



**Department
of Health**

**Medicaid
Redesign Team**

HIV/AIDS

Clinical Advisory Group Meeting 1

Meeting Date: September 3rd

September 2015

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- A. Clinical Advisory Group Roles and Responsibilities
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- C. Examples of Value Based Payment
- D. Outcome Measures
- E. Introduction to Ending the Epidemic

Introductions



Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will likely consist of the following:

Meeting 1

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- Contracting Chronic Care: the Different Options
- Examples of VBP
- Introduction to Outcome Measures
- Introduction to Ending the Epidemic

Meeting 2

- HIV/AIDS population – definition and analysis
- Introduction to Outcome Measures
- AIDS Institute Quality Program

Meeting 3

- HIV/AIDS Outcome Measures
- Wrap-up of open questions

Part I

A. Clinical Advisory Group (CAG) Roles & Responsibilities

Roles and Responsibilities Overview

Clinical Advisory Group Composition

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap.
- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements.

Composition of the CAG includes:

- Clinical experience and knowledge focused on the specific care or condition being discussed (HIV/AIDS)
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

CAG Objectives

- Understand the State's visions for the Roadmap to Value Based Payment
 - Understand the subpopulation (HIV/AIDS)
 - Review subpopulations/clinical bundles that are relevant to NYS Medicaid
 - Make recommendations to the State on:
 - outcome measures
 - data and other support required for providers to be successful
 - other implementation details related to each subpopulation/bundle
- ❖ *The CAGs will be working with standard definitions of the HIV/AIDS population (being HIV+/ having AIDS) as determined by the AIDS Institute. Also, the services deemed eligible are those covered by Medicaid MCOs and the HIV/AIDS SNPs. The CAGs are not asked to tailor definitions at this point, but focus on outcome measures and NYS implementation details.*
 - ❖ *Definitions are standard, but financial arrangements between plans and providers around the bundles and populations are not set by the State.*

B. Introduction to Value Based Payment

Brief background and context

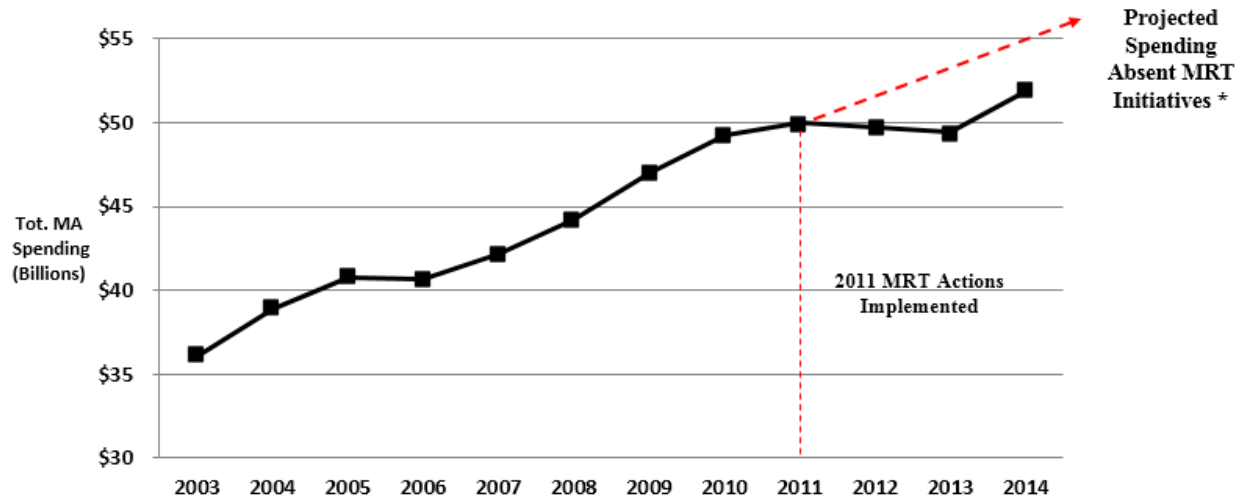
NYS Medicaid in 2010: the crisis

- > 10% growth rate had become unsustainable, while quality outcomes were lagging
 - Costs per recipient were double the national average
 - NY ranked 50th in country for avoidable hospital use
 - 21st for overall Health System Quality

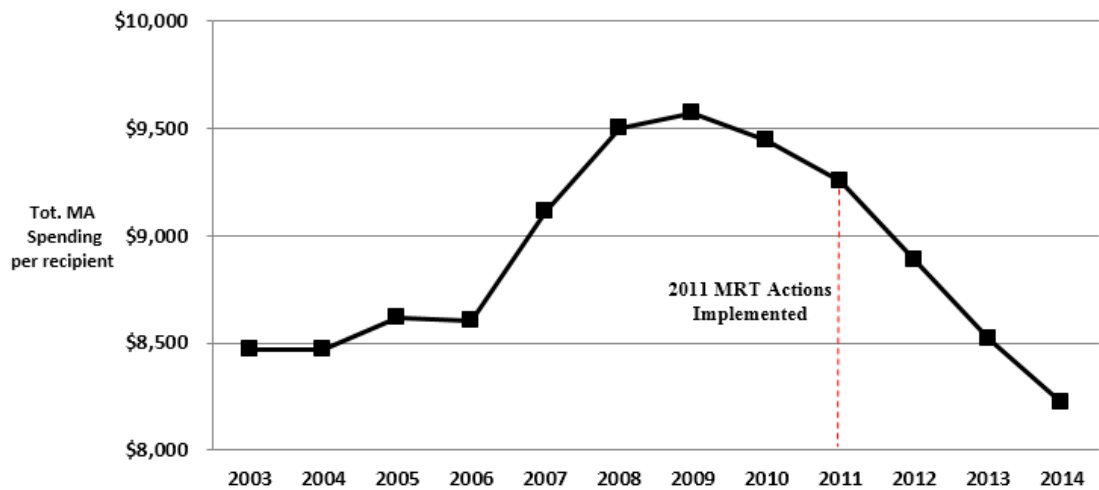
2009 Commonwealth State Scorecard on Health System Performance

<u>CARE MEASURE</u>	<u>NATIONAL RANKING</u>
Avoidable Hospital Use and Cost	<u>50th</u>
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Beneficiary to below 2003 Levels



Since 2011, total Medicaid spending has stabilized *while number of beneficiaries has grown > 12%*



Medicaid spending per-beneficiary has continued to decrease

Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system – DSRIP - can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
 - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
 - Current payment systems do not adequately incentivize prevention, coordination, or integration

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes:
value

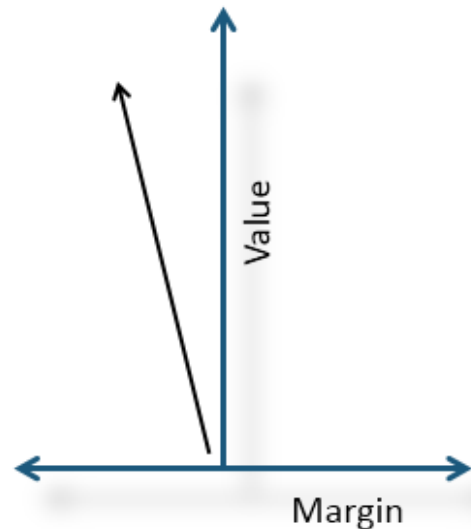
Payment Reform: Moving Towards Value Based Payments

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

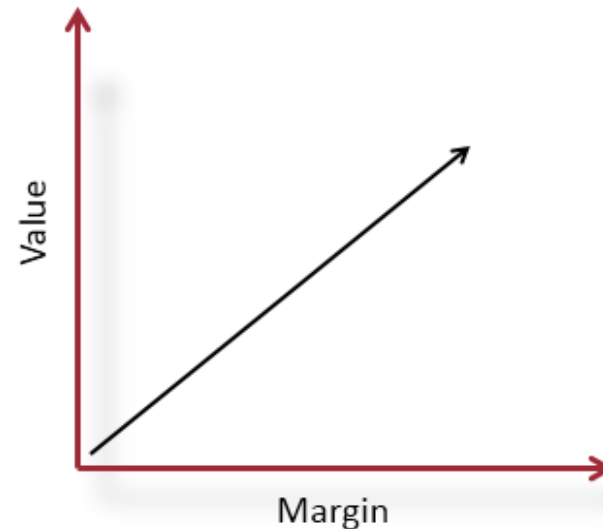
Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins by realizing value*

Current State
Increasing the value of care delivered more often than not threatens providers' margins

