

INTRODUCTION

Pursuant to the Grant Year 2019 (GY19) HIV Emergency Relief Program Ryan White HIV/AIDS Program Part A (RWHAP Part A) Funding Opportunity Announcement, dated May 30, 2018, the New York City (NYC) Department of Health and Mental Hygiene (DOHMH), as the Grant Recipient (Recipient) for the New York Eligible Metropolitan Area (NY EMA), respectfully submits this application for grant funding. The application describes the GY19 Plan to promote a comprehensive continuum of high-quality care and treatment through the support of core medical and support services that address gaps in the HIV care continuum for eligible people living with HIV (PLWH) in the NY EMA.

The GY19 Plan is responsive to Governor Andrew M. Cuomo's *2015 Blueprint for Ending the Epidemic (EtE)* and the *New York State (NYS) Integrated HIV Prevention and Care Plan* which set forth recommendations to reduce the annual incidence of new HIV infections to 750 from the current 3,000 in NYS. The *EtE Blueprint* is organized around three priorities:

- Identify persons with HIV who remain undiagnosed and link them to health care;
- Link and retain persons diagnosed with HIV to health care and get them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and
- Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (PEP) for high-risk persons to keep them HIV-negative.¹

On World AIDS Day December 1, 2016, the Governor also announced several new initiatives to End the Epidemic including zero HIV-related mortality, and no new infections related to injection drug use by 2020.¹

The NY EMA continues to align its services with the *EtE Blueprint* priorities. The NY EMA's efforts to identify PLWH and link them to care are described in the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan (*pp. 13-25*). All HIV care services in the NY EMA support the second priority, to link and retain PLWH in care, improve access to antiretroviral treatment (ART), and decrease viral load. PrEP is not purchased with RWHAP Part A funds, but the NY EMA leverages other funds and, as appropriate, the RWHAP infrastructure to build consumer and provider awareness of PrEP and PEP and to increase community capacity to provide PrEP and PEP. With the addition of EtE initiatives related to HIV-related mortality and elimination of new infections among people who inject drugs (PWID), the NY EMA has initiated work with funded providers to reduce preventable mortality and increased efforts to reduce new HIV infections among PWID. The NY EMA's service plan is described in this application.

NEEDS ASSESSMENT

A) Demonstrated Need.

1) Epidemiologic Overview.

a) Summary of the HIV epidemic in the EMA geographic area. The NY EMA, which includes the five counties/boroughs of NYC and the adjacent Tri-County region of Westchester, Rockland, and Putnam counties, is home to more than 10 million people (3% of the U.S. population).ⁱⁱ The NY EMA continues to have the largest HIV epidemic in the U.S., with approximately 6% of all HIV diagnoses in 2015 and 12% of the nation's PLWH in 2016.ⁱⁱⁱ As of

¹ NYS Governor's Office, Press Release, December 2016. Accessible at: <https://www.governor.ny.gov/news/governor-cuomo-announces-series-groundbreaking-new-initiatives-end-aids-epidemic-new-york-state>.

December 31, 2017, there were 129,698 reported PLWH in the NY EMA, representing 1.3% of the total NY EMA population (*see Table 1*). Of the 2,291 individuals diagnosed with HIV in the NY EMA in 2017, 18% were concurrently diagnosed with AIDS (within 31 days of their HIV diagnosis), a percentage that has remained relatively stable over the last five years.^{iv} From 2013 to 2017, there was a 24% decrease in HIV diagnoses in the NY EMA; however, the number of PLWH remains high. These figures demonstrate both the success of the NY EMA’s service system and the ongoing need for early intervention and care services to fulfill the goals of the *EiE Blueprint*.

Table 1: NY EMA Population and HIV Diagnoses/Prevalence by Region and County/Borough, 2017

	Population	HIV Diagnoses*	PLWH
New York City	8,622,698	2,157	125,884
Kings (Brooklyn)	2,648,771	640	30,239
Bronx	1,471,160	464	30,429
New York (Manhattan)	1,664,727	402	32,683
Queens	2,358,582	400	18,528
Richmond (Staten Island)	479,458	39	2,452
Outside NYC/Unknown	N/A	212	11,553
Tri-County Region	1,408,435	134	3,814
Putnam	99,323	2	141
Rockland	328,868	23	590
Westchester	980,244	109	3,083
Total	10,031,133	2,291	129,698

Sources: Population estimates: U.S. Census Bureau, American Fact Finder: Quick Facts –2017; New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC DOHMH, HIV Epidemiology and Field Services Program, data as of March 31, 2018; Putnam, Rockland, and Westchester counties: NYS Department of Health (NYSDOH), Bureau of HIV/AIDS Epidemiology, data as of April 30, 2018.

*HIV diagnoses include those who were concurrently diagnosed with HIV and AIDS.

b) Socio-demographic characteristics of newly diagnosed, PLWH, and persons at high risk. i-ii) Demographic and socioeconomic data. In 2017, among new HIV diagnoses in the NY EMA, 79% were male, 86% were non-White,² 68% were younger than 40, and 58% were men who have sex with men (MSM), including MSM with a history of injection drug use (IDU). In the same year, 3% of new HIV diagnoses in NYC were among transgender individuals, 98% of whom were transgender women; data on transgender and gender non-binary (TGNB) populations are not available for the Tri-County region. Roughly 86% of newly diagnosed transgender women were non-Hispanic Black³ or Latina, and 51% were ages 20-29.

Among PLWH, 72% were male, 79% were non-White, and 43% were MSM, including MSM with a history of IDU. Unlike new diagnoses, which have historically been concentrated among those younger than 40, people aged 50 and older accounted for 56% of PLWH in 2017, reflecting the aging of PLWH in the NY EMA and underscoring the importance of addressing the complex service needs of older PLWH.^v

² “Non-White” refers to those who do not identify as exclusively European American.

³ From this point forward, non-Hispanic Black Individuals will be referred to as Black, and non-Hispanic Whites will be referred to as Whites. The term “Black” is used throughout this document rather than “African American” because NYC has substantial numbers of people of Caribbean origin who do not identify as “African Americans.”

HIV prevalence is highest in low-income communities of color, where many individuals experience multiple challenges that severely impact health, such as poverty, trauma, mental health (MH) issues, food insecurity, and housing instability. Based on data from NYS Department of Health (DOH), as of June 2017, 66% of PLWH diagnosed and reported in the NY EMA were enrolled in Medicaid, and 24.9% were dually enrolled in Medicaid and Medicare (*see Table 2 on p. 11 for more details*). In comparison, 28% of all NY EMA residents were enrolled in Medicaid in the same time period.^{vi} Though individuals residing in neighborhoods where at least 30% of residents were living below the federal poverty level (FPL) represented 27% of all PLWH, they represented 35% of all deaths among HIV-positive individuals in 2017 in the NY EMA. See *Attachment 3* for the complete diagnoses, prevalence, and mortality table.

c) Rates of increase in HIV diagnosed cases within new and emerging populations.

i) Identifying emerging populations, unique challenges, and estimated costs to RWHAP Part A. As a jurisdiction with a widespread and mature epidemic, the NY EMA has a population of PLWH that has remained relatively stable demographically over the past decade or more. Between 2001 and 2017 specifically, the number of new HIV diagnoses reported in NYC decreased significantly across gender, race/ethnicity, age at diagnosis, borough of residence, and transmission risk. This decrease is significant for all subgroups, with the exception of transgender individuals and Asian/Pacific Islanders. The Recipient and Planning Council (PC) regularly monitor HIV surveillance trends, service utilization trends, and other data sources which continue to show HIV disproportionately affecting low-income communities of color; gay, bisexual, and other MSM (with increased disparities among young (ages 13-24) men who have sex with men (YMSM) and MSM of color of all ages); cisgender women of color; and transgender women, particularly transgender women of color. As the impact of HIV on the above populations has been persistent within the NY EMA, no population could be considered emerging.

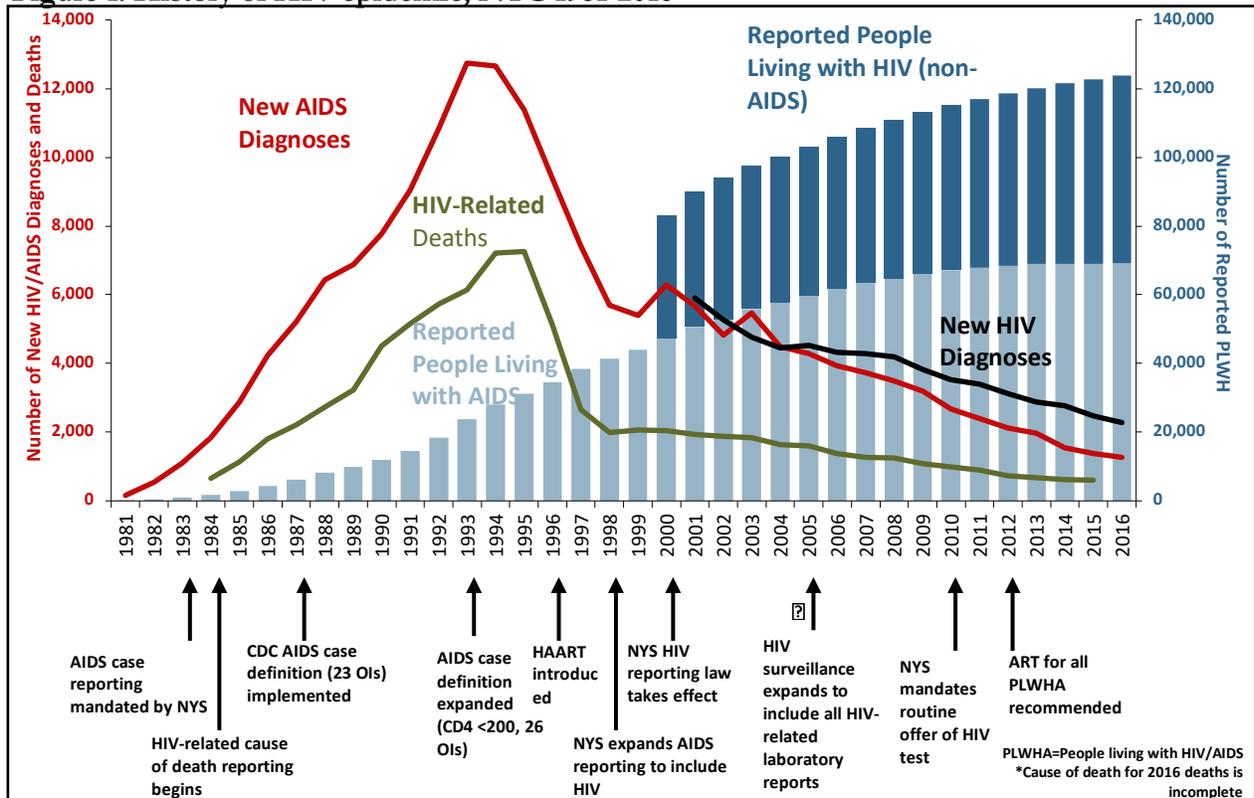
NYC ZIP codes with the highest rates of new HIV diagnoses in 2017 included those in the Lower Manhattan, Chelsea-Clinton, and Central Harlem-Morningside Heights neighborhoods; those with the highest HIV prevalence included ZIP codes in Chelsea-Clinton and Central Harlem-Morningside Heights. With the exception of Chelsea-Clinton, neighborhoods with high HIV diagnosis and prevalence rates were also among those with the highest poverty rates, with at least 30% of residents living below the FPL.^{vii} In 2016, a suppressed viral load (SVL) was least likely among individuals living in high-poverty neighborhoods compared with individuals living in lower-poverty neighborhoods.^{viii} Previous analyses showed that the rate of HIV/Hepatitis C Virus (HCV) co-infection was four times higher in high-poverty neighborhoods than in low-poverty neighborhoods; a similar pattern was seen for HIV/Hepatitis B and HIV/TB co-infection.^{ix}

Improving access to basic necessities for the most vulnerable individuals is crucial, in order for people to attend to their HIV health-related needs. Thus, the NY EMA allocates 43.3% of GY19 funds to support services, including \$10.4 million to housing services and \$8.9 million to food and nutrition services (FNS). The NY EMA further invested in legal services (\$4.3 million) and non-medical case management (n-MCM) services (\$6.0 million). To support retention of those most at risk for falling out of care and to address their unique challenges, the largest investment on the part of the NY EMA has been in Medical Case Management (MCM) (\$20.8 million), of which there are three models – Care Coordination (CCP), Transitional Care Coordination (TCC), and Tri-County MCM. Each of these programs serves to engage, link, and retain PLWH in medical care to further address

barriers to viral suppression.⁴ CCP, which was rebid in 2018, has medical eligibility criteria that ensure these resources are prioritized for those who most need them, including those with a history of falling out of care, those who are not virally suppressed, and those who are newly diagnosed. PLWH who have HCV and pregnant women who need additional adherence support are also eligible.

i) Increased need for HIV-related services. As the number of PLWH has risen and disparities have persisted, demands on the NY EMA’s service system and need for RWHAAP Part A funding along the entire HIV care continuum have grown. *Figure 1* below illustrates that the need for care remains high in NYC despite the decrease in HIV diagnoses, due to PLWH living longer, healthier lives.

Figure 1: History of HIV epidemic, NYC 1981-2016



While new diagnoses have declined, the rate in NYS is the highest among Northeastern states, and similar to that of some of the Southern states, where more than half of new diagnoses are currently concentrated. The average rate of HIV diagnoses in 2016 (per 100,000 people) was 16.8 in the South and 11.2 in the Northeast. However, NYS’s rate (17.2) is similar to rates in several of the southern states—where rates range from 4.2 in West Virginia to 31.8 in Georgia, including North Carolina (16.5), Mississippi (17.1), South Carolina (18.1), and Texas (19.8).^x Data presented at the Conference on Retroviral Opportunistic Infections (CROI) in 2016 showed that NYS had the sixth-highest lifetime risk of HIV diagnosis of any state and that the overall lifetime risk of HIV diagnosis for NYS residents was one in 69, compared to one in 99 for the U.S. population.^{xi}

⁴ Three subcategories are included under the MCM category: NYC Care Coordination, NYC TCC for the Homeless and Unstably Housed, and Tri-County MCM. Note that from here forward the term "Care Coordination Programs (CCP)" refers specifically to NYC Care Coordination efforts, while MCM describes the general category for the entire NY EMA.

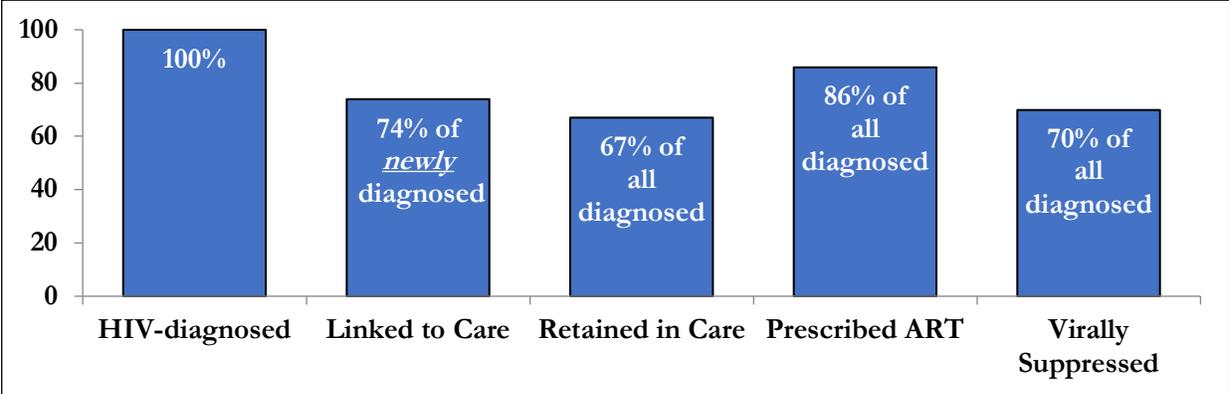
A study among MSM attending NYC Sexual Health Clinics (SHC) recruited between 2007 and 2011 showed that the HIV diagnosis rate among Black MSM was almost three times higher than among White MSM and nearly twice as high as among Latino MSM; MSM under the age of 20 had the highest HIV diagnosis rate compared to other age groups.^{xiii} Among all individuals who were newly diagnosed with HIV in NYC in 2016, Black PLWH aged 13-19, and those with a history of IDU, were the least likely to initiate care within three months of diagnosis. In addition, all of these subgroups, as well as MSM with a history of IDU, were least likely to achieve viral suppression within six months of diagnosis.^{xiii} In 2017, individuals with a history of IDU were disproportionately represented among deaths, making up only 12% of PLWH but 27% of deaths among HIV-positive individuals in the NY EMA.

In the 2014 National HIV Behavioral Surveillance (NHBS) cycle, out of the MSM in NYC interviewed, 53% of White MSM and 49% of MSM of color reported drug or alcohol use at the time of their last sexual encounter.^{xiv} According to the 2017 NYC Sexual Health Survey (SHS), 5% of MSM reported using methamphetamines within the past six months; there were no significant differences by age or race/ethnicity.^{xv} According to data from the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE),⁵ recent methamphetamine use among MSM in the RWHAP Part A population increased from 3% in 2012 to 6% in 2016. Previous work by the DOHMH found methamphetamines use to be associated with unsuppressed viral load.^{xvi}

Despite gains made in identifying PLWH in the NY EMA and linking them to medical care, HIV still causes significant morbidity and mortality, particularly in racial/ethnic minority communities. A study assessing the relationship between place-based characteristics and HIV viral suppression among MSM in NYC found that residents living in United Hospital Fund (UHF) neighborhoods where less than 30% of residents were Black had a statistically significantly higher likelihood of achieving viral suppression, compared to those living in UHF neighborhoods where over 30% of residents were Black.^{xvii} In another study assessing pre-death care patterns among PLWH in NYC, PLWH with HIV-related mortality had lower rates of viral suppression; rates of SVL were lowest among Black and Latinx PLWH. In addition, although 54% of deaths were due to non-HIV-related causes, 35% of Whites versus 48% of Black and Latinx individuals died due to an underlying HIV-related cause.^{xviii} Although deaths attributed to HIV have fallen from 1,209 in 2006 to 432 in 2016, HIV was the eight leading cause of premature death overall among NYC residents under 65 years of age, and the fifth leading cause of premature death for Black and Puerto Rican New Yorkers.^{xix}

2) HIV Care Continuum.

Figure 2: 2016 NY EMA HIV Care Continuum



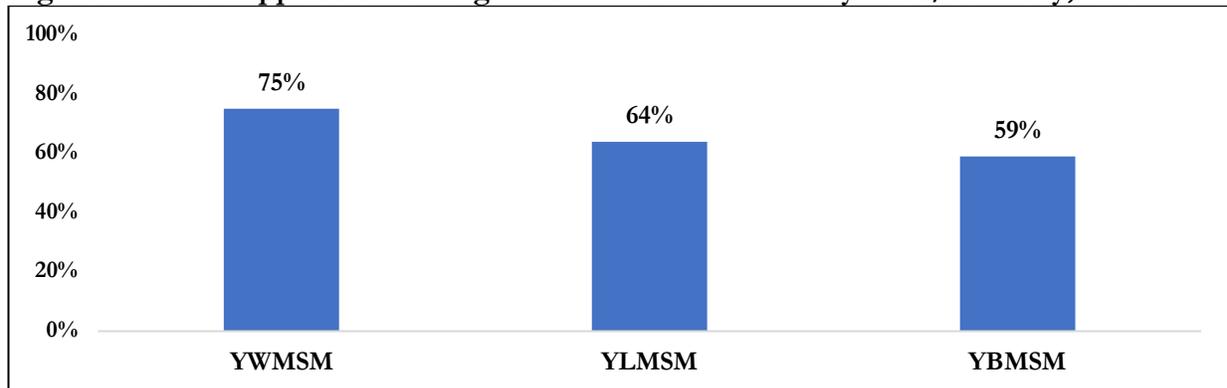
⁵ eSHARE is a web-based platform for HIV service provider reporting that permits enhanced information-sharing between programs within agencies and real-time access to demographic, services, and outcomes data at DOHMH.

Sources: Prescribed ART: NYC DOHMH, Medical Monitoring Project (MMP), 2016; All other: NYS DOH, Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017.

Notes: “HIV-diagnosed” includes those diagnosed by 12/31/2015 and living and residing in NYC or the Tri-County region as of 12/31/2016; “Linked to care” includes those who were newly diagnosed with HIV in 2016 with one or more viral load or CD4 count within 30 days of diagnosis; “Retained in care” includes those among the HIV-diagnosed with at least two VL or CD4 counts in 2016 that were at least 91 days apart; “Prescribed ART” is defined as the proportion of NYC MMP participants whose medical record included documentation of ART prescription during the 12 months prior to MMP interview date (interview date range June 3, 2015 - April 27, 2016); “Virally suppressed” includes those among the HIV-diagnosed whose most recent viral load in the year was <200 copies/mL.

Although the NY EMA is approaching national goals on retention and suppression, disparities exist among certain subpopulations. In 2016, young (ages 13-24) Black MSM (YBMSM), young Latino MSM (YLMSM), and Black women were three of the most disproportionately impacted populations in the NY EMA; these disparities are displayed in *Figures 3a and 3b*. HIV viral load data from 2016 reveals that among YMSM, only 59% of YBMSM, and 64% of YLMSM were virally suppressed as compared to 75% of young White MSM. In the same year, among women living with HIV, 67% of Black women were virally suppressed, compared to 71% of Latina women and 72% of White women. These disparities are addressed by geographically targeting services to high prevalence, underserved neighborhoods and prioritizing service types that address structural inequity, access to and engagement in care, support for adherence to ART, and basic survival needs (e.g. Housing, FNS, and CCP).

