INTRODUCTION

Pursuant to the Grant Year (GY) 2016 HIV Emergency Relief Program Ryan White Part A (RWPA) Funding Opportunity Announcement, dated August 27, 2015, the New York City (NYC) Department of Health and Mental Hygiene (DOHMH), as the Grant recipient (Grantee) for the New York Eligible Metropolitan Area (NY EMA), respectfully submits this application for grant funding. The application describes the GY16 plan to promote a comprehensive continuum of high-quality care and treatment through the support of core medical and support services that address gaps in the HIV Care Continuum for eligible people living with HIV/AIDS (PLWHA) in the EMA.

The GY16 plan is responsive to Governor Andrew M. Cuomo's plan, "Ending the Epidemic" (ETE), to bend the curve on NY's AIDS epidemic by 2020. Through this comprehensive strategy, the State plans to reduce the annual incidence of new HIV infections to about 750 from the current 3,000. If achieved, the total number of new infections will fall below the number of HIV-related deaths, and the number of PLWHA in New York State (NYS) will decrease for the first time since the start of the epidemic. ETE is a three-point program with the following priorities: 1) identifying PLWHA who remain undiagnosed and linking them to healthcare, 2) linking and retaining people diagnosed with HIV in healthcare and getting them on antiretroviral medications (ARVs) to maximize HIV viral suppression so they remain healthy and prevent further transmission, and 3) providing individuals at high-risk of acquiring HIV access to Pre-Exposure Prophylaxis (PrEP) to keep them HIV-negative.

The NY EMA has aligned its services with the goals outlined in the NYS ETE Blueprint.[i] The EMA's efforts to identify PLWHA and link them to care are described in the Early Identification of Individuals with HIV/AIDS (EIIHA) plan (*pp. 8-18*). All HIV care services in the EMA support the second priority, to link and retain PLWHA in care, improve ARV access, and decrease viral load. PrEP is not purchased with RW funds, but the EMA leverages other funds to build consumer and provider awareness of PrEP and Post-Exposure Prophylaxis (PEP) and to increase community capacity to provide PrEP and PEP. The EMA's service plan is described in this application.

NEEDS ASSESSMENT

(1) Jurisdictional Profile. The NY EMA, which includes the five boroughs of NYC and the adjacent Tri-County region of Westchester, Rockland, and Putnam Counties, is home to almost 9.6 million people (over 3% of the U.S. population[ii]). The EMA continues to have the largest HIV/AIDS epidemic in the U.S., with approximately 13% of the nation's PLWHA in 2012 and 7% of HIV (non-AIDS) diagnoses in 2013.[iii] As of December 31, 2014, there were 124,471 reported PLWHA in the EMA, representing 1.3% of the total EMA population. From 2012-2014 alone, 7,238 people were diagnosed with HIV in the EMA, and 5,655 were diagnosed with AIDS, demonstrating the ongoing need for HIV early intervention and care services (*see Table 1)*. Despite gains made in identifying PLWHA in the EMA and linking them to medical care, HIV/AIDS still causes significant morbidity and mortality, particularly in racial/ethnic minority communities. In 2013, among NYC residents under 65 years of age, HIV was the fifth leading cause of premature death overall, the third leading cause of premature death for non-Hispanic Blacks[1], and the fourth for Puerto Ricans.

The cost and complexity of managing the EMA's epidemic are high. As the number of PLWHA has risen by roughly 20% in NYC in the last decade, demands on the EMA's service system and need for RWPA funding have grown. HIV remains concentrated in low-income communities of color,

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

where many individuals experience multiple challenges that severely impact health, such as substance use, mental health (MH) issues, Hepatitis C Virus (HCV), and homelessness.

a. Table 1: NY EMA HIV and AIDS Diagnoses and Prevalence

HIV/AIDS diagnoses and reported PLWH/A in the NY EMA, 2012-2014						
	CY2012		CY2013		CY2014*	
	Diagnoses	PLWH/A	Diagnoses	PLWH/A	Diagnoses	PLWH/A
HIV**	2,569	50,731	2,316	51,660	2,353	53,051
AIDS	2,153	70,693	1,999	71,144	1,503	71,420

Sources: New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC DOHMH, HIV Epidemiology and Field Services Program, data as of June 30, 2015; Putnam, Rockland, and Westchester counties: New York State Department of Health (NYS DOH), Bureau of HIV/AIDS Epidemiology, data as of August 12, 2015.
*Data for CY2014 are incomplete for Tri-County because of a reporting lag.
**HIV diagnoses exclude those who were concurrently diagnosed with HIV and AIDS.

