Core Performance Measures

Updated October 2025

Background:

The Health Resource and Services Administration (HRSA) HIV/AIDS Bureau (HAB) maintains an efficient set of performance measures. HAB Performance Measures focus on priority topics unique to HIV care and treatment and do not include ones relevant to the general population. As per the Ryan White HIV/AIDS Program (RWHAP) legislation, HAB Performance Measures are consistent with U.S. Department of Health and Human Services (HHS) HIV Clinical Guidelines.

HRSA HAB prioritizes aligning HIV performance measures across federal programs by including HIV care and treatment measures in Centers for Medicare & Medicaid Services (CMS) quality measures programs. HRSA HAB supports the HIV viral suppression measure in the CMS Medicaid Adult Core Set and four electronic clinical quality measures (eCQMs) in the CMS Merit-based Incentive Payment System (MIPS). HRSA HAB eCQMs are endorsed by the CMS consensus based entity (CBE).

RWHAP recipients can include a combination of HAB Performance Measures and performance measures from other sources in their clinical quality management programs. RWHAP recipients can customize the HAB Performance Measures to reflect the needs of their client populations.

CMS hosts a measures inventory that RWHAP recipients can consult to identify performance measures in addition to HIV care and treatment.

Annually, HRSA HAB reviews the HAB performance measures and makes changes for the following reasons:

- HHS HIV Clinical Guidelines include new or updated information.
- HAB Performance Measure is no longer consistent with professional standards.
- CMS CBE identification number changes or there is no longer an equivalent measure endorsed by the CBE.

About the HAB Core Performance Measures:

HRSA HAB Core Performance Measures focus on common and essential aspects of HIV care and treatment. The Core Performance Measures were developed and updated to reflect the HHS HIV Clinical Guidelines. HAB Core Performance Measures are a good starter set of performance measures for clinical programs new to providing HIV outpatient ambulatory health services.

HAB Core Performance Measures are:

- Annual Retention in Care
- HIV Viral Suppression
- Pneumocystis Jiroverci Pneumonia (PCP) Prophylaxis
- Prescription of HIV Antiretroviral Therapy

Core Performance Measures Changes

- Reviewed and updated as needed HHS HIV Clinical Practice Guidelines citations for all Performance Measures.
- PCP Prophylaxis Performance Measure: Revised denominator criteria and removed patient exclusions regarding receipt of PCP prophylaxis.

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- Added the MIPS identification to the performance measures.
- Added eCQM identification number.
- Changed National Quality Forum number to the CBE number.
- Added the CBE designation number for the Annual Retention in Care measures.
- Removed CBE designation numbers for PCP Prophylaxis Performance Measure.
- Archived Performance Measures:
    - Gap in HIV Medical Visits measure
    - Medical Visit Frequency

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Performance Measure: Annual Retention in Care

Consensus Based Entity ID: 3752e

Merit-based Incentive Payment System ID: 340

CMS eCQM ID: CMS1157v2

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two encounters within the measurement year.

Numerator: Number of patients who had at least two[1] HIV medical care encounters[1] at least 90 days apart within a measurement year.

[1] At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing privileges.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV who had at least one HIV medical encounter within the measurement year.

Patients Exclusions: Patients who died at any time during the measurement year.

Data Elements:

1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least two medical care encounters at least 90 days apart during the measurement year? (Y/N)
        i. If yes, was at least one of the medical encounters a medical visit with a provider with prescribing privileges? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

Adult and Adolescent Guidelines:

"HIV treatment adherence includes initiating care with an HIV provider (linkage to care), regularly engaging in appointments (retention in care), and adhering to antiretroviral therapy (ART).…This low rate of viral suppression is primarily due to poor adherence to clinic appointments and ART….Knowledgeable providers and high-quality system processes are vital in promoting rapid linkage and sustained retention in care and adherence to ART….Finally, clinicians should recognize that adherence is a complex behavior requiring knowledge, motivation, memory, behavior change, external resources, and successful and persistent interaction with complex and, sometimes, challenging health care systems. The patient–provider relationship is central to improving HIV care engagement and adherence to treatment. Providers must recognize that adherence is a collaborative effort between clinicians and people with HIV."[2]