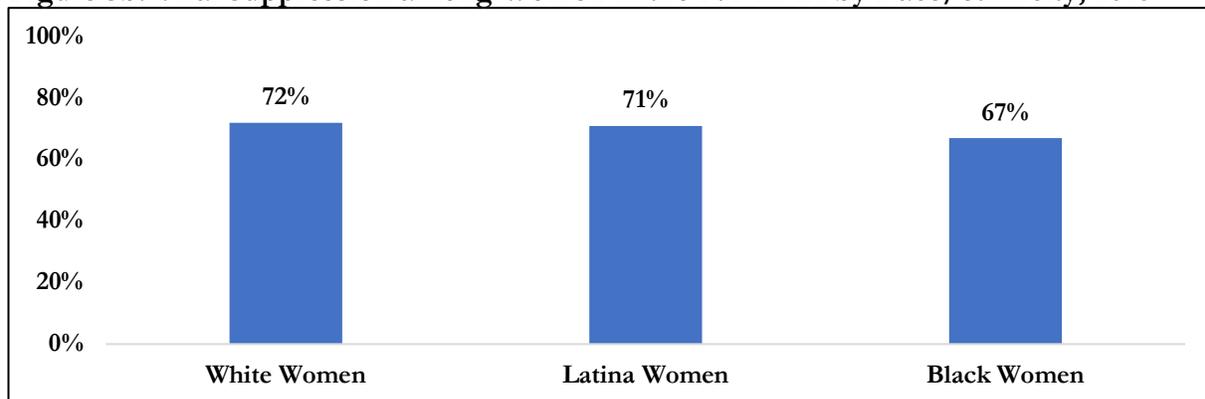
Figure 3a: Viral Suppression among YMSM in the NY EMA by Race/ethnicity, 2016



Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of 2017.

Notes: Data includes YMSM diagnosed by 12/31/2015 and living and residing in NYC or the Tri-County region as of 12/31/2016. Virally suppressed includes YMSM whose most recent viral load in the year was <200 copies/mL.

Figure 3b: Viral Suppression among Women in the NY EMA by Race/ethnicity, 2016



Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of 2017.

Notes: Data includes women diagnosed by 12/31/2015 and living and residing in NYC or the Tri-County region as of 12/31/2016. Virally suppressed includes women whose most recent viral load in the year was <200 copies/mL.

3) Co-occurring Conditions (see Attachment 4).

a) Hepatitis C Virus (HCV). An estimated 19% of people with HCV in NYC are unaware of their infection according to a serosurvey conducted in 2015 at a medical center in the Bronx.^{xx} Based on 2016 case reports, DOHMH estimates that the HCV prevalence rate in NYC is 1,228/100,000 in NYC, and the diagnosis rate is 44/100,000 in Tri-County.^{xxi} Roughly 12% of PLWH and 17% of RWHAP Part A clients in NYC were diagnosed and living with HCV by December 31, 2017. Within the Community Health Advisory & Information Network (CHAIN)⁶ cohort, lifetime risk of HCV infection was found to be associated with older age, being male, IDU, pre-1990 diagnosis of HIV infection, and less than a high school education.^{xxii}

HIV/HCV co-infection can lead to higher viral loads and accelerate the onset of HCV-related complications, including cirrhosis and end-stage liver failure, particularly among those whose HIV is not well-managed. In a recent analysis among individuals with HIV/HCV co-infection in NYC in 2016, individuals without durable HIV viral suppression were 66% less likely to initiate HCV treatment.^{xxiii} Facilitating engagement in HCV treatment is vital; according to preliminary findings from a DOHMH analysis of mortality among RWHAP Part A clients who were served through at least one long-term RWHAP program from 2013-2015, RWHAP Part A clients with an HCV diagnosis had significantly higher odds of death than individuals without this condition.

Currently, Medicaid covers the new Direct Acting Agents (DAAs) that cure HCV with very few limitations, but coverage under other forms of insurance varies widely. For those PLWH who are uninsured, or who need assistance with co-pays and deductibles, NYS AIDS Drug Assistance Program (ADAP) added most DAAs to the formulary in November 2016, with the exception of those made by one drug manufacturer. Despite the wider availability of effective, well-tolerated treatments in NYS, only 56% of co-infected individuals appear to have initiated HCV treatment by the end of 2017, indicating that, like with ARTs, insurance coverage alone is insufficient to support engagement in care and adherence to treatment. The NY EMA received a Health Resources Service Administration (HRSA) HIV/AIDS Bureau (HAB) Special Projects of National Significance (SPNS) grant (Project SUCCEED) to address HIV/HCV co-infection among PLWH of color in September 2016. Components of the implementation plan include clinical and non-clinical provider education and training, case investigation, and linkage to care. In July 2018, Governor Cuomo released the first in the nation strategy to eliminate HCV. It allocated \$5 million to advance the plan, and it appears those funds will be allocated primarily to community health centers and local health departments (other than NYC). Further, the plan will expand access to HCV treatment by implementing new policies that will increase access at harm reduction (HR) provider settings such as needle exchange programs. Additionally, to address barriers to care, NYS will require managed care organizations to (1) extend the prior authorization period to six months; (2) eliminate the requirement that patients undergo viral load testing in order to continue receiving HCV medication;

⁶ The CHAIN cohort study, in place since 1994, provides ongoing information on the characteristics, co-morbidities, and care needs and patterns of PLWH in the NY EMA. More than 4,000 PLWH have completed interviews conducted by researchers at Columbia University. The cohort is broadly representative of the PLWH in the NY EMA, with modest over-representation of Black men and women and Latino men, so that participants more closely represent the NY EMA's RWHAP Part A clients. In 2015, the CHAIN study started its third NYC cohort recruitment, focusing on PLWH under the age 40 (the 2015 new cohort). The study continues to follow-up a portion of the previous cohort recruited during 2008-2010 (the continuing cohort). The continuing cohort's age distribution represents more closely to the NYC surveillance age distributions of PLWH. The recruitment of the 2015 new cohort is on-going, and two-thirds of target enrollment has been completed. Because the study samples from medical and HIV social service agencies, over 98% of current CHAIN participants are connected to the HIV service system.

and (3) reimburse healthcare providers that use telehealth or videoconferencing services as a part of HCV treatment.

b) Sexually Transmitted Infections (STIs). STIs increase the risk of sexual HIV transmission.^{xxiv} In 2017, NYC's STI case rates were highest in neighborhoods with high HIV prevalence; Central Harlem, Chelsea, and the South Bronx have high rates of primary and secondary syphilis, gonorrhea, and chlamydia. In the NY EMA, rates of STIs are higher among PLWH than the general population. In 2017, rates (per 100,000) of chlamydia were 839.7 for the general population, but nearly double (1,486.3) for PLWH. This disparity is mirrored in rates of gonorrhea (275.2 compared to 1,019.1) and syphilis (21.1 compared to 177.9). Since 2001, the number of primary and secondary syphilis cases has increased six-fold in NYC overall; in 2017, 95% (1,712 of 1,799) of primary and secondary syphilis diagnoses were among men, 78% of which were among MSM. Among MSM with syphilis whose HIV status was known, 49% were HIV-positive. In 2017, almost 72,000 new chlamydia diagnoses were reported in NYC. There were also approximately 19,000 new diagnoses of gonorrhea reported in 2017; the highest case rates were seen among men of color under 29 years of age. Gonococcal infections with decreased susceptibility to azithromycin continue to be detected; however, there is little current evidence of drug resistance to cephalosporins.

c) Mental illness. In CHAIN surveys conducted between 2015 and 2018, 60% of the NYC and 43% of the Tri-County cohort had a low MH functioning score (<42.0 out of 100), while 40% of the NYC cohort, and 25% of the Tri-County cohort had very low scores on a standardized MH functioning measure (≤ 37.0 out of 100). Among NYC RWHAP Part A clients enrolled and served in 2017, 46% of those assessed in the year had at least one low MH functioning score (<42.0 out of 100), while 28% had at least one very low MH functioning score (≤ 37.0), indicating more severe MH issues. In a study examining the relationship between RWHAP Part A MH services utilization and mental health outcomes among PLWH, higher utilization of MH services was associated with improvements in MH functioning.^{xxv}

d) Substance use disorder. Among CHAIN participants surveyed between 2015 and 2018, 20% of the NYC cohort, and 4% of the Tri-County cohort reported problem substance use (i.e. cocaine/crack, heroin, methamphetamine use, or problem drinking) in the past six months. Additionally, 11% of the NYC cohort, and 17% of the Tri-County cohort reported ever using drugs intravenously. Among RWHAP Part A clients served in 2017, 17% of those assessed in the year reported recent hard drug (methamphetamine, cocaine, heroin, and/or prescription drugs) use. Of RWHAP Part A clients with some evidence of HIV medical care in 2017, 65% of those who reported recent hard drug use during the year were virally suppressed, compared to 82% of those who did not report recent hard drug use.

e) Homelessness. The NY EMA has a high prevalence of homelessness and housing instability, and a real estate market with an extremely low vacancy rate, creating an affordable housing shortage for those most in need.^{xxvi} Between 2010 and 2014, median rents in low-income neighborhoods increased by 26%, while real median household incomes fell by 7%.^{xxvii} Rent burden is high; in 2014, 56% of NYC renters paid more than one-third of their incomes for rent and utilities, and 34% paid more than one-half of their incomes for rent and utilities.^{xxviii}

Nearly 130,000 unique individuals accessed the NYC shelter system in fiscal year 2017, an increase of 57% over the past 15 years.^{xxix} Data from the annual NYC Homeless Outreach Population Estimate Street Survey in 2018 suggest that more than 3,600 homeless individuals may be unsheltered on any given night.^{xxx} Black and Latinx persons are disproportionately impacted by homelessness and housing insecurity, representing over 80% of NYC shelter residents in 2018.^{xxxi} Further, studies show that the large majority of street homeless New Yorkers have a MH diagnosis

and/or other chronic conditions.^{xxxii} As a response to this problem, NYC released its “Housing New York Plan” in 2014, which has already provided financing for 52,936 units of affordable housing.^{xxxiii}

The prevalence of homelessness among PLWH is especially high. During the most recent CHAIN survey period (2015-2018), 37% of the NYC cohort, and 11% of the Tri-County cohort were homeless or unstably housed. Additionally, 22% of NYC’s continuing cohort, 53% of the new NYC cohort, and 21% of the Tri-County cohort, reported needing housing assistance at the time of their interview.^{xxxiv} Housing instability and homelessness were also prevalent among HIV-positive RWHAP Part A clients served in 2017, with 9% of those assessed reporting accessing temporary housing during the year, and 23% reporting being unstably housed. Among those engaged in HIV medical care in 2017, 77% of temporarily housed and 69% of unstably housed clients were virally suppressed, compared to 83% of those with stable housing.

The provision of housing assistance and support services significantly reduces the costs associated with homelessness and improves health outcomes. A 2015 study by the University of Nevada found that the annual costs associated with unsheltered homeless individuals living in Southern Nevada was three times higher than providing permanent supportive housing.^{xxxv} A recent analysis found that the risk of acquiring HIV was 90% lower for homeless individuals in NYC who received three or more consecutive years of supportive housing, compared with homeless New Yorkers who applied for but were not placed in supportive housing.^{xxxvi} Another study observed that the average monthly healthcare and public service costs for chronically homeless individuals fell more than 53% following the provision of housing, substance use treatment, and other needed support services.^{xxxvii} Out of care PLWH enrolled in CHAIN who receive housing assistance were 2.5 times more likely to enter HIV primary care than those not receiving assistance and were 1.9 times as likely as other unstably housed PLWH to remain in care that meets clinical practice standards.^{xxxviii} NYC Housing Opportunities for Persons with AIDS (HOPWA) clients were more likely than non-enrolled PLWH to improve engagement in care, viral suppression and Cluster of Differentiation 4 (CD4) count, and longer-term HOPWA enrollment was associated with better HIV health outcomes compared to shorter enrollment.^{xxxix}

f) Formerly incarcerated individuals. Over two-thirds of NYS inmates return to NYC and reside in seven ZIP codes located in Central Brooklyn, Central and East Harlem in Manhattan, and the South Bronx, where new diagnoses and HIV prevalence are among the highest in NYC.^{xl} In 2014, approximately 80,000 people were released from NYS prisons and local jails to the NY EMA. Of those released, an estimated 3,760 (5%) were PLWH and returned primarily to these three districts.

Individuals released from jails and prisons experience more chronic diseases and drug use compared to those who have not been incarcerated.^{xli} From 2014-2016, an annual average of 2,100 PLWH were incarcerated in NYC jails; over 1,700 received a discharge plan and over 60% were released to the community with a plan.^{xlii} Consistent with historic trends, 70% were linked to primary care after incarceration.^{xliii} In 2016, over 80% of those linked to care were retained in care for at least 90 days. Thirty-nine percent of active RWHAP Part A clients assessed in 2017 reported a history of incarceration. Among those assessed and in HIV medical care in 2017, 70% of clients with a history of incarceration were virally suppressed, compared to 84% of those who had never been incarcerated.

A cost analysis found that the mean annual cost to achieve HIV viral suppression among formerly incarcerated individuals is \$8,432.^{xliv} These high costs may be attributable to the challenges that formerly incarcerated people often face when released, including reincarceration,

which disproportionately affects persons of color, homelessness, MH issues, substance use/addiction, joblessness, and other chronic conditions. The presence of these challenges can undermine continuity of care and linkage to case management, housing, financial assistance, and other services.

g) Tobacco dependence. Despite a record low prevalence of smoking in NYC (less than 14%), heavy tobacco use and dependence persist among several populations, including PLWH.^{xlv} In addition to the commonly known negative health effects of tobacco use, PLWH are at additional risk for HIV-specific negative health outcomes. An analysis conducted by evaluators at DOHMH found that recent tobacco smoking was reported by 40% of PLWH enrolled in RWHAP Part A programs in NYC between 2010 and 2013. Recent tobacco smoking was independently associated with low CD4 cell counts and unsuppressed viral load, even after controlling for several clinical and socio-demographic characteristics, including substance use and ART prescription status.^{xlvi} Data from a CHAIN study confirmed prior findings of the detrimental effect of smoking on long-term survival. Former smokers had a higher rate of long-term survival than current smokers, suggesting that smoking cessation interventions may be an effective means to lengthen life among PLWH.^{xlvii} Additional studies have found increased risk for some cancers and death, and a reduction in life expectancy related to tobacco use, regardless of viral load and CD4 count.^{xlviii} In studies exploring tobacco dependence and behavioral health, tobacco use is associated with worse substance use treatment outcomes and increased depressive symptoms.^{xlix}

Despite mounting evidence of the poor health outcomes among PLWH who smoke, studies show that tobacco smoking is not routinely addressed by HIV service providers, including support service providers such as those in RWHAP Part A-funded MH or HR services. Among RWHAP Part A clients enrolled and served in GY17, those receiving HR services had the highest rate of recent smoking, at 62%. Treating tobacco dependence in tandem with medical and behavioral health may increase the cost and complexity of individual care, but also provides significant short- and long-term health benefits.

4) Complexities of Providing Care. In addition to the conditions previously described, many PLWH in the NY EMA have co-morbid chronic conditions that compromise health and increase the cost and complexity of their HIV care. Among PLWH in the 2015-2018 round of CHAIN interviews, 75% of the NYC cohort and 84% of the Tri-County cohort suffered from at least one non-HIV-related chronic condition. Additionally, 85% of the NYC cohort and 62% of the Tri-County cohort reported having at least two chronic conditions, such as hypertension, heart disease, and/or diabetes. Having one or more co-morbid conditions has been found to be associated with a higher average number of annual ambulatory clinical and acute care visits (both inpatient and emergency department) among CHAIN participants, increasing the costs of healthcare. A CHAIN mortality study found that heart disease, substance use, and cancer were among the leading non-HIV-related causes of death. Non-HIV-related death rates in the CHAIN cohort remained in excess of those in the uninfected population matched by age, gender, and race/ethnicity.¹

a) Impact and response to a reduction of RWHAP Part A funding.

Impact. The NY EMA has seen reductions totaling nearly \$25 million since GY11, including a reduction of 3.1%, or \$3,070,712, in GY18. During this period of reductions, the PC and the Recipient have acted to preserve, to the greatest extent possible, those services that most directly impact the health of PLWH. While no service category has been spared reductions, historically, the impact has hit the New York EMA's commitment to ADAP and Early Intervention Services (EIS) the hardest, and resulted in the elimination of two service categories – Home and Community-based Health Services and Outpatient/Ambulatory Health Services. In the last two years, the

ADAP allocation alone has absorbed the bulk of the reductions after frank and thoughtful conversations and planning with the NYS HIV Uninsured Care Programs (NYS HUCP), the state program that administers ADAP among other programs for PLWH. The NYS HUCP was able to absorb the reductions by refocusing some of its rebate dollars and RWHAP Part B supplemental dollars to preserve NYS HUCP services. With each year’s reduction, the PC and the Recipient have been strategic in its response and have begun to proactively plan to ensure the impact does not begin to erode the NY EMA’s successes in viral suppression and a reduction in morbidity and mortality.

Response. To address the reduction in funding, the PC’s Priority Setting and Resource Allocation Committee (PSRA) re-assessed each category through an extensive review of service category-specific fact sheets in GY16. The fact sheets compiled up to five years of data on allocations, expenditures, service utilization (by service unit), and client demographics. The fact sheets also summarized data on payer of last resort (POLR) issues and systems-level considerations (e.g. changes in federal, state, and local funding and policies). The PC also worked closely with the NYSDOH to agree on a reduction of \$5,637,647 to the NY EMA’s allocation to ADAP to cover both the reduction in the grant award and the enhancements to categories with demonstrated need. The reduction to ADAP will be partially restored through reprogramming dollars from underspending contracts in the course of the year and carryover funds when available, and there will be no effect on the availability of medications for ADAP enrollees.

b) Table 2: NY EMA Uninsured and Poverty

Diagnosed and reported PLWH in NY EMA (N =91,930)	# of PLWH	% of PLWH
<i>a1.</i> PLWH in the NY EMA enrolled in Medicaid	60,214	65.5%
<i>a2.</i> PLWH in the NY EMA enrolled in Medicare and Medicaid/Medicare (dual eligible)	15,001	24.9%
<i>a3.</i> PLWH in the NY EMA enrolled in marketplace exchanges	19,725	21.5%
<i>b.</i> PLWH in the NY EMA without any insurance coverage	7,253	7.9%
Active RWHAP clients in the NY EMA, GY17 (N=15,017)		
<i>c1.</i> PLWH in the NY EMA living at or below 138% of 2018 FPL	12,860	85.6%
<i>c2.</i> PLWH in the NY EMA living above 138% and at or below 400% of 2018 FPL	1,531	10.2%
<i>c3.</i> PLWH in the NY EMA living above 400% and at or below 435% of 2018 FPL*	32	0.2%

Sources: Data in sections a. and b. provided by NYSDOH to NYC DOHMH. The numbers and corresponding percentages reflect insurance program enrollment available through June, 2017.

*Residents with income under 435% FPL are eligible for RWHAP services. This requirement for RWHAP in the NY EMA remains unchanged. There are no income restrictions for EIS services or Health Education/Risk Reduction (HE/RR).

c) Barriers to accessing healthcare.

Geographic variation. NYC is well known for its extensive subway system, but the NY EMA also includes three counties north of NYC that are mostly suburban and rural and lack many of the resources of NYC. Not only do non-NYC counties lack robust mass transit, they also do not have as many resources that support access to and retention in healthcare.

Thus, while New Yorkers are a highly insured population, access to healthcare and providers can be impacted by people’s access to transportation services and by the lack of specialists and service providers that meet their needs. To increase access to services, the NY EMA considers geographic distribution of contractors during procurement and contracting, and has allocated \$339,433 to medical transportation to provide access to taxi and gas vouchers, as appropriate, and to mass transit

options where available. The medical transportation program ensures that clients are able to attend appointments for services related to their HIV primary care, including medical care and MH appointments, and to pick up prescriptions.

Adequacy of health insurance coverage. Prior to implementation of the Affordable Care Act (ACA), NYS Medicaid covered non-disabled adults with incomes below 100% of the FPL. Expanded health insurance coverage options provide further coverage for PLWH, providing coverage for people with HIV up to 435% of the FPL at no cost through a combination of expanded Medicaid and NY State of Health insurance exchange plans with support for premiums and copays from the NYS HUCP (*see pp. 25-27 for details*). These changes affect health insurance options in the jurisdiction, as well as RWHAP Part A service needs and delivery. From June 2015 to June 2018, Medicaid enrollment has increased by 15% among PLWH in the NY EMA. In order to continue this trend, specific outreach and enrollment activities continue throughout the NY EMA to ensure that people eligible for health care coverage are enrolled and that coverage is maintained.^{li} Specifically, all RWHAP Part A contracts have mandated language that ensures assessment of insurance status, linkage and referral relationships with health plan navigation, and enrollment in health plan options for eligible individuals. Reductions to federal funding for navigators apply to states that participate in the federal Health Insurance Marketplace; NYS operates its own marketplace, so it is not impacted by the funding changes.

Cultural and language barriers. The NY EMA is home to more than 200 languages – with half of New Yorkers speaking a language other than English, including mono-lingual and multi-lingual individuals. Within the RWHAP Part A population, 27% of non-EIS clients in GY17 reported a language other than English as their primary language. Of clients reporting a primary language other than English, most speak Spanish (77%), followed by Haitian Creole/French Creole (6%), and French (5%). RWHAP Part A clients also speak Russian, Portuguese, Mandarin-Chinese, Arabic, Tagalog, and Thai, among other languages.

