INTRODUCTION

Pursuant to the Grant Year 2021 (GY21) HIV Emergency Relief Program Ryan White
HIV/AIDS Program (RWHAP) Part A Funding Opportunity Announcement, dated June 11, 2020,
the New York City Health Department (NYC HD), 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 GY21 plan to promote a comprehensive scale-up 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 with HIV (PWH) in the NY EMA. The GY21 plan is
responsive to federal, state, and local efforts to end the HIV epidemic.

In February 2019, the United States (U.S.) Department of Health and Human Services (HHS)
released an operational plan, Ending the HIV Epidemic: A Plan for America (EHE), which aims to
end the HIV epidemic in the U.S. by 2030.¹ The plan identifies 48 counties, plus Washington, D.C.,
and San Juan, Puerto Rico, where more than 50% of HIV diagnoses occurred in 2016 and 2017,
and an additional seven states with a substantial number of HIV diagnoses in rural areas. Four
NYC counties are designated as part of the EHE plan: Bronx, Kings (Brooklyn), New York
(Manhattan), and Queens. The EHE plan is comprised of four pillars: Diagnose, Treat, Prevent,
and Respond. The NYC HD Bureau of HIV (BHIV) is engaging all its programs and partners to
respond to the EHE plan by leveraging RWHAP Part A, Centers of Disease Control and
Prevention (CDC) HIV prevention and surveillance jurisdictional funding (CDC PS-18-1802), City
and State ending the epidemic resources alongside additional federal EHE funding from Health
Resources and Services Administration (HRSA) and CDC. Initial EHE resources (CDC PS-19-
1906) received by NYC in September 2019, support the development of the NYC EHE plan,
including an Epidemiological Profile and Situational Analysis for the four EHE counties in NYC.
A draft plan was submitted to the CDC in December 2019, followed by an extensive community
engagement process currently underway to ensure the NYC EHE plan is responsive to local needs.
The version of the NYC EHE plan currently receiving input from the community includes the
strategies listed below. A final plan will be submitted by March 2021.

• Strategy 1: Increase the number of people who know their HIV status by diagnosing HIV
infection as early as possible, promoting routine testing within health care facilities, and scaling
up testing options in non-clinical settings.

• Strategy 2: Prevent new HIV acquisition by increasing access to effective prevention
interventions, including pre- and post-exposure prophylaxis (PrEP and PEP), condoms, harm
reduction (HR), and supportive services.

• Strategy 3: Improve viral suppression (VS) and health outcomes for PWH by optimizing
medication adherence and access to care, improving coordination of clinical and supportive
services, and increasing access to immediate antiretroviral treatment (iART).

• Strategy 4: Enhance methods to identify and intervene on HIV transmission networks to better
support people and communities at increased risk of exposure.

• Strategy 5: In all NYC EHE strategies, utilize an intersectional, strengths-based, anti-stigma,
and community-driven approach to mitigate racism, sexism, homophobia, transphobia, and
other systems of oppression that create and exacerbate HIV-related health inequities.

The draft plan also includes two cross-cutting issues—Social and Structural Determinants of
HIV-Related Health Inequities—and works to ensure the HIV service delivery system is responsive
to these strategies.

To achieve the goals of the federal and NYC EHE plans, CDC EHE funding (CDC PS-20-
2010) will support a comprehensive HIV program (Component A) to increase HIV screening and
testing in health care and non-health care settings to reduce new HIV diagnoses and increase awareness of HIV status. The new funding will leverage and enhance existing systems and increase linkage to and engagement in HIV care and treatment and early initiation of treatment to improve engagement in care (EiC) and VS among PWH. Through an array of approaches and providers the funding will seek to increase screening, referral, and linkage to PrEP and other HIV prevention services, including syringe service programs, and improve the ability to respond to HIV transmission clusters and outbreaks. BHIV will work to partner with a diverse set of stakeholders within and outside the NYC HD to help inform the development and implementation of programmatic and advocacy activities.

Additionally, EHE resources from HRSA (HRSA-20-078) support Project Planned Resources for a Specific Population-level Equitable Response (Project PROSPER) which aims to improve access to effective HIV care and treatment and improve VS among PWH (EHE Pillar Two), and quickly respond to potential new HIV outbreaks (EHE Pillar Four) in NYC. Project PROSPER will achieve these goals by increasing organizational capacity through trainings for the HIV workforce; expanding implementation of evidence-informed strategies and interventions as well as emerging practices; and improving data collection and management systems.

All HIV care services in the NY EMA support EHE Pillar Four through efforts to link and retain PWH in care, improve access to antiretroviral treatment (ART), and decrease viral load (VL). Like the federal and NYC EHE plans, the GY21 plan is responsive to Governor Andrew Cuomo’s 2015 New York State Blueprint for Ending the Epidemic (NYS ETE Blueprint) and the NYS Integrated HIV Prevention and Care Plan (NYS Integrated Plan), which set forth recommendations to reduce the annual incidence of new HIV infections to 750 from the current 3,000 in NYS. The NYS ETE Blueprint is also a guiding document for the NY EMA.

Covid-19 has significantly affected New Yorkers, including PWH, as well as service provision across the NY EMA in GY20, and it is fully expected to continue to do so in GY21. On February 29, 2020, NYC identified its first case of COVID-19. In the ensuing weeks, the number of COVID-19 cases, hospitalizations, and deaths rose. NYC and NYS became the epicenter for the coronavirus pandemic in the U.S. By March 20, 2020, the number of reported daily cases rose to 4,014, with 665 hospitalizations, and 47 deaths. On that day, Governor Cuomo issued an executive order to place NYS on PAUSE requiring all non-essential businesses statewide to close in-office personnel functions effective on March 22, 2020.

With the NYS on PAUSE order, many non-clinical community-based organizations (CBOs) ceased providing in-person services in the community while they determined how to meet the needs of clients. Meanwhile, many hospitals were swamped with COVID-19 patients while they sought to set up outpatient telehealth services. Throughout this time, CBOs and clinics worked to transition to providing services virtually or through telehealth. As NYS regions began reopening in phases during the spring and summer, program services started to ramp up, but many continue to experience challenges in delivering services while complying with physical distancing and other requirements mandated by the state. To date, NYC has reported over 238,000 COVID-19 cases, more than 58,000 hospitalizations, and nearly 24,000 confirmed and probable deaths. Community members and service providers across the NY EMA are adjusting to COVID-19 and exploring new ways to conduct outreach and provide services while ensuring the safety of staff and clients as the pandemic evolves.

NEEDS ASSESSMENT

A) Demonstrated Need.
1) Epidemiologic Overview.

a) Summary of the HIV epidemic in the EMA geographic area. The NY EMA, which includes the five counties/boroughs of NYC and the adjacent Tri-County Region of Westchester, Rockland, and Putnam Counties, is home to nearly 10 million people (3% of the U.S. population). The NY EMA continues to have the largest HIV epidemic in the U.S., reporting in 2018 approximately 5% of all new HIV diagnoses and 13% of PWH nationwide. As of December 31, 2019, there were 132,148 people diagnosed and presumed to be living with HIV in the NY EMA, representing 1.4% of the total NY EMA population (see Table 1). Of the 1,881 individuals diagnosed with HIV in the NY EMA in 2019, 17% were concurrently diagnosed with AIDS (within 31 days of their HIV diagnosis), a percentage that has remained relatively stable over the last five years. From 2015 to 2019, there was a 28% decrease in HIV diagnoses in the NY EMA; however, the number of PWH remains high due to improved health outcomes associated with ART. These figures demonstrate both the success of the NY EMA’s service system in providing HIV care and ongoing need for early intervention and care services to fulfill the goals of the federal EHE plan.

Table 1. NY EMA Population and HIV Diagnoses and Number of PWH by Region and County/Borough, 2019

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>HIV Diagnoses*</th>
<th>PWH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New York City</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kings (Brooklyn)</td>
<td>2,559,903</td>
<td>459</td>
<td>30,572</td>
</tr>
<tr>
<td>Bronx</td>
<td>1,418,207</td>
<td>466</td>
<td>31,280</td>
</tr>
<tr>
<td>New York (Manhattan)</td>
<td>1,628,706</td>
<td>344</td>
<td>32,809</td>
</tr>
<tr>
<td>Queens</td>
<td>2,253,858</td>
<td>314</td>
<td>18,818</td>
</tr>
<tr>
<td>Richmond (Staten Island)</td>
<td>476,143</td>
<td>32</td>
<td>2,564</td>
</tr>
<tr>
<td>Outside NYC/Unknown</td>
<td>N/A</td>
<td>157</td>
<td>12,376</td>
</tr>
<tr>
<td><strong>Tri-County Region</strong></td>
<td>1,391,615</td>
<td>109</td>
<td>3,729</td>
</tr>
<tr>
<td>Putnam</td>
<td>98,320</td>
<td>5</td>
<td>122</td>
</tr>
<tr>
<td>Rockland</td>
<td>325,789</td>
<td>24</td>
<td>621</td>
</tr>
<tr>
<td>Westchester</td>
<td>967,506</td>
<td>80</td>
<td>2,986</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>9,728,432</td>
<td>1,881</td>
<td>132,148</td>
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</tbody>
</table>


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

b) Socio-demographic characteristics of newly diagnosed, PWH, and persons at high risk. i-ii) Demographic and socioeconomic data. In 2019, among people newly diagnosed with HIV in the NY EMA, 78% were men, 45% were non-Hispanic Black, 38% were Latino/Hispanic, 68% were younger than 40, and 55% were men who have sex with men (MSM), including MSM with a...
history of injection drug use (MSM-IDU). In the same year, 3% of new HIV diagnoses in NYC were among transgender people, 96% 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 90% of newly diagnosed transgender women were Black or Latina, and 56% of newly diagnosed transgender women were Black or Latina ages 20 to 29 years.

In 2019, among PWH in the NY EMA, 72% were men, 43% were Black, 33% were Latino/Hispanic, and 45% were MSM, including MSM-IDU. While new diagnoses remain concentrated among people younger than 40 (68%), people older than 50 accounted for more than half of PWH in 2019 (59%). This highlights the aging of PWH in the NY EMA and underscores the importance of addressing the complex needs of older PWH (OPWH).

The number of PWH is highest in low-income Black and Latino/Hispanic communities, where many individuals experience multiple challenges that severely impact health, including racism, stigma, poverty, trauma, mental health (MH) issues, food insecurity, and housing instability. Based on data from NYS Department of Health (NYSDOH), as of July 2020, 64% of PWH diagnosed and reported in the NY EMA were enrolled in Medicaid, and 22% were dually enrolled in Medicaid and Medicare (see Table 2 on p. 14 for more details). In comparison, 27% of all NY EMA residents were enrolled in Medicaid in the same time period. In 2019 in the NY EMA, PWH residing in high poverty neighborhoods (at least 30% of residents living below the federal poverty level (FPL)) represented 22% of all PWH, and 26% of all deaths among PWH; in comparison, PWH residing in low poverty neighborhoods (less than 10% of residents living below FPL), represented only 10% of all PWH, and 5% of all deaths among PWH in the NY EMA. See Attachment 3 for the complete diagnoses, number of PWH, and mortality table.

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

1. **Identifying emerging populations, unique challenges, and estimated costs to RWHAP Part A.** As a jurisdiction with a mature epidemic, the number of PWH in the NY EMA has remained relatively stable demographically over the past decade or more. However, the number of new HIV diagnoses reported in NYC from 2001 to 2019 decreased overall and among men and women, all age groups, all NYC boroughs of residence, and within most race/ethnicity and transmission risk categories. This decrease was significant (P value <0.01) for all subgroups except transgender people and Asian/Pacific Islander people.

Data from ongoing HIV surveillance, service utilization analyses, and other sources show that HIV continues to disproportionately affect low-income Black and Latino/Hispanic communities; cisgender gay, bisexual, and other MSM, with increased inequities among youth/young adult men ages 13 to 29 years who have sex with men (YMSM) and Black and Latino MSM; Black and Latina cisgender women; and Black and Latina transgender women. As the impact of HIV on the above populations has been persistent within the NY EMA, no population could be considered emerging.

In 2019, ZIP codes in the Chelsea-Clinton, High Bridge-Morrisania, and Central Harlem-Morningside Heights neighborhoods had the highest new HIV diagnosis rates among NYC neighborhoods; ZIP codes in Chelsea-Clinton and West Queens had the highest HIV prevalence. Many ZIP codes with high new HIV diagnosis rates were also among those with the highest poverty rates, including those in High Bridge-Morrisania. However, ZIP codes in the higher income Chelsea-Clinton neighborhoods were the exception, with the highest new HIV diagnosis rates but relatively low poverty and mortality rates. In 2017, people living in high poverty neighborhoods were least likely to have VS compared with people living in lower poverty neighborhoods. Previous analyses showed that the rate of HIV/hepatitis C (HCV) coinfection
was five times higher in high poverty neighborhoods than in low poverty neighborhoods; a similar pattern was seen for HIV/hepatitis B and HIV/tuberculosis (TB) coinfection.\textsuperscript{xi}

Improving access to basic necessities for the most vulnerable is critical to ensuring people address their HIV health needs. Thus, the NY EMA allocated 46% of GY21 funds to supportive services, including $12.5 million to housing services and $9.7 million to food and nutrition services (FNS). NY EMA further invested in oral health care ($690,630), emergency financial assistance (EFA) ($685,618), and other professional services (legal services) ($4.9 million). To support continued engagement of people most at risk for falling out of care and to address their unique challenges, NY EMA’s largest investment was in medical case management (MCM) ($22.6 million), of which there are two models in the GY21 plan: Care Coordination Program (CCP) and Tri-County MCM.\textsuperscript{2} Both programs serve to engage, link, and retain PWH in medical care to further address barriers to VS. CCP, which was rebid in 2018, has medical eligibility criteria that ensure these resources are prioritized for those who most need them, including people with a history of falling out of care, people who have not achieved VS, and people newly diagnosed with HIV. PWH with HCV and PWH who are pregnant, and who need additional adherence support, are also eligible for CCP services.

\textbf{ii) Increased need for HIV-related services.} As the number of PWH has increased and inequities 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 illustrates that the need for care remains high in NYC despite the decrease in new HIV diagnoses, due to PWH living longer, healthier lives. Figure 1. History of HIV epidemic, NYC 1981-2018

\textsuperscript{2} 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 NYS has declined, the HIV diagnosis rate in NYS is the highest among Northeastern states, and similar to that of some of the Southern states. The average rate of HIV diagnoses in 2018 (per 100,000 people) was 15.6 in the South and 9.9 in the Northeast. However, NYS's HIV diagnosis rate (12.6) is within the range of southern states—where rates range from 4.8 in West Virginia to 23.8 in Georgia, including North Carolina (11.5), South Carolina (14.1), Texas (15.3), and Mississippi (16.0).

Despite overall decreases in estimated HIV incidence among MSM of all race/ethnicities in NYC from 2014 to 2018, in 2018 the estimated incidence among Black and Latino MSM was more than twice the incidence among White MSM. MSM ages 25 to 29 years and 30 to 39 years had the highest HIV incidence rate compared to other age groups. HIV incidence among all MSM attending the NYC HD's Sexual Health Clinics (SHCs) declined from 2012 through 2017, but racial and ethnic inequities persist. Among people with newly diagnosed HIV in NYC in 2018, Black people, women, people ages 20 to 29 years and 50 years and older, people reporting heterosexual, MSM, or MSM-IDU risk less frequently initiated care within one month of diagnosis. There were also inequities in VS among newly diagnosed people in 2019, with Black people, people ages 40 years and older, people with a history of IDU, transgender people, and people of unknown transmission risk all having lower VS rates than their counterparts. In 2019, PWH with a history of IDU were disproportionately represented among all PWH who died, making up only 11% of PWH but 25% of deaths among PWH in the NY EMA.