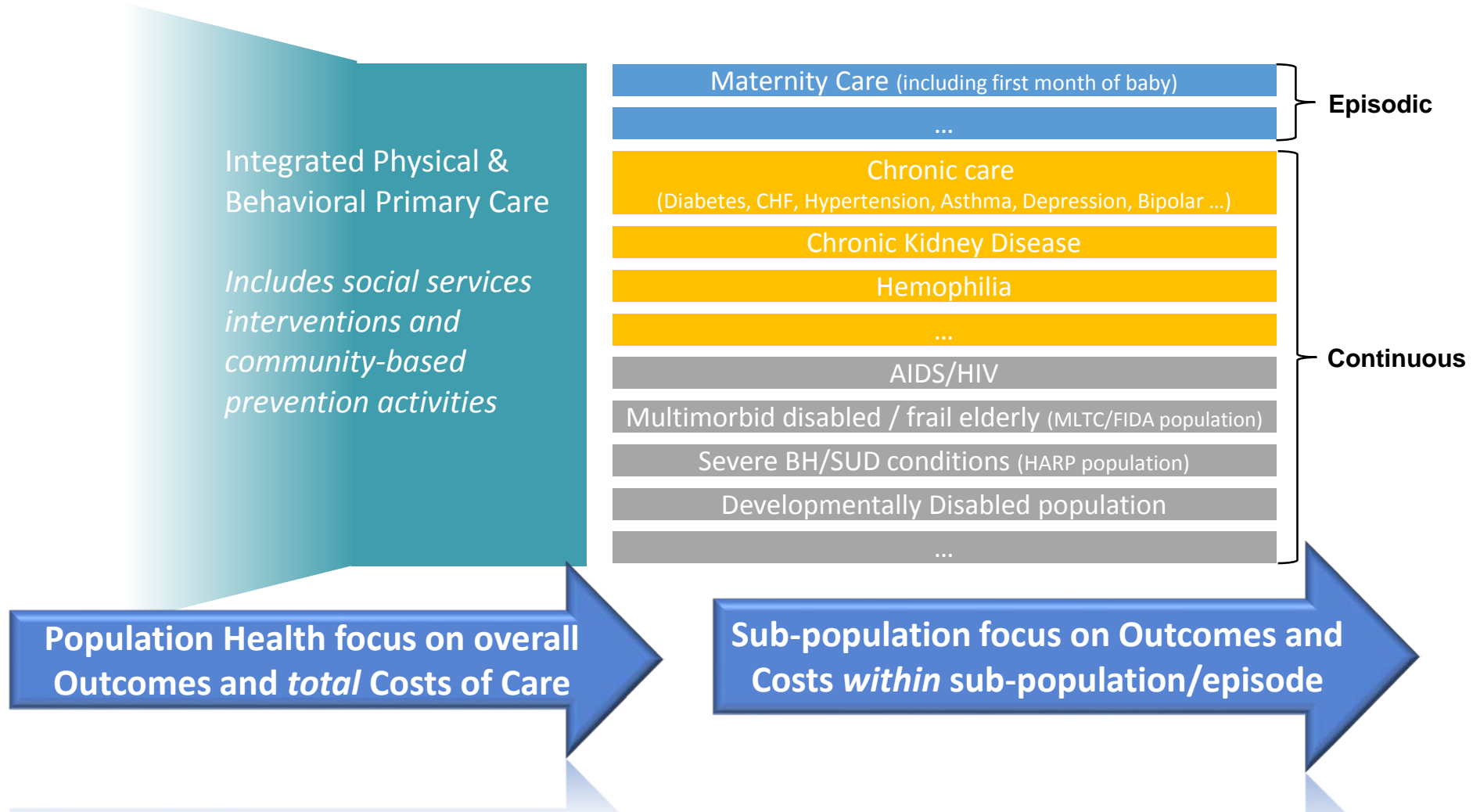


Future State
When VBP is done well, providers' margins go up when the value of care delivered increases



Goal – Reward Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

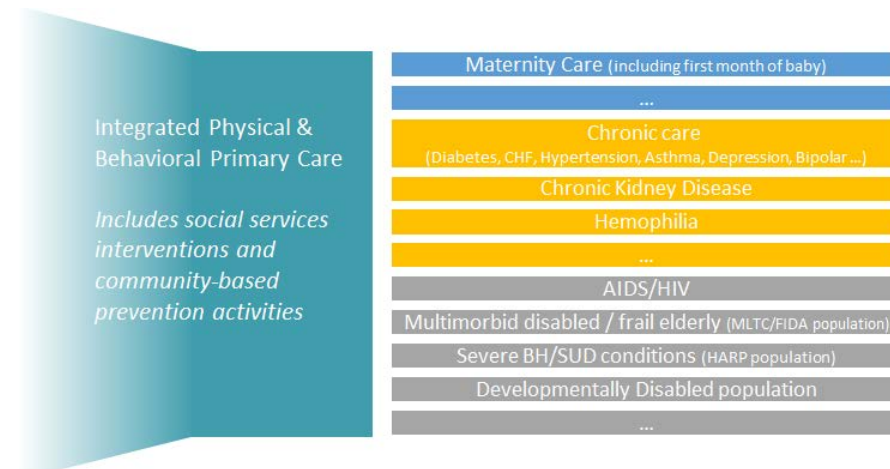


The Path Towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/PPS initiatives):

- For the total care for the total attributed population of the provider (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and



MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS

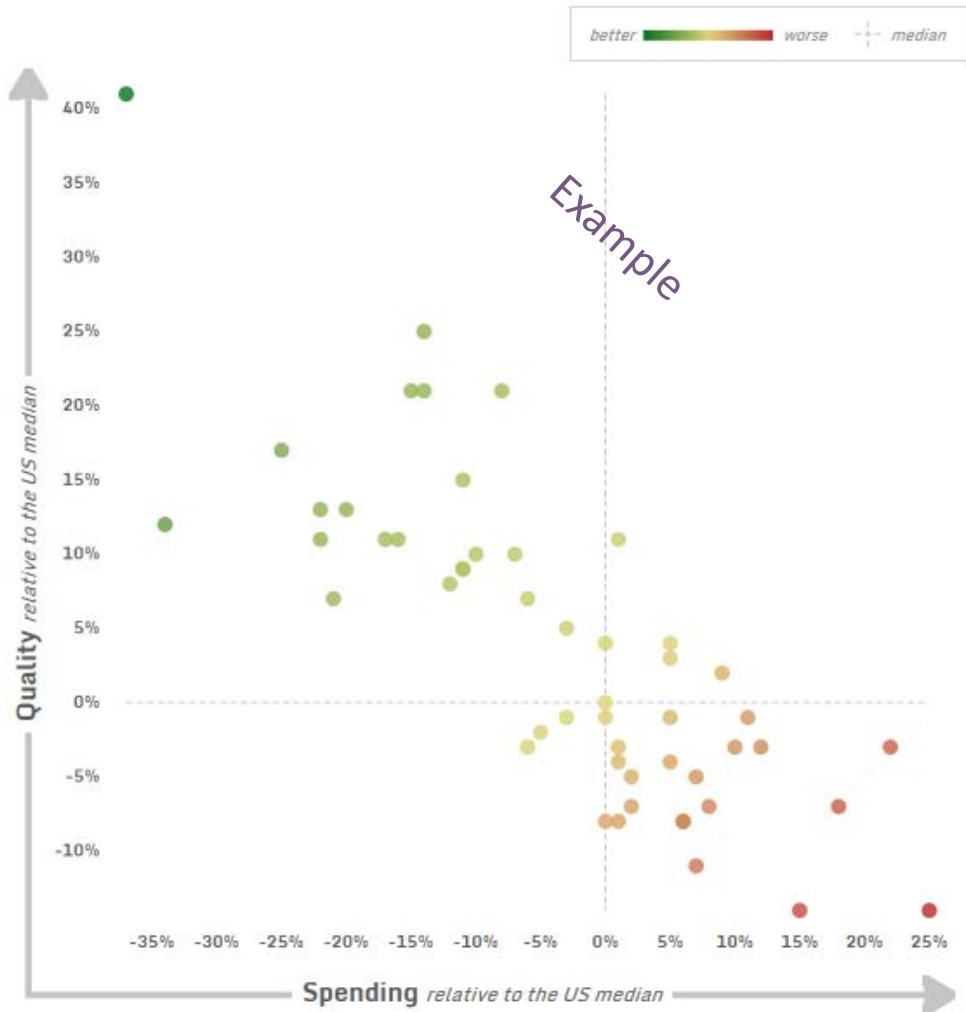
MCOs and Provider Groups can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and provider groups can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPSs)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

Value Information per VBP Arrangement – HIV/AIDS Subpopulation (using price-standardized data)



Providers and MCOs will receive

- Cost and Quality performance overviews per VBP arrangement (whether these arrangements are contracted or not)
- Including Target Budgets and actual costs (both cost-standardized, and, for their own beneficiaries, real-priced)

Initially, PDF reports will be used, but providers and MCOs will get access to web-based analytical tools to dynamically interact with these data

- Including drill downs by geography and provider
- Including drill down possibilities to individual patients (for own beneficiaries)

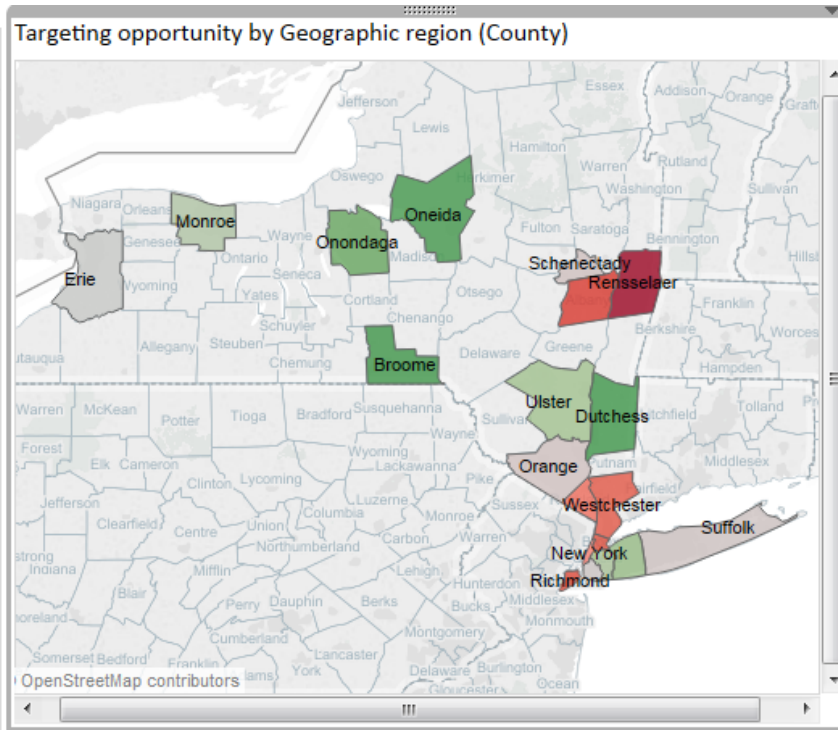
C. VBP for the HIV/AIDS Population

What is included in AIDS/HIV care?

