INTRODUCTION

Pursuant to the Grant Year 2020 (GY20) HIV Emergency Relief Program Ryan White HIV/AIDS Program (RWHAP) Part A Funding Opportunity Announcement, dated July 1, 2019, the New York City (NYC) Health Department, 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 GY20 Plan to promote a comprehensive scale 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 GY20 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 connect them with 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.[i]

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 (IDU) by 2020.[1]

The NY EMA continues to align its services with the *EtE Blueprint* priorities and work to identify PLWH and link them to care as described in the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan (*pp. 14-28*). 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 is working with funded providers to reduce preventable mortality and increase efforts to reduce new HIV infections among PWID. In the coming year, the NY EMA will further develop efforts to align with the National initiative *Ending the HIV Epidemic: A Plan for America* through work funded by CDC-RFA-PS19-1906, Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States, and HRSA-20-078, RWHAP Parts A and B. The NYC Health Department Bureau of HIV (BHIV) will engage all its programs and partners to address the four pillars of the National Plan: Diagnose, Treat, Prevent, and Respond; and efforts will focus on the four counties named in the National Plan (Bronx, Kings (Brooklyn), New York (Manhattan), and Queens) but will be relevant to services throughout the NY EMA. The NY EMA's service plan is described in this application.

NEEDS ASSESSMENT

A) Demonstrated Need.

[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.

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 nearly 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 December 31, 2018, there were 131,076 people diagnosed and reported with HIV/AIDS, and presumed to be living with HIV in the NY EMA, representing 1.3% of the total NY EMA population (*see Table 1).* Of the 2,018 individuals diagnosed with HIV in the NY EMA in 2018, 19% 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 2014 to 2018, there was a 29% 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 in providing HIV care and the ongoing need for early intervention and care services to fulfill the goals of the *EtE Blueprint.*

Table 1: NY EMA Population and HIV Diagnoses and Number of PLWH by Region and County/Borough, 2018

	Population	HIV Diagnoses*	PLWH
New York City	**8,398,748**	**1,917**	**127,287**
Kings (Brooklyn)	2,582,830	558	30,398
Bronx	1,432,132	440	30,749
New York (Manhattan)	1,628,701	375	32,808
Queens	2,278,906	358	18,684
Richmond (Staten Island)	476,179	31	2,531
Outside NYC/Unknown	N/A	155	12,117
Tri-County Region	**1,392,199**	**101**	**3,789**
Putnam	98,892	1	128
Rockland	325,695	24	588
Westchester	967,612	76	3,073
Total	**9,790,947**	**2,018**	**131,076**

Sources: Population estimates: U.S. Census Bureau, American Fact Finder: Quick Facts –2018; New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC Health Department, HIV Epidemiology and Field Services Program, data as of March 31, 2019; Putnam, Rockland, and Westchester counties: NYS Department of Health (NYSDOH), Bureau of HIV/AIDS Epidemiology, data as of June 27, 2019.

*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 2018, among new HIV diagnoses in the NY EMA, 78% were male, 45% were Black, 37% were Latinx, 66% were younger than 40, and 54% were men who have sex with men (MSM), including MSM with a history of IDU. In the same year, 3% of new HIV diagnoses in NYC were among transgender individuals, 95% of whom were transgender women. Data on transgender, gender non-conforming, or non-binary (TGNC/NB) populations are not available for the Tri-County region. Approximately 88% of newly diagnosed

transgender women were non-Hispanic Black[2] or Latina, and 54% of newly diagnosed non-Hispanic Black or Latina transgender women were between the ages of 20-29.

Among PLWH in the EMA, 72% were male, 43% were Black, 33% were Latinx, and 44% were MSM, including MSM with a history of IDU. Unlike previous new diagnoses, which have historically been concentrated among those younger than 40, those older than 50 accounted for more than half of PLWH in 2018 (58%). This highlights the aging of PLWH in the NY EMA and underscores the importance of addressing the complex needs of older PLWH (OPLWH).[v]

The number of PLWH is highest in low-income Black and Latinx communities, where many individuals experience multiple challenges that severely impact health, such as racism, poverty, trauma, mental health (MH) issues, food insecurity, and housing instability. Based on data from NYS Department of Health (DOH), as of February 2019, 68% of PLWH diagnosed and reported in the NY EMA were enrolled in Medicaid, and 25% were dually enrolled in Medicaid and Medicare (*see Table 2 on p. 11 for more details)*. In comparison, 29% 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 24% of all PLWH, they represented 30% of all deaths among PLWH in 2018 in the NY EMA. See *Attachment 3* for the complete diagnoses, number of PLWH, 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. However, between 2001 and 2017, 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 Asian/Pacific Islanders and transgender individuals with sexual contact as their HIV transmission risk. The Recipient and Planning Council (PC) regularly monitors HIV surveillance trends, service utilization trends, and other data sources, which continue to show HIV disproportionately affecting low-income Black and Latinx communities; cisgender gay, bisexual, and other MSM (with increased disparities among young men (ages 13-24) who have sex with men (YMSM) and Black and Latino MSM (hereafter, MSM of color of all ages)); cisgender women of color (WoC); and transgender women, particularly transgender WoC. 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 number of PLWH included ZIP codes in Chelsea-Clinton and Central Harlem-Morningside Heights. With the exception of Chelsea-Clinton, neighborhoods with high HIV diagnosis and number of PLWH were also among those with the highest poverty rates, with at least 30% of residents living below the FPL.[vii] In 2017, individuals living in high-poverty neighborhoods were least likely to have a suppressed viral load (SVL) 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]

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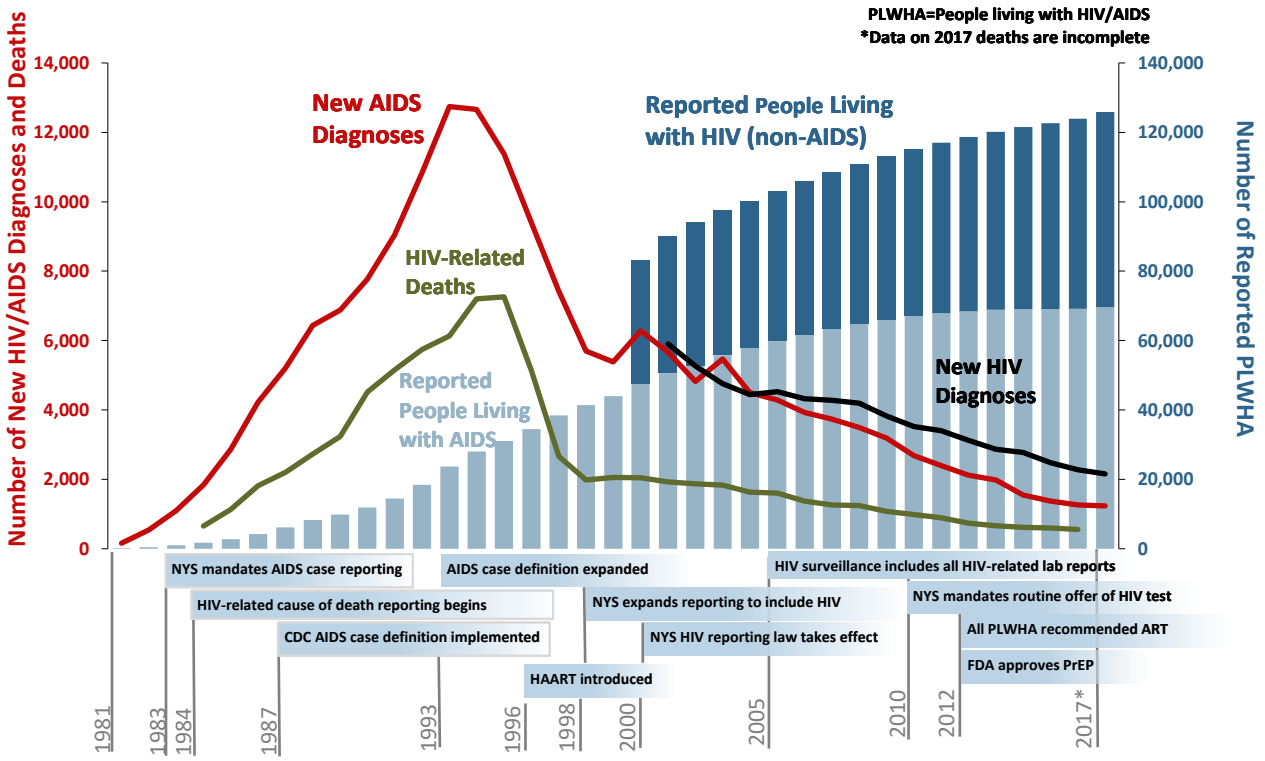
[2] From this point forward, non-Hispanic Black Individuals will be referred to as Black, and non-Hispanic White will be referred to as White. The term "Black" is used throughout this document rather than "African American" because NYC has substantial numbers of people of Caribbean origin who do not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

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 allocated 44% of GY20 funds to support services, including $12.9 million to housing services and $9.9 million to food and nutrition services (FNS). The NY EMA further invested in other professional services (legal services) ($4.5 million) and non-medical case management (n-MCM) services ($5.4 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) ($24.1 million), of which there are two models in the GY20 plan – Care Coordination Program (CCP) and Tri-County MCM.[3] Both of these programs serve to engage, link, and retain PLWH in medical care to further address barriers to viral suppression. 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 for CCP services.

ii) Increased need for HIV-related services. As the number of PLWH has increased and disparities have persisted, demands on the NY EMA's service system and need for RWHAP 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 new HIV diagnoses, due to PLWH living longer, healthier lives.

Figure 1: History of HIV epidemic, NYC 1981-2017



[3] Two subcategories are included under the MCM category: NYC Care Coordination 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.

While the number of new HIV diagnoses in the EMA has declined, the HIV diagnosis 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 HIV diagnoses are currently concentrated. The average rate of HIV diagnoses in 2017 (per 100,000 people) was 16.1 in the South and 10.6 in the Northeast. However, NYS's HIV diagnosis rate (14.0/100,000) is similar to rates in several of the southern states—where rates range from 4.3/100,000 in West Virginia to 24.9 in Georgia, including North Carolina (12.8), Mississippi (14.3), South Carolina (14.3), and Texas (15.4).[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]

A study among MSM attending NYC Sexual Health Clinics (SHC) recruited between 2007 and 2011 showed that the HIV incidence 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 incidence rate compared to other age groups.[xii] HIV incidence among all MSM attending SHC has declined from 2012 through 2017, but racial and ethnic disparities persist. Among people with newly diagnosed HIV in NYC in 2017, people with race/ethnicities other than White, women, those aged ≥55, people who identify as heterosexual, transgender people with sexual contact, and those with other transmission risk less frequently initiated care within three months of diagnosis. There were also disparities in viral suppression among PLWH in 2017, with transgender persons; people categorized as Other race/ethnicity, Native American, or Black; younger persons (under age 30); and MSM-IDU and IDU[4] all having lower viral suppression rates than their counterparts.[xiii] In 2018, individuals with a history of IDU were disproportionately represented among deaths, making up only 12% of PLWH but 25% of deaths among PLWH 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] NYC Health Department's Prevention Program routinely conducts surveys online and in-person among sexually active NYC MSM, aged 18-40. Among eligible participants in spring 2018, 5% reported methamphetamine use in the past six months; there were no statistically 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 2018. Recent methamphetamine use was highest among MSM living in Manhattan (8%) compared to MSM living in any other borough (Bronx and Brooklyn-6%, Queens and Staten Island-4%). Previous work by the NYC Health Department found methamphetamine 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 Black and Latinx 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 significant higher likelihood of achieving viral suppression, compared to those living in UHF neighborhoods where over 30% of

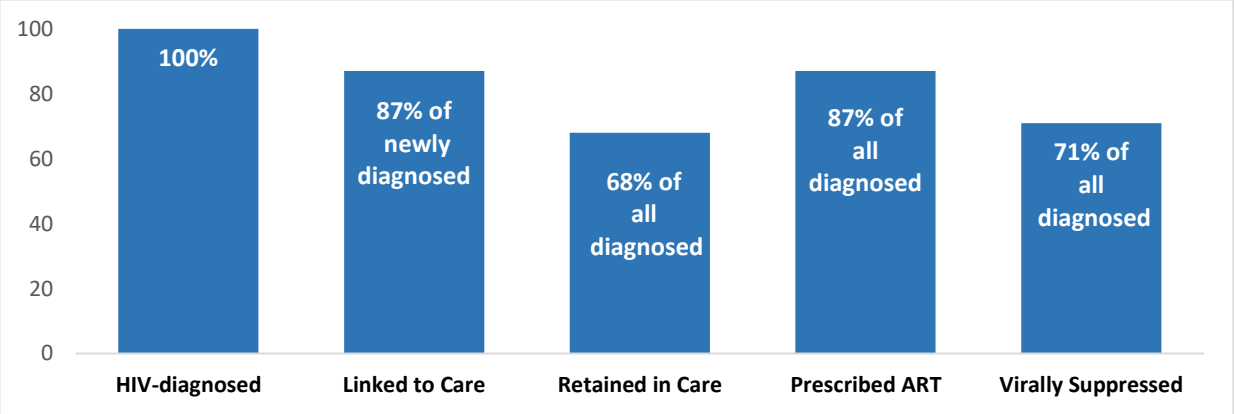
[4] Injection Drug Use (IDU) is used here to reflect surveillance data. When available, person-forward language, such as People Who Inject Drugs (PWID), is preferred.