In the 2017 National HIV Behavioral Surveillance cycle, 28% of the NYC MSM interviewed reported engaging in non-injection drug use for one week or more in the previous 12 months, and compared to those over the age of 50, a much higher proportion of MSM under the age of 50 reported binge alcohol use in the previous 12 months. NYC HD routinely conducts surveys online and in-person among sexually active NYC MSM, ages 18 to 40 years. Among eligible online participants in fall 2019, 4.7% (48/1,021) reported methamphetamine use in the past six months; there were no statistically significant differences by race/ethnicity. According to data from the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE), recent methamphetamine use among MSM in the RWHAP Part A population increased from 4.2% in fiscal year (FY) 2012 to 9.6% in FY19. Recent methamphetamine use was highest among MSM who are homeless (11.1%) compared to MSM with a residence in any other borough (Bronx, 8.8%; Brooklyn, 9.1%; Manhattan, 11%; Queens, 5.8%; and Staten Island, 9.4%). Previous work by the NYC HD found methamphetamine use to be associated with unsuppressed VL.

Despite progress toward identifying PWH in the NY EMA and linking them to medical care, HIV still causes significant morbidity and mortality, particularly among Black and Latino/Hispanic communities. A study assessing the relationship between place-based characteristics and VS 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 VS, compared to those living in UHF neighborhoods where more than 30% of residents were Black. In another study assessing pre-death care patterns among PWH in NYC, PWH with HIV-related mortality had lower rates of VS, with lowest rates among Black and Latino/Hispanic PWH. In addition, although 54% of deaths between 2007 and 2013 among NYC PWH were due to non-HIV-related causes, 35% of White people compared to 48% of Black and/or Latino/Hispanic people died due to an underlying HIV-related cause. Although deaths attributed to HIV have fallen from 2,012 in 2007 to 1,683 in 2018, HIV was the tenth leading cause of

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1 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 the NYC HD.
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.xx

2) HIV Care Continuum.

Figure 2. 2018 NY EMA HIV Care Continuum

![HIV Care Continuum Graphic](image)

Sources: Prescribed ART: NYC HD, Medical Monitoring Project (MMP), 2018; All other: NYSDOH, BHIV Epidemiology, data as of 6/26/20.  
Notes: “HIV-diagnosed”: those diagnosed by 12/31/18 and living & residing in NYC or the Tri-County Region as of 12/31/2018; “Linked to care”: those newly diagnosed with HIV in 2018 with one or more VL or CD4 count within 30 days of diagnosis; “Retained in care”: those among HIV-diagnosed with at least two VL or CD4 counts in 2018 at least 91 days apart; “Receipt of Care”: the proportion of NYC MMP participants whose medical record documented ART prescription during 12 months prior to MMP interview date (interview date range 9/19/18 – 4/23/19); “Virally suppressed”: those among HIV-diagnosed whose most recent VL in the year was <200 copies/ml.

Although the NY EMA (as seen in Figure 2) is working toward EHE goals related to retention in care (90%) and VS (90%), inequities exist among certain subpopulations. In 2018, Black MSM ages 13 to 29 years (YBMSM), Black women, Black OPWH, and Black transgender women were the most disproportionately impacted populations in the NY EMA; these inequities are displayed in Figures 3a through 3d. Among YMSM, only 67% of YBMSM were virally suppressed in 2018 as compared to 75% of White MSM ages 13 to 29 years (YWMSM) and 72% of Latino MSM ages 13 to 29 years (YLMSM). Barriers to care include the lack of youth- and young adult-friendly health clinics, lack of social and family support, and lack of technology use to connect patients to a community of other youth/young adults living with HIV and to help them readily access health care providers and track personal data and information.

In 2018, among women living with HIV in the NY EMA, VS was lower among Black women (73%) when compared to White women (77%) and Latina women (78%). Among OPWH, VS was lowest among Black OPWH (77%) compared to White OPWH (82%) and Latino/Hispanic OPWH (81%). HIV care has been fraught with stigma and racism, and the impact of age-related conditions coupled with structural inequities in care are a major barrier to care for Black OPWH. Similarly, among transgender women, VS was lowest among Black transgender women (64%) compared to White transgender women (71%) and Latina transgender women (72%).

These inequities are addressed in part by geographically targeting services to underserved neighborhoods with high numbers of PWH 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 BHIV’s Care and Treatment Program (CTP) also introduced a number of work groups focused on youth, OPWH, Black and Latina transgender women, and Black and Latina cisgender women, to more systematically identify strategies for reducing inequities. The Planning Council (PC) and CTP also created a service directive for
transgender PWH in NYC. A survey by Black and Latina Cisgender Women Work Group members found communities' top unmet needs include the role of race/racism and stigma in treatment of Black and Latina women with HIV; increasing trauma-informed approaches and services to address trauma experienced by Black and Latina women with HIV; and increasing access to comprehensive social supports for Black and Latina women with HIV. The Black and Latina Transgender Women Work Group identified the absence of transgender providers and staff in HIV medical care and service provision as a major barrier to care. Other barriers include internalized and enacted stigma and use of regular business hours for service provision.

Additionally, the NYS ETE initiative includes a goal that by the end of 2020, 75% of PWH will achieve sustained VS\(^4\). According to data reported to the NYC HD as of March 31, 2020, in 2019, 69% of PWH established in HIV medical care in NYC achieved sustained VS. Continued efforts to reduce inequities in VS among YBMSM, Black women, Black OPWH, and Black transgender women will drive progress towards these goals.

**Figure 3a. VS among YMSM in the NY EMA by Race/Ethnicity, 2018**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2018 VS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YWMSM</td>
<td>75%</td>
</tr>
<tr>
<td>YLMSM</td>
<td>72%</td>
</tr>
<tr>
<td>YBMSM</td>
<td>67%</td>
</tr>
</tbody>
</table>

Source: NYSDOH, Bureau of HIV/AIDS Epidemiology, data as of 6/26/20
Notes: Data includes YMSM diagnosed by 12/31/18 and living and residing in NYC or the Tri-County region as of 12/31/18. Virally suppressed includes YMSM whose most recent VL in the year was <200 copies/ml.

**Figure 3b. VS among Women in the NY EMA by Race/Ethnicity, 2018**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2018 VS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Women</td>
<td>77%</td>
</tr>
<tr>
<td>Latina Women</td>
<td>78%</td>
</tr>
<tr>
<td>Black Women</td>
<td>73%</td>
</tr>
</tbody>
</table>

Notes: Data includes women diagnosed by 12/31/18 and living and residing in NYC or the Tri-County region as of 12/31/18. Virally suppressed includes women whose most recent VL in the year was <200 copies/ml.

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\(^4\) Sustained VS defined as 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.
3) Co-occurring conditions (see Attachment 4).

a) Hepatitis C virus (HCV). Roughly 10.6% of PWH in NYC were diagnosed with HCV by December 31, 2018. HIV/HCV co-infection can lead to higher VLs and accelerate the onset of HCV-related complications, including cirrhosis and end-stage liver failure, particularly when HIV is not well-managed. In an analysis among people with HIV/HCV co-infection in NYC in 2016, those without durable VS were 66% less likely to initiate HCV treatment. Facilitating engagement in HCV treatment is vital; according to preliminary findings from a NYC HD analysis of mortality among RWHAP Part A clients served in at least one long-term RWHAP program from 2013-2015, clients diagnosed with HCV had significantly higher odds of death than those without HCV.

NYS Medicaid covers Direct Acting Agents (DAAs) that cure HCV with very few limitations, but coverage under other forms of insurance varies widely. For PWH 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 wider availability of effective, well-tolerated treatments in NYC, only 67% of co-infected RWHAP Part A clients appear to have initiated HCV treatment by the end of 2018; however, this is an increase from 59% at the end of 2017. In July 2018, Governor Cuomo released the nation’s first strategy to eliminate HCV allocating $5 million 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 HR provider settings such as syringe exchange programs. NYS will also require managed care organizations (MCOs) to (1) extend the prior authorization period to six months; (2) eliminate the requirement that patients undergo VL testing in order to continue receiving HCV medication; and (3) reimburse health care providers for use of telehealth or videoconferencing services as a part of HCV treatment.

b) Sexually transmitted infections (STIs). STIs increase the risk of sexual HIV transmission. In 2018, NYC's STI case rates were highest in neighborhoods with high HIV prevalence; Central Harlem and Chelsea have high rates of primary and secondary (P&S) syphilis, gonorrhea, and chlamydia. In the NY EMA, rates of STIs are higher among PWH than the general population. In 2019, the preliminary rate (per 100,000) of P&S syphilis was 23.6 for the general population, and nearly nine times higher (209.3) for PWH. This is mirrored in preliminary rates of gonorrhea (344.9 for general population vs. 1,206.1 for PWH) and chlamydia (907.2 for general population vs. 1,738.7 for PWH). Since 2001, the number of P&S syphilis cases has increased six-fold in NYC overall. Preliminary data show that in 2019, 95% (1,865/1,973) of P&S syphilis diagnoses were among men, and among those who reported the sex of their sex partners during interview, 88% were MSM; among MSM with P&S syphilis in 2019, 43% were PWH. These data also show that in 2019, over 76,000 new chlamydia diagnoses and approximately 29,000 new diagnoses of gonorrhea were reported in 2019; the highest case rates were seen among Black and Latino men under 29 years of age. Gonococcal infections with decreased susceptibility to azithromycin continue to be reported; however, there is little current evidence of drug resistance to cephalosporins.

c) Mental illness. In the Community Health Advisory & Information Network (CHAIN) surveys conducted between June 2015 and February 2020 among PWH, 37% of the NYC cohort and 24% of the Tri-County Region cohort reported having severe mental illness (SMI). Among NYC RWHAP Part A clients enrolled and served in 2019, 25% screened positive for depression and 24% screened positive for anxiety using the PHQ-4 tool. Additionally, analyses have found a VS disparity among GY18 RWHAP Part A clients with a recorded MH screen in eSHARE, 76% of clients with at least one MH diagnoses achieved VS. Clients who indicated psychosis had the lowest proportion of VS (67%), followed by bipolar disorder (69%). In a study examining the relationship between RWHAP Part A MH services utilization and MH outcomes among PWH, higher utilization of MH services was associated with improvements in MH functioning.

d) Substance use disorder (SUD). Among CHAIN participants surveyed from June 2015 to February 2020, 20% of the NYC cohort and 2.7% of the Tri-County Region cohort reported substance use, including IDU. Additionally, 11% of the NYC cohort and 21% of the Tri-County Region cohort reported lifetime IDU. Among RWHAP Part A clients served in 2019, 19% of those assessed reported recent hard drug use (e.g., cocaine, heroin, methamphetamine, and/or prescription drugs). Of RWHAP Part A clients with some evidence of HIV medical care (i.e., at least one lab report) in 2019, 65% 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. The CHAIN cohort study, in place since 1994, provides ongoing information on the characteristics, co-morbidities, and care needs and service use patterns of PWH in the NY EMA. More than 4,000 PWH have completed 15,516 interviews conducted by researchers at Columbia University. The cohort is broadly representative of the PWH 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.
increased by 26.2%, while real median household incomes fell by less than 3%. 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. The COVID-19 pandemic has exacerbated homelessness and housing instability. During the NYS on PAUSE order, many businesses closed or operated at a reduced capacity, resulting in loss of income for many households, increasing the risk of eviction and homelessness, and decreasing the ability to take shelter in place measures to minimize the risk of exposure to COVID-19.

Nearly 133,000 unique individuals accessed the NYC shelter system in FY19, a 61% increase over the last 10 years. Data from the 2020 annual NYC Homeless Outreach Population Estimate Street Survey suggest that nearly 3,900 homeless individuals may be unsheltered on any given night. Black and Latino/Hispanic people are disproportionately affected by homelessness and housing insecurity, representing 86% of NYC single adult shelter residents in 2020. Studies also show that the large majority of NYC street homeless have a MH diagnosis and/or other chronic conditions. In response, NYC released its Housing New York 2.0 Plan in 2017, and as of September 30, 2019, has created or preserved 136,912 units of affordable housing.

The prevalence of homelessness among PWH is especially high. Among CHAIN participants surveyed from June 2015 to February 2020, 15,146 per 100,000 of the NYC cohort, and 775 per 100,000 of the Tri-County Region cohort were homeless. Housing instability and homelessness were also prevalent among RWHAP Part A clients served in 2019, with 9% of those assessed reporting accessing temporary housing during the year, and 21% reporting being unstably housed. Among those engaged in HIV medical care in 2019, 78% of temporarily housed and 66% of unstably housed clients were virally suppressed, compared to 84% of those with stable housing, underscoring the added health benefits of being stably housed.

The risk of acquiring HIV is 90% lower for homeless people in NYC who receive three or more consecutive years of supportive housing, compared with homeless people in NYC who apply for but are not placed in supportive housing. The average monthly health care and public service costs for chronically homeless people can fall more than 50% following the provision of housing, substance use treatment, and other needed support services. PWH 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. PWH adhering to ART and who received housing assistance were 1.5 times more likely to remain adherent to ART treatment than those not receiving housing assistance. Research also shows longer-term HOPWA enrollment is associated with better HIV health outcomes compared to shorter enrollment.

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 the number of new HIV diagnoses and prevalence of PWH are among the highest in NYC. According to the NYC Community Health Survey (CHS), over 50,000 people returned to the NY EMA from NYS prisons and local jails within calendar year 2017. Of those released, an estimated 2,400 (8%) were PWH returning primarily to these three areas. Further, while the overall NYC jail census declined from 5,500 in March 2019 to 4,000 in March 2020, the percent of PWH in NYC jails doubled from 4% to 8%, illustrating the overrepresentation of PWH in NYC jails. Approximately 40% of RWHAP Part A clients assessed in 2019 reported a history of incarceration. Among those in HIV medical care in 2019, 69% of clients with a history of incarceration were virally suppressed, compared to 86% of those who had never been incarcerated.
A 2010 cost analysis found that the mean cost of providing linkages to care and social support services to achieve VS among formerly incarcerated PWH is $8,432. Compared to standard care, the cost per additional quality-adjusted life year saved is $72,285 suggesting HIV linkage services for formerly incarcerated people is cost-effective. These high costs may be attributable to the challenges that formerly incarcerated people—many of whom are Black or Latino/Hispanic—often face upon release, 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) COVID-19 and HIV.** To better understand the intersection of COVID-19 and HIV—including the number of PWH diagnosed with COVID-19, whether PWH are at increased risk for COVID-19, and whether PWH have poorer health outcomes following COVID-19 infection—NYC HD conducted a match of reported COVID-19 case and death data against HIV surveillance data. Using the NYC COVID-19 surveillance dataset of confirmed COVID-19 cases and confirmed and probable deaths attributed to COVID-19 (reported as of June 2, 2020), and data from the HIV Surveillance Registry (reported as of March 31, 2020), NYC HD found that PWH made up 1.2% of people diagnosed with COVID-19; a slight under-representation given PWH are 1.5% of the general NYC population. Of the PWH diagnosed with COVID-19, there was an over-representation of Black (45%) and Latino/Hispanic (41%) people compared with citywide diagnoses of COVID-19 (29% Black, 33% Latino/Hispanic). Furthermore, higher proportions of PWH with COVID-19 experienced more serious COVID-19 complications than citywide cases overall, with 42% hospitalized (vs. 26%), 5% admitted to ICU (vs. 3%), and 13% deceased (vs. 8%). The match also identified that 64.3% of PWH with COVID-19 had an underlying condition, versus 35.4% citywide with COVID-19. To address the needs of PWH and of RWHAP Part A subrecipients, the NY EMA transitioned to a cost-based reimbursement model to ensure clients are served effectively and programs costs are addressed. See p. 14 for additional details.