- ‘Subpopulation care’ includes *all* care for the *total* subpopulation
 - Chronic care (non-AIDS/HIV): > 40% of total costs
 - (depression/bipolar/diabetes/asthma)
 - Of total: medication (25% of total costs)¹
- Excluding those services that are/will not covered by Medicaid Managed Care

1. Based on Medicaid-only HIV/AIDS subpopulation; OHIP data; 2012-2013

	Total Cost	Volume
	\$0 \$2,000,000,000 OK	10K 20K
Bronx	\$1,123,687,265	15,529
Kings	\$826,882,596	12,725
New York	\$526,131,183	7,471
Queens	\$305,841,296	5,001
Richmond	\$86,818,126	1,073
Erie	\$52,974,659	939
Suffolk	\$44,892,594	802
Monroe	\$47,740,133	799
Westchester	\$46,587,422	796
Nassau	\$43,940,385	668
Onondaga	\$18,749,869	393
Albany	\$24,796,874	364
Orange	\$12,434,953	229
Dutchess	\$11,375,962	222
Schenectady	\$11,897,665	194
Rockland	\$11,203,047	159
Broome	\$7,646,043	157
Oneida	\$7,539,999	156
Ulster	\$7,571,940	130
Rensselaer	\$6,290,820	106



Measure (weighted aggregation for county)
 (*Actual-Expected* is not avail for Populations)

- Avg Cost
- Actual - Expected Cost

Note: Avg Cost is scaled for coloring
 (\$11,654) \$21,406

1. Episode/Populations Type

- Population
- Acute
- Procedural
- Chronic
- Other
- Unassigned Costs

SELECT Background for Episodes
 (Select Null for Population type)

- Null

2. Episode/Population

- Total population
- General population
- DD
- HARP
- HIV
- MLTC

3. Episode Level

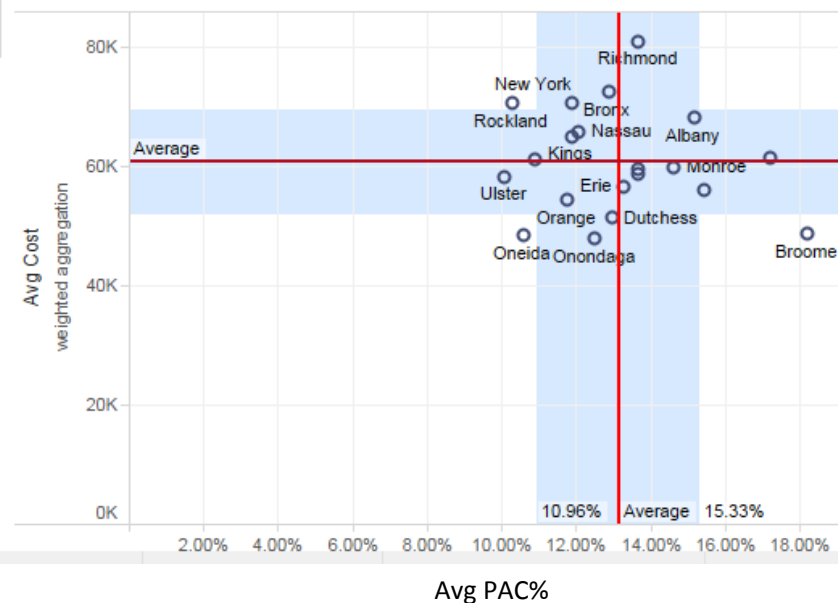
- 1 (Trigger Episodes)
- 3 (Complete Procedural)
- 4 (Complete Acute)
- 5 (Complete Chronic/Others)

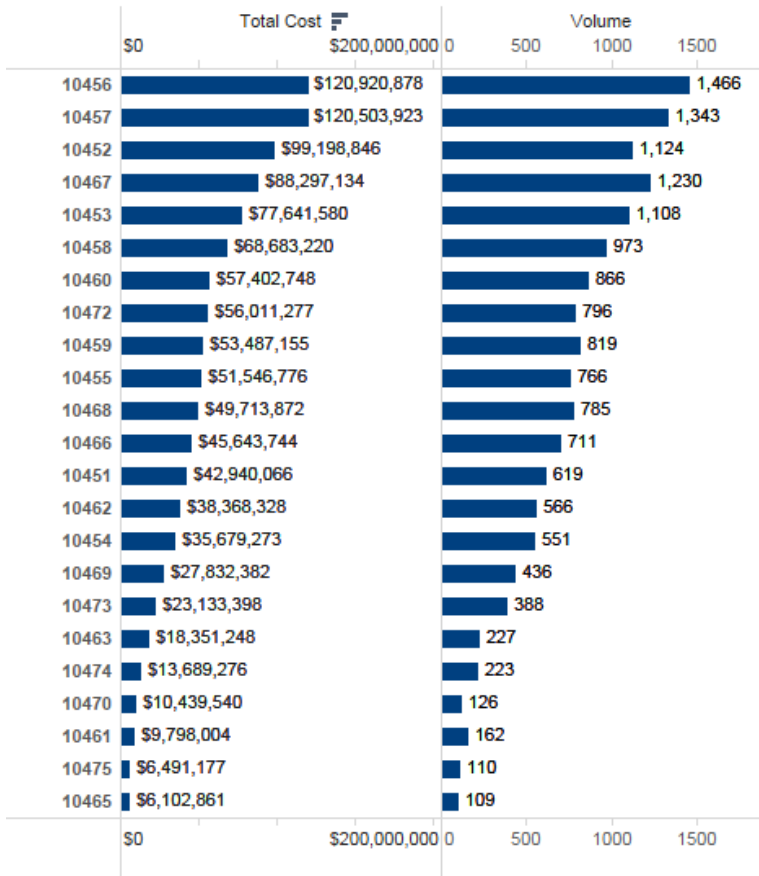
Set Min. Volume



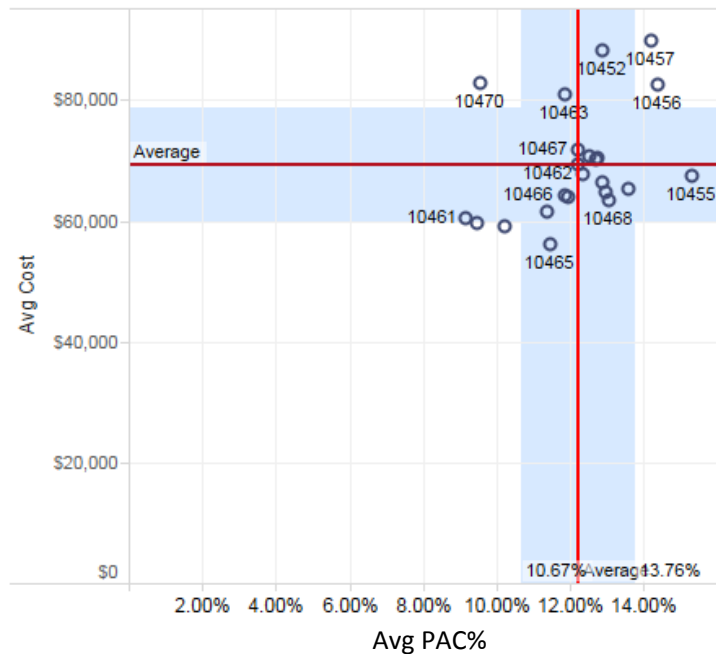
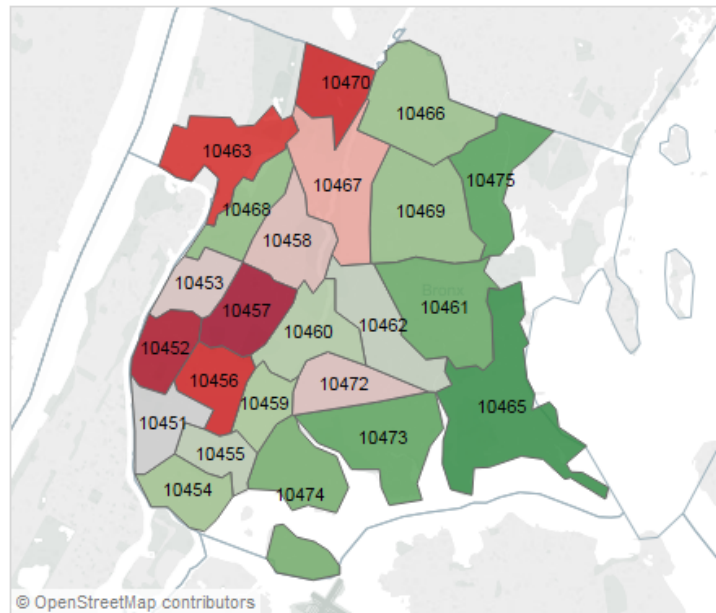
Group/Ungroup Maternity Care

Ungroup Maternity Care





Targeting opportunity by Geographic region (Zipcode)



Back to COUNTY level

Measure
 (*Actual-Expected* is not avail for Populations)
 Avg Cost
 Actual - Expected Cost

Note: Avg Cost is scaled for coloring
 (\$13,386) (\$20,352)

1. Episode/Populations Type

- Population
- Acute
- Procedural
- Chronic
- Other
- Unassigned Costs

SELECT Background for Episodes
 (Select Null for Population type)

- Null

2. Episode/Population

- Total population
- General population
- DD
- HARP
- HIV
- MLTC

3. Episode Level

- 1 (Trigger Episodes)
- 3 (Complete Procedural)
- 4 (Complete Acute)
- 5 (Complete Chronic/Others)