[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.

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 while rates of SVL were lowest among Black and Latinx PLWH. In addition, although 54% of deaths between 2007 and 2013 among NYC PLWH were due to non-HIV-related causes, 35% of White individuals versus 48% of Black and Latinx individuals died due to an underlying HIV-related cause.[xviii] Although deaths attributed to HIV have fallen from 1,115 in 2007 to 369 in 2017, HIV was the tenth leading cause of premature death overall among NYC residents under 65 years of age, and the fifth and sixth leading cause of premature death for Black and Puerto Rican New Yorkers, respectively.[xix]

2) HIV Care Continuum.

Figure 2: 2017 NY EMA HIV Care Continuum

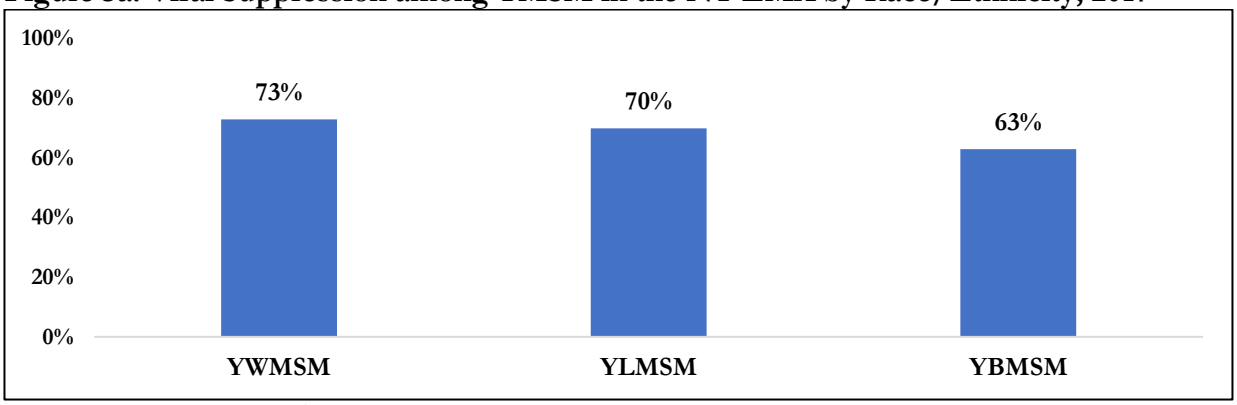


Sources: Prescribed ART: NYC Health Department, Medical Monitoring Project (MMP), 2017; All other: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of June 27, 2019.
Notes: "HIV-diagnosed" includes those diagnosed by 12/31/2017 and living and residing in NYC or the Tri-County region as of 12/31/2017; "Linked to care" includes those who were newly diagnosed with HIV in 2017 with one or more viral load or CD4 count within 91 days of diagnosis; "Retained in care" includes those among the HIV-diagnosed with at least two VL or CD4 counts in 2017 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 6, 2017 - April 12, 2018); "Virally suppressed" includes those among the HIV-diagnosed whose most recent viral load in the year was <200 copies/mL.

Although the NY EMA (*as seen in Figure 2*) is working towards National goals to end the HIV epidemic related to retention in care (90%) and viral load suppression (80%), disparities exist among certain subpopulations. In 2017, young (ages 13-24) Black MSM (YBMSM) and Black women were the most disproportionately impacted populations in the NY EMA; these disparities are displayed in *Figures 3a and 3b*. HIV viral load data from 2017 reveal that among YMSM, only 63% of YBMSM were virally suppressed as compared to 73% of young White MSM (YWMSM) and 70% of young Latino MSM (YLMSM). In the same year, among women living with HIV, viral suppression was lower among Black (70%) women when compared to White (73%) and Latina (74%) women. These disparities are addressed by geographically targeting services to underserved neighborhoods with high numbers of PLWH 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, CCP). In 2018, the Care and Treatment Program (CTP) also introduced a number of workgroups—including the Youth and WoC workgroups—in an effort to more systematically identify strategies for reducing disparities.

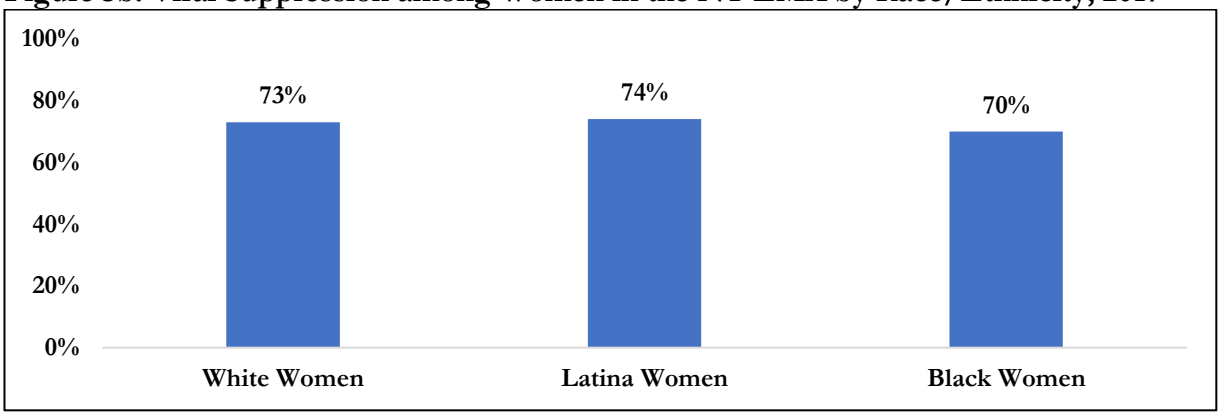
Additionally, NYS's EtE initiative includes a goal that by the end of 2020, 75% of PLWH will achieve sustained viral load suppression.[6] According to data reported to the NYC Health Department as of March 31, 2018, by the end of 2017, 66% of PLWH in NYC achieved sustained viral load suppression. Continued efforts to reduce disparities in viral load suppression among YBMSM and women will significantly contribute to the attainment of NYS's goal.

Figure 3a: Viral Suppression among YMSM in the NY EMA by Race/Ethnicity, 2017



Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of June 27, 2019.
Notes: Data includes YMSM diagnosed by 12/31/2017 and living and residing in NYC or the Tri-County region as of 12/31/2017. 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, 2017



Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of June 27, 2019.
Notes: Data includes women diagnosed by 12/31/2017 and living and residing in NYC or the Tri-County region as of 12/31/2017. 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). Roughly 10.6% of PLWH in NYC were diagnosed and living with HCV by December 31, 2018. 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 an 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.[xx] Facilitating engagement in HCV treatment is vital; according to preliminary findings from a NYC Health Department analysis of mortality among RWHAP Part A

[6] Sustained viral suppression defined as viral load (VL) <200 copies/mL on all VL tests in the previous two years among people with at least two VL tests in the previous two years.

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 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 69% of co-infected individuals appear to have initiated HCV treatment by the end of 2017, though that number is slightly higher (74%) for those established in HIV care. In July 2018, Governor Cuomo released the first strategy in the nation to eliminate HCV. It allocated $5 million to advance the plan, and those funds are meant to be allocated primarily to community health centers and local health departments (outside of NYC). Further, the plan seeks to expand access to HCV treatment by implementing new policies that will increase access at harm reduction (HR) provider settings such as syringe exchange programs. Additionally, to address barriers to care, NYS will require managed care organizations (MCOs) 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; 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.[xxi] In 2018, NYC's STI case rates were highest in neighborhoods with high numbers of PLWH; Central Harlem and Chelsea 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 2018, rates (per 100,000) of chlamydia were 840.2 for the general population, but nearly double (1,486.3) for PLWH. This disparity is amplified in rates of gonorrhea with nearly four times the rate for PLWH (303.0 compared to 1,019.1) and over seven times the rate of syphilis for PLWH (23.5 compared to 177.9). Since 2001, the number of primary and secondary syphilis cases has increased six-fold in NYC overall; in 2018, 95% (1,917 of 2,026) of primary and secondary syphilis diagnoses were among men, 79% of which were among MSM. Among MSM with syphilis whose HIV status was known, 46% were living with HIV. In 2018, almost 72,500 new chlamydia diagnoses were reported in NYC. There were also approximately 26,000 new diagnoses of gonorrhea reported in 2018; 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 currently a scarcity of evidence surrounding drug resistance to cephalosporins.

c) Mental illness. In the Community Health Advisory & Information Network (CHAIN)[7] surveys conducted between 2017 and 2019 among PLWH, 56% of the NYC and 46% of the Tri-County cohort had a low MH functioning score (<42.0 out of 100), while 37% of the NYC cohort, and 29% of the Tri-County cohort had very low scores on a standardized MH functioning measure (≤37.0

[7] The CHAIN cohort study, in place since 1994, provides ongoing information on the characteristics, co-morbidities, and care needs and service use patterns of PLWH in the NY EMA. More than 4,000 PLWH have completed 15,516 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 a new NYC cohort recruitment, focusing on PLWH under the age 40 (the 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 begun in 2015 is on-going, and 85% of target enrollment has been completed. Because the study samples from medical and HIV social service agencies, over 98% of current CHAIN participants have some connection to the HIV service system but vary in sustained engagement with HIV medical care.

out of 100). Among NYC RWHAP Part A clients enrolled and served in 2018, 23% screened positive for depression and 25% screened positive for anxiety using the PHQ-4 tool. In a study examining the relationship between RWHAP Part A MH services utilization and MH outcomes among PLWH, higher utilization of MH services was associated with improvements in MH functioning.[xxii]

d) Substance use disorder (SUD). Among CHAIN participants surveyed between 2017 and 2019, 20% of the NYC cohort, and 64% 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 21% of the Tri-County cohort reported lifetime use of intravenous drugs. Among RWHAP Part A clients served in 2018, 18% of those assessed reported recent hard drug (i.e., cocaine, heroin, methamphetamine, and/or prescription drugs) use. Of RWHAP Part A clients with some evidence of HIV medical care (i.e., at least one lab report) in 2018, 66% of those who reported recent hard drug use during the year were virally suppressed, compared to 83% 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.[xxiii] Between 2010 and 2014, median rents in low-income neighborhoods increased by 26%, while real median household incomes fell by 7%.[xxiv] Rent burden is high; in 2017, 50% of NYC renters paid more than one-third of their incomes for rent and utilities, while 32% paid more than one-half of their incomes for rent and utilities.[xxv]

More than 133,000 unique individuals accessed the NYC shelter system in fiscal year (FY) 2018, 67% higher than it was ten years ago.[xxvi] Data from the 2019 annual NYC Homeless Outreach Population Estimate Street Survey suggest that nearly 3,600 homeless individuals may be unsheltered on any given night.[xxvii] Black and Latinx persons are disproportionately impacted by homelessness and housing insecurity, representing 89% of NYC shelter residents in 2019.[xxviii] Further, studies show that the large majority of street homeless New Yorkers have a MH diagnosis and/or other chronic conditions.[xxix] As a response to this problem, NYC released its *Housing New York* Plan in 2014, which has already provided financing for 61,299 units of affordable housing.[xxx]

The prevalence of homelessness among PLWH is especially high. During the most recent CHAIN survey period (2017-2019), 30% of the NYC cohort, and 15% of the Tri-County cohort were homeless or unstably housed. Additionally, 33% of the NYC and 28% of the Tri-County cohort interviewed reported needing housing assistance at the time of their interview.[xxxi] Housing instability and homelessness were also prevalent among HIV-positive RWHAP Part A clients served in 2018, with 11% of those assessed reporting accessing temporary housing during the year, and 19% reporting being unstably housed. Among those engaged in HIV medical care in 2018, 79% of temporarily housed and 69% of unstably housed clients were virally suppressed, compared to 85% of those with stable housing, further pointing to the added health benefits that come from being stably housed.

