFS for case managers (Iowa). She found that it created an incentive for medical case managers to make a lot of calls at the end of the month to meet their targets. Washington State staff believes that the FTE model for medical case management allows a more collaborative approach with the subgrantees, who they report are more patient-centered than they might be under a FFS model.

Appendices

Appendix 1: LA County: *Fee-for-Service and Additional Reimbursement Incentives Guidelines*

Appendix 2: LA County: Mercer, *Medical Clinical Fee-for-Service Reimbursement Rate Study* (2008)

Appendix 3: Miami-Dade County: *Ryan White HIV/AIDS Program Service Delivery Guidelines Fiscal Year 2014 (Year 24) Section II – Cost and Eligibility Summary*

Appendix 4: New York City: *Performance-Based Reimbursement*

Appendix 5: New York City: *Reimbursement Plan for Ryan White HIV/AIDS Program Care Coordination* (2012)

Appendix 1

LA County: Fee-for-Service and Additional Reimbursement Incentives Guidelines

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Payment for services provided shall be subject to the Fee-For-Service Reimbursement and Additional Reimbursement Incentives provisions described below.

HIV/AIDS Medical Outpatient Services Fee-For-Service (FFS) Reimbursement

The fee-for-service reimbursement guidelines support quality of care and efficiency of services performed. To achieve this, payments are structured around providers meeting pre-established benchmarks for a combination of process and outcome measures. Reimbursement ranges from the base rate of \$284.86 per patient visit up to a maximum rate of \$375.22 for providers who meet or exceed the established benchmarks.

To assist providers in meeting performance targets and resource demands, the reimbursement rate for FFS Year 1 and Year 2 only is set at the rate of \$330.12 per patient per visit. This rate is mid-way between the base reimbursement rate of \$284.86 and the maximum rate of \$375.22. In Year 3, providers will receive a base payment rate of \$284.86 but may be eligible for a payment rate as high as \$375.22 based on their performance during Year 2.

This base rate will be paid with the expectation that the provider meets established benchmarks with a core set of eleven (11) clinical and performance measures, listed in Table 1.

Table 1. Core Measures

Measure	Benchmark
1.1 ART for pregnant women	100%
1.2 ART for CD4 <500	95%
1.3 PCP prophylaxis	95%
1.4 Adherence assessment and counseling	95%
1.5 Cervical cancer screen	90%
1.6 Hepatitis C screen	90%
1.7 HIV risk counseling	95%
1.8 Syphilis screen	90%
1.9 Tuberculosis screen	75%
1.10 Patient satisfaction survey response	100%
1.11 Data validation (Casewatch)	75%

Providers will qualify for additional reimbursement incentives only if performance on each of the eleven (11) core measures meets or exceeds the established benchmark during the measurement year. Providers, who meet the established benchmarks on all eleven (11) core measures, will be eligible to obtain additional reimbursement for a total of nine (9) Part A supplemental measures, listed in Table 2A and two (2) Part B supplemental measures listed in Table 2B.

Table 2A. Part A Supplemental Measures

Measure	Service Score	Reimbursement per Measure (\$3.03 x service score)	Benchmark
2.1 Chlamydia screen	1	\$3.03	90%
2.2 Gonorrhea screen	1	\$3.03	90%

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Measure	Service Score	Reimbursement per Measure (\$3.03 x service score)	Benchmark
2.3 Pneumococcal vaccination	1	\$3.03	85%
2.4 Influenza vaccination	1	\$3.03	75%
2.5 Hepatitis B screen	2	\$6.06	90%
2.6 Substance abuse assessment	3	\$9.09	90%
2.7 Mental health assessment	3	\$9.09	90%
2.8 Hepatitis B vaccination	3	\$9.09	90%
2.9 Tobacco cessation counseling	3	\$9.09	90%

Part A supplemental measures include a total of nine (9) measures. Each of the nine (9) Part A supplemental measures has been assigned a service score that reflects the level of complexity and time required to complete the measure. Service scores for each of the supplemental measures are given a rating from one (1) to three (3). A rating of one (1) indicates a measure requiring minimal effort and resources to complete or a low complexity measure. A rating of two (2) indicates a measure requiring moderate effort and resources to complete or a moderate complexity measure. A rating of three (3) indicates a measure requiring significant effort and resources to complete or a significant complexity measure.

The provider's rate of Part A supplemental reimbursement per patient is based on the number of Part A supplemental measures that meets or exceeds the established benchmark for the clinic population. To calculate this rate, the service score for each Part A performance measure is multiplied by \$3.03, and then added to the base rate of \$284.86. Providers will be paid at an increased rate per patient visit for each additional Part A supplemental measure for which performance meets or exceeds the established benchmark.

Table 2B. Part B Supplemental Measures

Measure	Reimbursement	Benchmark
2.10 Medical visits	\$18.00	90%
2.11 Viral load suppression <200 copies/mL when on ART	\$18.00	80%

Part B supplemental measures include a total of two (2) outcome measures reimbursed at \$18.00 each when the established benchmarks are met. Providers will qualify for additional Part B supplemental reimbursement only if performance on each of the eleven (11) core measures meets or exceeds the established benchmark during the measurement year.

The provider's total amount of Part A and B supplemental reimbursement per patient visit is based on the number of Part A and B supplemental measures that meet or exceed the established benchmark. This amount is added to the base rate of \$284.86. If all eleven (11) supplemental performance measure benchmarks are met, reimbursement will be at the maximum rate of \$375.40 per patient visit.

Performance Review and Rate Determination

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Provider performance during the preceding calendar year will be reviewed to determine payment rate. The first performance review, which will occur between February and June 2014, will examine calendar year 2013 data. Performance on the review will determine performance-based rates for Year 3. Going forward, rates will be determined based on annual performance review for the preceding calendar year and be effective on July 1st (Figure 1).

Figure 1. Performance Monitoring and Payment Determination Timeline

Calendar Year	2012			2013					2014					2015			
	Nov-Dec	Jan-Feb	Mar-Apr	May-Jun	Jul-Aug	Sept-Oct	Nov-Dec	Jan-Feb	Mar-Apr	May-June	Jul-Aug	Sept-Oct	Nov-Dec	Jan-Feb	Mar-Apr	May-Jun	July-Aug
Contract Year	Year 1			Year 2					Year 3					Year 4			
Monitoring Time								CY 2013 Review					CY 2014 Review				
Payment Rate	\$330.12							Varies based on Performance in CY 2013					Varies- CY 2014				

Sampling for Performance Measures

Patients with two (2) or more visits in the measurement year will be eligible for inclusion in the sampling for for all performance measures except for the following: patient satisfaction survey response, medical visits and viral load suppression. The two (2)-visit minimum is used to ensure that providers have the opportunity to perform the necessary screens, vaccination and counseling that would be difficult or impossible to complete for patients with only a single visit. Healthy Way LA and Ryan White Program patients will be used in the sample.

A standardized sampling methodology developed by the National HIVQUAL Project will be used to determine the number of patient records to be sampled at the Division of HIV and STD Programs (DHSP) on site reviews. It is expected that all providers enter patient level data on performance measures into DHSP's data system as described below.

Patient Satisfaction Survey (Core)

Patient satisfaction surveys are an essential tool to shaping patient centered care. Surveys allow for the quick identification of problems that patients experience and create a space for dialogue with patients, letting them know that their feedback is critical to providing effective and efficient care. The purpose of this measure is to determine whether the agency has implemented a process to routinely administer patient satisfaction surveys to its clinic population. This measure also determines the response rate of patients who received a patient satisfaction survey during the measurement year, which is important in considering the generalizability of the findings.

Table 4 below can be used to identify the number of completed surveys needed for various clinic sizes. The clinic size is determined by the number of providers (MD, DO, PA, or NP) who are seeing patients in the clinic regardless of the provider's FTE or the number of patients they see. The designated number of completed patient surveys determined in Table 4, must be obtained for **every provider** who practices in the clinic.

Table 4. Sampling by Clinic

	Number of Providers in the Clinic		
	<5	5-9	=/> 10
Number of Completed Surveys Per Provider Per Year	15	10	5

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

For example: a clinic with 8 providers would need to obtain a minimum of 10 completed patient surveys for each of the 8 providers per measurement year. If the clinic has fewer than 5 providers, a minimum of 15 returned/completed surveys per provider are needed for every provider in the clinic.

The eligible population for survey includes all clinic patients with at least 1 medical visit during the measurement year and is not limited to Ryan White Program patients. Providers with a smaller patient population should administer enough surveys during the measurement year to obtain no less than the required number of completed surveys per provider indicated in the above table.

Data Validation (Core)

The purpose of this measure is to determine the percentage of medical records reviewed during the measurement period that demonstrate consistency between DHSP's data system and the client's medical record (chart or electronic) with regard to the following twelve (12) data elements.

1. Age
2. Ethnicity
3. Gender
4. ART for pregnant women
5. ART for CD4<500
6. PCP prophylaxis
7. Adherence assessment and counseling
8. Cervical cancer screenin
9. Hepatitis C screen
10. HIV risk counseling
11. Syphilis screen
12. Tuberculosis screen

Providers will ensure that the above data elements are entered into DHSP's data system either manually or through an electronic data interface. Data validation will be performed through a medical records review of these elements and comparing that documentation to data in DHSP's data system. The eligible population for survey includes Ryan White Program patients with at least two (2) medical visits during the measurement year. The threshold for compliance is set at seventy-five percent (75%) which means that at least seventy-five percent (75%) of medical records reviewed will have all twelve (12) data elements reflected in each patient's medical record and in DHSP's data system.

Utilization of Medical Visits and Reimbursement of Additional Visits

Providers will furnish medical visits to the minimum number of clients to be served as stipulated in this contract. To ensure the appropriate utilization of medical visits, a maximum of ten (10) visits per patient per year is established. The ten (10)-visit per patient per year threshold only applies to Ryan White Program patients.

Each clinic will routinely track the number of medical visits per patient per year, as well as the clinic's overall total number of visits for the entire clinic patient population based on the total number of patients to be served.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Tracking medical visit utilization is essential in providing patients with access to needed clinical and medical care and follow-up while ensuring that providers adhere to their established budgeted allocations. Given that there are conditions and special circumstances where some patients may need more medical visits than the established ten (10)-visit per year threshold; providers will follow the DHSP review and approval process outlined in the protocol below in order to ensure reimbursement for those additional visits.

The DHSP review process will be retrospective to ensure that patient care is not compromised. The provider will not be able to bill any more visits over the ten (10)-visit threshold without DHSP's approval. Within this process, providers will have the option to request up to three (3) additional visits for patients that have reached the ten (10)-visit threshold, by providing appropriate justification following the protocol outlined below.

There are two scenarios for patients exceeding their ten (10)-visit per year threshold. Each scenario requires action as follows:

Scenario 1

A patient exceeds the ten (10)-visit per year threshold but overall total number of visits for the clinic's Ryan White Program patients remains under the maximum allowed total visits per the approved budget.

Provider will request for a retrospective (or prospective, if preferred) review of the visit(s) in question and approval for those visits and future additional visits up to three (3) visits. DHSP will review each patient's case and render its decision to approve visits incurred over the ten (10)-visit threshold and may authorize up to three (3) additional future visits or disapprove the visit(s) in question. Visits over the ten (10)-visit threshold that are not approved by DHSP pursuant to its review, will not be reimbursed.

Scenario 2

A patient exceeds the ten (10)-visit per year threshold and the clinic exceeds overall total number of Ryan White Program patient visits allowed per the approved budget.

In this scenario, provider will request for a retrospective review of the additional visit(s) in question and approval for those visits and future additional visits up to three (3) visits. In this scenario, the provider will not be able to bill any additional visits for these patients, without DHSP's approval. DHSP will review each patient's case and render its decision to approve the visits in question and may authorize up to three (3) additional future visits or disapprove the additional visit(s) in question. Additional visits over the ten (10)-visit threshold that are not approved by DHSP will not be reimbursed.

Protocol for DHSP Case Review, Decision and Appeals Process for Medical Visits Exceeding the ten (10)-Visit Per Year Threshold

Providers should routinely track the number of medical visits per patient per year, as well as the clinic's overall total number of visits for the entire clinic patient population based on the total number of patients to be served. When a patient exceeds the 10-visit threshold per patient per year, the following steps will be followed:

RYAN WHITE PROGRAM MEDICAL OUTPATIENT UTILIZATION INITIAL REQUEST AND APPEALS PROCESS

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

1. Provider completes the Ryan White Program Medical Outpatient Utilization Initial Request Form (URF01) and submits this form to DHSP for approval. Provider documents the medical justification for the visit(s) in question and requests any additional future visit up to three (3) visits. Request is submitted to DHSP via:
 - a. Mail: DHSP
Attention: DHSP Office of the Medical Director
600 S. Commonwealth Avenue, 10th Floor
Los Angeles, CA 9005
 - b. Secure Fax: (213) 252-4506
 - c. Email: dhsp-urqm@ph.lacounty.gov
2. DHSP will review the request/justification to determine if the documentation provided supports the level of service requested requiring the additional medical visit(s). DHSP's decision will be based on a review of information provided on the request form and when necessary, consultation with the provider and/or a site visit to review the patient's medical records.
3. DHSP will render a decision to approve or disapprove the request.
 - a. Approved Requests. DHSP has determined that documentation received contains the required justifications for the level of service requested. DHSP will approve the visit(s) in question. Up to three (3) additional future visits will also be approved per request and will be reimbursed under the specific provisions outlined in case scenarios one (1) and two (2) above.
Disapproved Requests. DHSP has determined that documentation received is insufficient to approve the past visit(s) in question and the additional visit(s) requested. DHSP will return the initial request form and document the specific reason(s) for denying the initial request.
4. The provider accepts DHSP's decision or files an appeal in response to DHSP's denial of the initial request by completing form URF01. Provider sends the appeal to DHSP by mail, secure fax, or email as indicated above.
5. DHSP will review the appeal. If the appeal is denied, DHSP will send a final denial letter to the provider that will include the specific reasons for the denial.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.1: Antiretroviral therapy (ART) for pregnant women	
Description: Percentage of HIV-infected pregnant women who are prescribed ART in the measurement year.	
Numerator:	Number of HIV-infected pregnant women who were prescribed ART during the second and third trimester in the measurement year.
Denominator:	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, ¹ at least twice in the measurement year.
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients² whose pregnancy is terminated by spontaneous or induced abortion. 2. Pregnant patients who are in the first trimester and newly enrolled in care during last three months of the measurement year. 3. Patients with documented referral to another perinatal HIV care program. 4. Patients with documented refusal of ART offered by provider.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient female? (Y/N) <ol style="list-style-type: none"> i. If yes, was she pregnant during the reporting period? (Y/N) <ol style="list-style-type: none"> 1. If yes, was she on ART during this reporting period? (Y/N)
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 5, Item 53 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	No national benchmarks available at this time. DHSP Benchmark = 100%
Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Rate of perinatal transmission in the measurement year ○ Number of events of perinatal transmission in the measurement year
Basis for Selection:	
<p>Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. ART can reduce perinatal HIV-1 transmission by nearly 70%.³</p> <p>Measure reflects important aspect of care that significantly impacts survival, mortality, and hinders transmission. Data collection is currently feasible and measure has a strong evidence</p>	

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

base supporting the use.

U.S. Public Health Service Guidelines:

Health care providers considering the use of antiretroviral agents for HIV-1 infected women during pregnancy must take into account two separate but related issues:

- Antiretroviral treatment of maternal HIV-1 infection, and
- Antiretroviral chemoprophylaxis to reduce the risk for perinatal HIV-1 transmission

The benefits of ART for a pregnant woman must be weighed against the risk of adverse events to the woman, fetus, and newborn. Although ZDV chemoprophylaxis alone has substantially reduced the risk for perinatal transmission, antiretroviral monotherapy is now considered suboptimal for treatment of HIV-1 infection, and combination drug regimens are considered the standard of care for therapy. Initial evaluation of an infected pregnant woman should include an assessment of HIV-1 disease status and recommendations regarding antiretroviral treatment or alteration of her current antiretroviral regimen.³

References/Notes:

¹A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

²“Patients” include all patients aged 13 years or older.

³Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. September 14, 2011. www.aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.2: ART for CD4 <500																					
Description: Percentage of patients ¹ with HIV infection and CD4 T-cell counts <500 cells/mm ³ who are prescribed ART in the measurement year.																					
Numerator:	Number of HIV-infected patients with CD4 T-cell counts <500 cells/mm ³ or an AIDS-defining condition who were prescribed an ART regimen ² within the measurement year.																				
Denominator:	Number of HIV-infected patients who have: <ul style="list-style-type: none"> • A CD4 T-cell count < 500 cells/mm³ or an AIDS-defining condition,² and • At least two medical visits with a provider with prescribing privileges,³ in the measurement year 																				
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients newly enrolled in care during last three months of the measurement year. 2. Patients with documented refusal to take ART in medical record. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient diagnosed with CDC-defined AIDS? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient prescribed ART during the reporting period? (Y/N) ii. If no, does the patient have two or more CD4 counts <500 cells/mm³? (Y/N) <ol style="list-style-type: none"> a. If yes, was the patient prescribed ART during the reporting period? (Y/N) 																				
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 2, Items 26 and 31 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison	<p>DHSP Benchmark: 95%</p> <p>CDC and HIVRN data consistent that 80% of those in care “eligible for ART’s”^{4,5,6}</p> <p>National HIVQUAL-US Data:^{6,7}</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>100%</td> <td>88.9%</td> <td>95.7%</td> <td>100%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	100%	88.9%	95.7%	100%
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Top 25%	100%	100%	100%	100%																	
Median*	100%	88.9%	95.7%	100%																	
Outcome Measures for	<ul style="list-style-type: none"> ○ Rate of opportunistic infections in the measurement year ○ Rate of HIV-related hospitalizations in the measurement year 																				

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Consideration:	○ Mortality rates
Basis for Selection:	
<p>Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating patients with AIDS-defining conditions and patients with CD4 T-cells between 350 and 500 cells/mm³.²</p> <p>Measure reflects important aspect of care that significantly impacts survival, mortality, and transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>	
U.S. Public Health Service Guidelines:	
<p>“Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness or with a CD4 T-cell count between 350 and 500 cells/mm³.”²</p>	
References/Notes:	
<p>¹“Patients” include all patients aged 13 years or older.</p> <p>²“Randomized controlled trials provide evidence supporting the benefit of ART in patients with CD4 counts <350 cells/mm³. However, such evidence showing benefit for patients with higher CD4 cell counts is not yet available. Based on cumulative observational cohort data demonstrating benefits of ART in reducing AIDS- and non-AIDS associated morbidity and mortality, the Panel now recommends ART for patients with CD4 count between 350 and 500 cells/mm³. For patients with CD4 count >500 cells/mm³, panel members are evenly divided: 50% favor starting ART at earlier stages of HIV disease; 50% view initiating therapy at this stage as optional. Panel members favoring earlier initiation of therapy base their recommendation on several recent developments: (1) report from at least one recent cohort study demonstrating survival benefit with initiation of ART at CD4 count >500 cells/mm³; (2) growing awareness that untreated HIV infection may be associated with development of many non-AIDS-defining diseases, including cardiovascular disease, kidney disease, liver disease, and malignancy; (3) availability of ARV regimens that are more effective, more convenient, and better tolerated than ARV combinations no longer in use; and (4) increasing evidence that effective ART reduces HIV transmission. The other 50% of the Panel members feel that current evidence does not definitively demonstrate clear benefit of ART in all patients with CD4 count >500 cells/mm³. They also feel that risks of short- or long-term drug-related complications, non-adherence to lifelong therapy in asymptomatic patients, and potential for development of drug resistance may offset possible benefits of earlier initiation of therapy. Thus, pending more definitive supporting evidence, these Panel members recommend that therapy in this setting should be optional and considered on a case-by case basis. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. October 14, 2011;. Available at aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf</p> <p>³A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.</p> <p>⁴Gebo, JAIDS January 2005, vol. 38, pp. 96-103.</p> <p>⁵Teshale Abstract #167, CROI 2005.</p> <p>⁶The National HIVQUAL data may not be directly comparable due to varying exclusions. Indicator definitions can be accessed at http://www.hivguidelines.org/Content.aspx?PageID=53.</p> <p>⁷http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf.</p>	

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.3: Pneumocystis pneumonia (PCP) prophylaxis																					
Description: Percentage of patients ¹ with HIV infection and a CD4 T-cell count < 200 cells/mm ³ who were prescribed PCP prophylaxis in the measurement year.																					
Numerator:	Number of HIV-infected patients with CD4 T-cell count < 200 cells/mm ³ who were prescribed PCP prophylaxis ^{2,3} in the measurement year.																				
Denominator:	Number of HIV-infected patients who: <ul style="list-style-type: none"> • had a medical visit with a provider with prescribing privileges,⁴ at least twice in the measurement year, and • had a CD4 T-cell count < 200 cells/mm³ 																				
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients with subsequent CD4 T-cell count < 200 cells/mm³ repeated within three months which rose above 200 cells/mm³ 2. Patients newly enrolled in care during last three months of the measurement year. 3. Patients with documented refusal to take PCP prophylaxis in medical record. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, was the CD4 T-cell count <200 cells/mm³? (Y/N) <ol style="list-style-type: none"> i. If yes, was PCP prophylaxis prescribed? (Y/N) <ol style="list-style-type: none"> 1. If no, was the CD4 count repeated within three months? (Y/N) <ol style="list-style-type: none"> A. If yes, did it remain < 200 cells/mm³? (Y/N) <ol style="list-style-type: none"> I. If yes, was PCP prophylaxis prescribed? (Y/N) 																				
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • HIVQUAL reports on this measure for grantee under review • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison:	<p>DHSP Benchmark: 95%</p> <p>IHI Goal: 95%⁵</p> <p>National HIVQUAL-US Data:⁶</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>93.3%</td> <td>90.9%</td> <td>92.3%</td> <td>94.4%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	93.3%	90.9%	92.3%	94.4%
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Median*	93.3%	90.9%	92.3%	94.4%																	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Rate of PCP in the measurement year ○ Mortality rates ○ Cost effectiveness 																				

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**Basis for Selection:**

PCP is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV-infection, yet is almost entirely preventable and treatable. Pneumocystis almost always affects the lungs, causing a form of pneumonia. People with CD4 T-cell counts < 200 cells/mm³ are at greatest risk of developing PCP.²

Before the widespread use of primary PCP prophylaxis and effective ART, PCP occurred in 70%-80% of patients with AIDS.⁷ The course of treated PCP was associated with a mortality rate of between 20% and 40% in persons with profound immunosuppression. Approximately 90% of cases occurred among patients with CD4 T-cell counts <200 cells/mm³.^{8,9} Measure reflects important aspect of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

U.S. Public Health Service Guidelines:

HIV-infected adults and adolescents, including pregnant women and those on ART, should receive chemoprophylaxis against PCP if they have a CD4 T-cell count <200 cells/mm³ or a history of oropharyngeal candidiasis.²

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

³ PCP prophylactic recommended in US PHS guidelines: TMP-SMX (preferred regimen at 1 DS QD, however tolerability may improve with 1 SS QD, 1 DS 3x a week), alternative regimens (in case of TMP-SMX intolerability) include: 1) dapsone + pyrimethamine + leukovorin; 2) atovaquone; 3) aerosolized pentamidine; 4) oral pyrimethamine + sulfaxodoxine (if sulfonamide hypersensitivity).

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP..

⁵ IHI Measure reads, “Percent of Patients with a CD4 Cell Count Below 200 cells/mm³ receiving Pneumocystis Carinii Pneumonia (PCP) Prophylaxis”

⁶ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁷ Phair J, Munoz A, Detels R, et al. The risk of Pneumocystis carinii pneumonia among men infected with human immunodeficiency virus type 1. Multicenter AIDS Cohort Study Group. N Engl J Med 1990;322:161–5.

⁸ Kaplan JE, Hanson DL, Navin TR, Jones JL. Risk factors for primary Pneumocystis carinii pneumonia in human immunodeficiency virus- infected adolescents and adults in the United States: reassessment of indications for chemoprophylaxis. J Infect Dis 1998;178:1126–32.

⁹ Kaplan JE, Hanson DL, Jones JL, Dworkin MS. Viral load as an independent risk factor for opportunistic infections in HIV-infected adults and adolescents. AIDS 2001;15:1831–6.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.4: Adherence assessment and counseling																					
Description: Percentage of patients ¹ with HIV infection on ART who were assessed for adherence (and counseled if suboptimal adherence) two or more times in the measurement year.																					
Numerator:	Number of HIV-infected patients, as part of their primary care, who were assessed for adherence and counseled ^{2,3} two or more times in the measurement year.																				
Denominator:	Number of HIV-infected patients on ART who had a medical visit with a provider with prescribing privileges ⁴ at least twice in the measurement year																				
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients newly enrolled in care during the last six months of the measurement year. 2. Patients who are not on ART. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, was the patient on ART? (Y/N) <ol style="list-style-type: none"> i. If yes, did he/she receive adherence counseling at least twice during the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, list the dates of these visits 																				
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • HIVQUAL reports on this measure for grantee under review • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison:	<p>DHSP Benchmark: 95%</p> <p>IHI Goal: 90%⁵</p> <p>National HIVQUAL-US Performance Data:⁶</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>95.8%</td> <td>92.0%</td> <td>97.5%</td> <td>98.4%</td> </tr> <tr> <td>Top 25%</td> <td>82.7%</td> <td>79.2%</td> <td>88.3%</td> <td>91.6%</td> </tr> <tr> <td>Median*</td> <td>57.5%</td> <td>39.7%</td> <td>46.8%</td> <td>55.7%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	Top 10%	95.8%	92.0%	97.5%	98.4%	Top 25%	82.7%	79.2%	88.3%	91.6%	Median*	57.5%	39.7%	46.8%	55.7%
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Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Percent of undetectable viral loads among patients on ART in the measurement year ○ Percent of patients with ART-resistance developed during therapy in the measurement year ○ Mortality rates ○ Incidence of HIV-related hospitalizations in the clinic population ○ Incidence of patients with progression to AIDS in the clinic population 																				

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**Basis for Selection:**

Adherence is a key determinant in the degree and duration of virologic suppression. Among studies reporting on the association between suboptimal adherence and virologic failure, non-adherence among patients on ART was the strongest predictor for failure to achieve viral suppression below the level of detection. HIV viral suppression, reduced rates of resistance, and improved survival have been correlated with high rates of adherence to ART.⁷

Prior to writing the first prescriptions, clinicians need to assess the patient's readiness to take medication. Patients need to understand that the first regimen is the best chance for long-term success. Resources need to be identified to assist in success. Interventions can also assist with identifying adherence education needs and strategies for each patient."⁷

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Although discussions of the importance of adherence to ART are important to begin prior to initiation of treatment, there is no standard of care for discussions to occur every six months for patients who may be years away from antiretroviral treatment.

U.S. Public Health Guidelines:

"...adherence counseling and assessment should be done at each clinical encounter"⁷

References/Notes:

¹ "Patients" include all patients aged 13 years or older.

² Assessment of adherence includes: 1) patient reports of adherence by: a) quantifiable scales, e.g. missed three out of ten doses; b) qualitative scale, e.g. Likert scale; or 2) quantification such as pharmacy dispensing records, pill counts, or direct observation therapy.

³ Adherence assessment should be provided by the provider with prescribing privileges. Adherence counseling should be performed for patients who report suboptimal adherence (less than 100% no missed doses). Counseling can be provided by any member of the multidisciplinary primary care team.

⁴ A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP..

⁵ IHI Measure reads, "Percent of Patients/Patients Assessed for Adherence to Antiretroviral (ARV) Therapy in the Past 4 Months."

<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientsAssessedforAdherencetoAntiretroviralARVTherapyinthePast4Months.htm>.

⁶ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁷ Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011. Available at

<http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

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Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.5: Cervical cancer screening																													
Description: Percentage of women with HIV infection who have a PAP screen in the measurement year.																													
Numerator:	Number of HIV-infected female patients ¹ who had PAP screen results documented in the measurement year.																												
Denominator:	Number of HIV-infected female patients who: <ul style="list-style-type: none"> • were ≥ 18 years old² in the measurement year or reported having a history of sexual activity, and • had a medical visit with a provider with prescribing privileges³ at least twice in the measurement year 																												
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients who were < 18 years old and denied history of sexual activity. 2. Patients who have had a hysterectomy for non-dysplasia/non-malignant indications. 3. Patients with documented refusal of PAP screen in medical record. 4. Patients newly enrolled in care during last three months of the measurement year. 																												
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient female? (Y/N) <ol style="list-style-type: none"> i. If yes, is she ≥ 18 years or reports having a history of sexual activity? (Y/N) 2. If yes, was the PAP screening completed during the measurement year? 																												
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 5, Items 42 and 52 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																												
National Goals, Targets, or Benchmarks for Comparison	<p>DHSP Benchmark: 90%</p> <p>IHI Goal: 90%⁴</p> <p>National HIVQUAL-US Data:⁵</p> <p>Percent of female patients who received a pelvic examination.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> <th>2009</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>94.1%</td> </tr> <tr> <td>Top 25%</td> <td>84.3%</td> <td>86.7%</td> <td>87.0%</td> <td>89.2%</td> <td>n/a</td> <td></td> </tr> <tr> <td>Median*</td> <td>70.5%</td> <td>67.7%</td> <td>71.8%</td> <td>73.3%</td> <td>70.0%</td> <td>66.7%</td> </tr> </tbody> </table>		2003	2004	2005	2006	2007	2009	Top 10%	100%	100%	100%	100%	100%	94.1%	Top 25%	84.3%	86.7%	87.0%	89.2%	n/a		Median*	70.5%	67.7%	71.8%	73.3%	70.0%	66.7%
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Top 10%	100%	100%	100%	100%	100%	94.1%																							
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Median*	70.5%	67.7%	71.8%	73.3%	70.0%	66.7%																							

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

	Bottom 10%				45.5%	33.3%
	*from HAB data base					
	Percent of female patients who received a pelvic examination and Pap test					
		2007			2009	
	Top 10%	100%			90.9%	
	Median	67.1%			62.1%	
	Bottom 10%	43.5%			31.6%	
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of cervical cancer in HIV-positive women in clinic population 					

Basis for Selection:

Human Papillomavirus (HPV) is a common infection in the general population. Current evidence suggests that over 50% of sexually active adults have been infected with one or more HPV types. According to population-based prospective studies, HPV precedes the development of cervical cancer.⁶

The American College of Obstetricians and Gynecologists (ACOG) identifies additional risk factors that might justify annual screening, including a history of cervical neoplasia, infection with HPV or other sexually transmitted diseases (STDs), or high-risk sexual behavior, but data are limited to determine the benefits of these strategies.⁷

Cervical cancer may be the most common AIDS-related malignancy in women. Although not a common diagnosis in women in the general population, according to New York City AIDS Surveillance data from 1990 to 1995, the observed cervical cancer cases in HIV-positive women were two to three times higher than the expected number of cases.⁸ Findings such as these resulted in the inclusion of cervical cancer in the Centers for Disease Control and Prevention (CDC) expanded definition of AIDS.⁹

When compared with HIV-negative women, HIV-positive women with invasive cervical cancer present at more advanced stages and with cancer metastasizing to unusual locations. HIV-positive women have poorer responses to standard therapy and have higher recurrences and death rates, as well as shorter intervals to recurrence or death.^{10,11}

The CDC currently recommends that HIV-positive women have a complete gynecologic evaluation, including a PAP smear, as part of their initial HIV evaluations, or upon entry to prenatal care, and another PAP smear six months later. If both PAP smears are negative, annual screening is recommended thereafter in asymptomatic women. The CDC further recommends more frequent screenings (every six months) for women with symptomatic HIV-infection, prior abnormal PAP smears, or signs of HPV infection.^{12,13}

Cervical cancer can often be prevented or detected in its earliest stages through effective screening with a PAP smear and avoidance of known risk factors. This accentuates the importance of routine gynecological care, which includes PAP smears for HIV-infected women.¹⁴ Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**U.S. Public Health Guidelines:**

“The Pap test should be obtained twice during the first year after diagnosis of HIV-infection and, if the results are normal, annually thereafter (AII). If the results of the Pap test are abnormal, care should be provided according to the Guidelines for Management of Women with Abnormal Cervical Cancer Screening Tests by ASCCP.”¹⁵

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Onset of sexual activity is not reliably reported or recorded. The age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ **Goal:** Greater than 90 percent of female patients/clients will have a documented Pap test in the past 12 months.

<http://www.ihl.org/knowledge/Pages/Measures/PercentofFemalePatientsClientswithanAnnualPapTest.aspx>

⁵ National HIVQUAL data looked at the percent of female patients who have an annual pelvic exam until 2007, when pelvic exam and Pap examination among female patients was added. Data was not collect data in 2008. HIVQUAL-US Performance Data Report, Ryan White Part C and Part D Funded Programs, Review Period: January 1, 2009 – December 31, 2009. Available at: <http://hivqualus.org/index.cfm/8418/10039>

⁶ Davis, AT. Cervical dysplasia in women infected with the human immunodeficiency virus (HIV): A correlation with HIV viral load and CD4 count. *Gynecologic Oncology*. 2001; 80(3):350–354.

⁷ Guide to Clinical Preventive Services, 2010-2011, Recommendations of the U.S. Preventive Services Task Force, p 47

<http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf> Available at:

<http://www.ahrq.gov/clinic/pocketgd.htm>

⁸ Chiasson, MA. Declining AIDS mortality in New York City. *New York City Department of Health. Bull NY Acad. Med.* 1997; 74:151–152.

⁹ Centers for Disease Control and Prevention (CDC). 1993. Revised classification system for HIV-infection and expanded surveillance case definition for AIDS among adolescents and adults. *MMWR*. 1992; 41(RR-17).

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm>.

¹⁰ Ibid.

¹¹ U.S. Department of Health and Human Services. Anderson, JA, editor. *Guide to the Clinical Care of Women with HIV*; 2005.

¹² National Institutes of Allergy and Infectious Diseases. *HIV Infection in Women*

<http://www.niaid.nih.gov/topics/hivaids/understanding/population%20specific%20information/pages/womenhiv.aspx>. Accessed 3/123/2012

13. Susan Richardson, MN, MPH, FNP-BC. *Health Care of HIV-Infected Women Through the Life Cycle*, in *Guide for HIV/AIDS Clinical Care*. U.S. Department of Health and Human Services, Health Resources and Services Administration

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HIV/AIDS Bureau, January 2011 <http://hab.hrsa.gov/deliverhivaidscares/clinicalguide11/>

¹⁴ Kjaer, S. Type specific persistence of high risk human papillomavirus (HPV) as indicator of high grade cervical squamous intraepithelial lesions in young women: population based prospective follow-up study, Brit Med J. 2002; 325: 572–578.

¹⁵ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2009;58(No. RR-4)
http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009.pdf

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.6: Hepatitis C (HCV) screening																					
Description: Percentage of patients ¹ for whom HCV screening was performed at least once since the diagnosis of HIV-infection.																					
Numerator:	Number of HIV-infected patients who have HCV status documented in chart since HIV diagnosis or initiation of care with provider ²																				
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year																				
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test. 2. Patients newly enrolled in care during the last three months of the measurement year. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is there documentation of the patient's Hepatitis C status (Hepatitis C Antibody positive or negative) in the medical record? (Y/N) 																				
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison	DHSP Benchmark: 90% IHI Goal: 95% ⁴ National HIVQUAL-US Performance Data: ⁵ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>94.4%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>86.2%</td> <td>88.8%</td> <td>90.5%</td> <td>90.9%</td> </tr> </tbody> </table> *from HAB data base		2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	94.4%	100%	100%	100%	Median*	86.2%	88.8%	90.5%	90.9%
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Median*	86.2%	88.8%	90.5%	90.9%																	
Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Hepatitis C- related mortality rates in the clinic population 																				
Basis for Selection:																					
<p>Approximately 15% to 30% of people with HIV are estimated to be co-infected with hepatitis C virus (HCV) in the United States, and up to 90% of those with HIV secondary to injection drug use are co-infected. Chronic liver disease from co-infection, including cirrhosis and hepatocellular carcinoma, leads to significant morbidity and mortality⁶ and HCV treatment may exacerbate the side effects of some antiretroviral medications.⁷</p>																					
Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on																					

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

U.S. Public Health Guidelines:

“HIV-infected patients should be tested routinely for evidence of chronic HCV infection”⁸
(3/29/09)

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Unless there is concern about ongoing exposure (e.g., via active injection drug use or sexual exposure), guidelines do not consistently recommend annual re-screening.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ IHI Measure reads, “Percent of Patients/Patients with Known Hepatitis C Status”
<http://www.ihf.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientswithKnownHepatitisCStatus.htm>.

⁵ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁶ Medscape: HIV and Hepatitis C Co-infection: Guideline and Commentary, Douglas G. Fish, MD <http://www.medscape.com/viewarticle/734975>

⁷ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1–167. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

⁸ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**Clinical Performance Measures for Adult/Adolescent Patients:
Core Measures**

Performance Measure 1.7: HIV risk counseling	
Description: Percentage of patients ¹ with HIV infection who received HIV risk counseling ² within the measurement year.	
Numerator:	Number of HIV-infected patients, as part of their primary care, who received HIV risk counseling within the measurement year.
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last three months of the measurement year.
Data Element:	1. Is the patient HIV-infected? (Y/N) a. If yes, did the patient receive HIV risk counseling at least once during the measurement year?(Y/N)
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 95% None available at this time
Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Incidence of new HIV-infection ○ Incidence of STD cases in clinic population ○ Rates of substance abuse counseling and referrals
Basis for Selection:	
<p>Reducing transmission of HIV in the United States requires new strategies, including emphasis on prevention of transmission by HIV-infected persons. Through ongoing attention to prevention, risky sexual and needle sharing behaviors among persons with HIV-infection can be reduced, and transmission of HIV-infection prevented. Medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other sexually transmitted diseases.⁴</p> <p>Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.</p>	
U.S. Public Health Guidelines:	
"HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and	

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subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks."^{4,5}

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² HIV risk counseling includes assessment of risk, counseling, and as necessary, referrals. Counseling occurs in the context of comprehensive medical care and can be provided by any member of the multidisciplinary primary care team.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003;52 (No. RR-12).

<http://www.cdc.gov/mmwr/PDF/rr/rr5212.pdf> or

http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare_TB.pdf.

⁵ Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.8: Syphilis screening																					
Description: Percentage of adult patients ¹ with HIV infection who had a test for syphilis performed within the measurement year.																					
Numerator:	Number of HIV-infected patients who had a serologic test for syphilis performed at least once during the measurement year.																				
Denominator:	Number of HIV-infected patients who: <ul style="list-style-type: none"> • were ≥ 18 years old in the measurement year² or had a history of sexual activity and were < 18 years old, and • had a medical visit with a provider with prescribing privileges³ at least twice in the measurement year 																				
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test, documented in the medical record. 2. Patients who are < 18 years of age⁴ and deny a history of sexual activity. 3. Patients newly enrolled in care during last three months of the measurement year. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient ≥ 18 years old or reports having a history of sexual activity? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient screened for syphilis with Nontreponemal test (RPR, VDRL) during the measurement year? 																				
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison	<p>DHSP Benchmark: 90%</p> <p>IHI Goal: 90%⁴</p> <p>National HIVQUAL-US Data:⁵</p> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>99.0%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>90.4%</td> <td>92.2%</td> <td>95.7%</td> <td>95.6%</td> </tr> <tr> <td>Median*</td> <td>73.7%</td> <td>78.5%</td> <td>82.1%</td> <td>80.0%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	Top 10%	99.0%	100%	100%	100%	Top 25%	90.4%	92.2%	95.7%	95.6%	Median*	73.7%	78.5%	82.1%	80.0%
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Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of syphilis in the clinic population 																				

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**Basis for Selection:**

HIV-1 infection appears to alter the diagnosis, natural history, management, and outcome of *T. pallidum* infection. Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use. Because the incidence of some STDs, notably syphilis, is higher in HIV-infected persons, the use of client-centered STD counseling for HIV-infected persons has been strongly encouraged by public health agencies and other health organizations. Consensus guidelines issued by CDC, the Health Resources and Services Administration, the HIV Medicine Association of the Infectious Diseases Society of America, and the National Institutes of Health emphasize that STD/HIV risk assessment, STD screening, and client-centered risk reduction counseling should be provided routinely to HIV-infected persons.⁶

Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America

Routine laboratory screening for syphilis is indicated for all sexually active MSM. Screening tests should be performed at least annually for sexually active MSM.

Serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis) should be performed at least annually for all sexually active, HIV-positive persons⁶

The resurgence of syphilis among persons with HIV infection in the United States underscores the importance of primary prevention of syphilis among persons with HIV infection. This should begin with routine discussion of sexual behaviors. Providers should discuss client-centered risk reduction messages and provide specific actions that can reduce the risk for acquiring sexually transmitted infections and for transmitting HIV. Routine serologic screening for syphilis is recommended at least annually for all sexually active HIV-infected persons, with more frequent screening (every 3--6 months) for those with multiple partners, unprotected intercourse, sex in conjunction with illicit drug use, methamphetamine use, or partners who participate in such activities. The occurrence of syphilis in an HIV-infected person is an indication of high-risk behavior and should prompt intensified counseling messages and strong consideration of referral for behavioral intervention. Persons undergoing screening or treatment for syphilis also should be evaluated for all common sexually transmitted diseases (STDs)⁷

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ IHI Measure reads, “Percent of Patients with Annual Syphilis Screen” (<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAnnualSyphilisScreen.htm>)

⁵ (http://www.hivguidelines.org/public_html/center/quality-of-care/hivqual-project/hivqual-

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[workshop/03-04-natl-score-top10-25.pdf](#))

⁶ Morbidity and Mortality Weekly Report December 17, 2010 Volume 59

⁷ Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents March 24, 2009

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.9: Tuberculosis screening																					
Description: Percentage of patients ¹ with HIV infection who received testing with results documented for latent tuberculosis infection (LTBI) in the measurement year.																					
Numerator:	Number of HIV-infected patients who received documented testing for LTBI with any approved test (tuberculin skin test [TST], interferon gamma release assay [IGRA], or T-spot) for the measurement year.																				
Denominator:	Number of HIV-infected patients who: <ul style="list-style-type: none"> • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA²; and • had a medical visit with a provider with prescribing privileges³ at least twice in the measurement year. 																				
Patient Exclusions	<ol style="list-style-type: none"> 1. Patient refusal of TST or IGRA⁴ 2. Patients newly enrolled in care during last three months of the measurement year. 																				
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, has the patient ever had previous documented culture-positive TB disease or previous documented positive TST or IGRA? (Y/N) <ol style="list-style-type: none"> i. If no, has the patient been tested for LTBI with a TST or IGRA in the measurement year? (Y/N) <ol style="list-style-type: none"> 1. If yes, are the results documented? (Y/N) 																				
Data Sources:	<ul style="list-style-type: none"> • Ryan White Program Data Report, Section 5, Item 47 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																				
National Goals, Targets, or Benchmarks for Comparison	DHSP Benchmark: 75% National HIVQUAL-US Data: ⁵ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>88.9%</td> <td>91.7%</td> <td>88.8%</td> <td>92.2%</td> </tr> <tr> <td>Top 25%</td> <td>77.4%</td> <td>73.5%</td> <td>74.8%</td> <td>78.2%</td> </tr> <tr> <td>Median*</td> <td>58.8%</td> <td>56.0%</td> <td>57.1%</td> <td>56.2%</td> </tr> </tbody> </table> *from HAB data base		2003	2004	2005	2006	Top 10%	88.9%	91.7%	88.8%	92.2%	Top 25%	77.4%	73.5%	74.8%	78.2%	Median*	58.8%	56.0%	57.1%	56.2%
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Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of TB disease in the clinic population 																				

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**Basis for Selection:**

HIV is the most important known risk factor for progression to TB disease from LTBI after exposure to infectious TB patients. There is a 2% to 8% TB risk per year within five years after LTBI for HIV-infected adults^{6,7} versus an 8% TB risk over 60 years for adults with LTBI but not HIV.⁸ The TB risk for HIV-infected persons remains higher than for HIV-uninfected persons, even for HIV-infected persons who are taking antiretroviral medications.^{9,10} TB disease is an AIDS-defining opportunistic condition that can be deadly. McCombs found a three-times adjusted odds of being diagnosed with TB at death and a five times adjusted odds of dying during TB treatment for HIV-infected TB patients compared with other patients from 1993 through 2001.¹¹

Immunologic and virologic evidence now indicates that the host immune response to *M. tuberculosis* enhances HIV replication and might accelerate the natural progression of HIV-infection.¹²

Providers should screen all HIV-infected patients for TB and LTBI as soon as possible after HIV diagnosis. TB and LTBI testing should be conducted among HIV-infected persons regardless of duration of infection since they are at increased risk for progressing to TB disease. Thus, an HIV-infected person having a prior positive TST for which he/she did not complete treatment is still eligible for treatment. However, early identification and treatment of TB disease improves outcomes and reduces the risk of transmission. TB should be suspected in any patient who has had a persistent cough for more than two to three weeks, especially if the patient has at least one additional symptom, including fever, night sweats (sufficient to require changing of bed clothes or sheets), weight loss, or hemoptysis (coughing up blood).

Identification of LTBI and completion of LTBI treatment reduces the risk of development of TB disease by 70 to 90 percent.¹³

Measure reflects important aspect of care that impacts HIV-related morbidity and mortality and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.

U.S. Public Health Guidelines:

Guidelines for TB services for HIV-infected persons, such as those jointly published by the PHS and the Infectious Diseases Society of America¹⁴ or by the Centers for Disease Control and Prevention (CDC)¹⁵ call for:

- provision of a TST or IGRA when HIV-infection is first recognized,
- annual TST or IGRA for HIV-infected persons who are initially TST-negative and belong to groups at substantial risk for TB exposure or if they experience immune reconstitution,
- chest radiographs and clinical evaluations to rule out active TB among those who are TST positive (reactions ≥ 5 mm) or who have symptoms (regardless of TST result), and
- LTBI treatment (once active TB has been excluded) for those having a positive TST/IGRA or for those who are recent contacts of persons with infectious active TB.¹⁶

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Previous documented culture-positive TB disease or previous documented positive TST or IGRA occurred prior to HIV diagnosis.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ History of receiving BCG is NOT an exclusion to receiving TST. See: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. MMWR, 2000/49(RR06);1-64.

⁵”PPD screening.”

<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>

⁶ Markowitz N, Hansen NI, Hopewell PC, et al. Incidence of tuberculosis in the United States among HIV-infected persons. *Annals of Internal Medicine*. 1997;126:123-32.

⁷ Selwyn PA, Hartel D, Lewis VA, et al. A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. *New England Journal of Medicine*. 1989;320:545-50.

⁸ Aronson NE, Santosham M, Comstock GW, et al. Long-term efficacy of BCG vaccine in American Indians and Alaska Natives: A 60-year follow-up study. *Journal of the American Medical Association*. 2004;291(17):2086-91.

⁹ The Antiretroviral therapy cohort collaboration. Incidence of tuberculosis among HIV-infected patients receiving highly active antiretroviral therapy in Europe and North America. *Clinical Infectious Diseases*. 2005;41:1772-1782.

¹⁰ Jones JL, Hanson DL, Dworkin MS, DeCock KM, and the Adult/Adolescent Spectrum of HIV Disease Group. HIV-associated tuberculosis in the era of highly active antiretroviral therapy. *International Journal of TB and Lung Disease*. 2000;4(11):1026-1031.

¹¹ McCombs SB. Tuberculosis mortality in the United States, 1993-2001. Oral presentation at CDC. Atlanta. December 2003.

¹² Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR 1998 Oct 30; 47(RR-20):1-58.

¹³ American Thoracic Society/Centers for Diseases Control and Prevention/Infectious Diseases Society of America. Treatment of tuberculosis. *Am J Respir Crit Care Med* 2003;167:603-662

¹⁴ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines>

¹⁵ Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR 1998 Oct 30; 47(RR-20):1-58.

¹⁶ Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR December 16, 2005 / Vol. 54 / No. RR-15.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.1: Chlamydia screen	
Description: Percentage of patients ¹ with HIV infection who had a test for Chlamydia ² within the measurement year.	
Numerator:	Number of HIV-infected patients who received a test for Chlamydia in the measurement year.
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test, documented in medical record. 2. Patients who are <18 yrs of age⁴ and deny a history of sexual activity. 3. Patients newly enrolled in care during last three months of the measurement year.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient > 18 years or sexually active? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient tested for urethral, rectal and/or cervical Chlamydia during the measurement period? (Y/N)
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic • Medical record data abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% None available at this time.
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of Chlamydia in the clinic population ○ Incidence of pelvic inflammatory disease in the clinic population
Basis for Selection:	
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STD's to treat infections and decrease HIV transmission to sexual partners. Many STD's increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.⁵ STD's can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.^{6,7} STD infections in seronegative partners increase the risk for acquiring HIV because they increase of the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.⁸ Susceptibility to transmission may therefore be enhanced. Chlamydia infection in women may often be asymptomatic but like other STD's can also increase the risk for HIV transmission and enhance transmission susceptibility. Providers should test women for Chlamydia infection at least annually to treat infections and to decrease the risk of Chlamydia and HIV transmission.</p>	

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Identification and treatment of STD's can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).⁷

U.S. Public Health Guidelines:

“During the first visit, consider testing all patients for urogenital chlamydial infection. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk.”⁷

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Vaginal screening is the preferred Chlamydia test for women. Chlamydia screening for men should be site specific using the following guidelines: (a) rectal screening test for men reporting receptive anal sex in the past year; and (b) urine screening test for men reporting insertive only sex in the past year. The preferred method of Chlamydia testing currently is the molecular test also known as nucleic acid amplification tests (NAAT). Other methods that may be used include direct fluorescent antibody stain (DFA), which detects chlamydia antigens, and DNA probe, another test that looks for chlamydia DNA but is less sensitive than NAAT. Testing for *Neisseria gonorrhoeae* (gonorrhea) and *Chlamydia trachomatis* is generally done simultaneously as the two organisms have similar clinical presentations.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

⁵ Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet*

1998;351(suppl 3):5--7

⁶ Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9

⁷ CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24

⁸ DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV-infection, *Sex Transm Infect* **75** (1999), pp. 3–17.

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.2: Gonorrhea screen	
Description: Percentage of adult patients ¹ with HIV infection who had a test for Gonorrhea ² within the measurement year.	
Numerator:	Number of HIV-infected patients who received a test for Gonorrhea in the measurement year.
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test, documented in medical record. 2. Patients who are <18 yrs of age⁴ and deny a history of sexual activity. 3. Patients newly enrolled in care during last three months of the measurement year.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is the patient >18 years or sexually active? (Y/N) <ol style="list-style-type: none"> i. If yes, was the patient screened for urethral, rectal, pharyngeal, and/or cervical gonorrhea during the reporting period? (Y/N)
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic • Medical record data abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% None available at this time.
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of gonorrhea in the clinic population ○ Incidence of pelvic inflammatory disease in the clinic population
Basis for Selection:	
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STDs to treat infections and decrease HIV transmission to sexual partners. Many STDs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.⁵ STDs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.⁶ STD infections in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.⁶ Susceptibility to transmission may therefore be enhanced.</p> <p>Identification and treatment of STDs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks.⁷ There are currently no guidelines that</p>	

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delineate annual testing.

U.S. Public Health Guidelines:

“During the first visit, consider testing all patients for urogenital gonorrhea. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk.”⁸

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Vaginal screening is the preferred Gonorrhea test for women. Gonorrhea screening for men should be site specific using the following guidelines: (a) rectal screening test for men reporting receptive anal sex in the past year; (b) urine screening test for men reporting insertive only sex in the past year; and (c) pharyngeal screening test for men reporting receptive oral sex in the past year. The preferred method of Gonorrhea testing currently is the molecular test also known as nucleic acid amplification tests (NAAT). Other methods that may be used include direct fluorescent antibody stain (DFA), which detects [antigens](#), and DNA probe, another test that looks for DNA but is less sensitive than NAAT. Testing for *Neisseria gonorrhoeae* (gonorrhea) and *Chlamydia trachomatis* is generally done simultaneously as the two organisms have similar clinical presentations.

³ Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁵ Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet*

1998;351(suppl 3):5--7

⁶ Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9

⁷ DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV-infection, *Sex Transm Infect* **75** (1999), pp. 3–17.

⁸ CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24.

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.3: Pneumococcal vaccination													
Description: Percentage of patients ¹ with HIV infection who have received a pneumococcal vaccination within the last 5 years.													
Numerator:	Number of HIV-infected patients who have received a pneumococcal vaccination within the last 5 years.												
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ² at least twice in the measurement year.												
Patient Exclusion:	<ol style="list-style-type: none"> 1. Patients with documented refusal of pneumococcal vaccine. 2. Patients with hypersensitivity to pneumococcal vaccine or its components. 3. Patients newly enrolled in care during last three months of the measurement year. 												
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is there documentation in the chart that the patient received the pneumococcal vaccine within the past five years? (Y/N) b. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of pneumococcal vaccine in medical record in past five years 												
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 												
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% National HIVQUAL-US Data: ³ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>97.7%</td> <td>95.8%</td> <td>97.5%</td> </tr> <tr> <td>Top 25%</td> <td>92.4%</td> <td>90.1%</td> <td>93.0%</td> </tr> </tbody> </table> *from HAB data base		2003	2004	2005	Top 10%	97.7%	95.8%	97.5%	Top 25%	92.4%	90.1%	93.0%
	2003	2004	2005										
Top 10%	97.7%	95.8%	97.5%										
Top 25%	92.4%	90.1%	93.0%										
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of pneumococcal infection in clinical population 												
Basis for Selection:													
Bacterial pneumonia is a common cause of HIV-1 related morbidity. Incidence of approximately 100 cases per 1,000 HIV-1 infected persons per year have been reported, a rate much higher than in the non-infected population. The most consistent predictor of bacterial infections is CD4 cell count. ⁴													

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**U.S. Public Health Guidelines:**

“Adults and adolescents who have a CD4+ T-lymphocyte count of > 200 cells/uL should be administered a single dose of 23-valent polysaccharide pneumococcal vaccine (PPV) if they have not received this vaccine during the previous five years (BII)”. Revaccination can be considered for patients who were initially immunized when their CD4+ T-lymphocyte counts were < 200 cells/uL in response to ART (CIII).⁵

“If earlier vaccination status is unknown, patients in this group [immunocompromised, including HIV] should be administered pneumococcal vaccine.”⁶

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁴ Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15).

⁵ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. April 10, 2009,58.
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

⁶ Centers for Disease Control and Prevention. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP) – MMWR April 4, 1997, Vol 46, No. RR-8. [Update for cochlear implants] MMWR August 8, 2003 52(31) [Update for Adults for PPSV23] MMWR September 2, 2010, 59(34) [for Children and high risk adolescents to 18] MMWR December 10, 2010, 59; pp 13

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.4: Influenza vaccination	
Description: Percentage of HIV-infected patients ¹ who received influenza vaccination within the measurement year ²	
Numerator:	Number of HIV-infected patients who received influenza vaccination within the measurement year.
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of influenza vaccine documented in the chart. 2. Hypersensitivity to influenza vaccine or allergy to its components including thimerosal, chicken protein, and egg protein. 3. Previous diagnosis of Guillain-Barre Syndrome. 4. Patients newly enrolled in care during last three months of the measurement year.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) 2. If yes, is there documentation in the chart that the patient received influenza vaccine in the past 12 months? (Y/N) <ol style="list-style-type: none"> a. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of Influenza vaccine in medical record in measurement year
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% None available at this time
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Mortality rates from influenza and pneumonia in the clinical population
Basis for Selection:	
<p>Influenza viruses cause disease among all age groups. While rates of infection are highest among children, rates of serious illness and death are highest among persons aged > 65 years, children less than two years, and persons of any age who have medical conditions that place them at increased risk for complications of influenza, including HIV.⁴</p> <p>Influenza vaccination is the primary method for preventing influenza and its severe complications.⁴</p>	

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Vaccination has been demonstrated to produce substantial antibody titers against influenza among vaccinated HIV-infected persons who have minimal AIDS-related symptoms and high CD4+ T-lymphocyte cell counts.³

U.S. Public Health Guidelines:

“As indicated in this report from the Advisory Committee on Immunization Practices (ACIP), annual influenza vaccination is now recommended for...adults and children who have required regular medical

follow-up or hospitalization during the preceding year because of ...immunodeficiency (including...human immunodeficiency virus).”⁴

“Because influenza can result in serious illness and because vaccination with inactivated influenza vaccine might result in the production of protective antibody titers, vaccination might benefit HIV-infected persons, including HIV-infected pregnant women. Therefore, influenza vaccination is recommended.”⁴

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Due to the unique nature of this measure and Influenza season/vaccine administration, the measurement period runs from April 1-March 31

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations from the Advisory committee on Immunization Practices (ACIP). MMWR2011; 60(33); pp 1128-1132 2010; 59(rr08); pp 1-62 59(31); pp 989-992.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.5: Hepatitis B screening	
Description: Percentage of patients ¹ for whom Hepatitis B screening was performed at least once since the diagnosis of HIV-infection.	
Numerator:	Number of HIV-infected patients who have documentation of Hepatitis B status ² since HIV diagnosis or initiation of care with provider.
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patient refusal of test. 2. Patients newly enrolled in care during last three months of the measurement year.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, is their documentation of Hepatitis B serologic status in the medical record? (Y/N)
Data Sources:	<ul style="list-style-type: none"> ○ Electronic Medical Record/Electronic Health Record ○ CAREWare, Lab Tracker, or other electronic data base ○ Medical record data abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% None available at this time.
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Incidence of Hepatitis B in clinic population ○ Hepatitis B-related morbidity and mortality in the clinic population
Basis for Selection:	
<p>Hepatitis B virus (HBV) is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection-drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic Hepatitis B, as evidenced by the detection of Hepatitis B surface antigen (HBsAg) in the serum persisting for a minimum of six months.⁴</p> <p>HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable Hepatitis B e antigen (HBeAg), accelerated loss of protective hepatitis B surface antibody (anti-HBs), and increased risk for liver-related mortality and morbidity.⁴</p> <p>Co-infection with HIV and HBV can complicate the care and treatment of HIV, and guide the selection of medications for ART.</p>	

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**U.S. Public Health Guidelines:**

“It is not clear that treatment of hepatitis B virus (HBV) improves the course of HIV, nor is there evidence that treatment of HIV alters the course of HBV. However several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV co-infection. Therefore, providers should know the HBV status of all patients with HIV. This also will guide the choice of medications for HIV treatment in the context of any possible HBV treatment. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”^{4,5}

References/Notes:

¹ “Patients” include all patients aged 13 years or older.

² Serologic tests to evaluate for Hepatitis B immunity and chronic Hepatitis B include:

- Hep B Surface Antigen (+/-)
- Hep B Surface Antibody (+/-)
- Additional markers: Hep B Core Antibody (IgG or IgM), Hep B e Antigen

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

⁵ Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.6: Substance use assessment																	
Description: Percentage of patients ¹ with HIV infection who have been assessed for substance use (alcohol and illicit substances) in the measurement year.																	
Numerator:	Number of patients with HIV infection who were assessed for substance use ² within the measurement year.																
Denominator:	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year																
Patient Exclusions:	1. Patients newly enrolled in care during last three months of the measurement year.																
Data Element:	1. Is the patient HIV-positive? (Y/N) a. If yes, was the patient assessed for substance use during the reporting period with documentation in medical record? (Y/N)																
Data Sources:	<ul style="list-style-type: none"> ○ Electronic Medical Record/Electronic Health Record ○ CAREWare, Lab Tracker, or other electronic data base. ○ HIVQUAL reports on this measure for grantee under review ○ Medical record data abstraction by grantee of a sample of records. 																
National Goals, Targets, or Benchmarks for Comparison:	DHSP Benchmark: 90% IHI Goal: 90% ^{4,5} National HIVQUAL-US Performance Data: ⁴ <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>92.3%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>74.4%</td> <td>86.4%</td> <td>92.7%</td> </tr> </tbody> </table> *from HAB data base		2003	2004	2005	Top 10%	100%	100%	100%	Top 25%	92.3%	100%	100%	Median*	74.4%	86.4%	92.7%
	2003	2004	2005														
Top 10%	100%	100%	100%														
Top 25%	92.3%	100%	100%														
Median*	74.4%	86.4%	92.7%														
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Substance use-related mortality rates ○ Rate of substance use-related hospitalizations ○ Rate of substance use referrals 																
Basis for Selection:																	
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. It is important to identify co-morbid illness such as substance use, which may complicate ongoing HIV treatment.																	
U.S. Public Health Guidelines:																	
“The chronic and relapsing nature of substance abuse as a biologic and medical disease, compounded by the high rate of mental illness, additionally complicates the relationship between health care workers and IDU. The first step in provision of care and treatment for these individuals is the recognition of the existence of a substance abuse problem. Whereas this is often open and obvious, patients may hide such behaviors from clinicians. Assessment of the patient for the presence of substance abuse should be part of routine medical history taking and																	

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should be done in a clinical, straightforward, and nonjudgmental manner”⁶

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Substance abuse assessment: prior history of substance use and abuse, prior substance abuse treatment, current use/abuse of substances. If patient has no history of substance abuse, annual monitoring for changes in substance use patterns is indicated.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ IHI Measure reads, “Percent of Patients/Patients Assessed for Substance Use and/or Tobacco Use in the Past 12 Months.”

<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientsAssessedforSubstanceUseandorTobaccoUseinthePast12Months.htm>.

⁵ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

⁶ Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.7: Mental health assessment																	
Description: Percentage of patients ¹ with HIV infection who have had a mental health assessment in the measurement year.																	
Numerator:	Number of HIV-infected patients who received a mental health assessment ² in the measurement year.																
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ³ at least twice in the measurement year.																
Patient Exclusions:	1. Patients newly enrolled in care during last three months of the measurement year.																
Data Element:	1. Is the patient HIV-positive? (Y/N) a. If yes, did the patient receive a mental health assessment during the reporting period? (Y/N)																
Data Sources:	<ul style="list-style-type: none"> ○ Electronic Medical Record/Electronic Health Record ○ CAREWare, Lab Tracker, or other electronic data base. ○ HIVQUAL reports on this measure for grantee under review ○ Medical record data abstraction by grantee of a sample of records. 																
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Top 10%	100%	100%	80.6%														
Top 25%	93.0%	89.5%	35.1%														
Median*	72.9%	66.7%	2.2%														
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Rate of mental health referrals ○ Mental health-related hospitalizations ○ Rate of suicide in the clinic population ○ Rate of mental health disorders being treated in the clinic population 																
Basis for Selection:																	
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. Mental health is an important predictor of ART adherence, and therefore may play a substantial role in a patient's ability to attain viral suppression on HIV medication. ⁵																	
U.S. Public Health Guidelines:																	
"Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and alter outcomes. Once evaluated, these factors should be managed accordingly." ⁶																	

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

References/Notes:

¹“Patients” include all patients aged 13 years or older.

² Mental health screen: documentation of prior mental illness, prior treatment of mental illness, documentation of any current mental health symptoms. If patient has no history of prior mental illness, annual monitoring for symptoms of mental illness (i.e. depression/anxiety) is indicated.

³ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁴ <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>. The Mental Health/Substance Use Subcommittee of the National HIVQUAL Clinical Advisory Committee include the following components for an annual Mental Health Screening for people with HIV: Cognitive function assessment, including mental status; Depression screening; Anxiety screening; Sleeping habits assessment; Appetite assessment; Domestic violence screening; Post Traumatic Stress Disorder screening; Psychiatric history (optional); Psychosocial assessment (optional)

⁵ Mellins CA, Havens JF, McDonnell C, et. al *AIDS Care*. 2009 Feb;21(2):168-77.

⁶ Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**Clinical Performance Measures for Adult /Adolescent Patients:
Supplemental Measures – Part A**

Performance Measure 2.8: Hepatitis B vaccination	
Description: Percentage of patients ¹ with HIV infection who completed the vaccination series for Hepatitis B.	
Numerator:	Number of HIV-infected patients with documentation of having ever completed the vaccination series for Hepatitis B ^{2,3} .
Denominator:	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges ⁴ at least twice in the measurement year
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients newly enrolled in care during the last 3 months of the measurement year. 2. Patients with evidence of current HBV infection (Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody, or Hep B DNA). 3. Patients with evidence of past HBV immunity (Hep B Surface Antibody). 4. Patients with documented refusal of Hepatitis B vaccine in medical record.
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, does the patient have documentation of Hepatitis B immunity or HBV-infection? (Y/N) <ol style="list-style-type: none"> i. If no, is there documentation that the patient has completed the vaccine series for Hepatitis B?(Y/N) ii. Documentation includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of vaccine dose(s) in medical record, or combination of outside records and medical records to achieve three doses of vaccine
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	<p>DHSP Benchmark: 90%</p> <p>Published data from the HIV Outpatient Study (HOPS) reports 17% of patients with HIV-infection who were eligible for vaccination received at least three doses of vaccine.⁵</p> <p>“Hepatitis B vaccination coverage among adults at high risk...[was] 45% in 2004.”⁶</p>

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Outcome Measures for Consideration:	<ul style="list-style-type: none"> ○ Incidence of Hepatitis B infection in the clinic population
Basis for Selection:	
<p>HBV is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection-drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic Hepatitis B, as evidenced by the detection of HBsAg in the serum persisting for a minimum of six months.³</p> <p>HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable HBeAg, accelerated loss of anti-HBs, and an increased risk for liver-related mortality and morbidity.^{3,7}</p> <p>There is a protective antibody response in approximately 30% to 55% of healthy adults aged ≤40 years after the first dose of vaccine. After age 40, the proportion of persons with a protective antibody response after a three-dose vaccination regimen declines. In addition to age, other host factors (e.g., smoking, obesity, genetic factors, and immune suppression) contribute to decreased vaccine response. Response to Hepatitis B vaccination also is reduced in other immune-compromised persons (e.g., HIV-infected persons, hematopoietic stem-cell transplant recipients, and patients undergoing chemotherapy).</p> <p>Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.</p>	
U.S. Public Health Guidelines:	
<p>“Several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV co-infection. Therefore, providers should know the HBV status of all patients with HIV. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”³</p>	
References/Notes:	
<p>¹“Patients” include all patients aged 13 years or older.</p> <p>² Patients in the middle of the vaccination series on 12/31/x would not be captured in the numerator in year x. They would, if the series was completed on schedule, be captured in year x+1.</p> <p>³ Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from</p>	

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CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

⁴ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

⁵ Tedaldi EM, Baker RK, Moorman AC, Wood KC, Fuhrer J, McCabe RE, Holmberg SD; HIV Outpatient Study (HOPS) Investigators. Hepatitis A and B vaccination practices for ambulatory patients infected with HIV. *Clinical Infectious Diseases*. 2004 May 15;38(10):1478-84.

(<http://www.journals.uchicago.edu/CID/journal/issues/v38n10/32448/32448.web.pdf>)

⁶ Centers for Disease Control and Prevention. Hepatitis B Vaccination Coverage Among Adults—United States, 2004. *MMWR* 2006;55:509-11

(<http://www.cdc.gov/mmwr/PDF/wk/mm5518.pdf>)

⁷ Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011. Available at

<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.9: Tobacco cessation counseling																																				
Description: Percentage of patients ¹ with HIV infection who received tobacco cessation counseling within the measurement year.																																				
Numerator:	Number of HIV-infected patients who received tobacco cessation counseling within the measurement year.																																			
Denominator:	Number of HIV-infected patients who: <ul style="list-style-type: none"> • Used tobacco products within the measurement year, and • had a medical visit with a provider with prescribing privileges² twice within the measurement year 																																			
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients who deny tobacco use throughout the measurement year. 2. Patients newly enrolled in care during last three months of the measurement year. 																																			
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-positive? (Y/N) <ol style="list-style-type: none"> a. If yes, did the patient use tobacco during the reporting period? (Y/N) <ol style="list-style-type: none"> i. If yes, did the patient receive tobacco cessation counseling documented in the medical record during the reporting period? (Y/N) 																																			
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records 																																			
National Goals, Targets, or Benchmarks for Comparison:	<p>DHSP Benchmark: 90%</p> <p>National HIVQUAL-US Data:³</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> <th>2007</th> <th>2009</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>93.3%</td> <td>97.8%</td> <td>98.4%</td> <td>100%</td> <td></td> <td></td> </tr> <tr> <td>Median*</td> <td>75.8%</td> <td>90.0%</td> <td>88.2%</td> <td>91.7%</td> <td>93.0%</td> <td>94.1%</td> </tr> <tr> <td>Bottom 10%</td> <td></td> <td></td> <td></td> <td></td> <td>45.5%</td> <td>50.0%</td> </tr> </tbody> </table> <p>*from HAB data base</p>		2003	2004	2005	2006	2007	2009	Top 10%	100%	100%	100%	100%	100%	100%	Top 25%	93.3%	97.8%	98.4%	100%			Median*	75.8%	90.0%	88.2%	91.7%	93.0%	94.1%	Bottom 10%					45.5%	50.0%
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Bottom 10%					45.5%	50.0%																														
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Rate of head and neck, and lung cancer ○ Rate of tobacco use in the clinical population 																																			

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Basis for Selection:

After Kaposi sarcoma and non-Hodgkin lymphoma, lung cancer is the most common cancer among HIV-infected individuals, with an incidence rate that is two to three times higher among HIV-infected individuals than in the general population.⁴ Risk factors associated with an increased risk for bacterial pneumonia, include low CD4+ count, injection-drug use, and cigarette smoking (454).

As tobacco use among HIV-infected patients poses significant health risks, tobacco-dependent patients should be provided assistance to enroll in smoking cessation programs. Various studies have shown that brief interventions by the clinician to encourage tobacco cessation and offer substitution programs can decrease smoking rates⁵ and tobacco use.⁶ Cessation reduces the risk of incidence or the progression of tobacco-related diseases and increases life expectancy.^{7,8,9} HIV care providers should provide cessation assistance in the form of counseling, pharmacotherapy, or referral to cessation programs.

Tobacco use in all forms is the biggest risk factor for oral cancer. Alcohol abuse combined with tobacco use increases risk. Clinicians should be alert to the possibility of oral cancer when treating patients who use tobacco or alcohol. Patients should be encouraged to not use tobacco and to limit alcohol use in order to decrease their risk for oral cancer as well as heart disease, stroke, lung cancer, and cirrhosis.¹⁰

The U.S. Preventive Services Task Force (USPSTF)¹¹ recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco Products, (*Grade: A Recommendation*) and that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke. (*Grade: A Recommendation*).

This USPSTF recommendation applies to adults 18 years or older and all pregnant women regardless of age. The USPSTF plans to issue a separate recommendation statement about counseling to prevent tobacco use in non-pregnant adolescents and children. Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone “quit lines.” Combination therapy with counseling and medications is more effective at increasing cessation rates than either component alone. Pharmacotherapy approved

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by the U.S. Food and Drug Administration and identified as effective for treating tobacco dependence in nonpregnant adults includes several forms of nicotine replacement therapy (gum, lozenge, transdermal patch, inhaler, and nasal spray), sustained-release bupropion, and varenicline.

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References/Notes

¹“Patients” include all patients aged 13 years or older.

²A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³HIVQUAL-US <http://hivqualus.org/>

⁴Meredith S. Shiels, PhD1, Stephen R. Cole, PhD2, Shruti H. Mehta, PhD1, and Gregory D. Kirk, PhD MD. Lung cancer incidence and mortality among HIV-infected and HIV-uninfected injection drug users. *J Acquir Immune Defic Syndr*. 2010 December 1; 55(4): 510–515. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2974802/pdf/nihms-237366.pdf>

⁵Page AR, Walters DJ, Schlegel RP, Best JA. Smoking cessation in family practice: The effects of advice and nicotine chewing gum prescription. *Addict Behav* 1986;11(4):443-6.

⁶Demers RY, Neale AV, Adams R, Trembath C, Herman SC. The impact of physicians' brief smoking cessation counseling: A MIRNET study. *J Fam Pract* 1990;31(6):625-9.

<http://thorax.bmj.com/content/55/12/987.full.pdf+html>

<http://jama.ama-assn.org/content/278/21/1759.full.pdf+html>

⁷Rigotti NA. Treatment of tobacco use and dependence. *N Engl J Med* 2002;346:506-512.

⁸Lancaster T, Stead L, Silagy C, Sowden A. Effectiveness of interventions to help people stop smoking: findings from the Cochrane Library. *BMJ* 2000;321:355-8.

⁹Methods, Successes, and Failures of Smoking Cessation Programs E B Fisher Jr., E Lichtenstein, D Haire- Joshu, G D Morgan, H R Rehberg *Annual Review of Medicine*, February 1993, Vol. 44, Pages 481-513.

¹⁰Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR* 2009;58(No. RR-4)

http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009

¹¹Guide to Clinical Preventive Services, 2010-2011, Recommendations of the U.S. Preventive Services Task Force, p 43- 44 <http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf>

Available at: <http://www.ahrq.gov/clinic/pocketgd.htm>

Detailed reviews and recommendations about clinical interventions for tobacco cessation are available in the U.S. Public Health Service Clinical Practice Guideline “Treating Tobacco Use and Dependence: 2008 Update” (available at <http://www.surgeongeneral.gov/tobacco>). Tobacco-related recommendations from the Centers for Disease Control and Prevention’s Guide to Community Preventive Services are available at:

<http://www.thecommunityguide.org/tobacco/index.html>. This USPSTF recommendation was first published in: *Ann Intern Med*. 2009; 150:551-555.

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Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part B

Performance Measure 2.10: Medical visits	
Description: Percentage of HIV-infected patients who are enrolled in outpatient medical services who had a medical visit with a provider ¹ with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting ² two or more times at least 3 months apart in the measurement year.	
Numerator:	Number of HIV-infected patients who had a medical visit with an HIV provider with prescribing privileges, i.e., MD, PA, NP, two or more times at least 3 months apart in the measurement year.
Denominator:	Number of HIV infected patients who were enrolled in outpatient medical services in the measurement year.
Patient Exclusions	<ol style="list-style-type: none"> 1. Patients newly enrolled in care during the last six months of the measurement year. 2. Patients who were incarcerated during the measurement year. 3. Patients enrolled in another clinic during the last 6 months of the measurement year.
Data Element:	<ol style="list-style-type: none"> 2. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> b. If yes, is the patient enrolled in outpatient medical care? (Y/N) <ol style="list-style-type: none"> 2. If yes, did the patient have a medical visit with an HIV provider two or more times, at least 3 months apart within the measurement year?
Data Sources:	Casewatch
National Goals, Targets, or Benchmarks for Comparison	<p>DHSP Benchmark: 90%</p> <p>No national benchmarks identified at this time.</p>
Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Rate of patient retention in care ○ Rate of HIV related hospitalizations in the measurement year ○ Rate of HIV related emergency room visits in the measurement year ○ Rate of opportunistic infections in the measurement year ○ Mortality rates
Basis for Selection:	

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Numerous studies describe the adverse impacts of poor retention in care on patient outcomes. In particular, poor retention in care is associated with the following outcomes: decreased likelihood of receiving antiretroviral therapy; higher rates of antiretroviral therapy failure; increased HIV transmission risk behavior; increased hospitalization rates; and worse survival.

Patients with greater initial retention in care had the greatest survival over 5 years of follow-up, and patients with the worst initial retention had the poorest survival³ Treatment guidelines recommend to test CD4 at entry into care then follow-up every 3-6 months before ART, every 3-6 months when on ART, then, in clinically stable patients with suppressed viral load, CD4 count can be monitored every 6-12 months.⁴ For adherent patients with suppressed viral load and stable clinical and immunologic status for >2-3 years, some experts may extend the interval for HIV RNA monitoring to every 6 months.

All patients who are clinically stable should be monitored at least every 4 months; this includes both patients who are receiving ART and those who are not. Visits may require more frequent scheduling at entry to care, for management of acute problems, or when starting or changing ART regimens.⁵

Patients infected with HIV face a complex array of medical, psychological, and social challenges. A strong provider-patient relationship, the assistance of a multidisciplinary care team, and frequent office visits are key aspects of care. Through both the specific services they provide and their overall approach to patients, clinics can have a substantial impact on the quality of care for HIV-infected persons.⁶

Greater experience among primary care physicians in the care of persons with AIDS improves survival.⁷

References/Notes:

¹ A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV (antiretroviral) therapy.

² An HIV care setting is one which received Ryan White Program funding to provide HIV care and has a quality management program to monitor the quality of care addressing gaps in quality of HIV care.

³ Giordano, TP. Perspective: Retention in HIV Care: What the Clinician Needs to Know. *Top Antivir Med* 2011; 19(1):12-16, IAS-USA

⁴ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1-167. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed [1/23/2012] [p. 6, Table 3. Laboratory Monitoring Schedule for Patients Prior to and After Initiation of Antiretroviral Therapy (Updated January 10, 2011)].

⁵ New York State Department of Health. Primary care approach to the HIV-infected patient. New

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York: New York State Department of Health AIDS Institute: www.hivguidelines.org; April 2011 update. p. 1. <http://www.hivguidelines.org/Content.aspx?pageID=257>

⁶AETC National Resource Center. Guide for HIV/AIDS Clinical Care. U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. January, 2011. Available at: <http://www.aidsetc.org/aidsetc?page=cg-00-00> Accessed February, 1, 2012.

⁷Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. J Gen Intern Med. 2003 Feb;18(2):157-8.

