HIV Quality of Care Quality Advisory Committee Meeting

55 Exchange Place, New York, NY

March 14, 2018 1:00 p.m. – 5:00 p.m.

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Welcome, Introductions and Announcements *Dr. Kelly Ramsey and Dr. Christine Kerr, CAC Co-Chair*	− Peter Gordon, former QAC co-chair, announced the end of his term as co-chair and thanked everyone who has worked with the QAC. Dr. Gordon will continue serving as a member of the QAC. − Kelly Ramsey and Christine Kerr, QAC co-chairs, welcomed the group.	
CAC Update *Leanna Thornton, CAC Co-Chair*	− Leanna Thornton, CAC co-chair, reported on the CAC meeting earlier in the day, highlighting the focus on drug user health and stigma.	
2017 Ending the Epidemic Data Report *Dr. James Tesoriero, AIDS Institute*	− Dr. James Tesoriero, AIDS Institute, presented on the 2017 Ending the Epidemic (ETE) data report. The objective of the presentation was to update attendees on the core and supplemental ETE metrics for 2017. **Ending the Epidemic Core Metrics** − The first core metric reported in the ETE blueprint is "incidence" (number of new HIV infections). The goal by the end of 2020 is to reduce the number of new infections to 750. Unlike new diagnoses, which are counted through public health reporting, this is an estimate that is calculated using a statistical method provided by the CDC, which is always changing. NYS is on track to achieve this goal of 750 by the end of 2020. − The second reported ETE core metric is "HIV status aware." By the end of 2020, the goal is to increase the percentage of people living with HIV who know their serostatus to at least 98%. Like the core metric HIV incidence, the percentage of PLWH who are aware of their status is an estimate, based on a CDC methodology and NYC refinements. − The third reported ETE core metric is "new HIV diagnoses." By the end of 2020, the goal is to reduce the number of new diagnoses by 55%. New HIV diagnoses in both NYC and the rest of the state have declined for a third consecutive year, reaching an all-time low of 2,769 in 2017. − There has been a decrease in the number of new HIV diagnoses for non-Hispanic black, Hispanic, and non-Hispanic white groups between 2007-2017. However, there has been no improvement in terms of disparities between the groups. − The fourth reported ETE core metric is "linkage to care after diagnosis." By the end of 2020,	

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	the goal is to increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis to at least 90%. This metric has increased by 12 percentage points since 2013 (currently at 81%) and the state is on track to hit the aggressive 2020 target of 90%. − The fifth reported ETE core metric is "time to AIDS." By the end of 2020, the goal is to reduce the rate at which persons newly diagnosed with HIV progress to AIDS by 50%. The state is on track to hit this target. − Because the metric "time to AIDS" requires newly diagnosed persons to be tracked 2 years from the date of their diagnosis, the data for this metric has a 2- year lag. We have seen a huge gain in this target for persons diagnosed in 2013 (2015 reporting year), which has been maintained throughout the last two years of data (2014 and 2015 diagnoses and 2016 and 2017 reporting periods). − The sixth reported ETE core metric is "receiving any care." By the end of 2020, the goal is the increase the percentage of persons living with diagnosed HIV infection (PLWDHI) who receive any care to 90%. 2017 saw the first positive movement in this metric since 2013, as the percentage of PLWDHI receiving any care increased from 80% to 83%. − Although the state fell short of the 2017 target of 86% for the "receiving any care" metric, 2017 provided solid evidence that data-to-care and other interventions are beginning to make a population-level difference. − The seventh reported ETE core metric is "viral-suppression-receiving any care." By the end of 2020, the goal is to increase the percentage of individuals living with diagnosed HIV infection and receiving any care with suppressed viral load to 95%. − This viral suppression metric looks at suppression among those people who appear to be "in care" in the surveillance system. 2017 saw continued stability in gains made over the past several years, with an 87% viral suppression rate realized among in-care PLWDHI. The 95% goal is a very achievable goal. − The eighth ETE metric is "viral suppression- PLWDHI." By the end of 2020, the goal is to increase the percentage of individuals living with diagnosed HIV infection with suppressed viral load to 85%. This metric looks at viral suppression among all people diagnosed with HIV in the state at the end of the year. − There was a 2% increase in viral suppression in 2016, to 72%, which was under the target the state set for 2016 (76%). − The ninth the reported ETE metric is "concurrent AIDS diagnosis." This metric tracks the cohort of people who are diagnosed with AIDS at the same time as their initial HIV diagnosis. By the end of 2020, the goal is to reduce the proportion of persons with a diagnosis of AIDS within 30 days of HIV diagnosis to 15%. − This final core metric has remained around 20% for years, indicating that the state needs to	