The provision of housing assistance and support services significantly reduces the costs associated with homelessness and improves health outcomes. A study from Nevada found that the annual costs associated with unsheltered homeless individuals living there was three times higher than providing permanent supportive housing.[xxxii] The risk of acquiring HIV is 90% lower for homeless individuals in NYC who receive three or more consecutive years of supportive housing, compared with homeless New Yorkers who apply for but are not placed in supportive housing.[xxxiii] The average monthly healthcare and public service costs for chronically homeless individuals can fall more than 50% following the provision of housing, substance use treatment, and other needed

support services.[xxxiv] PLWH enrolled in CHAIN whose HIV medical care did not meet minimum clinical standards and who receive housing assistance were 1.4 times more likely to enter appropriate HIV primary care than those not receiving housing assistance. ART adherent PLWH who received housing assistance were 1.5 times more likely to remain adherent to ART treatment than those not receiving assistance.[xxxv] Clients enrolled in NYC Housing Opportunities for Persons with AIDS (HOPWA) for more than one year are more likely than non-enrolled PLWH with similar demographic and baseline clinical characteristic to improve engagement in care, viral suppression, and CD4 count, and longer-term HOPWA enrollment is associated with better HIV health outcomes compared to shorter enrollment.[xxxvi]

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 number of PLWH are among the highest in NYC.[xxxvii] 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 who returned primarily to these three neighborhoods. Thirty-nine percent of active RWHAP Part A clients assessed in 2018 reported a history of incarceration. Among those assessed and in HIV medical care in 2018, 72% of clients with a history of incarceration were virally suppressed, compared to 85% 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.[xxxviii] These high costs may be attributable to the challenges that formerly incarcerated people – mainly Black and Latinx – often face when released, such as 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.[xxxix] In addition to the commonly known negative health effects of tobacco use, PLWH are at additional risk for HIV-specific adverse health outcomes. An analysis conducted by the NYC Health Department found that recent tobacco smoking was reported by 39% of PLWH enrolled in RWHAP Part A programs in the NY EMA in GY18. 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.[xl] 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.[xli] 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.[xlii] In studies exploring tobacco dependence and behavioral health, tobacco use is associated with worse substance use treatment outcomes and increased depressive symptoms.[xliii]

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 GY18, those receiving HR services in the NY EMA and MH services in the Tri-County had the highest rate of recent smoking, at 62% and 61% respectively. The NY EMA works with MH and HR providers to treat tobacco dependence in tandem with medical and behavioral health to support significant short- and long-term health benefits to PLWH.

4) Complexities of Providing Care.

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

Impact. The NY EMA has seen reductions totaling nearly $27 million since GY11, including a reduction of 1.6%, or $1,566,536, in GY19. 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 over the years, historically, the impact has resulted in the elimination of two service categories – Home and Community-based Health Services and Outpatient/Ambulatory Health Services – after the PC conducted a careful review of other payers. In addition, in the last three 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 their 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 reductions in morbidity and mortality.

Response. To address the reduction in funding, the PC's Priority Setting and Resource Allocation (PSRA) Committee re-assessed each category through an extensive review of Service Category-Specific Fact Sheets and Scorecards in GY18. The documents 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). To meet the reduction in the GY19 award, the PSRA Committee was able to utilize savings of $581,067 in the carrying costs of three service categories (n-MCM, MH, Health Education/Risk Reduction (HE/RR)). These service categories did not require the same funding level due to permanent contract take-downs or terminations, as reported by the Recipient. In order to cover the remainder of the reduction to the award, the PC worked closely with the NYSDOH to agree on a reduction of $834,817 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. Following the PC's approved reprogramming plan, 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	**# of PLWH**	**% of PLWH**
a1. PLWH in the NY EMA enrolled in Medicaid	61,575	67.5%
a2. PLWH in the NY EMA enrolled in Medicare and Medicaid/Medicare (dual eligible)	15,255	24.7%
a3. PLWH in the NY EMA enrolled in marketplace exchanges	18,689	19.4%
b. PLWH in the NY EMA without any insurance coverage	7,843	8.6%
Active RWHAP clients in the NY EMA, GY18 (N=15,017)		
c1. PLWH in the NY EMA living at or below 138% of 2019 FPL	12,659	89.2%
c2. PLWH in the NY EMA living above 138% and at or below 400% of 2019 FPL	1,479	10.4%

c3. PLWH in the NY EMA living above 400% and at or below 435% of 2019 FPL*	72	0.2%

Sources: Data in sections a. and b. provided by NYSDOH to NYC Health Department. The numbers and corresponding percentages reflect insurance program enrollment available through February 2019. The numbers and corresponding percentages in the second part of Table 2 are from eSHARE.
*Residents with income under 500% FPL are eligible for RWHAP services. There are no income restrictions for Early Intervention Services (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, 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 $358,144 to medical transportation to provide access to taxi and gas vouchers, as appropriate, and to mass transit options where available. The medical transportation program in the Tri-County region of the EMA ensures that clients are able to attend appointments for services related to their HIV primary care, including medical care, substance use disorder (SUD) treatment, MH appointments, and to pick up prescriptions.

Adequacy of health insurance coverage. NYS Medicaid, which expanded to include adults up to 138% FPL with the passage of the Affordable Care Act (ACA), provides insurance coverage for PLWH who are eligible. In addition, insurance coverage is available at no cost to people with HIV with an income up to 500% FPL through a combination of expanded Medicaid and NY State of Health insurance exchange plans alongside support for premiums and copays from the NYS HUCP (*see p. 28-30 for details*). These changes affected health insurance options in the jurisdiction, as well as RWHAP Part A service needs and delivery. From June 2016 to June 2019, Medicaid enrollment increased by 13% 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.[xliv] 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-Early Intervention Services (EIS) clients in GY18 reported a language other than English as their primary language. Of clients reporting a primary language other than English, most speak Spanish (78%), followed by French (5%), Haitian Creole (3%), and French Creole (3%). 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).[xlv] 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 was distributed by the NYC Health Department CTP Quality Management & Technical Assistance (QM/TA) Unit to RWHAP Part A providers in NYC in May 2019 and to Tri-County Providers in July 2019. Providers are contractually required to complete the self-assessment internally, identify areas for improvement, and include action steps in their annual RWHAP Part A QM 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.

Individuals diagnosed but not currently engaged in care. Based on the HIV care continuum, 32% of people diagnosed with HIV and presumed to still be living in the NY EMA are not currently engaged in care. In addition to robust support services, to locate and engage these individuals back into care, the RWHAP Part A program provides $795,259 in funding to the nationally recognized HIV Field Services Unit (FSU) at the NYC Health Department, which uses a data to care (D2C) model to identify PLWH who, according to surveillance data, have been lost to care. The aim is to identify and reach persons deemed to have never been 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 2018 FSU located 707 PLWH who had been out of care for at least 13 months or had never been in care since their HIV diagnosis. Of these, 486 (69%) were re-engaged or linked to HIV care; and 50 clients had unmet needs (e.g., housing, health benefits, transportation), 39 referrals were made to address their needs, and 20 accessed services. Thirty-seven percent (260/707) of not in care clients who reported having partners that could benefit from HIV testing were offered home test kits (Oraquick Rapid) to deliver to their partners, and 16% (42/260) accepted the home test kit. Among persons not in care, 18% (124) were found to have an HCV infection per the NYC Health Department viral hepatitis registry. Therefore, in addition to HIV linkage to care, 44% (55) of the persons with HIV/HCV co-infection were located and linked to HCV care.

Individuals who are not currently virally suppressed. In 2017, 29% of PLWH in the NY EMA were virally unsuppressed. In GY20, as in previous years, RWHAP Part A services will be distributed to reach high-need, underserved Black and Latinx 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. In addition, CCP clients obtain services co-located or linked with primary care providers. CCP programs linked with primary care are required to have a Memorandum of Understanding (MOU) between the Program and the primary care provider to ensure CCP staff are included as members of the care team, 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. Similar services are also provided in HR programs for those using substances.

Lastly, as described on *p. 48* 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 GY20.

a) Primary activities. The primary activities in the NY EMA's EIIHA Plan for GY20 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 city-wide 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 has supported routine screening in the past by issuing guidance to clinicians on HIV testing, conducting public health detailing to clinicians' offices on HIV testing, and giving grand round presentations to clinical practices and medical training programs. The EMA also uses City, 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 2017, an estimated 7.4% of PLWH in NYC were undiagnosed.[xlvi] 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 GY18, 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, 2018 - February 28, 2019

		Total		*Black		*Latinx		MSM		TGNC/NB	
		Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical	Clinical	Non-Clinical
a	# Test events	7,189	8,036	2,352	3,768	2,840	3,524	4,478	996	403	175

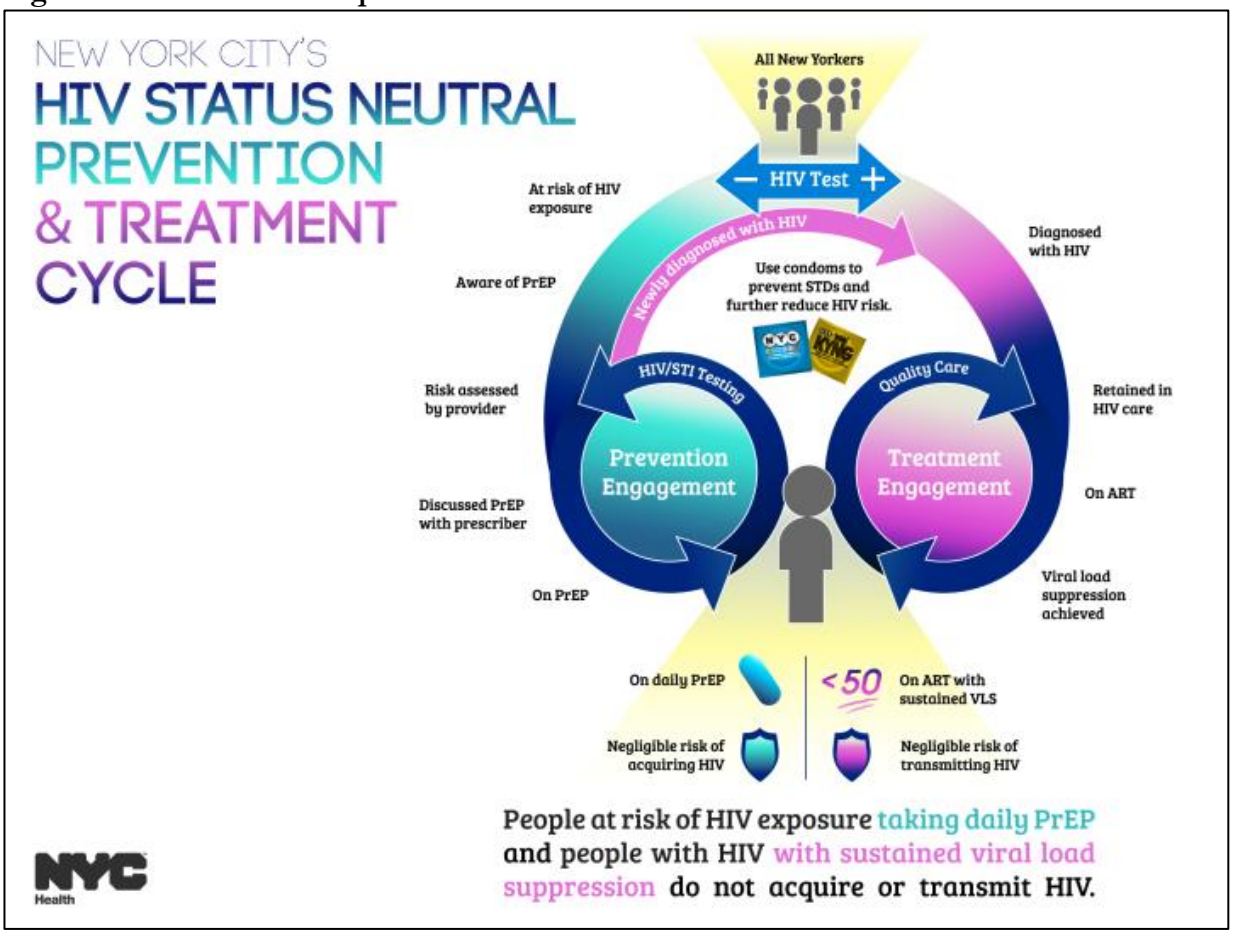
b	# Newly diagnosed positive test events	59	63	32	34	20	24	30	37	2	3
c	# Newly diagnosed confirmed positive test events	37	39	23	18	12	17	16	27	1	3
d	# Newly diagnosed positive test events with client linked to HIV medical care	40	36	19	19	19	15	21	22	1	3
e	# Newly diagnosed confirmed positive test events with client linked to HIV medical care	31	29	18	14	12	12	14	20	1	3
f	# Newly diagnosed positive test events with client referred for partner services	8	13	6	7	1	4	1	7	-	1
g	# Newly diagnosed confirmed positive test events with client referred for partner services	7	12	6	7	1	3	1	7	-	1
h	# Newly diagnosed positive test events with CD4 cell count and viral load testing ±¥	19	24	13	15	8	8	10	17	-	-
i	# Newly diagnosed confirmed positive test events with CD4 cell count and viral load testing ±¥	16	18	11	10	5	6	8	14	-	-

* Not mutually exclusive groups. Tests of clients that report being Black and Latino can be found in both sets of columns.
± Includes clients with lab test(s) occurring on or after confirmatory test date. Restricted to confirmatory test dates from 03/1/2018 to 02/28/2019 and lab tests that occurred within the same time period.
¥ CD4 and viral load data as of January 2019; data maybe incomplete due to reporting lag.