"Retention in care should be routinely monitored. There are various ways to measure retention, including measures based on attended visits over a defined period of time (constancy measures), and measures based on missed visits. Both approaches are valid and independently predict survival. Missed visits and a prolonged time since last visit are relatively easy to measure and should trigger efforts to retain or re-engage a person in care. Constancy measures (e.g., at least

two visits that are at least 90 days apart over one year, or at least one visit every six months over the last two years), can be used as clinic quality assurance measures."[2]

Pediatric Guidelines:

"After initiation of ART or after a change in antiretroviral (ARV) regimen, children should be evaluated for treatment adherence and clinical adverse effects within one to two weeks; laboratory testing for viral load response and toxicity is recommended at two to four weeks after treatment initiation or change in ARV regimen and every three to four months thereafter."[3]

"Clinicians and multidisciplinary teams should schedule frequent clinical in-person and/or telemedicine visits to monitor patients closely during the first few months after initiating a new ARV regimen."[3]

Use in Other Federal Programs:

This measure is a Merit-based Incentive Payment System (MIPS) quality measure. MIPS is a payment program administered by the Centers for Medicare and Medicaid Services.

References and Notes:

[1] At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing privileges.

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. L-2 through L-4.

[3] Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. Available online. Accessed October 2025. D-1 through D-3.

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Performance Measure: HIV Viral Suppression

Consensus Based Entity ID: 3210e

Merit-based Incentive Payment System ID: 338

CMS eCQM ID: **CMS314**

Description: Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.

Numerator: Number of patients with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.

Patient Exclusions: None

Data Elements:

1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
        i. If yes, did the patient have a HIV viral load test with a result <200 copies/mL at the last test? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

Adult and Adolescent Guidelines:

"These guidelines and the AIDS Clinical Trials Group (ACTG) now define virologic failure as a confirmed viral load >200 copies/mL – a threshold that eliminates most cases of apparent viremia caused by viral load blips or assay variability." [1]

"Individuals who are adherent to their antiretroviral regimens and do not harbor resistance mutations to the component drugs can generally achieve suppression eight to 12 weeks after ART initiation or after modification due to virologic failure; rarely, in some patients it may take longer."[1]

"The primary goals of antiretroviral therapy (ART) are to prevent HIV-associated morbidity and mortality and to prevent transmission of HIV to others. These goals are accomplished by using effective ART to achieve and maintain plasma HIV-1 RNA levels (viral load) below the quantification limits of commercially available assays. Durable viral suppression lowers the risk of both AIDS defining and other HIV-related complications, improves immune function and overall health, and allows people with HIV to live a lifespan approaching that of people without HIV. High plasma viral load is a major risk factor for HIV transmission; effective ART suppresses viremia and, consequently, substantially reduces the risk of sexual and perinatal HIV transmission.8,9 Modeling studies and ecological studies of populations with high ART uptake and high viral suppression rates suggest that expanded use of ART lowers the incidence of HIV and, eventually, the prevalence of HIV on a community or population level." [1]

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"The Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) recommends ART for all people with HIV to reduce the morbidity and mortality associated with HIV infection (AI) and to prevent HIV transmission to sexual partners and infants (AI). ART should be initiated as soon as possible after HIV diagnosis (AII)."[1]

Pediatric Guidelines:

"Based on accumulated experience with currently available assays, the current definition of virologic suppression is a plasma viral load that is below the quantification limit of the assay used (generally <20 copies/mL to 75 copies/mL) (see Table 7 below). This definition of suppression has been much more thoroughly investigated in adults with HIV than in children with HIV (see the Adult and Adolescent Antiretroviral Guidelines). Temporary viral load elevations ("blips") are often detected in adults on ART56 and generally defined as up to 200 copies/mL, but they may be as high as 500 copies/mL in children on ART57; these temporary elevations do not represent virologic failure as long as the values have returned to below the level of detection when testing is repeated. For definitions and management of virologic treatment failure, see Recognizing and Managing Antiretroviral Treatment Failure. These definitions of virologic suppression and virologic failure are recommended for clinical use. Research protocols or surveillance programs may use different definitions."[2]