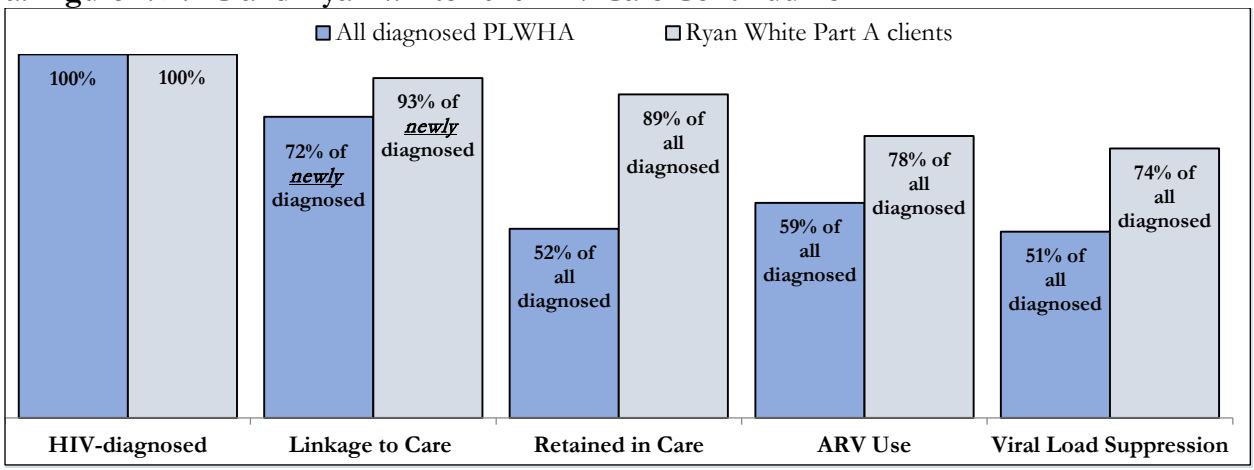
b. HIV/AIDS Demographics. While no community has been spared the effects of HIV, the distribution of PLWHA varies across the EMA. NYC neighborhoods with the highest proportion of new diagnoses and PLWHA include the South Bronx, the Manhattan neighborhoods of Chelsea-Clinton and Harlem, and Central Brooklyn. With the exception of Chelsea-Clinton, all of the neighborhoods in NYC with the highest HIV diagnosis rates and proportion of PLWHA also have high poverty rates. In the Tri-County region, HIV prevalence is highest in the communities of Westchester County that border NYC. Among PLWHA in the NY EMA as of December 31, 2014, 72% were male, 44% were Black, 32% were Hispanic, and 21% were non-Hispanic Whites. People aged 45 and older accounted for 67% of PLWHA, reflecting an increase over time in the median age of PLWHA and underscoring the importance of addressing the complex service needs of older PLWHA. By transmission risk category, 40% of PLWHA were men who have sex with men (MSM), 20% had heterosexual risk, and 16% reported a history of injection drug use (IDU). See *Attachment 3* for the complete prevalence table. In comparison, among new HIV diagnoses in 2014, 81% were male, 81% were non-White, 77% were younger than 45, and 63% had MSM transmission risk.