**h) Tobacco dependence.** Despite a record low prevalence of smoking in NYC (less than 14%), heavy tobacco use and dependence persist among several populations, including PWH. In addition to the commonly known negative health effects of tobacco use, PWH are at additional risk for HIV-specific adverse health outcomes. An analysis conducted by the NYC HD found that recent tobacco smoking was reported by 39% of PWH enrolled in RWHAP Part A in 2019. Recent tobacco smoking was independently associated with low CD4 cell counts and unsuppressed VL, even after controlling for several clinical and sociodemographic characteristics, including substance use and ART prescription status. 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 PWH. Additional studies have found increased risk for some cancers and death, and a reduction in life expectancy related to tobacco use, regardless of VL and CD4 count. In studies exploring tobacco dependence and behavioral health, tobacco use is associated with worse SUD treatment outcomes and increased depressive symptoms.

Despite mounting evidence of poor health outcomes among PWH 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 served in 2019, those receiving HR services in the NY EMA and MH services in the Tri-County Region had the highest rate of recent smoking, at 62% and 67% 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 PWH.
**i) Intimate Partner Violence (IPV).** The NYC HD’s PlaySure Network for HIV prevention is a citywide network of HIV testing sites, CBOs, and clinics working together to promote patient-specific approaches to sexual health and HIV prevention, increase access to PrEP and PEP, and link people who test positive for HIV to care. In 2019, among all PlaySure Network clients with a baseline assessment, approximately two-thirds said that their partner had never: physically hurt them, insulted or talked down to them, threatened them with harm, or screamed or cursed at them. Roughly 3% said that their partner had sometimes, fairly often or frequently physically hurt them, insulted or talked down to them, threatened them with harm, or screamed or cursed at them. However, 27% of clients declined to answer any of the questions. When asked about their interest in a referral to an IPV support program, 1.2% of clients said yes, 6.2% declined to answer, 27% said this was not applicable to them, and 66% said no.

**4) Complexities of Providing Care.**

4a) Impact and response to a reduction of RWHAP Part A funding.

Impact. The NY EMA has seen reductions totaling approximately $28 million since GY11, including a reduction of 1.4%, or $1,330,082, in GY20. 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 PWH. All RWHAP service categories have experienced reductions in funding over the years, and, after a careful review of other payers, four have been eliminated altogether: Home and Community-Based Health Services, Outpatient/Ambulatory Health Services, Transitional Care Coordination, and, most recently, Non-MCM. 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 and other programs for PWH. NYS HUCP was able to absorb the reductions by refocusing some of its rebate funding and RWHAP Part B supplemental funding to preserve NYS HUCP services. With each year’s reduction, the PC and the Recipient have been strategic in their response and proactively plan to ensure funding reductions do not erode the NY EMA’s successes in VS and reductions in morbidity and mortality.

Response. To address the reduction in funding, the PC’s Priority Setting and Resource Allocation (PSRA) Committee reassessed each category through an extensive review of Service Category-Specific Fact Sheets in GY20. 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 GY20 award, the PSRA Committee was able to utilize savings of $298,268 in the carrying costs of four service categories: n-MCM/Currently or Recently Incarcerated, n-MCM/General Population (NMG), MH, and HR. 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 $1,031,814 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 over the course of the year, and there will be no effect on the availability of medications for ADAP enrollees. In GY20, the PC enhanced two critical services—FNS and EFA—through unallocated Part A funds resulting from an Early Intervention Services (EIS) contract discontinuation and the reduction in the ADAP allocation.
The NY EMA was also able to increase support for housing through funding received under the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

b) Table 2. NY EMA Uninsured and Poverty

<table>
<thead>
<tr>
<th>Diagnosed and reported PWH in NY EMA</th>
<th># of PWH</th>
<th>% of PWH</th>
</tr>
</thead>
<tbody>
<tr>
<td>a1. PWH in the NY EMA enrolled in Medicaid</td>
<td>54,945</td>
<td>63.8%</td>
</tr>
<tr>
<td>a2. PWH in the NY EMA enrolled in Medicare &amp; Medicaid (dual eligible)</td>
<td>11,983</td>
<td>21.8%</td>
</tr>
<tr>
<td>a3. PWH in the NY EMA enrolled in marketplace exchanges</td>
<td>21,840</td>
<td>25.4%</td>
</tr>
<tr>
<td>b. PWH in the NY EMA without any insurance coverage</td>
<td>9,326</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active RWHAP clients in the NY EMA, GY20</th>
<th># of PWH</th>
<th>% of PWH</th>
</tr>
</thead>
<tbody>
<tr>
<td>c1. PWH in the NY EMA living at or below 100% of 2020 FPL</td>
<td>10,587</td>
<td>80.0%</td>
</tr>
<tr>
<td>c2. PWH in the NY EMA living at or below 138% of 2020 FPL</td>
<td>11,712</td>
<td>88.5%</td>
</tr>
<tr>
<td>c3. PWH in the NY EMA living at or below 400% of 2020 FPL</td>
<td>13,191</td>
<td>99.6%</td>
</tr>
<tr>
<td>c4. PWH in the NY EMA living at or below 500% of 2020 FPL*</td>
<td>13,224</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

Sources: Data in sections a. and b. provided by NYSDOH to NYC HD. Dual eligible is a subset of Medicaid enrolled. Numbers and corresponding percentages reflect insurance program enrollment available through July 2020. Numbers and corresponding percentages in section c. are from eSHARE.

*Residents with income under 500% FPL are eligible for RWHAP services. No income restrictions EIS or HE/RR.

As a result of the COVID-19 pandemic, the NYC unemployment rate was reported at 16% in August 2020. Since health insurance is tied to many individuals’ employment, many New Yorkers found themselves without coverage during the pandemic. Insurance coverage is even more critical for PWH to access necessary medical and supportive services that support VS. According to preliminary data from NYSDOH, more than 4,900 PWH in the NY EMA enrolled in Medicaid, Medicaid/Medicare (dual eligible), or the marketplace exchanges since February 2020 as a result of the COVID-19 pandemic (i.e., indicated job loss, COVID-19 positive test, etc.). Further, an estimated 1,600 PWH in the NY EMA have been without insurance coverage since February 2020.

c) Barriers to accessing health care.

COVID-19. In the current era of COVID-19, clients have experienced numerous barriers to care—reported VL labs to NYC surveillance dropped by 77% in April 2020 when compared to April 2019. To address the challenges and ensure the NY EMA preserves the HIV care system, the Recipient directed reimbursement for cost (versus performance-based reimbursement) until further notice. Use of telehealth has been strongly encouraged and taken up by the vast majority of service providers as appropriate (with the exception of housing and FNS providers which require mostly in-person contact with clients using CDC guidelines). Within the first month of the pandemic, the Recipient communicated the expectation that each client enrolled in each program be contacted to determine their needs with follow up as appropriate. As mentioned earlier, the Recipient worked with the PC to allocate additional resources to critical FNS, Housing, and EFA services.

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 or rural, and that 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 health care.

Thus, while New Yorkers are a highly insured population, limited transportation services and lack of local specialists and service providers serve as barriers to obtaining appropriate health care. To increase access to services, the NY EMA considers geographic distribution of contractors during procurement and contracting and has allocated $358,057 to medical transportation to provide access to taxi and gas vouchers, as appropriate, and to mass transit options where available. The medical...
A transportation program in the Tri-County Region of the NY EMA ensures that clients are able to attend appointments for services related to their HIV primary care, including medical care, SUD treatment, MH appointments, and to pick up prescriptions. In addition, the NY EMA will enhance EFA in GY21 to help address barriers to care for RWHAP Part A participants throughout the NY EMA. The EFA program is housed in the Tri-County Region, and while it was originally set up to serve that area, the program was enhanced in GY20 and GY21 to cover emergent needs directly affecting the care and treatment of RWHAP Part A clients throughout the NY EMA. The EFA service category entitles any RWHAP Part A participant up to $2,000 to cover the cost of an emergent need relating to their HIV care and treatment.

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 eligible PWH. In addition, insurance coverage is available at no cost to PWH with an income up to 500% of the 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. 33-35 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 December 2019, Medicaid enrollment increased by 17% among PWH 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. Specifically, all RWHAP Part A contracts require programs to assess insurance status and maintain linkage and referral relationships with health plan navigation services to facilitate enrollment in health plans for eligible individuals at enrollment and at every six month reassessment.

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 monolingual and multilingual people. Within the RWHAP Part A population, 26% of non-EIS clients in GY19 reported a language other than English as their primary language. Of clients reporting a primary language other than English, most speak Spanish (80%), followed by French (4%), Haitian Creole (3%), African languages (2.5%), and French Creole (2.2%). 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. 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). To help subrecipients recognize steps to make services more responsive to the diversity of clients receiving RWHAP Part A services, the Recipient formed a work group to develop a CLAS Standards self-assessment programs may use to compare their organizations against CLAS Standards. It includes 20 questions addressing governance, leadership, workforce, communication, language assistance, engagement, continuous improvement, and accountability. Providers are asked to complete the self-assessment internally, identify areas for improvement, and take action through quality improvement (QI) projects. NYC HD distributed the tool to NYC RWHAP Part A providers in May 2019 and to Tri-County Region providers in July 2019. Providers are contractually required to complete the self-assessment, identify areas for improvement, and include action steps in their annual RWHAP Part A Quality Management Plan.
Service gaps and plans to address them. The RWHAP Part A service portfolio is carefully designed to meet needs identified through surveillance, program evaluation, CHAIN data, and changes in the NY EMA’s health care landscape. Identified needs are addressed through incorporation of lessons learned and evidence-based interventions in service models to support effective diagnosis, linkage to and retention in care, and adherence to ART. COVID-19 has presented additional service needs that the RWHAP Part A program in the NY EMA has sought to address. As previously stated, the Recipient added funds to Housing, FNS, and EFA services to help ensure participants are housed, fed, and able to focus on their HIV care and treatment during the pandemic.

**Individuals diagnosed but not currently engaged in care.** Based on the HIV care continuum, 29% 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 supportive services to locate and engage these individuals back into care, the RWHAP Part A program provides $818,259 in funding to the nationally recognized Assess. Connect. Engage. (ACE) Team (formerly Field Services Unit) within the NYC HD’s BHIV, which uses a data-to-care (D2C) model to identify PWH who, according to surveillance data, have been lost to care. The aim is to identify and reach people 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 ACE Team has established collaborative relationships with NYC HIV medical providers, social services agencies, and community-based case management providers. In 2019, the ACE Team located 627 PWH who had been out of care for at least 13 months or had never been in care since their HIV diagnosis. Of these, 409 (65%) were re-engaged or linked to HIV care; and 108 clients had unmet needs (e.g., housing, health benefits, transportation), 82 referrals were made to address their needs, and 35 accessed services. Fifty-seven percent (343/606) of people currently not in care who refused to name partners were offered home test kits (Oraquick Rapid) to deliver to any unnamed partners they might think would benefit from HIV testing. Fifteen percent (50/343) accepted the home test kit and 88% (44/50) were confirmed to have received the test kit. Forty-one percent (18/44) of those who received the kits agreed to complete a follow-up interview about their experience. Among people not in care, 12% (74) were found to have an HCV infection per the NYC HD Viral Hepatitis Registry. Therefore, in addition to HIV linkage to care, 38% (28) of people with HIV/HCV coinfection were linked to HCV care.

**Individuals who are not currently virally suppressed.** In 2018, 25% of PWH in the NY EMA were virally unsuppressed. In GY21, as in previous years, RWHAP Part A services will be distributed to reach high-need, underserved Black and Latino/Hispanic 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 inequities. 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, have access to the clients’ 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 PWH of color.

Efforts to retain PWH in care and support ART adherence and VS include the RWHAP Part A MH programs, which engage people with psychiatric diagnoses through navigation; educate on MH issues; coordinate care between MH and medical care providers; treatment adherence support; and provide 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. 53 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 addressing barriers to VS.

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

1) **Planned Activities of the NY EMA EIIHA Plan for GY21.**

a) **Primary activities.** The primary activities in the NY EMA’s EIIHA plan for GY21 are (1) to promote and increase HIV testing, (2) to improve timely linkage of people newly diagnosed with HIV to medical care, and (3) to increase awareness of and referral to HIV prevention services, including PrEP, PEP, treatment as prevention, and condoms. In 2016, the NYC HD rolled out a “status neutral” approach to HIV prevention and care services that simultaneously addresses the needs of PWH and people not living with HIV (see Figure 4). The NY EMA’s EIIHA plan for GY21 will build upon the City’s successes with this approach and align with the final NYC EHE plan, including building upon activities funded through CDC PS-18-1802, RWHAP Part A, and other local, state, and federal funding sources, and those being planned and implemented under Project PROSPER and CDC EHE funding (see pgs. 1-2). The ultimate aim of all activities is to strategically advance HIV prevention efforts in the four EHE counties to accelerate NYC’s progress in reaching the national goal of a 75% reduction in new HIV infections by 2025.

**Figure 4. NYC HD Status Neutral Care Plan**

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

*Tier 1.* The first tier supports sustainable access to HIV testing services for the general population citywide by promoting routine HIV screening programs in health care facilities. The first-tier approach is consistent with the CDC’s 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 delivering grand round presentations to clinical practices and medical training programs. The NY EMA also uses City, CDC, and RWHAP Part A funding to support, but not supplant, HIV testing programs in health care 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 2019, an estimated 7% of PWH in NYC were undiagnosed. To maximize the impact of funding, routine screening funding is focused on clinical facilities serving neighborhoods that are 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 people who receive an HIV test during testing events across NYC among the NY EMA-contracted clinical and non-clinical providers. In GY19, the number of HIV tests was particularly high among enrolled Black and Latino/Hispanic people, with a higher proportion of Black individuals receiving a newly diagnosed confirmed positive test compared to Latino/Hispanic and other MSM individuals. Under CDC EHE funding (PS-20-2010), the NY EMA plans to expand capacity for routine testing by funding two cohorts of clinical providers to make system and policy level changes within their institutions to support routine HIV testing. The estimated start date for these contracts is mid-2021.

### Table 3. Newly Diagnosed Positive HIV Test Events March 1, 2019 – February 29, 2020

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Black</th>
<th>Latino/Hispanic</th>
<th>MSM</th>
<th>TGNC/NB*</th>
</tr>
</thead>
<tbody>
<tr>
<td># Test events</td>
<td>8,951</td>
<td>10,014</td>
<td>3,127</td>
<td>4,522</td>
<td>3,446</td>
</tr>
<tr>
<td># Newly diagnosed positive test events</td>
<td>119</td>
<td>81</td>
<td>66</td>
<td>41</td>
<td>49</td>
</tr>
<tr>
<td># Newly diagnosed confirmed positive test events</td>
<td>74</td>
<td>43</td>
<td>40</td>
<td>22</td>
<td>29</td>
</tr>
<tr>
<td># Newly diagnosed positive test events with client linked to HIV medical care</td>
<td>81</td>
<td>40</td>
<td>44</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td># Newly diagnosed confirmed positive test events with client linked to HIV medical care</td>
<td>62</td>
<td>33</td>
<td>32</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td># Newly diagnosed positive test events with client referred for partner services</td>
<td>19</td>
<td>15</td>
<td>10</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td># Newly diagnosed confirmed positive test events with client referred for partner services</td>
<td>12</td>
<td>13</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td># Newly diagnosed positive test events with CD4 cell count and VL testing</td>
<td>46</td>
<td>31</td>
<td>24</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td># Newly diagnosed confirmed positive test events with CD4 cell count and VL testing</td>
<td>38</td>
<td>23</td>
<td>21</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

*Not mutually exclusive groups. Tests of clients identifying as Black and Latino/Hispanic can be found in both sets of columns.