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	do more to make faster progress in reducing late diagnoses. Not only did the state fail to hit its target for 2017 of 17.6%, the percentage of people with a concurrent AIDS diagnosis increased from 18.8% to 19.8%. **Ending the Epidemic Supplemental metrics** − The first reported supplemental metric reported is the "stigma measure." By the end of 2020, the goal is to decrease stigma experienced among PLWDHI by at least 25%. This metric is measured based on the results of the Medical Monitoring Project (MMP). − The MMP uses results from a 10-question scale that looks at four dimensions of stigma including personalized stigma, disclosure concerns, negative self-image, and perceived public attitudes about PLWH. More information can be found here: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html. − The second supplemental metric reported is "viral load suppression-newly diagnosed HIV." By the end of 2020, the goal is to increase the percentage of persons newly diagnosed who received VLS within 3 months of diagnosis to 75%. This metric has doubled since 2013, improving from 22.7% to 47%. − The third reported supplemental metric is "sustained viral load suppression." This metric is defined as the percentage of PLWDH who were virally suppressed (<200 copies/mL) on all viral load tests in the previous two years. By the end of 2020, the goal is to increase the percentage of PLWDH with sustained viral load suppression to 75%. − The fourth reported supplemental metric is "newly diagnosed HIV+ persons who inject drugs." By the end of 2020, the goal is to reduce the percentage of persons newly diagnosed with HIV who indicate a history of injection drug use to 2.8%. In 2017 the state measured 4.2% (110 people) and if the state hits its 2020 target this will be 42 people. However, the current opioid epidemic is a major threat to this goal. − The fifth reported supplemental metric is "HIV related deaths." By the end of 2020, the goal is to reduce the percentage of deaths due to HIV to zero. This metric is determined by annual medical chart reviews, performed by IPRO, conducted on a representative sample of deaths occurring in NYS among PLWDH. Results will produce the proportion of deaths due to HIV/AIDS. For a baseline, IPRO chart reviews began with 2016 deaths. − A QAC participant asked if the chart review can be followed up with a workgroup based on the model from Demetre Daskalakis, NYC DOHMH Deputy Commissioner of Disease Control, to look at what was happening in the lives of the deceased patients and identify if there were obvious interventions. Dr. Kerr noted that a lot of work along those lines is currently being done, and significant progress has been made. − The sixth reported supplemental metric is "PrEP utilization." This metric is defined as the	