In addition to the demographic characteristics described above, there were 212 new HIV diagnoses among transgender individuals from 2009-2013, 99% of which were among transgender women. Transgender women made up 1% of the total number of new HIV diagnoses in NYC during this time period, while making up only 0.005-0.1% of the population. Roughly 93% of newly diagnosed transgender women were Black or Hispanic, and nearly 55% were ages 20-29.[iv]

(2) HIV Care Continuum for GY16. Through a combination of multiple federal, state and local funding streams, health programs, and collaborative HIV care and prevention planning and administration, the EMA ensures a comprehensive system of HIV care that also seeks to reduce new infections. A 2013 Office of National AIDS Policy progress report on the National HIV/AIDS Strategy (NHAS) cited NYC as a locality wherein health outcomes among PLWHA along the HIV Care Continuum and estimated HIV incidence rates have improved in recent years as a result of innovative implementation of the NHAS.[v] The success of the EMA's service delivery system is illustrated by a 35% decline in HIV (non-AIDS) diagnoses, which coincided with an increase in targeted testing efforts, and a 49% decline in deaths among persons with HIV in NYC from 2004 to 2014. The GY16 Plan was developed through a year-long, inclusive, evidence-informed community planning process, including consideration of the continued impact of the implementation of the Affordable Care Act (ACA). The GY16 Plan sustains and strengthens funding for programs with demonstrated success filling gaps in the HIV Care Continuum. In GY16, RWPA is expected to

serve over 17,000 PLWHA and reach nearly 40,000 people with Early Identification Services (EIS) programs, while delivering services to non-Medicaid eligible individuals and filling gaps in the HIV Care Continuum by providing services not covered by Medicaid.

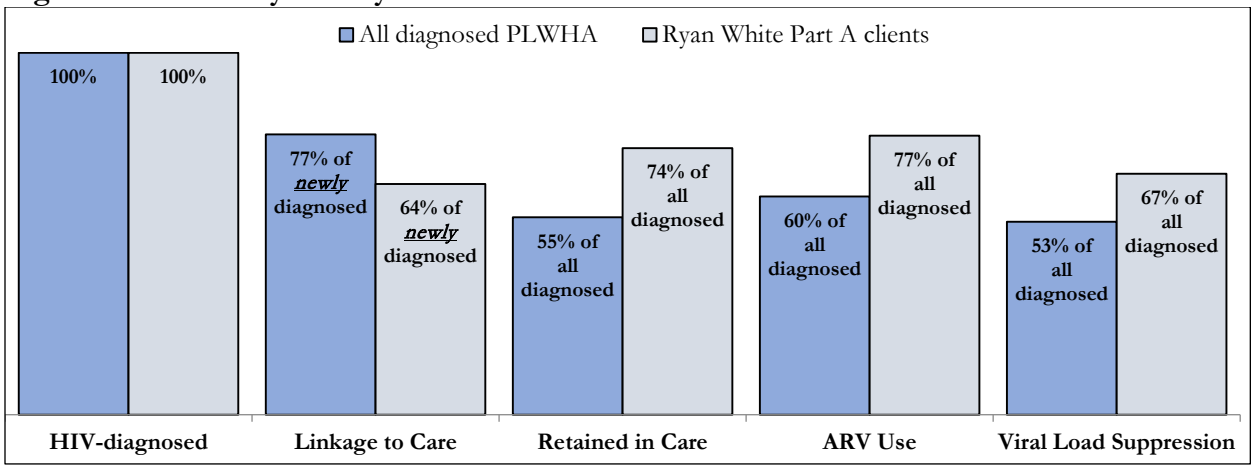
a. Figure 1: NYC and Ryan White 2014 HIV Care Continuums



Sources: NYC DOHMH, HIV Epidemiology and Field Services Program, data as of June 30, 2015; NYC DOHMH, HIV Care and Treatment Program, data as of August 8, 2015; NYC DOHMH, Medical Monitoring Project (MMP), 2013.
Notes: "Ryan White Part A clients" include clients enrolled and served by Ryan White Part A in NYC in 2014 who matched to the HIV Registry; "HIV-diagnosed" includes those diagnosed by 12/31/2013 and living and residing in NYC as of 12/31/2014; "Linkage to care" includes those who were newly diagnosed with HIV in 2014 with a viral load or CD4 count within 91 days of diagnosis; "Retained in care" includes those HIV-diagnosed with at least two VL or CD4 counts in 2014 that were at least 91 days apart; "ARV use" is defined for all PLWHA as participant report of current ARV use at time of interview, based on the 2013 MMP cycle, and for Ryan White Part A clients is defined as reported ARV prescription during 2014, based on eSHARE data; "Viral load suppression" includes those among the HIV-diagnosed whose most recent viral load in the year was ≤200 copies/mL.