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**Clinical Performance Measures for Adult /Adolescent Patients:
Supplemental Measures – Part B**

Performance Measure 2.11: Viral load suppression < 200 copies/mL when on ART									
Description: Percentage of HIV-infected patients on ARV therapy 12 weeks or more before last viral load and with at least one viral load test, with the last viral load undetectable or <200 copies/mL in the measurement year.									
Numerator:	Number of HIV-infected patients on ARV therapy 12 weeks or more before last viral load and with at least one viral load test, with the last viral load undetectable or < 200 copies/mL in the measurement year.								
Denominator:	Number of HIV-infected patients on ARV therapy 12 weeks or more before last viral load test during the measurement year.								
Patient Exclusions:	<ol style="list-style-type: none"> 1. Patients who are not on ARV therapy. 2. Patients who do not have a viral load test after 12 weeks or more of ARV therapy. 3. Patients who were incarcerated during the measurement year. 4. Patients who are newly enrolled in care within the last 3 months of the measurement year. 								
Data Element:	<ol style="list-style-type: none"> 1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> a. If yes, was the patient on ARV therapy at least 12 weeks or more? (Y/N) <ol style="list-style-type: none"> i. If yes, did the patient have at least one viral load test? (Y/N) <ol style="list-style-type: none"> 1. If yes, was the last viral load test undetectable ('<') or <200 copies/mL (list the date and result). 								
Data Sources:	<ul style="list-style-type: none"> • Electronic Medical Record/Electronic Health Record • Medical/laboratory record data abstraction of a sample of records • Health Way LA Data System 								
National Goals, Targets, or Benchmarks for Comparison	<p>DHSP Benchmark: 80%</p> <p>National HIVQUAL-US Data: ⁴ Last viral load undetectable or <200, among patients on ARV therapy >12 weeks</p> <table border="1"> <tbody> <tr> <td></td> <td>2009</td> </tr> <tr> <td>Top 10%</td> <td>94.1%</td> </tr> <tr> <td>Median</td> <td>78.6%</td> </tr> <tr> <td>Bottom 10%</td> <td>50%</td> </tr> </tbody> </table>		2009	Top 10%	94.1%	Median	78.6%	Bottom 10%	50%
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Bottom 10%	50%								

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Outcome Measures for Consideration	<ul style="list-style-type: none"> ○ Rate of opportunistic infections in the measurement year ○ Rate of patients with progression to AIDS in the measurement year ○ Mortality rates ○ Virologic suppression rates (In+Care Campaign http://www.incarecampaign.org/)
Basis for Selection:	
<p>The plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment as viral load is the most important indicator of response to ART⁵.</p> <p>Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>	
Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents:	
<p>Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART) (AI). Analysis of 18 trials that included more than 5,000 participants with viral load monitoring showed a significant association between a decrease in plasma viremia and improved clinical outcome [1]. Thus, viral load testing serves as a surrogate marker for treatment response [2] and can be useful in predicting clinical progression [3-4]. The minimal change in viral load considered to be statistically significant (2 standard deviations) is a threefold, or a 0.5 log₁₀ copies/mL change.</p> <p>Optimal viral suppression is generally defined as a viral load persistently below the level of detection (<20–75 copies/mL, depending on the assay used). However, isolated “blips” (viral loads transiently detectable at low levels, typically <400 copies/mL) are not uncommon in successfully treated patients and are not thought to represent viral replication or to predict virologic failure [5]. In addition, low-level positive viral load results (typically <200 copies/mL) appear to be more common with some viral load assays than others, and there is no definitive evidence that patients with viral loads quantified as <200 copies/mL using these assays are at increased risk for virologic failure [6-8]. For the purposes of clinical trials the AIDS Clinical Trials Group (ACTG) currently defines virologic failure as a confirmed viral load >200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability [9]. This definition may also be useful in clinical practice. (See Virologic and Immunologic Failure.)</p> <p>At Initiation or Change in Therapy. Plasma viral load should be measured before initiation of therapy and preferably within two to four weeks, and not more than eight weeks, after treatment initiation or after treatment modification. Repeat viral load measurement should be performed at four to eight week intervals until the level falls below the assay’s limit of detection.</p>	

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In Patients Who Have Viral Suppression but Therapy Was Modified Due to Drug Toxicity or Regimen Simplification. Viral load measurement should be performed within two to eight weeks after changing therapy. The purpose of viral load monitoring at this point is to confirm potency of the new regimen.

In Patients on a Stable Antiretroviral Regimen. Viral load should be repeated every three to four months or as clinically indicated. In adherent patients who have suppressed viral loads for more than two to three years and who are at stable clinical and immunological status, some clinicians may extend the interval to every six months.

Monitoring in Patients with Suboptimal Response. In addition to viral load monitoring, a number of additional factors should be assessed, such as no adherence, altered pharmacology, or drug interactions. Patients who fail to achieve viral suppression should undergo resistance testing to aid in the selection of an alternative regimen.⁵

References/Notes:

Guidelines state that viral load should be measured at least every three to four months depending on the stage of the disease. The timeframe of six months was determined by clinical expert consensus for the purpose of this measure, but can and should be measured at more frequent intervals if needed.

¹“Patients” include all patients aged 13 years or older.

²A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

³IHI Measure reads, “Percent of Patients/Patients with a Viral Load Test in the Past 4 Months.” <http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentofpatientswithvirallloadtestinthepast4months.htm>.

⁴ HIVQUAL-US Performance Data Report for Ryan White Part C and Part D Funded Programs (January 1, 2009 to December 31, 2009) <http://hivqualus.org/index.cfm/22/10039>

⁵ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1–167. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed [1/23/2012].

Appendix 2

**LA County: Mercer, *Medical Clinical Fee-for-Service Reimbursement Rate Study*
(2008)**

MERCER

Government Human Services Consulting



Office of AIDS Programs and Policy

Medical Clinical Fee-for-Service Reimbursement Rate Study

July 2008

Final Report

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Appendix F: Data Request and ESIS Form (January 2008)

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1

Executive Summary

The Los Angeles County Department of Health Services' Office of AIDS Programs and Policy (OAPP) directs the overall response to the HIV/AIDS epidemic in the County of Los Angeles under the supervision of the Los Angeles County Board of Supervisors. As part of its mandate, OAPP manages hundreds of contracts with dozens of agencies to provide high quality and cost-effective services to HIV-positive and AIDS-infected residents of the County of Los Angeles. Currently, OAPP reimburses its contracted outpatient medical clinics through a traditional line-item budget process. The Board of Supervisors required OAPP to consider a cost reimbursement methodology that would encourage provider accountability and productivity, track utilization more effectively, and ensure that providers are utilizing other funding resources, such as Medi-Cal, when available. Specifically, the primary medical care services for which the Board of Supervisors and OAPP initially intended to develop a fee-for-service (FFS) cost reimbursement methodology included:

- Ambulatory/Outpatient Medical Care (AOM)
- AIDS Drug Assistance Program (ADAP)
- Drug Resistance Testing
- Medical Case Management
- Medical Specialty
- Nutritional Counseling (Medical Nutritional Therapy)

The study specifications initially requested a service description and rate of reimbursement for referrals to Medical Specialty services. Mercer Government Human Services Consulting (Mercer) initially produced both a service description and rate of reimbursement for this referral service. However, Public Health Services (PHS) standards of care dictate that specialty services must be accessible to the HIV-positive client by the primary care provider. The service description developed for HIV/AIDS AOM, which considered the PHS requirements, requires referral standards for Medical Specialty care. A separate Medical Specialty service description results in redundant requirements. Mercer recommended Medical Specialty services not be funded as a

separate service description. Continuing to fund it separately would result in duplicative payment for the same service requirement under two service descriptions. Therefore, this report contains no rate recommendations for a separately reimbursed referral to Medical Specialty.

OAPP-funded providers have been successful in negotiating locally-derived rates of reimbursement that financially create access to these expensive services. Mercer recommends that special relationships between primary care and specialty care providers not be interrupted. Where there are no special relationships between providers for a needed specialty care service, Mercer recommends that rates of reimbursement should not exceed the Medicare/Medi-Cal established rates. Conceding to the Medicaid/Medicare rates (where there is no opportunity for rates derived through special relationships) is an established practice in publicly-funded HIV/AIDS primary health care.

Likewise, the PHS HIV/AIDS standards of care for drug resistance testing were changed to incorporate drug resistance testing and counseling as a routine component of HIV-related primary health care. Therefore, and in interest of maintaining recommendations that are current with the PHS standards, Mercer recommended the service description for Drug Resistance Testing not be funded as a separate service description, but rather be included as a routine requirement within the HIV/AIDS AOM Care service description. No rate recommendation for a separately reimbursed Drug Resistance Testing service is included in this report.

Further, during the time frame included in this study, Medical Case Management was being closely scrutinized by OAPP and the Commission on HIV. Because the configuration of services included in Medical Case Management was under review, this report contains no rate recommendation for a separately reimbursed Medical Case Management service.

The services for which Mercer set rates and developed service descriptions that are included in this report include:

**Outpatient Medical Care Services
Service Description and Rate Development**

- Ambulatory/Outpatient Medical Care (AOM)
- AIDS Drug Assistance Program (ADAP)
- Nutritional Counseling (Medical Nutritional Therapy)

Objectives of this study included:

- Review of national and local standards of care
- Review of the Los Angeles HIV/AIDS Continuum of Care Model included in the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)*
- Survey of other eligible metropolitan areas (EMAs) that have a FFS program
- Survey of current practice regarding coding of procedures and diagnosis among HIV/AIDS outpatient medical clinic providers
- Analysis of the costs of providing outpatient medical services based on the accepted standards of care
- Preparation of recommendations of FFS rates for the identified outpatient medical services
- Identification of services that are commonly reimbursed by third-party payers
- Identification of barriers to implementation
- Recommended guidelines for collection of fees

Based on a competitive bid for Work Order Request No. 6-49 issued in December 2003 by the Department of the Auditor-Controller of the County of Los Angeles, Mercer was engaged to complete this study and meet the aforementioned Board of Supervisors/OAPP objectives.

Direct-Care, Staff-Driven Rate Architecture

Mercer's direct-care, staff-driven rate architecture, tailored to the needs and objectives of OAPP, was utilized to complete this study. The four standard cost components included in this architecture are direct service staff wage, employment-related expenditures, program-related expenditures and general and administrative expenditures.

The rate architecture is a unique approach to reimbursement for health services in that it emphasizes "hands on" staff resources provided to the people receiving services and varies according to the professional level and quantity of staff time. Three key principles serve as the foundation for this system:

1. The most prominent and important variable in the determination of quality and the successful adherence to care standards is the direct service staff profile.
2. All other cost components, which are equally necessary, although less directly variable in response to differences in standards of care, can be expressed in relationship to direct service staff costs.
3. If all the compensation components are studied and their relationships to direct service staff cost profiles are determined, a standardized rate system can be produced by establishing the direct service staff profiles (in accordance with standards of care) and then building the total compensation (rate) according to the relationships of the other components to the service staff costs.

Study Methodology

The methodology adopted for this study has been specifically designed and successfully tested in numerous environments and jurisdictions to ensure reliability and soundness of the rates and a strong linkage to appropriate standards of service. In general, the methodology consists of the following steps:

- Review of study methodology with providers
- Collection and analysis of available information including clinical standards, best practices, California and national regulations and codes, provider cost reports, and provider general ledgers
- Development of service descriptions for each service category
- Completion of provider survey, interviews, and on-site reviews to collect additional information
- Establishment of costs associated with direct service staffing levels
- Calculation of cost components to be incorporated into the rate architecture including employment-related expense, program-related expenses and general and administrative expense percentages
- Synthesis of draft rates based on the combination of the various cost components
- Completion of budget impact and provider impact analysis
- Finalization of rates

The rate architecture for AOM is discussed in general below followed by a brief outline of the rate development for ADAP and Nutritional Counseling. Specific rate development processes are more fully outlined in Section 4.

For AOM services, the direct-care, staff-driven rate architecture is based on a blend of costs associated with physicians, physician assistants and nurse practitioners (referred to as physician-like professionals) who provide direct client services. Costs associated with these positions were provided by providers through submission of general ledgers and completion of an Encounter and Staff Information Sheet (ESIS) (Appendix F) in late January and early February 2008. The direct service wage utilized in the study was \$147,519. This was based on provider information reported on the ESIS for physicians, physician assistants, and nurse practitioners and then trended forward to the anticipated start of the year of implementation.

The remaining cost components – employment-related, program-related and general and administrative – were each calculated as a percentage of the direct care physician-like average wage based on providers' general ledger and ESIS information as described below.

The employment-related percentage was based on the average of five providers whose general ledger data was deemed complete enough for use in the study. Mercer used the

most recent general ledger year provided. For three providers, the time frame was March 1, 2006 to February 28, 2007. For one, the time frame was July 1, 2006 to June 30, 2007. For the last provider, it was January 1, 2006 to December 31, 2006. Mercer totaled the dollars from all providers in the employment-related category and divided by the total dollars for all providers for direct care professionals (physicians, physician assistants and nurse practitioners). The employment-related percentage used in Mercer's calculation was 42.07% of the direct service staff wage.

The program-related percentage was based on the average of the same five providers' general ledgers' information and was calculated in the same way as the employment-related percentage, i.e., based on the total dollars and not the average of the percentages. The program-related percentage used in Mercer's calculation was 228.04% of the direct service staff wage.

The general and administrative percentage was based on the average of four providers' general ledgers' information. One provider's general and administrative expenses were 2.5 times higher (as a percentage) than the next closest provider and the providers' general and administrative dollars were held out of the calculation. The general and administrative percentage used in Mercer's calculation was 31.7% of the total, or 171.79% of the direct service staff wage.

For the ADAP and Nutritional Counseling services, Mercer utilized wage information available from the US Department of Labor's Bureau of Labor Statistics (BLS) for the Los Angeles metropolitan area. The remaining cost components – employment-related, program-related and general and administrative – were each calculated as a percentage of the direct care wage based on a combination of providers' submission of cost reports, BLS information and professional estimates.

Stakeholder Input

In April 2004, OAPP and Mercer provided an overview of the scope of the study to HIV/AIDS outpatient medical care providers. Virtually all of the currently contracted providers had representation at the meeting.

Input on Financial Information

After the orientation meeting, Mercer conducted a series of nine separate telephone interviews with providers of services to gain a better understanding of the financial operations of the providers. The interviews provided complementary and anecdotal information in order to support the calculations that had been performed to derive cost components (employment-related expenditures and program-related expenditures).

Interviewees included two different individuals from AIDS Healthcare Foundation, two separate interviews with two different staff from Harbor UCLA Medical Center and two staff with Northeast Valley Health Corporation. Also interviewed were The LA Gay and

Lesbian Community Center, AltaMed Health Services Corporation and the Rand Schrader clinic. There were a series of phone calls with smaller providers that were not performed in the depth of those mentioned above.

Subsequent to this provider input, two Mercer staff visited eight provider sites in January 2007. The providers were asked to submit general ledgers with specific expenditure line-item detail. Nine providers submitted the general ledger information. The interview information and general ledger information were synthesized into an analysis resulting in revisions to the rates originally prepared.

The rates were published in a draft report on the OAPP website in October 2007 and an all-provider meeting was held on October 31, 2007. Providers voiced concerns at the meeting and were given until mid-January 2008 to submit written comments.

As a result of provider verbal and written input after release of the draft report in late October 2007, OAPP again requested recent general ledgers and completion of the ESIS to complete the study (see Appendix F) in order to provide Mercer with the most up-to-date provider general ledger information and to give providers an opportunity to provide actual direct service wages and encounter information. Nine providers complied by providing at least partial information.

Input on Clinical Information

Two specific tasks in the study related to the clinical delivery of services and necessitated extensive provider feedback. The first task was to assess the current HIV/AIDS Continuum of Care Model, County of Los Angeles (and Commission updates for 2003, 2004). See Appendix A for the graphic depiction of the approved model. Mercer staff conducted 11 interviews with staff representing the Commission on HIV, the Prevention Planning Committee, HIV/AIDS service providers and OAPP. These perspectives figured directly in Mercer's assessment of the HIV/AIDS Continuum of Care Model (Appendix B) as adequate, which was ultimately assessed as appropriately challenging and not in need of revisions.

The second task related to the delivery of clinical services was to develop service descriptions for the services for which rates would be set. To continue evaluating the appropriateness and effectiveness of the service descriptions for use in the County of Los Angeles, Mercer staff facilitated a focus group on November 8, 2004, with medical professionals providing HIV/AIDS services. The focus group meeting was attended both by providers who are and are not currently in the OAPP provider network. Focus group participants received the service descriptions in advance, and then were convened for a group-wide discussion at OAPP. Because of time restraints, participants were asked to submit comments on service descriptions that were not reviewed in this meeting. These comments were synthesized and provided to participants prior to a group-wide conference call in December 2004, where all final comments were addressed. A list of provider and other stakeholders having input into the study is included in Appendix C.

Additionally, at OAPP's request, a physician not currently in the provider network was interviewed in December 2004 regarding his review of the AOM service descriptions.

Lastly, relative to the AOM services description, a Commissioner from the Commission on HIV provided written comments.

As a result of the comments from the focus group on the Nutritional Counseling (Medical Nutritional Therapy) service description, an OAPP nutrition expert facilitated a review of the service description by nine Los Angeles-area registered dietitians. The comments and suggestions from these local professionals were also carefully considered and integrated into the Nutritional Counseling service description (Medical Nutritional Therapy).

In order to make sure adequate service delivery time frames were set for the enrollment services required for the ADAP service description, service providers were interviewed by telephone, and the reports of time actually expended, together with the specific activities provided, were synthesized and applied to both the service description and rate determinations.

OAPP-funded providers of home-based case management services were interviewed to make sure the Medical Case Management model would not duplicate these services. This was in response to a concern raised by a focus group participant. The issue of duplicating services was further researched with the OAPP staff and no duplications in service requirements were found with the Medical Case Management service description included in the rate study.

As noted in the previous section, two Mercer staff visited eight provider sites in January 2007. The purpose of the interviews was to gather additional and more in-depth information related to service provision. The programmatic inquiry focused on the exact nature of clinical services with attention given to the relationship between primary care providers and registered nurses, as well as program-related expenditure issues. Additional inquiry was made related to the nature of the people served and demographic influences on service provision. The information from the interviews was summarized in a report from Mercer titled "Summary of HIV/AIDS Medical Outpatient Services Rate Study: Provider Site Visits" (Appendix D).

Throughout this process, provider input, both clinical and financial, has been sought and considered in the development of the rates.

Study Outcomes

The outcomes and findings that emerged based on this study are documented in this report.

Rates were prepared for each service category based on the evaluation of national standards and local practice and through the analysis of provider cost reports and general ledgers. An impact analysis of these rates on OAPP’s budget, as well as individual providers, was completed. The rates developed in accordance with the study (“rate architecture”) methodology and recommended by Mercer are presented in the summary below:

OUTPATIENT MEDICAL CARE SERVICES			
	AOM Care Services	ADAP	Nutritional Counseling (Medical Nutritional Therapy)
Proposed Rate	\$375.37*	\$31.61	\$89.36 Initial Assessment \$29.79 Continuing Visit

*The recommended rate includes a “full load” of general and administrative costs. RWCA funds have historically been limited to 10% for general and administrative costs. If the rate is limited to 10% general and administrative costs, the rate would be \$284.86. This is discussed in Section 4.

Policy Decisions and Recommendations

Policy decisions were made during the course of the study. These included decisions on:

- Whether to fund the referral to a Medical Specialty service as a distinct service. Requirements for referral to specialty care are considered standard in HIV/AIDS AOM care and, as a result, are included in the AOM service description. Medical Specialty services needed by clients that currently are reimbursed separately from other services should be made as referrals and specialty providers should seek reimbursement as appropriate.
- Whether to fund the Drug Resistance Testing as a distinct service. Requirements for drug resistance testing have been revised by PHS; these services are routinely offered within the context of the routine medical management of HIV disease. The costs associated with the actual testing for drug resistance will continue to be supported through the State of California program; the medical tasks associated with screening for drug resistance and for pre- and post-test counseling are routine with the expectation that they be completed by the HIV/AIDS AOM care team.
- Whether Medi-Cal certification should be mandatory. In discussions with OAPP senior managerial staff, the importance of maximizing all available financial resources was a consistent topic, together with noting the legislative restraints on the use of Ryan White CARE Act (RWCA) funds as a funding source of last resort. Mercer concurs with OAPP that Medi-Cal certification for all AOM services providers should be required. All current providers are Medi-Cal certified. Any new providers in the network should have Medi-Cal certification as a condition of admission into the network.

With regard to these specific policy decisions, Mercer makes the following recommendations:

Medical Specialty

The service description for referral to Medical Specialty services initially addressed the primary care provider's assessment for the need for specialty care and the actual referral process. The service description, and therefore the corresponding rate of reimbursement, does not address the actual specialty care itself. OAPP will need to continue to fund the costs for medical specialty services outside of the rate study's rates.

Mercer recommends this service description no longer be funded as a distinct and separate service category. Referral to medical specialty services is commonplace in the medical management of HIV disease. The current standard of care and PHS guidelines fully integrate the assessment for the need for specialty care, as well as direct focused attention to referral tracking and monitoring for the benefit of the client being medically managed in an HIV/AIDS primary health care model. This service description was redundant with the guidelines for state-of-the-art HIV AOM care. The updated HIV/AIDS AOM service description incorporates the PHS guidelines addressing referral to medical specialty care.

Drug Resistance Testing

Because of recent changes in the PHS HIV/AIDS standards of care, Mercer recommends this service description no longer be funded as a distinct and separate service category. Drug resistance testing was earlier viewed as a highly specialized service but is now considered routine within the medical management of HIV disease. Therefore, the new expectations associated with drug resistance testing are incorporated as expectations within the HIV/AIDS AOM Care service description.

Mercer recommends that the actual costs of the blood screening continue to be absorbed by the State of California, Office of AIDS, Resistance Testing Program. The Mercer recommendation, therefore, does not assume these lab costs will be absorbed by the HIV/AIDS AOM providers contracted through OAPP. The medical tasks relevant to client pre- and post-testing counseling and education for drug resistance are now routine HIV/AIDS medical management services to be provided by HIV/AIDS practitioners contracted through OAPP.

Medical Case Management

During the time frame included in this study, Medical Case Management was being closely scrutinized by OAPP and the Commission on HIV. Because the configuration of services included in Medical Case Management was under review, this report contains no rate recommendation for a separately reimbursed Medical Case Management service.

Maximizing Medi-Cal Funding

The use of RWCA funds is restricted for services for which there are no other sources of funding. When a client meets the Center for Disease Control and Prevention's definition for a diagnosis of AIDS, the client becomes eligible for disability and thereby for HIV/AIDS medical services reimbursed by Medi-Cal. Undocumented individuals are not eligible for Medi-Cal services and therefore are eligible and remain dependent on RWCA funding for advanced medical management of HIV disease. OAPP may wish to audit a sample of medical records to ensure Medi-Cal is being used appropriately and RWCA funds are used only for non-Medi-Cal services and/or for non-Medi-Cal eligible clients.

Currently, all providers of AOM care are Medi-Cal certified providers. Any new providers in the network should have Medi-Cal certification as a condition of admission into the network. The RWCA (2000, as amended) permits use of funds for agency and system of care capacity building. This use of funds must be prioritized and allocated by the local HIV Health Services Planning Council, however. OAPP may wish to work collaboratively with the Los Angeles Commission on HIV to consider use of these funds to build capacity for maximum results from Medi-Cal billing and collection.

Implementation of Rates: Budget Impact Concerns

The AOM rate developed considers the full cost related to general and administrative expenditures. Historically RWCA funding has been limited to 10%. This limitation, of course, would significantly impact the rate. In Mercer calculations, the 10% limitation makes a \$100 difference in the rate. This issue is discussed more fully in Section 4.

Mercer recognizes that changes to the funding structure may significantly impact providers. For this reason, OAPP may wish to "shadow implement" the rate system. In "shadow implementation", providers are paid at historical funding levels and data is collected regarding what they would have been paid under the FFS system. In this way, OAPP would assess if the budget impact based on historical utilization presented in this report was accurate and which providers fall over or under historical funding levels.

If OAPP elects to implement the FFS system using a single rate for all AOM providers, Mercer recommends that OAPP should require an actual cash reconciliation no later than six months after the contract is initiated, and the rates should be reviewed based on the measurement of actual costs and utilization under the new system.



2

Background

On December 23, 2003, the Department of the Auditor-Controller of the County of Los Angeles issued Work Order Request No. 6-49 on behalf of the Department of Health Services OAPP. The Work Order Request sought the services of a consulting firm to develop appropriate FFS costs reimbursement rates for providing HIV/AIDS outpatient medical care services. In late February, 2004, Mercer was engaged to complete the study.

With an approved budget by the Board of Supervisors, OAPP contracts with County-operated and private outpatient medical clinics to provide comprehensive primary health care to individuals diagnosed with HIV/AIDS. These clinics receive County, State and RWCA funds that provide funding of last resort to individuals who meet eligibility qualifications and do not qualify for other health insurance programs. RWCA resources are prioritized by the Commission on HIV and provide reimbursement for those services meeting OAPP contracted goals and standards of care.

Because RWCA funds are funds of last resort, all outpatient HIV/AIDS medical clinic contractors must exhaust other sources of funds before billing the County for services. These include, but are not limited to, Medicare and Medi-Cal. Providers are required to screen and assess clients for other funding source eligibility, such as Medi-Cal, which must be utilized to pay for care when the client is eligible.

Currently, OAPP reimburses its contracted outpatient medical clinics through a traditional line-item budget process. The Board of Supervisors requested that OAPP consider a FFS cost reimbursement methodology that encourages provider accountability and productivity, tracks utilization more effectively and ensures that providers are utilizing other funding resources, such as Medi-Cal, when available. A drawback of the current reimbursement methodology is that there may be a financial disincentive to enrolling clients in Medi-Cal, as providers may find line-item reimbursement easier and financially advantageous.

Through this Work Order approved by the Board of Supervisors, OAPP sought assistance in implementing a FFS cost reimbursement methodology to replace the existing reimbursement system for HIV/AIDS outpatient medical services.

Objectives of the study included:

- Review of national and local standards of care
- Review of the Los Angeles HIV/AIDS Continuum of Care Model included in the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)*
- Survey of other EMAs that have a FFS program
- Survey of current practice regarding coding of procedures and diagnosis among HIV/AIDS outpatient medical clinic providers
- Analysis of the costs of providing outpatient medical services based on the accepted standards of care
- Preparation of recommendations of FFS rates for the identified outpatient medical services
- Identification of services that are commonly reimbursed by third-party payers;
- Identification of barriers to implementation
- Recommended guidelines for collection of fees

Specifically, the primary medical care services for which the Board of Supervisors and OAPP initially intended to develop a FFS cost reimbursement methodology included:

- AOM
- ADAP
- Drug Resistance Testing
- Medical Case Management
- Medical Specialty
- Nutritional Counseling (Medical Nutritional Therapy)

The study specifications initially requested a service description and rate of reimbursement for referrals to Medical Specialty services. Mercer initially produced both a service description and rate of reimbursement for this referral service. However, PHS standards of care dictate that specialty services must be accessible to the HIV-positive client by the primary care provider. The service description developed for HIV/AIDS AOM, which considered the PHS requirements, requires referral standards for Medical Specialty care. A separate Medical Specialty service description results in redundant requirements. Mercer recommended Medical Specialty services not be funded as a separate service description. Continuing to fund it separately would result in duplicative payment for the same service requirement under two service descriptions. Therefore, this report contains no rate recommendations for a separately reimbursed referral to Medical Specialty.

OAPP-funded providers have been successful in negotiating locally-derived rates of reimbursement that financially create access to these expensive services. Mercer recommends that special relationships between primary care and specialty care providers

not be interrupted. Where there are no special relationships between providers for a needed specialty care service, Mercer recommends that rates of reimbursement should not exceed the Medicare/Medi-Cal established rates. Conceding to the Medicaid/Medicare rates (where there is no opportunity for rates derived through special relationships) is an established practice in publicly-funded HIV/AIDS primary health care.

Likewise, the PHS HIV/AIDS standards of care for drug resistance testing were changed to incorporate drug resistance testing and counseling as a routine component of HIV-related primary health care. Therefore, and in interest of maintaining recommendations that are current with the PHS standards, Mercer recommended the service description for Drug Resistance Testing not be funded as a separate service description, but rather be included as a routine requirement within the HIV/AIDS AOM Care service description. No rate recommendation for a separately reimbursed Drug Resistance Testing service is included in this report.

Further, during the time frame included in this study, Medical Case Management was being closely scrutinized by OAPP and the Commission on HIV. Because the configuration of services included in Medical Case Management was under review, this report contains no rate recommendation for a separately reimbursed Medical Case Management service.

The services for which Mercer set rates and developed service descriptions that are included in this report include:

**Outpatient Medical Care Services
Service Description and Rate Development**

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- Nutritional Counseling (Medical Nutritional Therapy)

Mercer's direct-care, staff-driven rate architecture is a unique approach to rate construction that emphasizes "hands on" staff resources provided to the people receiving services and varies according to the professional level and quantity of staff time. Three key principles serve as the foundation for this system:

1. The most prominent and important variable in the determination of quality and the successful adherence to care standards is the direct service staff profile.
2. All other cost components, which are equally necessary, although less directly variable in response to differences in standards of care, can be expressed in relationship to direct service staff costs.

3. If all the compensation components are studied and their relationships to direct service staff cost profiles are determined, a standardized rate system can be produced by establishing the direct service staff profiles (in accordance with standards of care) and then building the total compensation (rate) according to the relationships of the other components to the service staff costs.

While the direct service staff profile is critical to this rate system, it is not the only cost component necessary to create rates. Rather, the direct service staff profile is the most prominent in supporting the services descriptions that promote quality care. The clear identification of service descriptions that promote quality care for the selected service categories was an integral part of this study, since the goal of the County of Los Angeles, as well as Mercer, was to develop rates that adequately support the provision of quality services, as defined by current regulations and quality care practices.

This report not only provides rates for the outpatient service categories included within this study, it also summarizes the methodology, findings, barriers to the implementation of the proposed rate system and recommendations to address these barriers. The remaining sections of the report are outlined below:

- **Section 3: Service Description Development**
 - Methodology for AOM, ADAP and Nutritional Counseling (Medical Nutritional Therapy)
 - Medical Specialty
 - Drug Resistance Testing
 - Medical Case Management
 - Review of the HIV/AIDS Continuum of Care Model
- **Section 4: Rate Development**
 - Cost Components
 - Methodology
 - Other EMAs – Rates
 - Future Rate Change Process
- **Section 5: Budget Impact Analysis**
 - Methodology
 - Budget Impact Results
- **Section 6: Third-Party Payer Reimbursement**
 - Methodology
 - Findings and Results

- **Section 7: Barriers/Disincentives and Recommendations**
 - Exceeding Accepted Standards
 - Maximizing Medi-Cal Funding
 - Medical Specialty, Drug Resistance Testing, and Medical Case Management

- **Section 8: Next Steps**

3

Service Description Development

Methodology for AOM, ADAP and Nutritional Counseling (Medical Nutritional Therapy)

Mercer's methodology for the development of rates that support clinically-appropriate outpatient services for people living with HIV/AIDS is based on the documentation of clear and accurate standards of care for each service category under study. The development of standard service descriptions was the first phase of the study. To successfully complete this phase, Mercer adopted the following approach:

Step 1: Exploratory Meetings with OAPP

Mercer first met with OAPP through face-to-face meetings and telephonic discussions to better understand the current standards of care in existing contracts with selected providers, as well as to understand the Board of Supervisors' expectations and OAPP's program requirements for the provision of quality services.

Step 2: Literature and Information Review

Following these initial discussions, Mercer performed an in-depth review of information and literature from multiple sources on standards and protocols of care for outpatient HIV/AIDS services. These sources include but are not limited to:

- OAPP Contracts and Standards of Care
- Commission on HIV Standards of Care
- California Code of Regulations
- Mayor's AIDS Leadership Council, HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches, December 2003
- County of Los Angeles HIV/AIDS Comprehensive Care Plan, August 2002 (and Commission updates for 2003, 2004)
- HIV/AIDS Continuum of Care Model, County of Los Angeles (and Commission updates for 2003, 2004, see Appendices A and B)

- Other State Resources: Program Guidelines and Standards of Care, and Best Practices from the California Department of Public Health, Office of AIDS (particularly, the Early Intervention Program model, and guidelines for the ADAP program).
- National Resources: the Public Health Service, Department of Health and Human Services (DHHS) guidelines for the medical management of HIV infection and other issues surrounding HIV infection, Standards of Care published by national health care professional associations and Best Practice Recommendations from the AIDS Education and Treatment Centers National Resource Center.

Step 3: Development of Service Descriptions

After reviewing and analyzing these materials, Mercer developed draft service descriptions in each of the categories of services selected for this study. Mercer's primary goal in preparing these documents was to ensure that the rates developed for these service categories were reflective of the most appropriate standards of care and were adequately designed to compensate providers for high quality services.

Step 4: OAPP Review

Mercer sought feedback from OAPP on the service descriptions. Several iterations were developed before the final drafts of the service descriptions were developed.

Step 5: Provider Interviews

Mercer conducted 11 interviews in September 2004 with staff representing the Commission on HIV, the Prevention Planning Committee, HIV/AIDS service providers and OAPP. These perspectives figured directly in Mercer's assessment of the HIV/AIDS Continuum of Care Model (Appendix B) as adequate, which was ultimately assessed as appropriately challenging and not in need of revisions. Additionally, these interview comments were considered during the revision to the initial draft of the service descriptions.

Step 6: Provider Input into Service Descriptions

Mercer consulted with Los Angeles County HIV/AIDS service providers in order to make the service descriptions as appropriate and effective as possible for use in the County of Los Angeles. A summarized list of provider and other stakeholder input is included as Appendix C.

As noted previously, Mercer conducted 11 interviews in September 2004 with staff representing the Commission on HIV, the Prevention Planning Committee, HIV/AIDS service providers and OAPP. These interview comments were considered during the revision to the initial draft of the service descriptions.

To continue evaluating the appropriateness and effectiveness of the service descriptions for use in the County of Los Angeles, Mercer facilitated a November 8, 2004 focus group with outpatient care professionals providing HIV/AIDS services. The focus group was

attended by both providers who are and are not currently in the OAPP provider network. Focus group participants received the service descriptions in advance, and then were convened for a group-wide discussion at OAPP. Because of time restraints, participants were asked to submit written comments on service descriptions that were not reviewed in this meeting. These comments were synthesized and provided to participants prior to a group-wide conference call in December 2004 where all final comments were addressed.

All focus group comments and suggestions were carefully reviewed and considered for inclusion as revisions to the service descriptions.

In order to have feedback from a physician practicing in the private sector who is not currently funded by OAPP. This physician was selected to review the AOM service description and feedback was obtained from this physician through telephone interview. The physician was selected by OAPP. The comments provided by the physician, encouraging Mercer and OAPP to continue with the development of state-of-the-art service standards for use in publicly-funded HIV/AIDS medical care, were summarized and presented to OAPP in memo format, as well as incorporated into the AOM service description.

As a result of the comments from the focus group on the Nutritional Counseling (Medical Nutritional Therapy) service description, an OAPP nutrition expert facilitated a review of the service description by nine Los Angeles-area registered dietitians. The comments and suggestions from these local professionals were also carefully considered and integrated into the Nutritional Counseling (Medical Nutritional Therapy) service description.

In order to make sure adequate service delivery time frames were set for the enrollment services required for the ADAP service description, service providers were interviewed by telephone, and the reports of time actually expended, together with the specific activities provided, were synthesized and applied to both the service description and rate determinations.

OAPP-funded providers of home-based case management services were interviewed to make sure the Medical Case Management model would not duplicate these services. This was in response to a concern raised by a focus group participant. The issue of duplicating services was further researched with the OAPP staff and no duplications in service requirements were found with the Medical Case Management service description included in the rate study.

Step 7: Commission's Feedback

Copies of draft services descriptions were provided to the Commission on HIV. One Commissioner provided written comments to OAPP staff and these comments were forwarded to Mercer. The Commissioner had questions regarding the service definitions and their comparison to definitions within Medi-Cal and Medicare, definition of fee schedules, the definition of Quality Assurance and concern for additional paperwork that may be required of potential clients to qualify for services. These questions are more

appropriately addressed through the legislative definitions and requirements attached to the RWCA or questions related to OAPP contracting guidelines and contracts. The Mercer FFS project does not redefine the RWCA service definitions but rather uses them explicitly. This study is not producing a fee schedule but rather specific reimbursement rates for specific services.

Step 8: Commission's Updated Standards of Care

During the same time period that the Mercer was developing service descriptions for this study, the Commission on HIV updated its Standards of Care. The most recent Standard of Care for Medical Outpatient was updated effective January 13, 2006. It notes that the Standard of Care “represents a synthesis of a significant number of published standards and research” including a key source document, the draft standard prepared for this study.

Step 9: Update Based on Comparison to Commission's Updated Standards of Care

OAPP provided a comparative analysis of differences in the Commission's updated Standards of Care in contrast to the service descriptions developed for this study. The service descriptions were revised to ensure compatibility with the Commission's Standards of Care.

Step 10: Finalization of Service Descriptions

After reviewing feedback stakeholders and reconciling differences identified in the Commission's Standards of Care, Mercer developed final service descriptions. Copies of service descriptions are provided in Appendix E.

Medical Specialty

The study specifications initially requested a service description and rate of reimbursement for referrals to Medical Specialty services. Mercer initially produced both a service description and rate of reimbursement for this referral service. However, PHS standards of care dictate that specialty services must be accessible to the HIV-positive or AIDS-infected client by the primary care provider. The service description developed for HIV/AIDS AOM, which considered the PHS requirements, requires referral standards for Medical Specialty care. A separate Medical Specialty service description results in redundant requirements. Mercer recommended Medical Specialty services not be funded as a separate service description. Continuing to fund it separately would result in duplicative payment for the same service requirement under two service descriptions. Therefore, this report contains no rate recommendations for a separately reimbursed referral to Medical Specialty.

OAPP-funded providers have been successful in negotiating locally-derived rates of reimbursement that financially create access to these expensive services. Mercer recommends that special relationships between primary care and specialty care providers not be interrupted. Where there are no special relationships between providers for a

needed specialty care service, Mercer recommends that rates of reimbursement should not exceed the Medicare/Medi-Cal established rates. Conceding to the Medicaid/Medicare rates (where there is no opportunity for rates derived through special relationships) is an established practice in publicly-funded HIV/AIDS primary health care.

Drug Resistance Testing

Likewise, the PHS HIV/AIDS standards of care for drug resistance testing were changed to incorporate drug resistance testing and counseling as a routine component of HIV-related primary health care. Therefore, and in interest of maintaining recommendations that are current with the PHS standards, Mercer recommended the service description for Drug Resistance Testing not be funded as a separate service description, but rather be included as a routine requirement within the HIV/AIDS AOM Care service description. No rate recommendation for a separately reimbursed Drug Resistance Testing service is included in this report.

Medical Case Management

Mercer worked collaboratively with select OAPP program management staff to identify an appropriate model for HIV/AIDS Medical Case Management, taking into consideration the Board of Supervisors' expectations and OAPP's existing service delivery pattern of using clinical nurses to provide care coordination. The Roy Adaptation Model for nursing case management was reviewed and mutually found appropriate for this service description initially. The service description delineated the following requirements for the delivery of Medical Case Management:

- Medical Case Management services are provided by a Registered Nurse (RN) in good standing and licensed in California by the State Board of Behavioral Sciences. The RN must practice within the scope of practice defined in the California Business and Professions Code, Section 2725, RN Scope of Practice (www.rn.ca.gov).
- Medical Case Managers must be certified through the OAPP HIV Case Management Certification Program (the OAPP Case Manager Certification Program is currently being revised to include training specific to Medical Case Management).
- Medical Case Managers are employed in provider agencies meeting the full requirements for HIV/AIDS AOM Care Services.
- Medical Case Management is a process of assessing, planning, coordinating, monitoring, and evaluating the medical services required to respond to a client's HIV/AIDS prevention and health care needs. The overall goal of Medical Case Management is to facilitate the coordination and sequencing of primary health care services in order to achieve optimal health outcomes.

- Medical Case Management is a service in the HIV/AIDS Continuum of Care offered in response to the growing complexity of HIV prevention and disease management. It is also offered in response to the need clients have expressed for expert guidance through an ever-increasing complement of services that comprise the comprehensive HIV/AIDS Continuum of Care.
- Medical Case Management focuses intentionally on the client's access, utilization, retention and adherence to Primary Health Care Core Services in the HIV/AIDS Continuum of Care. These Primary Health Care Core Services are described in the County of Los Angeles HIV/AIDS Comprehensive Care Plan (2002), available through the OAPP.
- Medical Case Management services are not required as a precondition for receiving other services in the HIV/AIDS Continuum of Care, neither are they intended to reduce or curtail the use of primary health care services. Rather, Medical Case Management services are intended to facilitate the client in obtaining and sustaining the best and most appropriate treatment. These services are client-centered and provided within an overall philosophy of assisting the client in becoming an effective self-manager of his or her own care.
- While the Medical Case Manager focuses on Primary Health Care Core Services, the Medical Case Manager also facilitates optimal health outcomes for the HIV-infected client, partners and social affiliates and the diverse health care professionals providing services in the HIV/AIDS Continuum of Care. The Medical Case Manager facilitates optimal health outcomes through advocacy, liaison, and collaboration to achieve continuity of care, effective communication and coordination of appropriate HIV/AIDS prevention and treatment services.