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	number of individuals filling at least one prescription for Truvada within the calendar year. By the end of 2020, the goal is to increase the number of individuals filling prescriptions for PrEP to 65,000. In 2017, 24,284 individuals had filled at least one prescription for Truvada within the calendar year. − The seventh reported supplemental metric is "PrEP utilization- Medicaid." This metric is defined as the number of Medicaid recipients filling at least one prescription for Truvada within the calendar year. By the end of 2020, the goal is to increase the number of Medicaid recipients filling prescriptions for PrEP to 30,000. In 2017, 6,025 Medicaid recipients were reported to have filled at least one prescription for Truvada within the calendar year. − NYS is outperforming the national measure for "PrEP utilization-Medicaid." However, a lot of work still needs to be done regarding PrEP utilization among people of lower socioeconomic status and underserved communities. − A participant asked if there is data about individuals who are diagnosed with HIV after being on PrEP. Dr. Tesoriero explained that they are starting to look at this. Every lab result includes those on PrEP. The field staff are starting to ask about PrEP and will have the ability to track this.	
European Drug User Health Models *Jason Farrell, Correlation – European Harm Reduction Network*	− Jason Farrell, from the Correlation - European Harm Reduction Network, presented on Drug Consumption Rooms (DCRs) in the Netherlands as well as the rest of Europe. This organization seeks to improve the quality and access to health and social services for marginalized groups. − DCRs are medically supervised centers where one can safely use drugs. Their aims are to reduce health problems stemming from problematic drug use, improve access to social, therapeutic, educational, and other health services for people who use drugs (PWUD), and to lower the nuisance of public amenity issues associated with drug use in public spaces. − In the Netherlands, drug use is low when compared to the United States, and HIV, HBV, and HCV infection rates are low for people who inject drugs (PWID). However, the MSM population are increasingly at a high risk for HCV, with a special area of concern for those that inject "chemsex" drugs. Of the 1,037 newly registered HIV patients in care at treatment centers, 68 percent of newly diagnosed were found in MSM. − The heroin epidemic ended for the country in 2008, and most heroin users are about 55 years old. There are about 600 of these users in heroin-assisted treatment, and they go to a clinic to use prescription heroin and in a controlled setting. − As heroin became a bigger problem in the 1970s, Dutch addiction treatment changed from emphasizing abstinence to harm reduction. Relapses' and chronic drug use's associations with addiction prompted this change. In the 1990s, harm reduction programming gained	

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	support from research that viewed addiction as a relapsing disease, and this led to the first DCRs in 1998. − During the period of 2012-2018, DCRs transformed into housing facilities and incorporated alcohol consumption rooms. As the overall drug problem in the Netherlands has improved, some DCRs have closed. This approach towards drug use and addiction has been embedded into the general health care and public health policies of the country, and DCRs are more accepted by the community today. − In the past three decades, DCRs have been spreading around Europe, with the Netherlands and Germany having the most, at 24 DCRs. In 2013, the Netherlands closed 7 DCRs due to a shrinking of their target audience. − There are four DCR models. The first, Integrated DCRs, are large centers that allow for all services, from STI testing and providing food to social work and methadone treatments. Specialized, or stand alone, DCRs are geared towards those who need them in a community. This allows them to provide better attention and cater to their users' needs and schedules, but the services available are only for supervised using and for testing. There are no medical support or case management. − Mobile DCRs have limited hours and services but are able to cover a wide area to provide methadone, first aid, condoms, prevention materials, and a needle exchange program. Lastly, Housing Facility DCRs have social and medical support for loneliness, depression, and stress on top of their drug services, but these services are only open to their residents, who must be over 45 years old. − To start a DCR, Mr. Farrell explained the importance of matching its goals to the needs of the drug users, and the significance of keeping the community involved. Dismantling perceived fears helps in implementing DCRs for the first time; in countries where DCRs opened, reports of drug dealing and drug use declined, even though their increase were subjects of debate before the DCR was opened. − Mr. Farrell expressed how a connection with the community is vital to the success of the DCR. The police, health authorities, community city hall, and volunteers all collaborate with DCRs in order to improve the local quality of life, and to keep others aware of the DCR's activities. Street monitoring and cleaning, neighborhood hotlines, and de-escalation measures are all ways the community and DCRs help one another. − One QAC member asked if the idea of drug users as public nuisance is stigmatizing. Mr. Farrell replied that communication is key; by expressing how DCRs can minimize people	