Tri-County. Because of delays in the availability of state surveillance data, the Tri-County region's HIV and Ryan White Care Continuums data are presented for 2013 (*Figure 2*).

Figure 2: Tri-County and Ryan White 2013 HIV Care Continuums



Sources: NYS DOH, Bureau of HIV/AIDS Epidemiology, data as of August 12, 2015.; NYC DOHMH, HIV Care and Treatment Program, data as of August 8, 2015; NYC DOHMH, Medical Monitoring Project (MMP), 2013.
Notes: "Ryan White Part A clients" include clients enrolled and served by Ryan White Part A in the Tri-County region in 2013 with PCSM status measures reported in eSHARE; "HIV-diagnosed" includes those diagnosed by 12/31/2012 and living and residing in the Tri-County region as of 12/31/2013; "Linkage to care" includes those who were newly diagnosed with HIV in 2013 with a viral load or CD4 count within 91 days of diagnosis; "Retained in care" includes those among the HIV-diagnosed with at least two VL or CD4 counts in 2013 that were at least 91 days apart; "ARV use" is defined for all PLWHA as participant report of current ARV use at time of interview, based on the 2013 NYC MMP cycle, and for Ryan White Part A clients as reported ARV prescription during 2013; "Viral load suppression" includes those among the HIV-diagnosed whose most recent viral load in the year was ≤200 copies/mL.

b. HIV Care Continuum Narrative.

(i) Use of HIV Care Continuum. In a shift led by the Planning Council's (PC) Needs Assessment Committee (NAC), since 2012, the EMA has employed the HIV Care Continuum as a tool to frame the planning, delivery, and monitoring of services. The HIV Care Continuum has become an essential tool for examining progress in addressing the epidemic. Through the combination of standardized indicators in a single digestible diagram, the HIV Care Continuum ensures the PC, the Grantee, RWPA providers and consumers focus efforts on increasing status awareness, linkage and engagement in care, ARV use and VLS.

The DOHMH routinely merges programmatic and HIV surveillance data for the production of comparable HIV Care Continuum indicators across different populations of PLWHA within the EMA. The results are then used in an integrated planning process to: identify/quantify unmet need; assess priority populations; set priorities for technical assistance (TA) and service implementation; and monitor progress toward meeting goals. This tool also enables comparisons of each updated HIV Care Continuum to those in previous years and other jurisdictions.

In the GY16 Plan, based on the NYC and Tri-County HIV Care Continuums, RW-funded services contribute to the NYS ETE objectives of: 1) identifying persons with HIV who remain undiagnosed and linking them to healthcare (the second stage in *Figures 1 and 2*); 2) linking and retaining persons diagnosed with HIV to healthcare (the second and third stages in *Figures 1 and 2*); and 3) initiating and maintaining persons on ARVs (the fourth stage in *Figures 1 and 2*) to maximize HIV viral suppression (the fifth stage in *Figures 1 and 2*) so they remain healthy and prevent further transmission. RW-funded programs ultimately contribute to decreased transmission by promoting engagement in HIV care and improved uptake of and adherence to ARVs, with the goal of increased viral suppression and improved health outcomes for PLWHA. In addition, the GY16 Plan is responsive to findings from the local *Needs Assessment for HIV Services* (Needs Assessment) and is consistent with the NHAS and the *Statewide Coordinated Statement of Need*. RWPA service category allocations can be found in *Attachment 8*. The EMA utilizes its Comprehensive Plan to conceptualize how to address gaps highlighted by analyses with the NYC and Tri-County HIV Care Continuums.

(ii) Systematic approaches to address gaps in the HIV Care Continuum.