* Transgender, gender non-conforming, or non-binary individuals
† Includes clients with lab test(s) occurring on or after confirmatory test date. Restricted to confirmatory test dates from 3/1/19 to 2/29/20 and lab tests that occurred within the same time period.

CD4 and VL data as of November 2019; data maybe incomplete due to reporting lag.

In the Tri-County Region, Medicaid and private insurers are the primary payers supporting the implementation of the NYS HIV testing law, with supplemental RWHAP Part A support for targeted testing among the uninsured and linkage to care for those who test positive for HIV.

Beyond directly contracting for testing services, the NYC HD has taken an additional approach to engage hospitals and community health centers in routine HIV screening through the citywide HIV testing initiative, New York Knows. New York Knows represents a NYC HD partnership with CBOs, community health centers, hospitals, colleges and universities, faith-based organizations, and businesses to provide voluntary HIV testing to all New Yorkers, routinize HIV testing in health care, identify PWH who are undiagnosed and link them to care, and connect people at risk of HIV to PrEP and other prevention services. Approximately five million HIV tests have been performed by New York Knows partners since 2008, with over 460,000 tests conducted in 2019. In 2019, New York Knows announced it will expand its focus to include other STIs and HCV.

Approximately 57,000 HIV tests are conducted each year at NYC HD’s eight SHCs. Integrated, opt-out HIV testing is available at NYC HD’s TB Chest Centers and SHCs for all patients presenting to a clinic. For over 10 years, 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 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, the SHCs test clients with the 4th generation Alere Determine test.

**Tier 2.** The second tier of the NY EMA’s EIIHA approach aims to decrease inequities in health outcomes by targeting HIV testing services in non-clinical settings. The NY EMA uses surveillance data to identify the priority populations and communities for these services. To align with its status neutral approach as well as new statewide HIV testing legislation and regulations, in 2017 the NYC HD issued a Request for Proposals (RFP) for HIV Testing and Status Neutral Navigation Services, which included funding from both CDC and RWHAP Part A EIS. Contracts began January 1, 2018. Under this program, CDC Prevention funds are used to contract with 11 clinical facilities to implement status neutral navigation to iART for those newly diagnosed with HIV or out of care, and navigation to PrEP for those who test negative for HIV; and RWHAP Part A EIS funds are used to contract with CBOs (non-clinical) to conduct targeted testing through community and online outreach with required MOUs with clinical providers for expedited linkage to care. The 14 RWHAP Part A-funded CBOs focus on gay, bisexual, and other MSM and TGNC/NB people and their partners, with particular attention to Black or Latino/Hispanic TGNC/NB individuals under 29 years old; Black and Latina/Hispanic heterosexual women, particularly those over 30 years old or living in areas with a high prevalence of STIs; and other priority populations. Funding was prioritized to applicants whose patient population resides in ZIP codes with high numbers of PWH and documented health inequities and/or that have a history of outreaching to priority populations. Selected agencies also have demonstrated cultural responsiveness in their work and have a history of successfully engaging with the priority populations. From March 2019 to February 2020, these funded testing programs conducted 5,665 HIV testing series, identified 58 people with new HIV diagnoses, and linked 58% of those newly diagnosed to HIV medical care within 30 days of diagnosis. These programs also linked 176 clients to a PrEP provider and 43 clients to a PEP provider. In 2021, this portfolio will be rebid so that all resulting contracts, regardless of funding source, will use similar service definitions, standardized payment points, and updated service
models to support HIV testing, linkage to iART, and linkage to PrEP and PEP. New contracts are expected to begin in July 2021.

In addition, RWHAP Part A and CDC funds support targeted testing at all jails in NYC including Riker’s Island. Using City funds, the Riker’s Island facility offers opt-out HIV testing at intake, and for those who decline, the RWHAP Part A- and CDC-funded contract supports outreach and follow-up to conduct an HIV test at a later date. Additionally, the Riker’s Island contract conducts group health education sessions for clients seen in the medical clinic or supportive services area of the jail. These HIV education sessions address topics such as PrEP, PEP, testing, transmission, and, most recently, COVID-19.

The NYC HD launched the Community Home Test Giveaway Virtual Program in April 2020 to address declines in in-person HIV testing during the COVID-19 pandemic. Participants receive online coupon codes from partner organizations to redeem online for a free OraQuick HIV self-test kit delivered to their home address. The program has partnered with 60 CBOs, community health centers, hospital-based clinics, small businesses, and other settings citywide, with 2,075 online coupon codes distributed and 1,914 codes redeemed to date. By promoting free HIV self-tests on multiple platforms, including social media, dating and hook-up apps, text messaging, and email, the program continues to reach communities most affected by HIV. HIV self-testing allows participants to learn of their HIV status from the safety of their home and helps facilitate initiation of PEP or continued adherence to PrEP, without going to a clinical facility for testing. In June 2020, the NYC HD announced Door 2 Door, a new service through which NYC residents can order condoms and other safe sex products for home delivery. Three of NYC HD’s eight SHCs are currently open and offering limited services for New Yorkers’ sexual and reproductive health needs during COVID-19. New Yorkers can also call the NYC SHC Hotline for telehealth services.

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 people 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 people 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, 25 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 2019 to February 2020, clinical programs initiated 464 clients on ART within four days of HIV diagnosis, initiated 437 clients on PrEP, and prescribed PEP to 167 clients. These funded programs join over 40 other contracted providers in delivering PrEP and PEP education, referral, linkage, and prescription services as part of the PlaySure Network.

Through the JumpstART program, SHCs provide HIV treatment on the day of diagnosis or to PWH who have never engaged in treatment, followed by linkage to care and partner services. The City’s SHCs also provide PrEP and PEP prescriptions to eligible patients. In 2019, there were 212 new HIV diagnoses in the SHCs, including 29 acute HIV cases; 40% of newly diagnosed patients received JumpstART on the day of diagnosis. A total of 1,130 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 (e.g., patient education and linkage to services) to increase access to rapid ART initiation, with higher reimbursement for those linked on the same day. Fifteen 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 PWH referred by emergency departments, outpatient and inpatient clinics, and HIV testing programs.

From March 2019 to February 2020, the NYC HD BHIV’s Clinical Operations and Technical Assistance (COTA) Program conducted a monthly training to increase iART knowledge and practices among HIV social service providers, navigators, and clinicians. To date, 81 clinical and social service HIV providers have been trained. Of the participants who completed the training evaluation to date, all respondents reported they were very satisfied or satisfied with the overall iART training, and all respondents agreed they were very prepared or prepared to use their learned skills in their job immediately. Since March 2020, the in-person training has been suspended due to COVID-19; however, the training was adapted to a webinar format and was delivered on March 12, 2020 to more than 85 attendees. A recorded version of the webinar has also been made available.

COTA also developed a one-hour iART training adapted from a full day training to strengthen clinical and social service providers’ knowledge, attitudes, and practices related to the implementation of iART. During the reporting period, COTA delivered the training three times: once in a public hospital, once in a Federally Qualified Health Center (FQHC), and once in a community-based housing organization, reaching more than 45 clinical and social service providers.

On August 21, 2020, COTA launched an iART public health detailing campaign to promote scaling iART in HIV clinics across NYC. COTA developed an iART public health detailing 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, etc.) to build the capacity of HIV clinic care teams to adopt and operationalize iART. COTA will deliver virtual outreach education visits (e-detailing visits) to HIV providers to disseminate key messages and resources related to iART. The action kits will be mailed to providers’ clinics and shared electronically after the e-detailing visits. Pre- and post-e-detailing visit evaluations will be administered to assess the impact of the visits and kits on iART practices within HIV care settings.

Under Project PROSPER and CDC EHE funding, on August 19, 2020, the NY EMA initiated an RFP for an Enhanced D2C (eD2C) Project, building on BHIV’s successful work with Brooklyn-based organizations to improve linkage, re-engagement, and durable retention in HIV care; and sustained VS. The eD2C RFP seeks to contract with clinical agencies providing HIV care and treatment in the Bronx, Queens, Manhattan, and Brooklyn. Funded contractors will work in close partnership with BHIV’s ACE Team and COTA to build clinic staff capacity to conduct D2C activities; triangulate clinic, external, and NYC HD data sources; and identify and outreach to PWH who have fallen out of care.

Increase rates of retention in care and VS. The NYC HD has funded a citywide scale-up of The Undetectables VS Program (The Undetectables) as part of the NYS ETE initiative. The Undetectables is an ART adherence intervention designed to promote sustained VS among PWH 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 VS. Participants may receive a $100 gift card incentive for each quarterly lab result showing VS (<200 copies/ml). The marketing campaign supports organizational culture change by engaging clients and staff on the importance of VS to individual and community health. The intervention was originally developed and pilot tested by Housing Works, an HIV service organization in NYC. In July 2016, the NYC HD awarded over $1.5 million annually in City-funded contracts to seven agencies across NYC, including one for Housing Works to provide training and TA on program implementation to awardees. As of December 31, 2019, The Undetectables programs have served approximately 2,890 PWH in NYC. Among those engaged in care (n=2,311), 88.7% were virally suppressed at their most recent lab. Among clients enrolled the entire 2018-19 GY (n=1,185), 76.7% demonstrated evidence of durable VS.

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 (PPSs) implemented The Undetectables in NYC and in Albany; and Amida Care, an HIV-focused MCO, launched Live Your Life Undetectable (LYLU) to provide the same financial incentive also requiring dual engagement in primary care and supportive services. More recently, VNS SelectHealth, another HIV-focused MCO, began providing the same financial incentive. Evaluation of City- and DSRIP-funded programs will assess the potential for financial incentives as components of value-based payment (VBP) 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 VL 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 VL test results. The TSRs are generated quarterly and sent to program staff by their quality management specialists (QMS). The Recipient also generates annual Agency-level Viral Suppression Reports (AVSR), which aggregate all agency-specific VS data into one report and compares it to all RWHAP Part A clients in NYC. To improve its utility, the AVSR was redesigned in 2019 with enhanced data visualizations to also look at VS among five specific priority populations (OPWH, Black or Latino cisgender MSM, cisgender YMSM, transgender women, and Black and Latina cisgender women) within each agency. These priority populations were selected to align with the NYC HD’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 CBOs and health care 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. These contracts will be re-bid in 2021, and in the process, the NY EMA will explore ways to better reach priority populations and use alternative delivery methods. In addition, when long-acting injectables become available, the NY EMA plans to integrate their use into its programs. 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 FY21. During the COVID-19 pandemic, providers may prescribe 90 days of medicines to patients taking daily PrEP.

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7 Engaged in care: Having greater than or equal to two VL labs at least 90 days apart during a period of interest.
8 Evidence of durable VS: Having no unsuppressed VL within a 12-month period.
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, people who inject drugs (PWID), sex workers, homeless individuals, and currently and formerly incarcerated individuals. In GY19, the Tri-County Region increased resources to reach YMSM and women of color (WoC); and in GY20, a RWHAP Part A-funded EIS contract was awarded to the WCDOH to continue this work, in addition to conducting outreach at the local syringe exchange program and county jail in order to engage PWID and incarcerated individuals. 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 and participates in ETE initiatives and NYLinks (see p. 26 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 HD-funded testing programs, the NYC HD 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 HD 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 HD 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 citywide. These include campaigns to increase awareness of HIV status (BeSure); encourage individuals to choose the combination of safer sex practices that work for them (PlaySure); emphasize initiation and adherence to HIV medications and biomedical prevention interventions (StaySure); encourage consumer and provider communications to improve sexual health and wellness, especially to Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) New Yorkers (Bare It All). In 2018, BHIV launched the Living Sure and Listos! Campaigns, which educate and promote PrEP use among cisgender and transgender women, and the Latino/Hispanic community, respectively; and in 2019, to promote the evidence-based finding of Undetectable=Untransmittable (U=U), BHIV launched its MadeEqual campaign. 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 campaigns and messaging into their digital platforms. With the ongoing COVID-19 pandemic, the NYC HD is prioritizing social marketing resources and activities to support COVID-related topics.

The ACE team, housed within the BHIV HIV Epidemiology Program, and the Tri-County region’s Health Departments provide partner notification services to PWH diagnosed by providers. BHIV’s ACE Team and Tri-County Region Health Departments’ 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 people who test positive. In 2019, the ACE team offered partner services to all newly diagnosed citywide. ACE interviewed 83% (1,425/1,712) of newly diagnosed in NYC and elicited 498 HIV-exposed partners. Seventy
percent (231/330) of partners with a negative or unknown HIV status were notified and 54% (124/231) were tested, of whom 17% (21/124) had newly diagnosed HIV infections. If those newly diagnosed do not return to receive their test results, ACE 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, ACE offered 77% (179/231) linkage to PrEP services, 23% (42/179) expressed interest in PrEP, and 71% (30/42) accepted the PrEP referral.

b) Major collaborations with other programs and agencies. Many NYC HD 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 Plan. Most recently, BHIV is working collaboratively with the PC and HPG as well as internal programs, the NYSDOH AI, City agencies, and community partners to develop the NYC EHE plan. Listening sessions with each EHE borough and priority populations (youth and transgender people) are currently underway to inform the draft plan presented to the PC and HPG for concurrence in January 2021.

BHV 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 HD programs and City agencies that provide services to populations heavily impacted by HIV, such as the Division of Mental Hygiene, Bureau of Sexually Transmitted Infections (BSTI), Bureau of Tuberculosis Control (BTBC), Bureau of Alcohol and Drug Use Prevention, Care, and Treatment (BADUPTC), CTP, Public Health Lab, Office of School Health, Administration for Children’s Services, and NYC Health + Hospitals. The NYC HD also works with NYC Health + Hospitals 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 medical care within 30 days of release. The NY EMA also collaborates with the U.S. HHS Region 2 to promote and support PrEP and PEP implementation in FQHCs, Title X clinics, and provide support to NYC providers to refer clients to MH and SUD services such as NYC Well, a 24/7 hotline staffed by trained MH professionals who provide assessments and treatment referrals.

Through a CDC-funded demonstration project, Project THRIVE, the NYC HD 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 HD hosted a day-long workforce development workshop. Starting from 2017, 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 HD’s solicitation process for contracted services, guidance on contract scopes, and the process of providing feedback to community members. During the COVID-19 pandemic, the CAB has continued to meet virtually.
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 PWH to care, link people not living with HIV to prevention services including PrEP, and make HIV testing a routine part of health care in NYC. The initiative recently added promotion of STI and HCV prevention into its programming. New York Knows holds regular steering committee meetings in all five boroughs and an annual all partners meeting. The NY EMA is also working closely with the local AIDS Education and Training Center and other City agencies to keep providers up to date on HIV and COVID-19. Preliminary data from New York Knows partners show a reduction in HIV testing in the first half of 2020 due to the COVID-19 pandemic. However, data reporting is incomplete. New York Knows has embraced virtual modalities to maintain its full meeting schedule since March 2020 and ensure maintained relationships and connections with and between community partners. Continued engagement has helped agencies adapt to delivering services while maintaining the safety of their clients and staff during COVID-19.

BHV also collaborates with the NYSDOH AI on NYLinks, a statewide project, and a continuation of a previously funded HRSA/HIV/AIDS Bureau (HAB) Special Projects of National Significance initiative, focused on improving linkage to and retention in care and VS. BHIV is an active participant in the Brooklyn regional collaborative established under NYLinks, with staff serving as co-chair of the work group, 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 coordinates with NYLinks to facilitate engagement of providers in Queens and Staten Island. In addition, BHIV staff participate in borough-based ETE Regional Group meetings, born out of the process to develop 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 Regional Group meetings to align with New York Knows meetings; and implement joint annual meetings of New York Knows, NYLinks, and NYS ETE Regional Groups in Brooklyn, Queens, and Staten Island.