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	from hanging out on the street and from drug materials being left around in public, the police and local residents are drawn to support DCRs.	
Harm Reduction in Practice in Ithaca, NY *Dr. Justine Waldman and Leslie Fareed, REACH*	− Dr. Justine Waldman presented on the scope and work of REACH, a nonprofit medical practice she founded to promote health equity through harm reduction principles. − REACH stands for Respectful Equitable Access to Compassionate Healthcare and serves all people without regard for ability to pay and is specially geared toward those who typically face stigma in the healthcare setting. − At REACH, providers treat the consequences of choices (such as drug use) which are often manifestations of trauma and abuse in themselves. − National statistics show over 7,000 overdose deaths in the U.S. annually, and increasing overdose deaths in New York State, particularly outside of New York city in rural areas of the state. − Opioid Use Disorder (OUD) is a chronic relapse disorder and can be managed, but not cured. Medication-assisted therapy with suboxone and methadone and the use of naloxone (Narcan) decrease infection, crime, and opioid use substantially: − Before starting REACH, Dr. Waldman was contracted as a physician with the NYS Syringe Exchange Program Health Hub. All 30 of her allotted prescription slots were used in her first year, which prompted her to open her own nonprofit medical practice, REACH. − REACH paid their staff members to take the waiver course. It currently has 10 providers on board and is expanding still. REACH has no trouble recruiting physicians because it is low threshold for providers to work there. − REACH was modeled after the NYS Drug User Health Hubs and is a private, independent medical practice that is nursing-intensive. It offers fully-integrated MAT, primary care, behavioral health, and Hep C treatment. REACH contracts with local providers to maximize the number of allowable Buprenorphine prescriptions available. − Other components of REACH include a peer advisory board, a food pantry, collaboration with Cornell's Center for Health Equity, and a relationship with the NYS Opioid Overdose Prevention Program. REACH is also a certified Tompkins County Living Wage employer. − REACH's healthcare is rooted in health equity (stigma free, compassionate care), not profit. Staff are taught to take up a servant leadership style, not a customer service style. − REACH sees patients from 22 counties across the state, and 82% of patients are enrolled in Medicaid. 675 patients were started on MAT in one year. Patient engagement is proving successful. − Dr. Waldman introduced Leslie Fareed, a client of REACH and a good friend of hers.	

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	− Ms. Fareed shared the struggles she went through due to juggling COPD and diabetes on top of substance use disorder. She described the barriers and discrimination she faced from doctors and treatment programs due to her drug use, despite doing everything she could to "get well," such using MAT. She was eventually referred to the REACH program, and said that from then on, "the ride has been phenomenal." − Dr. Kerr commented that Ms. Fareed raised a lot of important points about barriers to treatment. A lot of programs have several intakes before they will give out medication like buprenorphine. Low-threshold entrance into MAT programs is key. − A provider asked Dr. Waldman if she has encountered any allergic reactions to buprenorphine among her patients. Dr. Waldman responded that if a product isn't working for her patient, they usually try to go through every single buprenorphine product to see what they are comfortable with. Sometimes they will use Suboxone instead. Another QAC member mentioned that allergic reactions to buprenorphine are rare.	
Project SUCCEED at BronxCare *Courtney Dower, BronxCare*	− Courtney Dower, program manager at BronxCare Health System, presented on Project SUCCEED's integrative approach on eradicating HCV in HIV positive patients. − Project SUCCEED is a HRSA-funded NYC Health Department initiative that aims to eliminate HCV in PLWH residing in NYC. BronxCare was chosen as one of the sites to participate in Project SUCCEED. − BronxCare was chosen because they have a large population of coinfected patients. Of these patients, a large percentage are baby boomers and are on Medicaid/Medicare. 72% of their coinfected patients identify as male and 28% identify as female. 55% of these patients are black, 38% are classified as "other", 5% are classified as "unknown", and 2% white. − In addition, many of their patients have a documented drug use (81%). Of the 81%, 72% are currently using. − Ms. Dower noted that BronxCare must improve their ability to collect data due to the large percentage of "unknowns" seen in their demographic indicators. **Project SUCCEED Model** − Ms. Dower briefly explained each step that BronxCare had to complete to participate in Project SUCCEED. − First, staff members identified all coinfected patients. This was done by reviewing lists from both internal EMR and DOH lists to compile a complete coinfection panel. In addition, all patient charts were reviewed to determine, 1) if are they cured/not cured/on treatment/other, 2) what were their barriers to treatment, and 3) are they virally suppressed.	