1. *HIV diagnosis and linkage to care.* The earliest stages of the HIV Care Continuum involve the diagnosis of individuals not previously known to be HIV-positive and linking them to care. HIV testing programs, including those funded by RW EIS, are a key resource for this effort. Diagnosis is the first step to support linkage to primary HIV care and can lead to viral load suppression (VLS), improved health outcomes among PLWHA, and a reduction in the likelihood of onward HIV transmission. Routine testing programs, supplemented by CDC and RW-funded EIS programs, continue to locate those undiagnosed and link them to care. The EMA's efforts to reach undiagnosed PLWHA are further described in the GY16 EIIHA Plan. The EMA's service category breakdown and reimbursement structure are directly linked to HIV diagnosis and linkage to care outcomes to support successful health outcomes. As shown in *Figures 1 and 2*, an estimated 72% (NYC, 2014) and 77% (Tri-County, 2013) of newly diagnosed PLWHA were linked to care within 91 days of diagnosis. Linkage to care was achieved for 93% (NYC, 2014) and 64% (Tri County, 2013) of newly diagnosed RWPA clients, demonstrating the success of the DOHMH's early intervention efforts. Additional efforts will be undertaken to increase Tri-County's 64% linkage to care rate through a GY16 RFP, which will include payment points for timely linkage. Because HIV testing is widely available and paid for via a variety of payers, the PC has developed a directive that will allocate the majority of RW EIS dollars to EIS services other than testing, such as linkage to and engagement in care, to address the first gap (linkage) in the HIV Care Continuum. Targeted EIS programs will continue to be supported by RWPA to locate the hardest hit communities.

2. *Retention in care, ARV use, and viral load suppression.* The last three stages of the HIV Care Continuum are intricately linked. Clients' success at each stage is dependent on their current needs and life circumstances. For example, clients may be retained in care but not virally suppressed because of barriers to medication adherence. Rates of retention in care among NYC PLWHA are likely underestimated primarily due to the unmeasured outmigration among PLWHA (which would overestimate PLWHA still living in NYC). Efforts are currently underway to better estimate the number of PLWHA who are still in NYC. An estimated 11% (NYC, 2014) and 26% (Tri-County, 2013) of HIV-diagnosed RWPA clients were not retained in care. Some people who initially access care in the EMA drop out for extended periods; 38% of the current Community Health Advisory and Information Network (CHAIN)[2] longitudinal client cohort in NYC report dropping out of care for at least six months since their first HIV care visit (27% in Tri-County). Dropping out of care is associated with substance use, housing instability, MH issues, incarceration, inability to accept HIV diagnosis, stigma, and forgetfulness.[vi]

The EMA has sought to address the issues associated with dropping out of care through its comprehensive continuum of care. Since 2009, the EMA has funded comprehensive Medical Case Management (MCM)[3] services that actively support early engagement, maintenance in care, and treatment adherence. Alongside MCM services, RWPA funds: Supportive Counseling and Family Stabilization (SCF)[4] to reduce the negative effects of HIV stigma on the client through individual, group, and family psychosocial support; MH services to address barriers to engagement and retention in MH care including the provision of culturally appropriate services; harm reduction (HR)[5] services to reduce the harmful impacts of substance use and support well-being of substance users; and non-Medical Case Management (n-MCM) services specifically for those being discharged from NYC jails, to support successful engagement in medical and social support services post-release. Helping PLWHA address competing needs – including those related to housing instability, MH issues, and substance use – is associated with engaging in and returning to care.[vii] In addition, DOHMH-funded HIV testing programs (through RWPA and CDC funding) re-engage PLWHA who have not seen a medical provider in six months or longer and also conduct direct enrollment into care coordination programs (CCPs) at the time of first linkage. EIS funding also supports the Field Services Unit (FSU), which utilizes surveillance data to identify those out of care and facilitates their re-engagement in care through DOHMH/hospital and clinic partnerships.

The NYC (2014) and Tri-County (2013) HIV Care Continuum data indicate that 59% and 60%, respectively, of all diagnosed PLWHA used ARVs. ARV use among RW clients is estimated at 78% (NYC, 2014) and 77% (Tri-County, 2013) of those diagnosed prescribed ARVs. While primary care providers in NYS are encouraged to initiate ARVs for all persons diagnosed with HIV regardless of CD4 count (as of December 2011), some clinicians still factor in concerns regarding treatment readiness and potential non-adherence of some clients when prescribing. The HIV Care Continuums indicate that, among all diagnosed PLWHA, 51% in NYC (2014) and 53% in Tri-County (2013) were virally suppressed at their most recent viral load measure. For RW clients, 74% in NYC (2014) and

[2] The CHAIN cohort study, in place since 1994, provides ongoing information on the characteristics, co-morbidities, and care needs and patterns of PLWHA in the EMA. More than 2,800 PLWHA have completed interviews conducted by researchers at Columbia University. The cohort is broadly representative of the PLWHA in the EMA, with modest over-representation of Black men and women and Hispanic men, so that participants more closely represent the EMA's Part A clients. Because the study samples from medical and HIV social service agencies, over 96% of CHAIN participants are connected to the HIV service system.