Set Min. Volume

100 1,466

Group/Ungroup Maternity Care

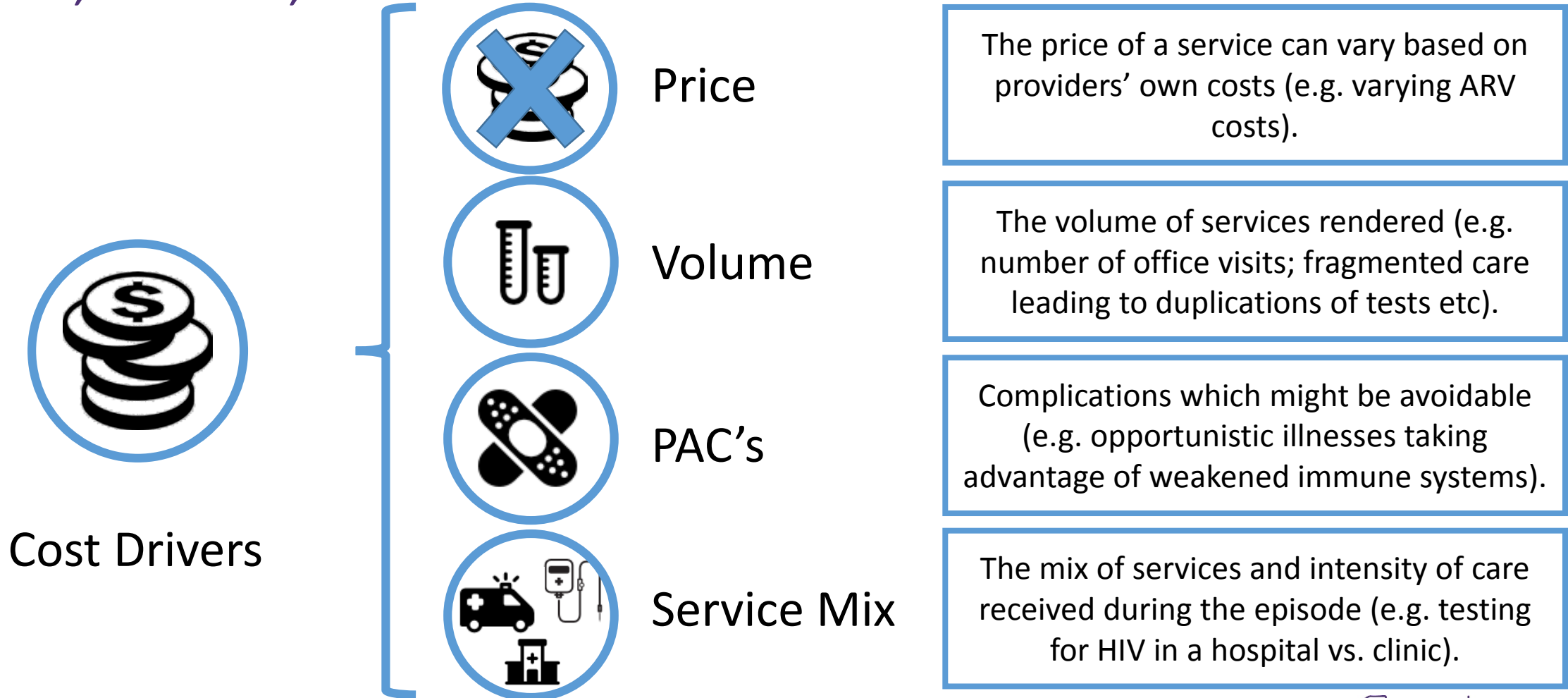
Ungroup Maternity Care

How would this work? (example not yet including ETE)

AIDS/HIV center becomes AIDS/HIV ACO – Level 2 (FFS with retrospective reconciliation):

- Responsible for total cost of all patients attributed (MCO attributes patients to center)
- Challenge: lowering total costs PMPY by
 - 1) finding where the ‘waste’ in the system is and
 - 2) investing smartly

Four Important Costs Drivers for the HIV/AIDS Population are Price, Volume, PAC's and Service Mix

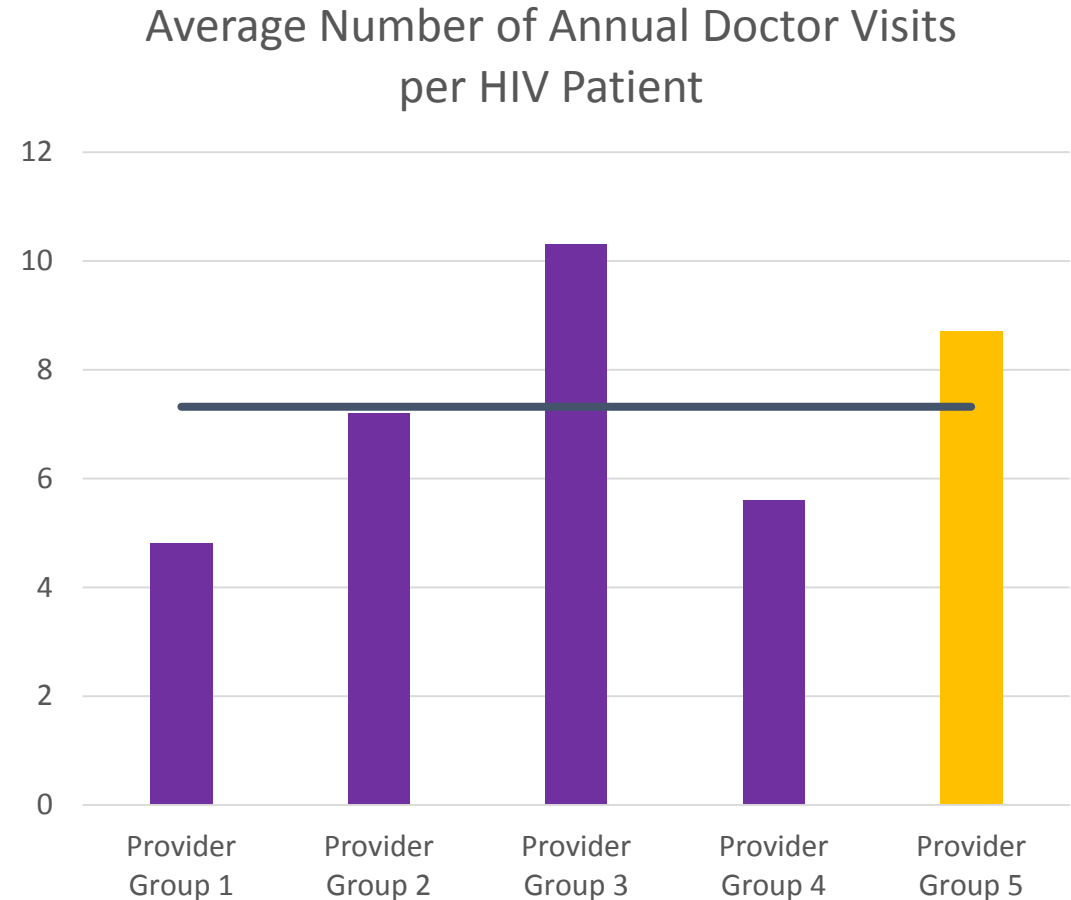


Decreasing Volume of Care

Fictional data

Eliminating Unnecessary Doctor Visits

- Provider Group 5 is located upstate and manages the care of 2,500 HIV patients.
- It turns out that Provider Groups 1 and 3 take care of a very different patient group, but Provider Groups 2 and 4 are comparable to Provider Group 5.
- In comparison to those, Provider Group 5 struggles to coordinate care across its individual providers, causing doctors to repeat tests and have difficulty managing side effects of ARV use. As a result, the average Provider Group 4 patient sees the doctor more often.