To address these diverse language needs, the NY EMA prints materials in the most common languages of the jurisdiction – English, Spanish, and French/Haitian-Creole. In addition, providers will often adapt and translate materials to meet the needs of their client populations; for example, an agency with expertise in serving Chinese-speaking clients translated CCP materials into Chinese.

To improve services to the diverse RWHAP Part A client population, the Recipient has taken steps to implement standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards).^{liii} The Recipient formed a work group to develop a CLAS Standards self-assessment survey. This assessment tool was designed to be completed by organizations receiving RWHAP Part A funding. It includes 20 questions addressing governance, leadership, workforce, communication, language assistance, engagement, continuous improvement, and accountability. The tool is being pilot tested with four RWHAP Part A providers that were chosen to represent a diverse range of service settings. Their feedback on the content and structure of the tool will inform final revisions before the tool is distributed to all RWHAP Part A providers in fall 2018. Providers will be contractually required to complete the self-assessment internally, identify areas for improvement, and include action steps in their annual Part A Quality Management Plan.

Service gaps and plans to address them. The RWHAP Part A services portfolio is carefully designed to meet needs identified through surveillance, RWHAP Part A program evaluation, CHAIN data, and changes in the NY EMA's health care landscape. Identified needs are addressed through the incorporation of lessons learned and evidence-based interventions in service models to support effective diagnosis, linkage to and retention in care, and adherence to ARTs. Historically and presently, Part A serves Black and Latina women at a proportion higher than or equal to their

representative portion of the NY EMA's PLWH population. In 2016, Black and Latina women represented 16% and 10% of PLWH in the New York EMA respectively, while Black and Latina women represented 20% and 10% of the HIV-positive Part A population, respectively. Activities to address service gaps in the NY EMA, based on the stages of the HIV care continuum, cover: Individuals diagnosed but not currently engaged in care. The RWHAP Part A program provides \$795,259 in funding to the nationally recognized HIV Field Services Unit (FSU) at DOHMH, which uses a data to care (D2C) model to identify PLWH who, according to surveillance data, are lost to care. In 2013, the FSU dedicated additional staff resources to the D2C team, with the aim of identifying and reaching persons deemed to have been never in care since HIV diagnosis to: (1) ensure that they were aware of their own diagnosis, and (2) assist them with linkage to HIV primary care and services. To do so, the FSU has established collaborative relationships with NYC HIV medical providers, social services agencies, and community-based case management providers. As a result, in 2017, FSU located 1,109 PLWH who had been out of care for at least nine months or had never been in care since HIV diagnosis. Of these, 714 (64%) were re-engaged or linked to HIV care. Forty-five percent (498/1,109) of out of care/never in care clients who acknowledged having sex or needle-sharing partners who could benefit from taking an HIV test, were offered home test kits (Oraquick Rapid) to deliver to their partners. Thirteen percent (67/498) accepted the home test kits. Among the 1,109 out of care/never in care persons, 137 were found to have HCV infection per the DOHMH viral hepatitis registry. Therefore, in addition to HIV linkage to care, 78 (57%) of the persons with HIV/HCV co-infection were located and linked to HCV care. Individuals who are not currently virally suppressed. In 2016, 30% of PLWH in the NY EMA were virally unsuppressed. In GY19, as in previous years, RWHAP Part A services will be clustered in high-need, underserved minority communities, with consideration given to the geographic distribution of Medicaid and RWHAP Parts B, C, D, and F-funded services and providers' capacity to address health disparities. CCP clients obtain services co-located or linked with primary care providers. A Memorandum of Understanding (MOU) ensures CCP staff are treated as members of the care team, are provided access to the patients' clinical information, and participate in joint case conferences. RWHAP Part A-funded initiatives will continue to be complemented by targeted Minority AIDS Initiative (MAI) programs that promote early diagnosis and linkage, adherence to treatment, and stable housing for PLWH of color.

Additional efforts to retain PLWH in care and support adherence to ART and SVL include the RWHAP Part A MH programs, which seek to engage persons with psychiatric diagnoses in MH care through navigation, education on MH issues, coordination of care between MH and medical care providers, treatment adherence support, and provision of psychiatric, individual, family, and group MH services for those without another payer.

Lastly, as described on p. 44 in the Clinical Quality Management (CQM) section, each NY EMA RWHAP Part A provider receives client level reports of those reported to eSHARE as not virally suppressed, in an effort to ensure that these clients are referred to services that address barriers to SVL.

Early Identification of Individuals with HIV/AIDS (EIIHA).

1) Planned Activities of the NY EMA EIIHA Plan for GY19.

a) Primary activities. The primary activities in the NY EMA's EIIHA Plan for GY19 are (1) to promote and increase HIV testing, (2) to improve timely linkage of persons who have newly diagnosed HIV infections to medical care, and (3) to increase awareness of and referral to HIV prevention services, including PrEP, PEP, treatment as prevention, and condoms.

Testing. The NY EMA uses a two-tier approach to pursue the EIIHA goal to increase status awareness and reduce the number of undiagnosed and late diagnosed individuals.

Tier 1. The first tier supports sustainable access to HIV testing services for the general population citywide by promoting routine HIV screening programs in healthcare facilities. The first-tier approach is consistent with the Center of Disease Control & Prevention’s (CDC) 2006 *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. Routine screening enables large numbers of people to be tested by taking advantage of established systems for service provision and provides HIV testing to all, regardless of risk, including those who do not perceive themselves to be at risk or whose providers do not perceive them to be at risk for HIV.

The NY EMA uses CDC and RWHAP Part A funding to support, but not supplant, HIV testing programs in healthcare settings and to support the implementation of community-level initiatives that promote HIV testing and normalize the testing experience, which has proven to be effective. In an analysis of individuals who received care at the Montefiore Medical Center’s emergency department in 2015, only 5% of HIV-positive individuals were unaware of their status.^{liii} The proportion of undiagnosed cases of HIV represents the lowest in the history of serosurveys in NYC emergency departments. To maximize the impact of funding, routine screening funding is focused on clinical facilities that serve neighborhoods disproportionately affected by HIV and are underserved, such as the South Bronx, Central Brooklyn, and East and Central Harlem. *Table 3* below provides a breakdown by race/ethnicity of HIV testing during testing events throughout NYC among the contracted providers. In GY17, the number of HIV tests was particularly high among Black and Latinx persons, with a higher proportion of Black individuals and MSM receiving a newly diagnosed confirmed positive test.

Table 3: Newly Diagnosed Positive HIV Test Events March 1, 2017 - February 28, 2018

	Black		Latinx		MSM‡		TGNB	
	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical
# Test events	18,647	6,313	23,354	5,986	324	2,188	720	221
# Newly diagnosed positive test events	107	63	67	57	87	75	2	7
# Newly diagnosed confirmed positive test events	96	48	53	41	75	66	1	4
% Newly diagnosed confirmed positive test events	89.7%	76.2%	79.1%	71.9%	86.2%	88%	50%	57%
# Newly diagnosed confirmed positive test events with client linked to HIV medical care	86	32	47	29	69	51	1	2
# Newly diagnosed confirmed positive test events with client referred for Partner Services	86	31	48	29	71	51	1	1
# Newly diagnosed confirmed positive test events with	86	31	47	30	70	52	1	1

	Black		Latinx		MSM‡		TGNB	
	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical
client referred to prevention services								
# Newly diagnosed confirmed positive test events with CD4 cell count and viral load testing * ± ¥	26	26	20	10	26	30	0	2

Note: This data represents contracted testing performed in NYC.

‡ The numbers reported are an underestimate of testing among MSM in clinical settings. Programs conducting targeted HIV testing collect risk information for clients regardless of the results. These numbers are reported in the Non-Clinical section. However, testing programs in clinical settings, consistent with the routine testing model, do not collect risk information on clients unless the client tests positive for HIV. As a result, clinical programs cannot determine the percentage of MSM tested among those with a negative test result. MSM clients who test negative served in clinical programs are, therefore, not captured.

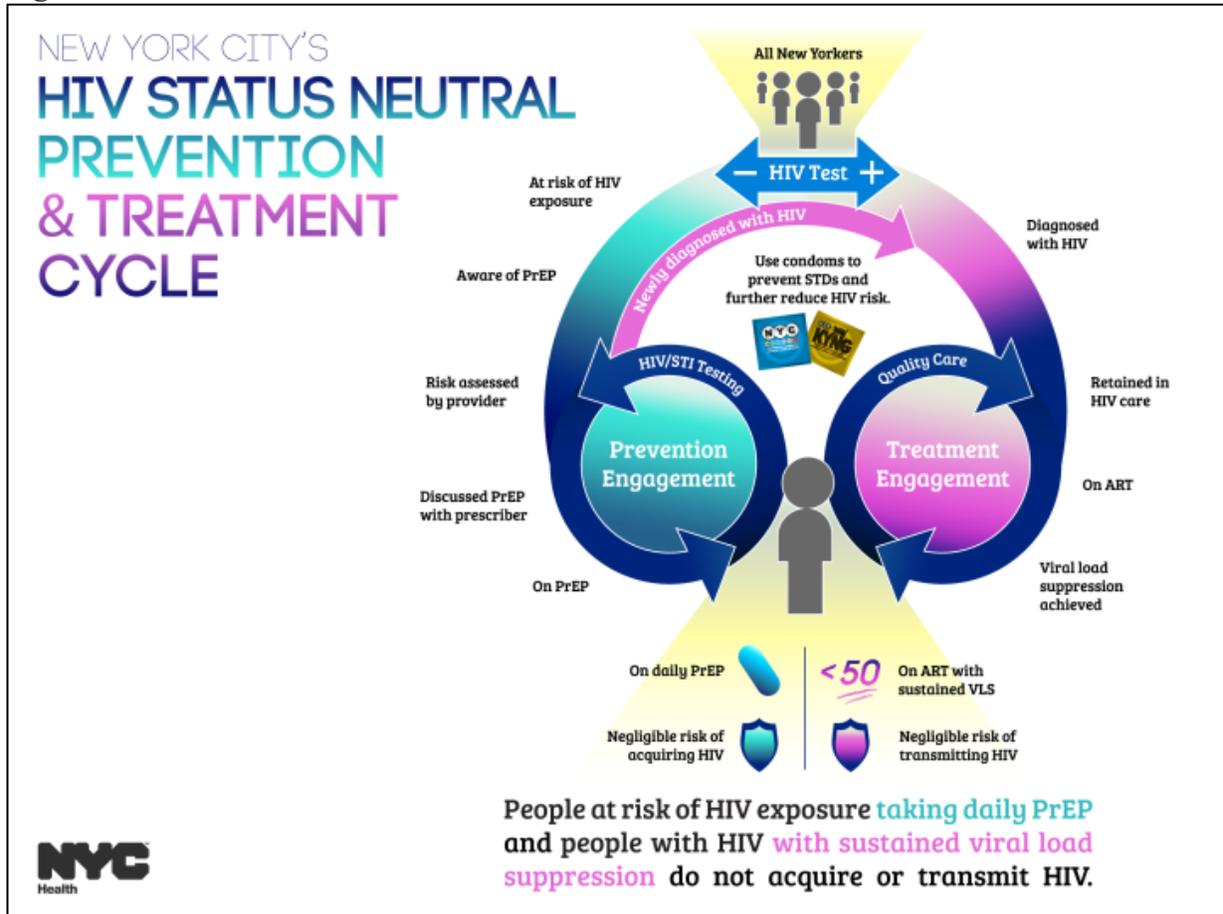
* De-duplicated by clientsysid, an eSHARE system ID that is assigned upon first enrollment at an agency and is unique to the client at that agency.

± Includes clients with lab test(s) occurring on or after confirmatory test date. Restricted to confirmatory test dates from 03/1/2017 to 02/28/2018 and lab tests that occurred within the same time period.

¥ CD4 and viral load data as of September 2017; data maybe incomplete due to reporting lag.

In 2016, DOHMH rolled out a “status neutral” approach to HIV prevention and care services that simultaneously addresses the needs of HIV-positive and HIV-negative persons (*see Figure 4*). To align with its new approach as well as new testing regulations and guidelines, in 2017 DOHMH issued a Request for Proposals (RFP) for HIV Testing and Status Neutral Navigation Services (Status Neutral Testing RFP), which includes funding from both CDC and RWHAP Part A. The solicitation, which re-bid the NY EMA’s HIV testing portfolio, includes awards for two types of HIV testing and linkage services; status neutral linkage and navigation services in clinical settings, and targeted HIV testing among priority populations. Contracts began January 1, 2018. The NY EMA also intended to fund clinical facilities to implement systems-level change for scaling up routine HIV testing in clinical settings. Due to a reduction in CDC funding, this service category was not funded. The NY EMA uses City Council and other funds to support routine HIV testing in NYC public hospitals and clinics. In the Tri-County region, Medicaid and private insurers are the primary payers supporting the implementation of the NYS routine testing law, with RWHAP Part A support for targeted testing among uninsured individuals and linkage to care for those who test positive for HIV.

Figure 4. DOHMH Status Neutral Care Plan



Beyond directly contracting for testing services, DOHMH has taken an additional approach to engage hospitals and community health centers in routine HIV screening is through the citywide HIV testing initiative, *New York Knows*. This program began in 2008 targeting the Bronx (*Bronx Knows*), extended to Brooklyn (*Brooklyn Knows*) in 2010, and subsequently expanded on World AIDS Day 2014 to all boroughs of NYC. *New York Knows* engages community providers to conduct routine screenings in clinical settings and targeted testing of priority populations in the community, link individuals with HIV to care and support services, and connect HIV-negative individuals to comprehensive prevention services. Approximately 4.1million HIV tests have been performed collectively since 2008 through all three initiatives combined. The *New York Knows* initiative is a public-private collaboration using RWHAP, CDC, Medicaid, and other insurance reimbursements to support HIV testing efforts.

The DOHMH Bureau of Sexually Transmitted Infections (BSTI) is the main provider of direct HIV testing services at DOHMH, conducting approximately 57,000 HIV tests annually, although DOHMH also provides integrated, opt-out HIV testing at its Bureau of Tuberculosis Control’s (BTBC) clinics. In February 2017, DOHMH announced an effort to significantly expand sexual health services and rebranded the DOHMH STD Clinics as SHCs. The overall goal of the rebranding has been to transform the STD clinics into “Destination Clinics” for sexual health services. The SHCs offer opt-out rapid HIV testing to all patients presenting to a clinic. For over ten years, the SHCs have performed pooled nucleic acid amplification testing (pNAAT) to detect acute HIV infections. pNAAT testing is limited to those individuals who are most likely to present

to the SHCs with acute infection, including MSM, people who have shared injection drug equipment, and people who exchange sex for money (or other material goods).

The NY EMA recommends that clinicians immediately offer ART to all persons diagnosed with HIV. SHCs provide persons who are diagnosed with HIV or are living with HIV but have never engaged in treatment with linkage to care and partner services through new and expanded programs including JumpstART, which initiates ART the same day of the HIV test or clinic visit, and PrEP navigation and initiation services and PEP for eligible patients. In 2017, there were 223 new HIV diagnoses in the SHCs (31 acute HIV cases); 52% of patients who were newly diagnosed at SHCs providing JumpstART at that time received JumpstART on day of HIV diagnosis; and 917 patients were initiated on PrEP.

Through the new HIV Testing and Status Neutral Navigation Services solicitation's second service category, the NY EMA funded clinical facilities to expand linkage to care services. Subrecipients are required to partner with JumpstART programs to increase access to rapid ART initiation, with higher reimbursement for those linked on the same day. The program leverages NYSDOH's Rapid Access to HIV Medications and Treatment Program (Rapid Tx). Through the solicitation of CCP programs, organizations initiating new contracts may also opt to provide immediate ART (iART).

Tier 2. The second tier of the NY EMA's EIIHA approach aims to decrease disparities in health outcomes by targeting HIV testing services in non-clinical settings. The NY EMA uses surveillance data to identify the key populations and communities for these services. Targeted testing services include couples-based testing and conducting testing in venues where people at high-risk for HIV can be found, using evidence-based recruitment practices such as the Social Network Strategy. Through one of the HIV Testing and Status Neutral Navigation Services solicitation's service categories, 15 selected community-based agencies are focusing on gay, bisexual and other MSM and TGNB persons and their partners, with particular attention to Latinx or Black TGNB individuals under 29 years; heterosexual women of color, particularly those over 30 years old or living in areas with a high prevalence of STIs; and other vulnerable populations. Funding was prioritized to applicants whose patient population resides in ZIP codes with high HIV prevalence and documented health disparities and/or that have a history of outreaching to key populations. Selected agencies also have demonstrated cultural competency in their work and have a history of successfully engaging with the priority populations.

Linkage and retention in medical care. The NY EMA promotes linkage to medical services for those who have diagnosed HIV infections through various strategies. All funded HIV testing programs are required to link newly diagnosed persons to care, as well as those previously diagnosed that have fallen out of care. To meet the revised national goal of earlier linkage to care, subrecipients receive higher reimbursement rates for linkage to care within 4, 14, and 30 days of diagnosis.

Increase rates of retention in care and SVL. DOHMH has funded a citywide scale-up of The Undetectables Viral Load Suppression Program (The Undetectables) as part of the EtE initiative in New York. The Undetectables is an ART adherence intervention designed to promote sustained SVL among PLWH who face individual and/or structural barriers to adherence such as poverty, housing instability, and behavioral health issues. The intervention combines a toolkit of evidence-based adherence support strategies, including financial incentives, and a superhero-themed social marketing campaign in the context of integrated medical, behavioral, and case management services. The toolkit includes client-centered adherence planning and support, motivational interviewing, adherence support groups, adherence devices (e.g., pill boxes), directly observed

therapy (DOT), and financial incentives to promote SVL. Participants may receive a \$100 gift card incentive for each quarterly lab result showing a suppressed viral load (<200 copies/mL). The marketing campaign supports organizational culture change by engaging clients and staff on the importance of SVL to individual and community health. The intervention was originally developed and pilot tested by Housing Works Community Healthcare, an AIDS service organization in NYC. In July 2016, NYC DOHMH awarded over \$1.5 million annually in EtE-funded contracts to seven agencies across NYC, including a contract for Housing Works to provide training and technical assistance (TA) on program implementation to awardees. As of May 2018, EtE-funded Undetectables programs have served approximately 1,700 PLWH in NYC. The Undetectables is also being disseminated in NYS through other channels. As part of Medicaid redesign efforts, two DSRIP Program Performing Provider Systems have begun to implement The Undetectables in NYC and in Albany. Evaluation of the EtE-funded and DSRIP-funded programs will inform the potential for financial incentives as components of value-based health care payment models.

Referral to PrEP and PEP services. In 2016, using CDC and city funds, the NY EMA funded the *PlaySure* Network, a network of over 50 community-based organizations (CBOs) and healthcare facilities to provide education on PrEP and PEP, navigation and linkage to clinical providers, and PrEP and PEP initiation with adherence support and clinical follow-up. As noted above, in 2017, the SHCs began providing PrEP services and providing full 28-day courses of PEP. Staff from the SHCs also provide status-neutral navigation services to PrEP/PEP providers and HIV medical care. The NY EMA will continue to support and expand these services in GY19.

In the Tri-County region, the Westchester County Department of Health (WCDOH) has implemented several programs through NYS funding to expand PrEP coverage in the Tri-County region. WCDOH has concentrated its focus and expanded its PrEP outreach to priority populations including MSM, transgender women, PWID, sex workers, homeless individuals, and currently and formerly incarcerated individuals. Specifically, in 2016, WCDOH implemented a PrEP education and treatment program in SHCs. Since implementation, five funded medical programs have connected 400 individuals to PrEP medications. In GY19, the Tri-County region will increase resources to reach young MSM and women of color. Additionally, WCDOH provides policy and programmatic leadership for NYSDOH AIDS Institute (NYSDOH AI) funded PrEP initiatives throughout the Tri-County region. WCDOH is a voting member of the NYS HIV Advisory Body within the Hudson Valley region, and participates in EtE initiatives and NY Links in the Upper and Lower Hudson Valley (which includes the Tri-County region). In this capacity, the WCDOH oversees HIV education, testing, and PrEP/PEP referral programs, and holds monthly provider meetings focused on training and program strategy.

Other Activities. For all DOHMH-funded testing programs, DOHMH recommends the use of HIV testing technologies that allow for detection of acute and early HIV infections, such as combination HIV antigen-antibody (4th and 5th generation) HIV tests. To support testing programs, DOHMH provides trainings and TA for providers and publishes testing and prevention resources online. To promote receipt of confirmatory testing among individuals with a preliminary-positive test result, DOHMH provides a discrete reimbursement point for confirmatory testing among HIV testing contracts. The specific reimbursement for confirmatory testing and recommended on-site collection of specimens have resulted in a higher proportion of tested clients receiving confirmatory results among those who test preliminary-positive.

To support the primary activities in the EIIHA Plan, the Bureau of HIV/AIDS Prevention and Control (BHIV) has created social marketing campaigns over the past several years to promote improvements in sexual health city-wide. The *BeSure* campaign aims to increase awareness of HIV

status. The *PlaySure* campaign encourages individuals to choose the combination of safer sex practices that work for them. As noted above, the NY EMA has funded the *PlaySure* Network to provide prevention services, including PrEP and PEP. The *StaySure* campaign emphasizes initiation and adherence to HIV medications and biomedical prevention interventions. The *Bare It All* campaign encourages consumer and provider communications to improve sexual health and wellness, especially to LGBTQ New Yorkers. In 2018, the NY EMA launched the *Living Sure* and *Listos!* campaigns to educate and promote PrEP use among women and the Latinx community, respectively. BHIV also utilizes digital media including established social media platforms to promote HIV prevention messaging to priority populations, and works with contracted agencies to integrate the campaigns and messaging into their digital platforms.