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

[4] Supportive Counseling and Family Stabilization are HRSA-defined psychosocial support services.

[5] Harm reduction services are HRSA-defined substance use services - outpatient.

67% in Tri-County (2013) were virally suppressed. The drop-off between engagement in care and VLS among RW clients underscores the difficulty of moving RW clients along the HIV Care Continuum, due to a multitude of barriers to care including unmet health and social needs. Further, many programs in the EMA have additional enrollment criteria, which include being newly diagnosed, not retained in care, and/or not virally suppressed, to ensure that RW services are targeted to those most in need of additional support. To this end, the EMA focuses Part A funds towards supporting evidence-based, client-centered programs that help PLWHA remain in care, increase ARV adherence, and develop self-management skills. The coordinated services provided to RW clients address the complex realities faced by PLWHA in the NY EMA, including substance use, MH issues, food insecurity, and housing instability – known barriers to long-term adherence and sustained VLS.[viii] To further address VLS, the EMA provides client-centered MCM with treatment adherence support, including modified Directly Observed Therapy (DOT) for those who need it, along with health education and risk reduction (HE/RR) services.

In 2014, as part of an effort to promote early ARV initiation, consistent ARV access, and improved VLS, the DOHMH Care and Treatment Program (CTP) began providing each RW provider agency with client-level reports, known as Treatment Status Reports (TSRs), every six months. The TSRs are prepared using data reported by RWPA providers in the Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE)[6]. Reports detail clients who do not appear to be virally suppressed, distinguishing whether or not the clients are currently prescribed ARVs. These client-level, custom reports are used to focus programmatic TA and facilitate communication and coordination between RW support service providers, clients, and their medical providers to support treatment access and adherence. TSRs are an integral component of the NY EMA's system-wide effort—the Undetectable Framework—to ensure that each PLWHA served has the appropriate resources and support to achieve VLS.

(iii) Health Disparities and the HIV Care Continuum. Health disparities are identified by monitoring demographic differences along the NYC and Tri-County HIV Care Continuums. These disparities are then addressed by targeting services geographically to high prevalence, underserved neighborhoods and prioritizing service types that address structural inequity and basic survival needs (e.g., Housing, Food and Nutrition Services (FNS), and the CCPs). At each stage of the NYC and Tri-County HIV Care Continuums, the proportional distribution of demographic groups, along each bar in the HIV Care Continuum, closely tracks the distribution among all PLWHA in the EMA.

In 2014, White PLWHA, individuals aged 13-24, and persons who inject drugs were least likely to be linked promptly to HIV medical care in NYC. In 2013, in the Tri-County region, Blacks, individuals aged 13-24, and PLWHA with heterosexual transmission risk appeared to be least likely to be linked to care; however, the number of new HIV diagnoses in Tri-County was small, thus these subgroup differences should be interpreted with caution.

PLWHA who are not engaged in care face numerous barriers, including lack of insurance coverage, substance use, and unmet need for other services that facilitate linkage to care (e.g., case management, housing, MH, and HR). Knowledge and attitudes, including disbelief about HIV serostatus and lack of trust in healthcare providers, contribute to delayed linkage to care.[ix]
To improve linkage to and retention in care, the RWPA provides a multi-session peer-led self-management workshop model to address psychosocial health, improve patient-provider relationships, reduce risk behaviors, and build skills for self-care. The model is implemented through HE/RR

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

contracts with community-based organizations (CBOs), where sessions are co-located with a range of healthcare and support services.