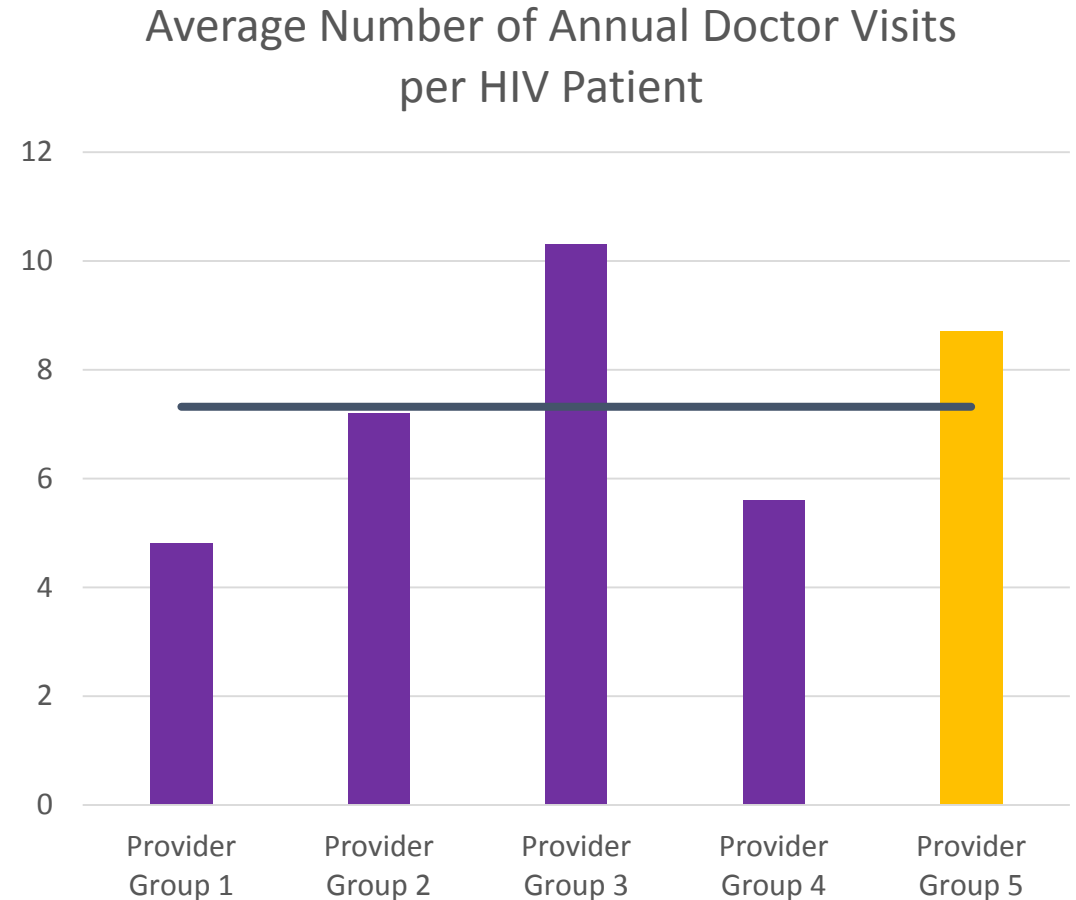


Decreasing Volume of Care

Fictional data

Eliminating Unnecessary Doctor Visits

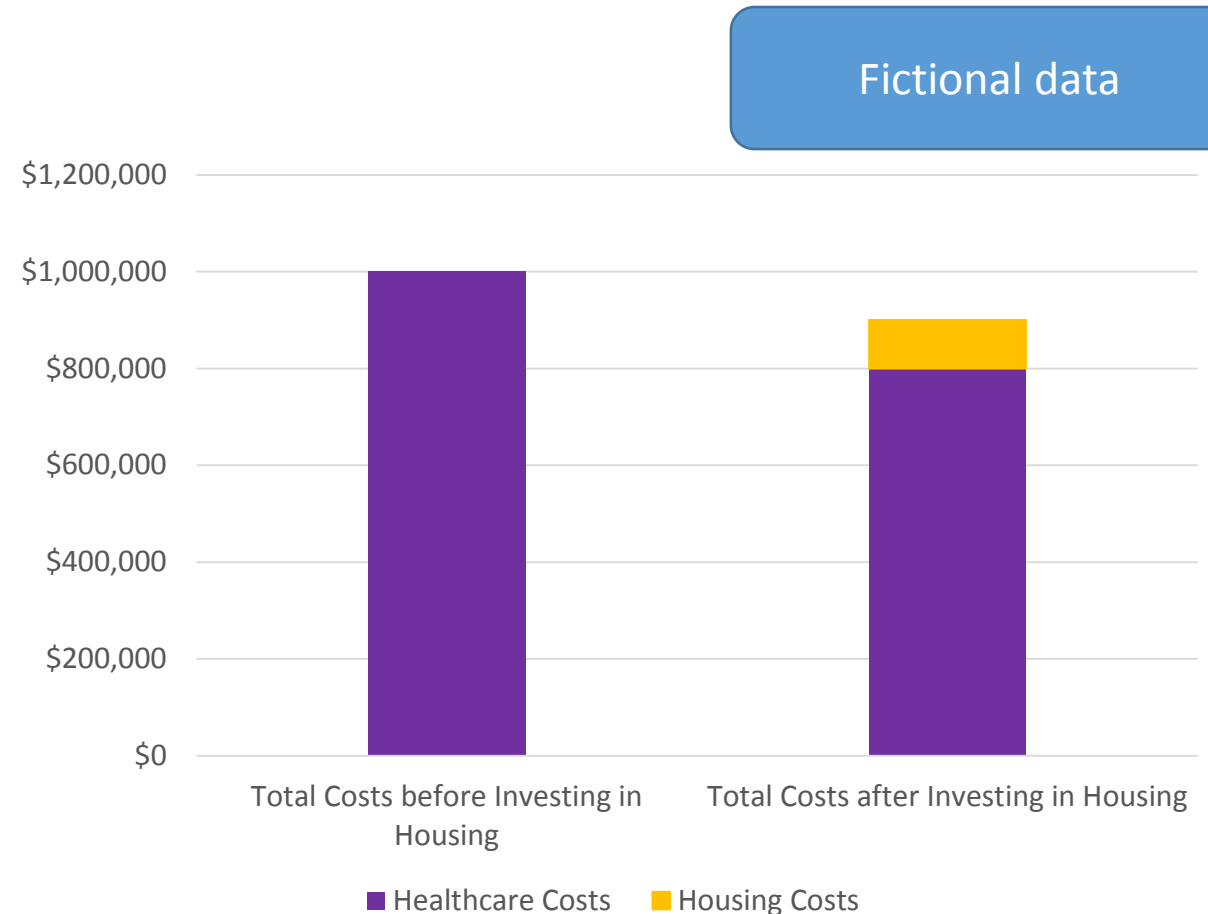
- After recognizing this problem, Provider Group 5 starts a program to align the care better.
- This results in a reduction of the average number of visits with 1.4 visits per year.
- With the number of patients the program saves $2,500 * 1.4 = 3,500$ visits per year.
- With an average cost of \$200 per visit (including tests etc.), the savings add up to \$700,000 a year.



Avoiding Potential Avoidable Complications (PACs)

Providing housing in order to reduce PACs

- Provider Group 2 has a relatively high PAC percentage. After some research, they find that among their patients the ones with the highest amount of PACs are the ones who do not have a stable housing situation.
- Instead of investing in more health services, this Provider Group decides to invest in housing subsidies.
- The decrease in healthcare costs turns out to be larger than the investments in housing, resulting in savings for the Provider Group.



Unique opportunity that DOH has embraced:

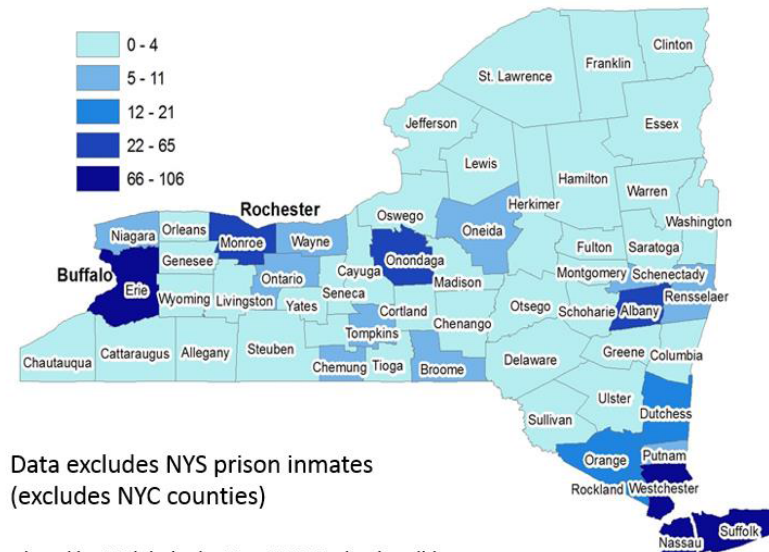
AIDS/HIV center becomes AIDS/HIV ACO:

- Level 1 (upside only): AIDS/HIV center could work on its own... would benefit from extensive outreach to CBOs, etc.
- Level 2 (up- and downside): because now risk is involved, AIDS/HIV center and participating providers will probably aim to set up more formal relationships with up- and perhaps also downstream providers
- Level 3 (full capitation): full freedom, yet requires fully fleshed out legal entity to manage contracts & subcontractors.

Background of Ending the Epidemic (EtE)

- In 2012 NYS had the highest HIV prevalence rate among all U.S. jurisdictions with HIV reporting (810 per 100,000)
- While declines are seen in new HIV diagnoses, the total number of people with HIV/AIDS (PWI) has increased from 110,000 in 2002 to over 132,000 in 2012
- On June 29, 2014, Governor Andrew Cuomo announced a blueprint to end the AIDS epidemic in New York State.

Number of New HIV Diagnoses in NYS, 2012 by County of Residence at HIV Diagnosis



Map developed by NYLinks in the May, 2014 Evaluation slide set

Ending the Epidemic (EtE) Goals

- The main goals of the blueprint are:
 - Identify patients with HIV who remain undiagnosed and link them to health care.
 - Link and retain individuals diagnosed with HIV to healthcare and get them on anti-HIV therapy to maximize HIV suppression.
 - Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk individuals to keep them HIV-negative.
- By the end of 2020 this should lead to:
 - Reduction of new HIV infections from 3,000 to 750 (per year)
 - Reduction of the rate at which individuals diagnosed with HIV progress to AIDS by 50%.

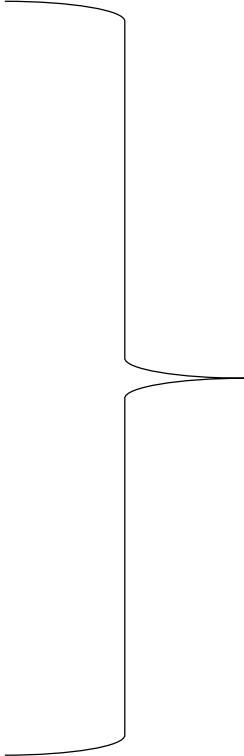
Unique opportunity that DOH has embraced:

**Make the End of the Epidemic initiative part
and parcel of the AIDS/HIV VBP initiative**

AIDS/HIV VBP Arrangement with ETE included

Three prongs:

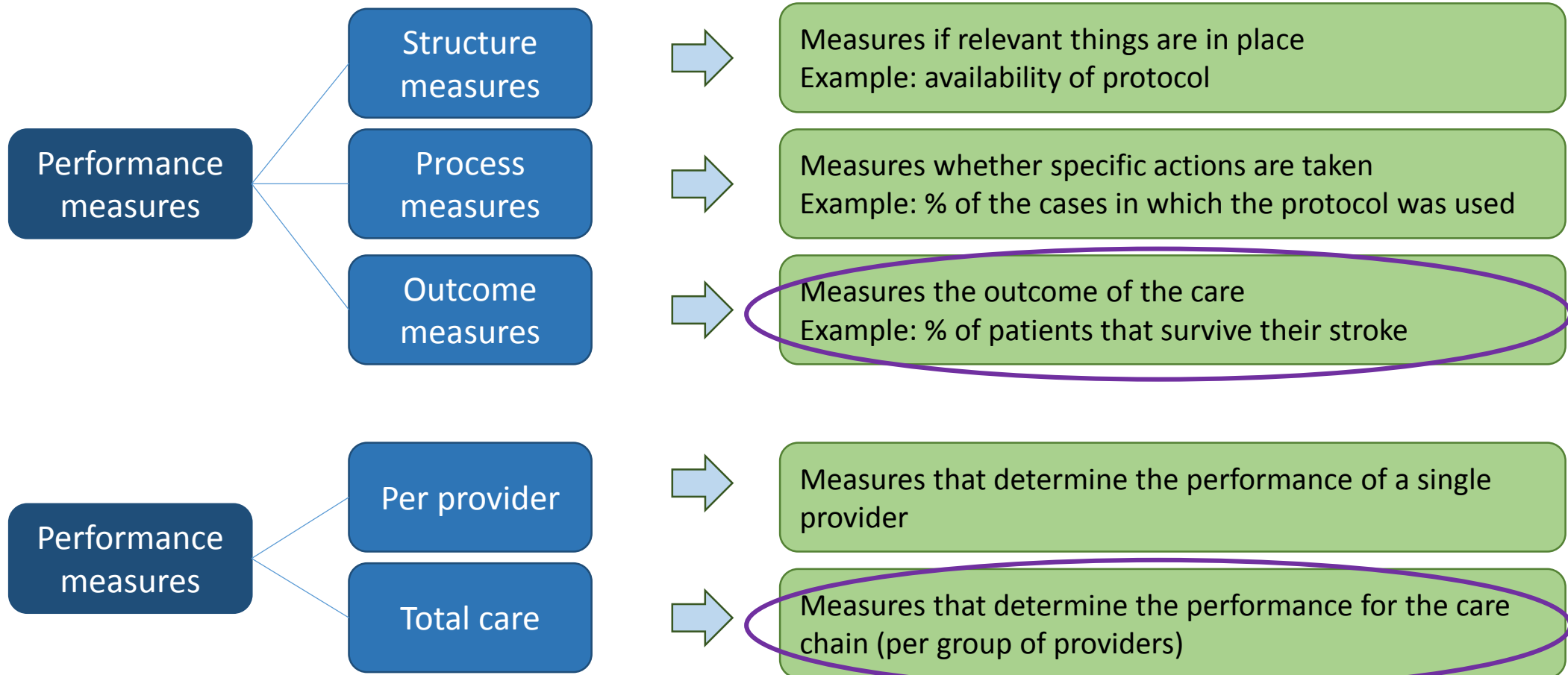
- Putting all known AIDS/HIV patients on ARVs
- Outreach to find & appropriately care for as yet unknown AIDS/HIV patients
- Adequately care for high-risk populations – including adequate PrEP use