The FSU, housed within the BHIV HIV Epidemiology, Field Services Program, and the Tri-County Region's Health Departments provide partner notification services to PLWH diagnosed by providers. The NYC BHIV FSU and Tri-county Health Department Disease Intervention Specialists elicit the names of potentially HIV-exposed partners, confidentially notify these partners of their possible HIV exposure, and offer HIV testing and linkage to care for persons who test positive. In 2017, FSU offered partner services to all newly diagnosed persons citywide. FSU interviewed 84% (1,751/2,097) of those newly diagnosed in NYC and elicited 752 HIV-exposed partners. Seventy-five percent (406/538) of partners with a negative or unknown HIV status were notified and 49% (198/406) were tested, of whom 18% (36/198) have newly diagnosed HIV infections. If those newly diagnosed do not return to receive their test results, FSU can assist testing providers in locating patients, notifying them of their results, and offering partner services. For partners with a negative or unknown HIV status, FSU offered 21% (79/370) linkage to PrEP services.

b) Major collaborations with other programs and agencies. Many DOHMH programs collaborate to identify individuals unaware of their HIV status. Under the leadership of the BHIV Prevention Program, all HIV testing programs in the NY EMA have standardized service models that ensure one data collection process across funding sources, enforce POLR requirements, eliminate duplication of services across funding streams, and coordinate monitoring and evaluation activities. BHIV programs practice a unified approach, collaborating with clinical operations, prevention, surveillance, and care and treatment programs. The BHIV also collaborates with other DOHMH programs and city agencies that provide services to populations heavily impacted by HIV, such as the Division of Mental Hygiene; BSTI; BTBC; Bureau of Alcohol & Drug Use Prevention, Care & Treatment; Public Health Lab; Office of School Health; and NYC Health + Hospitals (H+H). DOHMH also works with NYC H+H Correctional Health to coordinate comprehensive medical, dental, and MH services for inmates in NYC correctional facilities, including HIV testing and discharge planning to support linkage of inmates to community-based medical care within 30 days of release. Through a CDC-funded demonstration project, Project THRIVE, DOHMH collaborates with state and local agencies, such as the NYS Education Department's ACCES-VR program, Workforce1, and the Mayor's Office of Workforce Development, to support referral and linkage of clients to workforce development and employment services.

The *New York Knows* initiative collaborates with over 200 partner agencies that have pledged to support the goals of the initiative to: test every resident for HIV, link HIV-positive individuals to care, link HIV-negative individuals to prevention services including PrEP, and make HIV testing a routine part of healthcare in NYC. Steering committees have been created in each borough and citywide, and these committees meet regularly throughout the year to improve retention in care and viral suppression.

BHIV also collaborates with the NYSDOH AI on work done by NYLinks in Brooklyn which is a continuation of a previously funded HRSA/HAB SPNS initiative. NYLinks is a statewide project focused on improving linkage to and retention in care that supports the delivery of routine, timely care and viral suppression. BHIV is an active participant in the Brooklyn regional collaboratives established under NYLinks and is an implementing partner in a statewide scale-up of strategies that have been shown to have promise, including rapid access to treatment, timely linkage to care, as well as improved peer learning and networking among providers, community leaders, and consumers. BHIV is working with NYLinks to coordinate engagement of providers in other boroughs, including Queens and Staten Island. BHIV also works closely with the NYSDOH AI in the development and implementation of *Brooklyn EtE* key strategies. The *EtE Blueprint* serves as a foundation for the NYS (and NYC) *Integrated HIV Prevention and Care Plan*.

BHIV convenes the DSRIP HIV Coalition, which is comprised of the eight NYC hospital systems and their CBO partners who have undertaken HIV-specific projects as part of their Medicaid reform efforts. In addition, representatives from NYSDOH AI and all three Medicaid Special Needs Plans (SNPs), participate in the Coalition. The full Coalition and its subcommittees meet to share the status of their projects, identify strategies to improve HIV outcomes, and to learn about emerging NYS Medicaid changes that impact their programs. TA support is provided to the Coalition by BHIV in collaboration with NYC's largest SNP, Amida Care.

Finally, BHIV proactively engages members of priority communities to participate in and plan community events including NYC Pride events, NYC Black Pride, and World AIDS Day commemoration, among others. BHIV also actively participates in a number of coalitions across NYC such as End AIDS NY 2020 Coalition, NYC Kiki Coalition, and NYC LGBTQ Health Equity Coalition. In addition, BHIV also works with the Mayor's Office of Workforce Development, through the Considering Work Efforts Workgroup to inform staff on how to enhance the integration of employment services within HIV prevention, care, and treatment programs (*see p. 35 for more details*).

c) Anticipated outcomes of overall EIIHA strategy. The goals of the NY EMA's overall strategy include increasing the number of people aware of their HIV status, increasing the proportion of PLWH promptly linked to medical care and achieving viral load suppression, and increasing the proportion of populations at-risk for HIV infection receiving prevention services, including PrEP and PEP (*see pp. 24-25 for specific strategies*), which directly align with the goals of the *EtE Blueprint* and the NYS *Integrated HIV Prevention and Care Plan*. This "status neutral" approach to HIV prevention and care services addresses the needs of HIV-positive and HIV-negative persons with its success contingent on the coordination among providers of testing, prevention, and care services, regardless of an individual's HIV status.

The NY EMA proposes to monitor testing and linkage to prevention and care services through a variety of mechanisms. Programs funded to provide direct services, in clinical and non-clinical settings, report client-level data; clinical facilities that participate in borough-wide initiatives (*New York Knows*) report aggregate testing data to DOHMH. As the NY EMA continues to promote and fund testing programs that focus on priority populations, including gay, bisexual and other MSM, TGNB persons and their partners, heterosexual women of color, and other vulnerable populations, the proportion of residents in the NY EMA that have ever been tested for HIV continues to increase. Through the Community Health Survey (CHS), DOHMH tracks the percentage of NYC residents, aged 18 and older, who report ever testing for HIV. In 2016, 65% of adult NYC resident CHS respondents had ever tested for HIV, up from 60% in 2010.^{liv} At the same time, as discussed on *pp. 14-17*, in the last five years the number of NYC residents being tested for HIV has increased,

while the number of HIV diagnoses in the NY EMA has decreased. This declining trend in the number of new diagnoses is partly due to DOHMH's rigorous and comprehensive effort to increase HIV testing, link persons with diagnosed HIV infections to care, and support increased viral suppression within the first 12 months of care. The NY EMA expects these trends of increased percentages of NYC residents reporting to have ever received an HIV test and a decrease in new HIV diagnoses to continue with on-going implementation of the EIIHA strategy.

The NY EMA recommends and promotes prompt linkage to medical care. A planned outcome is an increased percentage of people with new HIV diagnoses initiating care. Currently, DOHMH tracks this indicator using HIV surveillance data and defines timely linkage as an HIV viral load, CD4, or genotype test drawn within one month (30 days) of HIV diagnosis. In recent years there has been a steady increase in timely care initiation among the newly diagnosed in NYC, from 65% in 2013 to 79% in 2017. As noted previously, the NY EMA employs several strategies to retain individuals in care, improve ART adherence, and promote sustained SVL. The outcome of these efforts will be measured through changes in the HIV care continuum.

As the NY EMA continues to promote and fund PrEP and PEP referral and care services, the proportion of at-risk residents, including MSM, TGNB individuals, and Black and/or Latina women, who are aware of and report using these services will increase. This outcome indicator will be measured through the SHS. Already, among sexually active NYC MSM aged 18-40 surveyed through the SHS in spring 2017, 96% were aware of PrEP, with no significant variation by race/ethnicity. Overall, 28% had taken PrEP in the past six months and this also did not significantly vary by race/ethnicity.^{lv} Among sexually active women of color aged 18-64, surveyed through the SHS in fall 2017, only 35% were aware of PrEP and less than 2% had taken PrEP in the past six months.^{lvi} The disparities in awareness among key populations and uptake across all populations underscore the need for continued intensive social marketing and education efforts, such as *Living Sure* and *Listos!*.

2) Planned efforts to remove legal barriers to routine HIV testing. In the last decade, DOHMH worked with NYSDOH and state elected officials to streamline and routinize HIV testing consistent with the CDC's 2006 recommendations. Prior to 2010, any person to be tested for HIV was required to provide written consent. In 2010, Governor Paterson signed into law a series of changes to the testing law, including requiring that HIV testing be offered to all patients ages 13 to 64 years receiving hospital or primary care services, with limited exceptions; allowing consent to HIV testing to be part of a patient's general consent to medical care including specific opt-out language; and, in non-correctional settings, allowing oral consent for rapid HIV testing. A 2012 evaluation of HIV testing volume 13 months before and after the 2010 law was enacted found a 13% increase in lab-based HIV testing following the enactment.^{lvii}

In 2014, Governor Cuomo signed into law legislation that eliminated the requirement for written consent for HIV testing except in correctional settings; the following year, further amendments allowed for oral consent in correctional settings.

To coincide with World AIDS Day 2016, Governor Cuomo signed into law legislation that further streamlined HIV testing by removing the requirement to obtain "informed consent" so that a provider, at a minimum, need only orally advise the patient that an HIV test is being performed and then document the advisement or objection in the patient's record. The legislation also removed the upper age limit, requiring HIV testing to be offered at least once as a routine part of health care to all patients ages 13 years or older receiving primary care services at an outpatient clinic or from a physician, physician assistant, nurse practitioner, or midwife. Hospitals must also offer HIV testing to all patients and individuals seeking services in emergency departments, with

limited exceptions. DOHMH continues to work with NYSDOH and other state agencies to build public and provider awareness of these changes through FAQs, fact sheets, and webinar and in-person trainings.

Other state legislative and regulatory activity has expanded access to HIV services in recent years. The World AIDS Day 2016 legislation expanded access to STI testing by allowing physicians and nurse practitioners to issue non-patient orders to nurses to screen individuals at increased risk for syphilis, gonorrhea, and chlamydia infection; it also expanded access to PEP by allowing physicians and nurse practitioners to issue non-patient specific orders to pharmacists to dispense up to seven days of PEP. In April 2017, NYSDOH finalized regulatory amendments classifying HIV as a STI. With this change, local health department clinics must provide HIV prevention and treatment, including PrEP, to patients either directly or by referral. Providers in any setting may provide these services to minors without parental/guardian consent or notification. Medical and billing records containing information regarding such services may not be sent to the parent/guardian without the minor's consent. The following month, NYSDOH finalized regulatory amendments expanding data sharing to allow care coordinators access to HIV-related information for the purpose of linkage to and retention in care.

GY18 EIIHA Plan target populations. The three selected distinct target populations are: (1) Black and Latino MSM; (2) TGNB persons and their partners; and (3) Black and Latina women living in high prevalence neighborhoods.

a) Populations targeted. The three populations were chosen to align with national and local priorities. They constitute four of the seven priority populations highlighted in the national goals to end the HIV epidemic.

b) Specific challenges with or opportunities for working with the targeted populations.

a) ***Black and Latino MSM.*** Fifty-eight percent of new HIV diagnoses in the NY EMA in 2017 were among MSM (including those who also have a history of IDU), more than any other transmission risk group. National data indicate that MSM of color and YMSM aged 13-24 years old, particularly YMSM of color, are at the highest risk for acquiring HIV. The CDC estimates that one in six MSM will have a diagnosed HIV infection in their lifetime, including one in two among Black MSM and one in four among Latino MSM.^{lviii} This holds true in the NY EMA, making them a high priority of the overall EIIHA Plan. In 2017, YMSM accounted for 15% of the new diagnoses in the NY EMA; of which, 88% were among YMSM of color. Research has shown that stigma and discrimination due to race and sexual orientation and lack of access to culturally competent services for MSM of color are barriers to HIV testing and medical services.^{lix} Further, some YMSM who experience homelessness/housing instability face additional barriers to healthcare including a lack of awareness of available resources, transportation, and financial resources and/or healthcare insurance.^{lx}

The NY EMA is working to reach and engage MSM individuals through a number of initiatives. The NY EMA promotes Undetectable=Untransmittable (U=U), the concept that PLWH who maintained an undetectable viral load for at least six months do not transmit HIV through sex, which was endorsed by the CDC in September 2017.^{lxi} The U=U initiative, in combination with the Status Neutral Testing RFP, provides an opportunity for providers to conduct targeted outreach and testing to Black and Latino MSM and link them to care and iART. The BHIV has initiated a workgroup to incorporate best practices associated with U=U to help the community understand the concept and incorporate it into sexual health decision-making to reduce stigma. Efforts underway include: a standardized slide set to substantiate U=U research including the PARTNERS, PARTNERS II, and HPTN 052 results and training modules for condom providers,

FSU, patient navigators, and health educators to support productive and knowledgeable discussions of U=U with program clients. Additionally, BHIV is also implementing a CDC-funded demonstration project, Project THRIVE, which seeks to improve testing, referral, linkage, and navigation to Prevention and Care services for MSM of color in Brooklyn. Under Project THRIVE, DOHMH has also conducted three listening sessions with MSM of color in Brooklyn to discuss the social determinants that impact their health. The community advisory body for Project THRIVE meets monthly with DOHMH staff to discuss and make recommendations on addressing these social determinants. In 2019, DOHMH will host a storytelling event to promote LGBT wellness and to address HIV-related stigma. City-funded EtE contracts also support Black MSM-led organizations to build organizational capacity and infrastructure, supported with experienced TA providers, to increase culturally appropriate services to these communities in NYC.

Finally, BHIV recently conducted a series of focus groups among MSM engaged in exchange sex, one of which was specifically with Latino-identified MSM. The purpose of the groups was to understand the overall experience of sex work among MSM in NY and the impact of exchange sex on MSM sex workers' health and safety, and to improve understanding of how medical and social service providers can support MSM sex workers. Findings from the groups revealed that most participants found themselves in a violent situation on at least one occasion and almost all felt it was their personal responsibility to protect themselves and their clients from HIV and STIs. Participants' experiences with healthcare providers varied; several participants noted perceived or realized discrimination from a provider, which impacted their ability to receive appropriate care. Participants in the non-Latino-identified group found sex work to be enjoyable and several described substance use as part of their work experience, whereas participants in the Latino-identified group expressed shame related to their engagement in exchange sex and none discussed drug use in relation to exchange sex. Across both groups, participants recommended provider training to reduce discrimination and improve knowledge of sex work and available services citywide to provide better referrals.

b) TGNB persons and their partners. In 2017, 3% of new HIV diagnoses in NYC were among transgender individuals, 98% of whom were transgender women. Black or Latina individuals made up roughly 86% of new diagnoses among transgender women, and 51% of newly diagnosed transgender women were ages 20-29. No local estimates of HIV prevalence exist, but national estimates of prevalence are 22-28% among transgender women.^{lxiii} The *EtE Blueprint* notes that stigma and discrimination contribute to HIV risk among transgender persons, which is amplified by related contextual factors such as poverty, unemployment, homelessness, violence, undocumented status, sex work and condom confiscation, MH, substance use, and poor access to healthcare and affirming providers.

TGNB persons and their partners are also included as priority populations in the above-mentioned U=U initiative and Status Neutral Testing RFP activities, and TGNB-led organizations are also recipients of the City-funded EtE contracts to build organizational capacity and infrastructure to increase the availability of culturally appropriate services. Additional efforts to increase competency include trainings for SHC and BHIV staff to increase their knowledge and competency in working with TGNB persons. Efforts to address the needs of TGNB persons living with and at risk for HIV include a workgroup comprised of BHIV and PC staff. This workgroup addresses the HIV care needs of transgender women of color by developing recommendations to ensure that gender affirming best practices are implemented across programs in the RWHAP Part A portfolio. BHIV is also implementing a study in 2018 with TGNB individuals who engage in sex work to inform future activities to support their health and well-

being. The study will conduct individual interviews with TGNB individuals who exchange sex for money to elicit information on: the overall experience of sex work among TGNB individuals in NYC; the impact of healthcare, law enforcement and employment policies and practices on their lives and work; the impact of sex work on their health and safety and how they navigate sexual health risks; and their experience accessing healthcare and supportive services.

c) Black and Latina women in high prevalence areas. In 2017 in the NY EMA, women made up 19% of new HIV diagnoses, and 89% of these diagnoses were among Black and Latina women. These proportions indicate a continued need for targeted EIS, including HIV testing and status neutral navigation services. Further, previous analyses by DOHMH have demonstrated that HIV diagnoses and prevalence are more likely to overlap with areas of poverty, high health disparities, and poor health outcomes; these are areas where Black and Latinx heterosexual persons typically reside. The Black and Latinx communities are highly diverse, and several subpopulations within these communities, including low-income individuals, substance users, and individuals who are foreign-born, have a higher risk of contracting HIV.

Other challenges experienced by Black and Latina women include stigma associated with HIV, cultural and language differences, and low self-perceived risk for HIV. For example, many Black and Latina individuals in the NY EMA live in high prevalence neighborhoods that place them at increased risk due to their social and sexual network, even though their own behaviors would not be perceived as “high-risk,” and thus they have low self-perceived risk for HIV, which may delay or prevent them from presenting themselves for testing. People who are foreign-born, especially those who are undocumented, may also delay seeking HIV testing and care services because of stigma associated with HIV, isolation, fear of exposure, and potential deportation, in addition to differences in culture and language.

The NY EMA aims to improve testing and linkage to prevention and care among Black and Latina women, including high-risk subpopulations, through the Status Neutral Testing RFP. Funded agencies conduct outreach to individuals who live in high-poverty areas, where HIV risk is higher, and will link them to appropriate services, including HIV testing, initiation of iART if they test positive, or to prevention services, such as PrEP and PEP if they test negative. Contracts are structured to incentivize agencies to link PLWH promptly to care and to immediate initiation of ART. In addition, BHIV will continue its public health detailing campaign to promote PrEP and PEP: in October, the fifth wave of the campaign will begin and focus on women’s health care providers. Additionally, the PrEP and PEP Action Kit includes patient and provider resources to raise awareness of PrEP and PEP and support initiation and retention in care and treatment. As noted previously, in March 2018, DOHMH launched a social marketing campaign, *Living Sure*, promoting PrEP and PEP usage among cisgender and transgender women.^{lxiii} This is the latest addition to DOHMH’s series of sex-positive campaigns, *BeSure*, *PlaySure*, *StaySure*, and *Bare It All*, which seek to improve sexual health and wellness among its target populations.

c) *Specific strategies that will be utilized with the target populations.* The NY EMA’s GY19 EIIHA Plan was designed to ensure that services provided to priority populations result in a reduction of the number of undiagnosed and late-diagnosed individuals, and that those newly diagnosed promptly access HIV care and treatment. The NY EMA will continue to support its enhanced HIV testing approach through its contracts awarded in 2018 (p. 15), along with several innovative programs that are aligned with the national goals, the *EtE Blueprint*, and the *NYS HIV Prevention and Care Integrated Plan* (p. 1) to achieve these objectives. Through Medicaid-funded and other third party-funded HIV screening in clinical settings and NY EMA programs supported by RWHP Part A, CDC, and other funds, including *NY Knows*, the NY EMA promotes and supports

routine HIV screening in all healthcare settings. To maximize the use of funds and to comply with POLR requirements, with the rebid of testing services in 2018, DOHMH prioritized RWHAP Part A EIS funds to address the needs of prioritized populations to receive HIV medical care by funding CBOs to provide HIV testing and support services. CDC funds support status neutral linkage and navigation in clinical facilities to provide PrEP and PEP services to eligible patients and offer immediate initiation of ART or prompt linkage to care to patients who are newly diagnosed with HIV or were previously diagnosed with HIV and identified as out of care. Further, under the funded testing contracts, agencies providing services located in and/or to a patient population that resides in ZIP codes with high HIV prevalence and documented health disparities were prioritized. The awarded contracts run through December 31, 2020.

Funded CBOs use innovative approaches, such as behavioral risk screening for PEP and PrEP, brief intervention, status neutral navigation activities (i.e. to iART, PrEP, or PEP), social marketing and new media engagement to those unaware of their status on dating apps and hook-up sites, and other targeted testing efforts are utilized to reach at-risk populations. A recent qualitative study^{lxiv} of barriers and facilitators to HIV primary care among vulnerable populations (YMSM, African immigrants, recently released prisoners, and transgender women) in NYC highlights the essential role of CBOs in engaging vulnerable populations in care, specifically referencing their tailored and culturally competent services.

C) Local Pharmaceutical Assistance Program (LPAP). The NY EMA does not fund an LPAP.

METHODOLOGY

A) Impact of the Changing Healthcare Landscape

1) Description of Healthcare Options for PLWH. Eligible New Yorkers may enroll in Qualified Health Plans (QHPs) (*see Table 4 below*), including Medicaid and Essential Plans, through the NY State of Health website (nystateofhealth.ny.gov). Consumers with incomes between 138% and 250% of the FPL may be eligible for some premium and cost-sharing assistance. In January 2016, NYS introduced Essential Plans, which are plans available to low-income people who don't qualify for Medicaid or Child Health Plus (*see Table 5 below*). The Essential Plan is for New Yorkers with incomes up to 200% of the FPL and have very low monthly premiums (maximum of \$20 per person per month), free preventive care, and no deductibles. Enrollment in QHPs and Essential Plans continues to grow, with a 9% increase in enrollment and a distinct decrease in premium payments between 2017 and 2018.^{lxv}

Individual plans vary by in-network provider and pharmacy benefit availability. Clients are encouraged to review resources within their desired health plan to determine if their preferred providers are in-network and if current medications are covered, and at which level. *Tables 4 and 5* provide an overview of the QHPs and Essential Plans available by county in the NY EMA.