The NYC HD convenes the NYC DSRIP HIV Coalition, comprised of eight hospital-led PPSs and their community partners. In 2015, NYS established the DSRIP program to redesign the health care delivery system, aiming to reduce avoidable hospital visits among Medicaid beneficiaries by 25%. DSRIP HIV Coalition members share best practices and relevant policy developments, and collaborate on HIV-related projects at the health systems level, such as strategies to improve VS and developing models for peer-delivered services. While DSRIP ended in March 2020, the HIV Coalition continues to meet to discuss the evolving NYS Medicaid environment and its impact on the HIV service delivery system.

Finally, BHIV proactively engages members of priority communities to participate in and plan community events including NYC Pride events and World AIDS Day commemoration, among others. BHIV also actively participates in a number of citywide coalitions, including the End AIDS NY 2020 Coalition, NYC Kiki Coalition, Long Term Survivors Wellness Coalition, and the ACT UP Meth Group. In addition, BHIV also works with the Mayor’s Office of Workforce Development, through the Considering Work Efforts Work Group, to inform staff on how to enhance the integration of employment services within HIV prevention, care, and treatment programs (see p. 45 for more details). In light of COVID-19, BHIV is engaging priority populations virtually.

c) Anticipated outcomes of overall EIIHA strategy. The goals of NY EMA’s overall strategy include increasing the number of people aware of their HIV status, increasing the proportion of PWH promptly linked to medical care and achieving VS, and increasing the proportion of
populations at-risk for HIV infection receiving prevention services, including PrEP and PEP (see p. 29-32 for specific strategies). These goals directly align with the goals of the EHE plan, NYS’s ETE Blueprint and Integrated Plan, and the NYC EHE plan. This status neutral approach addresses the needs of PWH and people not living with HIV with its success contingent on the coordination among providers of testing, prevention, and care services, regardless of an individual’s HIV status.

The NY EMA continues to promote and fund testing programs that focus on priority populations, including gay, bisexual, and other MSM; TGNC/NB people and their partners; Black and Latina heterosexual women; 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 CHS, the NYC HD 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 63% in 2012. At the same time, the number of HIV diagnoses in the NY EMA has decreased (see p. 17-20 for more details). This declining trend in the number of new diagnoses is partly due to the NYC HD’s rigorous and comprehensive effort to increase HIV testing, link PWH to care, and support increased VS 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 HD tracks this indicator using HIV surveillance data and defines timely linkage as a VL, 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 82% in 2018. As noted previously, the NY EMA employs several strategies to retain individuals in care, improve ART adherence, and promote sustained VS. The outcome of these efforts will be measured through changes in the stages of the HIV care continuum.

The NY EMA continues to promote and fund PrEP and PEP referral and care services with the goal of increasing the proportion of priority populations, including MSM, TGNC/NB individuals, and Black and/or Latina women, who are aware of and report using these services. This outcome indicator will be measured through the Sexual Health Survey (SHS). Among sexually active NYC MSM ages 18 to 40 years with an HIV negative/unknown status surveyed through the SHS in fall 2019, 97% were aware of PrEP and 36% had taken PrEP in the past 6 months. 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!

During the COVID-19 pandemic peak (March–April 2020), there were notable changes in services provision within the PlaySure Network. During this time period, there was a 54% decrease in linkages to PEP providers and a 46% decrease in linkages to PrEP providers. However, while PrEP initiations decreased 70% between February and April, PrEP follow-up visits remained stable suggesting that those who were already on PrEP were still maintaining adherence. As a likely result of the decrease in COVID-19 activity and the reopening of NYC, the provision of HIV prevention services increased in May and June 2020, but are still below pre-pandemic levels.

2) GY21 EIIHA Plan priority populations. The three selected distinct priority populations are: (1) Black and Latino MSM; (2) TGNC/NB people and their partners; and (3) Black and Latina cisgender women living in neighborhoods with high numbers of PWH.

a) Populations targeted. Three populations were chosen due to inequities in new diagnoses, EiC, and/or VS after a review of local epidemiologic data.
b) **Specific challenges with or opportunities for working with the targeted populations.**

a) **Black and Latino MSM.** Fifty-six percent of new HIV diagnoses in the NY EMA in 2019 were among MSM (including MSM-IDU), more than any other transmission risk group. National data indicate that MSM and YMSM, particularly Black and Latino, 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.iii This holds true in the NY EMA, making them a high priority of the overall EIIHA plan. In 2018, YBMSM and YLMSM accounted for 81% of all YMSM living with HIV in the NY EMA. Research has shown that stigma and discrimination due to race/ethnicity and sexual orientation and lack of access to culturally responsive services for MSM of color are barriers to HIV testing and accessing medical services.liii Further, some YMSM who experience homelessness or housing instability face additional barriers to health care including a lack of transportation, financial resources, and/or health care insurance and lack of awareness of available resources.liiv

b) **TGNC/NB people and their partners.** In 2019, 3% of new HIV diagnoses in NYC were among transgender people, 96% of whom were transgender women. Black or Latina women made up roughly 90% of new diagnoses among transgender women, and 56% of newly diagnosed transgender women were 20 to 29 years. No local estimates of HIV prevalence exist, but a 2019 systematic review and meta-analysis found that an estimated 14% of transgender women in the U.S. have HIV; by race/ethnicity, an estimated 44% of Black transgender women, 26% of Latina transgender women, and 7% of white transgender women have HIV.lv The NYS ETE Blueprint notes that stigma and discrimination, including sexism, transphobia, and racism contribute to HIV risk among transgender people, 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 health care and affirming providers.

c) **Black and Latina/Hispanic cisgender women in areas with high numbers of PWH.** In 2018, Black and Latina/Hispanic 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 HD have demonstrated that HIV diagnoses and prevalence are more likely to overlap with areas where increased poverty, health inequities, and poor health outcomes are found; these are areas where Black and Latina/Hispanic women typically reside. Risk factors for increased vulnerability among Black and Latina/Hispanic women include low income, substance use, being born outside the U.S., exposure to IPV, and having formerly incarcerated partners.

Other challenges experienced by Black and Latina women include stigma associated with HIV, cultural and linguistic barriers to care, 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/Hispanic 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.liv PrEP prescriptions among women are disproportionately lower than among men. Between July and December 2018 in NYC, men received PrEP prescriptions at 12 times the rate of women (18,311 vs. 1,524 prescriptions)lii, however, men have an HIV diagnosis rate that is more than four times higher than women.

Many Black and Latina/Hispanic women in the NY EMA live in neighborhoods with high numbers of PWH 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.” As such they have low self-perceived risk for HIV which may delay or prevent them from presenting for testing or considering PrEP as a prevention option. People born outside the U.S., especially undocumented, may also...
delay HIV testing and care services due to 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 GY21 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. 17), along with several innovative programs that are aligned with the national goals outlined in the EHE plan, NYS’s goals detailed in the ETE Blueprint, and NYC’s EHE 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 *New York Knows*, the NY EMA promotes and supports routine HIV screening in all health care settings. As stated earlier, 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 HD prioritized RWHAP Part A EIS funds to address the needs of prioritized populations to receive HIV medical care by funding 14 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. As noted previously, between March 2019 to February 2020, these funded testing programs conducted 5,665 HIV testing series, identified 58 individuals with new HIV diagnoses, and linked 58% of those newly diagnosed to HIV medical care within 30 days of diagnosis. These programs also linked 176 clients to a PrEP provider and 43 clients to a PEP provider. Awarded contracts run through December 31, 2020. Additionally, with Project PROSPER and CDC EHE funding, the NY EMA initiated an RFP on August 19, 2020 titled *Building Equity: Intervening Together for Health*. Launched by NYC HD BHIV’s COTA team, this RFP aims to provide HIV clinics with resources to replicate identified evidence-informed interventions that are focused on priority populations, and support clinics to build their human and structural capacity to improve engagement, retention, and VS among priority populations. The awarded contracts will run through February 29, 2024.

Funded CBOs use innovative approaches, such as behavioral risk screenings for PEP and PrEP, brief interventions, status neutral navigation activities 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 priority populations. A qualitative study lviii of barriers and facilitators to HIV primary care among vulnerable populations (YMSM, African immigrants, formerly incarcerated, and transgender women) in NYC highlights the essential role of CBOs in engaging these populations in care, specifically referencing their tailored and culturally responsive services.

To further increase accessibility of testing services, the NYC HD has conducted giveaways of in-home HIV self-tests since 2015. In 2018, the NYC HD 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. During the COVID-19 pandemic response, the NYC HD expanded distribution of self-tests to ensure testing access complied with stay-at-home orders. BHIV is currently exploring the integration of STI testing with the giveaway.

The NY EMA promotes U=U, the message that PWH who maintained an undetectable VL for at least six months do not transmit HIV through sex, which was endorsed by the CDC in September 2017 lxix. 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 priority populations and
link them to care and iART. The BHIV established a work group 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 have included: a standardized slide set to substantiate U=U research including the PARTNERS, PARTNERS II, and HPTN 052 results and training modules for condom providers, ACE team, patient navigators, and health educators to support productive and knowledgeable discussions of U=U with community program clients. BHIV’s Made Equal campaign launched in June 2019 to align with Global Pride events in NYC and promotes the U=U concept; and was designed to reduce HIV-related stigma, celebrate healthy sexuality and sexual pleasure, and redefine what it means to live with HIV. Made Equal appeared through outdoor ads across the City as well as digital media.

In addition to focusing on priority populations in the above-mentioned U=U initiatives and Status Neutral Testing RFP activities, the NYC HD also implements several initiatives specific to the EIIHA-identified priority populations. These initiatives include: Black and Latino MSM. 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 HD has conducted three listening sessions with MSM of color in Brooklyn to discuss the social determinants that impact their health. The CAB for Project THRIVE meets monthly with the NYC HD staff to discuss and make recommendations on addressing these social determinants. From fall 2019 to spring 2020, BHIV implemented a storytelling initiative throughout NYC to promote LGBTQ 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 PS-17-1711, the NYC HD formed the Project Sol CAB composed of HIV prevention and care service providers who largely identify as Latino MSM to inform 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 expands relationships with organizations serving Latino MSM to support programming for 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 NYC 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. Across both groups, participants recommended provider training to reduce discrimination and improve knowledge of both sex work and available services citywide to provide better referrals. The NYC HD will use this data to inform development of services moving forward.

TGNC/NB people 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 people. BHIV also convenes a Black and Latina Transgender Women Work Group to addresses the HIV care needs of Black and Latina transgender women by developing recommendations to
ensure gender affirming best practices are implemented across programs in the RWHAP Part A portfolio. In 2020, BHIV concluded a study with TGNC/NB people who engage in sex work to inform activities to support their health and well-being. The study conducted individual interviews with TGNC/NB people who exchange sex for money to elicit information on: the overall experience of sex work among TGNC/NB people in NYC; the impact of health care, 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 health care and supportive services. A comprehensive report is currently under review; it will be utilized to inform future activities and services for TGNC/NB people.

Black and Latina/Hispanic cisgender women in areas with high numbers of PWH. Agencies funded through the Status Neutral Testing RFP conduct outreach to people who live in high poverty areas (placing them at higher risk for HIV) 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 PWH promptly to care and initiate iART. In 2019, BHIV implemented the fifth wave of its public health detailing campaign to promote PrEP and PEP 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 NYC HD’s Center for Health Equity and 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 and a majority membership of WoC. 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 trauma-informed care, domestic violence/IPV, and immigration as high priority topics to be addressed at future Summits. As noted previously, in March 2018, the NYC HD launched a social marketing campaign, Living Sure, promoting PrEP and PEP usage among cisgender and transgender women. This is the latest addition to the NYC HD’s series of sex-positive campaigns, BeSure, PlaySure, StaySure, and Bare It All, which seek to improve sexual health and wellness among their respective priority populations.

3) Planned efforts to remove legal barriers to routine HIV testing. In the last decade, the NYC HD 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, NYS Governor David Paterson signed a testing law requiring 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 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 legislation further streamlining 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 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. NYC HD 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 specific 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 PWH.** 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 Plans are 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 150,000 enrollee increase between 2019 and 2020.

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. 2020 NY State of Health Plan Availability by County – Individual Market**

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<th>County</th>
<th>Emblem Health</th>
<th>Empire BlueCross BlueShield</th>
<th>Fidelis Care</th>
<th>Healthfirst</th>
<th>MetroPlus Health Plan</th>
<th>MVP Health Plan</th>
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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 Special Needs Plans (SNPs) offer additional coordination of care and include providers who are experienced with the needs of PWH. 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, which allows designated entities to maintain 100% of cost savings for the first five years for reinvestment into innovative services, HIV providers in NYC formed an Accountable Care Organization (ACO) for PWH. The ACO’s goals align with EHE goals, and will coordinate care in order to promote HIV prevention, improve PWH health outcomes, and decrease costs associated with poor health outcomes related to HIV and comorbidities. The Amida Care Innovator Network (ACIN), was incorporated in 2018, and the ACO Certificate of Authority (COA) was approved in February 2019. Following receipt of the COA, ACIN submitted its Innovator application to the State in June 2019. The Innovator program has been put on hold due to NYS budgetary reasons, but ACIN continues to communicate with NYS partners regarding the importance of the program.

In the lead-up to the effective dates for the ACA and Medicaid Redesign efforts, the NYC HD assessed provisions that 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 PWH have continued access to quality care, and to assess impacts of changes in Medicaid, Medicare, and the NY State of Health. 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, contractual language, and data reporting requirements clarify

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<th>County</th>
<th>Affinity Health Plan</th>
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Table 5. 2020 NY State of Health Essential Plan Availability by County

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 Special Needs Plans (SNPs) offer additional coordination of care and include providers who are experienced with the needs of PWH. 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, which allows designated entities to maintain 100% of cost savings for the first five years for reinvestment into innovative services, HIV providers in NYC formed an Accountable Care Organization (ACO) for PWH. The ACO’s goals align with EHE goals, and will coordinate care in order to promote HIV prevention, improve PWH health outcomes, and decrease costs associated with poor health outcomes related to HIV and co-morbidities. The Amida Care Innovator Network (ACIN), was incorporated in 2018, and the ACO Certificate of Authority (COA) was approved in February 2019. Following receipt of the COA, ACIN submitted its Innovator application to the State in June 2019. The Innovator program has been put on hold due to NYS budgetary reasons, but ACIN continues to communicate with NYS partners regarding the importance of the program.

In the lead-up to the effective dates for the ACA and Medicaid Redesign efforts, the NYC HD assessed provisions that 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 PWH have continued access to quality care, and to assess impacts of changes in Medicaid, Medicare, and the NY State of Health. 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, contractual language, and data reporting requirements clarify
RWHAP Part A client assessment and reassessment expectations. This ensures that clients have 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 mainstream 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 NYS, BHIV conducted an in-depth review and cross-walk of all RWHAP Part A services that were potentially reimbursable by Medicaid through FFS and mainstream 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.

The NYSDOH has notified stakeholders that they intend to submit an 1115 Medicaid Redesign Team Waiver amendment that would allow for pharmacy benefits to be carved out of Medicaid Managed Care starting in April 2021. The carve out is intended to generate Medicaid savings by centralizing pharmacy benefit management under FFS to increase transparency, maximize rebate revenues, and increase negotiating power. 340B entities in NYS such as FQHCs, hospitals, Ryan White providers, Medicaid Managed Care Plans (including HIV SNPs) have expressed concern that the carve out, if implemented, would result in reduced revenues. The revenues from 340B discounts are used to support outreach, engagement, and adherence services for PWH in NYS.