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	− The second step was to incorporate new and expand upon existing BronxCare quality of care programs. This was done by assessing all current resources within the institution and determining how they can utilize them based on each stratification of patients. In addition, areas of improvement were identified within current programs to enhance offerings. − The third and final step was to stratify patients and place them into the appropriate line of care. Virally unsuppressed and uncured patients were placed into BronxCare's Check Program and VLS Action Team Model. Virally Suppressed and uncured patients were also placed into the Check Program, but only went through step 1 of the VLS Action Team Model. BronxCare continued monitoring and providing additional support to patients that were on treatment but not yet cured. − The Check Program is a city council-funded, DOH-run, patient navigation program, and was established at BronxCare in 2016. Patients who have not yet been cured of HCV enroll in the Check Program to receive care coordination, treatment readiness, and patient education. **VLS Action Team Model** − The patient, physician, community health worker (CHW), social worker, and patient recruiter make up the VLS Action Team. − The patient recruiter outreaches to and engages patients via home visits, phone calls or letters. In addition, they run through patient contact update protocol and monitor the patient's viral load suppression and movement through the HIV care cascades. − The physician provides treatment and care, clinical advice in case management meetings, and conducts home visits if needed. − The social worker provides therapy as determined in case management meetings, orchestrates any referrals identified by the CHW, and conducts home visits if needed. − The community health worker identifies barriers to care for the patient, meets with the patient in clinic or in the field when identified, and orchestrates identified actions steps and care plan as determined by case management. − BronxCare is continuing to look for better ways to collaborate and build connections with other institutions throughout the Bronx. Ms. Dower explained the importance of sharing resources throughout the community so that patients can receive the best care possible. Internally, BronxCare is working on strengthening relations throughout different departments. − BronxCare has faced challenges locating patients, quick staff turnover, barriers to treatment, and combining different programs' infrastructure to address co-infection specifically.	

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	Currently, areas of improvement are being addressed in present/future projects to best support Project SUCCEED.	
NYC Health and Hospitals 2017 Cascade *Eunice Casey, H+H*	− Eunice Casey, NYC Health + Hospitals (NYCHH), presented the 2017 HIV Care Cascade data for her organization. − NYCHH had the primary goal of creating processes for ongoing QI monitoring, and a secondary goal focused on meeting their reporting requirements. To achieve these plans, they centralized their data collection, integrated information, and centralized data reporting. − NYCHH transitioned from a structure of six regional networks to a single centralized management system, from six separate instances of an EMR with QuadraMed to the single EMR of EPIC and transitioned from three separate revenue platforms to a single one. − The process of centralization carried many improvements. Multi-year comparisons previously could not be implemented, but now for QuadraMed facilities, the data server will allow for the analysis of patient retention and support tracking lost-to-follow-up patients seeking non-HIV care. − The new EMR includes structured fields for sexual orientation, gender identity, and HIV risk factors, and efforts are underway to also include housing status and other social determinants in the EMR. − For NYCHH's 2017 New Patient Cascade, 811 patients were newly diagnosed or new to care, with 723 of them being prescribed ART, 774 having their viral load monitored, and 548 of them being virally suppressed. − For their 2017 Open Patient Cascade, there were 13,153 open cases with 10944 achieving viral suppression, and 91%, 95%, and 97% being active with an HIV clinic visit, prescribed ART, or having their viral load monitored, respectively. − For the 2017 Active Case Cascade, 99% of the 11,939 active cases were prescribed ART and had their viral load monitored. 86%, at 10,319 cases, were virally suppressed. − For the NYCHH gap analysis, a comparison is made between NYCHH's outcome and the ETE benchmark. NYCHH is on target for the Receiving Any Care ETE metric, with 91% of patients receiving any care. − For Linkage within 30 Days for the Newly Diagnosed, they fall under the 90% benchmark by ten points at 80%, but Ms. Casey notes that if the indicator is extended beyond 30 days, the linkage rate increases to the ETE goal.	