Table 4: 2018 NY State of Health Plan Availability by County – Individual Market^{lxvi}

County	Empire BlueCross-BlueShield	Fidelis Care	Healthfirst New York	Health Insurance Plan of Greater New York*	MetroPlus Health Plan	MVP Health Plan	Oscar Insurance	United Healthcare
Bronx	x	x	x	x	x		x	x
Kings	x	x	x	x	x		x	x
New York	x	x	x	x	x		x	x
Putnam	x	x		x		x		x
Queens	x	x	x	x	x		x	x
Richmond	x	x	x	x	x		x	x
Rockland	x	x		x		x	x	x
Westchester	x	x		x		x	x	x

*Also known as EmblemHealth.

Table 5: 2018 NY State of Health Essential Plan Availability by County^{lxvii}

County	Affinity Health Plan	Fidelis Care	Health Insurance Plan of Greater New York*	Healthfirst New York	HealthPlus HP**	MetroPlus Health Plan	MVP Health Plan	United Healthcare	WellCare
Bronx	x	x	x	x	x	x		x	x
Kings	x	x	x	x	x	x		x	x
New York	x	x	x	x	x	x		x	x
Putnam					x		x		
Queens	x	x	x	x	x	x		x	x
Richmond	x	x	x	x	x	x		x	
Rockland	x	x					x	x	x
Westchester	x	x	x				x	x	

*Also known as EmblemHealth

**Also known as Empire BlueCross-BlueShield

QHPs are required to contract with “Essential Community Providers,” including many RWHAP Part A provider sites who care for medically underserved populations, and ensure a level of appropriate geographic distribution. There are currently eight QHPs and nine Essential Plans available in the NY EMA. Medicaid SNPs offer additional coordination of care and include providers who are familiar with the needs of PLWH. Current networks for NYS SNPs do not include the Tri-County region. SNP eligibility includes TGNB and homeless individuals, regardless of HIV status, in order to better address the needs of these underserved populations. Enabled by the NYS Value Based Payment Innovator program, HIV providers in NYC are forming an Innovator Accountable Care Organization (IACO) for PLWH. The IACO goals align with EtE

goals, and will coordinate care in order to promote HIV prevention, improve PLWH health outcomes, and decrease costs associated with poor health outcomes related to HIV and co-morbidities.^{lxviii} The IACO has completed its pilot phase and is in the process of incorporating and obtaining NYS approval to launch.

In the lead-up to the effective dates for provisions of the ACA and Medicaid Redesign efforts, DOHMH underwent extensive work to assess which provisions might affect consumers and providers in the NY EMA and how to help them adapt to the changes. The Care and Treatment Program (CTP) continues to allocate resources to support a Policy Advisor to monitor the healthcare landscape to ensure PLWH have continued access to quality care, and to assess impacts of changes in Medicaid, Medicare, and the NY State of Health, the healthcare exchange of QHPs and Essential Plans operated by NYS. This is to ensure that RWHAP Part A-funded services can fill gaps in the service system and adhere to POLR. The Policy Advisor develops consistent communications related to health systems changes, including notices to providers, presentations, and updates to recipient staff. In light of requirements that RWHAP Part A is POLR and that Part A providers ensure clients are appropriately enrolled in coverage, written communication, contractual language, and data reporting requirements were updated to clarify Part A client assessment and reassessment expectations. This helps to ensure that clients have adequate support to access health insurance, should they be eligible.

a) Effect on access to healthcare services and health outcomes. Both consumers and providers find it difficult to navigate pharmacy benefits. NYSDOH AI provides resources such as webinars and trainings to better navigate drug formularies, but providers and consumers continue to voice concerns regarding increases to out of pocket costs for patients.

In NYS a majority of QHPs were moderately accessible, meaning those covering seven to nine of the ten ART regimens, or those costing up to \$200/month/regimen. Essential Plans, which cover 2.9 times more New Yorkers than QHPs, help increase access to New Yorkers with the lowest incomes, since these plans include inpatient and outpatient care, physician services, diagnostic services, and prescription drugs with no annual deductible and low out of pocket costs. Essential Plan enrollees with incomes up to 150% of the FPL will have no monthly premium and have an annual out of pocket payment limit of \$200. Those with incomes up to 200% of the FPL will have a monthly premium of \$20 and an annual out of pocket payment limit of \$2,000. To help cover out of pocket costs, the NYS HUCP copay assistance is available for those with an income up to 435% of the FPL. The NY EMA has seen steady increases in ART usage (from 78% of all diagnosed in 2014 to 86% in 2016),^{lxxix} and as a result, increased viral suppression (from 67% in 2014 to 70% in 2016).^{lxxx} While it is difficult to attribute improved healthcare outcomes to a single policy or funding change, especially in the context of EtE efforts in the jurisdiction, enrollment in QHP coverage has been significantly associated with achieving viral suppression in at least two studies.^{lxxxi,lxxii} This is consistent with research findings regarding prescription drug coverage and health outcomes: low-income adults are less likely to take medicines as prescribed due to cost,^{lxxiii} conversely, adults with chronic medical conditions are more adherent when they have prescription drug coverage.^{lxxiv, lxxv}

2) Effects of the changing healthcare landscape on service provision and RWHAP Part A allocations.

a) Service provision and complexity of providing care to PLWH. The PC began work to address changes in the healthcare system beginning in 2011, with the development of its first Core Medical Services (CMS) Waiver application and directives for n-MCM and supportive counseling and family stabilization (SCF) service categories. As such, additional shifts were made in funding

allocations to Housing, FNS, SCF, and the newly created category of Emergency Financial Assistance (EFA) to increase services that support engagement in medical services that are funded through other payers. Increasing resources for these services also helped address inequities in access to medical care due to the burdens of poverty, homelessness, and food insecurity. Provisions of the ACA led to increased insurance access for RWHAP Part A clients through: (1) Medicaid expansion and (2) the availability of health insurance plans for purchase on the NY State of Health. Although there was greater access to insurance coverage due to Medicaid expansion, increases were relatively modest because NYS Medicaid previously covered single adults with income up to 100% of the FPL. The number of people enrolled in the NYS HUCP has remained stable in recent years as NYS achieved rapid Medicaid enrollment in the early years of the ACA through web-based expanded Medicaid access and, thus, had shorter gaps in Medicaid coverage. As stated on *pp. 10-11*, the Recipient, PC, and the NYS HUCP have worked together to ensure continued access to medications for PLWH through ADAP while ensuring continued resources are available for the medical and support services to clinics, hospitals, and CBOs. In GY18 these three parties negotiated an agreement that will help to mitigate the continued expected reductions in NY EMA RWHAP Part A formula funding through a reduction in the allocation to the NYS HUCP. From GY17 to GY18, funding for ADAP was reduced by 37.6%, which allowed the NY EMA to maintain programs and enhance FNS, SCF, and Housing services while continuing access to essential medications for PLWH.

b) Changes in RWHAP Part A allocations. The NYS HUCP continues to be a resource for those who are unable to access public or private insurance and those who need financial assistance with health insurance premiums and copays. The NY EMA continues to contribute to the ADAP prescription access program, paying directly for medications. The PC and Recipient also coordinate with the NYS HUCP to assess whether RWHAP Part A funding is needed for other services, including health insurance premium assistance and cost-sharing assistance. Through the CMS Waiver, the NY EMA has continued to allocate funding to further support social services, such as food and housing, to meet clients' basic needs. Redirecting funding from the provision of CMS to supportive services enhances the Recipient's efforts to maintain, engage, and retain clients in care who receive medical services and medications covered by other payers (Medicaid, NY State of Health Plans). Barriers to accessing basic necessities can have adverse health effects and offset progress from maintained adherence to ART. Investing in non-core services aligns with the NY EMA's goal to support clients in achieving viral suppression, improving their quality and length of life, and drastically reducing transmission.

B. Planning Responsibilities.

1) Planning and Resource Allocation.

a) Description of the community input process. Consistent with legislative requirements, the NY EMA in GY18 used a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate resources for GY19. The PC and its committees continued a multi-year process to reassess and rebid the RWHAP Part A portfolio, with the aim of ensuring that the NY EMA's service system addresses current needs and service delivery challenges. All PC sub-committees include a diverse range of consumers, providers, and other stakeholders and provide extensive opportunity for public comment, as described throughout this section.

The PC works closely with the Recipient and other DOHMH staff throughout the planning process, including having a dedicated staff liaison from the BHIV HIV Surveillance Unit assigned to the PC to provide up to date epidemiological data for planning purposes. This year, the PC accomplished the following:

- Utilized a data-driven planning tool to develop service priorities and determine funding allocations based on up to date information on PLWH needs, service utilization and gaps including the NY EMA’s Needs Assessment, the NYS *Integrated HIV Prevention and Care Plan*, Service Category fact sheets and RWHAP Part A Scorecards with multiple years’ historical utilization data, and data analyses from the NY EMA’s CHAIN study;
- Allocated 59.5% of RWHAP Part A and MAI funding to CMS for GY19;
- Continued funding for MCM, including the TCC and the newly rebid CCP Programs, to optimize medical outcomes;
- Allocated 3.1% of the GY19 portfolio for testing services to reduce the number of individuals who are unaware of their HIV status, and planned these resources in conjunction with the NYC HIV Prevention Program taking into account other testing resources;
- Allocated substantial resources to promote access to and maintenance in care for newly diagnosed individuals and to re-engage people who had fallen out of care;
- Took further steps to reduce unmet need and address the needs of emerging populations by revising the program service directive for FNS services in NYC, a decision based on data demonstrating the correlation between FNS and entry/retention in care and viral suppression,^{lxvii} and
- Approved across the board increases to all service categories in order to address funding reductions from previous years and address ongoing needs of PLWH.

A breakdown of the PC’s committees and corresponding activities are provided below: *Needs Assessment Committee (NAC)*. The NAC built on its previously developed comprehensive formal needs assessment for HIV services in the NY EMA. That assessment, produced with the assistance of the Recipient, reviewed a range of reports and presentations by DOHMH surveillance analysts, the CHAIN researchers, and the CTP Research and Evaluation Unit (REU) staff. Findings included: the latest estimate of PLWH unaware of their status, estimated numbers of PLWH not in care, accessibility and quality of services, service barriers, geographic patterns in HIV burden and distribution of resources, the impact of co-morbid conditions on HIV care, service utilization trends, unmet need, and provider capacity and capability, with special attention given to the HIV care continuum in order to identify populations that fall out of the continuum at each stage of care and treatment. In GY18, the NAC identified TGNB PLWH as a key population for further focus in the RWHAP Part A priority setting and resource allocation process. Recommendations included: increasing the capacity of the PC to address the needs of TGNB individuals seeking RWHAP Part A services; increasing the capacity of Part A-funded organizations to provide appropriate and relevant services to TGNB PLWH; evaluating current capacity of the Part A portfolio to improve health outcomes among TGNB clients; developing best practices and interventions that address stigma and discrimination against TGNB PLWH in Part A services; and addressing barriers to care unique to the TGNB persons’ experience.

Integration of Care Committee (IOC). The IOC guides the PC in defining individual service categories, reaffirming continuing models of care, and creating new evidence-based service directives. In GY18, the IOC developed a new service directive for the FNS service category. The FNS service category directive was developed by the IOC as a result of a collaborative decision-making process involving consumers, providers, and PC and Recipient staff who sought to address gaps in care that have persisted in the changing healthcare landscape. The NYS *Integrated HIV Prevention and Care Plan*’s goals and objectives (decreased delays in diagnosis, increased early linkage to HIV primary care, continued high engagement in primary care, increased treatment adherence, increased viral suppression, improved immunological health, decreased reliance on acute care, and diminished

sociodemographic disparities) are used for developing all RWHAP Part A service models in the NY EMA, and were key guideposts in the development of the FNS directive, as well as the previous year's CCP directive.

The new FNS directive allows the service to best meet evolving client needs. Requirements for the FNS directive were strengthened for nutritional assessments, and counseling and education delivered by a registered dietician. Also, guidelines were added concerning culturally sensitive and medically tailored meals designed to meet the specific medical conditions, medications, side effects and other needs of clients. Language from the IOC's previously developed master service directive (applicable to all service categories in the NY EMA) was expanded to emphasize client-centered care (where patients are included in decision making whenever possible) and support for the use of peers in service delivery. This builds on the elements of the master directive developed in the previous year to provide trauma-informed care (e.g. for survivors of domestic and sexual violence) and address the needs of people with sensory and mobility impairments. In addition, all clients will be assessed in regards to linkage and retention in medical care and viral load monitoring, which is routinely entered into eSHARE as a part of Primary Care Status Measures (*see CQM section, pp. 42-45 for additional details*).

Priority Setting and Resource Allocation (PSRA) Committee. Using data assembled by the NAC, service model definitions, and eligibility criteria established by the IOC, the PSRA Committee uses an objective, evidence-based tool to determine service priority rankings and financial allocations, forwarding its recommendations to the full PC for consideration. The tool requires the committee to use data to score service categories on a prioritization grid, with four criteria (individually weighted) for assigning scores to each service category, as described below.

1) *Payer of Last Resort (POLR)/ Alternate Providers of Services* (weight=15%). The PSRA Committee assessed each service to determine if RWHAP Part A is the primary funding source and whether other sources provide identical or equivalent services to PLWH in the NY EMA. Highest value was assigned to services funded only by RWHAP Part A, and where existing provider capacity was found to be inadequate to serve PLWH. In planning for GY19, the PSRA Committee examined service category fact sheets produced by the Recipient that examined each service category in depth. The fact sheets included POLR data and system-level considerations that examined other payers of Part A services in the NY EMA. The addition of continued funding in NYS for HIV CMS through Medicaid expansion, health insurance exchanges, other RWHAP parts, and the implementation of NYS Medicaid Health Homes was a critical factor in the PC's approval of the GY19 request for a waiver to the CMS requirement.

2) *Access to Care/Maintenance in Care* (weight=35%). The PSRA Committee assesses each service to determine the degree to which it contributes to access to or continuity of HIV primary care, including identifying people who do not know their HIV status. The highest value is assigned to services that have, as their primary goal, either direct provision of primary medical care or promotion of access to and maintenance in care through direct referral and linkage to medical services. Housing and FNS were deemed high priority services due to the importance of their role in addressing gaps in retention in care and SVL.

3) *Specific Gaps/Emerging Needs (Demographic/Special Population)* (weight=25%). The PSRA Committee assesses each service to determine the degree to which it reduces documented service gaps or meets the needs of special populations. The PSRA Committee reviewed data from the CHAIN study documenting the unmet need for key services in the study's representative cohort. The highest value was assigned to services that promote healthcare access and re-engagement for out of care or

underserved populations, including those who fail to engage in later stages of the HIV care continuum.

4) *Consumer Priority* (weight=25%). The PSRA Committee scored services based on consumer input, as provided by the PC Consumer Committee and the CHAIN cohort study. The highest value was assigned to services identified by PLWH as (1) significantly contributing to access to or maintenance in primary medical care, and (2) representing a key consumer priority.

The service category fact sheets also provided data on historical performance and service utilization by service type, which are used in the PSRA Committee's scoring of each criterion for every service category in the RWHAP Part A portfolio, as well as in allocation decisions, resulting in ranked priorities based on the criteria described above.

Tri-County Steering Committee. A local Steering Committee functioning as a sub-committee of the PC conducts service planning and makes resource allocation recommendations to the PC for Rockland, Putnam, and Westchester county services. Tri-County's 33-member Steering Committee includes 12 PLWH. All committee members received an orientation on the RWHAP legislation and the community-planning process. The committee utilizes the same PSRA tool that is described above to rank service priorities for the region. The Steering Committee reports to the Executive Committee (EC) and the full PC to obtain final approval of its spending plan. For GY19, the Steering Committee, using information from fact sheets specific to Tri-County services, recommended reducing the allocation for case management services due to the large amount of other payers for this service. Case Management funds were reallocated to increase resources for FNS and a newly developed EFA category in the Tri-County region.

i. Involvement of PLWH. The active, informed engagement of PLWH is essential to the planning process and helps ensure that PC decisions address the needs of consumers. In 2018, PLWH constituted 43% of the PC's 46 members. At the beginning of the planning cycle, after a concerted outreach and recruitment effort by PC staff, one-third of members were PLWH who are not aligned with a RWHAP Part A agency. The overwhelming majority (83%) of the PC's non-aligned PLWH are people of color. PLWH actively serve on all PC committees and make up 36% of the Tri-County Steering Committee. The governmental co-chair is a hearing-impaired PLWH, and the community co-chair and finance officer are both non-aligned PLWH. PLWH from outside the PC and its committees were closely involved in feedback on service quality, needs, and priorities through RWHAP Part A Client Experience Surveys and the ongoing CHAIN study.

The PC's Consumers Committee provides a forum for PLWH (PC and committee members, as well as other stakeholder community members) to be actively engaged in the planning process. HIV-positive PC members and HIV-positive PC staff assist community members in understanding the priority setting and resource allocation process, HIV epidemiology, the HIV care continuum, principles of community planning, group dynamics and decision-making, Quality Improvement/Quality Management (QI/QM), and the changing healthcare landscape and its effects on RWHAP services, including immigrant populations. The committee plays a key role in recruiting new members with a completely re-designed consumer outreach brochure which was distributed at all PC outreach events. The committee advocates for consumer engagement in the planning process, and supports training and mentoring new PC members (trainings to maximize informed participation and decision-making is available during the planning cycle).

To develop the GY19 Plan, the PC sought the Consumers Committee's input regarding special populations and geographic areas of the NY EMA that remain disproportionately affected by HIV. Members of the Consumers Committee serve on all committees of the PC, and were particularly active in providing input and feedback at the IOC, NAC, PSRA, and the Rules & Membership

Committees, as well as on the Consumer Advisory Committee of the NYSDOH HIV Quality of Care Committee, the NYS EtE borough and regional-based task forces, and the NY EMA Quality Management Committee, ensuring that consumer input and guidance is incorporated across the service system. In addition, committee members conducted a workshop at the NY EMA's 2017 Power of Quality Improvement Conference, where RWHAP Part A providers heard client perspectives on facilitators and barriers to engagement and retention in care as well as patient/provider relationships and communication.

ii. Addressing funding increases or decreases. The PC's data-driven planning tool allows for more objective, advance planning for funding increases or decreases. The tool includes built-in weighted formulas based on the prioritized ranking of the services that automatically calculate funding increases or decreases for each service category contingent upon the actual award. The PSRA Committee and PC also review data from the Recipient on service category spending in order to consider targeted reductions in the case of a funding decrease. For GY18, there was a decrease of \$3.01 million in the NY EMA's total grant award. The NY EMA was able to absorb the cut through a reduction in the ADAP allocation. The PC worked closely with NYSDOH to agree on a reduction to the NY EMA's allocation to RWHAP Part A ADAP, based on an assessment of NYS and RWHAP Part B resources and projections of ADAP enrollment (which has been decreasing due to expanded Medicaid and state insurance exchange enrolment under the ACA). The ADAP reduction allowed the PC to maintain services at their current levels, as well as increase resources to service categories with demonstrated unmet need. If the RWHAP Part A award is further reduced in GY19, the PC will adjust allocations based on expected need. However, the PC requests additional funding to cover the increased cost of service provision and to address unmet needs. Given the ongoing reductions in the NY EMA's award since GY11, critical service levels will most certainly be negatively impacted if further reductions in the RWHAP Part A award occur in GY19.

iii. MAI funding. Planning, including prioritization and allocation for MAI funding is integrated into service planning for RWHAP Part A funds and are aligned with the NYS *HIV Prevention and Care Integrated Plan* goal to reduce health disparities. MAI funds are concentrated in three CMS categories (ADAP, MCM, and EIS) and one support service category (Housing), all of which target the most heavily-affected, high-need communities, specifically communities comprised of Black and Latinx PLWH. Data showed continued gaps in these services for these populations, justifying the need for continued targeted programs. In particular, the PC sought to ensure that MAI funds were distributed to impact priority populations at multiple stages across the HIV care continuum.

iv. Use of data in the priority setting and allocation process. The PC and committees considered all available and relevant data to assess need, develop service models, prioritize services, and allocate resources for GY19, consistent with the goals in the NYS *HIV Integrated Prevention and Care Plan*. The PC utilized multiple data sources, including surveillance reports, the NY EMA RWHAP Part A service category fact sheets, Scorecards, CHAIN data, NYS HUCP data, HOPWA, and RWHAP Part A program data from eSHARE.

In an effort to increase access to CMS and reduce disparities in access to HIV care, the PC examined evidence of service gaps from the CHAIN study and HIV/AIDS surveillance, which supported the PC's allocation of \$25.3 million for MCM in GY19. CHAIN cohort members were defined as needing MCM services if they reported interrupted HIV medical care, missed HIV medical care appointments, or had no CD4 or viral load tests in the last six months. In interviews conducted between 2015 and 2017, 39% of CHAIN participants in NYC met the criteria for need of MCM services. Of those, only 12% reported adequate utilization of the service, defined as receiving

referrals to medical services through a case manager during the past six months. Evidence also shows sizable service utilization gaps for n-MCM services. These gaps justify the NY EMA's allocation of \$1.6 million in n-MCM funding to link people to medical and support services to remove barriers to optimal HIV primary care and to assist enrollment of PLWH eligible for the NY State of Health insurance exchange and expanded Medicaid in GY19. An additional \$4.4 million allocation to n-MCM for currently or recently incarcerated PLWH ensures linkage to care upon release for this marginalized population.