**a) Effect on access to health care 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. The NY EMA has seen steady increases in ART usage (from 78% of all diagnosed in 2014 to 90% in 2018), and as a result, increased VS (from 67% in 2014 to 75% in 2018). While it is difficult to attribute improved health care outcomes to a single policy or funding change, enrollment in QHP coverage has been significantly associated with achieving VS in at least two studies. 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; conversely, adults with chronic medical conditions are more adherent when they have prescription drug coverage.
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 PWH. 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, EFA, and the newly created Psychosocial Support Services (PSS) for Transgender, Intersex, Gender Non-Conforming or Non-Binary (TIGNCNB) people to increase services that support engagement in medical and MH services that may be funded through other payers. Increasing resources for these services also helped address inequities in access to medical care due to burdens of poverty, homelessness, food insecurity, race/ethnicity, and sexual/gender identity. 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. 13-14, the Recipient, PC, and the NYS HUCP have worked together to ensure continued access to medications for PWH through ADAP while ensuring continued resources are available for the core medical and support services at clinics, hospitals, and CBOs. From GY19-20, RWHAP Part A funding for ADAP was reduced by 34%, which allowed the NY EMA to absorb a portion of reduction to the NY EMA RWHAP Part A GY20 award while simultaneously enhancing the capacity of Housing services, FNS, and EFA in the NY EMA, in light of emergent needs of PWH resulting from COVID-19. Additionally, $50,000 in ADAP funding has been allocated to the newly created service category, PSS for TIGNCNB individuals, specifically for the development of a comprehensive TIGNCNB public resource directory and provider training curriculum.

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 contributes 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 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 engage and retain clients in care who receive medical services and medications covered by other payers. 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 VS, 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 GY20 used a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate resources for GY21. 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 HD staff throughout the planning process and has a dedicated staff liaison from the BHIV Surveillance Unit who is specifically assigned to the PC to provide up-to-date epidemiological data for planning purposes. This year, the PC accomplished the following:

- Received and provided input into EHE efforts including plans for development of the NYC EHE plan for Bronx, Kings, Manhattan, and Queens counties with the expectation of voting on concurrence in January 2021;
- Received an update on the HRSA 20-078 Project PROSPER to ensure coordination of this new NYC EHE effort with the RWHAP Part A system of care;
- Utilized a data-driven planning tool to develop service priorities and determine funding allocations based on up-to-date information on PWH needs, service utilization, and gaps, including the NY EMA’s Needs Assessment, the NYS Integrated Plan, a POLR Analysis, Service Category Fact Sheets with multiple years’ historical utilization data, and data analyses from the NY EMA’s CHAIN study;
- Allocated 54.3% of RWHAP Part A and MAI funding to CMS for GY21;
- Continued funding for MCM/CCP Programs to optimize medical outcomes;
- Allocated 4.9% of the GY21 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;
- Allocated funds to create oral health services in the NYC portion of the EMA; and
- Approved increases in targeted service categories in order to address ongoing needs of PWH, fill service gaps for special populations, and address new needs arising from the COVID-19 pandemic.

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 HD surveillance analysts, CHAIN researchers, and the CTP Research and Evaluation Unit (REU) staff. Findings included: the latest estimate of PWH unaware of their status, estimated numbers of PWH not in care, accessibility and quality of services, service barriers, geographic patterns in HIV burden and distribution of resources, 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 to identify populations that fall out of the continuum at each stage.

In GY20, the NAC identified PWH with SMI as a special population with inequitable health outcomes and greater likelihood of falling out of care. SMI is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment in one or more major life activities. A person with SMI may have major depression, schizophrenia or bipolar disorder, among others. NAC has been conducting an exhaustive review of data from multiple sources on the prevalence of SMI among PWH and RWHAP Part A clients, and the proportion of RWHAP Part A clients with an SMI diagnosis who were engaged or retained in care and virally suppressed. NAC reviewed a
data match between the NYC HD MH and HIV registries which found 1,326 individuals with SMI and diagnosed with HIV in NYC. Additionally, REU staff conducted a match between RWHAP clients screened for MH and the NYC Surveillance Registry found that those with reported MH diagnoses had lower rates of VS than those without a MH diagnosis. Those with more serious diagnoses (i.e., bi-polar disorder and/or reported psychosis) had the lowest VS of all. NAC reviewed the current RWHAP MH Services directive and standards of care to retool the category so that clients with SMI can be better linked to and retained in care and have their SMI and HIV diagnoses optimally treated. NAC is expected to complete a set of recommendations in fall 2020 that the PC can use as a road map for improving health outcomes for this population.

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 by the NAC in GY19, the IOC developed a new service directive for Oral Health Services to be provided in the NYC portion of the EMA (the Tri-County Region already has a small Oral Health program). The RWHAP Part A Oral Health program will fill a large identified unmet need through complementary Medicaid, Medicare, ADAP, and Part F services to ensure a robust system of care.

The service directive has many innovative features, including a screening tool to identify oral health discomfort and screening for human papillomavirus and oral cancers. The core of the service model includes: 1) provision of comprehensive preventative dental care, ensuring coverage of four dental cleanings per year including an annual deep scaling; 2) development of recommendations for common co-morbidities with oral health implications (e.g., diabetes, HCV); and 3) required trainings to build provider capacity to deliver services in a manner that is anti-racist and dismantles stigma. A portion of the allocated funding may be used to cover complex, high-cost services on a case by case basis, such as gum and bone grafts and implants. The directive also ensures that dental materials utilized are long lasting and of high quality; and supports replacement of dentures and other apparatus as needed.

The other principle component of the directive is a centralized Dental Case Management service to support: 1) full integration of oral health care into the service system; 2) increased capacity across the service system to improve access and utilization; 3) facilitation of consumer engagement and education; 4) provision of resources to support the more complex dental needs frequently associated with HIV; 5) development of a resource map to support completion of oral health treatment plans; 6) support of coordination of care with client’s care team; and 7) ensures emergency care is funded and available. This service will be incorporated into MCM.

PSRA Committee. Using data assembled by the NAC, and 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) 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 PWH 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 PWH. In planning for GY21, the PSRA Committee examined a POLR and Coordination of Services Analysis compiled the previous year by consultants on behalf of the PSRA Committee. The analysis helped PSRA Committee members understand how RWHAP Part A serves as POLR by providing core medical and supportive services for PWH 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 PWH. 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 GY21 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 VS.

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 unmet need for key services in the study’s representative cohort. The highest value was assigned to services promoting health care access and re-engagement of underserved populations, including those who are not engaged 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, consumer members of the Council and PSRA Committee, and the CHAIN cohort study. The highest value was assigned to services identified by PWH as significantly contributing to access to or maintenance in primary medical care and representing a key consumer priority.

The Service Category Fact Sheets also provided eSHARE data over a three-year period on enrollment, performance, service utilization by service type, spending rates, and client demographics (including by priority population), 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 Region 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 counties. The Tri-County Region’s 30-member Steering Committee includes 11 PWH. All committee members received an orientation on the RWHAP legislation and the community planning process. The committee uses the same PSRA tool described above to rank regional service priorities. The Steering Committee reports to the PSRA, Executive Committee (EC), and 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 to increase capacity.

i. Involvement of PWH. The active, informed engagement of PWH is essential to the planning process and helps ensure that PC decisions address needs of consumers. The PC’s Consumers Committee provides a forum for PWH (PC and committee members, as well as other stakeholder
community members) to be actively engaged in the planning process. PC members and staff living with HIV assist community members in understanding the priority setting and resource allocation process; HIV epidemiology; HIV care continuum; principles of community planning, group dynamics, and decision-making; QI/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 distribution of consumer outreach brochures, available in English and Spanish, at all PC meetings and 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 response to the challenges that COVID-19 presented to consumer involvement, the PC purchased tablets to loan to consumers who do not have appropriate computer equipment to participate in virtual meetings and read documents electronically. PWH participation continued during the planning year at the same high pre-pandemic levels, despite the challenges created by conducting all meetings virtually. In fact, the Consumers Committee held monthly listening sessions during the NYS on PAUSE order which allowed consumers to ask questions, raise issues in regard to gaps and services, and receive updates from the Recipient and NYC HD about COVID-19 guidelines and policy/service changes.

In GY20, PWH constituted 41% of the PC’s 49 members. At the beginning of the planning cycle, after a concerted outreach and recruitment effort by PC staff, one-third of members were PWH who are not aligned with a RWHAP Part A agency. The overwhelming majority (71%) of the PC’s non-aligned PWH are people of color. PWH actively serve on all PC committees and make up 37% of the Tri-County Region Steering Committee. The acting governmental co-chair is HIV-positive, and the community co-chair and finance officer are both non-aligned PWH. PWH 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 GY21 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 Region Steering, and Rules & Membership Committees, as well as the Consumer Advisory Committee of the NYSDOH HIV Quality of Care Committee, NYS ETE borough and regional-based task forces, and 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 2019 Power of Quality Improvement Conference, where RWHAP Part A providers heard client perspectives on the need for oral health services, and link between oral health, quality of life, and retention in HIV care.

**ii. Addressing funding increases or decreases.** The PC’s data-driven planning tool allows for an objective 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 GY20, there was a decrease of $1.3 million in the NY EMA’s total grant award (not including additional one-time funds received under the CARES Act). The NY EMA was able to absorb the cut through a reduction in the ADAP allocation. As described on p. 13-14, 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 decreased 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 GY21, 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, particularly those arising from the impact of the COVID-19 pandemic such as housing, financial, and food support. Additional resources are also needed to fund the new Oral Health services, as well as to fully fund expanded PSS for TIGNCNB PWH. 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 GY21.

**iii. MAI funding.** Planning for MAI funding, including prioritization and allocation of services, is integrated into service planning for RWHAP Part A funds and are aligned with the NYS Integrated Plan goal to reduce health inequities. 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, highest need communities, specifically communities comprised of Black and Latino/Hispanic PWH. Data showed continued gaps in these services for these populations, justifying the need for continued targeted programs. In particular, the PC sought to ensure MAI funds were distributed to impact these populations at multiple stages of 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 GY21, consistent with the goals in the NYS Integrated Plan. The PC utilized multiple data sources, including surveillance reports, the NY EMA RWHAP Part A Service Category Fact Sheets, 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 inequities 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 $22.6 million for MCM in GY21. Thirty-nine percent of CHAIN cohort members met the criteria of needing MCM services, defined so if they reported interrupted HIV medical care, missed HIV medical care appointments, or had no CD4 or VL tests in the last six months. Of those who needed MCM, only a minority reported adequate utilization of the service, defined as receiving referrals to medical services through a case manager during the past six months.

The overwhelming majority of the MCM commitment 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, self-management assessment, navigation, accompaniment, health promotion, and modified DOT. 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 HD-reported MCM outcomes data from the Costs, HIV Outcomes, and Real-world Determinants of Success (CHORDS) Study. Significant increases in EiC and VS 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/VS outcomes. In comparisons of CCP clients’ 12-month VS to the VS achieved among similar PWH, CCP-enrollees demonstrated higher rates of VS overall, with significant benefits over usual care for individuals who were newly diagnosed or who had no evidence of VS in the year prior to enrollment. Evidence of CCP effectiveness over usual care suggests health benefits for enrolled PWH and the public health value of intervention scale-up, focused on PWH with the greatest need.
Continued funding in GY21 at $22.6 million was allocated to MCM on the basis of CHORDS data indicating statistically significant VS benefits, above those of usual care, for high-need PWH.\textsuperscript{lxiv} For GY21, the PC also allocated $4.1 million to continue n-MCM services for currently or recently incarcerated PWH in order to ensure linkage to care upon release for this marginalized population. Through this program, recently incarcerated PWH are connected to medical and support services that address barriers to optimal HIV primary care and assist in enrollment of PWH eligible for the NY State of Health insurance exchange and expanded Medicaid.

After careful review of data from the Service Category Fact Sheets and POLR analysis, the PC chose to end funding in GY21 of NMG. All service types in this category (i.e., outreach, accompaniment, service coordination, client assistance) are provided across numerous RWHAP Part A categories (Health Education/Risk Reduction (HE/RR), MH, MCM, PSS, EIS). NYC HIV/AIDS Services Administration (HASA), Medicaid HHs, SNPs, RWHAP Parts B, C, and D, and RWHAP Part A CCP and Supportive Counseling all provide similar case management services. Almost half of active NMG clients were actively enrolled in at least one other RWHAP Part A-funded service. NMG has historically under-performed (nearly 20% in 2018), and given this category’s duplication of RWHAP Part A and other case management services, the PC determined that there is existing capacity to serve these clients through other programs. Furthermore, this funding can be reallocated to higher priority service categories and to fund new needs (e.g., Oral Health, COVID-19 response through increased allocation to FNS, EFA, and Housing).

Through Service Category Fact Sheets, the PC reviewed data highlighting the needs of historically underserved populations, including racial and ethnic minorities. Needs of PWH 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 Fact Sheets, the PC reviews service utilization data specifically by gender and age as well as by several special populations, including WoC, YMSM of color, OPWH, those who use substances, and TIGNCNB people. The data have shown that women make up a larger percentage of RWHAP Part A clients in the NY EMA (30.6%) than their proportion of the local epidemic (28.5%). 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 women, 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 FY19, Medicaid expended more than $686,435,595 to fund CMS for WICY populations far exceeding the NY EMA’s required set-aside $28,730,976. 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 LGBTQ teens, pregnant and perinatal women, WoC, perinatally infected youth, and YMSM.

The PC reviewed evidence on inequities in timely EiC for newly diagnosed people. The PC allocated $4.1 million to EIS in GY21 (including $1.6 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 newly and previously diagnosed PWH 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 health care access, which influenced the PC’s decision to continue to prioritize support for ADAP.

Data on unmet need and utilization of MH services among PWH in NYC, along with barriers that PWH 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 PWH with MH issues, including those with co-occurring SUDs, to improve quality of life and MH functioning; facilitate ongoing involvement in bio-psychosocial care and treatment, including adherence to ART and/or psychotropic medications; and reduce use of emergency care. The PC directed a total of $4.2 million to MH services for GY21.

In GY20, the EMA allocated $449,825 in RWHAP Part A funds to respond to the economic dislocation caused by COVID-19 by providing emergency funds to pay for necessities such as rent and utilities, as well as personal protective equipment for people who lost income due to the pandemic. In GY21, the PC continues the enhancement to the EFA category to respond to the ongoing COVID-19 crisis with a total allocation of $685,618.

COVID-19 has brought pressing challenges to PWH in the EMA. Food insecurity is at an all-time high and food banks throughout the EMA have reported shortages and an inability to meet the demand for assistance. For GY21, the PC has allocated an additional $1 million for FNS for a total of $9.7 million. The PC is also requesting an increase of $1.5 million in housing assistance for a total of $14.2 million in order to respond to the increased need for rental assistance due to COVID-19. As has been amply demonstrated, food and housing insecurity are major barriers to access to and retention in medical care and achieving VS.

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 the GY21 allocation for expanded Oral Health services in NYC, the PC examined unit costs of the current Tri-County Region program and determined that an additional $500,000 would allow for two pilot programs serving 280 clients, accounting for the increased expense of the higher quality services, procedures, and materials.

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 the GY21 plan, 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 PWH, gaps in services, and inequities in access to HIV care, and the ongoing effects of the changing health care landscape. The NYS Integrated Plan was a cornerstone for developing the goals and objectives of RWHAP Part A services. For example, the goals and objectives of the new Oral Health service directive were mapped to the goals and objectives of the NYS Integrated Plan, including: promoting access and maintenance in HIV-specific medical care; increasing proportion of clients with an undetectable VL and improved immunological health; reducing HIV-related morbidity and mortality; and reducing socio-demographic inequities 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 GY19 to the EC and full PC in July 2020.

b) **Deficiencies.** The EC determined that there were no deficiencies in the administrative mechanism, and no corrective action was needed for GY19.