In 2016, the NYC Health Department rolled out a "status neutral" approach to HIV prevention and care services that simultaneously addresses the needs of PLWH and people not living with HIV *(see Figure 4)*. To align with this approach as well as new testing regulations and guidelines, in 2017 the NYC Health Department issued a Request for Proposals (RFP) for HIV Testing and Status Neutral Navigation Services (Status Neutral Testing RFP), which included funding from both CDC and RWHAP Part A. Contracts began January 1, 2018. CDC Prevention funds are used to contract with 11 clinical facilities to implement status neutral navigation wrapped around routine HIV testing, including immediate ART (iART) for those newly diagnosed or out of care. Ryan White EIS funds are used to contract with 15 community (non-clinical) organizations to conduct targeted testing through community and online outreach with required MOU's with clinical providers for expedited linkage to care.

Additionally, 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 supplemental RWHAP Part A support for targeted testing among uninsured individuals and linkage to care for those who test positive for HIV.

Figure 4. NYC Health Department Status Neutral Care Plan



Beyond directly contracting for testing services, the NYC Health Department has taken an additional approach to engage hospitals and community health centers in routine HIV screening through the city-wide HIV testing initiative, *New York Knows*. This program began in 2008 as an initiative focused on 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 people not living with HIV to comprehensive prevention services. Approximately 4.1 million HIV tests have been performed collectively since 2008 through all three initiatives combined, with over 410,000 tests conducted in 2018. The *New York Knows* initiative is a public-private collaboration using RWHAP, CDC, Medicaid, and other insurance reimbursements to support HIV testing efforts.

The NYC Health Department Bureau of Sexually Transmitted Infections (BSTI) is the main provider of direct HIV testing services at the NYC Health Department, conducting approximately 57,000 HIV tests annually at City Clinics. The NYC Health Department also provides integrated, opt-out HIV testing at its Bureau of Tuberculosis Control's (BTBC) chest clinics. In February 2017, the NYC Health Department announced an effort to significantly expand sexual health services and rebranded the NYC Health Department STD Clinics as *Sexual Health Clinics* (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 10 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). For the general population, beginning in June 2018, all SHCs have moved to the 4th generation Alere Determine test, which replaced the 3rd generation OraQuick Advance test.

In September 2019, the NYC Health Department BHIV's Clinical Operations and Technical Assistance (COTA) unit began conducting monthly iART training to increase iART knowledge and practices among HIV social service providers, navigators, and clinicians. This one-day training will outline the rationale and best practices for enacting a call to action to promote iART for all people newly diagnosed as living with HIV as well as those returning to care after a long lapse. The training will review clinical guidelines and current data on iART, share best practices on iART implementation, and navigate insurance barriers and referral processes. In addition, COTA will launch an iART detailing campaign in January 2020 to promote scaling up iART in HIV clinics across NYC. COTA is in the process of developing an iART action kit, which includes a variety of clinic resources (e.g., brief guidance documents, workflow examples, payment options guidance, genotype testing guidance, patient facing materials) to build the capacity of HIV clinic care teams to adopt and operationalize iART. COTA will conduct face-to-face education visits to HIV clinics to disseminate the iART action kits. COTA will continue to provide on-going, tailored TA to clinics after initial visits to ensure clinics are supported as needed.

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. Through one of the Status Neutral Testing RFP's service categories, funded by RWHAP Part A, 15 selected community-based agencies are focusing on gay, bisexual, and other MSM and TGNC/NB persons and their partners, with particular attention to Latinx or Black TGNC/NB individuals under 29 years old; heterosexual WoC, 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 numbers of PLWH 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. From March 2018 to February 2019, these funded testing programs conducted 3,248 HIV tests, identified 36 individuals with new HIV diagnoses, and linked 64% of those newly diagnosed to HIV medical care within 30 days of diagnosis. These programs also linked 79 clients to a PrEP provider and 26 clients to a PEP provider.

In addition, RWHAP Part A and CDC funds support targeted testing at the Riker's Island jail facility. Using City funds, the Riker's Island facility offers opt-out testing at intake, and for those who refuse a test, the RWHAP Part A-funded and CDC-funded contract supports outreach and follow-up to conduct an HIV test at a later date.

Linkage and retention in medical care. The NY EMA promotes linkage to medical services and immediate initiation of HIV treatment (i.e., iART) 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, in 2018, the Recipient began promoting and funding programs to link persons newly diagnosed with HIV to HIV medical care within four days of

diagnosis and to offer HIV treatment to these clients on the first HIV medical visit, as well as provide prescription and support services for PrEP and PEP to those with a negative HIV test result. Subrecipients receive higher reimbursement rates for linkage to care within four days of diagnosis, and lower reimbursement for linkage within 14 and 30 days of diagnosis. From the Status Neutral Testing RFP, 26 clinical and non-clinical agencies were funded to provide prompt linkage to care with initiation of HIV treatment at the first medical visit. These facilities also provide prescription and support services for PrEP and PEP. From March 2018 to February 2019, these programs initiated ART with 201 persons within four days of HIV diagnosis, initiated PrEP with 114 individuals, and prescribed PEP to 37 individuals. These funded programs join over 40 other funded contractors to provide PrEP and PEP education, referral, linkage, and prescription services; collectively they are known as the *PlaySure* Network.

The City's 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 the JumpstART program, 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 2018, there were 213 new HIV diagnoses in the SHCs (24 acute HIV cases); 53% of patients who were newly diagnosed at SHCs providing JumpstART at that time received JumpstART on the day of HIV diagnosis; and 1,454 patients were initiated on PrEP.

Through the Status Neutral Testing RFP, the NY EMA funded clinical facilities to expand linkage to care services. The programs leverage the NYSDOH's Rapid Access to HIV Medications and Treatment Program (Rapid Tx) by providing wrap-around services (i.e., patient education and linkage to services) to increase access to rapid ART initiation, with higher reimbursement for those linked on the same day. Sixteen CCP programs have opted to include iART in their service provision, whereby RWHAP Part A resources provide wrap-around case management, entitlement services, and client education for newly diagnosed or out of care PLWH referred by emergency rooms, outpatient and inpatient clinics, as well as HIV testing programs.

BHIV's COTA unit initiated a study to assess clinical and non-clinical providers' knowledge, attitudes, and practices related to iART. Online structured surveys and in-person, in-depth interviews were administered to providers, and data are currently being analyzed. A stakeholder meeting to disseminate the results of the pilot and engage providers in strategic planning around strengthening iART efforts in NYC was conducted on July 10, 2019.

Increase rates of retention in care and SVL. The NYC Health Department has funded a city-wide 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 SVL (<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, the NYC Health Department 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 TA on program implementation to awardees. As of December 31, 2018, EtE-funded Undetectables programs have served approximately 2,300 PLWH in NYC, and 90% of clients engaged in care (1,612) were virally suppressed. The Undetectables is also being disseminated in NYS through other channels. As part of Medicaid redesign efforts, two Delivery System Reform Incentive Payment (DSRIP) Program Performing Provider Systems have begun to implement The Undetectables in NYC and in Albany; and Amida Care, an HIV-focused insurance plan, launched Live Your Life Undetectable (LYLU) to provide the same financial incentive under similar requirements (dual engagement in primary care and supportive services). 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.

In addition to The Undetectables, in FY18, Primary Care Status Measures (PCSM)-based data were presented at meetings with providers and also shared via the program-specific Treatment Status Reports (TSRs). TSRs are line-level reports displaying coded identifiers and the ART status of clients who are overdue for a viral load test result update in eSHARE (which is used by all NY EMA RWHAP Part A-funded providers) or who were not virally suppressed as of their last viral load test results. The TSRs are generated quarterly and sent to program staff by their quality management specialists (QMS). The Recipient also generates Agency-level Viral Suppression Reports (AVSR), which aggregate all agency-specific viral load suppression data into one report and compares it to all RWHAP Part A clients in NYC. The AVSR was redesigned in 2019 to also look at viral suppression among five specific priority populations (OPLWH, Black or Latino cisgender MSM, cisgender YMSM, transgender women, and cisgender WoC) within each agency. These priority populations were selected to align with the NYC Health Department's Race to Justice initiatives to advance racial equity and social justice.

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 GY20.

In the Tri-County region, the Westchester County Department of Health (WCDOH) has implemented several programs through NYS funding and NY EMA RWHAP Part A EIS funding to expand HIV testing and linkage to services, including PrEP, 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. In GY19, the Tri-County region increased resources to reach YMSM and WoC. 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 *NYLinks* (*see p. 21 for more detail*) 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 NYC Health Department-funded testing programs, the NYC Health Department 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, the NYC Health Department 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, the NYC Health Department 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, 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 Lesbian, Gay, Bisexual, Transgender, and Queer (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. In 2019, BHIV launched *Made Equal*, a social marketing campaign to promote the evidence-based finding of Undetectable=Untransmittable (U=U). 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 and 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 2018, FSU offered partner services to all newly diagnosed persons city-wide. FSU interviewed 84% (1,510/1,789) of those newly diagnosed in NYC and elicited 585 HIV-exposed partners. Seventy-three percent (318/433) of partners with a negative or unknown HIV status were notified and 53% (168/318) were tested, of whom 18% (30/168) had 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 58% (168/288) linkage to PrEP services, 35% (48/138) expressed interest in PrEP, and 90% (43/48) accepted the PrEP referral.

b) Major collaborations with other programs and agencies. Many NYC Health Department programs collaborate to identify individuals unaware of their HIV status. Under the leadership of the BHIV Prevention Program, all contracted 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. Further, the Prevention Program's key community partner is the HIV Planning Group (HPG). Similar to the RWHAP Part A PC's role with RWHAP Part A programs, the HPG supports all HIV prevention activities through representation of the perspectives of communities impacted by the local HIV epidemic and by reviewing and providing

feedback and input in support of the NYS *Integrated HIV Prevention and Care Plan*. BHIV programs practice a unified approach, collaborating with clinical operations, prevention, policy and external affairs, social media and condom expansion, surveillance, and CTPs. The BHIV also collaborates with other NYC Health Department 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, CTP; Public Health Lab; Office of School Health; Administration for Children's Services; and NYC Health + Hospitals (H+H). The NYC Health Department 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. The NY EMA also collaborates with the Health and Human Services Region 2 to promote and support PrEP and PEP implementation in Federally Qualified Health Centers, Title X clinics, and provide support to NYC providers to better refer clients to MH and SUD services such as NYC Well, a 24/7 hotline staffed by trained mental health professionals who provide assessments and treatment referrals.

Through a CDC-funded demonstration project, Project THRIVE, the NYC Health Department 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. To further these efforts, the NYC Health Department hosted a day-long workforce development workshop. In 2017 and 2018, Project THRIVE's Community Advisory Board (CAB) held multiple discussion sessions on the effects of social determinants of health (i.e., stigma and violence, MH, employment, and criminal justice) on linkage and retention in care. Based on these discussions, the CAB created recommendations for addressing social determinants of health in HIV prevention and treatment. These recommendations have informed the NYC Health Department's solicitation process for contracted services, guidance on contract scopes, and the process of providing feedback to community members.