The overwhelming majority of the MCM program is the CCP service model. CCP is a core component of promoting retention in medical care and medication adherence through clinical eligibility criteria and intensive services such as client centered care planning, navigation, accompaniment, health promotion, and modified directly observed therapy (mDOT). In revising the CCP service directive last year for a re-bid of this service category for contracts starting in GY19, the IOC examined DOHMH-reported MCM outcomes data from the Costs, HIV Outcomes, and Real-world Determinants of Success (CHORDS) Study. Significant increases in engagement in care (EiC) and SVL occurred in all subgroups examined, including those with key barriers to HIV care and treatment adherence. Findings showed a link between reducing psychosocial barriers and greater improvement on 12-month EiC/SVL outcomes.^{lxxvii} In comparisons of CCP clients' 12-month SVL to the SVL achieved among similar PLWH, CCP-enrollees demonstrated higher rates of SVL overall, with significant benefits over usual care for individuals who were newly diagnosed or who had no evidence of SVL in the year prior to enrollment.^{lxxviii} Evidence of CCP effectiveness over usual care suggests the public health value of intervention scale-up, focusing on PLWH with the greatest need. Continued funding was allocated to CCP on the basis of the CHORDS data indicating statistically significant SVL benefits, over and above those of usual care, for high-need PLWH in that program.

Through Scorecards, the PC reviewed data highlighting the needs of historically underserved populations, including racial and ethnic minorities. Needs of PLWH of color were assessed through an analysis of epidemiologic trends, utilization patterns by race/ethnicity, disproportionate service needs documented in the CHAIN cohort study, and comparison of geographic distribution of HIV/AIDS cases through mapping RWHAP Part A services. Through the aforementioned Scorecards, the PC reviews service utilization data specifically by gender and age as well as by several special populations, including women of color, YMSM of color, PLWH aged 50 years or older, immigrants, substance users, and TGNB individuals. The Scorecards have shown that women make up a far larger percentage of RWHAP Part A clients in the NY EMA (42%) than their proportion of the local epidemic (27%). Youth aged 19 years and under are similarly over-represented as a proportion of Part A clients (3%) compared with their proportion of the local epidemic (0.5%).

The PC uses these data to prioritize specific service categories that promote access to care for women, such as SCF services, where a disproportionate share of the clients are female, and which provides family-focused services that aim to remove barriers to care. The PC also promotes the meaningful participation of women living with HIV on the PC and its committees, where they bring an invaluable perspective on the barriers to care for women. The NY EMA ensures adequate and continued support of CMS for women, infants, children, and youth (WICY) through ongoing collaboration with the NYS Medicaid program. In FY17, Medicaid expended more than \$622,859,403 to fund CMS for WICY populations far exceeding the NY EMA's required set-aside of \$26,006,753. In addition, the NY EMA is home to nine RWHAP Part D grantees, many of them multi-site consortiums, which specialize in serving WICY populations and sub-populations such as

LGBT teens, pregnant and perinatal women, women of color, perinatally infected youth, and YMSM.

The PC reviewed evidence on disparities in timely EiC for newly diagnosed people. The PC allocated \$4.5 million to EIS in GY19 (including \$1.8 million in MAI funding) for targeted outreach and testing, and for return to care services targeting individuals found to be out of care for at least six months. The PC also allocated \$932,570 under Health Education/Risk Reduction (HE/RR) to support HIV self-management education programs for people who have newly diagnosed HIV infections and those with barriers to maintaining care. The PC also reviews NYS HUCP demographic reports. These reports provided evidence that many MSM of color depend on the NYS HUCP for healthcare access, which influenced the PC's decision to continue to prioritize support for ADAP.

Data on unmet need and utilization of MH services among PLWH in NYC, along with barriers that PLWH with MH issues face with respect to accessing care, led the PC to continue supporting a MH service model that seeks to increase engagement in MH services, provides treatment and care to PLWH with MH issues, including those with co-occurring substance use disorders, to improve quality of life and MH functioning; to facilitate ongoing involvement in bio-psychosocial care and treatment, including adherence to ART and/or psychotropic medications; and to reduce use of emergency care. The PC directed a total of \$4.5 million to MH services for GY19.

The PC reviews unit costs for each RWHAP Part A service category, considering the original funding allocations and modifications for each service category over a three-year period along with client utilization, expenditures, and service units. For example, when considering increasing the allocation for FNS in GY 2018, the PC examined unit costs and determined that an additional \$1.8M would allow for a 30% increase in the rates that providers are paid per service, allowing them to improve food quality, consistent with a need long-identified by providers and clients of FNS programs.

The PC also developed an annual plan for anticipated unspent funds, reallocating funds based on need and service costs, and prioritizing reallocated funding to ADAP as these funds become available to the NY EMA RWHAP Part A portfolio.

v. Changes in the prioritization and allocation process. In developing its GY19 Plan, the PC and its committees used the same well-established priority setting tools and process as in the previous year. Updated data was incorporated to reflect a greater understanding of the local epidemic, the needs of PLWH, gaps in services, and disparities in access to HIV care, and the ongoing effects of the changing healthcare landscape. The NYS *Integrated HIV Prevention and Care Plan* was a cornerstone for developing the goals and objectives of RWHAP Part A services. For example, the goals and objectives of the revised FNS service directive were specifically mapped to the goals and objectives of the NYS *Integrated HIV Prevention and Care Plan*, including: promoting access and maintenance in HIV-specific medical care, increasing the proportion of clients with an undetectable viral load and improved immunological health, reducing HIV-related morbidity and mortality, and reducing socio-demographic disparities in those areas.

2) Administrative Assessment. Consistent with legislative mandates, the PC assesses the efficiency of the administrative mechanism in timely allocation of RWHAP Part A funds to areas of greatest need in the NY EMA.

a) Assessment of Recipient's activities. The PC's EC is charged with assessing the efficiency of the administrative mechanism in the timely allocation and contracting of RWHAP Part A funds according to the PC's priorities and allocations. Recipient staff presented quarterly commitment and expenditure reports for all Base- and MAI-funded service categories in NYC and the Tri-

County region to the EC as requested, and answered any inquiries about increases or lags in spending by service category as well as in the Administration and QM lines. The EC also assessed all legislatively required aspects of the administrative mechanisms, including contract executions and renewals, procurement, and timeliness of sub-contractor payments and spending. The EC reported its findings to the full PC in July 2018.

b) Deficiencies. The EC determined that there were no deficiencies in the administrative mechanism, and no corrective action was needed for GY17.

3) Letter of Assurance from Planning Council Chair(s) (see Attachment 6).

4) Resource Inventory.

a) Coordination of services and funding streams. The flexibility of RWHAP Part A funding has enabled the NY EMA to develop a range of innovative programs and service delivery strategies that respond to the specific access barriers faced by the NY EMA's PLWH most in need of services.

i) HIV resources inventory (see Attachment 5).

ii) Needed resources, and steps taken to secure them. To further develop the infrastructure necessary to address HIV/HCV co-infection, the NY EMA applied for and was awarded a SPNS grant from HRSA to address HIV/HCV co-infection among people of color. The grant is \$650,000 a year for three years and it increasing training and practice transformation capacity that will be sustainable after the project is completed in GY19.

Additional resources needed to fulfill the goals of the *EtE Blueprint* have been secured through DOHMH funding, allowing for contracts to increase the availability of PrEP/PEP, support viral suppression, provide clinical services, pharmacotherapy, and HR support for MSM and transgender women using methamphetamines, and increase the capacity of TGNB-led and Black MSM-led CBOs. In GY17, the Recipient worked with the NYS HUCP to support immediate initiation of ART upon diagnosis through coordination with RWHAP Part A EIS and MCM-funded providers. The NYS HUCP provides iART and related medical and laboratory services through its Rapid Tx program while RWHAP Part A EIS and CCP resources will serve to provide support services to newly diagnosed clients in need of iART through work to coordinate benefits and insurance, assess urgent needs, and provide support and accompaniment through patient navigation to support linkage to and retention in care.

Addressing income as a social determinant of health is an important endeavor to meet the needs of PLHW in the EMA given that 85.6% of RWHAP Part A clients earning less than 138% of the FPL. While RWHAP Part A resources are not able to support efforts to re-engage PLWH in the workforce, DOHMH has utilized other resources to address this need. In 2017, DOHMH was successfully awarded funding for three years from the CDC to launch a demonstration project focused on improving HIV prevention and care outcomes among MSM of color in Brooklyn. For the purposes of this funding, behavioral health services include job training or employment services. BHIV, in collaboration with the Mayor's Office of Workforce Development, has created an internal working group consisting of staff across units, known internally as "Considering Work Efforts Workgroup." A key goal of this group is to inform staff on how to enhance the integration of employment services within HIV prevention, care, and treatment programs to ultimately advance the overall health outcomes of HIV-positive consumers throughout the NY EMA. A key deliverable of this initiative will be the "Career Power Source" event which will take place on October 3rd, 2018. This all-day event will bring together consumers, providers, and subject matter experts in an effort to increase access to jobs, employment services, training and educational resources for the target populations mentioned above.

To address an important aspect of morbidity and mortality for PLWH, the EMA has also prioritized tobacco dependence support in our behavioral health programs, with a focus on increasing access to nicotine replacement therapy (NRT), which in the last few years has become more readily available through Medicaid. A specialized NRT benefits navigation training grounded in HR and motivational interviewing principles is being developed for implementation prior to GY19.

The NY EMA also used EtE funds to support methamphetamine-specific HR programs to address the harmful effects of methamphetamine use, alongside RWHAP Part A funded HR services to address the needs of both HIV-positive and HIV-negative methamphetamine users. Yet another EtE funded program utilizes elements of CCP to provide status neutral navigation and assessment to PEP, PrEP, MH, housing, and substance use services to those at risk for HIV.

WORKPLAN

A) HIV Care Continuum Table and Narrative.

1) HIV Care Continuum Table (see Attachment 7).

2) HIV Care Continuum Narrative.

a) Utilizing the HIV Care Continuum in resource planning. The NY EMA uses the HIV care continuum stages to prioritize populations for service system planning, instead of traditional priority populations based on demographics. Because of this, the NY EMA takes a strategic systems-level approach to planning for services for those with unmet need. For 2016, the NY EMA was able to produce a combined continuum for NYC and the Tri-County region, for all PLWH (*see Figure 2*). Information on all PLWH was obtained using the NYS Surveillance Registry. Recent work has been done both in NYC and NYS to better account for unreported deaths and out-migration in the PLWH denominator.^{lxix} Using NYS's methodology, individuals who have diagnosed AIDS infections with no evidence of care for five years and individuals with diagnosed HIV infections (non-AIDS) with no evidence of care for eight years are excluded from the total number of diagnosed PLWH. This approach yields a more accurate estimate of the number of PLWH who are still living and residing in the NY EMA, and allows for better estimation of progress along the HIV care continuum. DOHMH's Medical Monitoring Project in NYC provides an estimate of ART prescription status for all PLWH.

b) Changes in the HIV Care Continuum. From 2014-2016, the proportion of clients engaged along the different stages of the NY EMA HIV care continuum has remained relatively stable, with increases in linkage to care, ART prescription, and SVL, and a slight decrease in retention in care. The NY EMA is invested in evaluating the strategies and interventions necessary to address unmet need and move PLWH along the HIV care continuum to viral suppression. As such, the NY EMA has been an engaged participant in the HRSA-funded Care Continuum Learning Collaborative (CCLC), where the NY EMA Recipient staff share their HIV care continuum-related project plans with peers (Baltimore, Detroit, Tampa/St. Petersburg, Houston/Harris County, and Phoenix/Maricopa County) in their assigned workgroups. In Year 3 of the CCLC, the NY EMA focused on developing a surveillance-based client-level viral suppression progress report, which was disseminated to CCP in July and August 2018, as part of a new D2C initiative. Also, the NY EMA created a protocol to implement a value-based payment model across CCP, with the aim of incentivizing QI among subrecipients.

The NY EMA has been at the forefront of evaluating interventions across the portfolio of services. This includes utilizing resources from the National Institutes of Health, HRSA, and CDC, among others, to work with academic and other partner institutions to conduct in-depth research

and evaluation of outcomes within and across subpopulations of interest. One such example has been the work of the CHORDS study to evaluate the CCP model of MCM. This multi-year, multi-phase project has evaluated care engagement and viral suppression outcomes among CCP clients overall and according to baseline viral load, housing, MH, and substance use status. The initial work of the CHORDS study has resulted in CCP being listed as an evidence-informed intervention on the CDC Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention under the Linkage to, Retention in, and Re-engagement in HIV Care chapter. In addition, this study has highlighted the impact of resolution of psychosocial needs on HIV outcomes; CCP clients reporting cessation of hard drug use post-enrollment showed significantly greater improvement in engagement in care from the period prior to enrollment than those with continuing hard drug use, and clients obtaining stable housing post-baseline showed significantly greater improvement in SVL than those remaining in unstable housing.^{lxxx} In addition, the REU of CTP has also received new NIH R01 funding for an implementation science study, Program Refinements to Optimize Model Impact & Scalability based on Evidence (PROMISE), which will evaluate the changes in the CCP model resulting from the new service directive that resulted in an RFP and new CCP contracts.

Other work has demonstrated the need in the NY EMA for supportive services that reduce barriers to viral suppression. As noted above, previous work by DOHMH among HIV-positive MSM enrolled in RWHAP Part A programs in the NY EMA found crystal meth use to be associated with unsuppressed viral load.^{lxxxi} In a separate analysis, controlling for sociodemographic and clinical characteristics, recent tobacco smoking was also found to be associated with unsuppressed viral load.^{lxxxii} In an analysis of the NYC RWHAP Part A FNS program, among clients analyzed between 2011 and 2013, controlling for sociodemographic characteristics, consistent food insufficiency was found to be associated with unsuppressed viral load.^{lxxxiii} The CHAIN study has also demonstrated a relationship between unmet needs and poorer health outcomes, including analyses of the relationship between housing need and retention in HIV medical care,^{lxxxiv} and has shown that services to address these unmet needs reduce the likelihood for poor outcomes. For example, in a longitudinal analysis comparing individuals who were food insecure at one interview and receiving FNS and were then not food insecure by the next interview with individuals who continued to be food insecure, those with resolved food insecurity were less likely to have missed appointments, to have a detectable viral load, and to have had an emergency room visit or an inpatient stay compared to those who remained food insecure.^{lxxxv} To address the needs of food insecure PLWH the new FNS directive, which is more client centered and emphasizes the role of healthy eating and food access on HIV health, was recently approved by the PC along with an increased service allocation to support PLWH who are food insecure to move through the HIV care continuum.

B) Funding for Core and Support Services.

1) Service Category Plan.

a) Service Category Plan Table (see Attachment 8).

b) MAI Service Category Plan Narrative.

MAI Initiatives. As previously described, low-income communities of color are disproportionately affected by HIV in the NY EMA. The NY EMA strategically uses MAI funding to reduce health disparities, increase service access, and improve health outcomes for underserved PLWH, including Black, Latinx, and Asian/Pacific Islander men and women. In GY17, 93% of HIV-positive clients served by the MAI program were persons of color: 53% were Black, 37% Latinx, and approximately 1% Asian/Pacific Islander. The NY EMA strives to use its resources to address HIV health disparities associated with race/ethnicity, particularly among Black and Latinx populations who

account for 86% of all HIV-positive people served by RWHAP Part A, while they constitute only 76% of all PLWH in the NY EMA.

Among RWHAP Part A clients served in NYC in 2016, the racial/ethnic disparity in viral suppression rates persists; 73% of Black RWHAP Part A clients were virally suppressed in 2016, compared to 77% of Latinx persons, 82% of Whites, and 90% of Asian/Pacific Islanders. This disparity was in spite of similar rates of retention and ART use across racial/ethnic groups. Among transgender women, viral suppression rates were lower for transgender Black and White women (60% and 71%, respectively), than for transgender Latina women (81%). Similarly, viral suppression rates were low among those aged 20-29, regardless of race or ethnicity, but rates within this age group were lower among Black and Latinx PLWH (64% and 68%, respectively) than among Whites (76%).

Approaches for MAI populations. Due to the large proportion of racial/ethnic populations at risk for lower rates of SVL served by the entire RWHAP Part A program, the PC and the Recipient work to develop strategies and interventions throughout the portfolio, which will support positive health outcomes for people of color living with HIV. Thus, there are not separate planning processes for racial/ethnic minority populations or for MAI funding. The PC moved away from planning based on traditional demographic target populations in 2014, and instead focuses on those who are not achieving the goals of each stage of the HIV care continuum. By doing this, the PC focuses on barriers that contribute to disparities at each stage of the continuum.

MAI activity descriptions. The GY18 MAI funds have been allocated to program services in four service categories: ADAP, EIS, MCM, and Housing Services. These four service categories were selected by the PC to receive MAI dollars because of their combined ability to make an impact along each stage of the HIV care continuum among priority populations by focusing on social determinants of health such as lack of access to regular medical care and unstable housing. The MAI program service models do not vary from the same service categories in the RWHAP Part A program portfolio; rather, the MAI program prioritizes services to communities where disproportionately burdened minority populations live. All contracted RWHAP Part A services in the NY EMA, including MAI, are required to adhere to CLAS Standards. The NY EMA applies the eligibility criteria below to ensure that MAI funds are directed to high-need communities. Other than ADAP, each MAI-funded agency/program must:

- Direct its services to residents of ZIP code areas with 150 or more reported living HIV/AIDS cases among the MAI prioritized populations;
- Have the majority of its program and administrative sites located in ZIP codes with 150 or more reported living HIV/AIDS cases among the MAI prioritized populations; and
- Demonstrate that at least 75% of its current active clients who receive HIV/AIDS services are from the MAI prioritized populations.

ADAP instead exclusively serves Black, Latinx, and Asian/Pacific Islander clients from the NY EMA who are eligible for ADAP with MAI funds.

c. Core Medical Services waiver. A CMS waiver will be submitted prior to this grant application (see Attachment 9).

RESOLUTION OF CHALLENGES

The NY EMA continues to strive to deliver the best possible services aimed at increasing the health of PLWH in its concerted effort to end the epidemic while adhering to the RWHAP legislation and accompanying policies. In GY18, the Recipient has worked to resolve a number of challenges through collaboration with the PC, consumers, funded providers, Public Health Solutions

(PHS)/Contracting and Management Services (CAMS), and NYSDOH AI colleagues. *Table 6* below highlights the most salient resolved challenges.