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 PWH most in need of services.

i) **HIV resources inventory (see Attachment 5).**

ii) **Needed resources, and steps taken to secure them.** As mentioned in the introduction, new resources from both HRSA and CDC are welcome additions to support NYC’s EHE efforts. The BHIV has received awards for developing the NYC EHE plan (CDC PS-19-1906) based on a community engagement process—this effort has transitioned to virtual listening sessions to inform a plan that will be reviewed and voted upon by both the PC and the HPG in January 2021. The BHIV also received additional resources from the CDC to address the four pillars of the EHE plan (CDC PS-20-2010) and funding from HRSA to support EHE efforts in the Treatment and Response pillars (HRSA 20-078; Project PROSPER) while also serving as a Capacity Building Assistance Provider (HRSA-19-1904) to Northeastern EHE jurisdictions. The activities being planned and implemented under Project PROSPER and CDC EHE program will build upon the City’s successes and align with the final NYC EHE plan (see pgs. 1-2); and aim to strategically advance HIV prevention efforts in the four EHE counties to accelerate NYC’s progress in reaching the national goal of a 75% reduction in new HIV infections by 2025. The CTP is supporting Project PROSPER through review of RFPs for replicating evidence-informed models of care and strengthening data collection and utilization in clinical care settings to improve HIV care outcomes. Additional NYC resources fund programs to fulfill the goals of the NYS ETE Blueprint, allowing for contracts to increase the availability of PrEP/PEP, support VS, 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. In GY20, the NYS HUCP adapted their enrollment process to allow for same-day provision of services and ART for the majority of clients to support iART upon diagnosis. This change has allowed RWHAP Part A EIS and MCM-funded providers and CDC-funded Status Neutral navigation clinical contractors to implement iART by leveraging the NYS HUCP resources. The NYS HUCP provides immediate access to ART and related medical and laboratory services through its ADAP and ADAP Plus programs 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 PWH in the EMA given that 88.5% 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 PWH in employment services, the NYC HD has utilized other resources to address this need. To support PWH needs to engage in employment, the NYC HD leveraged three-years of grant funding from the CDC (15-1506, Project THRIVE) which began in 2017 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, created an internal working group consisting of staff across units, known internally as “Considering Work Efforts Work Group,” which is now funded with City resources. 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 overall health outcomes of PWH throughout the NY EMA. A key deliverable of this initiative was the successful execution of “Career Power Source,” an annual community event that took place in October in 2018 and 2019, with current plans to hold a virtual event in 2020. 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 priority 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 PWH who use methamphetamines and people not living with HIV who use methamphetamines. In 2020 a crisis line and “come down” room were added to services offered to people who use methamphetamine. Another ETE funded program utilizes elements of CCP to provide status neutral navigation and assessment to PEP, PrEP, MH, housing, and SUD services to those at risk for HIV.

WORKPLAN
A) HIV Care Continuum Table and Narrative.
B) HIV Care Continuum Table (see Attachment 7).
C) HIV Care Continuum Narrative.

a) Utilizing the HIV care continuum in resource planning. The NY EMA takes a strategic systems-level approach to planning for services for those with unmet need. The PC and the CTP Operations 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 PWH, using 2018 data (see Figure 2). Information on all PWH 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 PWH. This approach yields an accurate estimate of the number of PWH who are still living and residing in the NY EMA and allows for better estimation of progress along the HIV care continuum. The NYC HD’s MMP in NYC provides an estimate of ART prescription status for all PWH.

b) Changes in the HIV care continuum. From 2014-2019, the proportion of clients engaged along the different stages of the NY EMA HIV care continuum has remained relatively stable, with
a slight decrease in linkage to care and a slight increase in retention in care, ART prescription, and VS. The NY EMA is invested in evaluating the strategies and interventions necessary to address unmet need and move PWH along the HIV care continuum to VS. As such, the NY EMA was an engaged participant in the HRSA-funded Care Continuum Learning Collaborative, where the NY EMA Recipient staff shared their HIV care continuum-related project plans with peers (Baltimore, Detroit, Tampa/St. Petersburg, Houston/Harris County, and Phoenix/Maricopa County) in their assigned work groups. The NY EMA focused on developing a surveillance-based client-level VS progress report, which was disseminated to CCP providers in July and August 2018 (and semi-annually thereafter), as part of a new D2C initiative. These reports continue to be shared with providers. Also, the NY EMA created a protocol to implement a VBP model across CCP, with the aim of incentivizing QI among subrecipients. The model will be implemented post COVID-19 to ensure the model is based on accurate data.

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 example has been the work of the CHORDS study to evaluate the CCP model of MCM. This multi-year, multi-phase project evaluated care engagement and VS outcomes among CCP clients overall and according to baseline VL, housing, MH, and SUD status. Initial work of the CHORDS study resulted in CCP being listed as an evidence-informed intervention in the CDC Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention under the Linkage to, Retention in, and Re-engagement in HIV Care chapter. In addition, this study has highlighted the impact of resolution of psychosocial needs on HIV outcomes. CCP clients reporting cessation of hard drug use post-enrollment showed significantly greater improvement in EiC from the period prior to enrollment than those continuing hard drug use, and clients obtaining stable housing post-baseline showed significantly greater improvement in VS than those remaining in unstable housing. 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. This endeavor will evaluate 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 VS. As noted above, previous work by the NYC HD among MSM living with HIV enrolled in RWHAP Part A programs in the NY EMA found crystal meth use to be associated with unsuppressed VL. In a separate analysis, controlling for sociodemographic and clinical characteristics, recent tobacco smoking was also found to be associated with unsuppressed VL. 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 VL. 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, 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 VL, and to have had an emergency room visit or an inpatient stay compared to those who remained food insecure. To address the needs of food insecure PWH the new FNS directive, which is more client-centered and emphasizes the role of healthy
eating and food access on HIV health, was approved by the PC resulting in a procurement process and new contracts in GY20, along with an increased service allocation to support PWH who are food insecure to move through the HIV care continuum. The new contracts are aimed at addressing issues relating to food insecurity, increasing access to care and treatment, and addressing racial and health inequities for PWH 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 inequities, increase service access, and improve health outcomes for underserved PWH, including Black, Latino/Hispanic, and Asian/Pacific Islander people. In GY20, 94% of PWH served by the MAI program were people of color: 54% were Black, 37% Latino/Hispanic, and 2% Asian/Pacific Islander. The NY EMA strives to use its resources to address HIV health inequalities associated with race/ethnicity, particularly among Black and Latino/Hispanic populations who account for 87% of all PWH served by RWHAP Part A, while they constitute only 76% of all PWH in the NY EMA.

Among RWHAP Part A clients served in NYC in 2019, the racial/ethnic inequity in VS rates persisted; 78% of Black RWHAP Part A clients were virally suppressed in 2019, compared to 82% of Latino/Hispanic clients, 87% of White clients, and 91% of Asian/Pacific Islander clients. Across gender categories, VS rates were lowest among transgender clients (74%), 89% of whom were Black or Latino/Hispanic and 80% of whom were transgender women.

**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.

**MAI activity descriptions.** The GY21 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 (including HIV testing and linkage services) 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 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 populations; and
- Demonstrate that at least 75% of its current active clients who receive HIV/AIDS services are from the MAI populations.
ADAP exclusively serves Black, Latino/Hispanic, and Asian/Pacific Islander clients from the NY EMA who are eligible for ADAP with MAI funds.

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

RESOLUTION OF CHALLENGES
The NY EMA continues to strive to deliver the best possible services aimed at increasing the health of PWH in its concerted effort to end the epidemic while adhering to the RWHAP legislation and accompanying policies. In GY20, 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

<table>
<thead>
<tr>
<th>Challenges/Barriers</th>
<th>Proposed Resolutions</th>
<th>Intended Outcomes</th>
<th>Current Status for RWHAP Part A/Care Continuum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing Culturally Responsive Care</td>
<td>In GY19, the Recipient disseminated a CLAS Standards self-assessment to service providers throughout the NY EMA RWHAP Part A portfolio, results of the assessment are to be incorporated into subrecipient QM plans. The Recipient also collaborates with others in BHIV to engage community partners in addressing stigma, including CHAIN researchers who issued a special report about experiences of stigma among survey participants in GY20. Most importantly, under the newly created PSS for TIGNCNB people, all providers will participate in a comprehensive cultural responsiveness/ awareness training program, with a multi-day curriculum and all-encompassing TIGNCNB resource directory. Both materials will be developed and created by community members identifying as TIGNCNB in GY20 and GY21.</td>
<td>Improve cultural responsiveness across the RWHAP Part A service portfolio, focused on addressing the complex needs of TIGNCNB populations within the NY EMA.</td>
<td>VS among Black Transgender women is 11% lower than the larger population of PWH (64% vs 75%, respectively). This data underscores the need to better meet the needs of Black TIGNCNB PWH by increasing cultural responsiveness at the provider level, engagement at the participant level, and service quality in core medical and support service environments that lead to VS.</td>
</tr>
<tr>
<td>Addressing Needs of OPWH (Age 50+)</td>
<td>The recipient conducted seven focus groups in collaboration with the community-based Long-Term Survivors Wellness Coalition to assess the unmet needs of OPWH for use in developing future service models aimed at tackling the diverse needs of this priority population. In GY20, the recipient shared results which indicate the needs of OPWH are far more complex than maintaining their HIV care and treatment, and extended to MH and systems navigation for</td>
<td>Address HIV related health inequities and reduce the effect of co-morbidities on OPWH in order to improve health outcomes and reduce preventable mortality.</td>
<td>Work to improve the quality of care to improve retention and VS, and reduce preventable mortality for OPWH.</td>
</tr>
</tbody>
</table>

New York EMA H89HA00015
### Challenges/Barriers

at least one service during March 2017-February 2018, 58% were OPWH. Moreover, inequities persist among older people of color with VS rates being the lowest among Black and Latino/Hispanic OPWH when compared to their White counterparts. Moreover, death rates among Black and Latino/Hispanic OPWH were significantly higher than death rates among White OPWH.

### Proposed Resolutions

conditions outside of their HIV diagnosis. In GY21, the Recipient will work with the PC to ensure programming is responsive to the needs of those aging with HIV in the NY EMA. In addition, the Recipient will coordinate with Project PROSPER to learn from successes and challenges of the implementation of a clinical model of care for Black and Latino/Hispanic OPWH.

### Intended Outcomes

Increase the quality and responsiveness of services offered to priority populations disproportionately affected by HIV in the NY EMA RWHAP Part A portfolio; decrease inequities identified in priority populations across the HIV care continuum; and improve general health outcomes across priority populations in the NY EMA.

### Current Status for RWHAP Part A/Care Continuum

The vast majority of RWHAP Part A clients are Black and Hispanic/Latino in the NY EMA. Given the VS inequity between these populations and White PWH the Recipient will work to improve the quality of care and services offered, with the goal of reducing new diagnoses, unsuppressed VL, and preventable mortality among Black and Latino/Hispanic PWH in the NY EMA.

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9 However, the YWMSM VS proportions are more labile given that their numbers are also small (<100 in the denominator in each year, as compared with >400 YBMSM and >300 YLMSM in each year).
### Challenges/Barriers

**Addressing the Needs of PWH with Disabilities**

Under federal, state, and local law, health providers are required to provide reasonable accommodations to individuals with a 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. In 2017, 45% of RWHAP Part A program participants reported having at least one disability at their most recent visit.

### Proposed Resolutions

Based on a RWHAP provider survey, a review of data in regard to the needs of PWH with disabilities and recommendations from the PC’s NAC, the Recipient developed a provider resource guide to aid in better addressing the needs of individuals with various types of disabilities in the NY EMA. Additional efforts include increasing the availability of trainings and TA addressing reasonable accommodations among contracted providers and improved data collection in eSHARE through an update to the disability questionnaire to include more sensitive and inclusive language around disabilities. The resource guide is in final development stages and will be updated as per guidance from the NYC Mayor’s Office of Disabilities.

### Intended Outcomes

Ensure the provision of reasonable accommodations to PWH with disabilities in order to increase access to and retention in care. Ensure services are delivered in a culturally responsive manner, and are tailored to address provider needs for working with this population.

### Current Status for RWHAP Part A/ Care Continuum

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

**Addressing the COVID-19 pandemic in the RWHAP Part A Portfolio**

A recent CHAIN survey set out to uncover how participants have been impacted by the COVID-19 pandemic. The results indicated that up to 48% of participants are at a higher risk for serious illness from COVID-19, and 97% had significant increased risk for COVID-19 due to structural inequity indicators, including recent homelessness/housing instability, poverty, and history of incarceration. Furthermore, the findings indicate that up to 49% of participants are experiencing financial hardships and/or are struggling to make ends meet. In addition, a larger proportion of participants (30%) indicated they had been laid off, or had work hours greatly reduced without pay, posing additional barriers for optimal care and treatment.

### Proposed Resolutions

Enhancements have been made in GY20-21 to provide additional funding to EFA, FNS, and Housing services to address emergent financial needs (which have increased in light of COVID-19), food insecurity, and homelessness/housing instability for PWH in the NY EMA. Additionally, in GY20, the recipient provided flexible service provision standards for RWHAP Part A providers to ensure both provider and client safety while guaranteeing continuity of services during the COVID-19 pandemic. In addition, the recipient authorized a number of changes to contracts, including the provision of remote services, to ensure service continuity for RWHAP Part A clients in the NY EMA, and to prioritize the health and safety of program staff, clients, and communities served.

### Intended Outcomes

Ensure RWHAP Part A providers are able to adapt to the current health care landscape, which has shifted both greatly and swiftly in light of COVID-19, and to enable continuity of care and provision of essential support services to PWH in the NY EMA. Additionally, the enhancement made to EFA, FNS, and Housing services will ensure RWHAP Part A participants are not displaced, and are able to continue to adhere to their treatment regiments without the added stresses associated with homelessness, housing instability, or food insecurity.

### Current Status for RWHAP Part A/ Care Continuum

Continue to provide essential support services to those most impacted by both HIV and COVID-19 to ensure continued progress along the HIV care continuum for RWHAP Part A participants in the NY EMA.
EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM). The CQM program is a collaborative effort overseen by the RWHAP Part A Project Director and involves BHIV CTP QM/TA and REU, COTA, and Prevention; Housing programs; NYSDOH AI; PHS; PC; consumers; and RWHAP 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 PWH. 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 Director of QM/TA, 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, through the CQM program, the grantee develops and implements trainings for RWHAP Part A providers to improve service quality and support QM activities. In August 2019, QM/TA started releasing quarterly memos to advise service providers of updates or clarifications about service definitions and standards, service reporting, documentation, deliverables, and training expectations. The quarterly memos are part of the grantee’s plan to improve the quality of TA services by organizing and coordinating the distribution of information.

As part of the CQM program, the NY EMA QM Committee updates and implements 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 Region, Housing, HIV Prevention, COTA, and other areas as needed. The plan outlines the CQM program’s activities in five domains: consumer engagement, collaboration and coordination, capacity building, service engagement, and service quality. In 2020, the Committee added a new health equity domain, with the objective of improving systems to reduce inequities in health outcomes driven by structural racism. Adding a domain in this area is also consistent with NYC HD’s emphasis on addressing racism as a driver of health inequity and poorer health outcomes.