Use in Other Federal Programs:

- This measure is a Merit-based Incentive Payment System (MIPS) quality measure. MIPS is a payment program administered by the Centers for Medicare and Medicaid Services.
- This measure is linked to an exact or similar indicator(s) within Healthy People 2030 and the Ending the HIV Epidemic in the U.S. initiative.

References and Notes:

[1] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. C-11 and through E-2.

[2] Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. Available online. Accessed October 2025. D-8.

[3] Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. Available online. Accessed October 2025. D-1 through D-3.

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Performance Measure: Pneumocystis Jiroverci Pneumonia (PCP) Prophylaxis

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of patients with a diagnosis of HIV, who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis.

Numerator: Patients who were prescribed PCP prophylaxis.

Denominator: Use denominator definition that reflects the patient's age. The denominator is the sum of the patients who meet the different denominator definitions.

Denominator 1: Number of patients aged 13 years and older with HIV (including during pregnancy) with CD4 counts <100 cells/mm^3 regardless of plasma HIV levels OR CD4 counts between 100 and 200 cells/mm^3 with plasma HIV RNA levels above detection limits, who had at least two medical visits at least 90 days in between each visit during the measurement year.

Denominator 2: Number of patients aged six years through 12 years with a diagnosis of HIV and a CD4 count below 200 cells/mm^3, who had at least two visits at least 90 days in between each medical visit during the measurement year.

Denominator 3: Number of patients aged one year through five years with a diagnosis of HIV and a CD4 count below 500 cells/mm^3 or a CD4 percentage below 15%, who had at least two medical visits at least 90 days in between each visit during the measurement year.

Denominator 4: All patients aged less than 12 months with a diagnosis of HIV, who had at least two medical visits at least 90 days in between each visit during the measurement year.

Patient Exclusions:

Denominator 1 exclusion: Patients receiving pyrimethamine-sulfadiazine for treatment or suppression of toxoplasmosis.

Data elements:

Numerator and denominator 1:

1. Is the patient aged 13 years old or older and does the patient have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least two medical visits at least 90 days apart in the measurement year? (Y/N)
        i. If yes, did the patient have a CD4 counts <100 cells/mm^3 regardless of plasma HIV levels or a CD4 counts between 100 and 200 cells/mm^3 with plasma HIV RNA levels above detection limits? (Y/N)
            1. If yes, was PCP prophylaxis prescribed? (Y/N)

Numerator and denominator 2:

1. Is the patient aged six to 12 years old and does the patient have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least two medical visits at least 90 days apart in the measurement year? (Y/N)
        i. If yes, did the patient have a CD4 count <200 cells/mm^3 ? (Y/N)
            1. If yes, was PCP prophylaxis prescribed? (Y/N)

Numerator and denominator 3:

1. Is the patient between 1-5 years old and does the patient have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least two medical visits at least 90 days apart in the measurement year? (Y/N)
        i. If yes, did the patient have a CD4 count <500 cells/mm^3 or CD4 percentage <15%? (Y/N)
            1. If yes, was PCP prophylaxis prescribed (Y/N)

Numerator and denominator 4:

1. Is the patient less than 12 months old and does the patient have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least two medical visits at least 90 days apart in the measurement year? (Y/N)
        i. If yes, was PCP prophylaxis prescribed (Y/N)?