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 PLWH to care, link people not living with HIV to prevention services including PrEP, and make HIV testing a routine part of healthcare in NYC. *New York Knows* holds regular steering committee meetings in all five boroughs. In 2019, the NYC Health Department hosted an All-Partner meeting for both clinical and non-clinical partners. Topics covered by plenary presentations and breakout sessions included an update on HIV testing, strategies to integrate combination prevention in routine clinical settings, data utilization to improve prevention services, working with non-traditional partners, building a community reputation for serving MSM, improving services for WoC, and providing services to immigrant communities.

BHIV also collaborates with the NYSDOH AI on *NYLinks*. *NYLinks* is a statewide project, and a continuation of a previously funded HRSA/HIV/AIDS Bureau (HAB) Special Projects of National Significance (SPNS) initiative, focused on improving linkage to and retention in care and viral suppression. BHIV is an active participant in the Brooklyn regional collaborative established under *NYLinks*, with staff serving as Co-Chair of the workgroup, 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. In addition,

BHIV staff participate in borough-based EtE Steering Committee meetings, born out of the process to develop and implement the NYS *EtE Blueprint,* and provide regular updates on surveillance data and prevention and care activities. NYSDOH AI and BHIV also coordinate *NYLinks* and EtE Steering Committee meetings to align with *New York Knows* meetings; and implement joint annual meetings of the *New York Knows*, *NYLinks*, and EtE Steering Committee workgroups in Brooklyn, Queens, and Staten Island.

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 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 the End AIDS NY 2020 Coalition, NYC Kiki Coalition, Long Term Survivors Wellness 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. 39 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 p. 24-25 for specific strategies)*. These goals directly align with the goals of the national *Ending the HIV Epidemic: A Plan for America* and *NYS's EtE Blueprint* and *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.

As the NY EMA continues to promote and fund testing programs that focus on priority populations, including gay, bisexual, and other MSM, TGNC/NB persons and their partners; heterosexual WoC; and other vulnerable populations. Due to these and additional efforts outlined in the EIIHA plan, the proportion of residents in the NY EMA that have ever been tested for HIV continues to increase. Through the Community Health Survey (CHS), the NYC Health Department tracks the percentage of NYC residents, aged 18 and older, who report ever testing for HIV. In 2017, 66% of adult NYC resident CHS respondents had ever been tested for HIV; up from 60% in 2010.[xlvii] At the same time, 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 (*see p. 14-17 for more details).* This declining trend in the number of new diagnoses is partly due to the NYC Health Department'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. With the on-going implementation of the EIIHA strategy, the NY EMA expects a continued increase in the percentage of NYC residents reporting ever having received an HIV test and continued decrease in the percentage of new HIV diagnoses.

The NY EMA EIIHA incorporates a planned outcome to increase the percentage of people with new HIV diagnoses initiating care. Currently, the NYC Health Department 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 80% 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 stages of 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, TGNC/NB 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 Sexual Health Survey (SHS). Among sexually active NYC MSM aged 18-40 surveyed through the SHS in spring 2018, 92% 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.[xlviii] The low uptake underscores the need for continued services to engage people and link to PrEP as well as intensive social marketing and education efforts, such as *Living Sure* and *Listos!*.

2) GY20 EIIHA Plan target populations. The three selected distinct target populations are: (1) Black and Latino MSM; (2) TGNC/NB persons and their partners; and (3) Black and Latina women living in neighborhoods with high numbers of PLWH.

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-four percent of new HIV diagnoses in the NY EMA in 2018 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.[xlix] This holds true in the NY EMA, making them a high priority of the overall EIIHA Plan. In 2017, YBMSM and YLMSM accounted for 84% of all YMSM living with HIV in the NY EMA. 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.[l] Further, some YMSM who experience homelessness or housing instability face additional barriers to healthcare including a lack of awareness of available resources, transportation, and financial resources and/or health care insurance.[li]

b) TGNC/NB persons and their partners. In 2018, 3% of new HIV diagnoses in NYC were among transgender individuals, 95% of whom were transgender women. Black or Latina women made up roughly 88% of new diagnoses among transgender women, and 54% of newly diagnosed transgender women were between the ages of 20-29. No local estimates of HIV prevalence exist, but national estimates of prevalence are 22-28% among transgender women.[lii] 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 needs, substance use, and poor access to healthcare and affirming providers.

c) Black and Latina cisgender women in areas with high numbers of PLWH. In 2017, Black and Latina cisgender women accounted for 90% of all cisgender women living with HIV in the NY EMA. These proportions indicate a continued need for targeted EIS, including HIV testing and status neutral navigation services. Further, previous analyses by the NYC Health Department have demonstrated that HIV diagnoses and prevalence are more likely to overlap with areas where increased poverty, health disparities, and poor health outcomes are found; these are areas where Black and Latina women who have sex with men typically reside. Several subpopulations of Black and Latina women, including low-income individuals, people who use substances, and individuals who were born outside of the U.S., have a higher risk of contracting HIV.

Other challenges experienced by Black and Latina women include stigma associated with HIV, cultural and language differences, lack of knowledge of HIV prevention tools such as PrEP and PEP, and low self-perceived risk for HIV. For example, a 2017 telephone survey of Black and Latina women in NYC found that only 34% of respondents had ever heard of PrEP and 60% felt they would not benefit from taking PrEP or PEP. PrEP prescriptions among women are disproportionately lower than among men. Between January and June 2018, men received PrEP prescriptions at 12 times the rate of women (16,494 vs. 1,364 prescriptions); however, men have an HIV diagnosis rate that is four times higher than women. Many Black and Latina women in the NY EMA live in neighborhoods with high numbers of PLWH 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 were born outside the U.S., 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.

c) Specific strategies that will be utilized with the target populations. The NY EMA's GY20 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 outlined in *Ending the HIV Epidemic: A Plan for America* and NYS's goals detailed in the *EtE Blueprint* and the *Integrated HIV Prevention and Care 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 RWHAP 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 (Status Neutral Testing RFP), the NYC Health Department prioritized RWHAP Part A EIS funds to address the needs of prioritized populations to receive HIV medical care by funding 15 CBOs to provide HIV testing and support services. CDC funds 11 status neutral linkage and navigation programs in clinical facilities to provide PrEP and PEP services to eligible patients, and offer iART 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 a high need area and/or to a patient population that resides in ZIP codes with high numbers of PLWH and documented health disparities were prioritized. From March 2018 to February 2019, these funded testing programs conducted 3,248 HIV tests, identified 36 individuals with new HIV diagnoses, and linked 64% to

HIV medical care within 30 days of diagnosis. These programs also linked 79 clients to a PrEP provider and 26 clients to a PEP provider. The awarded contracts run through December 31, 2020.

Funded CBOs use innovative approaches, such as behavioral risk screenings for PEP and PrEP, brief interventions, 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 to reach at-risk populations. A recent qualitative study[liii] 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.

To further increase accessibility of testing services, the NYC Health Department has conducted giveaways of in-home HIV self-tests since 2015. In 2018, the NYC Health Department conducted a targeted awareness campaign among MSM and TGNC/NB NYC residents who have sex with men through online ads. By completing a brief eligibility survey, these individuals were able to access free HIV self-tests, and over 2,500 individuals accessed HIV tests through this initiative.

The NY EMA promotes U=U, the message 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.[liv] The U=U initiative, in combination with the Status Neutral Testing RFP, provides an opportunity for providers to conduct targeted outreach and testing to the target populations 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 community program clients. BHIV also released its latest sexual health marketing campaign, *Made Equal*, in June 2019, aligning with Global Pride events in NYC. *Made Equal* promotes the U=U concept, and is designed to reduce HIV-related stigma, celebrate healthy sexuality and sexual pleasure, and redefine what it means to live with HIV. *Made Equal* is currently appearing in subway cars, subway stations, buses, and bus shelters across the city, as well as on digital media.

In addition to being priority populations in the above-mentioned U=U initiatives and Status Neutral Testing RFP activities, the NYC Health Department also implements several initiatives specific to the EIIHA-identified target populations. These initiatives include:

<u>Black and Latino MSM.</u> The CDC demonstration project, Project THRIVE, seeks to improve testing, referral, linkage, and navigation to prevention and care services for MSM of color in Brooklyn. Under Project THRIVE, the NYC Health Department has 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 the NYC Health Department staff to discuss and make recommendations on addressing these social determinants. In fall 2019, BHIV will launch a storytelling initiative throughout NYC to promote LGBT wellness and to address HIV-related stigma. CDC-funded 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.

In September 2018, in response to being awarded funds for CDC PS17-1711, the NYC Health Department formed the Project Sol CAB composed of HIV prevention and care service providers who largely identify as Latino MSM to inform all aspects of the project as they are developed,

ensuring that work is sensitive and engaging to Latino MSM, particularly in developing quality molecular HIV surveillance protocols, provider trainings, CBO detailing, and social media campaigns. The Project Sol CAB also enriches and expands development of relationships with organizations serving Latino MSM to support programming that engages and sustains Latino MSM living with and at risk for HIV in HIV prevention, care, and treatment services.

In 2018, BHIV 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 to improve understanding of how medical and social service providers can better 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 enacted 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 both sex work and available services city-wide to provide better referrals. The NYC Health Department will use this data to inform development of services moving forward.

TGNC/NB persons and their partners. TGNC/NB-led organizations are 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 TGNC/NB persons. Efforts to address the needs of TGNC/NB 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 WoC by developing recommendations to ensure that gender affirming best practices are implemented across programs in the RWHAP Part A portfolio. BHIV is also currently implementing a study with TGNC/NB individuals who engage in sex work to inform future activities to support their health and well-being. The study is conducting individual interviews with TGNC/NB individuals who exchange sex for money to elicit information on: the overall experience of sex work among TGNC/NB 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.

Black and Latina cisgender women in areas with high numbers of PLWH. Agencies funded through the Status Neutral Testing RFP conduct outreach to individuals who live in high-poverty areas, where HIV risk is higher, and link them to appropriate services, including HIV testing, 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 immediately initiate ART. In 2018, BHIV implemented the fifth wave of its public health detailing campaign to promote PrEP and PEP, which was focused 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. In 2016, BHIV founded the Women's Advisory Board (WAB), a diverse group of dedicated and passionate women leaders with expertise serving

and empowering women within their communities. WAB was founded as a collaboration between *New York Knows*, HPG, and the NYC Health Department's Center for Health Equity and, in subsequent years, CTP. Since the first meeting, the WAB has grown to over 50 members, representing 11 organizations across all boroughs, and includes cisgender and transgender women as well as non-White women. The WAB is committed to improving HIV prevention and care for women in NYC through dialogue and concerted action. On March 9, 2019, the WAB led the third annual Women's Health and Activism Summit to garner input where participants identified MH, domestic violence, and immigration as high priority topics to be addressed at future Summits. As noted previously, in March 2018, the NYC Health Department launched a social marketing campaign, *Living Sure*, promoting PrEP and PEP usage among cisgender and transgender women.[lv] This is the latest addition to the NYC Health Department's series of sex-positive campaigns, *BeSure*, *PlaySure*, *StaySure*, and *Bare It All*, which seek to improve sexual health and wellness among their respective target populations.

3) *Planned efforts to remove legal barriers to routine HIV testing.* In the last decade, the NYC Health Department 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.

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 age 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. The NYC Health Department 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. This change has allowed the RWHAP Part A program to provide surveillance data on clients not virally suppressed to CCPs to encourage continued enrollment and increased adherence services.

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

METHODOLOGY

A) Impact of the Changing Health Care Landscape

1) Description of Health Care 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 435,000 enrollee (7%) increase between 2018 and 2019.[lvi]

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: 2019 NY State of Health Plan Availability by County – Individual Market[lvii]

County	Emblem Health	Empire BlueCross-BlueShield	Fidelis Care	Healthfirst	MetroPlus Health Plan	MVP Health Plan	Oscar	United Healthcare
Bronx	✕	✕	✕	✕	✕		✕	✕
Kings	✕	✕	✕	✕	✕		✕	✕
New York	✕	✕	✕	✕	✕		✕	✕
Putnam	✕	✕	✕			✕		✕
Queens	✕	✕	✕	✕	✕		✕	✕
Richmond	✕	✕	✕	✕	✕		✕	✕
Rockland	✕	✕	✕			✕	✕	✕
Westchester	✕	✕	✕			✕	✕	✕

Table 5: 2019 NY State of Health Essential Plan Availability by County[lviii]

County	Affinity Health Plan	Emblem Health	Empire BlueCross BlueShield HealthPlus	Fidelis Care	Healthfirst	MetroPlus Health Plan	MVP Health Plan	UHCCP	WellCare of New York
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	x
Rockland	x			x			x	x	x
Westchester	x	x		x	x		x	x	

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 experienced with the needs of PLWH. Current networks for NYS SNPs do not include the Tri-County region. SNP eligibility includes TGNC/NB 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 in the process of 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.[lix] The Amida Care Innovator Network (ACIN) was incorporated in 2018, the ACO Certificate of Authority (COA) was approved in February 2019. ACIN is one of 10 agencies that has received a COA and is now listed on the NYSDOH website. Following receipt of the COA, ACIN submitted its Innovator application to the State, which is currently under review.