An initial rate was developed for Medical Case Management based the services description modeled on the Roy Adaptation Model. However, during the time frame included in this study, Medical Case Management was being closely scrutinized by OAPP and the Commission on HIV. The Commission revised its Standard of Care effective for Case Management, Medical Services effective May 11, 2006. Because the configuration of services included in Medical Case Management was under review, and continues to be under review, this report contains no rate recommendation for a separately reimbursed Medical Case Management service.

Review of Continuum of Care Model

A task identified in the Work Order requested a review of the Los Angeles HIV/AIDS Continuum of Care Model Strategic Planning Process (1999–2001). In 2001, the new HIV/AIDS Continuum of Care Model was jointly approved and adopted by the Commission and OAPP.

From the beginning, the HIV/AIDS Continuum of Care Model was a bold statement of commitment to improving the HIV-related health outcomes for all individuals and families at-risk for or infected with the HIV virus, and to reducing the disparities in HIV-related health outcomes for racial, ethnic, and social minorities in the County of Los Angeles. Moving towards fulfillment of this commitment, planners, providers and OAPP staff use the model to focus concretely on how the HIV/AIDS Continuum of Care Model's HIV/AIDS Primary Health Care Core Services will be made available to County of Los Angeles citizens who depend on publicly-funded HIV/AIDS services.

The HIV/AIDS Continuum of Care Model pushes beyond the single issue of “access to services” to a more complex question of how to assure that clients have appropriate access to services, utilize them consistently, are effectively retained in services over time, and adhere to medical regimens while receiving HIV/AIDS services. This service formula, “Access – Utilization – Retention – Adherence”, underscores a second commitment, providing care coordination services for those who need them so that improvements in HIV-related health outcomes may, in fact, be achieved. The HIV/AIDS Continuum of Care Model is a client-centered and flexible one, with multiple points of entry, and while it sets a clear standard by delineating the critical HIV/AIDS service components in a state-of-the-art Continuum of Care Model, it does not impose a single set of services for any one or all clients who may seek services within this Continuum of Care Model.

There is a third commitment evidenced in the HIV/AIDS Continuum of Care Model's design, a commitment to effectively integrate HIV prevention services with care and treatment services. HIV prevention services are an integral component of HIV/AIDS primary health care core services. Planners, providers and OAPP staff are focusing not only on how to seamlessly link the prevention and care service systems, but how to give equal weight to HIV prevention in the context of routine and recurring medical care.

In the review conducted by Mercer, providers saw the Model's attempt at “true integration” and its view of “HIV disease as a continuum, clarifying the whole spectrum of need” as clear strengths. Challenges to meeting the Continuum of Care Model's expectations included provider training and capacity-building needs, establishing provider agreement on meeting the expectations when the service system is already so fully developed and assistance in developing the provider partnerships needed to offer any one client the full range of possible services.

The features of the HIV/AIDS Continuum of Care Model are concretely represented in the service descriptions. Use of the service descriptions with updates over time will likely assist providers in more closely approximating the expectations described in the HIV/AIDS Continuum of Care Model. However, providers will need direct support to enhance their abilities to fully implement this Model.

Based on Mercer's review of the national HIV/AIDS standards of care and on the commitment of the providers to implement the HIV/AIDS Continuum of Care Model, Mercer recommends that the Board of Supervisors support OAPP and its partners in planning and system development based on the Continuum of Care Model as currently defined.

4

Rate Development

The second phase of the project involved the development of FFS rates for services included in the study using the Mercer's direct-Care, staff-driven rate architecture. To understand this rate methodology, an understanding of the various cost components is critical. The cost components, and a description of each, are presented below.

Cost Components

There are four standard cost components that are assumed to be common to all social and medical services. These include:

1. Direct Service Staff Wage
2. Employment-Related Expenditures
3. Program-Related Expenditures
4. General and Administrative Expenditures

Direct Service Staff Wage

The definition of direct service staff wage consists of the following two elements:

1. The staff must be people who are performing tasks in the furtherance of the objectives of the service. In other words, they must be doing what they are doing in order to meet some objective defined in the service. They are not considered direct service staff solely by their qualifications.
2. The person who is receiving the service and who is expected to benefit from it must be present, most of the time. "Most" is defined as 90% or more.

There is a need to be specific in the definition of direct service staff because service descriptions often describe minimal amounts of time that should be spent in any given period. In some cases, this may be provided by a variety of qualifying staff. Equally, there may be staff associated with the program that have the same qualifications as direct

service staff but who do not perform tasks related to the service and so would not satisfy the minimum requirements of the service standard.

Employment-Related Expenditures

Simply stated, employment-related expenditures are all the benefits received by employees of the service agency. Benefits generally fall into two categories:

1. Discretionary Benefits: those benefits that employers may elect to provide but are not mandated to do so by any governmental authority.
2. Non-Discretionary Benefits: those benefits that are mandated by a governmental authority.

Program-Related Expenditures

Program-related expenditures are all the expenditures that support the objectives and the provision of the service, but cannot be tied to any particular person receiving the service. For this reason, program-related expenditures are considered “indirect” rather than general and administrative expenditures. Supervision of direct service staff, staff who do not spend 90% of time with clients but who work with clients, supplies related to the service, consultative services to general staff, client transportation and staff training/education are all examples of program-related expenditures. It is important to note that many factors influence the inclusion or exclusion of cost types in this category, but the two most prominent are the service descriptions and the funding source regulations.

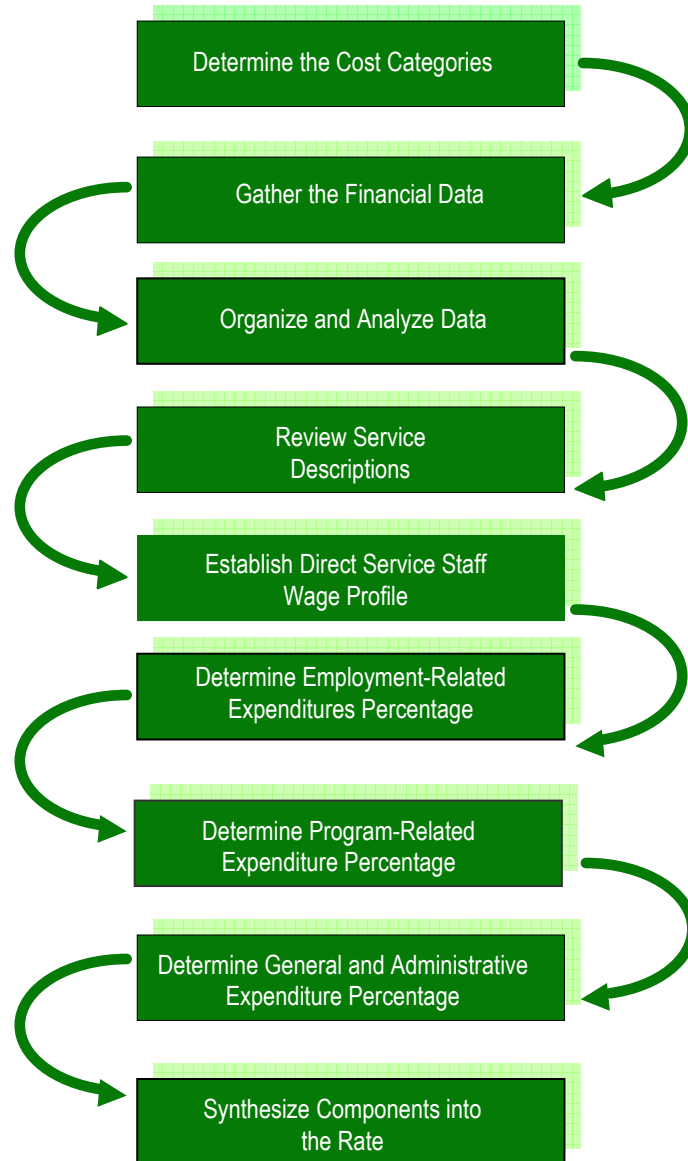
General and Administrative Expenditures

General and administrative expenditures are the costs of being in business. General and administrative expenditures have nothing directly to do with the type of program, the type of service, or the product offered. These expenditures are costs that are as common to automotive manufacturing firms as they are to pizza parlors or as common to doctors’ practices as they are to amusement parks. General and administrative expenses include administrative salaries, insurance, travel and entertainment, office expenses, lease or rental costs for office space, depreciation, property insurance, equipment rental and other interests. In most instances, the categories of costs included in this component are similar in both non-profit and for-profit organizations.

Methodology

Mercer’s methodology for rate development is based on reported costs, appropriate clinical practices, and established service descriptions. This methodology has been successfully used and replicated in multiple states for a variety of health and human services. The process chart on the following page provides an overview of rate development, and each step is discussed in detail in subsequent sections of this report.

Rate Development Methodology – A Process Chart



The following narrative explains each step of the rate development with a description of the processes and actions taken by Mercer to successfully complete each of these steps.

Step 1: Determine the Cost Categories

The first step in developing standardized rates for services was to study each service description in great detail to determine if the four cost categories described previously will be sufficient, or if additional categories would be needed to address program and provider-specific issues.

Some components will vary because of differences in the way services are described. For example, in some institutional settings, nursing care is considered an integral part of the services that each resident will need and levels of nursing are expressed as requirements of the service description. In this case, a nurse would be considered a Direct Service Staff because the two parts of the definition of Direct Service Staff (furtherance of objectives and 90% client contact) have been met. In other settings, nursing care may or may not occur, or it may be of a consultative nature to the facility itself and not specific to any particular client. In this case, the cost of the nurse would be a part of program-related expenditures.

For this study, for all services (AOM, ADAP and Nutritional Counseling) Mercer used the component categories described earlier, including:

- Direct Service Staff Wage
- Employment-Related Expenditures
- Program-Related Expenditures
- General and Administrative Expenditures

Step 2: Gather the Financial Data

The next step undertaken by Mercer was to determine the nature, quantity and quality of existing expenditure data for providers. The underlying questions that were addressed as part of this exercise were as follows (in this order):

1. What are the line-item costs related to the services?
2. Are the costs reported in enough detail so as to be identifiable in the categorizations determined necessary in Step 1?
3. If not, in what manner will the information be gathered?
4. Is the available data current?
5. Is the available data reliable?
6. Are the line-items somewhat consistent between providers of the same service?

Data must meet the following conditions to be useable in rate development:

- The data must be available (reports must exist)
- The data should be current

- The data should be accurate and objectively supportable
- The data should be in enough detail so as to allow for categorization, according to the determined categories necessary
- Line-items within the data should be consistent between providers of the same service

With regard to AOM Services, Mercer found that the general ledgers and ESIS provided by providers in late January/early February 2008, in general, met these conditions. For ADAP and Nutritional Counseling, the cost reports provided in the first year of the study were helpful but did not meet two of the criteria above. The cost report information was not in enough detail to allow for categorization and line-items within the data were not consistent between providers. For this reason, Mercer relied much more heavily on BLS data for the Los Angeles metropolitan area to develop the rate for ADAP and Nutritional Counseling as described in subsequent steps.

Step 3: Organize and Analyze Data

In this step, for AOM services, provider general ledger and ESIS information was organized so that the cost components could be compared in a consistent manner across providers. This organization of the information allowed for the successful completion of the component analysis. The final result of the component analysis was an understanding of each of the cost components' relationship to Direct Service Staff costs for each of the service categories analyzed. These components were expressed in terms of a relationship, i.e., as a percentage. For ADAP and Nutritional Counseling services, cost report data and BLS information was organized and analyzed for the completion of the component analysis.

Step 4: Review Standards

In the fourth step of the rate development, Mercer reviewed the service descriptions prepared in the first phase of the study to establish the proper type and quantity of Direct Service Staffing levels and the general profiles of the Direct Service Staff specific to the service description. This information formed the cornerstone of the completed rates.

Step 5: Establish Direct Service Staff Wage Profile

Mercer then proceeded to establish the wages associated with the staff described in the service descriptions as Direct Service Staff. Depending on the unique nature of the service being studied, this can be performed in a number of ways. Wage and benefit studies can be performed, analysis of provider data can be completed, research into objective sources of wage and benefit information such as BLS can be done, prevailing market wages currently paid by providers in the area can be reviewed, and finally, administrative discretion may be used to set wage levels as a matter of policy.

For this particular study, Mercer used the analysis of the provider general ledger data to establish direct service staff wage levels for physician-like staff for AOM services. The average physician-like costs from the usable provider general ledger data was \$147,519.85. Mercer first trended individual providers' average physician-like wage at

4% annually from the midpoint of the most recent year of the reported expenditures on the ESIS to the midpoint of the year of the anticipated start date, March 1, 2009, and then averaged all providers' physician-like wages.

For ADAP and Nutritional Counseling services, Mercer utilized data from BLS wage information. For ADAP, Mercer selected the occupation called Medical Records and Health Information Technician (code 29-2071) for the Los Angeles metropolitan area. The annual wage identified in the most recent BLS report was trended at a 4% increase per year from the midpoint of the year of the available data to the midpoint of the year of the anticipated start date, March 1, 2009. The annual direct service staff wage level for an ADAP worker for purposes of the rate development was \$46,110.91.

For Nutritional Counseling, Mercer selected the occupation called Dietitians and Nutritionists (code 29-1031) for the Los Angeles metropolitan area. The annual wage identified in the most recent BLS report was trended at a 4% increase per year from the midpoint of the year of the available data to the midpoint of the year of the anticipated start date, March 1, 2009. The annual direct service staff wage level for a Dietician/Nutritionist for purposes of the rate development was \$84,107.39.

Step 6: Determine Employment-Related Expenditures Percentage

Mercer calculated the employment-related expenditure percentage using provider general ledger information for the AOM service. The average employment-related expenditures percentage expressed as percentage of direct service staff wage level was 42.07%. The employment-related percentage was based on the average of five providers whose general ledger data was deemed complete enough for use in the study. Mercer used the most recent general ledger year provided. For three providers, the time frame was March 1, 2006 to February 28, 2007. For one, the time frame was July 1, 2006 to June 30, 2007. For the last provider, it was January 1, 2006 to December 31, 2006. Mercer totaled the dollars from all providers in the employment-related category and divided by the total dollars for all providers for direct care professionals (physicians, physician assistants and nurse practitioners).

For ADAP and Nutritional Counseling, Mercer used historical BLS information, considered the rise in trend of benefit costs, and ultimately used 30%.

Step 7: Determine Program-Related Expenditures Percentage

For the AOM service, Mercer isolated all accounts from information provided in provider general ledgers that were identified as program-related. Then the amounts in those cost line-items were totaled and compared to direct care staff costs in order to derive a percentage (228.04%) that expressed the relationship. The program-related percentage was based on the average of the same five providers' general ledgers' information and was calculated in the same way as the employment-related percentage, i.e., based on the total dollars and not the average of the percentages. The program-related percentage used in Mercer's calculation was 228.04% of the direct service staff wage.

For the ADAP and Nutritional Counseling services, Mercer used initial analysis from cost reports and estimated expenditures related to program-related needs, and ultimately utilized 68% for ADAP services and 49% for Nutritional Counseling.

Step 8: Determine General and Administrative Expenditure Percentage

According to early discussions with OAPP and the Health Resources and Services Administration (HRSA), the federal agency responsible for the award, administration, and regulation of RWCA funding, OAPP is permitted to compensate provider agencies for general and administrative expenditures, but only up to a maximum of 10% across all provider agencies. In other words, the general and administrative percentage funding cannot exceed 10% for the entire system. It is permitted to compensate individual provider agencies at different general and administrative percentage levels provided that the entire dollar expenditure in this category, taken in total, does not exceed 10%.

Based on this information, a general and administrative percentage of 10% was calculated. The direct service staff wage plus the employment-related expenditures plus the program-related expenditures constitutes a subtotal (subtotal 1), which is adjusted for the general and administrative by “grossing up” the total by the general and administrative percentage such that:

$$\text{Subtotal 1 divided by } (1 - \text{General and Administrative Percentage}) = \text{Total Rate}$$

Review of the providers’ general ledgers for AOM services show that the reported true costs borne by providers exceed the 10% cap. On average, provider general and administrative costs were approximately 32% of total program costs. It is important to note that Mercer’s categorization of reported general and administrative costs included facility costs such as rent and equipment. Providers may argue that they must have specialized facilities and equipment to treat HIV-positive/AIDS-infected persons in a primary care setting.

The goal of the rate development study was to develop a rate that considered all costs. All costs should be considered and the final rate reflects the true reported cost of services. The general and administrative percent of total program reported costs was 31.7% or 171.79% of the direct staff care wage. The general and administrative percentage was based on the average of four providers' general ledgers' information. One provider’s general and administrative expenses were 2.5 times higher (as a percentage) than the next closest provider and the providers’ general and administrative dollars were held out of the calculation. The general and administrative percentage used in Mercer's calculation was 31.7%.

In Step 9, below, Mercer has included two calculations of the AOM Rate for OAPP’s consideration: one rate with 10% general and administrative costs and one with 31.7% of total costs (or 171.79% of the direct staff care wage).

The general and administrative rate for ADAP and Nutritional Counseling was calculated at 10%. The direct service staff wage plus the employment-related expenditures plus the program-related expenditures constitutes a subtotal (subtotal 1), which is adjusted for the general and administrative by “grossing up” the total by the general and administrative percentage such that:

$$\text{Subtotal 1 divided by } (1 - \text{General and Administrative Percentage}) = \text{Total Rate}$$

Step 9: Synthesize Cost Components into the Rate

In this step, the individual calculations in the previous steps were combined to formulate the rates for individual services. Once the percentages for the three components (employment-related, program-related and general and administrative) have been calculated, the final step is to identify the “denominator”, i.e., the number of encounters expected to be delivered. For AOM services, Mercer calculated the average number of encounters provided in the most recent year as reported on the provider ESIS resulting in 2,130 per year. For ADAP services, Mercer estimated 35 minutes per average encounter, i.e., blended average encounters for new admissions and recertifications, for a total of 3,566 encounters per year adjusted by 10% less as a capacity adjustment for a total of 3,209 encounters per year. Similarly, for Nutritional Counseling services, Mercer estimated 60 minutes per encounter for an initial assessment and 20 minutes per encounter for a continuing visit for a total of 2,080 and 6,240 encounters per year, respectively, adjusted by 10% less as a capacity adjustment for a total of 1,872 and 5,616 encounters per year, respectively.

AOM with 10% General and Administrative Cap

Direct Care Staff Wage = \$147,518.85	\$ 147,519
Employment-Related = 42.0749% of direct care staff wage	\$ 62,068
Program-Related = 228.0417% of direct care staff wage	\$ 336,404
Subtotal	\$ 545,991
General and Administrative = 10% of total	\$ 60,665
Total	\$ 606,656
Encounters = 2,129.6462	÷ 2,130
Rate	\$ 284.86

AOM with Actual General and Administrative

Direct Care Staff Wage = \$147,518.85	\$ 147,519
Employment-Related = 42.0749% of direct care staff wage	\$ 62,068
Program-Related = 228.0417% of direct care staff wage	\$ 336,404
Subtotal	\$ 545,991
General and Administrative = 31.7% of total or 171.7852% of direct care staff wage	\$ 253,416
Total	\$ 799,407
Encounters = 2,129.6462	÷ 2,130
Rate	\$ 375.37

ADAP

Direct Care Staff Wage = \$46,110.91	\$ 46,111
Employment-Related = 30% of direct care staff wage	\$ 13,833

Program-Related = 68% of direct care staff wage	\$ 31,355
Subtotal	\$ 91,299
General and Administrative = 10% of total	\$ 10,144
Total	\$ 101,443
Encounters = 3,209	÷ 2,130
Rate	\$ 31.61

Nutritional Counseling – Initial Assessment

Direct Care Staff Wage = \$84,107.39	\$ 84,107
Employment-Related = 30% of direct care staff wage	\$ 25,232
Program-Related = 49% of direct care staff wage	\$ 41,213
Subtotal	\$ 150,552
General and Administrative = 10% of total	\$ 16,728
Total	\$ 167,280
Encounters = 2,129.6462	÷ 1,872
Rate	\$ 89.36

Nutritional Counseling – Continuing Visit

Direct Care Staff Wage = \$84,107.39	\$ 84,107
Employment-Related = 30% of direct care staff wage	\$ 25,232
Program-Related = 49% of direct care staff wage	\$ 41,213
Subtotal	\$ 150,552
General and Administrative = 10% of total	\$ 16,728
Total	\$ 167,280
Encounters = 2,129.6462	÷ 5,616
Rate	\$ 29.79

Other EMAs – Rates

Mercer interviewed three EMAs for comparisons on approaches to FFS contracting and reimbursement methods. The EMAs were selected by OAPP.

1. Miami-Dade EMA: This EMA uses the Florida Medicare Part B rates as the basic structure of a “unit cost” system. There are two sets of codes that are carved out for special rates: one subset of codes is reimbursed at 150% of the Medicare Part B rate and the fees for another subset of “supplemental” codes are individually negotiated per provider. These codes are “supplemental” in the sense that they represent procedures/services not covered under other fee schedules. Providers are issued a contract with a line-item budget that describes acceptable expenditures and bill by unit cost or by code. At the end of the contract period, should billings exceed actual expenditures, providers must return the excess. Providers are not reimbursed for more than the contract budget.
2. Harris County (Houston) EMA: This EMA uses a “unit cost model” that is not based on actual costs as determined by the providers. The administrative agency and planning council review customary payments for services from other payers (private insurance, and especially Medicaid and Medicare), review the historical pattern of numbers of visits/encounters the EMA has financially supported, and considers the maximum funding available for each service category. A “unit cost” is subjectively negotiated from these reviews. Each provider agency is reimbursed at this standard

- unit cost. The unit cost is actually a “maximum allowable” billing rate and providers tend to bill at the maximum allowable rate. Unit definitions are very broadly defined. Providers are contracted at a finite amount and these contracts are not augmented within any one contract period.
3. St. Louis EMA: This EMA “borrowed” from the rates established by the State ten years ago and these rates still exceed the Medicaid/Medicare rates for Missouri. Providers sign a simple agreement to accept these reimbursement rates and bill by CPT codes. The codes largely relate to a defined visit and are not procedure-driven. All providers use a single lab, and the lab negotiates directly with the administrative agency. There is a strong individual private provider network in this EMA.

If these three EMAs, taken with the Los Angeles County EMA as a fourth, are representative of the approaches to FFS reimbursement, the following can be noted:

- EMAs tend to use the Medicaid/Medicare rates as a basis to rate-setting, practically and creatively building on these rates in varied ways. The end result is often specific to the EMA, and reflects a negotiated “acceptability” between the RWCA administrative agency and the contracted providers of RWCA services.
- The decision to address actual costs, and to use these cost analyses in rate-setting, varies with the EMAs capacity for cost-based analyses (i.e., whether there are financial data management systems in place to collect and manipulate actual cost-based information). The “amount of work” for providers in establishing true and actual costs is frequently mentioned as a justification for conceding to Medicaid/Medicare rates with some negotiated variations or augmentations that speak to provider-identified concerns with public sector rates.
- There is an operative assumption that the RWCA funds are not sufficient to fully reimburse for true and actual costs for providing care. This is particularly acute when discussing medical care services. There is always an assumption that the amount of service delivery would have to be severely curtailed if true and actual costs were reimbursed through RWCA funds alone.
- Each EMA relies on a sense of “charity” within large institutional providers to show a willingness to take care of HIV-positive clients knowing that only a reasonable amount of the costs will be reimbursed through the RWCA funds.

Future Rate Change Process

The direct staff wage rate architecture is adaptable to change by making appropriate adjustments to the calculations within the architecture. Mercer has provided OAPP with the detailed rate modeling analytical files in Microsoft Excel that allow for adjustments to various rate components which will result in automatic recalculation of rates. Some areas where changes could occur are as follows:

- If political will exists to increase the assumption of direct service staff wage levels over time (Mercer assumed a 4% annual increase) and the decision to increase them is made and funded, the wage levels can be immediately changed and the rates will automatically recalculate.

- If unfunded mandates become funded, those changes can be made to the appropriate component (usually employment-related expenditures or general and administrative expenditures) and again, the rates will automatically recalculate.
- Service descriptions will usually either affect the Direct Service Staff profile or the program-related expenditure percentage. If so, these may involve a more complicated recalculation of the rate system components but the architecture remains unchanged.

Data Manipulation Capacity: Claims Adjudication

At the request of the OAPP, Mercer performed an analysis of the Casewatch® data management system. The purpose of the analysis was to express an opinion about the system's ability to process and report claims and authorization information in a format and process compatible with that required by Medicaid (Medicaid Management Information System). Mercer performed the analysis with the following findings:

- The Casewatch® system contains fields which would allow for the prior-authorization of services by modality code as identified by OAPP or through the use of Common Procedural Terminology (CPT) procedure codes.
- The system reporting capacities are quite flexible and can be designed to fit the needs of the user in a variety of ways.



5

Budget Impact Analysis

In any rate development exercise, the importance of evaluating the impact of the rates on the program budget at the existing level of funding cannot be overemphasized. Additionally, it is also critical to assess and seek to quantify the impact of the rates on the individual providers. This is especially important for HIV AOM services in the County of Los Angeles, where different compensation systems have been developed over long periods of time, with different negotiation characteristics. In such an environment, the replacement of these reimbursement amounts with a standardized published rate system will result in increases in rates for some providers while others may see decreases in reimbursement rates. For this reason, Mercer performed an in-depth budget analysis to study the impact of the rate system on each provider to determine the amount of increase or decrease they will experience. This information was provided in the draft report released in October 2007. However, the provider community argued that the encounters supplied by OAPP, against which the rate was multiplied, were problematic and should not be used. In this final report, Mercer could only analyze the net gain/loss for those AOM providers who had submitted an ESIS and a general ledger.

Methodology

The process used to perform the budget impact analysis for Los Angeles County consisted of the following steps:

- Establish existing allocation: This was provided by providers on the ESIS.
- Establish proposed rates: The development of proposed rates is discussed in this report in Section 4.
- Calculate budget variance: Mercer calculated the difference between current allocations and anticipated allocations if the new rate was implemented.
- Measure impact on individual providers: The impact of the proposed rate system on each individual provider agency was then calculated and expressed in total dollar amounts.

Budget Impact Results

A comparison to previous AOM allocation to anticipated allocation for those providers who submitted an ESIS are provided below:

Provider	Net Gain or Loss at \$375.37 Rate	Net Gain or Loss at \$284.86 Rate
1	\$ (737,047.59)	\$ (3,515,187.20)
2	\$ 666,290.96	\$ 156,007.49
3	\$ 9,356.75	\$ (146,769.36)
4	\$ (961,383.38)	\$ (1,663,181.54)
5	\$ (85,422.36)	\$ (275,850.96)
6	\$ 164,714.91	\$ 106,337.32
7	\$ (444,172.57)	\$ (568,982.95)
8	\$ 68,965.43	\$ 23,711.49
9	\$ 116,707.86	\$ (327,414.35)



6

Third-Party Payer Reimbursement

In delivering any health or health-related service, the presence of multiple funding and payer sources inevitably results in high levels of complexity, both in terms of billing practices and reimbursement mechanisms. This is all the more true for publicly-funded systems such as the HIV/AIDS services that owe the majority of their budgets to funding sources of last resort. Typically, processing claims as a payer of last resort is a function described as Coordination of Benefits and relates to billing the appropriate entity responsible for payment. Coordinating payment from multiple funding sources including Medicare (Title XVIII), Medicaid (Title XIX), HRSA Ryan White CARE Act funds, State and County, private-sector or private insurance can be daunting when a client is eligible for more than one insurance or funding program. To better understand the complexities of multiple reimbursement mechanisms and to create a rate system that encourages the appropriate and optimal use of available funding sources, OAPP included an evaluation of third-party reimbursement as a component of this rate study.

Methodology

To address the issue of third-party reimbursement and to identify whether services for people living with HIV/AIDS are being reimbursed by other insurers or third-party payers, Mercer performed a series of investigatory activities that are summarized in the steps outlined below.

Mercer focused on a review of an array of services associated with people living with HIV/AIDS for the purpose of analyzing the status of Coordination of Benefits. Mercer also reviewed current processes for determining client co-payments.

Step 1: Collect Information on OAPP Data Systems

Mercer obtained existing information from the client information systems from OAPP staff. The specific “screen prints” from the current OAPP prior-authorization and claims processing information systems that were collected and reviewed include:

- Client Basic Data
- OAPP Report Demographics
- HRSA Client Level Information

Step 2: Analyze Information System Elements and Reports

Upon receiving the screen prints, Mercer evaluated each one for evidence of three components of Coordination of Benefits among the funding sources:

- Indication that the person receiving services was eligible for coverage under one of the other funding programs, particularly at the time of eligibility for services, through OAPP.
- Identification of the agent that gathers the information for billing purposes and at what stage of assessment or services the information is gathered from the person receiving services. For example, was the information gathered at the time the referral was being considered by the provider, during an eligibility or intake review, by the provider at the time services were to be provided, or even later during services?
- Any evidence that the data field in which the information would be entered is a required field and whether it would be of the sort that might link to a claims processing or prior-authorization module that would be able to pend a claim or a prior-authorization as a result of the field being populated with the specific evidence of third-party coverage.

Step 3: Discuss Initial Observations with OAPP

After the initial review and analysis, Mercer met with staff of OAPP and the Office of the Auditor-Controller staff to discuss preliminary findings and to seek clarification on certain issues related to third-party coverage. Through these discussions, many of Mercer's observations were confirmed.

Step 4: Review Public Sources of Funding

For the primary care services included within this study, Mercer evaluated other public sources of funding available in the County of Los Angeles to determine if the services are covered by these public programs and if so, whether providers are maximizing these funds for the clients that they serve.

Step 5: Review Commercial Insurance Coverage

Another key area of focus for this rate study was the availability of commercial insurance coverage for the service categories included in this study. To address this, Mercer reviewed benefit packages of national and local commercial insurance providers and also interviewed experts in insurance benefit design to determine existing levels of coverage for these services.

Findings and Results

The observations made as a result of this analysis are presented in this part of the report under the following sub-sections:

- Third-party Coverage and Reimbursement
- Coordination of Benefits
- Co-payments and Client Fees

Third-Party Coverage and Reimbursement

For the primary care services included within this rate study, RWCA funds obtained through HRSA must be considered funds of last resort. This is clearly mandated in the CARE Act of 2000 legislation. Outside this funding source, Mercer found that in the County of Los Angeles, a number of third-party funding programs currently exist and may be utilized to serve HIV/AIDS clients. Each of the key funding sources is discussed below and wherever possible, the amount of funding available from each source is also outlined.

Federally Qualified Health Center Program

Because the PHS Section 330 Community Health Center Program and the Federally Qualified Health Center Programs are considered “sister” programs with other federally-funded special population health programs, Mercer debated briefly the advantages and disadvantages of OAPP-funded medical providers becoming federally qualified health centers (FQHCs). This was considered because it would provide a way to take advantage of the cost-based reimbursement the FQHC program provides to community and public health centers. However, the organizational development challenges that come with this designation proved to be too onerous for some of the currently-funded community health providers. For example, the Board of Directors of an FQHC must comply with the PHS Section 330 51% consumer member standard. The administrative and financial reporting requirements are quite sophisticated and would make for comprehensive technical assistance needs for some community providers, together with demanding substantial financial development to support the corresponding organizational development and management needs. Most important, however, is the wholesale change of organizational focus this designation would require as FQHCs must demonstrate a capacity to provide comprehensive general primary care to all clients. Currently, OAPP funds are used to support specialized HIV/AIDS primary care only and some of the currently funded providers do not directly provide general comprehensive primary care to their clients, let alone to the client’s family members or social affiliates. Therefore, to recommend this designation be pursued by all OAPP-funded providers at this time is too sweeping an organizational, financial and mission change.

Medi-Cal Program

Medi-Cal is the State of California's Title XIX Medicaid entitlement program and the largest source of publicly-funded care services in the State. Medi-Cal is governed by stringent and complex federal regulations, as well as California-specific rules, to ensure optimal and appropriate use of public funds for health care delivery. Physical health providers appear to be more aware of Medi-Cal funding regulations and utilize this fund source where appropriate. However, providers should be clear that the expectation is that all Medi-Cal allowable service reimbursement be collected and the contracts should reflect this requirement.

On the surface, obtaining Medi-Cal reimbursement may seem a fairly simple process linked to three main criteria:

- Service must be a covered Medi-Cal benefit
- Client must be eligible and enrolled in Medi-Cal or the designated waiver
- Provider must be certified to participate in Medi-Cal

However, the more one delves into the program and its regulations, the more complicated and elaborate the system becomes. For providers, the complexity of Medi-Cal begins with the large number of unique programs that exist under the Medi-Cal umbrella. Some of these programs are structured as traditional FFS reimbursement models while others are covered through managed care arrangements. States, such as California, have exercised the option made available through the Social Security Act to "waive" certain federal requirements and implement innovative health delivery programs through both program waivers (Section 1915(b) and (c)) and research and demonstration waivers (Section 1115). Each of these waiver programs targets a specific population, has its own unique eligibility criteria and often has distinct services covered within the program's benefit package. Adding to this complexity, each individual Medi-Cal program has its own provider application process. This process may also vary by provider category.

Medi-Cal Covered Services

As a way of assessing whether the Mercer rates of reimbursement are within the public sector range, Mercer conducted a review of services covered by Medi-Cal. For this particular set of medical services, the attempt to make one-to-one comparisons with Medi-Cal was not possible. This is because of the particular approach used by OAPP in the delivery of a service (e.g., the Roy Adaptation model for medical case management), because there were no one-to-one correspondences in services (e.g., the State model for ADAP enrollment services), or because of the recent revisions to PHS guidelines that are changing HIV/AIDS medical service delivery. The service descriptions developed by Mercer were based on the service delivery approaches discussed with OAPP and stakeholders. Additionally, the Mercer rate setting architecture is a method that weds reimbursement rates with the most current standards of care. Therefore, as the following summary will demonstrate, the Mercer rates are not comparable to Medi-Cal rates (with the exception of Nutritional Counseling (Medical Nutritional Therapy)):

1. HIV/AIDS AOM Care Services: This service description has two new aspects that are not paralleled in the service model underlying current Medi-Cal rates. First, the service description includes new service components, implemented in the routine medical encounter, that are based on the PHS guidelines' recent emphasis on the integration of HIV prevention within primary medical care, the significance of treatment adherence services and the essential attention to nutrition. These requirements expand the scope and duration of the routine medical encounter, and define enhanced areas of expertise needed by the primary care provider in each routine medical encounter.

Second, the service description (and corresponding rate of reimbursement) is based on a specific personnel model (physician-like professionals).

As a result the Mercer rate of reimbursement incorporating these features is not comparable with current Medi-Cal FFS rates of reimbursement nor with the service model on which the Medi-Cal rates are based.

2. Eligibility, Education and Enrollment Services for ADAP: California service components in this service description are defined and specified by the California Department of Public Health, Office of AIDS and they are distinctive to how the RWCA, AIDS Drug Assistance Program is implemented in California. There is no comparable Medi-Cal program with which to compare rates of reimbursement for this service.
3. Nutritional Counseling (Medical Nutrition Therapy): There is a Medi-Cal reimbursement rate for Medical Nutrition Therapy; however, this rate was established January 1, 1993, for the AIDS Medi-Cal Waiver Program (MCWP). The development of AIDS Waiver Programs preceded advances in health outcomes as a result of HIV-related pharmaceuticals, and State health financing departments established them as a way to keep AIDS patients out of expensive hospital and/or nursing home care.

The Medi-Cal rate is: Nutritional Counseling \$33.48/hour

The OAPP service description and corresponding reimbursement rate currently does not include the costs for nutritional supplements as a discrete billable item, and neither does the above Medi-Cal rate. In the MCWP, "Nutritional Supplements/Home Delivered Meals" are capped at \$150.00 per client per month. This cap also was established January 1, 1993. The Mercer rate study uses current, geographically relevant Bureau of Labor Statistics data as an indicator of actual personnel hiring costs, and then factors these costs with other real-time program and administrative costs derived from actual agency cost reports. Therefore, the Mercer rate of reimbursement is a more realistic reimbursement rate for this service in 2007.

A note from Medicare/Medicaid: The American Dietetic Association (ADA) proactively works to assist Registered Dietitians in understanding billing procedures and actively describes appropriate billing codes. There are Medicare/Medicaid CPT codes for Medical Nutrition Therapy released by the Centers for Medicare and Medicaid Services (CMS) and included in the American Medical Association's (AMA) Current Procedural Terminology CPT book. Medi-Cal has not adopted these codes for reimbursement.

Coordination of Benefits (Third-Party Payment)

Coordination of Benefits is described as the function of identifying third-party coverage for services needed by a client and to bill these multiple third-party payers before accessing funds of last resort. This is often the responsibility of the provider of service and oversight and monitoring is provided by the funding agency. In many cases, a designated third-party administrator may also be used to assist in this process. As demonstrated through the preceding discussion, there are multiple funding sources for AOM Care services in the County of Los Angeles and the task of Coordination of Benefits across all these funding sources becomes all the more critical especially in the wake of increasing costs of care and flat or declining budgets for service delivery.

On examination of OAPP information system screen prints, Mercer found that there is a single question in the group of screen prints that, if filled in, would indicate whether or not the individual was covered for services by a third-party insurance plan. Mercer also found that third-party coverage information is supposed to be gathered by provider agencies at referral and periodically thereafter.

Mercer was able to confirm that while the data field in the current system is a required field for providers and that the information is sometimes gathered about third-party coverage, the submission of the data confirming third-party payment is not linked to any outside claims adjudicating system. Therefore, there is no process within OAPP to actually track whether the client has third-party coverage and if the provider submitted a third-party claim.

Utilization of third-party payer information in a client information file by cross-referencing the information in claims adjudication assures a "cost avoidance" approach as opposed to a "pay and chase" approach. The cost avoidance approach is recommended by federal funding sources, such as Medicaid. However, linking the data field related to third-party payer to prior-authorization and claims adjudication systems that are apart from the systems containing third-party information, and particularly when used by agents other than the prior-authorization and claims processing agencies (as is the case with OAPP), can involve major systems restructuring and be prohibitively expensive.

Due to the costs associated with the integration of systems to link third-party payer information to prior-authorization and claims adjudication data, Mercer recommends that

the most efficient and cost-effective solution is to build on the processes already in place. Specifically, by ensuring that the data field for third-party payment is a required field and the information system links the field to the invoice from the provider, OAPP will have this information available for its back-end review and follow up. Through discussions with OAPP staff it was noted that currently OAPP does review fee determination and third-party payer coverage as part of their on-going monitoring processes. This retrospective monitoring process is often time-consuming and complicated.

In practical terms, OAPP could employ one of two different options to accurately track third-party coverage information:

Option 1

OAPP could require that the providers submit an invoice that contains third-party payer information. When a client has third-party payer coverage, the invoice must be accompanied by an Explanation of Benefits from the insurer as evidence the insurer has been billed for covered services. OAPP then can reimburse providers only for the uncovered service up to the amount of the published rate.