More details on ETE later;
we will discuss how to include ETE in
the VBP arrangement in more detail
during the next HIV/AIDS CAG

D. Introduction to Outcome Measures

To assess value and cost a small key set of performance measures is needed. Focus should be on outcome measures for total care.



Outcome measures for the HIV/AIDS population

- Many quality measures available
- Discussion: which outcome measures should be taken into account?

Examples of outcome measures and proxies of outcome measures¹

% of people with HIV linked to care	% people with HIV getting continuous care	% of people with HIV with access to permanent housing
Viral load suppression	Daily functioning	HIV testing
Late HIV diagnoses	Quality of life	Patient satisfaction

Before next meeting: can you all think about what relevant outcome measures for the HIV/AIDS population should be taken into account?
Which of those measures are already available?



**Department
of Health**

E. Ending the Epidemic in New York State

September 3, 2015



Governor Andrew Cuomo announcing his new initiative to combat the AIDS epidemic before the 2014 NYC Gay Pride Parade.

Defining the End of AIDS

Goal

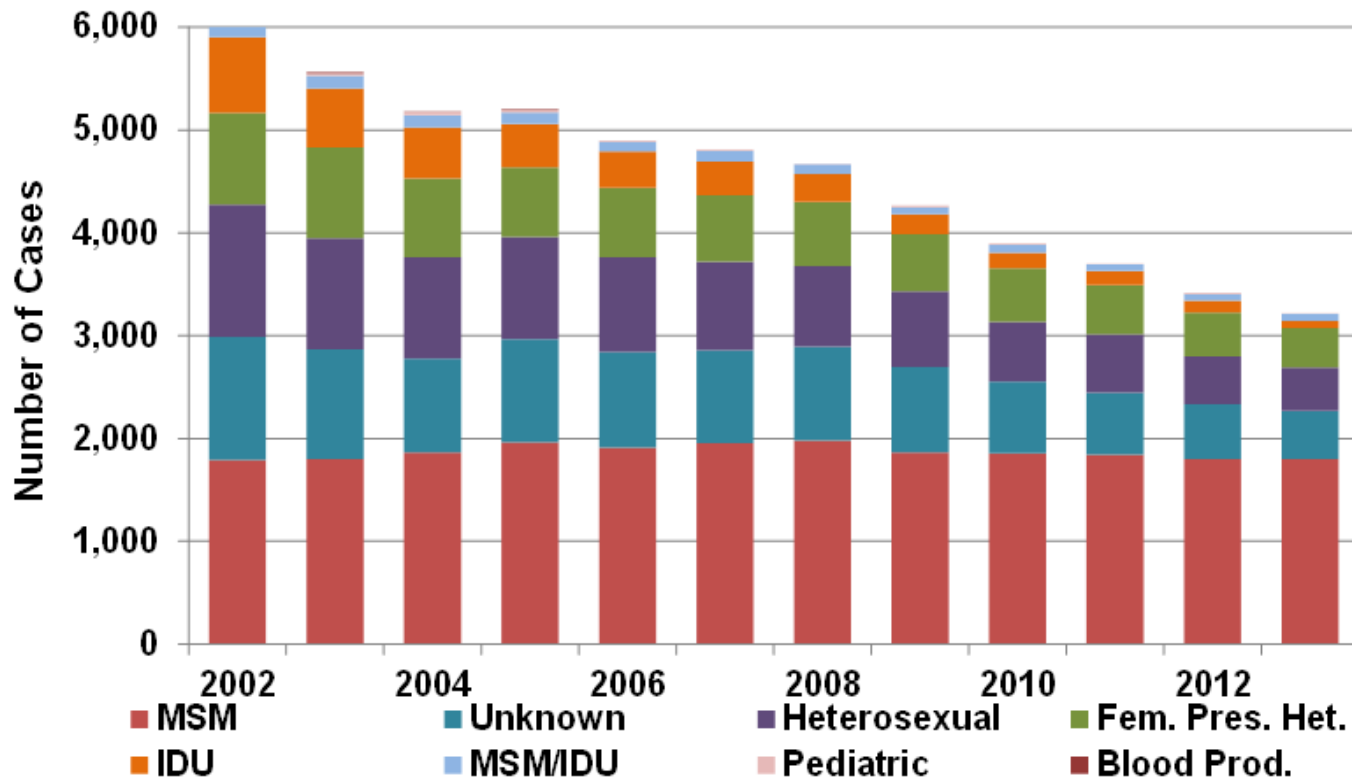
Reduce from 3,000 to 750 new HIV infections per year by the end of 2020.

Three Point Plan

1. Identify all persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.
3. Provide Pre-Exposure Prophylaxis for persons who engage in high risk behaviors to keep them HIV negative.

Key Populations

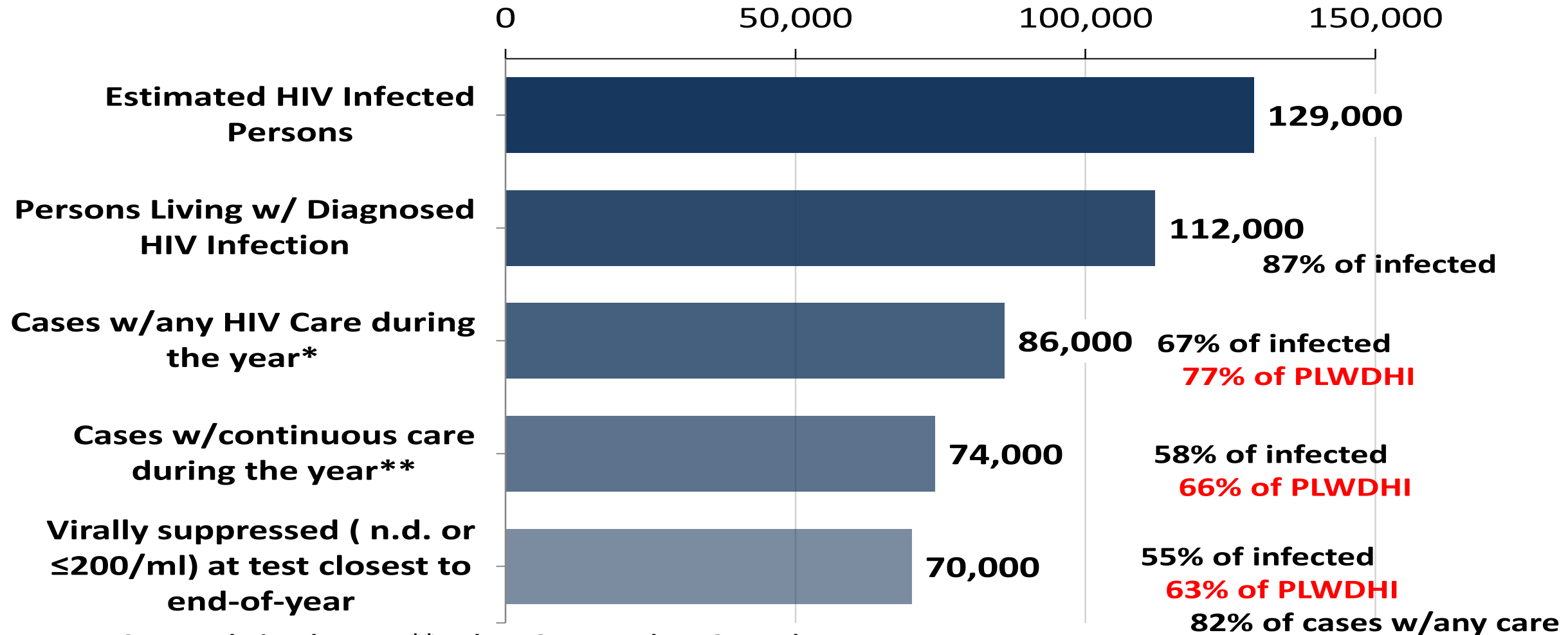
Newly Diagnosed HIV Cases by Year of Diagnosis and Transmission Risk, New York State, 2002-2013*



The Task Force ensured that prioritizing the needs of key populations significantly impacted by HIV and AIDS became a central component of the final ETE Blueprint document.

New York State Cascade of HIV Care, 2013

Persons Residing in NYS† at End of 2013



* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart

†Persons presumed to be residing in NYS based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.





Mark Harrington and Charles King getting arrested at AIDS 2012 protest.

Establishment of the Ending the Epidemic Task Force



October 14, 2014

Governor Cuomo announced the **appointment of an Ending the Epidemic Task Force** made up of key stakeholders representing public and private industry and community leaders expert in the field of HIV/AIDS.