Table 6. Resolution of Challenges

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
<p>Increased Ability to Diagnose and Link to Care Five percent of HIV-positive individuals are unaware of their status. In order to reach these populations, the NY EMA has established a jurisdictional EIIHA plan to ensure testing is available across clinical, hospital and CBO settings for routine and targeted testing and linkage services, including support for initiation of iART.</p>	<p>The Recipient has worked with all planning bodies in the jurisdiction to:</p> <ul style="list-style-type: none"> • Support routine and targeted testing and linkage contracts with payment for timely linkage and MOU with a medical provider who can provide timely access to initial medical appointments • Implement the revised program model for the Care Coordination/MCM Service Category, which includes: <ul style="list-style-type: none"> ○ The provision of iART ○ A new D2C strategy to identify individuals lost to care and individuals who are not virally suppressed to improve coordination of and linkage to care ○ mDOT, which includes video-based DOT to increase availability of the service <p>The above mentioned, in tandem with the newly renovated Chelsea SHC, will aid in increasing the diagnosis, linkage, retention, and SVL of PLWH.</p>	<p>Increase ability to:</p> <ul style="list-style-type: none"> • Prevent HIV through navigation and coordination of care and treatment services • Identify virally unsuppressed individuals through implementation of a D2C strategy; • Increase linkage to medical care and initiation of ART for persons newly diagnosed, out of care, lost to care and/or virally unsuppressed. 	<p>Continue to increase number and percentage of PLWH who are aware of their status, link newly diagnosed and out of care PLWH to care, and increase timely initiation of ART.</p>
<p>Food Insecurity, coordination of care, and viral load suppression Food security is an essential component in obtaining and maintaining positive health outcomes for PLWH. Research has shown that food insecurity is associated with unsuppressed viral load,^{lxxxvi} and increased morbidity and mortality among PLWH.^{lxxxvii} As PLWH are more likely to be food insecure and live in low-income areas where nutritious food options are not easily accessible, the recipient has focused on addressing this key challenge throughout GY18.</p>	<p>In working toward achievement of the NYS <i>Integrated HIV Prevention and Care Plan's</i> goals and objectives, the recipient and PC created a new service directive for the FNS service category to aid in addressing issues relating to food insecurity, increasing access to care and treatment, and improving health outcomes along the HIV care continuum for PLWH.</p>	<p>Through focusing on addressing social and economic barriers to health, the new FNS directive will aid PLWH in achieving optimal health outcomes by combatting food insecurity while regularly assessing clients care and treatment outcomes. In doing so, providers will be positioned to ensure progress along the HIV care continuum for those who have fallen out of care, are not treatment adherent, and whose viral load remains unsuppressed.</p>	<p>The PC approved the new FNS service directive in GY18. In GY 19, the recipient will release a RFP for the FNS service category. Programs will be selected, and contract execution will be completed in GY 19.</p>

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
<p>Mortality Recent surveillance and eSHARE analyses of mortality have highlighted the need to work across the system to address this issue. In the NY EMA, RWHAP Part A clients, especially those with MH and HCV diagnoses, represent many of the sub-groups with poorer health outcomes and excess mortality, despite wide availability of effective treatment options.</p>	<p>Among HIV-positive RWHAP Part A clients with death as the subrecipient-reported reason for program closure, the Recipient conducted a preliminary analysis of eSHARE data on factors associated with mortality. Through a more recent merge of eSHARE with surveillance data covering NYC deaths through 2016, the Recipient has quantified excess mortality, and has characterized care and treatment engagement prior to death, for RWHAP Part A clients vs. other PLWH. The Recipient will also assess patterns of service utilization (across the entire portfolio) prior to death to identify missed opportunities and future points of Part A intervention. Using the findings from these merged analyses, the Recipient will work with Part A-funded providers to strengthen the service system to reduce preventable mortality.</p>	<p>Reduce preventable mortality through a concerted effort across the RWHAP Part A portfolio to address the needs of those at risk of preventable mortality.</p>	<p>Continue to work to increase engagement in care, increase viral suppression, increase cure rate for those infected with HCV, and reduce disparities in HIV health/survival outcomes.</p>
<p>Culturally Competent Care Increase provision of culturally responsive care to effectively meet the needs of a diverse population of clients in RWHAP Part A services.</p>	<p>The PC's master directive includes the following language: <i>Services should be client-centered, nonjudgmental, guided by HR principles, trauma informed, culturally and age-appropriate, sensitive to physical and sensory impairments, and tailored to the population served.</i> In GY16 and GY17, the Recipient worked with providers to implement CLAS Standards to address the needs of a diverse client population across RWHAP Part A-funded services. In GY19, the Recipient will implement a CLAS Standards self-assessment across the service system. A pilot of the assessment occurred in August 2018, feedback will be incorporated into the tool to ensure it is responsive to provider needs for assessing CLAS standards.</p>	<p>Increase the provision of culturally competent care to meet the needs of a diverse population so that all persons served with RWHAP Part A funds can have access to quality care and services.</p>	<p>Work to better meet the needs of a diverse client population by increasing engagement and service quality in core medical and support service environments that lead to viral suppression.</p>
<p>HIV and Aging As more of the NY EMA's PLWH benefit from the improved health outcomes and longevity associated with SVL, additional co-morbidities associated with HIV and aging must be incorporated in the system of care. As of December 31, 2017, more than half of</p>	<p>In GY 18, the Recipient convened an Open Forum with community members and subject matter experts to share research, assess service resources for PLWH over 50, and develop initial recommendations to improve care for this population. The Forum also aided the recipient in generating a timeline of activities for addressing HIV and Aging among RWHAP Part-A clients. The Recipient will conduct 7 focus groups</p>	<p>Reduce the effect of co-morbidities on PLWH over 50 in order to improve health outcomes and reduce preventable mortality.</p>	<p>Work to improve the quality of care to improve retention and viral suppression, and reduce preventable mortality for PLWH over 50.</p>

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
<p>PLWH in NYC were aged 50 and older. Among HIV+ RWHAP Part A clients in NYC who had at least one service during March 2016-February 2017, 52% were aged 50 and older.^{lxxxviii}</p>	<p>in collaboration with the community-based Long Term Survivors Wellness Coalition to assess and address the needs of Older PLWH for use in developing future service models and interventions aimed at addressing the diverse needs of this population.</p>		
<p>TGNB Competent Care As HIV disproportionately affects TGNB individuals, namely transgender women of color, additional focus on this population must be incorporated in the system of care. In 2017, TGNB individuals comprised 3% of all new HIV diagnoses in NYC. In 2013-2017, 281 transgender persons were newly diagnosed with HIV, with transgender women comprising 99% of those newly diagnosed. Additionally, Black and/or Latinx PLWH made up 89% of diagnoses among transgender persons.</p>	<p>In GY 18, the PC identified TGNB PLWH as a key population of focus in the RWHAP Part A PSRA process. Recommendations included:</p> <ul style="list-style-type: none"> • Increase PC’s capacity to address the needs of TGNB individuals • Increase the RWHAP Part A-funded organizations’ capacity to provide appropriate and relevant services to TGNB PLWH • Evaluate current capacity of the Part A portfolio to improve health outcomes among TGNB clients • Develop best practices and interventions that address stigma and discrimination against TGNB PLWH in Part A services • Address barriers to care unique to the TGNB experience <p>In GY19, the Recipient will coordinate efforts between BHIV’s Transgender Liaison and leaders in the TGNB community to develop and pilot a training around culturally competent care for TGNB individuals. Additionally, a CTP priority workgroup is focused on beginning to implement the PC’s recommendations that are relevant to RWHAP Part A funded providers.</p>	<p>Increase the provision of culturally competent care to meet the needs of TGNB persons served with RWHAP Part A funds; and increase access to quality care and services among this priority population.</p>	<p>Work to better meet the needs of the NY EMA’s TGNB population so that all have the tools to access care and treatment, remain treatment adherent, and become virally suppressed.</p>
<p>Engaging Women of Color in Care and Treatment Recent surveillance and eSHARE analyses indicate that women of color have been disproportionately affected by HIV. Among new diagnoses of women in 2017, 64% were Black and 25% were Latina.</p>	<p>In GY18, the Recipient developed a workgroup to help address disparities in new HIV diagnoses among women of color throughout the NY EMA. The Recipient will work with planning bodies, community members, and experts in the field to evaluate eSHARE data that will aid in assessing where women of color are being served in the RWHAP Part-A portfolio, identify gaps in the HIV care continuum, and identify appropriate outreach venues. Analyses will help lead efforts in creating culturally sensitive and relevant</p>	<p>Increase the amount of effective and responsive services offered to women of color in the NY EMAs RWHAP Part-A portfolio, decrease disparities for women of color throughout the HIV care continuum, and reduce general health outcome disparities in women of</p>	<p>Work to improve the quality of care, types of services offered, and reduce new diagnoses and preventable mortality for women of color in the NY EMA.</p>

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
	program(s) on healthy living and effective care and treatment focused on women of color.	color living with HIV in the NY EMA.	
Tri-County Administration and Compliance Increase the responsiveness and ability to move money to where it is most needed within the Tri-County Portfolio.	In GY18, the Recipient released an RFP to elicit proposals from RWHAP Part A service providers for 8 service categories: MCM, MH, oral health, medical transportation, psychosocial support, FNS, housing, and EFA services. In an effort to align monitoring and compliance across the NY EMA, all RWHAP Part-A contracts in the Tri-County region will be performance based/fee-for-service under uniform guidance for all NY EMA RWHAP Part A providers.	Ensure that the region is better able to respond and adapt to future funding decreases and system changes. This effort also supports compliance with POLR as fundable services under Medicaid change.	An RFP for the Tri-County Region has been released. Proposals for the 8 service categories will be submitted to the Recipient at the end of GY18. New contracts for the remaining service categories are to begin March 2019, which gives sufficient time to procure services and provide TA.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM). The CQM program is a collaborative effort that is overseen by the RWHAP Part A Project Director and involves the DOHMH CTP Quality Management & Technical Assistance Unit (QM/TA) and Clinical Operations and Technical Assistance (COTA) Program, the REU, HIV Testing Unit, Housing, NYSDOH AI, PHS, the PC, consumers, and RWHAP Part A providers. In GY18 the NY EMA issued an updated Quality Management Plan for the NY EMA in line with HRSA PCN 15-02. Positive feedback on the Plan and the CQM Program was received at the HRSA site visit conducted earlier this year.

Through TA, the CQM program seeks to: (1) strengthen RWHAP Part A providers' quality efforts; (2) build providers' capacity for QM while also providing guidance in program model implementation; and (3) improve care across the continuum. The objectives of the CQM program are to build capacity for QM among RWHAP Part A providers, to increase collaboration between RWHAP and Medicaid-funded providers, to provide opportunities for peer learning among RWHAP Part A providers, and to ensure the continuation of high-quality services for PLWH. These objectives are consistent with national goals for increasing the capacity of HIV systems of care that include diverse service providers.

Several processes are in place to provide TA and capacity-building assistance. The CTP QM/TA team members, under the supervision of the CTP QM Director, identify gaps in the RWHAP Part A system and develop strategies to address gaps and assess quality. Quality Management Specialists (QMSs) on the CTP QM/TA team, along with REU evaluation specialists, provide TA to RWHAP Part A providers with an emphasis on using data and QI tools to improve care. More specifically, the CQM team members develop and implement trainings for Part A providers to improve service quality and support QM activities; plan and implement provider meetings to facilitate peer learning among Part A providers; provide one-on-one TA in program implementation and QI; and work with NYSDOH AI staff to plan and deliver an annual QI conference for the NY EMA.

Additional CQM efforts are shared with the COTA Program, to increase coordination between the RWHAP Part A program and non-RWHAP Part A-funded outpatient ambulatory care services. CTP meets monthly with BHIV colleagues in COTA, who are evaluating HIV primary care

facilities in NYC to assess client characteristics, clinical and support service capacity, and HIV care outcomes. COTA is also conducting in-person TA visits to support facilities in meeting the NYS EtE initiative's goals. Data from COTA's evaluation and TA activities is used to determine how RWHAP Part A services may better support clinical services, including healthcare settings that receive Part A funding through subawards. The NYSDOH AI also coordinates RWHAP Part B and Medicaid clinical organizational assessments with COTA. CTP and COTA participate in a cross-part QM committee led by NYSDOH AI and collaborate with them on regional QM efforts overlapping with the NY EMA. Overlapping jurisdictional initiatives include; NY Knows, which works to increase HIV testing and Linkage; the NYLinks program to increase retention and viral load suppression through cross RWHAP Part collaboration; and the EtE borough-based and Lower Hudson Valley steering committees which support implementation of the *EtE Blueprint*.

DOHMH REU staff are responsible for analyzing eSHARE data, as well as consumer survey and supplemental evaluation data, to produce and present service category- and agency-level quality performance indicator and consumer feedback reports. Additional analyses (e.g. HIV care continuum measures and mortality rates disaggregated by service category or by client demographic, clinical and/or psychosocial characteristics) help identify disparities in HIV-related health outcomes that may be addressed through QM/TA efforts.

CTP draws on the expertise of the NYSDOH AI to provide peer learning support through the annual Power of QI Conference. In November 2017, the fourth annual Power of QI conference was held with the theme "Turning the Corner." Conference workshops, including the consumer-led session "The Consumer Solar System," which highlighted the consumer experience of barriers to care. Building on CTP REU's work earlier in the year, QM/TA staff facilitated a workshop session engaging a broad spectrum of stakeholders in the development of strategies to address preventable causes of death among PLWH. As with previous years, the conference also provided a forum for providers to share the results of their QM projects through oral and poster presentations. Over 200 service providers, consumers and other stakeholders across the NY EMA attended the Power of QI conference. Participants of the conference also selected the following poster presentations for recognition:

- 1st place for Turning the Corner & Best Overall. Mt. Sinai Institute for Advanced Medicine, Care Coordination: "Personalizing Tobacco Cessation: Utilizing Care Coordination to Augment Provider-based Screening & Counseling"
- 2nd place for Turning the Corner. St. John's Riverside Hospital, Medical Case Management: "Impact of Mental Health & Substance Use on Retention in Care/Viral Load Suppression"
- 2nd place for Best Overall. Harlem United: "Integrated Harm Reduction Program Implementing Client-Program Standard Contracts for Improved Service Delivery of Healthy Living Project"

The CQM program engages the NY EMA QM Committee in the work of updating and implementing the QM plan (the most recent update was completed in the first quarter of GY18). The committee includes key stakeholders from CTP, the PC (both consumers and staff), NYSDOH, Tri-County, Housing, HIV Prevention, COTA, and other areas as needed. The updated plan outlines the CQM program's activities in five domains: consumer engagement, collaboration and coordination, capacity building, service engagement, and service quality.

1) Use of performance measure data to evaluate disparities in care. Consistent with national goals, BHIV is expanding its efforts to support viral suppression citywide by drawing on the NYC surveillance-based HIV care continuum Dashboards to address care quality at the clinic level. The CQM program has collaborated in these efforts by ensuring that RWHAP Part A services support engagement and retention in high-quality clinical care and treatment to achieve and maintain SVL.

For example, as part of an effort to promote early ART initiation, consistent ART access, and improved viral suppression, CTP began providing each RWHAP Part A provider agency with client-level reports, known as Treatment Status Reports (TSRs) in 2014. The TSRs are prepared every three months using data reported by Part A providers in eSHARE. Reports list clients who do not appear to be virally suppressed, distinguishing whether or not the clients are currently prescribed ARTs. These client-level, custom reports are used to focus programmatic TA and facilitate communication and coordination between RWHAP support service providers, clients, and their medical providers to promote medical and ART adherence. In 2017, CTP launched Part A Agency-level Viral Suppression Reports (AVSR). For each organization receiving funding from the Part A program, REU prepared an annual report showing the proportion of each organization's Part A clients who were classified as virally suppressed at their last viral load test of the calendar year, for multiple years (thus tracking trends over time). Organizations were also able to see how their annual viral suppression proportion compared to that for all Part A clients in NYC. The AVSR uses viral load data reported to the NYC HIV Surveillance Registry. Starting in July 2018, CTP has begun to provide client-level reports on viral suppression and care status based on information in the NYC HIV Surveillance Registry. Each report lists all clients in a program's current caseload and categorizes them as needing follow-up for connection to care and/or for viral suppression, requiring case closure due to death, being virally suppressed at last update, or being stably suppressed throughout the report year. This new surveillance-based "Client Progress Report (CPR)" was rolled out first to NYC CCP providers who have been re-awarded CCP contracts under the recent re-bid. The CPR is designed to facilitate care team decision-making regarding enrollment of some existing clients in the new contracts and closure (with or without a hand-off to other services) of other existing clients, to make room for new enrollment among persons with current high need. Although not all RWHAP Part A programs appear to meet the NYS legal criteria for receiving these reports, the CTP is exploring possibilities for expanding this D2C activity beyond CCP, if resources permit and if early provider feedback suggests sufficient potential value of this information-sharing with eligible staff in other RWHAP Part A service models (likely starting with MH services).

Data collected routinely from RWHAP Part A providers include client-level sociodemographic, psychosocial and health outcomes information, as well as service utilization information. In support of national goals, these data – particularly when merged with comprehensive laboratory data from HIV surveillance – enable the NY EMA to evaluate a range of disparities in care, including those related to race/ethnicity, gender, age, transmission risk category, and geographic location, among other factors (e.g. housing stability). Over 90% of those served in the RWHAP Part A program identify as part of a racial/ethnic minority group, and the vast majority are also living below the FPL. As a result, outcomes do not necessarily reflect conventional/general-population racial, ethnic, or income disparities. However, since the sociodemographic subgroups over-represented in the local Part A program tend to experience disparities in health outcomes, the NY EMA takes a system-wide approach to improving care and outcomes for those served by the Part A program, including drawing on a centralized Client Experience Survey, as well as strengthening inter-agency coordination and referral systems and maximizing the use of data systems to flag clients in need of timely intervention. These approaches ensure that each client served has the appropriate resources and individualized support to achieve and maintain SVL. To further address disparities, DOHMH is also ensuring that subrecipients provide services consistent with CLAS standards according to a protocol designed by QM/TA staff. The protocol to be fully implemented in GY19 calls for Part A-funded organizations to assess their compliance with CLAS standards and incorporate efforts to improve compliance into their QM plans.

2) Use of CQM data to inform service delivery. Trends identified through the CQM program enable key stakeholders to assess RWHAP Part A service quality and fidelity to service model guidance over time. Quality indicators, developed in collaboration with RWHAP Part A-funded providers, are often used to inform provider QM plans, which are designed to improve service delivery. The indicator data are reviewed for trends to inform long-range service delivery planning and to review the impact of related QI projects. CQM indicator reporting is one of several resources that allow the PC to incorporate data-driven changes in the service system upon careful consideration with the Recipient.

CQM findings have also informed the PC's IOC Committee work on revisions to the CCP model directive which has resulted in the rebid of CCP contracts in GY18. During TA site visits and provider meetings, staff from organizations funded to provide MCM services reported that some health education topics (covered as part of the health education component of the MCM program) were redundant, an observation supported by eSHARE data. As a result, the health education aspect in the revised model of the intervention combines topics and introduces new ones, such as HCV. To address barriers to conducting DOT and improve utilization of the service, newly bid CCPs may provide mDOT using videoconferencing. To better engage clients in the management of their own care, CTP developed a self-management protocol to guide CCP staff in assessing patients' capacity for self-management and in coaching to improve self-management skills. CQM findings also informed changes in how MCM services have been reimbursed. Under the original MCM program model, programs are reimbursed on a per-member-per-day basis with rates varying by level of service frequency. Qualitative assessments found that, under this reimbursement method, program staff devoted substantial time and effort to monitoring service frequency in order to maintain consistent reimbursement. This sometimes detracted from the actual delivery of services to clients according to their needs and led to programs underreporting service utilization when the threshold for payment was reached. Reimbursement for MCM services is transitioning to fee-for-service, freeing staff to devote more attention to service delivery and making it more likely that services reported will reflect true utilization. This, in turn, will facilitate evaluation model implementation, and the timely identification of areas for improvement or provider-to-provider knowledge transfer.

ORGANIZATIONAL INFORMATION

A. Grant Administration. Through the rigorous monitoring and accountability measures described below, the NY EMA ensures that RWHAP Part A funds are used effectively to address the country's largest and most complex HIV epidemic. Eighty percent of the NY EMA's GY18 RWHAP Part A contracts are paid based on performance, with subrecipients paid on a fee-for-service basis and/or for achievement of specific deliverables. Managing the portfolio into a results-oriented reimbursement model has increased efficiency and contributed to effective resource management with timely reallocation of dollars to highly utilized services and minimal carryover. Through multi-pronged efforts, the NY EMA ensures Part A serves as the POLR.

1) Program Organization. With over 25 years of experience as a RWHAP Part A Recipient, the NY EMA is committed to efficient program administration, aiming to maximize the effectiveness of HIV services. In GY17, the NY EMA spent more than 99.63% of its RWHAP Part A formula award and 99.99% of its MAI award.

a) RWHAP Part A Administration (see Attachment 10). The Mayor of the City of New York serves as the CEO of the NY EMA. The Mayor has designated DOHMH as the administrative and fiscal agent for RWHAP Part A. As *Attachment 10* illustrates, the NY EMA's RWHAP Part A program

is administered by CTP in DOHMH BHIV. The BHIV is headed by an Assistant Commissioner, who oversees a staff of 287 FTE in the HIV Prevention, Care, Clinical Operations and Technical Assistance, Surveillance, and Administration programs, which includes 40.02 full-time equivalents (FTE) under the RWHAP Part A grant.

The Director of CTP (.90 FTE) oversees all staff responsible for service planning, TA, QM, research and evaluation, and RWHAP Part A planning and grant administration, as well as RWHAP Part A fiscal oversight in collaboration with the Director of Administration (.5 FTE). The Deputy Director of CTP (.9 FTE) collaborates with the Grant Fiscal Administrator (1.0 FTE), and program and administrative fiscal staff (2.4 FTE) to ensure adherence to all applicable HRSA grant reporting and monitoring requirements. The Deputy Director oversees and coordinates the activities of two Program Planners (2.0 FTE) and serves as an alternate to the Director of CTP for PC business and communications with HRSA. The Director of QM/TA (1.0 FTE) oversees a total of 13.0 FTE including: one Deputy Director, two Program Managers (PMs), eight QMSs, one Implementation Specialist and one Project Coordinator. The Deputy Director of HIV Prevention (in-kind) oversees the TA provided to the EIS providers, in coordination with HIV Prevention. The Director of Housing (.30 FTE) oversees three Housing Coordinators (3.0 FTE total) who oversee Part A housing subrecipient activities to ensure that housing services and resources are monitored and implemented in a coordinated manner with HOPWA across the NY EMA. The Director of Research and Evaluation for the Housing Services Unit (.5 FTE) coordinates with the Director of Housing and the Director of REU for housing services monitoring and evaluation. The Director of COTA (.25 FTE) oversees 1.36 FTE in TA and Training for healthcare providers. The Deputy Director of Business Systems (.8 FTE), under the leadership of the Director of Administration (.5 FTE), oversees contract administration and procurement, including eSHARE data system implementation across Prevention and RWHAP with 2.51 FTE.

RWHAP Part A funds 8.45 FTE in the CTP REU, overseen by the Director of REU (.75 FTE). Using multiple methods, including merged analyses of provider-reported, HIV surveillance, and survey data, REU staff evaluate RWHAP Part A client and program needs, service utilization, and health outcomes. REU staff track progress on NYS *Integrated HIV Prevention and Care Plan* goals, analyze and prepare eSHARE data for site visits and provider meetings, report on QM performance indicators at the service category and agency levels, elicit consumer input through surveys and focus groups, and improve Ryan White Services Report completeness.

The PC Director (1.0 FTE) reports to the DOHMH Deputy Commissioner for Disease Control and oversees staff who support the planning and administrative functions of the PC (5.0 FTE total). The PC and Recipient meet weekly to coordinate planning activities and ensure work is conducted in alignment with the MOU approved by HRSA in 2012.