The Health Insurance Portability and Privacy Act (HIPAA) contains certain clauses related to claims processing and Coordination of Benefits which though once were recommendations of the General Accounting Office, are now requirements under HIPAA. Clause §162.1801 Coordination of Benefits Transactions and Clause §162.1802 Standards for Coordination of Benefits require that all electronic claims be submitted in ASC X 12N 837- Health Care Claim format which includes any prior paid components of the claim. Towards this end, HIPAA Subpart P – Health Care Payment and Remittance Advice §162.1601(b) Health Care Payment Remittance Advice Transaction requires the submittal of Explanation of (Medicare) Benefit (EOB, EOMB) documentation as part of claim submission, again in ASC X 12N 835 format.

This means that it is now required for publicly-funded health and social services which are subject to HIPAA to submit all claims after having been determined to be coverable by any third party, that such documentation be submitted with the claim in the proper format, and that only the unpaid (net) amount be claimed by the HIPAA-compliant agency.

Option 2

A second option for OAPP could be the use of a Third-Party Administrator (TPA) or a similar external entity to work with the providers to provide confirmation of client eligibility prior to reimbursement and to verify that the primary insurer has been billed for covered services. This option may be a simpler alternative to implement given the complexity of current funding streams and should be explored further by OAPP.

Co-payment and Client Fees

Co-payment is a cost-sharing arrangement in which a person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. The service provider has responsibility for collection of the co-payment because insurance payments to the provider are made net the co-payment. However, in the case of Medi-Cal enrollees and Medi-Cal-funded services, it is not permissible for an agency to assess a co-payment from the person receiving services.

Providers interviewed in the first phase of this project universally reported that most of their clients were not assessed a co-payment. According to the providers, two issues made collecting co-payments problematic. Providers worried about the administrative burden of collecting the co-payment and about their liability if they refused services because the client did not have the co-payment.

Co-payment is probably not an avenue for significant additional revenue collection by OAPP. Hence, AOM rates that have been proposed as part of this study are designed to be net of any client fees or co-payments.

OAPP should develop a standard policy specifying the management of client fees. The Medicare program has established some guidelines relating to the management of client fees and may be referenced in establishing this policy. The guidelines are incorporated within various chapters of the Medicare Claims Processing Manual.

It is important to note that based upon early conversations with HRSA staff, Mercer found that HRSA does not have any specific recommendations on client fees and allows individual HIV/AIDS Agency discretion as to the structure and management of such an arrangement with appropriate disclosure.

7

Barriers/Disincentives and Recommendations

The best designed and most successful rate systems are those that are based on requirements for quality care. Mercer has sought to adapt the rate architecture based on service descriptions developed based on a combination of current program requirements and recognized best practices. Throughout this process, Mercer identified barriers to the implementation of the proposed rate architecture that could potentially discourage or even prevent cost-effective, high quality service delivery. Specific attention was given to the following areas:

- Restrictions on financial compensation methodologies
- Restrictions from outsourced labor and the collection of donations
- Any guiding regulations that may impede the ability of the County of Los Angeles to develop the provider network related to procurement
- Prohibitive regulation for management and establishment of sites
- Excessive restrictions and requirements that are not feasible in the County of Los Angeles
- Community-based restrictions, such as availability of qualified staff that meet staff requirements

Some of the key barriers identified through the course of this study are listed and discussed below. Wherever appropriate, Mercer has recommended strategies that the Board of Supervisors through OAPP could explore to address or alleviate these barriers or disincentives.

Exceeding Accepted Standards

In Work Order No. 6-49, Mercer was asked to suggest ways to incentivize providers to exceed the accepted standards; however, Mercer found that the adoption of the new HIV/AIDS Continuum of Care Model set a high standard for all providers of HIV-related medical services in Los Angeles County. The model was based on earlier federally-funded pilot or “demonstration project” innovations (e.g., the integration of

prevention and treatment services in medical settings) that are now accepted standards in the PHS Primary Care Guidelines. To date, the Office of AIDS Programs and Policy and the Commission on HIV are cooperating in system planning and agency infrastructure development initiatives that will facilitate fulfilling these accepted standards. When interviewing providers, Mercer found them in full support of the new HIV/AIDS Continuum of Care Model but also interested in technical support and capacity-building opportunities that will assist them in meeting the Model's expectations. The recommendation at this time is to solidly implement the accepted, higher standards of care that support the HIV/AIDS Continuum of Care Model.

Because the science and practice of HIV/AIDS medical management continues to rapidly evolve, exceeding the current PHS standards in any one year is rarely achieved. Mercer recommends OAPP and the Commission on HIV continue to implement its public health role in announcing and distributing standards of care revisions and updates, and continue their roles in agency and provider education, training, development and capacity-building as a way to remove barriers to meeting these standards of care.

Maximizing Medi-Cal Funding

As discussed in the previous section of this report, Medi-Cal is a significant, albeit a complex, source of funding for HIV/AIDS services and it is critical that providers maximize the funding available through this entitlement program.

Mercer Recommendations: CARE Act of 2000 legislation mandates that CARE Act funds be the payer of last resort, and HRSA has mandated that wherever other programs such as Medicaid exist for HIV/AIDS services, these funds must be maximized before using RWCA funding. Based on these mandates, many states and jurisdictions require their HIV/AIDS providers actively participate in the Medicaid program. For the selected services in the County of Los Angeles, Mercer recommends the following:

- OAPP and the Commission should work closely with the California Department of Public Health to identify and clearly define HIV/AIDS services that could be reimbursed by Medi-Cal and to identify the appropriate Medi-Cal programs/waivers that HIV/AIDS providers may participate in.
- The collaboration with California Department of Public Health could extend to the task of increasing awareness and knowledge among HIV/AIDS providers of the importance and need for maximizing Medi-Cal funding for individual service components that are delivered. The California Department of Public Health provides training sessions to providers on various topics related to the Medi-Cal program. Providers should be encouraged to avail of these training opportunities.
- OAPP could use its established training curriculum to offer additional training and technical assistance to providers on the utilization of Medi-Cal as a fund source. This is an area that has been deemed a HRSA priority and RWCA grant funds have been utilized in other states to offer this type of technical assistance. In the past, HRSA has provided third party payment training in the County of Los Angeles. Attendance at these types of training should be mandatory for providers that contract with OAPP.

- OAPP may wish to audit a sample of medical files to determine if Medi-Cal funding is underutilized.

Medical Specialty, Drug Resistance Testing and Medical Case Management

Mercer Recommendation: Mercer recommends the service description written for Referral to Medical Specialty Service not be funded as a separate and distinct reimbursable service. The requirement to assess for, refer to, and track specialty care services is an integrative component of the PHS guidelines for HIV-related primary medical care. Therefore, the separate service description for Referral to Medical Specialty Service is redundant and duplicative of the service description for Ambulatory/Outpatient Medical care services.

In making this recommendation, Mercer is also recognizing and recommending the long term RWCA “best practice” of local provider-to-local specialty provider negotiated rates for specialty care be continued. This practice and the subsequent negotiated rates customarily have a charity basis that has prevented significant use of RWCA funds for a single expensive specialty care service and thereby permitted distribution of these limited funds across many needed medical services.

This recommendation in no way is intended to lessen the focus and attention given by OAPP to continue to fund medical specialty services; however, as prior discussion in the report has emphasized, a single rate of reimbursement for medical specialty service is neither feasible nor desirable.

Mercer Recommendation: Because of changes in the PHS HIV/AIDS standards of care, Mercer recommends this service description no longer be funded as a distinct and separate service category. Drug resistance testing was earlier viewed as a highly specialized service but is now considered routine within the medical management of HIV disease. Therefore, the new expectations associated with drug resistance testing are incorporated as expectations within the HIV/AIDS Ambulatory Outpatient Medical Care service description.

Mercer recommends that the actual costs of the blood screening continue to be absorbed by the State of California, Office of AIDS, Resistance Testing Program. The Mercer recommendation, therefore, does not assume these lab costs will be absorbed by the HIV/AIDS AOM providers contracted through OAPP. The medical tasks relevant to client pre- and post-testing counseling and education for drug resistance are now routine HIV/AIDS medical management services to be provided by HIV/AIDS practitioners contracted through OAPP.

Mercer Recommendation: Because the configuration of services included in Medical Case Management was under review, this report contains no rate recommendation for a separately reimbursed Medical Case Management service. Mercer worked collaboratively with select OAPP program management staff to identify an appropriate model for HIV/AIDS Medical Case Management, taking into consideration the Board of Supervisors' expectations and OAPP's existing service delivery pattern of using clinical nurses to provide care coordination. The Roy Adaptation Model for nursing case management was reviewed and mutually found appropriate for this service description initially. An initial rate was developed for Medical Case Management based on the Roy Adaptation Model. During the time frame included in this study, Medical Case Management was being closely scrutinized by OAPP and the Commission on HIV. The Commission revised its Standard of Care effective May 11, 2006. However, Medical Case Management continues to be reviewed and revised as a service and no service description or rate recommendation is included in this report.

Acuity Modifier

OAPP asked Mercer to explore an acuity modifier in the rate development process. The construction of such a modifier should follow these steps:

1. Identify the co-morbidity(s) that would most probably result in a more intense level of need (e.g. hepatitis).
2. Select the case files of individuals for whom the co-morbidity diagnosis applies.
3. Pull the expenditure records for the individuals with co-morbidities and make a comparison between those cost profiles and those of the general patient population.
4. Express the modifier as a percentage applied to the proposed rates.

The use of a diagnostic profiling approach (International Classification of Disease) or service procedure approach (CPT codes) is not recommended unless the consistency and accuracy of the use of diagnostic and procedure codes can be established and linked to expenditure records in a meaningful way.

It is also possible to adjust the rates by providers based on the percentage of AIDS-infected persons treated versus the percentage of HIV-infected people treated. The table below shows a list of current providers and the range of the clients' status.

Providers' Self-Reported Percentage of AIDS Patients (January 2007)

Provider	% AIDS-infected
Harbor UCLA	90%
Catalyst	60%
St. Mary's	60%
City of Pasadena	54%
El Proyecto	50%
AltaMed	47%
T.H.E. Clinic	47%
Watts	35% – 40%

Provider	% AIDS-infected
North East Valley	30% – 40%
AIDS Health Care Foundation	35%
MLK/OASIS	32%
Children’s Hospital	20% – 30%
Gay and Lesbian Center	13%

Lastly, OAPP could consider an adjustment based on the status of the client in treatment: New Patient/Newly Diagnosed, Regular Visit, Follow-Up/Brief Visit. However, current cost data is not available to differentiate the rates but could be studied over time.

Mercer Recommendation: Because accurate cost data on acuity differentials is not readily available, Mercer recommends OAPP initially pay providers a single rate, reconcile payment against actual costs on a routine basis, and develop an acuity adjuster, if necessary, as the issue is studied further.

Implementation of Rates: Budget Impact Concerns

Mercer Recommendation: Finally, Mercer offers recommendations related to the implementation of the standardized rate system. The first recommendation addresses the issue of the general and administrative percentage to be used for the final rate calculation and the second recommendation relates to reconciliation of the allocation paid to providers at the single rate versus the true costs.

Mercer recommends that OAPP engage in internal policy decisions regarding the general and administrative percentage to be used for a single provider rate. At the 10% cap rate, providers may be under-funded for their true total costs.

OAPP should consider a reconciliation process that compares paid rates against true costs for providers after six months. OAPP could choose to “shadow implement” the rates, paying the providers with the historical funding methodology and comparing it to what payment would have been if providers had been paid the single rate.



8

Next Steps

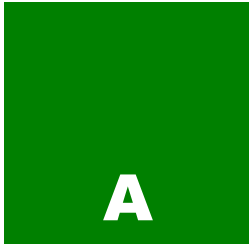
Through this study, an actuarially sound and locally relevant rate system has been proposed that supports clinically appropriate services for people living with HIV/AIDS in the County of Los Angeles. A critical next step in the implementation of the rates is the finalization of policy and process decisions related to the level of budget funding available for these services. This will also involve policy decisions regarding the level of impact that OAPP will allow individual providers to sustain as a result of the new rates. Adjustments to the rates can be made based on these policy decisions.

It is commendable that throughout the study, OAPP has demonstrated a strong commitment to ensuring a collaborative process in rate development. To that end, OAPP and Mercer have met with and interviewed providers on an on-going basis. To facilitate the successful implementation of this proposed rate architecture, this level of County and provider collaboration should be continued and strengthened.

In any rate development exercise, the initial hurdles and barriers that may be encountered are numerous. This is clearly demonstrated in the list of barriers that were identified through the course of this rate study and that were presented in this report. While Mercer has sought to present recommendations and potential solutions that address or mitigate these barriers, it is clearly understood that implementation will not be without issues. The issue of the general and administrative percentage to use in the rate calculation is an example of an immediate policy issue that must be considered and resolved. Some recommendations deserve immediate attention while others should be addressed in and throughout the RFP process. Other issues may require a more sustained and long-term approach and can be addressed after the release of the RFP. A summary of the recommendations are presented in the table below.

Mercer is privileged to have had the opportunity to work with OAPP and the County of Los Angeles on this exciting and innovative rate study. Based upon Mercer's experiences in the areas of HIV/AIDS and rate development across the United States, it is clear that the County of Los Angeles is a leader in the effort to link HIV/AIDS reimbursement to

appropriate clinical standards and practices thereby ensuring both high quality and cost-effective service delivery. Mercer is confident that through the collaboration of the County and its HIV/AIDS providers, a planned and coordinated implementation strategy, and appropriate training for all those involved, OAPP will be able to successfully implement this rate architecture and serve as a model for structured and equitable reimbursement methodologies for other HIV/AIDS programs nationwide.

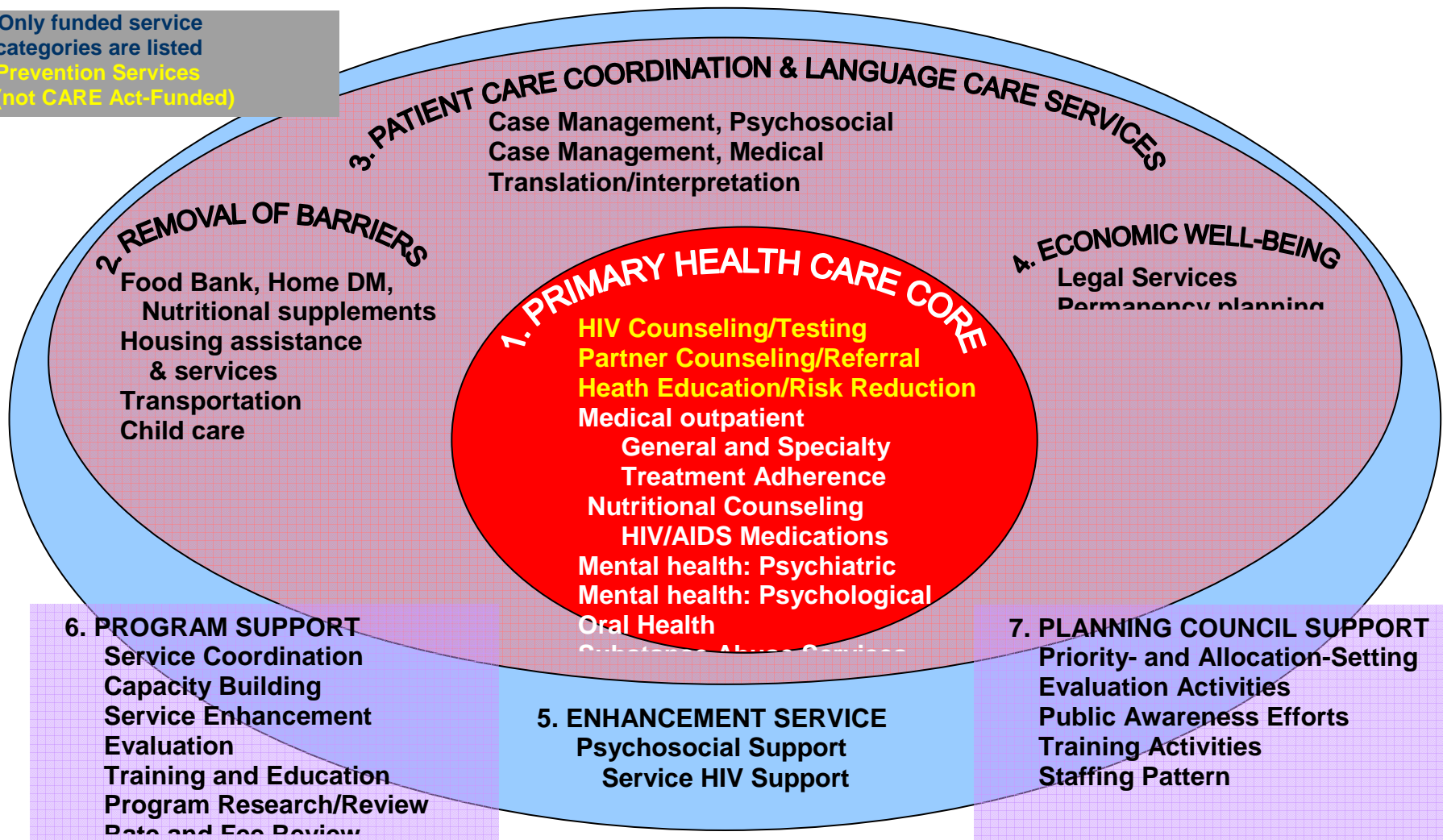


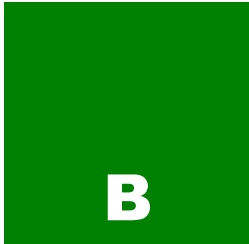
HIV/AIDS Continuum of Care Model, County of Los Angeles

The Commission on HIV approved the HIV/AIDS continuum October 14, 2004

HIV/AIDS CONTINUUM OF CARE MODEL, COUNTY OF LOS ANGELES

Only funded service categories are listed
Prevention Services
(not CARE Act-Funded)





Review of HIV/AIDS Continuum of Care Model

HIV/AIDS Medical Clinics Fee-for-Service Reimbursement Rate Study

County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy

Mercer Government Human Services Consulting

Work Order Request No. 6-49 (January 2004)

Work Plan Task III.a.3: Review Continuum of Care Model

Melanie L. Sovine, PhD

November 22, 2004

► Introduction

The HIV/AIDS Continuum of Care Model is an outcome of the County of Los Angeles Strategic Planning Process (1999-2001). In 2001, the new Continuum of Care was jointly approved and adopted by the County of Los Angeles Commission on HIV (Commission), the Prevention Planning Committee (PPC), and the Office of AIDS Programs and Policy (OAPP).

The model was first adopted for use in health systems planning and development, and planners and staff continue to use this model as a foundation in the annual “Priority and Allocations Process” required by the Ryan White CARE Act (RWCA). The model figured prominently in the development of the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)* and has proven helpful in broadening the focus of planners and providers beyond government resources when financial planning and development needs are raised.

Improving HIV-Related Health Outcomes. From the beginning, the HIV/AIDS Continuum of Care Model was a bold statement of commitment to improving the HIV-related health outcomes for all individuals and families at risk for or infected with the HIV virus, and to reducing the disparities in HIV-related health outcomes for racial, ethnic, and social minorities in the County of Los Angeles. Moving towards fulfillment of this commitment, planners, providers, and OAPP staff use the model to focus concretely on how the Continuum of Care Model’s HIV/AIDS **Primary Health Care Core Services** will be made available to County of Los Angeles citizens who depend on publicly-funded HIV/AIDS services.

Patient Care Coordination. The HIV/AIDS Continuum of Care Model pushes beyond the single issue of “access to services” to a more complex question of how to assure that clients have appropriate access to services, utilize them consistently, are effectively retained in services over time, and adhere to medical regimens while receiving HIV/AIDS services. This service formula, Access-Utilization-Retention-Adherence, underscores a second commitment (i.e., providing Patient Care Coordination services for those who need them so that improvements in HIV-related health outcomes may, in fact, be achieved). The HIV/AIDS Continuum of Care Model is a client-centered and flexible one, with multiple points of entry, and while it sets a clear standard by delineating the critical HIV/AIDS service components in a state-of-the-art continuum of care model, it does not impose a single set of services for any one or all clients who may seek services within this Continuum of Care Model.

Integration of Prevention and Care Services. There is a third commitment evidenced in the HIV/AIDS Continuum of Care Model’s design; a commitment to effectively integrating HIV prevention services with care and treatment services. HIV prevention services are an integral component of the HIV/AIDS **Primary Health Care Core Services**. Planners, providers, and OAPP staff are focusing not only on how to seamlessly

link the prevention and care service systems, but how to give equal weight to HIV prevention in the context of routine and recurring medical care.

The HIV/AIDS Continuum of Care Model is a conceptual tool that helps planners, providers, and staff review service needs from a comprehensive perspective, not just in terms of the services categorical funding sources are willing to support. It is being used to better inform quality assurance and standard of care activities, and is used as a general guideline when monitoring the practice of clinicians and other health/social service practitioners. Finally, the HIV/AIDS Continuum of Care Model is currently being used by OAPP staff to revise funding program “Requests for Proposals,” and one provider interviewed for this report described using the model to “better integrate and manage the core team” now needed in the HIV/AIDS primary health care program she supervises.

Approach to Model Review. As a part of *The HIV/AIDS Medical Clinics Fee-for-Service Reimbursement Rate Study (Work Order Request No. 6-49, January 2004)*, Mercer Government Human Services Consulting (Mercer) agreed to review the HIV/AIDS Continuum of Care Model noting specifically:

- the key strengths and weaknesses of the current model;
- existing barriers to the attainment of the goals of the model;
- opportunities to address these barriers and enhance the model; and
- opportunities to link this model with appropriate incentives.

Mercer reviewed the model and related goals described in the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)*. Because the Commission continues to improve the model through its planning processes, Mercer also reviewed the most current version of the model approved by the Commission on October 14, 2004.

The Work Order Request called for interviews with Commission members, HIV/AIDS service providers, and OAPP staff. OAPP and Commission staff jointly identified the individuals to be interviewed by Mercer. They included individuals capable of speaking from both the prevention services and care services perspectives. A set of open-ended interview questions was developed to permit interviewees to respond to each of the four areas listed above. Mercer conducted the interviews by telephone and sorted the responses into the same four areas listed above. The interview responses are presented in summary form in this report.

Relying significantly on the interview material, Mercer completed the review by drawing observations from the collected perspectives and formulated suggestions provided in the last section of this report.

Mercer Peer Review. All work performed by Mercer is subjected to a strict quality assurance process. Mercer has clear professional standards regarding the process of “peer review” (quality control) at various steps in product development. Mercer utilized this

peer review process in the development of this report. We applied peer review from a number of perspectives, reviewing this work product as follows:

- *Technical Peer Review* to ensure accuracy and overall reasonableness;
- *Consulting Peer Review* to ensure the soundness of the approach and to ensure that the appropriate issue/question has been completely addressed in a clear manner;
- *Editorial Peer Review* for grammatical and spelling correctness as well as professional appearance; and
- *Final Look Peer Review* to ensure a professional work product appearance that meets the delivery and other specifications.

OAPP Internal Review. Before release of this report, Mercer reviewed its contents with the managerial staff of OAPP and incorporated the revisions suggested by them. Drafts of the report were reviewed by managerial staff representing both HIV prevention and care/treatment services.

▶The HIV/AIDS Continuum of Care Model



The HIV/AIDS Continuum of Care Model is conceptually defined by a core of HIV/AIDS **Primary Health Care Core Services** considered to be essential to improving the health outcomes for all citizens of the County of Los Angeles at risk for or infected with HIV/AIDS. Primary care in this model includes services for physical and emotional health, and the core gives mutual weight to both HIV prevention and care and treatment services.¹ Medication services are a component of *Outpatient Medical Services*, provided to interrupt or delay the progression of HIV disease, prevent and treat opportunistic infections, and promote optimal health.

The **Primary Health Care Core Services** is supported by *Wrap-around Services* categorized as services for the *Removal of Barriers*, for *Patient Care Coordination and Language Services*, services related to *Economic Wellbeing*, and *Enhancement Services*. While the *Wrap-around Services* are related generally to improving health outcomes, these services, when combined with the **Primary Health Care Core Services**, are especially related to reducing the disparities in health outcomes experienced by racial, ethnic, and social minorities in the County of Los Angeles. They are also intended to assure clients access and receive appropriate primary care services.

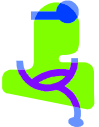
¹ For a thorough description of the HIV/AIDS Continuum of Care Model, see the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)*, pp. 1-3 through 1-8, available through OAPP.

The services listed within *Removal of Barriers* are designed to help optimize the critical paths through which clients access, utilize, are retained in and are adherent to primary care services. *Patient Care Coordination* and *Language Services* provide clients with the expert guidance needed to fully utilize continuum of care services. Services related to *Economic Wellbeing* assist in the amelioration of poverty and the removal of financial roadblocks to continuing in prevention and care services. *Enhancement Services* are self-help oriented services designed to improve the quality of life for specific populations or communities.

The HIV/AIDS Continuum of Care Model is intended to guide planners and service providers in the development of quality, state-of-the-art services in HIV/AIDS. It is intended to promote a more equitable development and access to HIV/AIDS **Primary Health Care Core Services** in the County of Los Angeles, and intended to permit a more culturally-appropriate development of *Wrap-around Services* within and across communities in the County of Los Angeles.

► **The Model Review’s Relationship to the Rate Study**

The medical services rate reimbursement study focuses on six services that are critical components to the HIV/AIDS Continuum of Care Model’s **Primary Health Care Core Services**. The study includes a thorough review and revision of service descriptions according to national standards of care, and takes into consideration costs and service delivery issues related to meeting the national standards.

<p>Medical Services Rate Study</p>  <p>Ambulatory/Outpatient Medical Care</p> <p>Referral to Medical Specialty Services</p> <p>Drug Resistance Testing</p> <p>Medical Nutrition Therapy</p> <p>Medical Case Management</p> <p>ADAP Enrollment</p>

The study is designed to facilitate OAPP in procuring and providing quality, state-of-the-art HIV prevention, and care services. Therefore, the rate study includes a general review of the HIV/AIDS Continuum of Care Model in order to flag variables that strengthen and/or challenge the provision of these services within the prescribed HIV/AIDS Continuum of Care.

The Continuum of Care Model review is not a full-scale evaluation of the HIV/AIDS Continuum of Care Model, but rather a supporting activity that offers broad perspective and helpful suggestions to improve the model that cradles the medical services in the rate reimbursement study.

► **Summary of Model Review Interviews**


The summary that follows is paraphrased from 11 telephone interviews conducted by Mercer. Phrases presented in quotation marks are direct, anonymous quotes from

interviewees. A few quotes are selected for emphasis in text boxes and are linked, with permission, to the interviewee that made the statement.²

Key Strengths and Weaknesses. Planners, providers, and staff all expressed full support for the HIV/AIDS Continuum of Care Model, saw it as providing appropriate direction for HIV/AIDS services in the County of Los Angeles, and described weaknesses more in terms of challenges in implementing the model. Interviewees tended to pair strengths and weaknesses rather than to list discrete or unrelated strengths or weaknesses.

■ The model is a “true attempt at integration” and looks at “HIV disease as a Continuum of Care.” However, it is “difficult to get providers to look at HIV in this same way,” to not look at the service they provide as a distinct unit. Providers need to work within the linkages and “view the client’s overall care as a continuum.”

■ The HIV/AIDS Continuum of Care Model recognizes that each client is an individual with “a specific need for a specific set of services.” However, the geography of the County of Los Angeles is very large and is “hard to navigate services.” This allows for “splitting and duplication of services” within the Continuum of Care Model.



Fariba S. Younai, DDS


“HIV disease is a continuum. You cannot say one service is more important than the other. A client’s overall care is a continuum.”

■ The model “clarifies the whole spectrum of need” but it is sometimes “unclear that just because the service is needed does not mean RWCA funds will provide it.”

■ The model actually synthesizes “all that has gone on before in HIV” and presents this as a “phenomenal Continuum of Care Model.” However, the presentation is “not simple enough” for those who do not have “a historical background in HIV.” It is hard to “get the whole meaning of the recipe” and there is “not enough room to learn” about the model.

■ The model identifies needs overall and “allows the County of Los Angeles to take a look at how the County should respond” to these needs. The model “shows that services are interlinked and there must be collaboration among the agencies.” However, the model does not have “specific pathways” that describe how the model will be implemented across the County of Los Angeles.

■ The model “envisions a continuum that is not linear.” It is “holistic and it reflects accurately the multiple points of entry” needed in a Continuum of Care Model.



Debbi Collins, MPAS, PA-C

“Management of HIV disease is complicated. It cannot be managed without all the disciplines cohesively involved. The Continuum of Care model supports the ‘good management’ of care that crosses many areas of life, community, and families.”

² Any misstatement in the paraphrased or directly quoted phrases is the unintended error of Mercer.

The model promotes the understanding that “not everyone will experience the Continuum of Care Model the same.” Not actually a weakness of the model, but when applying the model “it is difficult to comply with the requirements of funders who are more rigid and more linear in their thought patterns.”

■ The “concept is ideal. People are not linear and need many things.” However, “we need to communicate it better” and the model “assumes that people have skill sets they don’t have, like prevention skills.”

■ The model “wants you to institute other aspects of care, not just medical care, and it supports patient involvement. It supports the **Primary Health Care Core Services** having linkages between the patient and the community. It breaks down a lot of barriers for people with chronic illness.” However, the model is challenged by “changing dollars” and by “changing types of patients” whose health management is more difficult.

Barriers to Attaining the Model's Goals.

The goals related to the HIV/AIDS Continuum of Care Model discussed in this review are those described in the *County of Los Angeles HIV/AIDS Comprehensive Care Plan (August 2002)*. Interviewees were encouraged to refresh themselves generally on these goals prior to the interview.

■ The procurement process cannot be “based solely on the Continuum of Care Model” and both the “preservation of historically-funded agencies” and “stakeholder protection” is sometimes barriers to making the changes needed in the service delivery system.

■ The “system had already developed and grown large” before the new Continuum of Care Model was approved. Changes after-the-fact are difficult to make. Also, providers in the Continuum of Care “get funding through different streams” and these funders have “existing mind-sets” that differ from the goals of the HIV/AIDS Continuum of Care Model.

■ The goal of the Continuum of Care Model “is really seamless services and the barriers are logistic. Seven to ten ‘Centers of Excellence’ are needed that are medically-centered with support services built around them.”

■ The goals require “changes to the way services have been organized traditionally” and “working with new partners” is sometimes a barrier for providers who have been “working within the same structures for 15 to 20 years.” It is “hard for some providers to affect ‘cultural diversity’ because of who they are and where they are.”



Wilbert C. Jordan, MD, MPH

“‘Barriers’ is the wrong word. I am not sure we are aware, it has not been put to us right. My plate is full. We need someone to come and point out to us what we need to do on-site.”

“We have to find people who are interested in broadening their horizons. We need people with greater interests. Then, we have to teach them when they do become interested. We need a way to feed each other within regions or districts, not just at the Commission where things have gotten very technical.”

■ The Continuum of Care Model’s goals and objectives are “not yet incorporated into agency contracts” and many providers “do not know there are goals related to an HIV/AIDS Continuum of Care Model.” Most providers are “responding to the contract deliverables only and are not involved in setting the goals” and “do not see how the money plays out according to the new continuum.”

■ Agencies do not have the funds and “lack the infrastructure to make this [meeting the goals] happen. Medical staffs are being pulled off to get other things done. There is a nursing shortage.”

■ It is hard to know if goals are being met when data is not being collected that is needed to measure the goals. Agency staff is not “computer savvy” and “overall technological capacity is low.” There needs to be an “integrated, standardized *Continuous Quality Improvement Program* across the board.”

■ HIV/AIDS is a “difficult disease to manage and you have to help clients manage their lives” to manage HIV disease well. “You have to have help; you must be a part of a network and providers lack knowledge about how this type of network works.”

Opportunities to Address Barriers and Enhance the Model. The interviewees were uniformly engaged in offering suggestions for how to address barriers they identified. Rather than offering suggestions on ways to change the conceptual model, suggestions were made for how to enhance abilities to fully implement the model as currently defined. The suggestions may be summarized as follows:

1) Continuing education and technical support is needed to assist planners and providers in transitioning from thinking about discrete services to thinking about services in a Continuum of Care Model and how one set or category of HIV services relates to other sets or categories of services.

■ Staff providing services need education and on-site support to apply “this thinking” to direct patient prevention and care services.

2) More attention should be directed toward a “system-wide approach” to evaluation and *Continuous Quality Improvement Program*, together with concrete support to agency staff to collect and synthesize computerized service utilization and service outcome data.

3) Hands-on assistance to develop effective partnerships and practical training on how to work within service partnerships, across professional, cultural, social, and geographical boundaries is needed.

■ Medical care and social service providers need to “better align themselves as equally necessary partners, creating cohesion and unity in the continuum.”

- 4) Opportunities for providers and planners within regions or districts to “talk about how the whole continuum is evolving” should be available, and an improved approach/method for needs assessment must be developed.

Linking Incentives to the Model. This section of the Work Order Request was conceptualized when the County of Los Angeles HIV/AIDS service environment included a few providers who, on their own initiative or through special demonstration funding, were attempting to innovatively restructure services in a way that now corresponds to the HIV/AIDS Continuum of Care Model. The question was how to motivate or “incentivize” all agencies to exceed program standards and adopt the innovations, particularly the integration of prevention with care and treatment services, when federal program guidance did not yet require these changes.

The development of the HIV/AIDS Continuum of Care Model occurred during this same period. Many of the innovative features of the model were included as a way to prepare the County of Los Angeles service providers for the anticipated adoption of these same features as program standards by federal sources like the RWCA and the *Community HIV Prevention Planning Programs*. Over the last two years, national standards of care and federal program guidance indeed have been revised. Service innovations once seen as exceeding the requirements are now national standards within federally-required models of service delivery.

While some technical aspects and innovative features of the HIV/AIDS Continuum of Care Model may not be fully understood by all County of Los Angeles providers, interviewees agreed the model has become the normative standard to guide an evolving HIV/AIDS service delivery system in the County of Los Angeles. Interviewees were uniformly in support of incentives (i.e., technical assistance, educational opportunities, skills, and capacity-building initiatives) to encourage continual organizational improvement among all agencies. “Money” was described as a tool, an appropriate and needed tool, for providing quality services or for constructing a changed system of care. Interviewees uniformly agreed provider agencies should be fully reimbursed for actual costs associated with fulfilling the expectations of the model. However, interviewees also uniformly agreed agencies “should not simply be given more money” because they meet the expectations of the HIV/AIDS Continuum of Care Model.

While interviewees acknowledged the growing problem of increasing administrative and service mandates in a shrinking funding environment, most were more concerned about how to capture financial information in order to be able to “maximize the use of RWCA funds” to fully support needed services. Planners, providers, and staff wanted to know how to stretch funds efficiently to meet unmet needs rather than augmenting agency budgets as a way to motivate compliance with Continuum of Care Model standards. Others expressed a priority for addressing disparities in agency funding and capacity that are evident across districts and the County of Los Angeles service planning areas before “rewarding agencies with more money.”

► Mercer Observations and Recommendations: the County of Los Angeles HIV/AIDS Continuum of Care Model

- 1) Based on Mercer’s review of the current national HIV/AIDS standards of care and the commitment of those interviewed to implementing the HIV/AIDS Continuum of Care Model, Mercer recommends OAPP and its partners in planning and systems development; continue on the established course with the model as currently defined.³

■ One interviewee commended the HIV/AIDS Continuum of Care Model’s ability to “define the relationship between services.” This is a critical point: the model clusters services in relationship to desired health outcomes, suggesting that certain clusters of services must be available to any one single patient if a specific health outcome is desired. Other interviewees noted the necessity of providing services within a network of providers; necessary because, again, certain clusters of services are needed to produce certain desired health outcomes, and no one agency offers all services within the HIV/AIDS Continuum of Care Model.

■ Providers are socialized into thinking more categorically and singularly about the services they provide. Mercer recommends continuing education of provider agencies on the “relationship between services” as this will facilitate agency partnership development and will lead naturally into a shared quality assurance approach for the resulting service delivery system.

- 2) Having turned a sophisticated corner in defining a state-of-the-art HIV/AIDS Continuum of Care Model and setting expectations for its full implementation, Mercer concurs with OAPP’s first step of establishing the costs associated with the provision of state-of-the-art services and determining a rate of reimbursement to financially support agencies in providing these services.

■ While financial reimbursements are typically prominent in discussions of service delivery expectations, adequate financial reimbursements alone will not assure the full implementation of the HIV/AIDS Continuum of Care Model. Mercer suggests OAPP engage in technical assistance and capacity-building efforts targeted specifically to

³ Due to the legislative requirements for Priority and Allocations in the RWCA, the Commission and OAPP engage in discussions annually about the rank order of services in the HIV/AIDS Continuum of Care Model. This activity is relevant to meeting grant requirements but is no longer particularly helpful in solving more complex implementation problems posed by providing HIV/AIDS services in the County of Los Angeles. Therefore, “as currently defined” indicates, Mercer finds the components of the HIV/AIDS Continuum of Care Model to be well defined; it does not indicate support for or against the rank ordering of services in any one specific grant year.

agencies needing support to fulfill the service expectations set by the HIV/AIDS Continuum of Care Model.

- 3) HIV/AIDS is still a service environment where key individuals personally impact the availability and quality of services within and among agencies. Mercer encourages efforts by OAPP to develop and sustain visionary leadership among agency directors (and other managers) and among health care providers employed in managerial roles. A shared vision and continued inspiration for the HIV/AIDS Continuum of Care Model among agency medical and managerial leaders will directly impact the success if its implementation across the County of Los Angeles.

■ Leadership development among direct care providers is another area to target for HIV/AIDS Continuum of Care Model support. Because of the conflict of interest concerns in RWCA and Community HIV Prevention Planning, finding a way to involve direct care providers in system of care development can be a challenge. Providers will be interested most in how the HIV/AIDS Continuum of Care Model concretely, practically is applied in direct care or practice settings. Mercer recommends OAPP create special opportunities to support peer relationships among health care practitioners, and use these relationships as a way of mutually encouraging and supporting state-of-the-art service provision.



Mercer wishes to express gratitude to the following individuals for their insight and perspectives on the HIV/AIDS Continuum of Care Model provided through interviews.

Commission and PPC Members/Staff

Fariba S. Younai, DDS
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UCLA School of Dentistry

Anna Long, Chief of Staff of Public Health
County of Los Angeles, Department of Health Services

Kathy Watt, Executive Director
Van Ness Recovery House

Wilbert C. Jordan, MD, MPH
Medical Director, Oasis Clinics HIV/AIDS Programs

Craig Vincent-Jones, Executive Director
Commission on HIV

HIV/AIDS Service Providers

Deborah O. Collins, MPAS, PA-C
Director, Preventive Health Clinical Services
City of Long Beach, Department of Health and Human Services

Andrew Signey, Assistant Director
St. Mary's Medical Center, CARE Programs and Clinics

Nick Rocca, LCSW
Clinic Administrator, HIV Division
Katrin Dayanim, Grants and Contracts Manager
North East Valley Health Corporation

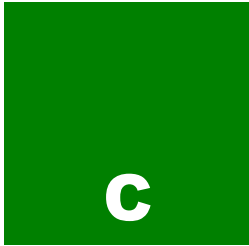
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Public Health Nurse, Medical Outpatient, CARE Services Division



Provider and Other Stakeholder Input

Stakeholder and Provider Input into the Mercer Rate Study

As described in the report narrative in Section 3, “Service Description Development”, Mercer received input from stakeholders and HIV/AIDS service providers during the course of the study. The individuals providing input are listed below, categorized according to the specific aspect of the study in which they participated.