The Task Force is responsible for **developing and issuing a Blueprint** for New York State to achieve the Governor's three stated goals.

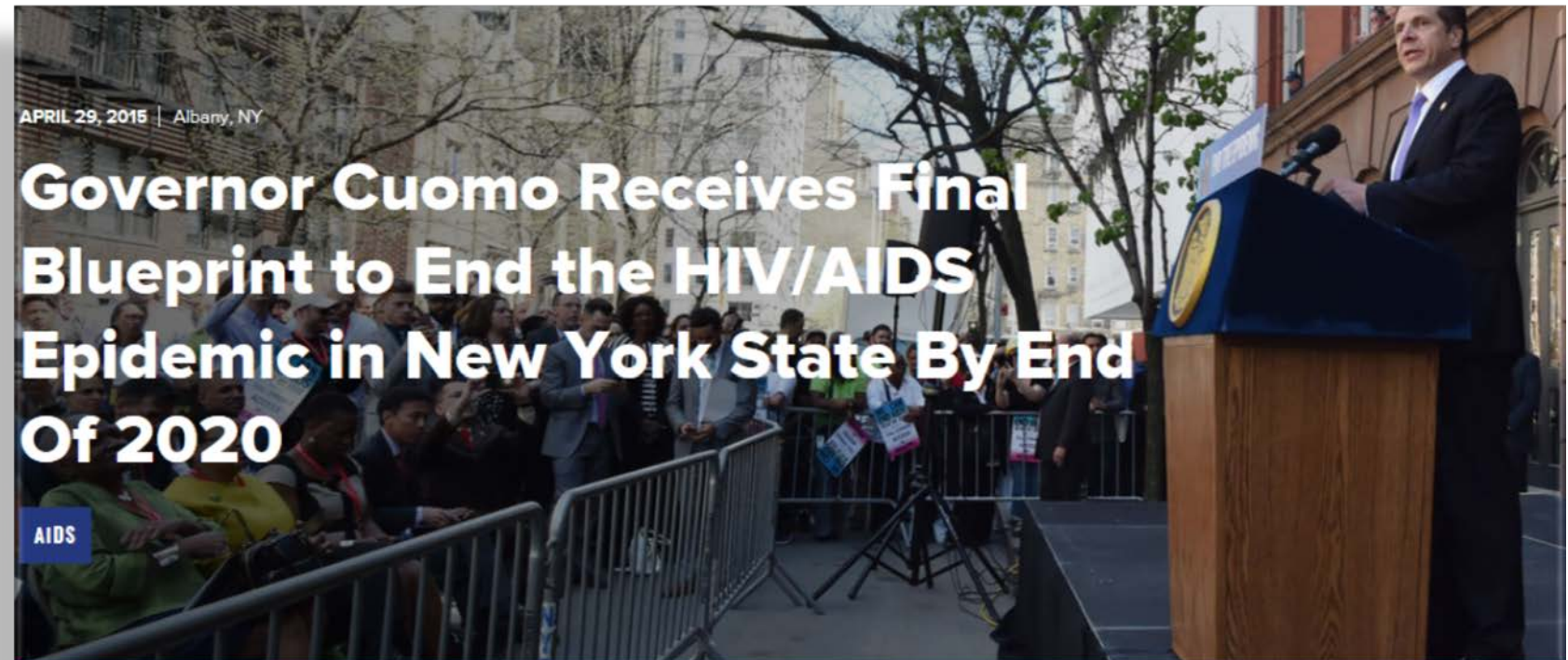
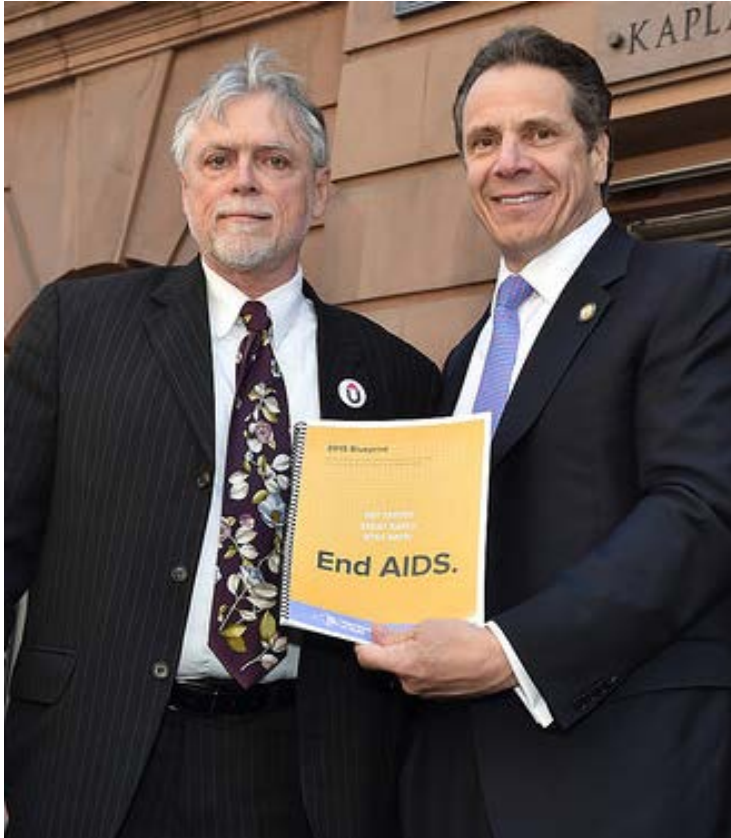


- ✓ Members **met** on five occasions between Oct 2014 & Jan 2015.
- ✓ Task Force consisted of 64 members who are expert in the field of HIV and AIDS & key stakeholders representing public and private industry, including academics, medical and supportive service providers, consumers, advocates and community leaders.
- ✓ 17 regional listening forums held across NYS and 2 phone sessions targeting youth/young adults. Over 565 participants.
- ✓ 294 recommendations received via a Survey Monkey link on the NYSDOH AI webpage from October to January.
- ✓ 4 Committees of Task Force reviewed, discussed and prioritized recommendations.

Public Release of the Blueprint

April 29, 2015

We must add AIDS to the list of diseases conquered by our society, and today we are saying we can, we must and we will end this epidemic. ~Governor Cuomo



<https://health.ny.gov/EndingtheEpidemic>

2015 Blueprint

For achieving the goal set forth by Governor Cuomo to end the epidemic in New York State by the end of 2020.

GET TESTED.
TREAT EARLY.
STAY SAFE.

End AIDS.



health.ny.gov/et

BP1: Make routine HIV testing truly routine: New York State has a law that mandates primary care providers as well as hospitals and emergency departments to offer HIV testing to all persons between the ages of 13 and 64, with certain exceptions. This law was modified in 2014 to remove the requirement for written consent except in correctional settings. Compliance is substantially below optimal levels, leading to missed opportunities where persons with undiagnosed infection are in systems of care without their HIV being identified. Electronic hard stop prompts to remind providers to offer testing should be used, and provider education is needed. HIV testing should be an expected part of all comprehensive annual primary care visits. In sum, to identify persons who remain undiagnosed, facilities and practitioners must follow the law, and New York State must enforce it. Additional settings for routine testing should be permitted, such as dental offices, pharmacies and mental health facilities, and additional changes to the law should be considered for New York to adopt a true opt-out testing model. [CR1].

Ending the Epidemic Task Force Committee Recommendation CR1

Recommendation Title: Enforcing and Expanding Routine Testing

1. For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? 1, 2 and 3

2. Proposed Recommendation: HIV testing is the first step on the HIV treatment cascade and the base for HIV prevention. New York State's HIV Testing Law requires healthcare professionals to offer a voluntary HIV test to all patients (with limited exceptions) between the ages of 13 and 64. Studies have shown that routine testing discovers HIV infection among people who do not perceive themselves at risk, yet New York State's testing law is unenforced and often disregarded.

New York State must work to improve adherence to the current law:

1) The state should educate medical and social service providers on the requirements of the law, on what a positive or negative test result means, that HIV is a treatable infection, on how to deliver test results in a humane way, on how to protect the rights, dignity and confidentiality of those being tested and on how to link individuals to adequate, affordable healthcare whether they are HIV-positive or HIV-negative and at continued risk. NYS Department of Health contracts should mandate that medical and social service staff receive this education annually. New York State should work with local medical societies and community groups to provide this education. This education will be especially important as New York State expands routine testing to more settings. The state needs to provide a venue for people to report testing that fails to honor a patient's rights.

2) The state should eliminate an economic disincentive to testing by using its powers to facilitate the reimbursement of third-party payers for every HIV test. This would include using its power to regulate the insurance industry. Such a measure would also enable the state to examine third-party payer billing records to better understand the scope of testing [see 4 below].

3) New York State should use its powers of accreditation, licensing, funding and issuing of guidelines, etc. to make routine HIV testing the standard of care. The state should consider making HIV testing part of obtaining a driver's license or a state identity card for non-drivers [Alex Carballo-Olguin, Task Force member]. The standard panel of preventative screenings that are part of the annual comprehensive primary care provider visit must include HIV testing and linkage to care. As a best practice, all health care systems required to offer HIV

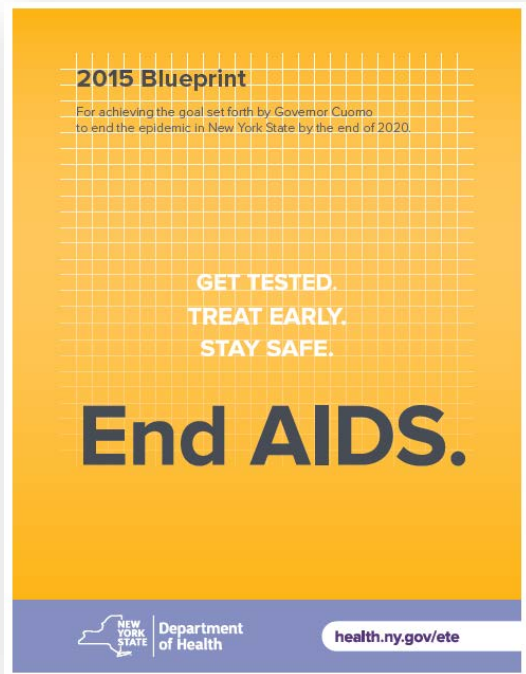
Ending the Epidemic Task Force Committee Recommendation CR1

Recommendation Title: Enforcing and Expanding Routine Testing



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Ending the Epidemic Bench Marks



”ETE’s key benchmark is lowering annual incident HIV infections to 750 by the end of 2020.”