In the lead-up to the effective dates for provisions of the ACA and Medicaid Redesign efforts, the NYC Health Department 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 CTP continues to allocate resources to support a Policy Advisor to monitor the health care 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 health care 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 requirements. 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 the POLR and that Part A providers ensure clients are appropriately enrolled in coverage, written communication, contractual language, and data reporting requirements clarify RWHAP Part A client assessment and

reassessment expectations. This ensures that clients have adequate support to access health insurance, should they be eligible.

During the past several years, NYS has undertaken a variety of initiatives to reduce costs and improve health outcomes for Medicaid enrollees. These initiatives have resulted in the creation of several specialized insurance products and service lines that include payment for supplementary services for vulnerable New Yorkers. In addition to the services paid for by Medicaid fee for service (FFS) and MCO plans, the additional products and services considered applicable to RWHAP Part A clients are Health Homes (HH) for people with a variety of qualifying conditions who can benefit from coordination of care, HIV SNPs for people living with and at increased risk of HIV, Health and Recovery Plans (HARPs) for people with complex behavioral health needs, and Home and Community Based Services (HCBS) for a subset of HARP enrollees who need additional support to achieve behavioral health goals. In order to ensure the RWHAP Part A continues to function as the POLR in a rapidly shifting and complex environment of Medicaid programs in New York, BHIV conducted an in-depth review and cross-walk of all RWHAP Part A services that were potentially reimbursable by Medicaid through FFS and MCO plans, HHs, SNPs, HARPs, and HCBS in the spring of 2019. This analysis resulted in the creation of POLR guidance for service providers and a review tool for contract oversight staff to use during site visits at agencies with contracts in the applicable service categories.

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.

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 between 150% and 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 500% of the FPL (increased from 435% as of July 2019). The NY EMA has seen steady increases in ART usage (from 78% of all diagnosed in 2014 to 87% in 2017),[lx] and as a result, increased viral suppression (from 67% in 2014 to 71% in 2017). 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.[lxi,lxii] 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;[lxiii] conversely, adults with chronic medical conditions are more adherent when they have prescription drug coverage.[lxiv, lxv]

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

a) Service provision and complexity of providing care to PLWH. The PC has been working to address changes in the health care system since 2011, with the development of its first Core Medical Services (CMS) Waiver application. As such, additional shifts were made in funding allocations to Housing, FNS, Psychosocial Support Services (PSS), 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 Marketplace. 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 *p. 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 core medical and support services at clinics, hospitals, and CBOs. From GY18 to GY19, RWHAP Part A funding for ADAP was reduced by 37.6%, which allowed the NY EMA to maintain programs and enhance FNS, PSS, 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 GY19 used a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate resources for GY20. The PC and its committees, with aid from the Recipient, 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 is responsive to current needs and identified challenges. All PC subcommittees include a diverse range of consumers, providers, and other stakeholders, and provide extensive opportunities for public comment, as described throughout this section.

The PC works closely with the Recipient and other NYC Health Department staff throughout the planning process, and has a dedicated staff liaison from the BHIV Surveillance Unit specifically 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*, a POLR Analysis, Service

Category Fact Sheets, RWHAP Part A Scorecards with multiple years' historical utilization data, and data analyses from the NY EMA's CHAIN study;

- Allocated 56.2% of RWHAP Part A and MAI funding to CMS for GY20;
- Continued funding for MCM/CCP Programs to optimize medical outcomes;
- Allocated 5.0% of the GY20 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 to coordinate with 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; and
- Approved increases in targeted 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 NYC Health Department surveillance analysts, 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 GY19, the NAC identified Oral Health services in the NYC portion of the EMA as a key area of focus (the Tri-County portion of the EMA already has Oral Health as a RWHAP Part A service category). After an exhaustive review of data and extensive testimony from providers and consumers, the NAC found that existing programs only cover essential services and do not adequately cover the oral health needs of PLWH. For instance, reimbursement limitations frequently do not cover replacements for lost or broken dentures, reimburse for the cheapest quality materials, and limit dental work that preserves the long term oral health of patients. NAC recommendations included: (1) Fund RWHAP Part A Oral Health Services in NYC to fill gaps in coverage by Medicaid, Part F, and other sources; (2) Develop a screening tool with validated questions to identify oral health discomfort and issues among consumers, ensure linkage to oral health services, and develop health education modules that incorporate the need for dental services and oral hygiene; (3) Include in the Oral Health Service Model a Dental Case Management component that can afford the opportunity to address social isolation, reduce anxiety, and improve consumer engagement and education; (4) Ensure coverage of at least four dental cleanings per year; and (5) Develop provider recommendations for common co-morbidities (e.g., diabetes, HCV, HPV). These recommendations will be taken up by the PC's Integration of Care (IOC) and PRSA subcommittees in GY20 which will ensure any RWHAP Part A funded services complement Medicaid, Part F, and ADAP services to ensure a robust system of oral health care for PLWH.

The NAC also developed a set of recommendations to improve access to RWHAP Part A services for people with physical or sensory disabilities. Forty-five percent of RWHAP Part A clients reported through eSHARE that they have some kind of disability (e.g., mobility, hearing, sight, cognition). In order to ensure that PLWH with disabilities have access to the full range of services, the NAC recommends that: (1) RWHAP Part A programs implement improved data collection through validated screening tools; (2) the Recipient train providers on how to provide

reasonable accommodations; (3) the Recipient provide guidance to providers on how to ensure compliance with all relevant federal, state and local laws governing access; and (4) the Recipient identify funding resources that providers can use to ensure Americans with Disabilities Act (ADA) compliance. The full Council will consider these recommendations in fall 2019 for implementation in GY20.

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. Building on work done in GY18, the IOC developed a new service directive for PSS targeted to the population of people of transgender, intersex, and gender non-conforming or non-binary (TGINCNB) experience in GY19. The PSS TGINCNB 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 and health outcomes that have persisted for this population. The NYS *Integrated HIV Prevention and Care Plan*'s goals and objectives (i.e., 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 directive.

The new PSS TGINCNB directive will require programs to: (1) Conduct an initial patient intake assessment and periodic reassessments to identify TGINCNB patients' unmet medical and social needs and to appropriately support their capacity for self-management; (2) Coordinate all levels of medical and behavioral health as needed (e.g., logistics coordination, appointment scheduling, preparation and reminders, accompaniment, transportation assistance, return to care, outreach and in-reach activities, and ensure linkage and engagement in other needed medical or specialty care, MH, HR and/or substance use services); (3) Ensure access to and consistent use of ART using Motivational Interviewing techniques and other adherence tools; (4) Provide individual and group support services that promote engagement and maintenance in care (including transitional, supportive and permanent housing that is safe for people of TGINCNB experiences), adherence to primary medical care, and modes of healthy living; and (5) Link clients to programs and services that facilitate client stabilization, including life skills training, financial literacy, and educational support. The directive also includes language from the IOC's previously developed master service directive (applicable to all service categories in the NY EMA) that emphasize the provision of client-centered, trauma informed care (where patients are included in decision making whenever possible), support for the use of peers in service delivery, and address the needs of people with sensory and mobility impairments. In addition, all clients will be assessed in regard to linkage and retention in medical care and viral load lab dates, which is routinely entered into eSHARE as a part of PCSM *(see CQM section, p. 46-49 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 individually weighted criteria 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. The 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 GY20, the PSRA Committee examined a newly developed POLR and Coordination of Services Analysis compiled by consultants on behalf of the PSRA Committee. The analysis helped the PSRA Committee members understand how RWHAP Part A serves as a POLR by providing core medical and supportive services for PLWH who have no other source of coverage or face coverage limits, and provides services not covered by Medicaid and other payers. Due to NYS Medicaid's robust service coverage, the NY EMA prioritizes funding for supportive services, many of which are not covered by NYS insurance plans, but are vital to the health and wellbeing of PLWH. Services not covered by Medicaid and private insurance include many of the supportive and coordination services that have been expanded since the NY EMA obtained the CMS Waiver. The PSRA Committee also utilized 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 RWHAP 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 NYS HH program was a critical factor in the PC's approval of the GY20 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 subcommittee of the PC conducts service planning and makes resource allocation recommendations to the PC for Rockland, Putnam, and Westchester county services. Tri-County's 34-member Steering Committee includes 13 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. Most of the service portfolio in

the Tri-County region was recently re-bid for GY20, and the Steering Committee recommended proportional increases to the regional RWHAP Part A portfolio in order to increase capacity.

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. 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. PC members and staff who are living with HIV 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 health care landscape and its effects on RWHAP services. The committee plays a key role in recruiting new members, including the distribution of consumer outreach brochures, available in English and Spanish, at all PC outreach events. The committee advocates for consumer engagement in the planning process, and supports training and mentoring of new PC members (trainings to maximize informed participation and decision-making are available during the planning cycle).

In 2019, PLWH constituted 43% of the PC's 48 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 (72%) of the PC's non-aligned PLWH are people of color. PLWH actively serve on all PC committees and make up 40% 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 of 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.

To develop the GY20 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, Tri-County Steering, 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 QM 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 2018 Power of Quality Improvement Conference, where RWHAP Part A providers heard client perspectives on participation in client/consumer advisory boards as a way to facilitate QI, engagement and retention in care as well as patient/provider relationships and communication. The Consumer Committee also co-presented along with PC and NYC Health Department staff at the 2018 National Ryan White Conference on HIV Care & Treatment regarding community-based research they conducted that provided recommendations on how to improve patient-provider relationships and keep PLWH engaged in HIV care.

ii. Addressing funding increases or decreases. The PC's data-driven planning tool allows for an objective and advanced planning process 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 GY19, there was a decrease of $1.57 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. As described on page 11, the PC worked closely with NYSDOH to agree on a reduction to the NY EMA's RWHAP Part A allocation to 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 enrollment under the ACA). The ADAP reduction allowed the PC to maintain services at their current levels. If the RWHAP Part A award is further reduced in GY20, 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 GY20.

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 *Integrated HIV Prevention and Care 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 GY20, consistent with the goals in the NYS *Integrated HIV Prevention and Care Plan*. The PC utilized multiple data sources, including surveillance reports, the NY EMA RWHAP Part A Service Category Fact Sheets, Scorecards, POLR Analysis, 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 $24 million for MCM in GY20. 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 $1.3 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 GY20. An additional $4.1 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, which receives the largest service category allocation in the NY EMA's portfolio. 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 in GY18 for a re-bid of this service category for contracts starting in GY19, the PC examined NYC Health Department-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.[lxvi] 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.[lxvii] Evidence of CCP effectiveness over usual care suggests health benefits for enrolled PLWH and 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.[lxviii]

Through Service Category Fact Sheets and 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 Fact Sheets and Scorecards, the PC reviews service utilization data specifically by gender and age as well as by several special populations, including WoC, YMSM of color, OPLWH, immigrants, substance users, and TGINCNB individuals. The data have shown that women make up a larger percentage of RWHAP Part A clients in the NY EMA (42%) than their proportion of the local epidemic (26.5%). Youth aged 19 years and under are similarly over-represented as a proportion of RWHAP Part A clients (2.7%) 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 PSS 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 FY18, Medicaid expended more than $83,476,557 to fund CMS for WICY populations far exceeding the NY EMA's required set-aside $26,002,948. 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, WoC, perinatally infected youth, and YMSM.

The PC reviewed evidence on disparities in timely EiC for newly diagnosed people. The PC allocated $4.3 million to EIS in GY20 (including $1.7 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 $878,094 under 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; provide treatment and care to PLWH with MH issues, including those with co-occurring SUDs, 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 million to MH services for GY20.

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 GY20, the PC examined unit costs and determined that an additional $1.45 million would allow for a 10% increase capacity, allowing them to fill gaps 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 over-performing service categories and 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 GY20 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 current local epidemic, the needs of PLWH, gaps in services, and disparities in access to HIV care, and the ongoing effects of the changing health care 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 new PSS TGINCNB service directive were 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, and answered 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 on GY18 to the full PC in July 2019.

b) Deficiencies. The EC determined that there were no deficiencies in the administrative mechanism, and no corrective action was needed for GY18.