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	− With the Viral Suppression metric for Open Cases, NYCHH fell under the benchmark of 85% by only two points. Their demographic analysis of the 588 open cases that were not virally suppressed suggested an absence of disproportionate representation in the non-active, unsuppressed patient population. − Lastly, for the Viral Suppression metric for Active Cases, NYCHH achieved a suppression rate of 86%, while the benchmark is 95%. Patients under 30 years of age had a suppression rate of 72%. − In order to better their quality improvement, NYCHH will alleviate the reporting burden of clinic sites so that more efforts can be focused on care improvement. Population Health Data tools will be used to improve understanding of QI concerns. − Standardization of systems such as HIV testing and documentation processes will be addressed, and toolkits to support independent QI projects will be available. Furthermore, the connections between HIV clinics and the larger facility will be strengthened, and a quality management cycle will be established.	
2018 Organizational Cascades *Daniel Belanger, AIDS Institute*	− Dan Belanger, AIDS Institute, gave a brief update of the 2018 organizational treatment cascades review process. − The 2018 review will now combine patient-level data with the cascades. A single template developed by Chris Wells, AIDS Institute, will be used to enter patient data, the QI plan, and methodology, which will then be submitted to the Health Commerce System for eventual review by quality coaches for final approval. − The template will contain all patient-level data including open, active, and new-to-care/newly diagnosed patients and service line information. It will also validate the data at the click of a few buttons, so hopefully this will make the process easier and more streamlined. The template will also generate the visual graphs for the open-active patient cascades and demographic breakdown. − Information captured by this year's review will include the last HIV delivery clinic where patients were seen, the number of days from diagnosis to linkage to care, and the time to viral load suppression within 91 days. − Having patient-level identifiers strengthens the data and gives more information about patients, allowing sites to tailor QI to needs of patients. − Providers should describe how they are involving consumers in their QI activities. − Submission Process: o Identify someone at your site who is registered to use the reporting system, Health Commerce System (HCS). Otherwise, contact Joe Kobilca at joseph.kobilca@health.ny.gov, who can register individuals.	

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	o Confirm your primary contact and authorized approvers with Ziyad McLean, Ziyad.McLean2@health.ny.gov.
	    o Enter data and written statements into the data template.
	    o Submit template to HCS.
	− At the time of the meeting, approval for the data entry template was pending. Since sites have the data definitions already, they should be able to collect the data now and fill it in once they have the template. Submission guidance and the template will be released at the same time.
	− Dr. Pete Gordon, former QAC co-chair, asked if there is any chance that the data elements will change. They will not.
	− Dr. Barry Zingman asked if it was possible to save data and then merely update it next review cycle. Mr. Wells responded that this is possible, because it's an Excel file. At large institutions, it is better to organize, and input data externally, and then copy and paste it into the Excel workbook.
	− Mr. Wells commented that the template provides an automation of scored data that that can be organized according to preference. It's a tool that has broader utility than simply the annual updates.	

Amida Care and Value-Based Payments *Doug Wirth and Nick Ligouri, Amida Care*	− Doug Wirth, President and CEO of Amida Care, and Jerry Ernst, Chief Medical Officer of Amida Care, gave an overview of Amida Care's Value Based Payments (VBP) plan as a Medicaid Special Needs Plan (SNP). − Amida Care is the largest SNP in NYS, with around 7,300 members, and is one of the fastest growing Medicaid health plans. It began as a nonprofit medical plan for HIV providers who were concerned about their patients' care through the Managed Care Organization (MCO) business model that saves money by rationing care and putting barriers in place. Its goals include ensuring care for all, increasing viral suppression rates, improving quality outcomes, and preventing costly care. − Amida Care's has seen improvements in clients' viral suppression rates, HCV cure rates, and retention in primary care. Amida Care members have also seen a decline in ER visits and hospital admissions. The plan has also saved $150 million in cost savings for NYS Medicaid program since 2008. − Providers have concerns about VBP's effect on access and quality of care as well as fear that financial risk will pressure providers to restrict care and reduce utilization services to save money. Plans and providers should work together towards the same goal, higher quality of care and cost savings, but contribute differently.	