1. Review of the HIV/AIDS Continuum of Care Model

Commission and Prevention Planning Committee (PPC) Members/Staff included:

- Fariba S. Younai, DDS, Clinical Professor, Oral Biology and Medicine, UCLA School of Dentistry; Anna Long, Chief of Staff of Public Health, County of Los Angeles, Department of Health Services; Kathy Watt, Executive Director, Van Ness Recovery House;
- Wilbert C. Jordan, MD, MPH, Medical Director, Oasis Clinics HIV/AIDS Programs; and,
- Craig Vincent-Jones, Executive Director, Commission on HIV.

HIV/AIDS Service Providers included:

- Deborah O. Collins, MPAS, PA-C, Director, Preventive Health Clinical Services, City of Long Beach, Department of Health and Human Services;
- Andrew Signey, Assistant Director, St. Mary’s Medical Center, CARE Programs and Clinics;
- Nick Rocca, LCSW, Clinic Administrator, HIV Division;
- Katrin Dayanim, Grants and Contracts Manager, North East Valley Health Corporation.

OAPP Staff included:

- Sophia Rumanes, Program Supervisor, Prevention Services Division;
- Rochelle Floyd, RN, MSN, FNP, Program Manager, Medical Outpatient, CARE Services Division;
- Phillip Barragan, Program Manager, Medical Outpatient, CARE Services Division; and
- Shirlissa Johnson-Edwards, RN, BSN, Public Health Nurse, Medical Outpatient, CARE Services Division.

2. Service Description Focus Group

Participants were asked to sign an OAPP sign-in sheet. Representatives from the following agencies (listed in order of signing) attended the Focus Group:

- Mallory Witt, MD and Julie Rees from Harbor-UCLA;
- Adam Ouderkirk, Peter Reis and Scott McKenzie from AIDS Health Care Foundation;

- David Burdem and Wilbert C. Jordan, MD, from OASIS;
- Maxine Liggins from Public Health/SPA 5 and 6; and,
- Felix Carpio, MD from AltaMed.

OAPP Staff attended the Focus Group also, including Jan King, MD, Medical Director, who provided comments.

3. Private Physician Unfunded by RWCA

Feedback from a physician practicing in the private sector, not currently funded by OAPP, was provided by Mark Katz, MD (Regional HIV/AIDS Physician Coordinator, Department of Internal Medicine, West Los Angeles Kaiser Permanente) reviewed the HIV/AIDS Ambulatory/Outpatient Medical Care Services service description. Mark Katz, MD was selected by OAPP as a reviewer representing the private sector.

4. ADAP Enrollment Clarifications

Providers giving input on timeframes for enrollment for ADAP services were Irma Ramirez and Deama Sherman, both ADAP enrollment coordinators in locally funded agencies.

5. Home Based vs. Medical Case Management Clarifications

The question as to whether the new Medical Case Management model would duplicate services provided in the Home Based Case Management Program was raised by Felix Carpio, a Focus Group participant. The question was further researched with the OAPP Attendant Care and Homemaker Services staff members, Roberta Young and Bonnie Moore.

6. Written Comments from a Commission Member

Brad Land, HIV+ Fifth District Commissioner, sent written questions to OAPP that were, in turn, forwarded to Mercer.

7. On-site Provider Reviews

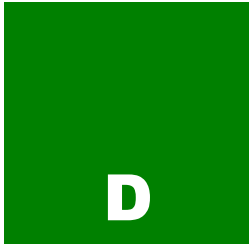
Two Mercer staff visited providers in January 2007. Please see Appendix D for more information.

8. Provider Meeting on Draft Report

Mercer presented information and listened to provider feedback in a meeting on October 31, 2007 after release of draft report.

9. Review of Provider Written Comments

Provider comments provided from November 2007 to January 2008 were reviewed.



**Executive Summary of HIV/AIDS Medical Outpatient
Services Rate Study: Provider Site Visits (January
2007)**

Executive Summary

The Los Angeles County (County) Department of Public Health, Office of AIDS Programs and Policy (OAPP) directs the overall response to the HIV/AIDS epidemic in the County under the supervision of the County's Board of Supervisors. As part of its mandate, OAPP contracts with numerous service providers (Providers) in various categories to provide high quality and cost-effective care services to HIV-positive residents of the County. OAPP contracts with both County operated and private outpatient medical clinics to provide comprehensive primary care to individuals diagnosed with HIV/AIDS. Currently, OAPP reimburses its 24 contracted outpatient medical clinics through a traditional line-item budget process. The Board of Supervisors requires OAPP to consider a cost reimbursement methodology that will encourage Provider accountability and productivity, track utilization more effectively, and ensure that Providers are utilizing other funding resources, such as MediCal, when available. Based on a competitive bid for Work Order Request No. 6-49 issued by the Department of the Auditor-Controller of the County, Mercer Government Human Services Consulting (Mercer) was engaged to complete this study and meet the aforementioned Board of Supervisors/OAPP objectives. Because of the number and complexity of services included in primary care ambulatory outpatient medical care, and in an effort to ensure Providers are not overburdened with billing and reporting requirements, the rate architecture for this particular service is being developed separately and will be discussed in the final report.

As part of the rate study development process, Mercer drafted service descriptions for four service areas including medical outpatient care. A careful review of the draft service descriptions was completed by both the Commission on HIV (COH) and the OAPP contracted HIV/AIDS outpatient service Providers. This analysis prompted a series of rate study related questions from community stakeholders, including the HIV Medical Outpatient Providers Caucus (Caucus). In response to the concerns raised related to the rate study development process, OAPP revised the Mercer rate study deliverables to include six to eight on-site visits to medical outpatient Providers, and one community stakeholders meeting to allow for additional rate study input and clarification. In consideration of recommendations offered by the Caucus, OAPP scheduled site visits for Mercer that reflected the diversity of the Provider types (small, large, HIV only, HIV in a primary care setting, rural, single site, multi-site, hospital-based, County Provider site, etc.) and represented each Service Planning Area (SPA). Providers not hosting a site visit were invited to attend the Stakeholders meeting with Mercer and OAPP to be held after the completion of the scheduled site visits. The Stakeholders meeting was open to all OAPP-funded medical outpatient Providers and offered an opportunity to share any additional rate study related input not captured through the site visits.

To assist in this information gathering effort, a Discussion Guide was created by OAPP, with input from the Caucus, and was distributed prior to the site visits. Providers hosting a site visit were advised to be prepared to answer questions listed in the Discussion Guide

at the time of the site visit. Providers not hosting a site visit were encouraged to complete the Discussion Guide and submit their responses to OAPP.

To ensure that the clinical complexities in the treatment of HIV/AIDS and the breadth and depth of the services being delivered by the Providers would be captured during this process, OAPP requested that a clinician with expertise in HIV/AIDS conduct the site visits. Mercer's Linda Shields, RN, BSN, of the Clinical and Behavioral Health Services division conducted a total of seven site visits, two Provider interviews at the OAPP offices, and participated in the Stakeholders meeting. Additionally, Mercer's John Villegas-Grubbs, Rate Architect Consultant, participated in the series of visits, interviews, and meetings in order to gain a better understanding of the financial operations of the Providers. Mr. Villegas-Grubbs provided clarification on the methodology of the rate architecture, as well as gathered anecdotal information to support calculations to be performed on the cost components being used in the study. Providers were asked to submit general ledgers as well as cost reports to assist in the calculations.

On-site visits were conducted with AIDS Healthcare Foundation, The Catalyst Foundation, City of Pasadena Andrew Escajeda Clinic, St. Mary Medical Center C.A.R.E. Clinic, Northeast Valley Health Corporation, L.A. Gay & Lesbian Center, and Harbor-UCLA Medical Center. A joint interview session was conducted at the OAPP offices with Watts Healthcare Corporation and T.H.E. Clinic, Inc. A total of 11 Providers attended the Stakeholders meeting including AIDS Healthcare Foundation, The Catalyst Foundation, City of Pasadena Andrew Escajeda Clinic, St. Mary Medical Center C.A.R.E. Clinic, L.A. Gay & Lesbian Center, Northeast Valley Health Corporation, Watts Healthcare Corporation, T.H.E. Clinic, Inc., AltaMed Health Services, El Proyecto del Barrio, and Martin Luther King Jr. / Charles Drew OASIS Clinic. An additional 5 Providers completed the Discussion Guide questionnaire, including: AltaMed Health Services, El Proyecto del Barrio, Martin Luther King Jr. / Charles Drew OASIS Clinic, Childrens Hospital Los Angeles Division of Adolescent Medicine, and East Valley Community Health Center HIV Comprehensive Care Clinic. General ledgers were submitted by Watts Healthcare Corporation, AltaMed Health Services, The Catalyst Foundation, City of Pasadena Andrew Escajeda Clinic, Northeast Valley Health Corporation, AIDS Healthcare Foundation, L.A. Gay & Lesbian Center, St. Mary Medical Center C.A.R.E. Clinic, and El Proyecto del Barrio. A summary of Provider participation is included as Appendix A.

Findings

The outcomes and findings that emerged during this information gathering phase of the study are documented in the report in detail and sorted by individual Provider. Additionally, an overview of the collective findings is presented below.

- The patient demographics within each SPA varied tremendously. There were differences noted between individual Providers within the same SPA. This diversity is

not significantly unusual, as it appears to be a reflection of the diversity of the general population of the County itself. Demographics varied by age, race, and lifestyle. The average patient's age fell within the 25 – 49 year old range. Although Caucasians made up a large portion of the HIV/AIDS population, there was a significant number of ethnic minorities represented. Males made up the majority of the cases; however, the number of females was reportedly growing. Substance Abuse and homelessness, as well as an increasing number of undocumented clients, was noted throughout the County.

- Comorbidities consistent across each SPA were Depression/Mental Health, Substance Abuse, Hepatitis C, and Cardiovascular Conditions, particularly Hypertension. The lack of antihypertensives on AIDS Drug Assistance Program (ADAP) formulary presented treatment issues for many. Also notable was the rise in the incidence of sexually transmitted diseases (STDs) including a high reinfection rate. The most prevalent of which being Syphilis.
- Service delivery patterns of each Provider appeared to be adapted to meet the specific needs of their community and the patient demographics they served. Community dynamics varied around each Provider location from an existing HIV/AIDS stigma and phobia to a strong history of activism, acceptance, and general support.
- Providers indicated they were overburdened with billing and reporting requirements from various Funders, both private and government. There were multiple forms to complete and numerous data entry screens necessary to input required client documentation. Most found the information system “Casewatch” to be cumbersome to navigate, and resource intensive with issues such as: connection drops; mandated fields for every entry; difficult to update; confidentiality concerns using a shared system; conflicts with Providers internal organizational Privacy Policies; lack of interface with existing systems, and a backlog of cases to be entered. Also, extensive time was noted to be spent by Direct Care Staff completing supplemental services forms such as Housing, ADAP, Dental, Disability, Food Provisions, as well as reviewing and processing medication refills, lab and testing results, and clinical trial progress. There were eligibility, payment and denial issues, as well as difficulties in getting clients enrolled in other programs such as MediCal.
- The majority of Providers struggled with treatment issues resulting from lack of timely access to specialists and subspecialists. The most difficult referrals to obtain throughout the County were consistently those to Orthopedics, Neurology, Dermatology, and Gastroenterology. Additionally, lack of access to Preventive Health services was noted within every SPA particularly in the areas of colon cancer screenings (flex sig/colonoscopy) and breast cancer screenings (timely mammograms).

- Transportation costs and coordination was a barrier to service and care for many. Whether it was due to the geographic distances between necessary services, or the homelessness and transience, or the poverty level of the clients who had neither a car nor funds for a bus, it remained a concern throughout the County.
- The staff at each site visited appeared to be dedicated and personally committed to serve the population. Many of whom would work additional uncompensated hours, and/or donate needed resources. However, the Nursing shortage and lack of qualified medical staff (HIV experience and interest) as well as insufficient, noncompetitive salaries and benefit packages is causing staffing challenges for all Providers.

Recommendations

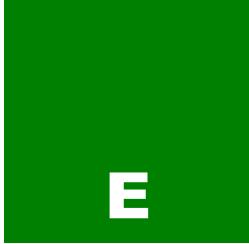
The report provides recommendations intended to assist OAPP and key stakeholders in addressing the barriers to service and care delivery and to ensure successful implementation of the new rate architecture.

- Because the science and practice of HIV/AIDS medical management continues to rapidly evolve, Mercer recommends OAPP continue to collaboratively work with Providers to remove barriers to delivering and providing access to quality care and service within the County by such means as:
 - Encourage the use of the Caucus as a forum for Quality Improvement initiatives, such as the sharing of best practices in both care and service.
 - Continue to implement its public health role, in collaboration with Providers, in distributing standard of care revisions and updates.
 - Assess and respond to the unique needs within specific patient demographics and evaluate service variances.
 - Continue in its role in Provider education, training, development, and capacity-building.
 - Reevaluate OAPP's data needs and collection methods, assessing the impact of the reporting requirements to the Providers overall resources, as well as potential integration with their existing Informatics and Financial Systems.
 - Work collaboratively with the Caucus, the local Physician community, and existing stakeholders to evaluate methods of attracting and retaining Specialty and Subspecialty services for the HIV/AIDS population.
- MediCal is a significant, albeit, a complex source of funding for HIV/AIDS services and it is critical that Providers maximize the funding available through this

entitlement program. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act legislation mandates that CARE Act funds be the payer of last resort, and the Health Resources and Services Administration (HRSA) has mandated that wherever other programs such as Medicaid exist for HIV/AIDS services, these funds must be maximized before using Ryan White CARE Act funding. Based on these mandates, many states and jurisdictions require their HIV/AIDS Providers actively participate in the Medicaid program. For the selected services in the County, Mercer recommends the following to OAPP:

- Work closely with the Providers to identify and clearly define HIV/AIDS services that could be reimbursed by MediCal and to identify the appropriate MediCal programs/Waivers that Providers may participate.
- Collaborate with the California Department of Public Health/Office of AIDS to increase awareness and knowledge among Providers of the importance and need for maximizing MediCal funding for individual service components that are delivered. DHS provides training sessions to Providers on various topics related to the MediCal program. Providers should be encouraged to participate in these training opportunities.
- Consider use of OAPP’s established training curriculum to offer additional training and technical assistance to Providers on the utilization of MediCal as a funding source. This is an area that has been deemed a HRSA priority and Ryan White grant funds have been utilized in other states to offer this type of technical assistance. In the past, HRSA has provided third party payment training in the County. Attendance at these types of training should be mandatory for Providers that contract with OAPP.
- Audit a random sample of medical files and claims information from various Providers to determine if MediCal funding is underutilized. Additionally, conduct an analysis of trends in MediCal denials (reasons and frequency), as well as issues in eligibility.

Mercer is privileged to have had the opportunity to work with OAPP and the Providers in the County on this exciting and innovative segment of the rate study. Based upon Mercer’s experiences in the areas of HIV/AIDS and rate development across the US, it is clear that the County is a leader in the effort to implement a structured model of equitable reimbursement methodology for HIV/AIDS services, while upholding appropriate clinical standards and practices, thereby ensuring both high quality and cost-effective service delivery. Mercer is confident that through the collaboration of the County and its HIV/AIDS Providers, a planned and coordinated implementation strategy, and appropriate training for all those involved, OAPP will be able to successfully implement this rate architecture and thereby serve as a model for other HIV/AIDS programs nationwide.



Service Descriptions

**Department of Public Health
Office of AIDS Programs and Policy**

**Medical Clinic Services
Special Rate Study**

**HIV/AIDS AMBULATORY/OUTPATIENT MEDICAL CARE
SERVICES DESCRIPTION**

This service description is adopted by the County of Los Angeles, Department of Public Health, Office of AIDS Programs and Policy (OAPP), to guide providers in the development and implementation of **HIV/AIDS Ambulatory/Outpatient Medical (AOM) Care Services** to individuals at risk for and living with HIV/AIDS. Federal legislation, policy and program guidance, and State of California statutes, regulations, and rules governing licensing and service provision, supersede the **HIV/AIDS AOM Care Services** description.

SERVICE

HIV/AIDS AOM Care Services

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DESCRIPTION

HIV/AIDS AOM Care Services are provided by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), Physician’s Assistant (PA), or Nurse Practitioner (NP) in an outpatient, community-based, or office-based setting. **HIV/AIDS AOM Care Services** are provided in accordance with the Los Angeles Commission on HIV Standards of Care, Medical Outpatient Services (final January 13, 2006) and form the critical foundation of the HIV/AIDS Continuum of Care adopted on October 14, 2004.

HIV/AIDS AOM Care Services are guided by practice guidelines and protocols (i.e., www.hopkins-aids.edu, www.hivguidelines.org, or www.hab.hrsa.gov) consistent with the Public Health Service (PHS) guidelines (www.aidsinfo.nih.gov/) and the Los Angeles Commission on HIV Standards of Care.

HIV/AIDS AOM Care Services funded by the OAPP are implemented in a service delivery environment where other models of HIV/AIDS primary care are developed and supported by other funders (e.g., the “Early Intervention Program” funded through the State of California, Office of AIDS). While there may be differences in the service delivery requirements among these programs, it is the intent and practice of OAPP to collaborate and cooperate with other funded programs so as to not create unnecessary barriers or impediments for clients who utilize these programs.

PROGRAM REQUIREMENTS

The following requirements are minimum for **HIV/AIDS AOM Care Services**; provider agencies providing these services may exceed these requirements.

General Requirements: The provider agency must ensure its ability to meet the needs of the client by meeting the following general requirements:

- Administrative and Clinical Policies and Procedures. The provider agency must develop, implement, and revise, as necessary, standardized administrative policies and procedures and clinical protocols to comprehensively guide the **HIV/AIDS AOM Care Services**, including assessment, treatment, and referral of clients. The procedures and protocols must be submitted to OAPP for review and approval upon request. Upon request, revisions to the procedures and protocols may require OAPP approval.

Provider agencies must have a Client Grievance Policy and Procedure that is reviewed with each client in a language and format the client can understand. A written copy must be provided to each client and a signed and dated receipt form must be included in each client record. All AOM professionals must comply with the established process for client grievances.

- Tuberculosis Screening. All **HIV/AIDS AOM Care Services** staff, other provider agency employees, volunteers, and consultants must be screened for tuberculosis when providing services to persons with HIV disease or AIDS and who have routine, direct contact with clients. Provider agencies must comply fully with the “*Guidelines for Tuberculosis Screening*” required for all agencies with County of Los Angeles contracts.



***Clinic Management
Policies, Protocols, and Procedures***
For assistance in developing administrative policies and procedures related to clinical and health program management, consult the technical assistance and training services available through the National Association of Community Health Centers



Guidelines for Tuberculosis Screening
The TB Control Program
2615 S. Grand Avenue, Los Angeles, CA 90007
(213) 744-6151

- Postexposure Prophylaxis (PEP). Provider agencies must have a policy and procedure to reduce the risks for occupational HIV and Hepatitis exposure. Provider agencies must aggressively promote and monitor risk reduction behaviors and must actively support HIV/AIDS AOM primary care professionals in PEP (National Clinician's PEP Hotline: (800) 448-4911 or www.ucsf.edu/hivcntr; Hepatitis Hotline: (888) 443-7232 or www.cdc.gov/hepatitis; Reporting of Occupationally Acquired HIV: (800) 893-0485).
- State Mandated HIV Reporting. Consistent with the State Health and Safety Code (Section 2643.5), all AOM practitioners and OAPP-funded County of Los Angeles and community-based HIV medical outpatient clinics must comply with the mandated reporting of clients whose laboratory test results indicate HIV, a component of HIV, or antibodies to or antigens of HIV. Each HIV/AIDS AOM practitioner must, within seven calendar days of receipt of a client's confirmed HIV test, report the client's full name, date of birth, and gender.
- Clinical Trials. The provider agency's **HIV/AIDS AOM Care Services** must be directly linked with AIDS clinical treatment units and research consortia of community physicians.
- Clinical Care Protocols. The **HIV/AIDS AOM Care Services** must be consistent with the PHS guidelines (www.aidsinfo.nih.gov) and the Los Angeles Commission on HIV Standards of Care. AOM Care primary care professionals must utilize established practice guidelines in order to facilitate consistency in providing state-of-the-art prevention and care services for all clients.



Clinical Trials

AIDS Clinical Trials Group (ACTG):
AIDS Clinical Trials Info: (800) 874-2572
HIV/AIDS Treatment Info Service:
www.aidsinfo.nih.gov

HIV/AIDS prevention and care practice guidelines may be downloaded or ordered in bulk from the following websites: Los Angeles Commission on HIV Standards of Care (www.hivcommission-la.info/soc.asp) Johns Hopkins AIDS Service (www.hopkins-aids.edu), New York Department of Health AIDS Institute (www.hivguidelines.org), federal HIV/AIDS Bureau (www.hab.hrsa.gov), and CDC's Division of AIDS Prevention-Treatment (www.cdc.gov). [*A Guide to Primary Care for People with HIV/AIDS, 2004* provides clinical

New Guidelines: nPEP



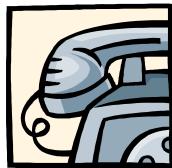
Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Users, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services. MMWR 2005;54 (No. RR-2).

treatment guidelines in a question-and-answer format to health professionals treating adults living with HIV/AIDS. CD-ROM, www.ask.hrsa.gov/detail.cfm?id=HAB00355, with a *Pocket Guide*, www.hab.hrsa.gov/tools/HIVpocketguide/index.htm.]

HIV/AIDS AOM health care professionals are encouraged to remain current with the research literature related to adherence by referencing the American Public Health Association's special HIV/AIDS treatment adherence initiative: "*Best Practices: Adherence to HIV Treatment Regimens*" (www.apha.org: "Science & Programs").

- AOM HIV Prevention and Disease Management Competency. The provider agency must have personnel policies and procedures requiring and supporting the continued education of all HIV/AIDS health care professionals. Provider agencies are expected to budget costs for HIV/AIDS continuing education, specifically in HIV prevention and disease management, to purchase practice guidelines in formats easily accessible and usable for practitioners, and to provide routine access to computerized educational and prevention/care treatment problem-solving (i.e., www.thebodypro.com, www.hivinsite.ucsf.edu, www.hopkins-aids.edu, or www.nlm.nih.gov/medlineplus/aids.html).

Clinical Management of the HIV-Infected Adult: A Manual for Mid-Level Clinicians
<http://bphc.hrsa.gov/quality/HIVAIDSManual.htm>



National HIV
Telephone
Consultation Service
Warmline

(800) 933-3413

Provider agencies must have consultation protocols to assist HIV/AIDS AOM health care professionals in easily seeking expert advice and consultation whenever there is any question about the best way to manage a specific client. This is especially important when a client is experiencing ARV treatment failure or when a client with advanced HIV disease is vulnerable to multiple opportunistic processes. Seeking expert advice and utilizing the many local or regional university-based consultation services is evidence of competent prevention and disease management.

- Client-Staff-Colleague Communication. Provider agencies must have current written policies and procedures addressing communications between the AOM staff, clients, or other professionals.
- Client Appropriateness for Provider Agency Services. Prior to or during an initial assessment, if it is determined the medical needs of the client cannot be met by the agency providing **HIV/AIDS AOM Care Services**, a referral must be made to an

alternate provider. The **HIV/AIDS AOM Care Services** staff must directly assist the client with access to another HIV/AIDS AOM provider.

- Client Satisfaction. The agency providing **HIV/AIDS AOM Care Services** must perform semi-annual assessments of clients' needs and satisfaction by conducting random, anonymous client surveys.
- Client Records. The agency providing **HIV/AIDS AOM Care Services** must maintain a client record for each client, documenting each face-to-face patient/practitioner encounter. Documentation must be consistent with the agency's clinical policies and procedures for client record keeping.



HIV/AIDS Clinical Charting Forms?

The Florida/Caribbean AIDS Education and Training Center offers a comprehensive set
http://www.faetc.org/charting_forms/index.asp

- Records Maintenance. Provider agencies must have a formal process for storing, maintaining, and managing client files. Client file systems must be organized for ease in information retrieval and synthesis. Client records must be secure to ensure confidentiality and should not be disclosed without the client authorization, guardian authorization, or other legal requirement.



**Medical Record
has Current?**

Problem Lists
Medication Lists
Flow Sheets
Lab Reports
Special Study Reports
Consult Reports
Inpatient Discharge
Summaries
Immunizations
Risk Assessments
Verification of HIV Status

Patient



**Records of Health Maintenance Activities Appropriate
for HIV Infected Individuals**

Influenza Vaccine
Tetanus/Diphtheria Update
Pneumovax
Pap Screening
Hepatitis Screening, Vaccination
TB Screening
Family Planning
Counseling on Safer Sex
Counseling on Food and Water Safety
Counseling on Nutrition
Harm Reduction for Alcohol and Drug Use

- Service Evaluation. The client record must include a record of services provided by multiple professionals and paraprofessionals in sufficient detail to permit an evaluation of these multidisciplinary services.

Eligibility: Eligibility requirements ensure that OAPP funds are used only for the purchase of **HIV/AIDS AOM Care Services** that cannot be paid for through other sources. Clients are eligible for **HIV/AIDS AOM Care Services** after a financial screening that validates OAPP funds are the payer of last resort for the client's care. In addition, clients must meet all of the following criteria:

- **HIV Status.** Client must provide verification of HIV status. Acceptable verification includes one of the following: (a) a copy of the client's seropositive test results (Elisa and Western Blot) from the test provider, (b) a signed document from a physician verifying the client is HIV-positive, (c) lab results (i.e., viral load) at any time during the client's lifetime that show the presence of the human immunodeficiency virus, or (d) written verification from a psychosocial or medical case manager or other health and social services provider who has one of the above documents in the client's file.
- **County of Los Angeles Residence.** Client must provide information to establish residency in the County of Los Angeles.
- **Income.** Clients must provide proof/documentation of income to verify OAPP funds will be used as the payer of last resort for the service. Clients who do not have coverage under or are ineligible for Medi-Cal or other third-party payment, are eligible for OAPP-funded services. Income eligibility must be verified annually.

All clients must be assessed for ADAP, Medi-Cal, Medicare, VA Benefits, HMO, or private insurance. Providers are required to screen clients for eligibility to these programs before providing services supported by CARE Act Part A funding.

Client Rights: All clients requesting and/or receiving **HIV/AIDS AOM Care Services** have rights and responsibilities outlined in "*People with HIV/AIDS Bill of Rights and Responsibilities*" adopted by the County of Los Angeles Commission on HIV Health Services (April 2004).

Provider agencies must have a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. A written copy must be provided to each client and a signed and dated receipt form must be included in each client record.

Client-Centered Treatment: **HIV/AIDS AOM Care Services** must ensure that clients are given the opportunity to ask questions and receive accurate answers regarding health and social services provided by HIV/AIDS AOM practitioners. In addition, clients must be given the opportunity to ask questions and receive accurate answers on services to which they are referred, especially (but not limited to) the full complement of services making up the Primary Health Care Core Services in the HIV/AIDS Continuum of Care.

Patient and health care provider discussions during prevention and care services encounters form the foundation of a relationship built on trust and confidence where clients are seen as active partners in the decisions about their personal health care regimen. HIV/AIDS AOM practitioners are encouraged to review client-oriented HIV/AIDS prevention and care websites to become more familiar and versatile in discussing HIV/AIDS from a client-centered approach (i.e., www.projectinform.org, www.aidsnutrition.org, or www.thebody.com).

Clients must be fully educated about their medical needs and treatment options within the standards of medical care. Client education must be documented in the client record with details of each intervention.

Referral and Coordination of Care: HIV/AIDS AOM Care Services must have written procedures and protocols in place for referring clients to health and social services. The referral system must include a process for tracking and monitoring referrals and for documenting the results of referrals from the providers of health and social services to which clients are referred. HIV/AIDS AOM practitioners are required to follow the provider agency's established referral policies and procedures for services beyond their internal **HIV/AIDS AOM Care Services**.

- Medical Specialists and Required Memoranda of Understanding (MOUs). The provider agency must have written MOUs with all medical specialists, treatment adherence educators, Registered Dietitians (RDs), and psychosocial case managers used by the provider agency's AOM practitioners for referral. The MOUs must describe the procedure for both written and verbal communications between the referring HIV/AIDS AOM practitioner and the consulting health or social service professionals. All MOUs must be submitted to OAPP's Medical Director for review before the MOUs are formally executed. All revisions to the MOUs, and revisions to provider agency referral policies and procedures, must be approved by OAPP.
- California Regulations on Referrals to RDs. In California, referrals to RDs must be made by health care providers authorized to prescribe dietary treatments. The referral must be accompanied by a written prescription signed by the health care provider detailing the client's diagnosis and including a statement of the desired objective of dietary treatment. An RD may accept or transmit verbal orders or electronically-transmitted orders from the referring physician consistent with an established protocol to implement Medical Nutrition Therapy (California Business and Professions Code, Sections 2585-2585.8). Provider agency policies and procedures for making and receiving referrals for Medical Nutrition Therapy must comply with California regulations.

Quality Management (QM): Provider agencies funded to provide **HIV/AIDS AOM Care Services** are required to have a QM Program that will facilitate the delivery of state-of-the-art HIV/AIDS services. Provider agencies needing technical assistance (TA) guidance on the development of QM Programs are encouraged to consult the Quality Management Technical Assistance Manual (this TA document is available at www.hab.hrsa.gov/).

The provider agency's QM Program must include:

- QM Plan. The QM Program must be based on a provider agency-wide, written QM Plan that addresses both HIV prevention and care services.

- QM Committee. The QM Program must be guided by a provider agency QM Committee formally convened minimally quarterly to assure the QM Program's goals and objectives are met.
- Client Feedback Process. The QM Program must describe how ongoing client feedback will be obtained and utilized to improve access, utilization, retention, and adherence to HIV preventative services and care.
- Client Grievance Process. The QM Program must describe the implementation of the provider agency's Client Grievance Process (see requirement for Client Grievance Policy and Procedure above). Client grievance data must be tracked, trended, and reported to the provider agency's QM Committee for use in making improvements in HIV services and care.

The provider agency's QM Program must be able to meet the following expectations:

- Medical Record System. Routine and recurring audits of the provider agency's medical record system must demonstrate service records are organized, complete, and current. HIV/AIDS service delivery information must be organized clearly and consistently, supporting ease of review and consideration by any and all social and health care practitioners. Reports from these audits must describe the identification of concrete problems in HIV/AIDS services record keeping, together with practical solutions and documentation for problem-resolve.



Basic HIV/AIDS Medical Records Policy and Procedure Checklist

- Uniform format with a logical flow of information
- Information, including prescriptions, legible
- Timely entry of data
- All information appropriately dated
- Problem-oriented in SOAP format: including documentation of reason for every visit, past and present medical histories, findings of physical examinations, documentation of special studies ordered, documentation of clinical assessments or diagnoses, health education and risk reduction activities, documentation of referrals and consults, treatment plans (return appointments, drug therapy, referrals, etc.), and HAART discussion
- Necessary patient and family identifiers
- Signed consents for prevention and treatment services
- Consents signed by client for release of information for each referral made
- Provider signatures legible
- Conspicuous listing of quantitative viral measures, drug allergies, and drug resistance
- Documentation of patient education (risk reduction, treatment regimens, adherence, nutrition, and health maintenance, etc.)
- Evidence of screening or referral of patients at risk for TB, hepatitis, or sexually-transmitted disease (STD) infection
- Evidence of screening and referral of patients for medical nutrition therapy
- Evidence of referral for health care maintenance, including immunizations
- Evidence of coordination of services among providers
- Evidence of assessment for the need and/or provision of psychosocial and/or medical case management
- Evidence of assessment for mental health and/or substance abuse services

- Consistency of HIV Practice Patterns. The provider agency QM Program must make routine and recurring audits of service delivery records in order to assess the degree to which individual practitioners are providing services consistent with the federal guidelines for the medical management of HIV infection and other issues surrounding HIV infection. OAPP strongly encourages internal peer review as an approach to continually improving quality and consistency in HIV practice patterns. The federal guidelines are available at www.aidsinfo.nih.gov.

In order to specifically focus the provider agency's audits for compliance within the guidelines, provider agencies are encouraged to adopt currently published HIV/AIDS practice guidelines that assist practitioners in following concrete and specific service protocols. These practice guidelines are typically available from the websites supported by the respective professional associations and from selective HIV/AIDS academic research institutions (i.e., www.hopkins-aids.edu or <http://hivinsite.ucsf.edu>). Practitioners providing HIV prevention in medical settings must consult and comply with "*Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*," (MMWR: July 18, 2003/Vol. 52/No. RR-12).


- Required Provider Agency Indicators. The provider agency QM Program must identify quality assurance indicators documenting successful clinical and service delivery outcomes in the following areas:
 - (a) Documenting the completion and incorporation of needed referrals from across the HIV/AIDS Continuum of Care Primary Health Care Core Services and the integration of referral results and recommendations into the client's primary care treatment process.
 - (b) Documenting the successful integration of care and treatment services in medical care settings.
 - (c) Documenting the provider agency's success in achieving adherence with care and prevention treatment plans.
 - (d) Documenting the clinical outcome indicators as required by OAPP.
- Required System-Wide Indicators. Finally, provider agencies are required to participate in all system-wide QM reviews conducted by OAPP. The specific indicators for the system-wide review will be identified annually by OAPP and will focus on four critical areas:
 - (a) Reducing disparities in health outcomes for the County of Los Angeles' social, racial, and/or ethnic minorities.
 - (b) Increasing health outcomes for all recipients of services in the HIV/AIDS Continuum of Care.

- (c) Prevention of HIV infection and prevention of progression to HIV-related illness and disease, disability, and death.
- (d) Indicators related to the HIV/AIDS Continuum of Care's emphasis on the continuity of access, utilization, retention, and adherence for clients.

Cultural Sensitivity and Linguistic Competence: Clients have the right to **HIV/AIDS AOM Care Services** provided by a qualified, HIV-knowledgeable and capable primary health care practitioner who is culturally- and linguistically-competent, who communicates and educates in culturally-congruent ways, and who works in collaboration with the client's team. The AOM staff must demonstrate cultural sensitivity and linguistic competency specifically in the service they provide. The AOM staff must also demonstrate cultural sensitivity and linguistic competency for the target population they are serving (see, "*The Provider's Guide to Quality and Culture*," <http://bphc.hrsa.gov/quality/Cultural.htm>).

Translation/Language Interpreter's federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to Limited English Proficiency (LEP) patients at no cost, in order to ensure equal and meaningful access to health care services.

Resources on Culturally-Competent Health Care?
UCSF School of Medicine, Department of Medicine



"Primary Care: Clinical Practice Guidelines"
<http://medicine.ucsf.edu/resources/guidelines/culture/html>

"National Standards for Culturally and Linguistically Appropriate Services in Health Care"
<http://www.omhrc.gov/clas/finalcultural1a.htm>

"Rationale for Cultural Competence in Primary Care"
Policy Brief 1, National Center for Cultural Competence
<http://gucchd.georgetown.edu/nccc/nccc6.html>

Documentation: Provider agencies providing **HIV/AIDS AOM Care Services** are required to meet all expectations for client and service delivery contract reporting and documentation. Provider agencies must utilize the County of Los Angeles's "Casewatch" system to register the client's eligibility data, demographic/resource data, enter service utilization data, medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care.

For clients not receiving Medi-Cal benefits, providers are required to document if a client was referred to apply for Medi-cal, if recently applied for Medi-Cal, date/ applied, application status, and if not referred, must document why the client was not referred.

The “Casewatch” system must be used to invoice for all delivered services, to standardized reporting, to improve efficiency of billing, to support program evaluation processes, and to provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in the County of Los Angeles. Provider agencies must ensure data quality and compliance with all data submission requirements.

DEFINITION OF ENCOUNTER

The US Department of Health and Human Services/Health Resources and Services Administration (HRSA) publishes the Uniform Data System (UDS) Reporting Instructions for Section 330 Grantees (last updated in 2006). The definition of an encounter is:

“Encounters are Documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. To be included as an encounter, services must be documented.” (Page 5)

Additional guidance relative to encounters includes:

1. To meet the criterion for "independent judgment," the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate encounter. Independent judgment implies the use of the professional skills associated with profession of the individual being credited with the encounter and unique to that provider or other similarly or more intensively trained providers.
2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though a complete health record is not created. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts do not result in encounters.
4. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving immunizations, and filling/dispensing prescriptions do not constitute encounters.

5. A provider may be credited with no more than one encounter with a given patient in a single day, regardless of the types or number of services provided.
6. The encounter criteria **are not** met in the following circumstances:
 - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
 - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
 - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
 - When the **only** services provided are lab tests, x-rays, immunizations, TB tests and/or prescription refills.
 - Services performed under the auspices of a WIC program or a WIC contract.

REQUIRED

STAFFING

Staffing and the HIV/AIDS Continuum of Care Model: The HIV/AIDS Continuum of Care Model and the Los Angeles Commission on HIV Standards of Care have clear and distinct implications for staffing models needed to fully implement comprehensive services. Provider agencies providing HIV/AIDS AOM Care Services should develop staffing models with four key points in mind:

1. The HIV/AIDS Continuum of Care's "*Primary Health Care Core Services*" represents a set of multidisciplinary services that by definition requires a coordinated team of medically-diverse professional and auxiliary health care practitioners. While this collection of practitioners generally may all be categorized as medically-related, each health care professional must practice with a multidisciplinary understanding of his or her professional knowledge and skills. In other words, the practice of HIV/AIDS medicine...prevention or care...is not narrowly biomedical in its focus. **Professionals must work in multidisciplinary teams with an expanded understanding of HIV/AIDS primary health care services.**
2. Experience and research has shown that services must be provided to a client through a coordinated and seamless approach, even though no one single provider agency necessarily directly employs all categories of professional and auxiliary staff needed to provide the full compliment of Continuum of Care services. This coordinated and seamless approach is actually reflected in the PHS standards and made even more concrete in the established HIV/AIDS practice guidelines. **Provider agencies are required to comply with the PHS Standards of Care and Los Angeles Commission on HIV Standards of Care, yet provider agencies are not expected to directly employ all of the needed health care professionals as a way to fully**

- meet these standards.** Provider agencies will need to collaborate in order to make the HIV/AIDS Continuum of Care accessible across the County of Los Angeles, and AOM Care professionals will need to collaborate across provider agency boundaries in order to surround a client with the full compliment of needed services.
3. The multidisciplinary approach to providing services in a professionally-diverse Continuum of Care is not an artifact of luxury, but rather a result of the complex nature of HIV disease itself coupled with the challenges the populations most affected by HIV bring to the service setting. Making sure communities in the County of Los Angeles have access to any and all of the services in the HIV/AIDS Continuum of Care is a daily and determined act of financial problem-solving. Provider agencies must use financial resources from many sources in a resource-limited funding environment. **AOM staffing patterns will combine direct hire, targeted consulting and contracting, and referral as a way of fulfilling the expectations in the PHS Standards, Los Angeles Commission on HIV Standards and the HIV/AIDS Continuum of Care.**
 4. The clinical care of persons with HIV/AIDS requires clinicians with specialized experience in the practice of HIV medicine. Knowledge about the clinical management of HIV infection has rapidly evolved requiring frequent changes in state-of-the-art practice and the integration of evidence-based advances into routine care for persons at risk for or living with HIV. Extensive clinical care experience with direct management of ARV therapy, along with significant diagnostic, therapeutic, and prevention education experience in the ambulatory care of the HIV-infected client is requisite. **Provider agencies must employ, contract, or refer to AOM health care professionals who are prepared to provide services in a scientifically-rigorous (including culturally-competent) environment.**

**Department of Public Health
Office of AIDS Programs and Policy**

**Medical Clinic Services
Special Rate Study**

**ELIGIBILITY, EDUCATION, AND ENROLLMENT
SERVICES
for the AIDS DRUG ASSISTANCE PROGRAM
SERVICE DESCRIPTION**

This service description is adopted by the County of Los Angeles, Department of Public Health, Office of AIDS Programs and Policy (OAPP), to guide providers in the development and implementation of **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program (ADAP)**. These services are provided to individuals living with HIV/AIDS. Federal legislation, policy and program guidance, and State of California statutes, regulations, and rules governing licensing and service provision, supersede the Ambulatory/Outpatient Medical (AOM) Care Services description.