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.

Additional resources needed to fulfill the goals of the *EtE Blueprint* have been secured through NYC Health Department funding, allowing for contracts to increase the availability of PrEP/PEP, support viral suppression, provide clinical services, pharmacotherapy, HR support for MSM and transgender women using methamphetamines, and increase the capacity of TGNC/NB-led and Black MSM-led CBOs. As described on *p. 17*, in GY19, the Recipient worked with the NYS HUCP to support iART upon diagnosis through coordination with RWHAP Part A EIS and MCM-funded providers and CDC-funded Status Neutral navigation clinical contractors. The NYS HUCP provides iART and related medical and laboratory services through its Rapid Tx program while RWHAP Part A EIS and CCP resources provide support services to newly diagnosed clients in need of iART through coordination of benefits and insurance, assessment of urgent needs, and the provision of support and accompaniment services through patient navigation to enhance and ensure adequate linkage to and retention in care.

Addressing income as a social determinant of health is an important endeavor to meet the needs of PLWH in the EMA given that 85.6% of RWHAP Part A clients earn less than 138% of the FPL. While RWHAP Part A resources are not able to support efforts to engage PLWH in employment services, the NYC Health Department has utilized other resources to address this need. In 2017, the NYC Health Department 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. In addition, 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 was the successful execution of "Career Power Source," a community event that took place October 3, 2018. As a result of its success, a second "Career Power Source" occurred on September 18, 2019. This all-day event brings 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.

The NY EMA 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. 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. The PC and the Administration and Planning Team regularly use the HIV care continuum to understand gaps and identify new service models that might be able to meet those gaps. The HIV care continuum is also used to measure progress towards EtE goals. The NY EMA was able to produce a combined continuum for NYC and the Tri-County region, for all PLWH, using 2017 data *(see Figure 2)*. Information on all PLWH

was obtained using the NYS Surveillance Registry. Using NYS's methodology, individuals who have been diagnosed with AIDS with no evidence of care for five years and individuals who have been diagnosed with HIV (non-AIDS) with no evidence of care for eight years are excluded from the total number of diagnosed PLWH. This approach yields an 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. The NYC Health Department's MMP in NYC provides an estimate of ART prescription status for all PLWH.

b) Changes in the HIV care continuum. From 2014-2017, the proportion of clients engaged along the different stages of the NY EMA HIV care continuum has remained relatively stable, with a large increase in linkage to care and a slight increase in retention in care, ART prescription, and viral suppression. 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 providers in July and August 2018 (and semi-annually thereafter), 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 (NIH), HRSA, and CDC, among others, to work with academic and other partner institutions to conduct in-depth assessment 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 in the CDC Compendium[lxix] 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.[lxx] In addition, the REU of CTP received new NIH R01 funding for an implementation science study, Program Refinements to Optimize Model Impact & Scalability based on Evidence (PROMISE). This endeavor will evaluate the changes in the CCPs resulting from the PC's GY18 service directive.

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 the NYC Health Department 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.[lxxi] In a separate analysis, controlling for sociodemographic and clinical characteristics, recent tobacco smoking was also found to be associated with unsuppressed viral load.[lxxii] Additionally, 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.[lxxiii] 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,[lxxiv] and has shown that providing 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.[lxxv] 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. Additionally, in GY19, the Recipient drafted a new RFP to re-bid the FNS service category in NYC with contracts to begin in GY20. The new RFP implements an updated service model aimed at addressing issues relating to food insecurity, increasing access to care and treatment, addressing racial and health inequities, and improving health outcomes along the HIV care continuum for PLWH in the NY EMA.

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 persons. In GY18, 94% of PLWH 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 PLWH 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 2018, the racial/ethnic disparity in viral suppression rates persisted; 76% of Black RWHAP Part A clients were virally suppressed in 2018, compared to 81% of Latinx clients, 88% of White clients, and 93% of Asian/Pacific Islander clients. This disparity was in spite of similar rates of retention and ART use (except among Asian/Pacific Islander clients who had the highest rate of retention) across racial/ethnic groups. Across gender categories, viral suppression rates were lowest among transgender clients (76%), 93% of whom were Black and Latinx and 91% of whom were transgender women, than for cisgender women and men (80% and 79%, respectively).

Approaches for MAI populations. Due to the large proportion of racial/ethnic populations served by the entire RWHAP Part A program, the PC and the Recipient work to develop strategies and interventions throughout the portfolio that 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 is able to focus on barriers

that contribute to disparities at each stage of the continuum.

MAI activity descriptions. The GY20 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 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 was 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 GY19, 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
Ability to Diagnose and Link to Care Seven percent of PLWH 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.	The Recipient has continued to work with all planning bodies in the jurisdiction to support routine and targeted testing and linkage contracts with payment points for timely linkages and execution of a MOU with a medical provider who can provide direct access to initial medical appointments. In GY19, the recipient implemented the revised program model for the MCM service category,	Increase ability to: 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; provide treatment adherence support through increased provision of mDOT, including video-based services; and prevent HIV infections through	Continue to increase number and percentage of PLWH who are aware of their status, link newly diagnosed and out of care PLWH to care, increase timely initiation of ART, and increase SVL.

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
	which includes: the provision of iART in 16 NYC CCPs; implementation of a new D2C strategy to work with CCP providers by supporting TA in identifying individuals lost to care and individuals who are not virally suppressed to improve coordination of and linkage to care; and mDOT, which includes video-based DOT to increase availability of the service.	navigation, coordination of care, treatment, and medication adherence services to achieve SVL.	
Providing Culturally Competent Care Research has shown that stigma and discrimination due to race, sexual orientation, and lack of access to culturally competent services, especially for MSM of color, are barriers to HIV medical services.[lxxvi] This challenge must be addressed to increase the provision of culturally responsive care to effectively meet the needs of a diverse population of clients participating in RWHAP Part A services across the NY EMA.	In GY19, the Recipient disseminated a CLAS Standards self-assessment to service providers throughout the NY EMA RWHAP Part A portfolio, after a pilot of the assessment tool occurred in August 2018. Feedback from the pilot was incorporated into the tool to ensure it was responsive to provider needs for assessing CLAS standards at their own agencies. Providers incorporate their assessment findings into their QM plans and receive TA from the Recipient to ensure adequate adherence to CLAS Standards across the NY EMA.	Increase the provision of culturally competent care across the RWHAP Part A service portfolio. Service providers will use this tool to ensure they are compliant with CLAS standards and are meeting client needs so that all persons served with RWHAP Part A funds can have access to quality care and services.	Work to better meet the needs of a diverse client population by increasing cultural competency at the provider level, engagement at the participant level, and service quality in core medical and support service environments that lead to viral suppression.
Addressing Needs of Aging PLWH As more of the NY EMA's PLWH benefit from the improved health outcomes related to SVL, additional co-morbidities associated with HIV and aging must be incorporated in the system of care. As of December 31, 2018, more than half of PLWH in NYC were aged 50 and older. Among HIV+ RWHAP Part A clients in NYC who had at least one service during March 2017-February 2018, 58% were aged 50 and older.[lxxvii]	In GY18, the recipient conducted seven focus groups in collaboration with the community-based Long Term Survivors Wellness Coalition to assess and address the unmet needs of OPLWH for use in developing future service models and interventions aimed at tackling the diverse needs of this priority population. In GY19, the Recipient began conducting the qualitative analysis process. Upon completion, the Recipient will hold a community forum to discuss	Address HIV related health disparities and reduce the effect of co-morbidities on PLWH over 50 in order to improve health outcomes and reduce preventable mortality.	Work to improve the quality of care to improve retention and viral suppression, and reduce preventable mortality for PLWH over 50.

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
Moreover, disparities persist among racial/ethnic minorities with viral load suppression rates being the lowest among Latinx and Black PLWH aged 50 and older when compared to their white counterparts. Likewise, death rates among Latinx and Black PLWH aged 50 and older were significantly higher than death rates among White PLWH aged 50 and older.	results and identify priority needs to be addressed through future programming across the NY EMA RWHAP Part A service portfolio.		
Addressing Health and Racial Equity Across the RWHAP Part A Portfolio Recent surveillance and eSHARE data analyses indicate that racial and ethnic minority populations are disproportionately affected by HIV. Although the NY EMA is working towards national goals on retention and suppression, disparities exist among certain subpopulations. In 2017, YBMSM and Black women were two of the most disproportionately impacted populations in the NY EMA. HIV viral load data from 2017 reveals that among YMSM, only 63% of YBMSM were virally suppressed as compared to 73% YWMSM and 70% YLMSM. In the same year, among women living with HIV, viral suppression was lower among Black (70%) women when compared to White (73%) and Latina (74%). Overall, the majority of women living with HIV identified as Black and Latina (90%).	In GY19, the Recipient initiated Race to Justice work across the NY EMA service portfolio. The Recipient has developed, implemented, and maintained workgroups designed to advance racial health equity and influence future RWHAP Part A programming focused on: WoC; Youth; Mortality; Housing; OPLWH; and Transgender women. In addition, the Recipient developed and offered a Race to Justice training for RWHAP Part A contracted providers. These trainings will continue in GY20. The Recipient will also work with planning bodies, community members, and experts in the field to evaluate eSHARE data that will aid in assessing where each priority group is being served in the RWHAP Part A portfolio and to identify gaps in the HIV care continuum. Analyses will help lead efforts in creating culturally sensitive and responsive programming on healthy living and effective care and treatment.	Increase the provision of effective services offered to priority populations disproportionately affected by HIV in the NY EMAs RWHAP Part A portfolio; decrease disparities identified in priority populations across the HIV care continuum; and improve general health outcomes across priority populations in the NY EMA.	Work to improve the quality of care, types of services offered, and reduce new diagnoses and preventable mortality among priority populations of PLWH in the NY EMA.
Streamlining Services to Improve Housing for PLWH in NY EMA	The Recipient and PC worked throughout the planning year to streamline	Increase the capacity of RWHAP Part A housing services providers within the	In GY19, the PC voted to eliminate TCC with the recommendation to re-

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
While medical care and treatment options for PLWH have improved, factors associated with poor health outcomes persist, including homelessness or unstable housing.[lxxviii] CHAIN Project findings indicate that receipt of housing was a strong and consistent predictor of increased access to medical care and treatment, retention in care, and improved health outcomes. In 2018, 19% of RWHAP Part A participants were unstably housed while 8% reported living in temporary housing. As homelessness or unstable housing serve as large hindrances for viral load suppression, this is an essential challenge to address.	the RWHAP Part A service delivery system in the NY EMA. In GY19, the PC focused on the provision of housing services, initially reviewing TCC, a MCM program targeting homeless and unstably housed PLWH who are not securely engaged in HIV primary care. eSHARE data analyses revealed that the majority of clients enrolled in TCC were already engaged in primary care and demonstrated a more pressing need for housing services already provided under RWHAP Part A Housing Services. In order to streamline service provision, the IOC voted to eliminate the current TCC program model in GY20 with the recommendation that the current TCC allocation ($1.44 million) be used to enhance housing services in the NY EMA.	NY EMA to meet the needs of PLWH who are homeless and/or unstably housed. Through streamlined and enhanced housing services. Inequities across the HIV care continuum can be better addressed for those whose housing status serves as an impediment to positive health outcomes.	allocate funding to Housing Services. An enhancement to the current housing services award allocation is expected to be voted on by PSRA and the full PC in GY20. This streamlining of services will help to improve housing and health outcomes for homeless and unstably housed PLWH in the NY EMA.
Addressing the Needs of PLWH with Disabilities Under federal, state, and local law, health providers are required to provide reasonable accommodations to individuals with disability. A 2016 survey of RWHAP Part A providers in the NY EMA identified major challenges to the provision of care for people with disabilities, including: time constraints, lack of resources, lack of funding, and lack of training/education.	The Recipient and PC worked collaboratively in addressing the challenges identified in the 2016 survey of RWHAP Part A providers. Based on the survey and feedback from the PC, the Recipient worked to create a resource manual for providers (to be completed in GY20), which will include: background on the ADA; technical terms and descriptions for each disability; guidance on communicating with clients with disabilities; and training and TA opportunities. To increase the accessibility of RWHAP Part A providers and to inform the resource manual, the PC held a "Disabilities Forum" to generate recommendations for working with people	Ensure the provision of reasonable accommodations to PLWH with disabilities in order to increase access to and retention in care. Ensure services are delivered in a culturally competent manner, and are tailored to address provider needs for working with this population.	Work to improve the quality of care and types of services offered to ensure access for all RWHAP Part A participants with disabilities in the NY EMA.