Some 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 regularly 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, Prevention, and COTA and the NYSDOH AI collaborate on shared jurisdictional initiatives including: New York Knows, which works to increase HIV testing and linkage; the NYLinks program to increase retention and VS through cross-RWHAP-Part collaboration; and the ETE borough-based and Lower Hudson Valley steering committees which support implementation of the NYS ETE Blueprint and are providing input into the NYC EHE plan.
NYC HD REU staff are responsible for analyzing eSHARE data, as well as consumer survey and supplemental evaluation data, to produce and present portfolio-wide and service category- and agency-level quality performance indicators. 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 inequities in HIV-related health outcomes that may be addressed through program planning and 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 2019, the sixth annual Power of QI conference was held with the theme, *Using Unexpected Results to Improve Performance*, which emphasized that trial and error are essential to the process of improving systems. The Consumers Committee of the PC welcomed conference attendees during the opening plenary and conducted a workshop focusing upon meeting needs for oral health services. HRSA’s RWHAP Center for Quality Improvement and Innovation also conducted a workshop about quality improvement through the Project Extension for Community Health Outcomes collaborative. The conference provided a forum for participants to share QM projects through workshops and presentations. Over 250 service providers, consumers, and other stakeholders across the NY EMA attended the Power of QI conference. Bridging Access to Care received the award for best overall project for “A Look at One HPA Program’s Retention Rates and Why Housing Was Lost” examining and addressing root causes driving housing loss in their program.

1) **Use of performance measure data to evaluate inequities in care.** Consistent with national goals, BHIV is expanding its efforts to support VS 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 VS. For example, as part of an effort to promote early ART initiation, consistent ART access, and sustained VS, 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 ART. 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 VL test of the calendar year, for multiple years (thus tracking trends over time). Organizations were also able to see how their annual VS proportion compared to that for all RWHAP Part A clients in NYC. The AVSR uses VL 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 (OPWH, Black or Latino cisgender MSM, cisgender YMSM, transgender women, and Black and Latina cisgender women) selected in accordance with the NYC HD’s Race to Justice initiatives for advancing racial equity and social justice. The updated, expanded AVSR also provides breakdowns of VS proportions among clients “newly enrolled” and clients “established in services,” along with guidance for report interpretation (i.e., lower VS among newly enrolled clients may reflect successful outreach to more vulnerable PWH).

In July 2018, CTP began providing Client Progress Reports (CPRs), client-level reports on VS 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 VS, 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 people 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 inequities 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, disability status). Over 90% of those served in the RWHAP Part A program identify as Black or Latino/Hispanic, and the vast majority (80%) are also living below 100% of the 2020 FPL. As a result, local RWHAP Part A outcomes do not necessarily reflect conventional/general-population racial, ethnic, or income inequities. 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 strengthening inter-agency coordination and referral systems and 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 clients served have the appropriate resources and individualized support to achieve and maintain VS. To further address inequities, the NYC HD ensures 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 into their QM plans.

The COVID-19 crisis may temporarily interfere with CTP’s ability to use performance data to manage service quality. During NYS’s PAUSE order, funded organizations worked to re-organize their service delivery systems. In some cases, this made it challenging for them to consistently report their program activities, including data that CTP uses to evaluate service delivery and prepare reports. According to NYC surveillance data, regular VL monitoring has been disrupted, as health care providers responded to the crisis and shifted to remote modes of service delivery, and as patients followed stay-at-home orders, resulting in declines in blood draws for laboratory testing and in reports to the Surveillance Registry as of April 2020.

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.

Most recently, CQM findings informed changes in how CCP services are reimbursed under the 2017-18 re-solicitation, transitioning from the administratively burdensome per-member-per-day reimbursement to FFS. In an effort to ensure service quality, QM/TA staff in CTP worked with CCP providers on an ambitious project to design a system for VBP, an innovative approach for the NY EMA using the Exploration, Preparation, Implementation, and Sustainment framework, a conceptual model of evidence-based practice implementation. In 2019, QM/TA staff invited representatives from CCP programs and other key stakeholders to participate in the design of a
system for VBP for program services. Over the course of four meetings, stakeholders collaborated to consider measures for VBP and payment benchmarks. Using exercises inspired by nominal group technique, stakeholders expressed preferences for types of measures and benchmarks. The grantee will test the new VBP system for CCP comparing the new program data and the program data from the previous GY before implementing in 2021.

**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. Of the NY EMA’s GY20 RWHAP Part A contracts, 48% are reimbursed FFS and 38% are reimbursed through a hybrid FFS and/or for achievement of specific deliverables. Managing the portfolio in this way contributes to efficient 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.** GY21 will be the NY EMA’s 31st 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 GY19, the NY EMA spent nearly 100% of its RWHAP Part A formula award (with $18,525 requested carryover) and more than 99% of its MAI award (with $79,479 in requested carryover).

**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 HD 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 HD BHIV. The BHIV is headed by an Assistant Commissioner, who oversees a staff of over 280 people across eight programs, which includes 49.07 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 Program Planning and Operations (1.0 FTE), collaborates with the Senior Grant Manager (1.0 FTE) and program and administrative fiscal staff (2.45 FTE) to ensure adherence to all applicable HRSA grant reporting and monitoring requirements. The Director of Program Planning and Operations (1.0 FTE) oversees and coordinates the activities of three Program Planners (2.7 FTE) and serves as an alternate to the Director of CTP for PC business and communications with HRSA. The Director of QM/TA (0.94 FTE) oversees a total of 8.0 FTE staff including: one Deputy Director, one QM Project Manager, three QMSs, one Behavioral Health Specialist, one Senior QMS, and one QM Liaison. The Director of HIV Health Equity (1.0 FTE) oversees the implementation of health equity practices within planning, quality management, and TA in CTP. The Director of HIV Prevention (in-kind) oversees the TA provided to the EIS providers, in coordination with the HIV Prevention program. The Director of Housing (0.3 FTE) oversees three Housing Coordinators (2.3 FTE) who manage 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 and in compliance with RWHAP Part A requirements. The Director of REU for the Housing Services Unit (0.5 FTE) coordinates with the Director of Housing for housing services monitoring and evaluation. The Director of COTA (0.2 FTE) oversees 0.26 FTE in TA and training for health care providers. The Director of Administration (0.5 FTE) oversees human resource staff as well as the Deputy Director of Business Systems (0.8 FTE), who manages contract
administration and procurement, including eSHARE data system implementation across Prevention and Care funded with 5.24 FTE for RWHAP Part A (additional FTE is covered with other funds). RWHAP Part A funds 9.75 FTE in the CTP REU, overseen by the Director of REU (0.7 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 portfolio-wide, 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 HD Deputy Commissioner for Disease Control and oversees a total of 4.9 FTE staff who support the planning and administrative functions of the PC. 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. The Senior Policy Analyst (0.36 FTE) informs the PC and Recipient of health policy developments and their effect on the NY EMA system of care. The Epidemiologic Liaison (0.4 FTE) works with the PC and HIV Surveillance to provide epidemiological data necessary for PC decision-making.

Temporary Assignment of State and Local Personnel during a Public Health Emergency. In the midst of the COVID-19 response a number of RWHAP Part A supported staff have been activated to assist with response activities including: contact tracing, public information, COVID-19 health equity, and communications. Activated staff report their time dedicated to the response in the City Time system which allows all time dedicated to the response to be charged to the Office of Emergency Management. Given this ability to track staff time during the emergency response, there has been no cost to RWHAP Part A associated with the COVID-19 activation. Given the City’s ability to track and assign costs associated with the response, the Recipient has not needed to request permission from the Secretary of HHS for temporary assignment of RWHAP Part A funded staff.

There are currently several vacant Recipient positions: the Assistant Commissioner of BHIV, the Director of COTA, a Health Equity Coordinator, a QMS, an HIV/HCV Evaluation Specialist, an Evaluation Specialist, the Director of Housing, the Senior Grant Analyst, and the Contract Manager. The Assistant Commissioner of BHIV and the Director of COTA positions were 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; however, as the City experiences reductions in tax revenue, there is a hiring freeze affecting all vacant positions. The Director of CTP will advocate for hiring of essential grant positions and update the NY EMA’s HRSA Project Officer on a regular basis. The NYC HD has an emphasis on recruiting and hiring candidates that are racially and ethnically diverse and more reflective of the NYC population across all roles and levels of leadership. This priority has increased the number of channels in which the NYC HD advertises and recruits for positions. Positions may remain open in order to give hiring managers the opportunity to meet with a diverse candidate pool.

b) Staffing, SOW, and evaluation of contractor or fiscal agent. PHS, the NYC HD’s Master Contractor, assists in the administration of the RWHAP Part A program in the NY EMA. The Master Contract was recently re-solicited and PHS was awarded a new nine-year term which is currently being negotiated. Under the direction of the Chief Strategy Office (CSO) and Vice President for CAMS, and four Directors – Senior Director for Programs and Contract Management, Director of Finance and Operations, Director of Business System, and Director of Informatics – PHS administered 144 RWHAP Part A-funded contracts in GY20. PHS employs 19.51 FTE monitoring staff, 2.95 FTE contract administration staff, and 11.61 FTE planning and administrative
staff for a total of 34.07 FTE. The CSO ensures PHS adheres to terms of the Master Contract with the NYC HD and has ultimate responsibility for all operations. 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. Director of Informatics is responsible for development and management of PHS’s information systems, developing policies and procedures for data collection, and ensuring data integrity for contract payment and monitoring. Director of Finance and Operations is responsible for developing, implementing, and monitoring fiscal policies, administrative procedures, and the portfolio’s fiscal compliance. Director of Business Systems is responsible for guiding the procurement process, leading 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 NYC HD, 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. NYC HD facilitates a monthly coordination meeting and Data Work Group 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 NYC HD 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 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. 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, currently all site visits are conducted virtually.

**NYC HD 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 the number of subrecipients on contract status 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.** The NY EMA’s multi-faceted contract monitoring process includes monthly electronic data submissions, comprehensive semi-annual reviews, site visits, documentation reviews, frequent telephone and email contact, and other meetings as necessary. Beginning in GY20 PHS and the Recipient initiated a plan to streamline visits as a result of HRSA HAB’s GY18 site visit recommendations so that subrecipients receive no more than one site visit per contract per year. However, these face-to-face visits are currently suspended due to COVID-19; alternative fiscal and compliance monitoring is occurring through virtual site visits. 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 HD 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 HD 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 conform to the contract's budget and scope of services. In addition, providers are assigned a NYC HD QMS with expertise in the relevant programmatic content. QMSs provide one-on-one TA and guidance in QM 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 to ensure that consistent guidance is provided to RWHAP Part A subrecipients through joint site visits. Site visit findings that are successfully addressed post site visit 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 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 NYC HD. The process starts with targeted TA in an expected timeframe; should improvement not result, corrective measures are implemented which require a written plan with timeframes for specific metrics of required performance.

Due to the impact of COVID-19, many subrecipients were required to transition to virtual services while maintaining contract compliance. For example, one subrecipient came up with a novel approach to outreach efforts in the absence of site/community-based visits. The COVID-19 pandemic forced the agency to rethink traditional outreach approaches such as neighborhood outreach, home visits, and accompaniments. Many of the agency’s clients often have no phone, access medical care sporadically, and unpredictably present to the clinics for urgent visits. To meet
this need during the pandemic, agency Navigators and Care Coordinators developed a relationship with on-site clinic staff to catch clients as they walked into the clinic for unscheduled visits. On-site nurses and medical assistants now immediately reach out to the agency team via cell when a lost-to-care client presents for care. This allows the agency team an opportunity to do a phone visit with the patient while they wait in an exam room.

ii) Process for ensuring compliance with the single audit requirement. Consistent with the HHS 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 GY19, PHS contracted with 85 subrecipients; however, only 76 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 but one of the 76 audit packages were submitted in GY19. The audit package for one subrecipient was submitted during GY20. Of all audit packages received, 44 (58%) were submitted late. The reasons for late submission of the audits vary but included among them are turnover of key staff in the subrecipients’ finance area and delayed start of the audits. PHS retains the right to hold payment for failure to submit audit packages and did do so during GY19 for several subrecipients. During GY19, 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 GY19, 24% of the NY 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 9% 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 semi-annual updates on corrective measures. 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 GY19, the NY EMA continued its robust process to ensure 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 GY20 RWHAP Part A Spending Plan to address gaps, especially those in Medicaid.

Beginning in GY11 and continuing through GY20, 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 NY EMA generally prioritizes non-Medicaid covered services and individuals in service design and planning. Hence, the history of applying for the CMS waiver.

As described on p. 36, the Recipient conducted an analysis in GY19 resulting in the creation of updated POLR guidance for service providers and a review tool for contract oversight staff to use during site visits at agencies with contracts in applicable service categories (able to bill Medicaid). During contract negotiations, PHS and subrecipients identify all potentially reimbursable services and explore sources of third-party payment. Contracts that include services potentially reimbursable by Medicaid and other payers are subject to a review of 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 and reassessment.

Many PWH 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 PWH 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 PWH who are eligible for other sources of assistance access those resources before the RWHAP Part A care system, and that PWH are receiving enrollment assistance from application counselors who understand the HIV care system.

iii) Tracking and use of program income. The NYC HD 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 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 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 HD. 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 HD, which in turn, the department uses to report by service category to the PC. On a quarterly basis, NYC HD 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 must report the aggregate amount of program income generated and costs covered by it. The Director of Finance and Operations and Assistant Comptroller at PHS manages fiscal tracking and reporting and reports directly to the CSO and Chief Financial Officer, who are part of PHS’s senior management team. At the NYC HD, the Grant Fiscal Administrator and the Director of Program Planning and Operations of CTP, all overseen by the Director of CTP and the Director of Administration in the BHIV, are responsible for fiscal oversight and reporting on the RWHAP Part A grant, including implementation of the HRSA/HAB National Monitoring Standards.

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

NYC HD fiscal staff and the Director of Program Planning and Operations 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 Program Planning and Operations 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 as well as authorize and process payments into PHS’ accounting system. 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 HD separately tracks Formula, Supplemental, MAI, and Carryover funds through PHS data and accounting systems, PAMS and Intacct, and AMS Advantage. In standard quarterly reports, PHS reports expenditures to the NYC HD in each funded service category, outlines funding commitments per service category, and summarizes spending rates. The reports are combined with separately tracked NYC HD program fiscal spending data and presented to the PC to monitor expenditures, allocate funding for next year’s spending plan, and develop a carryover plan for unspent funds at closeout.

**iii) Subrecipient reimbursement.** PHS reimburses subrecipients monthly and the contract management system logs and time-stamps receipt of monthly reports and automatically uploads expenditure data. The NYC HD 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 (i.e., 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 HD developed and provided subrecipients with the *Guide to Requirements for Services: Payability and Data Reporting*, which PHS updates routinely. This 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 documented in subrecipient files and the PHS contract management database.

The PHS contract management database computes the payment and notes any disallowances. CMs generate payment authorization reports, validate them, enter the payment into the accounting system, and attaches the payment documents to the entry in the accounting system. The payment is then reviewed by the 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). 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. The GY19 reprogramming plan 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.

The NYC HD working closely with PHS develops standardized reimbursement rates for performance-based contracts. To ensure reimbursement rates can cover subrecipients program operating costs, the NYC HD and PHS develop rates that are inclusive of the following: 1) current market salaries for service staff, 2) salary costs of support staff, 3) average Fringe Benefit Rate, 4) costs of other than personnel services (OTPS), 5) Indirect Costs/Overhead (capped at the legislative amount), and 6) a markup for missed client appointments. The NYC HD and PHS create a mockup program and associates costs to test the feasibility of the reimbursement rates.

_Maintenance of Effort (see Attachment 11)._
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lxxxiv CHAIN Cohort Inter-wave & COVID-19 Check In – Preliminary Findings, July 2020.