SERVICE

Eligibility, Education, and Enrollment Services for ADAP

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DESCRIPTION

ADAP provides drugs that prolong quality of life and delay the deterioration of health to individuals infected with HIV who otherwise could not afford them. ADAP is funded by the Ryan White CARE Act (RWCA) and state funds (see www.dhs.ca.gov/aids/Programs/CARE/adap.htm).

To access ADAP drug reimbursement services, clients must be enrolled through local enrollment sites. The local enrollment sites provide drug reimbursement services to HIV-infected individuals in the County of Los Angeles who have no other means to pay for these services. Enrollment sites in the County of Los Angeles are reimbursed for services through an OAPP contractual agreement.




PROGRAM REQUIREMENTS

The following requirements are minimum for **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program**. Provider agencies providing these services may exceed these requirements.

General Requirements: The program must ensure its ability to meet the needs of clients by meeting the following general requirements:

- Administrative and Program Policies and Procedures. The provider agency must develop, implement, and revise, as necessary, standardized administrative policies and procedures and program protocols to comprehensively guide the drug reimbursement **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program**. The procedures and protocols specific to the ADAP program are provided by the California Department of Public Health /Office of AIDS, including periodic updates. The provider agency providing enrollment services must fully comply with these state guidelines (see *ADAP Coordinator's Reference Guide*, May 2001, and the Ramsell Corporation's *California State ADAP Enrollment and Eligibility Manual*, April 2004).

All clients requesting and/or receiving drug reimbursement services have rights and responsibilities outlined in "People with HIV/AIDS Bill of Rights and Responsibilities" adopted by the County of Los Angeles Commission on HIV Health Services (April, 2004).



- Provider agencies must have a Client Grievance Policy and Procedure that is reviewed with each client in a language and format the client can understand. A written copy must be provided to each client and a signed and dated receipt form must be included in each client record. All staff must comply with the established process for client grievances.
- Client Records. Provider agencies must have a formal process for storing, maintaining, and managing client files. Client file systems must be organized for ease in information retrieval and synthesis. Client documentation must be continuous and consistently current. Client records

must be secure to ensure confidentiality and should not be disclosed without the client authorization, guardian authorization, or other legal requirement. Access to charts and records for periodic monitoring by the California Department of Public Health/Office of AIDS and OAPP staff is required.

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- Confidentiality. All staff with access to client information must receive training on confidentiality, appropriate exchange of information, and consent processes. This training must be consistent with the established policies and procedures that professionally govern release of medical information. Provider agency consent forms must comply with state and federal law, must be signed by an individual legally able to give consent, and must include a consent for release/exchange of information for every individual/provider agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.
 - Physical Office Space. The provider agency must provide the Enrollment Coordinator and Eligibility Staff with space to conduct uninterrupted interviews for eligibility screening.
 - Client-Staff-Colleague Communication. Provider agencies must have current written policies and procedures addressing communications between the enrollment staff, clients, or other professionals.
 - Documentation. Provider agencies providing **Eligibility, Education, and Enrollment Services for AIDS Drug Assistance Programs** are required to meet all expectations for client and service delivery contract reporting and documentation. Provider agencies must utilize the County of Los Angeles’s “Casewatch” system to register the client’s eligibility data, demographic/resource data, enter service utilization data, medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care.

For clients not receiving Medi-Cal benefits, providers are required to document if a client was referred to apply for Medi-cal, and if the client recently applied for Medi-Cal, the date applied, application status. If the client is not referred, the provider must document why the client was not referred.

The “Casewatch” system must be used to invoice for all delivered services, to standardized reporting, to import efficiency of billing, to support program evaluation processes, and to provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in the County of Los Angeles. Provider agencies must ensure data quality and compliance with all data submission requirements.

Eligibility: Eligibility requirements ensure that OAPP funds are used only for the purchase of services that cannot be paid for through other sources. Clients are eligible for services after a financial screening validates OAPP funds are the payer of last resort for the client’s care. In addition, agencies providing services must ensure clients meet all of the following criteria:

- HIV Status. Client must provide verification of HIV status. Acceptable verification includes one of the following: (a) a copy of the client’s seropositive test results (Elisa

and Western Blot) from the test provider, (b) a signed document from a physician verifying the client is HIV-positive, (c) lab results (i.e., viral load) at any time during the client's lifetime that shows the presence of the human immunodeficiency virus, or (d) written verification from a psychosocial or medical case manager or other health and social services providers who have one of the above documents in the client's file.

- County of Los Angeles Residence. Clients must provide information to establish residency in the County of Los Angeles.
- Income. Clients must provide proof/documentation of income to verify OAPP funds will be used as the payer of last resort for the service. Clients who do not have coverage under or are ineligible for Medi-Cal or other third-party payment are eligible for services. Income eligibility must be verified annually.
- Age. Clients must be 18 years of age or older.

ADAP Enrollment Sites: Provider agencies providing **Eligibility, Education, and Enrollment Services for AIDS Drug Assistance Programs** must first be approved by California Department of Public Health/Office of AIDS and OAPP as an ADAP Enrollment Site. ADAP Enrollment Sites, further, are registered by jurisdiction and must be registered prior to housing any Enrollment Coordinator/Eligibility Staff within the facility.

- Staff Training. Provider agencies must cooperate in assuring the required staff training for the Eligibility Coordinator and Eligibility Staff is completed. The Enrollment Coordinator and Eligibility Staff must be certified through and receive training from Ramsell Corporation prior to enrolling clients in ADAP or within 90 days of beginning enrollment services.

Client Rights: All ADAP clients and people who wish to become ADAP clients have the following rights according to the statement of *Client Rights*. These rights include, but are not limited to (www.ramsellcorp.com/client/ca):

- Information on Eligibility Requirements. Clients or potential clients must be advised of ADAP eligibility requirements and the right to apply for ADAP assistance by completing the ADAP eligibility screening process and submitting an enrollment application.
- Confidentiality. All ADAP enrollment application and all ADAP transactions conducted with a participating pharmacy will be handled in a confidential manner in compliance with applicable state and federal laws.
- Right to Appeal. The right to appeal a program denial due to income requirements or to appeal the inaccuracy of an ADAP co-payment computation.

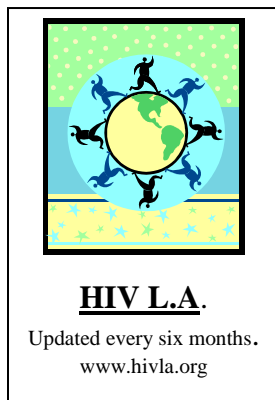
- Nondiscrimination. The right to receive services without discrimination as to race, color, age, disability, homelessness, religion, gender, sexual orientation, or national origin.
- Courteous and Respectful Service. The right to receive courteous and respectful service from ADAP Enrollment Coordinators and Eligibility Staff and participating pharmacies.
- Grievance. The right to grieve any event related to access or to delivery of ADAP services that violates any of the above-stated rights.

"If you believe you have been denied your rights or treated unfairly or discourteously at any point in the ADAP enrollment process, or in receiving pharmacy services, you may contact your local ADAP coordinator for your area or the State Office of AIDS at (916) 327-6806."

www.ramsellcorp.com/client/ca/client_rights.php



Referral and Coordination of Care: The provider agency providing drug reimbursement enrollment services must have written procedures and protocols in place for referring clients to other health and social services. The referral system must include a process for tracking and monitoring referrals, and for documenting the results of referrals from the providers of health and social services to which clients are referred. The Enrollment Coordinator and Eligibility Staff are required to follow the agency's established referral policies and procedures when referring clients to other health and social in the HIV/AIDS Continuum of Care.



The Enrollment Coordinator will maintain current information on County-wide HIV/AIDS care and prevention services, for example, a current HIV L.A. Directory of Services. The Enrollment Coordinator will maintain knowledge of local, state, and federal service and funding resources or service-funding resource limitations influencing the client's availability or utilization of HIV/AIDS services.

Quality Management (QM): Provider agencies funded to provide drug reimbursement enrollment services are required to have a QM Program that will facilitate the delivery of state-of-the-art HIV/AIDS services. Provider agencies needing technical assistance (TA) guidance on the development of QM Programs are encouraged to consult the Quality Management Technical Assistance Manual (this TA document is available at www.hab.hrsa.gov/).

The agency must report on QM indicators specific to **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program**.

Cultural Sensitivity and Linguistic Competence: Clients have the right to **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program** provided by qualified, HIV-knowledgeable and capable staff who is culturally-sensitive and linguistically-competent, who communicate and educate in culturally-congruent ways, and who work with the client's health care team. The Enrollment Coordinator/Eligibility Staff must demonstrate cultural sensitivity and linguistic competency specifically in the services provided. The staff must also demonstrate cultural sensitivity and linguistic competency for the population receiving the services (see "*The Provider's Guide to Quality and Culture*," <http://bphc.hrsa.gov/quality/Cultural.htm>).

Translation/Language Interpreter's federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California's 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to Limited English Proficiency (LEP) clients at no cost, in order to ensure equal and meaningful access to health care services.

DEFINITION OF ENCOUNTER

The US Department of Health and Human Services/Health Resources and Services Administration (HRSA) publishes the Uniform Data System (UDS) Reporting Instructions for Section 330 Grantees (last updated in 2006). The definition of an encounter is:

“Encounters are Documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. To be included as an encounter, services must be documented.” (Page 5)

Additional guidance relative to encounters includes:

1. To meet the criterion for "independent judgment," the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate encounter. Independent judgment implies the use of the professional skills associated with profession of the individual being credited with the encounter and unique to that provider or other similarly or more intensively trained providers.
2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these

services are documented, the documentation criterion is met even though a complete health record is not created. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts do not result in encounters.

4. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving immunizations, and filling/dispensing prescriptions do not constitute encounters.
5. A provider may be credited with no more than one encounter with a given patient in a single day, regardless of the types or number of services provided.
6. The encounter criteria **are not** met in the following circumstances:
 - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
 - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
 - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
 - When the **only** services provided are lab tests, x-rays, immunizations, TB tests and/or prescription refills.
 - Services performed under the auspices of a WIC program or a WIC contract.

Specific guidance on encounters related to **Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program** includes the following:

- Providers should request reimbursement when an Enrollment Coordinator or Enrollment Staff completes an eligibility determination after meeting face-to-face with a client for approximately 45 minutes or more.
- Providers should request reimbursement for the provision of education and information when the Enrollment Coordinator or Enrollment Staff meets face-to-face with the client for approximately 20 minutes or more to provide education or information.

REQUIRED STAFFING

Eligibility, Education, and Enrollment Services for the AIDS Drug Assistance Program is provided by Enrollment Coordinators who supervise ADAP services at local sites and by Eligibility Staff who screen clients for eligibility to receive services, provide basic education about drug reimbursement services, provide clients with information on approved drug formulary and pharmacy sites, address client grievances and complaints,

maintain documentation on services provided for each client, and re-certify client eligibility annually, or more frequently, if needed.

The ADAP Enrollment Site Program must have the following staff:

- Enrollment Coordinator.
- Eligibility Staff.

There are no minimum educational or credentialing standards for an individual to be an Enrollment Coordinator or Eligibility Staff. However, the Enrollment Coordinator and Eligibility Staff must be certified through and receive training from Ramsell Corporation prior to enrolling clients in ADAP or within 90 days of beginning enrollment services.

**Department of Public Health
Office of AIDS Programs and Policy**

**Medical Clinic Services
Special Rate Study**

**NUTRITIONAL COUNSELING
(MEDICAL NUTRITION THERAPY)
SERVICE DESCRIPTION**

This service description is adopted by the County of Los Angeles, Department of Public Health, Office of AIDS Programs and Policy (OAPP), to guide providers in the development and implementation of **Nutritional Counseling (Medical Nutrition Therapy)** services to individuals living with HIV/AIDS. Federal legislation, policy and program guidance, and State of California statutes, regulations, and rules governing licensing and service provision, supersede the **Medical Nutrition Therapy** service description.

SERVICE

Medical Nutrition Therapy

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DESCRIPTION

In HIV/AIDS, clients may be at nutritional risk at any point of their illness. **Medical Nutrition Therapy** is a critical companion service to HIV/AIDS disease prevention and management. **Medical Nutrition Therapy** services are provided in accordance with the Los Angeles Commission on HIV Standards of Care, Medical Nutrition Therapy (final October 8, 2006), are provided in conjunction with routine and recurring HIV/AIDS primary health care services, and are preferably delivered on-site with the HIV/AIDS Ambulatory/Outpatient Medical (AOM) Care Services to better support a client's access to, utilization of, retention in, and adherence to **Medical Nutrition Therapy**.

In the County of Los Angeles' HIV/AIDS Continuum of Care adopted on October 14, 2004, **Medical Nutrition Therapy** is a Primary Health Care Core Service. **Medical Nutrition Therapy** is directly related to improving health outcomes for HIV-infected clients, and it combines an emphasis on disease prevention and disease management. Good nutrition is important in building and sustaining the immune system. Achieving good health and preventing malnutrition is essential in maintaining positive health outcomes for people living with HIV.



HIV/AIDS Resource on Food-Drug
Interactions?
www.foodmedinteractions.com

Medical Nutritional Therapy is appropriate both for clients who have or have not initiated medication therapies for HIV disease management.



PROGRAM REQUIREMENTS

The following are minimum requirements for the provider agency providing **Medical Nutrition Therapy**. Service providers may exceed these requirements.

General Requirements: The provider agency providing **Medical Nutrition Therapy** must ensure its ability to meet the needs of the client by meeting the following general requirements:

- Administrative and Clinical Policies and Procedures. The provider agency offering **Medical Nutrition Therapy** must develop, and revise, as necessary, related standardized administrative policies and procedures and clinical protocols as part of the overall AOM Care Services. The policies, procedures, and protocols must be submitted to OAPP for review and approval upon request. Revisions to the procedures and protocols may, upon request, require OAPP approval.
- Provider agencies must have a Client Grievance Policy and Procedure that is reviewed with each client in a language and format the client can understand. A written copy must be provided to each client and a signed and dated receipt form must be included in each client record. All AOM professionals must comply with the established process for client grievances.
- Clinical Care Protocols. The provider agency offering **Medical Nutrition Therapy** services must comply with the Public Health Service (PHS) guidelines (www.aidsinfo.nih.gov) and the Los Angeles Commission on HIV Standards of Care. Agency primary care professionals must utilize established practice guidelines in

order to facilitate consistency in providing state-of-the-art prevention and care services for all clients.

HIV/AIDS prevention and care practice guidelines may be downloaded or ordered in bulk from the following websites: Los Angeles Commission on HIV Standards of Care for Medical Nutrition Therapy (www.hivcommission-la.info/soc.asp), Johns Hopkins AIDS Service (www.hopkins-aids.edu), New York Department of Health AIDS Institute (www.hivguidelines.org), federal HIV/AIDS Bureau (www.hab.hrsa.gov), and CDC's Division of AIDS Prevention-Treatment (www.cdc.gov).

The agency must have a written policy, procedure, and protocol to facilitate compliance with the California Business and Professions Code, Section 2585-2586.8 (www.leginfo.ca.gov/calaw.html) which, among other aspects, specifies that a referral shall be accompanied by a written prescription signed by the health care provider detailing the patient's diagnosis and including a statement of the desired objective of dietary treatment, unless a referring physician and surgeon has established or approved a written protocol governing the patient's treatment.

The provider agency offering **Medical Nutrition Therapy** services must comply with the Los Angeles Commission on HIV Standards of Care for Medical Nutrition Therapy and with Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols (revised December 2002). The provider agency will utilize established HIV nutrition practice guidelines and protocols in order to facilitate consistency in providing state-of-the-art **Medical Nutrition Therapy** services for all clients.

Other **Medical Nutrition Therapy** guidelines and protocols may be obtained from the American Dietetic Association (www.eatright.org/Public/Other/index_adap0600.cfm), Health Resources and Services Administration (www.aids-etc.org/aidsetc?page=et-30-20-01) and as noted in the Commission on HIV Standard of Care for Medical Nutrition Therapy.

The provider agency must utilize the "Nutrition Screen and Referral Criteria for Adults (18+Years) with HIV/AIDS, March 2005"^{4,5} (http://www.hivaidsdpg.org/Data/QM/HIV_Adult_Nutrition_Screen_Referral_Criteria_200207.pdf).

- **HIV Prevention and Disease Management Competency.** The provider agency must have personnel policies and procedures requiring and supporting the continued

⁴ Adapted from: Fenton M, Heller L, Vazzo L, et al. Dietitians in AIDS Care, AIDS Project Los Angeles, 1998. Nutrition screening referral criteria included in: *Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols*. Approved by the Los Angeles County Commission on HIV Health Services, September 1999.

⁵ Adapted from the C.A.R.E. Program and Clinics – Catholic Healthcare Org, a Ryan White CARE Act Title III Grantee providing early intervention services and primary health care to people living with HIV and AIDS in Long Beach, CA; developed by Tammy Darke, RD, CNSD. Adapted by Fenton M, 5/2000, then by the ADA HIV/AIDS DPG special working groups members in 5/2002 and 3/2005.

education of all HIV/AIDS health care professionals, including Registered Dietitians (RD) and Dietetic Technician Registered (DTR). All DTRs must work under the supervision of an experienced RD. Provider agencies are expected to budget costs for HIV/AIDS continuing education, specifically in HIV prevention and disease management, to purchase practice guidelines in formats easily accessible and usable for primary care providers, and to provide routine access to computerized educational and prevention/care treatment problem-solving (i.e., www.thebodypro.com, www.hivinsite.ucsf.edu, www.hopkins-aids.edu, or www.nlm.nih.gov/medlineplus/aids.html) for all agency health care professionals, including RDs.



The American Dietetic Association (ADA) has developed a *Scope of Dietetics Practice Framework* and supporting documents, “Evaluation tools practitioners and their managers can use to gauge and channel performance” (*Journal of the American Dietetics Association*, April 2005, www.adajournal.org). These evaluation tools include:

- a. RDs Standards of Practice in Nutrition Care.
 - b. Standards of Professional Performance for Dietetics Professionals (expands the previously titled “Standards of Professional Practice”).
 - c. ADA’s Code of Ethics.
- Client-Staff-Colleague Communication. Provider agencies must have current written policies and procedures addressing communications between the primary care staff (including RDs), clients, or other professionals.
 - Client Satisfaction. RDs providing **Medical Nutrition Therapy** services must perform semi-annual assessments of clients’ needs and satisfaction by conducting random, anonymous client surveys. RDs may cooperate with the agency’s general needs assessments and client satisfaction surveys so long as these assessments and surveys adequately address need for and satisfaction with **Medical Nutrition Therapy** services.
 - Client Records. The provider agency must maintain a client record for each client, documenting each face-to-face patient/practitioner encounter. Documentation of **Medical Nutrition Therapy** services must be consistent with the agency’s clinical policies and procedures for client record keeping.
 - Records Maintenance. Provider agencies must have a formal process for storing, maintaining, and managing client files. Client file systems must be organized for ease in information retrieval and synthesis. Client records must be secure to ensure confidentiality and should not be disclosed without the client authorization, guardian authorization, or other legal requirement.

- **Case Conferencing.** To fully address the HIV/AIDS Continuum of Care needs, and in order to coordinate patient care services, the agency must provide primary health care services in a multidisciplinary team approach. Case conferencing is required. Case conferencing should focus on client treatment concerns and challenges and must include perspectives from medical, social, and prevention team providers. The RD offering **Medical Nutrition Therapy** must participate regularly, in person or by phone, in the multidisciplinary team case conferences at the HIV/AIDS AOM Care Services sites.

Eligibility: Eligibility requirements ensure that OAPP funds are used only for the purchase of **Medical Nutrition Therapy** that cannot be paid for through other sources. Clients are eligible for **Medical Nutrition Therapy** services after a financial screening that validates OAPP funds are the payer of last resort for the client's care. In addition, clients must meet all of the following criteria:

- **HIV Status.** Client must provide verification of HIV status. Acceptable verification includes one of the following: (a) a copy of the client's seropositive test results (Elisa and Western Blot) from the test provider, (b) a signed document from a physician verifying the client is HIV-positive, (c) lab results (i.e., viral load) at any time during the client's lifetime that show the presence of the human immunodeficiency virus, or (d) written verification from a psychosocial or medical case manager or other health and social services provider who has one of the above documents in the client's file.
- **County of Los Angeles Residence.** Client must provide information to establish residency in the County of Los Angeles.
- **Income.** Clients must provide proof/documentation of income to verify OAPP funds will be used as the payer of last resort for the service. Clients who do not have coverage under or are ineligible for Medi-Cal or other third-party payment are eligible for OAPP-funded services. Income must be verified annually.

Client Rights: All clients requesting and/or receiving **Medical Nutrition Therapy** have rights and responsibilities outlined in "*People with HIV/AIDS Bill of Rights and Responsibilities*" adopted by the County of Los Angeles Commission on HIV Health Services (April 2004).

Provider agencies must have a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. A written copy must be provided to each client and a signed and dated receipt form must be included in each client record. RDs must comply with the established policies and procedures for Client Rights and Responsibilities.

Client-Centered Treatment: The provider agency providing **Medical Nutrition Therapy** must ensure that clients are given the opportunity to ask questions and receive accurate answers regarding all health and social services provided by the provider agency's health care practitioners. In addition, clients must be given the opportunity to ask questions and receive accurate answers on services to which they are referred, especially (but not limited to) the full complement of services making up the Primary Health Care Core Services in the HIV/AIDS Continuum of Care.

Patient and health care provider discussions during prevention and care services encounters form the foundation of a relationship built on trust and confidence where clients are seen as active partners in the decisions about their personal health care regimen. RDs are encouraged to review client-oriented HIV/AIDS prevention and care



**Did You Know?
California has State Requirements
For Referrals to RDs!**

websites to become more familiar and versatile in discussing HIV/AIDS from a client-centered approach (i.e., www.apla.org, www.projectinform.org, www.aidsnutrition.org, or www.thebody.com).

Clients must be fully educated about their health care needs and treatment options within the standards of medical care. Client education must be documented in the client record with details of each intervention.

Referral and Coordination of Care: The provider agency providing **Medical Nutrition Therapy** services must have written procedures and protocols in place for referring clients to other health and social services. The referral system must include a process for tracking and monitoring referrals and for documenting the results of referrals from the providers of health and social services to which clients are referred. RDs are required to follow the provider agency's established referral policies and procedures for services beyond their internal **Medical Nutrition Therapy** Program.

- **California Regulations on Referrals to RDs.** Referrals to RDs in California must be made by health care providers authorized to prescribe dietary treatments. The referral must be accompanied by a written prescription signed by the health care provider detailing the client's diagnosis and including a statement of the desired objective of dietary treatment. A RD may accept or transmit verbal orders or electronically transmitted orders from the referring physician consistent with an established protocol to implement **Medical Nutrition Therapy** (California Business and Professions Code, Sections 2585-2585.8). Provider agency policies and procedures for making and receiving referrals for **Medical Nutrition Therapy** must comply with California regulations.
- **Written Reports.** The RD offering **Medical Nutrition Therapy** must provide a written report of the nutrition assessment, plan, and intervention(s) to the referring provider agency within an agreed upon and reasonable period of time but not to exceed more than two weeks. Copies of the comprehensive nutrition assessment,

nutrition progress notes, and care plan must be sent to the referral provider agency and placed in the client's file.

Quality Management (QM): Provider agencies funded to provide **Medical Nutrition Therapy** are required to have a QM Program that will facilitate the delivery of state-of-the-art HIV/AIDS services. Provider agencies needing technical assistance (TA) guidance on the development of QM Programs are encouraged to consult the Quality Management Technical Assistance Manual (this TA document is available at www.hab.hrsa.gov/).

The provider agency's QM Program must include:

- QM Plan. The QM Program must be based on a provider agency-wide, written QM Plan that addresses both HIV prevention and care services.
- QM Committee. The QM Program must be guided by a provider agency QM Committee formally convened minimally quarterly to assure the QM Programs goals and objectives are met. The RD offering **Medical Nutrition Therapy** must participate regularly with the QM Committee to discuss operational and quality improvement issues and utilization review.
- Client Feedback Process. The QM Program must describe how ongoing client feedback will be obtained and utilized to improve access, utilization, retention, and adherence to HIV preventative services and care.
- Client Grievance Process. The QM Program must describe the implementation of the provider agency's Client Grievance Process (see requirement for Client Grievance Policy and Procedure above). Client grievance data must be tracked, trended, and reported to the provider agency's QM Committee for use in making improvements in HIV services and care.

The provider agency's QM Program must be able to meet the following expectations:

- Medical Record System. Routine and recurring audits of the provider agency's medical record system must demonstrate service records are organized, complete, and current. HIV/AIDS service delivery information must be organized clearly and consistently, supporting ease of review and consideration by any and all social and health care practitioners. Reports from these audits must describe the identification of concrete problems in HIV/AIDS services record keeping, together with practical solutions and documentation for problem-resolve.
- Consistency of HIV Practice Patterns. The provider agency QM Program must make routine and recurring audits of service delivery records in order to assess the degree to which individual practitioners are providing services consistent with federal

- guidelines for the medical management of HIV infection and other issues surrounding HIV infection. The federal guidelines are available at www.aidsinfo.nih.gov.
- In order to specifically focus the provider agency’s audits for compliance with the guidelines, provider agencies are encouraged to adopt currently published HIV/AIDS practice guidelines that assist practitioners in following concrete and specific service protocols (i.e., *Clinical Infectious Disease* 2003:36, Supplement 2:S52-62). These practice guidelines are typically available from the websites supported by the respective professional associations (i.e., www.hivaidsdpg.org or www.eatright.org) and from selective HIV/AIDS academic institutions or research-based organizations (i.e., www.aids-etc.org, www.hopkins-aids.edu, or <http://hivinsite.ucsf.edu>). Practitioners providing HIV prevention in medical settings must consult and comply with “*Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*” (MMWR: July 18, 2003/Vol. 52/No. RR-12).
 - **Required Provider Agency Indicators.** The provider agency’s QM Program must identify quality assurance indicators documenting successful clinical and service delivery outcomes in the following areas:
 - (a) Documenting the completion and incorporation of needed referrals from across the HIV/AIDS Continuum of Care Primary Health Care Core Services and the integration of referral results and recommendations into the client’s primary care treatment process.
 - (b) Documenting the successful integration of care and treatment services in medical care settings.
 - (c) Documenting the provider agency’s success in achieving adherence with care and prevention treatment plans.
 - (d) Documenting the clinical outcome indicators as required by OAPP.
 - **Required System-Wide Indicators.** Finally, provider agencies are required to participate in all system-wide QM reviews conducted by OAPP. The specific indicators for the system-wide review will be identified annually by OAPP and will focus on four critical areas:
 - (e) Reducing disparities in health outcomes for the County of Los Angeles’s social, racial, and/or ethnic minorities.
 - (f) Increasing health outcomes for all recipients of services in the HIV/AIDS Continuum of Care.
 - (g) Prevention of HIV infection and prevention of progression to HIV-related illness and disease, disability, and death.
 - (h) Indicators related to the HIV/AIDS Continuum of Care’s emphasis on the continuity of access, utilization, retention, and adherence for clients.

Cultural Sensitivity and Linguistic Competence: Clients have the right to **Medical Nutrition Therapy** services provided by a qualified, HIV-knowledgeable, and capable RD who is culturally- and linguistically-competent, who communicates and educates in culturally-congruent ways, and who works in collaboration with the client’s team. The

RD must demonstrate cultural sensitivity and linguistic competency specifically in the services provided. The RD must also demonstrate cultural sensitivity and linguistic competency with the target population receiving the services (see “*The Provider’s Guide to Quality and Culture*”: <http://bphc.hrsa.gov/quality/Cultural.htm>).

Translation/Language Interpreter’s federal and state language access laws (Title VI of the Civil Rights Act of 1964 and California’s 1973 Dymally-Alatorre Bilingual Services Act) require health care facilities that receive federal or state funding to provide competent interpretation services to Limited English Proficiency (LEP) patients at no cost, in order to ensure equal and meaningful access to health care services.



**National Standards for Culturally- and Linguistically-Appropriate
Services in Health Care**

<http://www.omhrc.gov/clas/finalcultural1a.htm>

Documentation: Provider agencies providing **Medical Nutrition Therapy** are required to meet all expectations for client and service delivery contract reporting and documentation. Provider agencies must utilize the County of Los Angeles’ “Casewatch” system to register the client’s eligibility data, demographic/resource data, enter service utilization data, medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care.

For clients not receiving Medi-Cal benefits, providers are required to document if a client was referred to apply for Medi-cal, if recently applied for Medi-Cal, date/ applied, application status, and if not referred, *must document* why the client was not referred.

The “Casewatch” system must be used to invoice for all delivered services, to standardized reporting, to import efficiency of billing, to support program evaluation processes, and to provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in the County of Los Angeles. Provider agencies must ensure data quality and compliance with all data submission requirements.

DEFINITION OF ENCOUNTER

The US Department of Health and Human Services/Health Resources and Services Administration (HRSA) publishes the Uniform Data System (UDS) Reporting Instructions for Section 330 Grantees (last updated in 2006). The definition of an encounter is:

“Encounters are Documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the

provision of services to the individual. To be included as an encounter, services must be documented.” (Page 5)

Additional guidance relative to encounters includes:

1. To meet the criterion for "independent judgment," the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate encounter. Independent judgment implies the use of the professional skills associated with profession of the individual being credited with the encounter and unique to that provider or other similarly or more intensively trained providers.
2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though a complete health record is not created. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts do not result in encounters.
4. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, giving immunizations, and filling/dispensing prescriptions do not constitute encounters.
5. A provider may be credited with no more than one encounter with a given patient in a single day, regardless of the types or number of services provided.
6. The encounter criteria **are not** met in the following circumstances:
 - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
 - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
 - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
 - When the **only** services provided are lab tests, x-rays, immunizations, TB tests and/or prescription refills.
 - Services performed under the auspices of a WIC program or a WIC contract.

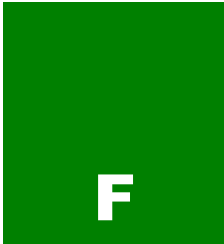
Specific guidance on encounters related to **Medical Nutrition Therapy** includes the following:

- An initial assessment defined by the Commission on HIV Standard of Care, is estimated at one hour.
- A continuing visit, designed to meet the needs identified in the assessment, is estimated at 20 minutes.
- Providers should request reimbursement for an initial assessment with a client only when the assessment took approximately one hour or more.
- Providers should request reimbursement for a continuing visit with a client only when the continuing visit took approximately 20 minutes or more.

REQUIRED STAFFING

Medical Nutrition Therapy must be provided by a RD. Qualifications of RDs are provided in the Los Angeles County Commission on HIV Standards of Care for Medical Nutrition Therapy as follows.

- The RD must have completed a Bachelors, Masters, and/or Doctorate degree in nutrition and related sciences.
- The RD must have completed a supervised internship or equivalent.
- The RD must pass a national exam which credentials her/him as a Registered Dietitian by the Commission on Dietetic Registration.
- Continuing education is required to maintain certification.



Data Request and ESIS Form (January 2008)

OAPP sent the data request, reproduced below, to providers in January, 2008.

From: Monique Collins [<mailto:mcollins@ph.lacounty.gov>]
Sent: Monday, January 07, 2008 3:33 PM
To: OBrien, Quentin
Cc: Michael Green
Subject: MOP Data Request

Hi Quentin-

As requested, I am sending you the data request by Mercer for the MOP Rate Study. Please send out to all MOP Caucus representatives for their review and response. If possible I would like to get the data back by Friday, January 18, 2008. This information will help Mercer in their analysis to capture true costs across providers. We hope to get a broader response from providers.

(Below Mercer Instructions)

1. General Ledgers in Excel

Please provide a General Ledger. Our preference is for providers to submit a General Ledger for the time period March 1, 2005 through February 28, 2006 (Year 15) and (separately) for March 1, 2006 through February 28, 2007 for Ryan White Care Act (RWCA) funds for ambulatory outpatient services only. Alternatively, providers may provide a General Ledger for a different time period that covers at least six months in duration with a start date that begins January 1, 2005 or later. We recognize that not all providers may keep RWCA funding and/or ambulatory outpatient care services separate from other fund sources and service provision in their General Ledgers. Please provide whatever information you have. However, please identify the fund sources captured, the time period covered, and the services covered in the General Ledger(s) in the cover e-mail when you send the General Ledger(s) to OAPP. Any submission not provided in Microsoft Excel will not be considered. Any submission that does not identify in the cover e-mail the fund sources, time period, and services included will not be considered.

2. Encounter and Staffing Information on attached Excel Spreadsheet

Please complete the attached Excel spreadsheet titled Encounter and Staffing.xls. Use information from your General Ledger and any back-up detail you may have. As you scroll over Columns B, C, and F on the attached spreadsheet to input your organization's information, "pop up" boxes provide instructions. Boxes highlighted in yellow should be completed.

The most important thing about this spreadsheet is to make sure the funding information reported in the General Ledger(s), and now reiterated in the spreadsheet (Rows 6 through 8 and Rows 13 through 19), relates directly to the number of encounters reported (Rows 9 and 10). The expenses reported for staffing (Column B, beginning on Row 13 on the attached spreadsheet, as well as Column F, beginning on Row 13, if your organization submitted a second General Ledger for a separate time period) must tie directly to the staffing expenses identified in the General Ledger(s) submitted. Any submission that does not clearly tie the expenses reported for staffing to the General Ledger will not be considered. In short, the attached spreadsheet is asking for information on encounters as these are not provided in the General Ledgers as well as more specific information on staffing that is not provided on some presentations of the General Ledgers. The information is not meaningful, however, unless the number of encounters as well as dollar amount expended and number of specific staff all relates directly to the General Ledger information provided.

3. Staffing Ratios Information

At the presentation on October 31, 2007, some providers indicated they were aware of published studies related specifically to staffing HIV/AIDS clinics. If you have succinct empirical information (internal studies, peer-reviewed professional studies, literature review information) about the number of annual encounters typically provided by an outpatient clinic, please provide the actual study or a direct website link.

All information is requested to be sent electronically by Friday, January 18, 2007 5:00 p.m. to Monique Collins at mcollins@ph.lacounty.gov.

Monique Collins, MPH, CHES
State Grant Manager
Planning and Research Division
Office of AIDS Programs and Policy
(213) 351-8084

**Medical Clinical Fee-for-Service
Reimbursement Rate Study**

Provider Name:
Contact Person's Name:
Contact Person's Telephone:
Contact Person's E-mail:

Time Period General Ledger 1 Covers
Fund Sources General Ledger 1
Covers
Total Funding (i.e., expenditures)
Identified on General Ledger 1

Number of Encounters Delivered

Actual or Estimated Encounters?

00/00/00 - 00/00/00
\$ -

Time Period General Ledger 2
Covers
Fund Sources General Ledger 2
Covers
Total Funding (i.e., expenditures)
Identified on General Ledger 2

Number of Encounters Delivered

Actual or Estimated Encounters?

00/00/00 - 00/00/00
\$ -

General Ledger Salary Amount:
- Physicians
- Physician Assistants
- Nurse Practitioners
- Registered Nurses
- Nurse (Other than RN)
- Other Direct Care Professional Staff
- Other Non-Direct Care Staff

	Staffing in Dollars	Staffing in FTE
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	

Note: The dollar amount in Row 20, Column B should directly correlate to the General Ledger line item(s) for salary. If it does NOT, please explain why below:

General Ledger Salary Amount:
- Physicians
- Physician Assistants
- Nurse Practitioners
- Registered Nurses
- Nurse (Other than RN)
- Other Direct Care Professional Staff
- Other Non-Direct Care Staff

	Staffing in Dollars	Staffing in FTE
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	
\$ -	0.0	

Note: The dollar amount in Row 20, Column F should directly correlate to the General Ledger line item(s) for salary. If it does NOT, please explain why below:



Medi-Cal Rate Comparison

MEMO

To: **Charles L. Henry, Director**
County of Los Angeles, Office of AIDS Programs and Policy

Date: April 7, 2005 (with revisions)

From: Mercer Human Resource Consulting (Melanie L. Sovine, Ph.D., Terri Goens, John Villegas-Grubbs)

Subject: **Medi-Cal Rate Comparisons**

Introduction

Mercer Government Human Services Consulting (Mercer) has delivered recommended fee-for-service reimbursement rates for services identified as part of medical services under Work Order No. 6-49. Following the pattern from the prior Mercer rate study on substance abuse and residential services, a comparison with Medi-Cal rates was requested by the Office of AIDS Programs and Policy (OAPP). Mercer completed that comparison, and this memo relays the resulting information to OAPP.

Findings

1. Eligibility, Education and Enrollment Services for ADAP: The service components in this service description are defined and specified by the Office of AIDS, California Department of Public Health, and they are distinctive to how the Ryan White Care Act (RWCA), Part B, AIDS Drug Assistance Program is implemented in California. There is no comparable Medi-Cal program with which to compare rates of reimbursement for this service.
2. Drug Resistance Testing: The rate of reimbursement for this service description is for the blood draw and both the pre-/post-test counseling sessions. The Mercer rate does not reimburse costs for the actual blood laboratory analysis. The costs for resistance analysis are processed through a separate voucher system; vouchers are submitted with the sample to the County of Los Angeles, DHS, Public Health Laboratory.

Medi-Cal rates for resistance testing are available; however, these rates cover the costs for blood draw and actual laboratory analysis of the blood sample, and these rates do not reimburse for counseling. Therefore, the Medi-Cal rates do not reimburse for costs comparable to the costs reimbursed by the Mercer rate.

Mercer did attempt to identify a similar service from other programs (e.g., STDs, genetic testing, diabetes) where education-counseling and blood draws prior to

treatment regimen initiation/changes are common. There were no Medi-Cal rates based on a service bundle matching OAPP's Drug Resistance Testing.

3. Referral to Medical Specialty Services: The service description reimburses for the medical examination required to determine the appropriate referral(s) and the referral, itself. The Mercer rate does not reimburse for the cost of the actual medical specialty service.⁶

Medi-Cal, at one time, reimbursed for a similar⁷ service through the "Fee-for-Service Managed Care" model. In this delivery model Medi-Cal beneficiaries were assigned a primary care provider for what was called "medical case management". The primary care provider acted as a gatekeeper for specialty services. These providers were paid on a fee-for-service basis. Phased-out in June 2003, the model no longer operates in California. There is no comparable Medi-Cal model for this OAPP service description.⁸

4. Nutritional Counseling (Medical Nutritional Therapy): There is a Medi-Cal reimbursement rate for Medical Nutritional Therapy; however, this rate was established January 1, 1993 for the AIDS Medi-Cal Waiver Program (MCWP). The development of AIDS Waiver Programs preceded advances in health outcomes as a result of HIV-related pharmaceuticals, and State health financing departments established them as a way to keep AIDS patients out of expensive hospital and/or nursing home care.