- HIV Incidence**
for example: Estimated number of new infections (750)
- HIV prevalence**
for example: Deaths; new diagnoses; acute infections; incidence
- Disease Stage Progression**
for example: Analysis of timing of progression from HIV to AIDS; CD4 count analyses
- STD Prevention is HIV Prevention**
for example: STD rates; new diagnoses; STD and HIV co-infection
- Viral Suppression**
for example: Cascade of Care
- Stigma**
for example: Positive Pathways in DOCCS facilities
- Housing**
- PrEP and nPEP**
- HIV Testing**
- Syringe Access**
- Key Populations**

Blueprint Recommendations (BPs)

Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.

BP5: Continuously act to monitor and improve rates of viral suppression

BP6: Incentivize Performance

BP7: Use client-level data to identify & assist patients lost to care or not virally suppressed

BP8: Enhance & streamline services to support the non-medical needs of persons with HIV.

BP9: Provide enhanced services for patients within correctional and other institutions.

BP10: Maximize opportunities through DSRIP process to support programs.

BP29: Expand & enhance the use of data to track and report progress

The Investment

**\$10 Million towards Ending the Epidemic services
and expenses in the 2015-2016 Budget**

Article VII

2014 - 2015 Amendments

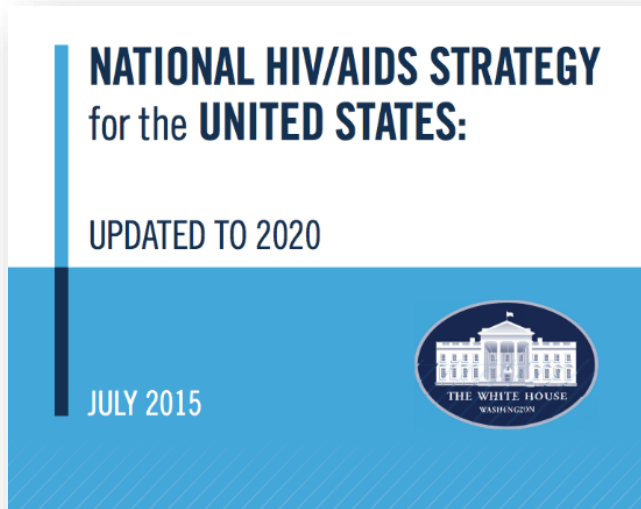
- Elimination of written consent for HIV testing.
- Expand data sharing between state and local health departments and health care providers for linkage and retention efforts.
- Implementation of a “30% rent cap” affordable housing protection.

Article VII

2015 - 2016 Amendments

- Elimination of written consent for HIV testing in correctional facilities.
- Limiting the admission of condoms in criminal proceedings for misdemeanor prostitution offenses.
- Addressing the legality of syringes obtained through syringe exchange programs.

Blueprint Alignment with NHAS 2020



<https://aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>

STRATEGY GOALS

1. Reduce New Infections
2. Increase Access to Care and Improve Health Outcomes for People Living with HIV
3. Reduce HIV-Related Health Disparities and Health Inequities
4. Achieve a More Coordinated National Response to the HIV Epidemic

POLICY AND ACTION

“Several jurisdictions have, through focused efforts, seen decreasing trends in HIV, including the States of New York and Massachusetts and the cities of San Francisco and Los Angeles. In addition, some States and local areas have put forth their own plans to “end AIDS,” such as **New York State**, Washington State, and San Francisco.” – NHAS 2020 Pg. 17

New and Expanded Programs

- **NY Links**, improves systems for linking to and retention in care, as well as for monitoring, recording, and accessing information about HIV.
- **Expanded Partner Services Program (ExPS)** uses HIV surveillance data to identify previously known HIV positive individuals who appear to be out-of-care in order to re-engage them in medical care.
- The **Linkage, Retention and Treatment Adherence Initiative** facilitates patient entry into treatment and uses collaborative strategies and interventions to retain patients in care, promote adherence to antiretroviral treatment (ART), and achieve viral suppression.
- **Positive Pathways**, working with HIV-positive incarcerated persons to encourage the initiation of medical care and treatment for HIV during incarceration.
- Use of targeted **social marketing and messaging** efforts to identify persons with HIV.
- Expand **targeted health care services** to Young MSM.
- Utilize the **new HIV testing algorithm** to diagnose asymptomatic early HIV infections.
- Announced **\$3 million in funding** directed toward linking up to 1,000 people from the populations at greatest risk for HIV/AIDS to PrEP.
- Launch of the **PrEP Assistance Program (PrEP-AP)**.
- \$1 Million to fund **“One Stop STD Clinics”** in NYC.

Recommendations in support of decreasing new infections and disease progression

Increase momentum in promoting the health of people who use drugs

- Target services to substance users, particularly young substance users.
- Provide funding enhancements to five programs targeting young injection drug users to offer HIV and HCV testing, access to prevention, health care and mental health services, as well as opioid overdose prevention.
- Expand the Syringe Exchange Program (SEP) to additional communities.
- Work with Division of Criminal Justice Services to minimize unnecessary syringe related arrests.



Ensure access to stable housing

- Implementation of a “30% rent cap” affordable housing protection.

MORE THAN A HOME
How Affordable Housing for New Yorkers Living
With HIV/AIDS Will Prevent Homelessness,
Improve Health and Reduce Costs



Activities Report Card & Dashboard

The AIDS Institute will develop and post an annual ETE Activity Report Card to assist in sharing progress towards our stated goals as well as on recommendations included in the ending the epidemic Blueprint document.

Key metrics will be systematically tracked at the state and local levels, with publicly available results. The AIDS Institute will develop an ETE Dashboard which will assist in sharing progress towards our stated goals and share key metrics and data relevant to ending the epidemic in NYS.



Implementation: AAC ETE Subcommittee

AIDS Advisory Council (AAC) Ending the Epidemic (ETE) Subcommittee:

The Subcommittee will ensure on-going formal involvement of the AAC in follow-up and recommendations on the implementation of the Ending the Epidemic Task Force (ETE TF) recommendations.

- 16 Members: The selection of members to the Subcommittee was conducted as part of the completion of the work of the ETE TF and is representative of each ETE TF Committee
- Bi-Monthly meetings
- Co-Chairs: Charles King, President and CEO, Housing Works, Inc.
Marjorie Hill, PhD, CEO, Joseph Addabbo Family Health Center
- Ending the Epidemic Website:
<https://health.ny.gov/EndingtheEpidemic>



NYS Regional Discussions

- Receive updated information about HIV/AIDS in your region/borough.
- Provide input on identified service gaps in your region/borough.
- Participate in regional/borough discussions about ending the epidemic.



NYS Regional Discussion Dates

<input checked="" type="checkbox"/> Syracuse	August 3	Manhattan, Lower	September 21
<input checked="" type="checkbox"/> Buffalo	August 12	Brooklyn	September 24
<input checked="" type="checkbox"/> Rochester	August 13	Queens	October 13
<input checked="" type="checkbox"/> Albany	August 18	Staten Island	October 14
<input checked="" type="checkbox"/> Hudson Valley	August 24	Nassau County	November 12
<input checked="" type="checkbox"/> Bronx	August 31	Suffolk County	November 13
Manhattan, Upper	September 22		

	Members	Percent
Total NYS HIV/AIDS Medicaid Members Submitted for Match to BHAЕ (Identified by AI algorithm CY2011 - CY2013)	73,125	100%
Total Submitted Medicaid Members Matched to CDC Confirmed Case (by Bureau of HIV/AIDS Epidemiology (BHAЕ))	59,807	82%
Number Deceased as of 12/31/2014 REMOVED (Based on date of death with no paid claims beyond date of death)	5,623	9%
Total Remaining Medicaid Members Matched to CDC Confirmed Case with Deceased Removed	54,184	91%
Total DUALS with Deceased REMOVED (Duals defined as having Medicare anytime during CY2011 – July 2015)	13,807	25%
Total NON-DUALS with Deceased Removed	40,377	75%
NON-DUALS		
Non-Duals WITH VL Suppression in CY2011 - July 2015 (Defined as most recent VL < 200 copies/ml)	30,152	75%
Non-Duals WITHOUT VL Suppression (Defined as most recent VL >= 200 copies/ml OR no documented VL test)	10,225	25%
DUALS		
Duals WITH VL Suppression in CY2011 - July 2015 (Defined as most recent VL < 200 copies/ml)	11,567	84%
Duals WITHOUT VL Suppression (Defined as most recent VL >= 200 copies/ml OR no documented VL test)	2,240	16%
	Members	Percent
TOTAL Non-Duals WITHOUT VL Suppression	10,225	100%
Total Medicaid Managed Care Enrollees (Based on having any capitation payments between 1/2014 - July 2015)	8,207	80%
Remaining members without any plan affiliation (May have MMC and/or Medicaid eligibility issues)	2,081	20%
	Members	Percent
TOTAL Duals WITHOUT VL Suppression	2,240	100%
Total Medicaid Managed Care Enrollees (Based on having any capitation payments between 1/2014 - July 2015)	496	22%
Remaining members without any plan affiliation (May have MMC and/or Medicaid eligibility issues)	1,744	78%

Not for Distribution

Source: NYS Department of Health, AIDS Institute, Office of Medicaid Policy and Programs
 Medicaid Match Data and Medicaid Data Warehouse (MDW) run date 8/12/15; BHAЕ data run 8/2015

"Based on their most recent viral load reported through December 2014, 74.6% of the HIV-infected individuals enrolled in Medicaid between 2011 and 2013 were virally suppressed."

NYSDOH AIDS Institute Office of Medicaid Policy and Programs



Department of Health



**Department
of Health**

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