There are currently several vacant Recipient positions. Three QMSs, the Deputy Director of Business Systems, and one Computer Systems Manager (.67 FTE). One of the QMSs is posted currently and two of the postings are dependent on FY19 funding levels. The Deputy Director of Business Systems recruitment has concluded, a candidate has been named, but was not in place as of this grant submission. The Computer Systems Manager recruitment will be posted soon. Candidates are generally named within 90 days of when a job is posted and usually start 6-12 weeks after being named. BHIV administration has worked with DOHMH Central Human Resources to improve recruitment and on-boarding processes for new applicants. DOHMH has an emphasis on recruiting and hiring candidates that are racially and ethnical diverse which has increased the number of channels in which DOHMH advertises and recruits for positions. Positions may remain open in order to give hiring managers the opportunity to meet with a diverse candidate pool. Additional

coordination with Human Resources has resulted in streamlining approval processes and posting positions more quickly after vacancies occur. Human Resources sends an automated message at select intervals alerting hiring managers to how long job announcements have been posted and reminds them to check the hiring portal with a 90 day expectation from posting to naming a hire. Despite this, vacancies remain as the job market in New York is currently in the applicant’s favor in the health and IT sectors.

c) Staffing, SOW, and evaluation of contractor or fiscal agent. PHS, DOHMH’s Master Contractor, assists in the administration of the RWHAP Part A program in the NY EMA. Under the direction of the Chief Strategy Office (CSO) and Vice President for CAMS, VP of Informatics and three Directors – a Senior Director for Programs and Contract Management, a Director of Finance and Operations, and a Director of Business System, PHS administers 174 Ryan White Part A-funded contracts in GY18. The CSO ensures PHS adheres to the terms of the Master Contract with DOHMH and has ultimate responsibility for all operations. The Senior Director for Programs and Contract Management oversees programmatic and fiscal monitoring of subrecipients and develops procedures, policies and standards for contract negotiation and monitoring of subcontractor program performance. The VP of Informatics is responsible for development and management of PHS’s information systems. The VP is responsible for developing policies and procedures for data collection and ensuring integrity of data for contract payment and monitoring. The Director of Finance and Operations is responsible for developing, implementing and monitoring fiscal policies and administrative procedures, and for the portfolio’s fiscal compliance. The Director of Business Systems is responsible for guiding the procurement process and leads the coordination of cross-unit project management and continuous QI efforts to ensure compliance with all relevant regulations and terms of the Master Contract.

PHS, under direction from DOHMH, manages the procurement process for RWHAP Part A funds, contract administration including development of subrecipients’ contract scopes and budgets, compliance monitoring, TA, subrecipient payment including performance-based reimbursement, fiscal and data management, and external reporting. PHS employs 18.04 FTE monitoring staff, 3.22 FTE contract administration staff, and 13.88 FTE planning and administrative staff for a total of 35.14 FTE. DOHMH facilitates a monthly coordination meeting and a monthly Data Workgroup with PHS, to ensure compliance with contractual and HRSA policy requirements, address challenges in the administrative mechanism, including procurement and contracting, and to facilitate communication between DOHMH and PHS leadership.

Monitoring of Master Contract. The Master Contractor reports directly to BHIV on all aspects of its administrative and fiscal processes as outlined in the contractual agreement. BHIV monitors the Master Contractor for compliance with the terms of the contractual agreement by conducting site visits, tracking receipt of required reports, and reviewing performance via the Program Progress Report.

BHIV’s program and fiscal monitoring staff conduct a minimum of two site visits per contract period for the Master Contract. Generally, site visits occur on the following schedules for the following review periods:

Table 7. Master Contract Review Schedule

Site Visit	Site Visit Month	Review Period
1	June	9/1 to 2/28
2	December	3/1 to 8/31

The site visits consist of a program and fiscal review for a sample of subrecipients. The Master Contract site visits include an entrance interview to discuss changes since the last site visit and the procedure for the current site visit, as well as an exit interview to discuss findings from the current site visit. BHIV reserves the right to conduct additional site visits or adjust site visit dates if necessary.

DOHMH Master Contract Subrecipient Sampling Methodology. BHIV staff review at least 10% of RWHAP subrecipients, and BHIV staff review all subrecipients that were on a contract status (“concern,” “corrective,” or “conditional”) during the site visit review period. If this selection is less than 10% of all subcontracts, then the remaining subcontracts are randomly selected to complete a 10% sample of all subcontracts.

The program and fiscal monitoring staff evaluate documents and files to ensure contractual requirements are being met by the Master Contractor. The program and fiscal monitoring staff complete a site visit report that identifies the material reviewed, compliance with contractual requirements, and if applicable, findings and recommendations to the Master Contractor to remedy findings identified during the site visit.

2) Grant recipient accountability. Close and continual monitoring of RWHAP Part A contracts ensures compliance with all applicable federal requirements and maximizes the return on RWHAP Part A investments. As described below, monthly contract-level reports and annual site visit reports are reviewed and kept on-site at PHS and the DOHMH.

a) Monitoring. The NY EMA’s multi-faceted contract monitoring process includes monthly electronic data submissions, comprehensive semi-annual reviews, at least two on-site visits each year, documentation reviews, frequent telephone and email contact, and other meetings as necessary. All RWHAP Part A providers are required to maintain standardized client-level data records with de-identified client-level extracts reviewed monthly by PHS for reimbursement and by DOHMH for service utilization analysis. Using eSHARE, subrecipients finalize client-level data entry by the 15th of each month, the point at which PHS and DOHMH consider subrecipient-reported data to be ready for assessment for reimbursement and performance. In addition, PHS requires the submission of a monthly Program Narrative Report, which details successes and challenges of the previous month and identifies staff vacancies and changes in program operations. These reports are reviewed by PHS in advance of reimbursement. PHS Contract Managers (CMs) review reported spending and withhold reimbursement if subrecipients fail to submit required monthly programmatic reports, external audit reports, and/or if reports are incomplete or contain unbudgeted or unallowable costs.

PHS CMs are responsible for both fiscal and programmatic contractual monitoring, ensuring that costs and service activities are allowable and appropriate within a contract’s budget and scope of services. In addition, providers are assigned a DOHMH QMS with expertise in the relevant programmatic content. QMSs provide one-on-one technical and QM support and convene provider meetings to facilitate peer-led discussions of lessons learned. CMs and QMSs meet at least twice a year per service category to share data on contract performance, review qualitative information on services, and develop action plans to address challenges. While QMSs focus on QM and program development and implementation, CMs monitor contract deliverables and service documentation, conduct fiscal monitoring, and ensure compliance with relevant eligibility and administrative requirements, including client-level reporting.

QMSs and CMs collaborate and ensure that consistent guidance is provided to RWHAP Part A subrecipients through joint site visits. Site visit findings may be successfully addressed within two weeks post site visit and, thus, may not lead to formal corrective action. Each RWHAP Part A

contract specifies the nature of services to be delivered, eligibility requirements for clients, licensing or other staff qualifications, and contractual expectations. Contracts specify the number of clients to be served and service delivery targets. Each subrecipient providing Part A services must have operational grievance procedures in place (including whistleblower policies) and a mechanism for consumer input. Each subrecipient must collect and maintain client-level data in accordance with the NY EMA's reporting requirements for enrolled clients.

i) Common program and fiscal subrecipients' monitoring findings and corrective action process. The three most common fiscal and program monitoring findings are documentation issues, data inaccuracies, and insufficient service levels. Documentation issues, including the need for information consistent with standards of a service type or model as well as missing or incomplete documentation of services, may result in recoupment for services and low service levels. TA is then provided within a targeted timeframe, usually three to six months, to facilitate improvement. For providers with persistent performance concerns, PHS implements a progressive process for corrective action in coordination with DOHMH. This process starts with targeted TA with an expected timeframe for improvement. Should that not occur, corrective measures are implemented which require a written plan with timeframes for specific metrics of required performance. For example, one FNS subrecipient was found to inconsistently report reassessment and treatment plan updates and failed to document elements of a service type consistent with the service model. The program was required to submit a corrective action plan where they outlined plans for re-training key staff on reassessments and using an alert system to remind staff when reassessments were due. It also outlined plans to use a tool to capture duration of sessions and specific elements of the nutritional counseling service type to ensure documentation reflected the model's integrity. The contract was performance-based and, without these corrective measures, reimbursement for nutritional counseling sessions would not have been possible. Within two quarters of the compliance period, the subrecipient was able to successfully track and implement necessary changes and was removed from compliance status. In addition, the subrecipient recognized the need to reduce projections and modified targets for the nutritional counseling service type. Generally, providers are expected to achieve compliance within two quarters of the contract year. If compliance is not exhibited after four quarters, a contract is put on conditional status and reimbursement may be impacted.

In the most egregious cases, a contract may be terminated for failure to achieve performance levels. One example of this scenario was seen with a CCP subrecipient. The program had been on corrective action in the prior year for documentation issues which, with assistance, were successfully addressed. However, the subrecipient continued to experience other problems impacting services, including general infrastructure deficiencies and a leadership vacuum. Multiple meetings with senior leadership and options for potential community partnerships and improved clinical oversight of the program were attempted throughout the year without improvement. The subrecipient continued to have persistent low services levels as well as challenges with clinical supervision and staff grievances. They were plagued by staffing vacancies as the facility faced closure. Although the hospital remained open, client enrollment was severely impacted and the award for the contract was significantly reduced to reflect reduced service levels. Resignation of the key physician for the program was a determining factor in the inability to continue this contract. Though contract termination is relatively rare; this contract was terminated in GY16. It is noteworthy that the majority of providers are able to achieve acceptable performance levels, with a minority receiving the support of some combination of the above interventions.

ii) Process for ensuring compliance with the single audit requirement. Consistent with the Health and Human Services Uniform Administrative Requirements (45 CFR 75), RWHAP Part A subrecipients are contractually required to submit a single audit report, when applicable, within 30 days after its completion, but no later than nine months after the end of the audit period. A subrecipient is deemed out of compliance if it fails to submit its audit reports by the required due date. Written notification of the delinquency is sent to the subrecipient and payments may be placed on hold pending full compliance. If a single audit is not applicable, the subrecipient must submit a letter of explanation from its auditor or Chief Executive Officer. The letter of explanation must be accompanied by a list showing all of the subrecipient's federal grant revenue and expenses in order to support its claim that is exempt from preparing the single audit report. PHS communicates any material changes in federal and state audit requirements as they occur, to ensure compliance with up-to-date audit rules. In GY17, PHS contracted with 81 subrecipients; however, only 72 audit packages were required to be submitted. All 72 audit packages were submitted in GY17; however, 33 (46%) were submitted late. PHS's Fiscal Manager (FM) and Fiscal Analyst (FA) ensure audit reporting compliance of all subrecipients, conduct a detailed review of audits, follow up on findings identified in the audit, and submit a management letter, if issued. Satisfactory responses from subrecipients are a condition of ongoing compliance, and in some instances, their ability to draw down funds.

iii) Addressing subrecipient audit findings. Twenty-nine percent of the EMA's RWHAP Part A subrecipients' audit reports contained issues noted in GY17. Issues ranged from general observations to auditor recommendations, some of which were unrelated to the RWHAP Part A programs or the agencies' infrastructure. Of the issues noted, only 13% were identified as material weaknesses. Issues cited included: lack of written methodology for expenses allocated to government grants, lack of full compliance with federal and Office of Management and Budget guidelines, lack of an updated financial policy and procedures manual, lack of time and effort record keeping, insufficient back-up documentation supporting purchases, lack of accounts analysis and bank reconciliation performance, inadequate segregation of duties, deficiencies in internal controls, and net assets deficits. For subrecipients with audit findings, PHS requests quarterly updates on corrective measures implemented. In cases where management provides an inadequate or lack of response, the agency may be placed on corrective or conditional status and PHS then requests a corrective action or compliance plan to resolve the audit deficiency, during which time agency reimbursements are placed on hold. None of the agencies with material weakness noted in audit reports were placed on corrective or conditional status. PHS was satisfied with the agencies' responses and action taken to resolve the material weaknesses, which typically follow the audit recommendations.

b) Third party reimbursement. During GY17, the NY EMA expanded its already robust process to ensure that all RWHAP Part A funds serve as the POLR. As previously mentioned, the PC undertakes a comprehensive analysis of all available resources and service delivery systems in the process of establishing priorities and allocations for funding. The PC uses an objective priority-setting tool, with one of four criteria being 'POLR/Alternate Providers of Service.' This tool helped the PC to design the GY19 RWHAP Part A Spending Plan to address gaps, especially those in Medicaid.

Beginning in GY11 and continuing through GY18, the Recipient and PC staff have implemented the National Monitoring Standards and ongoing monitoring of the changing healthcare landscape. This includes review and analysis of resources released by HRSA/HAB (e.g. policy notices) and the NYS Medicaid Redesign Team, as well as items published by national policy

organizations and the media, which support implementation of POLR. This information was shared with stakeholders through presentations to committees of the PC and Recipient staff, including the monthly Recipient report issued to the PC. Information gleaned through these efforts was incorporated into the *POLR Tool*. The NY EMA requires agency certification to bill Medicaid in all applicable service categories (MCM, MH, Oral Health, and Medical Transportation).

i) Monitoring third party reimbursement. Contractual provisions define RWHAP Part A reimbursement as “last dollar funds pursuant to federal law,” mandating that payments cannot duplicate reimbursement that has already been made or can reasonably be expected to be made by other payers. Contracts require subrecipients to carefully monitor third party reimbursement. As mandated in the RFP and in the eventual contract, all RWHAP Part A providers must participate in applicable NYS Medicaid programs for those services reimbursed by Medicaid.

During contract negotiations, PHS and subrecipients identify all potentially reimbursable services and explores all sources of third party payment. PHS conducts single payer verification activities to ensure that services billed to RWHAP Part A have not been billed elsewhere. Contracts that include services that are potentially reimbursable by Medicaid and other payers are subject to an annual review of all billing records associated with a patient visit. This review forces coordination between grants management and Medicaid billing staff.

MCM service design and contracts have expressly taken into account other case management services such as those reimbursed through Medicaid, mandating coordination with NYS-funded case management programs, including Medicaid Health Homes.

ii) Documentation of client screening and ensuring POLR. All subrecipients are required to document the screening of every client for Medicaid, Medicare, the NYS health insurance exchange, or other third-party insurance eligibility and to help eligible clients apply at intake and reassessment, every six months. eSHARE requires input of insurance status for both new and continuing clients, prohibiting submission of reporting forms until such questions are answered. The reporting software captures insurance provider type at time of assessment.

Many PLWH with incomes between 138 and 400% of the FPL are eligible for discounted premiums for plans on the NY State of Health insurance exchange, resulting in more PLWH with health insurance. All service providers who provide benefits counseling and enrollment services are required to become Certified Application Counselors, as training capacity allows, or establish a referral relationship with designated navigator agencies. This helps to ensure that PLWH who are eligible for other sources of assistance access those resources before the RWHAP Part A care system, and that PLWH are receiving enrollment assistance from application counselors who understand the HIV care system.

iii) Tracking and use of program income. DOHMH and PHS require subrecipients to establish a sliding fee schedule and caps-on-charges policy. Subrecipients are required to track and report program income for all service categories. In addition to reporting the amount of program income earned, programs also report how they have or will use the income to improve RWHAP Part A programs. The most common use of program income is to pay for administrative costs that were not covered under the 10% administrative cap. Because of the safeguards designed to ensure that RWHAP services are designed in light of other local resources RWHAP Part A funds remain the POLR, with very few instances when a program might earn program income from RWHAP activities.

c) Fiscal oversight.

i) Fiscal staff accountability. The NY EMA ensures the efficient use of funds for their intended purpose through fiscal monitoring and accountability protocols. Fiscal staff is supervised by senior

managers at PHS and DOHMH. Spending is recorded and tracked in the PHS data and payment management systems, which are reconciled with the PHS financial accounting system on a quarterly basis. PHS staff prepare and submit detailed quarterly spending reports to DOHMH, which in turn the department uses to report by service category to the PC. On a quarterly basis, DOHMH staff prepare service category spending reports to the PC to review and discuss the NY EMA's spending rate. Unobligated balances are tracked continuously and funds are reprogrammed as necessary in order to maximize services and spending by redirecting funds to services in accordance with the PC-approved reprogramming plan. At the end of the contract term, subrecipients are required to calculate and report the aggregate amount of program income generated and costs covered by it. The Director of Finance and Operations at PHS manages fiscal tracking and reporting and reports directly to the CSO, who is part of PHS's senior management team. At DOHMH, the Grant Fiscal Administrator, an FA, and the Deputy Director of CTP, all overseen by the Director of CTP and the Director of Administration in the BHIV, are responsible for fiscal oversight and reporting on the RWHAP Part A grant, including implementation of the HRSA/HAB National Monitoring Standards.

Roles and responsibilities of fiscal staff. With the NY EMA's use of performance-based reimbursement, PHS's organizational fiscal monitoring of programs is a combination of efforts that includes agency on-site fiscal review by the CM who is responsible for fiscal monitoring of cost-based contracts and who verifies expenditures are adherent to subrecipients' approved budgets and the Contract Coordinator (CC) who verifies the appropriateness of documentation for services for which the subrecipient received performance-based payment. The CM and CC's work is supervised by a PM. An FM and FA conduct an additional review of the subrecipient's audited financial statements and single audit reports.

DOHMH fiscal staff and the Deputy Director of CTP, in collaboration with the Master Contractor, prepares and submits the following information to HRSA: administrative budgets, allocation and expenditure tables, the SF424A and the Federal Financial Reports, unobligated balance and carryover requests, and other fiscal documents required under the conditions of award. In addition, PHS fiscal staff and the Deputy Director of CTP interpret and summarize the fiscal monitoring standards into policies and procedures for the NY EMA, seeking clarification from HRSA as necessary.

Coordination of program and fiscal staff. The assignment of a CM for RWHAP Part A contracts ensures that a single staff member develops an understanding of each contract's program and fiscal operations. In addition to site visits, CMs review expenditure reports for cost-based contracts and services data for performance-based contracts, and authorize payments, which are processed by Accounting Associates, as outlined in the attached staff organizational chart (*see Attachment 10*). In addition, semi-annual reviews of the portfolio for compliance with contract terms include the audit review, so that CMs and their supervisors are aware of organizational findings that may affect RWHAP Part A contracts.

ii) Tracking funds. DOHMH separately tracks Formula, Supplemental, MAI, and Carryover funds through the PHS data system, PAMS, and AMS Advantage. In standard quarterly reports, PHS reports expenditures to DOHMH in each funded service category, outline funding commitments per service category, and summarizes spending rates. These reports are combined with separately tracked DOHMH program fiscal spending data and presented to the PC to monitor expenditures, and allocate funding for the following year's spending plan as well as develop a carryover plan for unspent funds at closeout.

iii) Subrecipient reimbursement. PHS reimburses subrecipients on a monthly basis. The PHS contract management system logs and time-stamps receipt of monthly reports and automatically uploads expenditure data. In addition, DOHMH extracts data from the client-level database (eSHARE) on the 16th of each month, transmitting it to PHS for payment processing and compliance monitoring.

CMs review reports to determine payment. For cost-based contracts, reported expenditures must be consistent with approved budgets and allowable per the RWHAP program. For performance-based contracts, client-level data correspond to approved service types for payment. Services exceeding approved amounts for each class are disallowed unless a contract is modified to shift projected services between service types or a request for enhancement funding is approved. In addition, many services have utilization restrictions for payment, such as frequency limits, minimum group size, or prerequisites. When possible these rules are enforced electronically, through the payment system database, others are found only through site visits. PHS and DOHMH developed and provided subrecipients with the *Guide to Requirements for Services: Payability and Data Reporting* (the Payability Guide), which PHS updates routinely. The Payability Guide provides guidance on submitting data for performance-based contracts. The current version is available on the PHS website.

In the second half of each month, PHS emails subrecipients an electronic report called the Master Itemization Report, which summarizes and itemizes all services recognized by the systems to date. Particular services may be flagged for a number of reasons, including incomplete data entry, duplicate client entries, and failure to meet programmatic requirements. Such problems are identified through a combination of automated data checks and site visits by CMs and CCs. Some problems may be correctible while others may result in recoupment during closeout.

Reimbursements may be withheld despite complete monthly reports. Reasons for withholding include expired insurance policies, delinquent reports, or previously identified disallowances in excess of outstanding contract balances. All withheld reimbursements are discussed with supervisory staff and are documented in subrecipient files and the PHS contract management database.

The PHS contract management database computes the payment and notes any disallowances. CMs print a payment authorization form, sign, and forward it to PHS accounting staff for entry into the accounting system. Payment is then forwarded to PMs, who supervise the CMs, for final review and approval. Accounting staff reconcile payments to ensure back-up documents support payment. Upon approval, the PHS Accounts Payable Department issues payments once a week, via check or electronic transfer (as selected by the subrecipient). Accounting staff log payment dates in the payment system and reconcile all payments with the accounting system. PHS pays subrecipients within 30-45 days of receipt of all required reports, with the exception of payment withheld pending receipt of any delinquent report.

In addition, over-performing performance-based contracts may be eligible for enhancements to reimburse them for services if unobligated funding is available and modified service category allocations adhere to the PC's reprogramming plan. GY18 has allowed for reallocation between service categories up to 20%. Such enhancements reimburse subrecipients for any incremental costs associated with the provision of additional services.

PHS administers the Year End Cost Report (YCR) for performance-based contracts to inform the process of reimbursement rate adjustments. The YCR provides PHS and DOHMH with the actual annual costs of running funded programs. Total actual annual costs include both direct personnel and other than personnel expenses, as well as, any in-kind costs and/or the value of volunteers and donated other than personnel expenses costs (e.g. supplies, space). PHS requires

subrecipients to submit the YCR after the completion of the closeout process. PHS initiates disciplinary action including holding payments, and requests the completion of a Corrective Action Plan for organizations that do not submit a completed YCR by the established due date.

PHS also requires the submission of the Infrastructure Self-assessment Questionnaire (ISAQ). Performance-based subrecipients are required to complete the ISAQ outlining their fiscal policies and procedures and identifying any internal control challenges. Subrecipients that identify infrastructural deficiencies are referred for TA. Certain deficiencies, such as outstanding tax liability, are cause for further investigation and may result in withholding of payment and other disciplinary action.

Maintenance of Effort. *See Attachment 11.*

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