The Medi-Cal rate is: Nutritional Counseling..... \$33.48/hour⁹

The OAPP service description and corresponding reimbursement rate currently does not include the costs for nutritional supplements, and neither does the above Medi-Cal

⁶ There are local medical specialty providers who negotiate a reimbursement rate for their services that are not reflective of the actual costs of the service. Providers have been willing to do this as a way to help meet the medical needs of those who have no or limited resources to pay for the services. The Mercer rate setting architecture cannot take into consideration the "charity" implicit in these negotiated medical specialty rates.

⁷ Because a description of the actual service components is no longer available, the referenced Medi-Cal model is qualified as "similar", but not necessarily "comparable", to the OAPP service description for Referral to Medical Specialty Services.

⁸ This service description is under discussion for continuance in the rate study. This discussion has largely been carried out through Mercer-OAPP shared conference calls and no decision has been made as of the date of this Memo. The discussion stems from the fact that this service (medical exam for needed referral and making of referral) is actually a required and routine service component in the *HIV/AIDS Ambulatory/Outpatient Medical Care Services* service description, and therefore may be redundant.

⁹ There also is an allowance for travel time (billing up to one additional hour) under strict guidelines in the MCWP (see, "AIDS Waiver Program Billing Codes and Rates", October 2004 Provider Manual, Medi-Cal Publications, <http://files.medi-cal.ca.gov>).

rate. In the MCWP, “Nutritional Supplements/Home Delivered Meals” are capped at \$150.00 per client per month. This cap also was established January 1, 1993.

The Mercer rate study uses current, geographically relevant Bureau of Labor Statistics data as an indicator of actual personnel hiring costs, and then factors these costs with other real-time program and administrative costs derived from actual agency cost reports. Therefore, the Mercer rate of reimbursement (\$57.85) is a more realistic reimbursement rate for this service in 2005.¹⁰

A Note from Medicare/Medicaid: The American Dietetic Association (ADA) proactively works to assist Registered Dietitians in understanding billing procedures and actively describes appropriate billing codes. There are **Medicare/Medicaid** CPT codes for Medical Nutritional Therapy released by the Centers for Medicare and Medicaid Services (CMS) and included in the American Medical Association’s (AMA) Current Procedural Terminology CPT 2001 book. Medi-Cal has not adopted these codes for reimbursement.

Nutritional Supplements: As for the costs of nutritional supplements, OAPP is currently engaged in internal discussions as to whether to include this cost in the actual reimbursement rate or to retain this cost as a separate line-item in an agency contract budget. Mercer will revise the rate, if needed, and in response to OAPP’s final policy decision.

5. Medical Case Management: The OAPP service description for Medical Case Management is based on a specific theoretical framework developed by Sr. Callista Roy, PhD, RN, i.e., the “Roy Adaptation Model.” This is a decidedly professional nursing model that results in a “nursing diagnosis” and treatment plan that is implemented and monitored within a multidisciplinary health care team. There are no Medi-Cal medical case management programs (or codes) that correspond to the Roy model as employed in the OAPP service description.

There is a further consideration: at this time, OAPP is phasing in this model of RN-delivered Medical Case Management services due to limited funding. The Mercer rate is based on one FTE clinical nurse using 30% time in medical case management [patient care coordination] with a caseload of no more than 30 unduplicated clients at any one point in time. The Mercer rate reimburses according to days of enrollment; Medi-Cal rates are based on actual service encounters (e.g., evaluations, hourly visits and/or timed encounters [e.g., per quarter hour]) and therefore are not comparable.

6. HIV/AIDS Ambulatory/Outpatient Medical Care Services: This service description has two new aspects that are not paralleled in the service model underlying current Medi-Cal rates. First, the service description includes new service components, implemented in the routine medical encounter, that are based on the PHS guidelines’

¹⁰ There is anecdotal evidence that a decision to forego Medical Nutrition Therapy is made in favor of other needed Waiver services because of the \$13,209.00 cap per client per year for Medi-Cal Waiver services. Medical Nutrition Therapy is a requirement in the current HIV/AIDS PHS Guidelines.

recent emphasis on the integration of HIV prevention within primary medical care, the significance of treatment adherence services, and the essential attention to nutrition. These requirements expand the scope and duration of the routine medical encounter, and define enhanced areas of expertise needed by the primary care provider in each routine medical encounter.¹¹

Second, the service description (and corresponding rate of reimbursement) is based on a specific personnel model [1 FTE physician (or midlevel) to 2 clinical support nurses]. This “medical support team” model is derived from the PHS Section 330 Community Health Center Program’s utilization statistics (Region 9), and is used in the OAPP service description as a way of assuring adequate provider support for the new standards of care in HIV/AIDS primary health care.

As a result the Mercer rate of reimbursement incorporating these features is not comparable with current Medi-Cal fee-for-service (FFS) rates of reimbursement nor with the service model on which the Medi-Cal rates are based.¹²

Conclusion

The Ryan White CARE Act has funded the planning and the development of a substantial, yet politically fragile, HIV/AIDS service delivery system. Federal allocations to the RWCA are made annually. The funding allocation, particularly the level of funding each year, is not guaranteed. Because the RWCA is not considered to be the sole, indeed not even the primary, source of funding to meet HIV/AIDS needs, HIV/AIDS providers must depend on other public and private sector providers to complete the HIV/AIDS service delivery system. Unchecked competition among providers for limited financial resources is a potentially destructive force in the HIV/AIDS service system, and competition can inadvertently be introduced into the service environment through varying rates of reimbursement.

¹¹ To clarify, Medicaid (and therefore Medi-Cal), HIV/AIDS primary care services are subject to the same PHS HIV/AIDS Guidelines. Mercer is not adding additional requirements in the service descriptions and thereby confounding comparisons, rather Mercer is updating the rates of reimbursement based on the same, shared HIV/AIDS Guidelines and Mercer is not aware of Medi-Cal review and revision of rates of reimbursement based on the new requirements.

¹² Mercer identified many fee-for-service Medi-Cal rates for general outpatient medical care. These rates vary according to the type of single professional delivering the care (physician only, nurse, etc. vs. a medical team model) as well as by level of office visit (new vs. established, levels 1-5). For some of these rates, there are rate augmentations for care provided to children and for care provided in emergency rooms. The FFS rates range from \$12.00 (office visit, level 1, established patient) to \$82.70 (office visit, level 5, new patient)...\$57.20 level 5, established patient). For children and emergency room visits, the ranges are \$13.09 (office visit, level 1, established patient) to \$62.41 (office visit, level 5, established patient), and in the ER \$12.00 (level 1, established patient and \$28.44 new patient) to \$102.71 (level 5, new patient and \$71.04 established patient). The Mercer rates are not based on visit type nor are they based on differences in service delivery settings.

Typically, a comparison with Medicaid is completed as a way of assuring reimbursement rates are within an acceptable public sector range. In the RWCA programs, conceding to the Medicaid reimbursement rate is also an established way for meeting a legislated administrative management requirement for using costs-per-unit of service in subcontracting for service provision.¹³ And, reimbursing for services (and accepting reimbursements) within the range of Medicaid reimbursement rates has also helped to build the much needed collaborative public-private provider relationships.

In this set of six medical services, however, comparisons with the Medi-Cal rates were not helpful. This is because of the particular approach used by OAPP in the delivery of a service and/or because of the recent revisions to PHS guidelines that are changing HIV/AIDS medical service delivery. The Mercer service descriptions were carefully based on the service delivery approaches discussed and consensed with OAPP,¹⁴ and the Mercer rate setting architecture is a method that weds reimbursement rates with the most current standards of care. Therefore, the Mercer rates are not comparable to Medi-Cal rates.

¹³ As a result, some may ask why not use the Medicaid service components and corresponding rates as compared to establishing new service descriptions and rates. As can be seen from the Memo, OAPP contracts for services that are distinct from Medicaid approaches to HIV/AIDS services. While Medicaid reimbursement rates have been a place of “common ground” financially, routine Medicaid services have rarely been seen as model approaches for HIV/AIDS care. This, then, is the point of departure: no longer conceding to the Medicaid rates before financially reviewing whether the published rates fully “cover” the ever-updating HIV/AIDS standards of care.

¹⁴ Mercer and OAPP worked collaboratively to best define all service descriptions. This statement pertains to external requirements imposed on OAPP in certain circumstances, such as the requirements for assessing eligibility for ADAP directed by the CA Office of AIDS, appropriately adopted in the service descriptions regardless of their comparability to Medi-Cal services.

MERCER

Government Human Services Consulting

Mercer Government Human Services
Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500

Appendix 3

Miami-Dade County: Ryan White HIV/AIDS Program Service Delivery Guidelines Fiscal Year 2014 (Year 24) Section II – Cost and Eligibility Summary

**Ryan White Program
Service Delivery Guidelines
Fiscal Year 2014
(Year 24)**

**Section II –
Cost and Eligibility Summary**



*Miami-Dade County
Office of Management and Budget
Grants Coordination*

RYAN WHITE PROGRAM
FY 2014 (YEAR 24)
COST AND ELIGIBILITY SUMMARY



Miami-Dade County
Office of Management and Budget
Grants Coordination

Effective March 1, 2014

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2014 (YR 24) <u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank	Food Bank Occurrence	<p>Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Rate</p> <p>Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing, and other line items listed on the approved budget.</p>	<p>Food Bank Services may be accessed on an emergency basis ONLY.</p> <p>The provision of this service will be limited to twelve (12) occurrences in a Ryan White Program Part A fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week.</p> <p>General Provision: Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis.</p> <p>Weekly client limit = \$50.00 per week at each pickup.</p> <p>Monthly client limit = \$50.00 per week multiplied by the number of times the original day of pick-up occurs in the month.</p>	250%	<p>I, II, III Client eligibility for this service must be certified by the Medical Case Manager</p> <p>Medical Case Management Referral and has applied for Food Stamps, as appropriate.</p>	<p>Yes</p> <p>A Ryan White Program Certified Referral, or an Out-of-Network Referral including appropriate backup documentation, is required for this service.</p>

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2014 (YR 24)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Food Bank (continued)	Additional Food Bank Occurrence	Dollars per Food Bank Occurrence (weekly bag of groceries, including personal hygiene products), Plus a Dispensing Rate	<p>Additional Occurrences: A severe change to the person’s medical condition (i.e., new HIV-related diagnosis/ symptom, wasting syndrome, protein imbalance, recent chemotherapy, etc.) may also warrant additional occurrences of food bank services.</p> <p>Provision for Families: Each additional adult who is HIV+ and lives in the same household is eligible to receive an additional \$50 per week in groceries, subject to the same general provisions above. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is HIV+) is also eligible to receive \$20 per week, subject to the same general provisions above.</p>	250%	<p>The client must be reassessed for the “warranting” medical condition every three (3) months.</p> <p>Additional occurrences require a Ryan White Program Nutritional Assessment Letter for Food Bank Services to be completed by an independent physician or registered dietician not associated with the Part A food bank provider.</p> <p>For Families: The client must provide documentation to prove the dependent’s age and place of residence.</p>	<p align="center">Yes</p> <p>A Ryan White Program Certified Referral, or an Out-of-Network Referral including appropriate backup documentation, is required for this service.</p>

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2014 (YR 24)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services [ADAP Premium Plus Insurance Program/AIDS Insurance Continuation Program (ADAP/APPI)] (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Number of ADAP/APPI premium payments made on behalf of a Ryan White Program Client, Dollars per Insurance Premium, Unduplicated # of Clients Served, and Dollars Expended per Client	Number of ADAP/APPI premium payments made on behalf of a Ryan White Program Client, Dollars Expended per Insurance Premium per Client Note: additional rules for reimbursement are pending negotiations between the County and the service provider	Reimbursement will be based on documentation of the cost of each insurance premium. Maximum amount of assistance a client may receive on a monthly basis is \$750.	400%	I, II, III	Yes Client must have insurance under a group, individual, or COBRA policy. Client must be willing to sign all required forms and to provide eligibility information. A complete financial assessment and disclosure are required.

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2014 (YR 24)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (Insurance Deductibles) (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Number of Insurance Deductible payments made on behalf of Ryan White Program Clients, Dollars per Deductible, Unduplicated # of Clients Served, and Dollars Expended per Client	Number of Insurance Deductible payments made on behalf of Ryan White Program Clients, Dollars Expended per Client per Deductible Note: additional rules for reimbursement are pending negotiations between the County and the service provider	Reimbursement will be based on documentation of dollars expended per deductible. Maximum amount of assistance a client may receive on an annual basis is \$2,500.	400%	I, II, III	Yes A complete financial assessment and disclosure are required.

*LEGEND: I = HIV+ Asymptomatic, II = HIV+ Symptomatic, III = AIDS (As Defined by the CDC)

<p align="center">RYAN WHITE PROGRAM COST AND ELIGIBILITY SUMMARY – FY 2014 (YR 24)</p> <p align="center"><u>IMPORTANT: To be eligible for local Ryan White Program Part A and Minority AIDS Initiative (MAI)-funded services, the HIV+ client must be a permanent resident of Miami-Dade County and meet local income level requirements.</u></p>						
SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (Co-payments & Co-insurance for medical visits, labs, diagnostics, and prescription drugs) (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Dollars per Co-payment/Co-Insurance Encounter, Unduplicated # of Clients Served and Dollars per Client	Dollars Expended per Co-payment/Co-Insurance Encounter Note: additional rules for reimbursement are pending negotiations between the County and the service provider	Reimbursement will be based on documentation of dollars expended per co-payment/co-insurance encounter. Assistance is restricted to those medications listed on the most current approved Ryan White Program Prescription Drug Formulary	400%	I, II, III Physician's Prescription	Yes A complete financial assessment and disclosure are required.

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Insurance Services (Monthly Premium Payments for Enrollment in Federal Health Insurance Exchange Programs) (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Number of Health Insurance Exchange premium payments made on behalf of a Ryan White Program Client, Dollars per Insurance Premium, Unduplicated # of Clients Served, and Dollars Expended per Client	Number of Health Insurance Exchange premium payments made on behalf of a Ryan White Program Client, Dollars Expended per Insurance Premium per Client Note: additional rules for reimbursement are pending negotiations between the County and the service provider	Reimbursement will be based on documentation of the cost of each insurance premium. Maximum amount of assistance a client may receive on a monthly basis is \$750. This amount is subject to change.	400%	I, II, III	Yes Client must have active health insurance under a group or individual plan that has, at a minimum, all medications on the most recent Florida AIDS Drug Assistance Program Formulary. Client must be willing to sign all required forms and to provide eligibility information. A complete financial assessment and disclosure are required.

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Legal Assistance	Hour of legal consultation and/or advocacy provided by an attorney or paralegal	Cost of one hour of legal consultation and/or advocacy provided by an attorney or paralegal	\$90.00 per Hour	200%	I, II, III	Yes A Ryan White Program Certified Referral, or an Out-of-Network Referral including appropriate backup documentation, is required for this service.

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Medical Case Management (including MAI)	Type of One-Minute Activity with or on behalf of Client (Face-to-Face or Other) and Unduplicated # of Clients Served OR Type of One-Minute Activity Performed by a Case Management Supervisor (chart review, consultation, etc.)	One unit equals one minute of actual time	\$1.00 / Minute	400%	I, II, III	Yes
Medical Case Management: Peer Education and Support Network (PESN) (including MAI)	Type of One-Minute Activity with or on behalf of Client (Face-to-Face or Other) and Unduplicated # of Clients Served	One unit equals one minute of actual time	\$0.50 / Minute	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Mental Health Therapy/ Counseling (Level I) Individual and Group (PhD, EdD, or PsyD; and licensed by the State of Florida as a Licensed Clinical Psychologist, LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	Individual: ½ Hour Counseling Session per Client Group: ½ Hour Counseling Session per Counselor	Individual: \$32.50 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service) Group: \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes
Mental Health Therapy/ Counseling (Level II) Individual and Group (MS, MA, MSW, or MEd; and licensed by the State of Florida as a LCSW, LMHC, or LMFT)	½ Hour Counseling Session and Unduplicated # of Clients Served	Individual: ½ Hour Counseling Session per Client Group: ½ Hour Counseling Session per Counselor	Individual: \$32.50 per unit (MAX: 32 encounters per fiscal year and 5 units or 2 ½ hours per session; 1 encounter = 1 day of service) Group: \$35.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Oral Health Care	Client Office Visit, Oral Health Care Procedure Provided, and Unduplicated # of Clients Served	Multiplier applied to procedure rate listed in the State of Florida Medicaid Dental Services Fee Schedule, revised for January 1, 2014; reimbursement rates based on the American Dental Association's 2014 Current Dental Terminology (CDT 2014), codes for dental procedures	<p>Maximum Multiplier Rate of 3.0</p> <p>Maximum Annual Limit (Ryan White Part A Program Fiscal Year) for Oral Health Care Services: \$3,000 per client</p> <p>Very limited exceptions to the annual cap may be approved by the County, with consultation from the Miami-Dade HIV/AIDS Partnership's Oral Health Care Subcommittee as needed, on a case-by-case basis for the provision of preventative oral health care services only.</p> <p>(NOTE: This service is limited to procedures found on the most current Ryan White Program Oral Health Care Formulary.)</p>	400%	I, II, III	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
<p>Outpatient Medical Care [including Minority AIDS Initiative (MAI)]</p> <p>(NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)</p>	Client Medical Visit and Unduplicated # of Clients Served	<p>Multiplier applied to reimbursable procedure rate listed in the Year 2014 Florida Medicare Part B Physician Fee Schedule (Participating, Locality/Area 04), file dated December 31, 2013 revised, for Evaluation and Management (E&M) codes for outpatient medical care and psychiatric visits only. Inpatient and emergency room services are not covered.</p> <p>All other non-E&M procedures will be reimbursed at the 2014 applicable Medicare rate as referenced in this outpatient medical care section.</p>	<p>Maximum multiplier rate of 1.50 will be applied to Medicare reimbursable rates for Evaluation and Management codes for outpatient medical care and psychiatric visits only.</p> <p>No multiplier will be applied to non-E&M procedures.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
<p>Outpatient Medical Care (including MAI)</p> <p>(cont'd)</p> <p>(NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)</p>	(see previous page)	<p>Medical Procedures performed at Ambulatory Surgical Centers (ASCs) will be reimbursed at rates found in the 2014 Florida Medicare ASC Fee Schedule, by HCPCS Codes and Payment Rates, for Core Based Statistical Area (CBSA) Miami (33124), modified January 8, 2014. (Update pending)</p> <p>Medical Procedures performed at Outpatient Hospital centers will be reimbursed at rates found in the approved Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2014 Fee Schedule (January 2014), dated December 19, 2013.</p>	<p>No multiplier will be applied to the Medicare ASC Reimbursement Rates. Billing is restricted to organizations with on-site or affiliated ASCs only.</p> <p>No multiplier will be applied to the Medicare OPPS Reimbursement Rates. Billing is restricted to organizations with on-site or affiliated outpatient hospital centers only.</p>	400%	<p>I, II, III</p> <p>Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional</p> <p>Any referral to specialty medical care and outpatient hospital or ambulatory surgical centers on behalf of a Ryan White Program client must include documentation or a notation that the service requested is a Ryan White Program-allowable condition (i.e., is in relation to a client's HIV</p>	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
<p>Outpatient Medical Care (including MAI)</p> <p>(cont'd)</p> <p>(NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)</p>	(see previous page)	(see previous page)	(see previous page)	(see previous page)	<p>diagnosis, a related co-morbidity, a condition aggravated or exacerbated by HIV, or a complication of HIV treatment). Please refer to the OMB-GC/RW's clarification letter dated December 20, 2013, and the accompanying list of Sample Conditions.</p>	(see previous page)

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<p>Outpatient Medical Care (including MAI)</p> <p>(cont'd)</p> <p>Labs / Injectables</p> <p>(NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)</p>	(see previous page)	<p>Laboratory procedures will be reimbursed at rates included in the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule, for Florida (FL), revised for January 2014.</p> <p>Injectables will be reimbursed at rates included in the 2014 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, dated December 17, 2013.</p>	<p>No multiplier will be applied to laboratory fees.</p> <p>No multiplier will be applied to injectable fees.</p>	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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Outpatient Medical Care (including MAI) (cont'd) Consumable Medical Supplies (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client	Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Fee Schedule, for Florida (FL), revised for January 2014. If no Medicare Rate is available for approved DME and consumable medical supplies, providers will be reimbursed at the Medicaid DME for Recipients of All Ages fee schedule rates, dated December 2013. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate. Allowable items are limited.	No multiplier will be applied to DME fees.	400%	I, II, III Referral from a primary care physician is required for outpatient specialty care, except for psychiatric services which may be requested by a mental health care professional	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Outreach Services (including MAI)	Type of 15-Minute Outreach Encounter [Face-to-Face or Other (i.e., Telephone Contact, Referral Activity, etc.)] and Unduplicated # of Clients Served See the full Service Definition for details regarding the minimum required new connections (50%), and the re-connections (50%), to outpatient medical care and/or medical case management	Line Item Budget Reimbursement will be based on a line item budget (for actual expenses incurred per month by the outreach service provider).	Outreach services will be paid based on full-time equivalent (FTE) employees providing direct services as outlined in the corresponding service definition, as well as on the basis of other allowable direct and administrative costs. Reimbursement of salaries will be based on the approved budget and productivity as recorded by hours spent doing allowable outreach activities, HIV+ people contacted, their risk factors, and the # of HIV+ people connected to care. All administrative and/or indirect expenses (other than those associated with the delivery of outreach services) are capped at 10% of the total award for the service category.	N/A	I, II, III	Yes

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Prescription Drugs (including MAI for all components) (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Individual Drugs Dispensed, # of Filled Prescriptions, \$ Spent per Drug, and Unduplicated # of Clients Served	PHS of Injectable/ Non-Injectable Medication Plus Flat Rate Dispensing Fee OR AWP of Injectable/ Non-Injectable Medication Minus Discount Rate	PHS Price Plus Flat Rate Dispensing Fee OR AWP Minus Applied Discount Rate of No Less Than 10% (NOTE: This service is limited to medications found on the most current Ryan White Program Prescription Drug Formulary. Prescription drug providers should use the most cost-effective product, either brand or generic, whichever is less expensive at the time of dispensing.)	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity or Prior Authorization Form, if applicable	Yes

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Prescription Drugs: Consumable Medical Supplies (for Administering Prescribed Medications only) (NOTE: THIS INFORMATION IS SUBJECT TO CHANGE UPON FURTHER GUIDANCE RELATED TO IMPLEMENTATION OF THE AFFORDABLE CARE ACT.)	Number of Clients Served, Consumable Medical Supply Distributions per Client (for Administering Prescribed Medications Only), and Dollar Amount Spent per Client	Allowable flat rate listed in the Medicare Durable Medical Equipment and Supplies Fee Schedule, for Florida (FL), revised for January 2014. If no Medicare Rate is available for approved DME and consumable medical supplies, providers will be reimbursed at the Medicaid DME for Recipients of All Ages fee schedule rates, dated December 2013. In such case, providers must submit a request to the County for a Supplemental Reimbursement Rate.	No multiplier will be applied to approved DME or consumable medical supplies.	400%	I, II, III and Physician's Referral or Prescription, with Letter of Medical Necessity, if Applicable	Yes

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SERVICE CATEGORY <i>(listed in alphabetical order)</i>	REPORTING UNIT	REIMBURSEMENT UNIT	REIMBURSEMENT CAP	MAXIMUM % OF 2014 FEDERAL POVERTY LEVEL	ELIGIBLE HIV STATUS*	REQUIRED MEDICAID/ OTHER SCREENING
Substance Abuse Counseling – Outpatient (Level I) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client & Family Member</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$30.00 per unit</p> <p>Group: \$34.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes
Substance Abuse Counseling – Outpatient (Level II) Individual and Group	½ Hour Counseling Session and Unduplicated # of Clients Served	<p>Individual: ½ Hour Counseling Session per Client and/or Family Member, as appropriate</p> <p>Group: ½ Hour Counseling Session per Counselor</p>	<p>Individual: \$27.00 per unit</p> <p>Group: \$30.00 per unit (minimum of 3 Ryan White clients to maximum of 15 total clients)</p>	400%	I, II, III	Yes

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Substance Abuse Counseling – Residential – Residential (including MAI)	# of Days of Residential Substance Abuse Treatment per Client and Unduplicated # of Clients Served	Cost of One Day of Residential Counseling Treatment Per Client	\$125.00 per client day [up to a maximum of 120 days within a 12-month period; 12-months begins on the 1 st day of client’s residential treatment regardless of Part A / MAI provider] [includes the cost of family member(s) participating in the substance abuse counseling session provided during day of treatment]	300%	I, II, III	Yes A Ryan White Program Certified Referral, or an Out-of-Network Referral including appropriate backup documentation, is required for this service.

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Transportation Vouchers (Discounted EASY Tickets)	Dollars per Voucher, # of Vouchers, and Unduplicated # of Clients Served	Dollars per Voucher Plus a Dispensing Rate Not to Exceed 15%	Cost of Vouchers Plus Dispensing Rate Not to Exceed 15%	150%	I, II, III Medical Case Management Referral Case Manager re-certification required every 6 months.	Yes Clients must be screened for eligibility of Miami-Dade County Golden Pass Program, Special Transportation Services (STS), Miami-Dade Transit Transportation Disadvantaged Program, Medicaid, etc. ----- A Ryan White Program Certified Referral, or an Out-of-Network Referral including appropriate backup documentation, is required for this service.

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Appendix 4

New York City: *Performance-Based Reimbursement*

Performance-based reimbursement

Public Health Solutions' reimbursement approach aligns contractor payment with performance. We do this in four ways:

- Per Member, Per Day (Care Coordination) – see attached (21% of the value of our portfolio)
- Fee-for-Service (41% of the value of our portfolio)
- Deliverables-Based (6% of the value of our portfolio)
- Hourly (4% of the value of our portfolio in dollars)

Regardless of reimbursement model, all contracts must complete a line-item budget which is reviewed for cost allowability and reasonability; service projections, which must demonstrate reasonable staff effort and caseloads; a scope of work, which clearly outlines project expectations, with staff responsibility; and a general contract agreement which lays out all relevant requirements and regulations governing the contract.

Fee-for-Service

Overview: Services are associated with reimbursement rates, payable based on reporting of client-level data in eSHARE, the EMA's client-level data system. Each month we analyze eSHARE data to process payment. The product of reported billable services for the month and their associated reimbursement rates is our payment to contractors. Projected services multiplied by their associated reimbursement rates equals the total contract award.

Mechanics: Each month contractors enter service data into eSHARE. eSHARE data are extracted and transferred to Public Health Solutions' payment system, which organizes them for payment, multiplying services by reimbursement rate and subjecting data to certain payment rules (see below). Ultimately, the system generates a payment which is reviewed by a Contract Manager and a supervisor before being processed.

Contractors receive a monthly report called the Master Itemization Report (MIR), which lists and summarizes services recognized by our system. Potentially disallowable services (e.g., duplicate services, violations of frequency limits, and problems identified through site visits) are flagged for possible recoupment. Contractors reconcile the MIR against their own records.

Rate development: Some rates are negotiated with individual contractors. In that case, we establish a ceiling rate for each service type. More commonly, we compute rates and publish them in Requests for Proposals so that prospective applicants can determine whether they wish to apply for funding. Most payment points are outputs (e.g., counseling sessions, HIV tests, meals served); others are short-term outcomes (e.g., linkages to care, housing placement, workshop completion). In general, calculated rates and rate ceilings reflect the following inputs:

Expenses: Salary (at levels/job titles we deem reasonable and appropriate), fringe benefits (average nonprofit rate), OTPS (with allowances for special services such as food for food and nutrition programs or rent for housing assistance programs), administration (we allow 12% because several large contracts in the EMA have very low administrative spending, keeping us below 10% in the aggregate).

Service time: We make assumptions about how long a service should take (including preparation, charting and data entry), and thus how productive we expect a worker and program to be. We understand that some clients do not show for scheduled appointments despite the program's mobilization to serve them, and build in a no-show allowance in our rate calculations.

Outcomes and incentive payments: Some of our reimbursement points are culminating events such as linkage to care, graduation and housing placement. We assign rates to these events using a combination of benchmarking and programmatic knowledge, since their inputs (time and human resources) vary significantly among programs.

We review and, as indicated, adjust reimbursement rates approximately every two to three years based on analysis of service intensity, time and costs. When funding permits, we sometimes provide modest increases to reflect rises in the cost of living.

Rules: Some services have supplemental payment rules specific to the service category. For example, HIV testing, mental health counseling services and housing placement have frequency caps. Group services have minimum group sizes. Some services, like HIV confirmatory testing and Transitional Care Coordination graduation, have service prerequisites. Other services, like outreach activities in a homeless youth initiative, are capped as a percentage of the overall contract amount.

Monitoring:

Programmatic: On-site visits include a retrospective review of documentation of service provision, client eligibility, provider eligibility and adherence to service models and funding guidelines. Deficient documentation and failure to adhere to client and/or provider eligibility and service model requirements can result in recoupment. Monitoring staff also review monthly narrative reports highlighting achievements and challenges.

Fiscal: Audit packages (financial statements, A-133, management letters) are reviewed annually, with any relevant findings pursued with senior fiscal staff. At the end of the year, we request a line-item expense report by "service family" (a cluster of services usually sharing a reimbursement rate), which is used to inform future rate adjustments.

Spending Management: Several times during the year we analyze spending to determine whether contracts are on track to spend their full award. Using established criteria, we "take down," or reduce, low-performing contracts and redirect that funding to contractors who are exceeding their prorated targets. Contractors with "takedowns" can appeal our decision. We rescind takedowns in approximately 30% of appeals. Contractors have an incentive to overperform since, pending availability

of funds, we can pay them for exceeding their contract award amounts. As a result of our aggressive spending management, we spend almost 100% of program funds.

Deliverables

Some programs are reimbursed on completion of program deliverables. We often employ this approach during programs' start-up periods, when deliverables include activities such as staff training, space rental, establishment of a Consumer Advisory Board and completion of policies and procedures. Some services have very challenging and/or delayed fee-for-service outcomes, so we reserve a portion of the contract award for draw-down through completion of regular deliverables such as programmatic reports or training. Such contracts have a hybrid reimbursement model, with some deliverables and some fee-for-service.

Hourly

Our EMA reimburses legal services providers on an hourly basis – the recording methodology to which attorneys are accustomed. Hourly rates are capped based on reasonableness and average costs.

Reflections

A recent survey of service providers indicates that after seven years, almost 60% think that on balance, the benefits of performance-based reimbursement outweigh its challenges. Benefits include the ability to earn more for exceeding targets and to modify their budgets as they deem necessary, without the need for funder approval. The challenges are emphatically financial: lower-than-projected performance means they may not cover their fixed costs. Performance deficiencies can come about as the result of staff vacancies, damage to facilities which compromises service capacity, difficulty recruiting clients and client no-shows. In addition, during the transition to performance-based reimbursement, program administrators have described the need to employ program and clinical staff who are data-oriented, that is, who are able and willing to project, track and analyze service revenue at the caseload and program level. In addition, quality management for data processing has emerged as critical, so that providers develop the understanding of their client-level data entry as billing vouchers or accounts receivable.

From the EMA's perspective, information systems have been the key to the success of our system, translating client-level data entry into program payments. We work with numerous systems: eSHARE, the repository of client information (enrollment, demographics and services) used by service providers; a contract management system developed and used by Public Health Solutions for contracting and payment, the Master Contractor for DOHMH; and a "bridge" system that allows us to import data from eSHARE into our contract management system, applying program rules to correctly calculate payments and highlight potentially unallowable items. The contract management system, known as MAPS, generates reports for contractors and EMA staff to ensure accurate payment and reporting (both at the contract level and the aggregate grant level) and to support operational management and improvement.

Public Health Solutions' contract management staff are responsible for programmatic and fiscal operations, which requires a level of program and fiscal analysis capacity not assumed in a more conventional line-item budget contract (where fiscal staff manage budgets and billing and program staff monitor program deliverables). DOHMH staff provide technical assistance on program models, eSHARE and quality management.

Appendix 5

New York City: Reimbursement Plan for Ryan White HIV/AIDS Program Care Coordination (2012)

New York City Department of Health & Mental Hygiene

Bureau of HIV/AIDS Prevention & Control

Reimbursement Plan for Ryan White Care Coordination (RWCC)

Overview

Beginning in March 2012, Ryan White Care Coordination (RWCC) reimbursement has a three-part structure:

- (1) Per-member-per-day payments for enrollment in the various tracks
- (2) Milestone payments for transitions that step a patient down to a lower intensity track
- (3) Fee-for-service for Directly Observed Therapy (DOT) and Outpatient Bridge Medical Care (OBMC)

This document describes the method by which RWCC costs were determined and used to generate the rates for payment.

Cost calculation

RWCC- specific inputs and assumptions include:

Table 1: Inputs and assumptions for unit service costs

Salary information was culled from contract review and other contractor solicited input in 2008 and reflect recommended staffing credentials from the RWCC RFP and protocol.	
Annual salary of a Navigator	\$35,000.00
Annual salary of a Care Coordinator	\$50,000.00
Annual salary for field DOT	\$30,000.00
Annual salary for center DOT*	\$50,000.00
Other inputs and assumptions	
Field travel time (per event)	30 min (used for field DOT)
Markups: Indirect personnel**; OTPS; Fringe; Admin	20%; 25%; 30%; 12%
Medical care in low intensity	1 visit/4 months
Medical care in high intensity	3 visits/2 months
Service frequencies are dictated by the Care Coordination Protocol	

*Salary is for a licensed practical nurse (LPN)

**The markup is defined as a percent added to the base direct service salary to account for indirect personnel time (e.g. the time it takes for a supervisor to oversee the work done)

Reimbursement Rate Calculation

(1) *Per-member-per-day (PMPD) payments for enrollment in the various tracks.*

A) Base PMPD Rates

Base PMPD payment calculations were originally set in 2011 using a method of assembling service costs within program tracks. The time period for calculation was set at one day to obviate the need for prorating or complex rules for track assignment for payment. A month was considered to have 30.42 days on average.

B) Adjusting PMPD rates by carving out DOT as an activity reimbursed on a fee-for-service (FFS) basis

DOT when administered as a daily service added complexity and uncertainty to our rules for making payments on a PMPD basis. Because of the nature of the service it is not prone to overuse and consequent cost inflation, it is therefore amenable to FFS payment with a few simple controls (e.g. limit one per day).

C) Adjusting for Medicaid Community Follow-up Program (CFP)

Based on conversations with the New York State Department of Health AIDS Institute, the following services *are* reimbursable under the COBRA Community Follow Up Program (CFP): Plan development; Appointment assistance (excluding Accompaniment); Accompaniment; Benefits assessments. The following services *are not* reimbursable under the CFP: Health Promotion (Basic, Quarterly, Monthly, Weekly – including Adherence Education); DOT. This identified the need for integration and therefore cost adjustments for enrollees receiving services from both the CFP and RWCC.

Table 2: Net rates after adjusting for DOT, and CFP

Track	Expected # Mos. In Track	Base (Unadjusted) PMPD	Final PMPD after DOT Carve-out	Final PMPD w/CFP Adjustment
A	12	\$1.07	\$1.07	\$0.58
B	3	\$1.68	\$1.68	\$0.91
C1	6	\$14.86	\$14.86	\$8.02
C2	7.5	\$22.98	\$22.98	\$12.41
D	6	\$32.80/\$49.76*	\$22.98	\$12.41

*Clinic-based vs. field-based DOT before DOT carve out.

PMPD Payment Rules

The payability of each day’s enrollment will be validated on the basis of a threshold (T) of services provided during the preceding time period (P).

For clients enrolled in CFP, Health education/promotion services are the **only** services that count toward validation.

For clients enrolled in Ryan White only, services which count toward validation include the following: Case finding, Intake assessment, Medical assessment/reassessment, Other assessment/reassessment, Care plan/service plan, Case conference, Accompaniment, Assistance with entitlements and benefits, Assistance with health care, Assistance with housing, Assistance with social services, and Health education/promotion. (Note that services must be face-to-face; those performed over the phone do not count toward validation.)

Table 3: PMPD payment rules

	Expected frequency	Look Back Period (P)	Payment Threshold (T)	Rule
Track D	4.345	30	2	<i>If actual units of services over previous P days >= T, pay PMPD for today, IF NOT do not pay</i>
Track C2	4.345	30	2	“
Track C1	3	92	2	“
Track B	2	183	1	“
Track A	2	183	1	“

In addition to the provision of these services according to the timeframes specified, for clients enrolled in Ryan White only there is another way a day may be validly payable: by having an Outreach for patient re-engagement service within a 7-day look back period. This method of validating payment is only permitted for a 60 day period beginning with the last recorded face-to-face service.

These payment rules were implemented in month ten of the new reimbursement model (December 2011). The tracks and threshold value for payment are shown in Table 3. (It is anticipated that sometime in 2012, these payment rules may be expanded to require periodic adherence assessments for all tracks except A.)

(3) Milestone payments for transitions that step a patient down to a lower intensity track

The RWCC model is based on the idea that intensive navigation-type case management can stabilize even some of the most complex cases, that health behavior skills can be augmented over time, and that service delivery, therefore, should be tailored to individual need and intensification or scale back of services implemented as warranted. Milestone payments are used in order to promote provider attention to patient movement through the program. A milestone is defined as an allowed transition from a track of higher intensity to one of lower intensity that lasts for 60 days or longer without regression to a higher intensity track in that period.

Milestone payments are set to be equal to one month (i.e. 30.42 days) of the capitated rate of the track exited from (after calculating those rates net the milestone amount). Exceptions: Both the A and B track (graduation) milestones would have excessively low values by this method and are set at \$75. There is no hard data behind determining the size of the milestone payment. Rather, we chose a reasonable starting point relative to the basis – PMPD – with the idea that it can be adjusted in following years depending on the degree to which it incentivizes the desired outcome. Milestone payments were calculated based solely on unblended RW funds because CFP funds could only be attributed to a part of PMPD payment and were adjusted for DBR carve out.

Table 4: Milestone payment amounts

Transition	ID	Milestone payment
A → grad	1	\$75.00
B → grad	2	\$75.00
C1 → B	3	\$290.60
C2 → B	4	\$753.20
C2 → C1	5	\$462.61
D → C2	6	\$449.39

*The valuation of the C2 → B milestone at \$564.90 is equivalent to that of the stepwise progression C2 → C1 → B.

Milestone payment rules

- For any enrollment, a provider may be paid either the set of milestones {3,5} or else {4}.
- Only transitions that represent clinical progress are payable; those initiated by patient request or refusal of higher level service are not payable.
- Each milestone may be paid only once over the course of a patient enrollment. Some transitions will naturally be repeated due to regression, but only the first within an enrollment will be payable as a milestone.
- In order to limit circumvention of the above rule no client may be formally dis-enrolled until 60 days after loss of contact or end of participation. Any return of the enrollee to service during the 60 day window constitutes a continuation of the prior enrollment.
- A milestone can only be paid 60 days or more after the transition occurred to ensure the definition of a milestone was met.

(4) Fee-for-service for DOT and OBMC services.

Incorporation of DOT service costs added unwarranted complexity to PMPD rate setting. Both home and center-based DOT service were, therefore, carved out of the capitated rate to be reimbursed separately on a fee-for-service basis. OBMC services were always set to be reimbursed separately on a fee-for-service basis and were never part of the PMPD rate setting process; OBMC has been fee-for-service since December 2009.

Table 5: Fee-for-service DOT and OBMC rates

	Rate
Cost per unit of center-based DOT	\$9.82
Cost per unit of field-based DOT	\$26.78
OBMC Initial visit with labs	\$300
OBMC medical visit	\$175
OBMC Navigator visit	\$100