Department of Health & Human Services Clinical Practice Guidelines:

Adult and Adolescent Guidelines:

"Chemoprophylaxis against PCP should be given to adults and adolescents with HIV (including pregnant people) with CD4 counts <100 cells/mm3 regardless of plasma HIV levels (*AIII*) and those with CD4 counts between 100 and 200 cells/mm3 with plasma HIV RNA levels above detection limits (*AI*). Patients receiving pyrimethamine-sulfadiazine for treatment or suppression of toxoplasmosis do not require additional prophylaxis for PCP (*AII*).[1]

Pediatric Guidelines:

"Chemoprophylaxis is highly effective in preventing PCP. Criteria for its use are based on the patient's age and CD4 count or percentage. Prophylaxis is recommended for all HIV-infected children aged ≥ 6 years who have CD4 counts <200 cells/mm^3 or CD4 percentage <15%, for children aged 1 to <6 years with CD4 counts of <500 cells/mm^3 or CD4 percentage <15%, and for all HIV-infected infants aged <12months regardless of CD4 count or percentage (*AIII)*." [2]

"Infants born to HIV-infected mothers should be considered for prophylaxis beginning at 4 to 6 weeks of age. HIV-infected infants should be administered prophylaxis until age 1 year, at which time they should be reassessed on the basis of the age-specified CD4 count or percentage thresholds mentioned previously (*AII*)."[2]

Use in Other Federal Programs:

This measure is not used in other federal programs.

References and Notes:

[1] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Department of Health and Human Services. Available online. Accessed October 2025. Y-4.

[2] Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children: Recommendations from the National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association of the Infectious Diseases Society of America, and Pediatric Infectious Diseases Society. Department of Health and Human Services. Accessed October 2025. V-5.

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Performance Measure: Prescription of HIV Antiretroviral Therapy

Consensus Based Entity ID: No equivalent measure

Merit-based Incentive Payment System ID: No equivalent measure

CMS eCQM ID: No equivalent measure

Description: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy (ART)[1] for the treatment of HIV infection during the measurement year.

Numerator: Number of patients prescribed HIV ART[1] during the measurement year.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.

Patient Exclusions: None

Data Elements:

1. Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)
    a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)
        i. If yes, was the patient prescribed HIV ART[1] during the measurement year? (Y/N)

Department of Health and Human Services Clinical Practice Guidelines:

Adult and Adolescent Guidelines:

"The Panel on Antiretroviral Guidelines for Adults and Adolescents (the Panel) recommends ART for all people with HIV to reduce the morbidity and mortality associated with HIV infection and to prevent HIV transmission to sexual partners and infants. ART should be initiated as soon as possible after HIV diagnosis."[2]

“ART initiation on the same day of HIV diagnosis in the outpatient setting may be used as a strategy to increase ART uptake and engagement in care, to accelerate the time to ART-mediated viral suppression, and, consequently, to reduce the potential for HIV transmission. Benefits of rapid ART initiation are supported by randomized controlled trials that were performed in resource-limited settings outside of the United States and observational trials in the United States that included both immediate initiation of ART (on the day of diagnosis) and rapid ART initiation (within days or weeks of diagnosis).”[2]

Pediatric Guidelines:

"Antiretroviral therapy (ART) should be initiated in all infants and children with HIV infection (AI for children aged <3 months, AI* for older children).”[3]

“Rapid ART initiation (defined as initiating ART immediately or within days of HIV diagnosis), accompanied by a discussion of the importance of adherence and provision of subsequent adherence support, is recommended for all children with HIV.”[3]

"Rapid treatment initiation … is recommended except in children with cryptococcal meningitis, tuberculous meningitis, and disseminated *Mycobacterium avium* complex disease. Due to

concerns regarding the risk of immune reconstitution inflammatory syndrome, ART initiation may be deferred briefly until the optimal timing relative to treatment of these opportunistic infections."[3]

Use in Other Federal Programs:

This measure is not used in other federal programs.

References and Notes:

[1] HIV antiretroviral therapy is described as the prescription of at least one U.S. Food and Drug Administration approved HIV antiretroviral medication.

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available online. Accessed October 2025. E-2 through E-3.

[3] Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. Available online. Accessed October 2025. E-1 through E-2.

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