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status for RWHAP Part A/ Care Continuum
	with disabilities in the RWHAP Part A program. A key output of these recommendations in GY20 will be data collection on disabilities within the RWHAP Part A client population, and the provision of education and dedicated trainings to RWHAP Part A providers on ADA compliance and working with people with disabilities.		

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 NYC Health Department CTP QM/TA and REU, COTA, Prevention, Housing, NYSDOH AI, PHS, the PC, consumers, and RWHAP Part A providers.

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 increase collaboration between RWHAP and Medicaid-funded providers; provide opportunities for peer learning among RWHAP Part A providers; and 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. 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 RWHAP Part A providers to improve service quality and support QM activities; plan and implement provider meetings to facilitate peer learning among RWHAP 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.

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 July 2019). The committee includes key stakeholders from CTP, the PC (both consumers and staff), NYSDOH AI, 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. In 2019, the committee is adding a new health equity domain. The Institute for Healthcare Improvement recognizes equity

among the domains for ensuring quality. Adding a domain in this area is also consistent with the department's emphasis on addressing racism as a driver of health inequity.

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. The CQM program uses data from COTA's evaluation and TA to determine how RWHAP Part A services may better support clinical services, including health care settings that receive RWHAP Part A funding through subawards. COTA also coordinates closely with the NYSDOH AI on RWHAP Part B and Medicaid clinical organizational assessments. CTP and COTA participate in a joint committee led by NYSDOH AI to coordinate and collaborate on overlapping, regional QM efforts. Overlapping jurisdictional initiatives include: *New York 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*.

NYC Health Department 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 indicators 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 2018, the fifth annual Power of QI conference was held with the theme "Engagement for Improvement." The consumers committee of the PC welcomed conference attendees during the opening plenary and conducted a workshop about systems for consumer engagement. HRSA's RWHAP Center for Quality Improvement and Innovation also conducted a workshop about addressing health disparities. As with previous years, the conference 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 selected the following poster presentations for recognition:

- *Best Poster for Engagement for Improvement.* Special Needs Clinic New York-Presbyterian Hospital/Columbia Medical Center: "Spanish-speaking HIV+ Women's Group: A Consumer Advocacy Role".
- *Best Poster Overall.* Family Health Centers at NYU Langone: "Addressing Health Disparities in Viral Load Suppression through Drilldown of Demographic Data"

1) Use of performance measure data to evaluate disparities in care. Consistent with national goals, BHIV is expanding its efforts to support viral suppression by addressing 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 sustained viral suppression, CTP began providing each RWHAP Part A provider agency with client-level reports, known as TSRs, in 2014. The TSRs are prepared every three months using data reported by RWHAP 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 ART use and adherence. In 2017, CTP launched the RWHAP Part A AVSR, and for each organization receiving funding from the RWHAP Part A program, REU prepared a report showing the proportion of each organization's RWHAP 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 RWHAP Part A clients in NYC. The AVSR uses viral load data reported to the NYC HIV Surveillance Registry. CTP released new versions of the AVSR in July 2019, breaking down results for five priority subpopulations (OPLWH, Black or Latino cisgender MSM, cisgender YMSM, transgender women, and cisgender WoC) selected in accordance with the NYC Health Department's Race to Justice initiatives for advancing racial equity and social justice. The updated, expanded AVSR also provides breakdowns of SVL proportions among clients "newly enrolled" and clients "established in services", along with guidance for interpretation (i.e., lower SVL among newly enrolled clients may reflect successful outreach to more vulnerable PLWH).

In July 2018, CTP began providing Client Progress Reports (CPRs), 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. CTP rolled out CPRs first to NYC CCP providers who had been re-awarded CCP contracts under the most recent re-solicitation. For these programs, the CPR was 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.

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 service utilization and care continuum indicators, 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 Black or Latinx, 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 RWHAP Part A program tend to experience poorer health outcomes, the NY EMA takes a system-wide approach to improving care and outcomes for those served by the RWHAP Part A program. This approach has included 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. Together, these data collection, data sharing and systems coordination efforts help ensure that each client served has the appropriate resources and individualized support to achieve and maintain SVL. To further address disparities, the NYC Health Department is also ensuring that subrecipients provide services consistent with CLAS standards according to a protocol designed by QM/TA staff. The protocol calls for RWHAP 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 annual 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 findings informed changes in how CCP services are reimbursed under the most recent re-solicitation, transitioning from per-member-per-day reimbursement to FFS. In an effort to ensure service quality, CTP is working with CCP providers to design a system for value-based payment, an innovative approach for the NY EMA. Over the coming year, CTP and program staff will collaborate on the design and selection of measures and methods for value-based payment.

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-eight percent of the NY EMA's GY19 RWHAP Part A contracts are paid based on performance, with subrecipients paid on a FFS basis and/or for achievement of specific deliverables. Managing the portfolio as a results-oriented reimbursement model has sustained 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 RWHAP Part A serves as the POLR.

1) Program Organization. GY20 will be the NY EMA's 30th year as a RWHAP Part A Recipient and the NY EMA is committed to efficient program administration, aiming to maximize the effectiveness of HIV services. In GY18, the NY EMA spent more than 99.72% of its RWHAP Part A formula award and 100% 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 the NYC Health Department 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 the NYC Health Department BHIV. The BHIV is headed by an Assistant Commissioner, who oversees a staff of over 250 people across eight programs, which includes 46.8 full-time equivalents (FTE) under the RWHAP Part A grant.

The Director of CTP (.85 FTE) oversees all staff responsible for service planning, TA, QM, REU, 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 Director of Planning and Administration (P&A) (1.0 FTE), formerly the Deputy Director of CTP, collaborates with the Grant Fiscal Administrator (1.0 FTE) and program and administrative fiscal staff (2.5 FTE) to ensure adherence to all applicable HRSA grant reporting and monitoring requirements. The Director of P&A oversees and coordinates the activities of three Program Planners (2.9 FTE) and serves as an alternate to the Director of CTP for PC business and communications with HRSA. The Director of QM/TA (.94 FTE) oversees a total of 8.75 FTE including: one Deputy Director, two Program Managers (PMs), four QMSs, one Implementation Specialist, one QM Liaison, 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 (2.35FTE total) who oversee RWHAP 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 REU 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 1.25 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 Care partially funded with 4.2 FTE RWHAP Part A.

RWHAP Part A funds 9.75 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 NYC Health Department 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 2019.

There are currently several vacant Recipient positions. The Director of P&A, the Health Equity Manager, Senior Research Analyst, a Tri-County Planner, and an Evaluation Specialist. The Director of P&A was only recently vacated and the rest of the positions are posted and in progress. 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 NYC Health Department Central Human Resources to improve recruitment and on-boarding processes for new applicants. The NYC Health Department has an emphasis on recruiting and hiring candidates that are racially and ethnically diverse which has increased the number of channels in which the NYC Health Department 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. Additionally, vacancies remain as the job market in New York is currently in the applicant's favor in the health and IT sectors.

b) Staffing, SOW, and evaluation of contractor or fiscal agent. PHS, the NYC Health Department'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, and four Directors – a Senior Director for Programs and Contract Management, a Director of Finance and Operations, and a Director of Business System, and Director of Informatics – PHS administered 150 RWHAP Part A-funded contracts in GY19. The CSO ensures PHS adheres to the terms of the Master Contract with the NYC Health Department 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 Director of Informatics is responsible for development and management of PHS's information systems, and 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 the NYC Health Department, 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 18.38 FTE monitoring staff, 3.13 FTE contract administration staff, and 11.27 FTE planning and administrative staff for a total of 32.78 FTE. The NYC Health Department 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 the NYC Health Department 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.

NYC Health Department 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 NYC Health Department.

a) Monitoring. The NY EMA's multi-faceted contract monitoring process includes monthly electronic data submissions, comprehensive semi-annual reviews, and in GY19, at least two on-site visits each year, documentation reviews, frequent telephone and email contact, and other meetings as necessary. Beginning in GY20 PHS and the Recipient are initiating a plan to streamline visits to be less than two per year as a result of HRSA HAB's GY18 site visit recommendations. 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 the NYC Health Department for service utilization analysis. Using eSHARE, subrecipients finalize client-level data entry by the 15th of each month, the point at which PHS and the NYC Health Department 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 spending levels for cost-based contracts and total drawdown of reported services data for performance-based contracts and withhold reimbursement if subrecipients fail to submit required monthly programmatic reports, external audit reports, and/or if reports are incomplete or contain unapproved services as well as 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 NYC Health Department 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 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 RWHAP 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 the NYC Health Department. 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 MH subrecipient was found to have very low performance levels in 17 out of 19 service types (performing below the expected 85% service level) despite being fully staffed. The agency also lacked in responsiveness when the NYC Health Department or PHS would attempt to communicate. The contract was placed on corrective action for an initial five-month period as a way to formally communicate to the agency the egregiousness of their low performance and their lack of responsiveness. The agency was required to develop a Corrective Action Plan (CAP) which helped them identify their need for guidance and assistance. As part of their CAP, monthly TA calls with the NYC Health Department and PHS were scheduled which enhanced/fortified communication with the agency. Agency staff began to utilize several client recruitment methods to enroll clients in the MH program such as: morning huddles in the HIV practice, morning huddle in the Support Center, participation in monthly HIV Care Rounds, review of daily patient registration logs, and review of HIV providers' daily appointment schedules. In addition, the agency began to reach out to agencies with whom they had existing linkage agreements to explore additional client enrollment in the MH Program. They also addressed the need to provide more comprehensive data when completing the monthly Electronic Program Narrative Reports in order to include qualitative and quantitative information as well as program updates or program operations and challenges. The consistent and frequent communication with PHS led to an overall improvement. Currently, the agency is performing significantly better with 17 of 19 service types at or above the compliant threshold.

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 it 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 GY18, PHS contracted with 91 subrecipients; however, only 81 audit packages were required to be submitted since several RWHAP subrecipients are part of larger consortiums and their financials are consolidated into one audit package. All 81 audit packages were submitted in GY18; yet, 33 (41%) were submitted late. PHS retains the right to hold payment for failure to submit audit packages and did do so during GY18 for several subrecipients. During GY18, the subrecipient payment holds were released upon submission of their audit packages. 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. In GY18, 23% of the EMA's RWHAP Part A subrecipients' audit reports contained issues noted. 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 11% 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. PHS will then request a corrective action or compliance plan to resolve the audit deficiency; during this time the agency's 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 GY18, 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 GY19, the Recipient and PC staff have implemented the National Monitoring Standards and ongoing monitoring of the changing health care 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 attending the RWHAP all-recipients conference, 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. In addition, the New York EMA generally prioritizes non-Medicaid covered services and individuals in service design and planning. Hence, the history of applying for the CMS waiver.

During contract negotiations, PHS and subrecipients identify all potentially reimbursable services and explores all sources of third party payment. Contracts that include services that are potentially reimbursable by Medicaid and other payers are subject to all billing records associated with a patient visit. This review forces coordination between grants management and Medicaid billing staff.

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 500% 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. The NYC Health Department 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. Due to the safeguards intended 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. To improve tracking of program income, contract language regarding 340B program income was added to all contract documents in FY19 to ensure that subrecipients are aware that if they are using their RWHAP Part A subrecipient status for 340B eligibility, 340B program income must be reported to the recipient on a yearly basis. A letter highlighting the contract language and addressing frequently asked questions was also sent to all subrecipients.

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 the NYC Health Department. 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 the NYC Health Department, which in turn, the department uses to report by service category to the PC. On a quarterly basis, NYC Health Department 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 the NYC Health Department, the Grant Fiscal Administrator and the Director of Planning and Administration 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.

<u>Roles and responsibilities of fiscal staff.</u> 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. A FM and Fiscal Administrator conduct an additional review of the subrecipient's audited financial statements and single audit reports.

NYC Health Department fiscal staff and the Director of Planning and Administration 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 Director of Planning and Administration 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 is conducted which 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. The NYC Health Department 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 the NYC Health Department in each funded service category, outline funding commitments per service category, and summarizes spending rates. These reports are combined with separately tracked NYC Health Department program fiscal spending data and presented to the PC to monitor expenditures, 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, the NYC Health Department 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 the NYC Health Department 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 report, sign, and forwards it to PHS's accounting staff for entry into the accounting system. Payment is then forwarded to PMs, who supervise the CMs, for final review and approval ensuring 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 the NYC Health Department 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 CAP 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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