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	− Traditionally, health plans pay claims and receive calls from providers about claims billing. Mr. Wirth commented that plans should do more than this. They also need to do more to provide information and real-time data to HIV primary care providers. − Amida Care's model for VBP contracts in the HIV delivery system includes fee-for-service claims payments, a quality incentive program, a viral load suppression incentive and gain/risk share. − Fee-for-service (FFS) claims payments option allows provider partners to continue to bill and be reimbursed through claims as usual. − The Quality Incentive Program (QIP) is available for level one VBP providers. QARR/HEDIS and HIVQUAL measures are used as quality markers, and providers receive financial incentives for performance above NYS benchmarks. − Amida Care has also introduced a VLS incentive. Providers can earn $200, paid to the institution, for each virally suppressed plan member every six months. They have also introduced the "Live Your Life – Undetectable" program, which provides plan members with an incentive for viral suppression. Incentivizing providers and patients align their goals and rewards them for meeting it. Amida Care is the first plan to be approved to do this for members. However, there are systemic barriers to broader uptake of incentives for consumers. Amida Care is advocating for incentives to be counted on par with providers. − Consumers can earn $100 per quarter loaded onto an Amida Care Visa card when their two quarterly viral load tests show suppression. The incentive is modeled after Housing Works Undetectables program. − One participant asked if the VLS incentive will result in cost increases over time. Mr. Wirth explained the VLS incentive counts in total medical costs. It is based on reported information about increased viral suppression, which results in overall cost reduction. This does not decrease the costs of medication, and there are reductions in hospitalizations. The cost of the VLS incentive is offset by reduced hospitalizations. − The member incentive is cost neutral. The state approved the program but does not cover the costs of the incentives. Incentives cost $1.2 million for providers and $1 million for consumers. Mr. Wirth explained that most of their consumers are in smaller facilities and experience more chronic diseases, so better health outcomes can be achieved by keeping them in care. − A QAC member commented that incentives do not work for many providers because the funds are paid to their institutions. Some institutions do put money back into the program	

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	and hire staff; this is Amida Care's preferred payment method. However, Amida Care has no control over MCO contracts. − Amida Care's model for VBP contracts in a HIV delivery system demonstrates its strong commitment to quality outcomes through the Quality Incentive Program (QARR/HEDIS/HIVQUAL) and drives VLS improvement with provider and member incentives. It has a balanced approach to financial risk sharing that mitigates risk or increases gain share, with higher quality. Integrated Plan-Provider Quality Care Workgroups are provided. At present, more than 20% of Amida Care's total costs are in level one plans. By the end of 2019, more than 60% will be in level one costs. Of those costs, 45% will be in level one and more than 15% will be in level two. − Total Cost of Care (TCC) reporting and education are offered to support providers. TCC Reports provide a comprehensive picture of total benefit costs and utilization, by breaking each member's costs into categories. Reports are prepared and delivered monthly via a secure website, so providers are aware of their patients' status. − Technical training on TCC reporting is offered to providers via webinars and in-person meetings as well as engagement on use. Mr. Wirth noted that providers need to learn to work with data and think differently about the top quartile in terms of costs. − TCC reports contain four modules: patient view, PCP view, Rx view, and inpatient view. Providers can open the report and see different views available to them. Mr. Wirth noted that many providers are surprised by the Rx view because they are unaware of their patients' other interactions with the hospital system and medical care. People whose costs are on the high end can be easily identified. − Amida Care is training physicians to look at significant inpatient costs or limited outpatient costs with a level of information they have not had before, including prescriptions and admitting diagnosis. As a Medicaid health plan, Amida Care has the responsibility of partnering and sharing real-time data with providers to facilitate successful adoption of VBP plays. − Amida Care has developed an innovative Accountable Care Organization (ACO) focused on HIV care and at-risk population management. The ACO is made up of nine HIV providers in: seven community health centers, one DAC, and one community-based independent physician association. The ACO will be launched in NYC in 2020 and will expand to the rest of NYS. − The rationale for providers to participate in an ACO is to simplify practice management and interactions with payer. There is a single payer with one model of care, and one VBP	

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	contract covers all patients. There is a single set of core quality metrics, all working towards viral suppression. − In the first five years of the ACO, Amida Care has projected $167 million in savings. − AmidaCare is working to develop an integrated delivery system for community-based care outside of large hospital-centered systems. − Dr. Gordon commented that innovation is necessary to meet ETE goals. Mr. Wirth added the PrEP target will not be met if PrEP is not given to Medicaid patients and lower income residents. He believes the HIV primary care system SNP is the perfect system to address this issue.	