Among both RW clients in NYC (2014) and RW clients in Tri-County (2013), Blacks and Hispanics were more likely to be retained in care, while individuals aged 20-29 were less likely to be retained in care. Among RW clients in care in NYC, ARV use was similar across racial/ethnic groups, though lower for individuals aged 25-39 and people who inject drugs. In comparison, among RW clients in care in Tri-County, ARV use was lower among Blacks, individuals aged 20-29 and those with heterosexual transmission risk. In both NYC and Tri-County, VLS rates among RW clients were lowest among Blacks, individuals aged 20-29 and persons with likely exposure to HIV through injection drug use. The comprehensive CCP model, with 52% of the 2014 program clients identifying as Black, helps those who need additional support to maintain engagement in care and achieve VLS.[x] Culturally competent and linguistically appropriate services, available throughout the jurisdiction and concentrated in the neighborhoods with the highest burden of HIV, are a key component of the EMA's ongoing plan to address gaps and barriers to care.

(iv) Barriers or challenges to the HIV Care Continuum. The remaining barrier to the use of an EMA-wide HIV Care Continuum is one that likely exists for many EMAs that encompass multiple health department jurisdictions. Since the HIV surveillance data for the Tri-County region are housed in a separate system, DOHMH staff cannot directly analyze Tri-County surveillance data to develop a single EMA-wide HIV Care Continuum graph, or one for all RW clients. The Tri-County region thus has its own HIV Care Continuum graph (*Figure 2*), which utilizes a different time period because of delays in the availability of state surveillance data, relative to NYC surveillance data. HIV Surveillance staff at NYS and NYC continue to work together to standardize indicator definitions and coordinate on leveraging HIV surveillance data to track EMA progress along the HIV Care Continuum.

(3) Demonstrated Need.

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

(i) EIIHA Data.

Table 2: Newly Diagnosed Positive HIV Test Events (a-g):

Newly Diagnosed Positive HIV Test Events: January 1-June 30, 2015		Black	Hispanic	MSM[7]
a.	# Test events	16,811	20,038	1,325
b.	# Newly diagnosed positive test events	132	92	116
c.	# Newly diagnosed positive test events with client linked to HIV medical care	97	67	94
d.	# Newly diagnosed confirmed positive test events	117	86	109
e.	# Newly diagnosed confirmed positive test events with client referred for Partner Services[8]	117	86	109
f.	# Newly diagnosed confirmed positive test events with client referred to prevention services	101	72	96
g.	# Newly diagnosed confirmed positive test events with CD4 cell count and viral load testing[9]	Only available to report for 2014 – see below.		

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

[8] FSU is prevented by State law from reporting whether a client was interviewed for partner services. The data reported represent referrals to partner services.

Newly Diagnosed Positive Events: January 1-June 30, 2014		Black	Hispanic	MSM
(d.)	# Newly diagnosed confirmed positive test events	134	99	116
(g.)	# Newly diagnosed confirmed positive test events with CD4 cell count and viral load testing	87	67	83

Table 3: Previously diagnosed positive HIV test events (a-g):

Previously Diagnosed Positive HIV Test Events: January 1-June 30, 2015		Black	Hispanic	MSM
a-b.	# Test events and # previously diagnosed positive test events	21	8	4
c.	# Previously diagnosed positive test events with client linked to HIV medical care	9	0	3
d.	# Previously diagnosed confirmed positive test events	10	3	4
e.	# Previously diagnosed confirmed positive test events with client referred for Partner Services	10	3	4
f.	# Previously diagnosed confirmed positive test events with client referred to prevention services	7	1	3
g.	Total # previously diagnosed confirmed positive test events with CD4 cell count and viral load measure	Only available to report for 2014 – see below.		
Previously Diagnosed Positive Events. January 1- June 30, 2014*		Black	Hispanic	MSM
(d.)	# Previously diagnosed confirmed positive test events	10	8	2
(g.)	# Previously diagnosed confirmed positive test events with CD4 cell count and viral load testing	8	6	1

**Previously diagnosed positive HIV test events.* The testing programs funded by DOHMH are primarily focused on identifying individuals who are newly diagnosed with HIV. An individual whose positive HIV status is known at the onset of the encounter would not be offered testing. There are instances in which individuals initially report having an unknown or negative HIV status and are tested by programs, only to disclose a previous diagnosis upon receipt of preliminary positive test results. As a result, the reported number of previously diagnosed positive test events does not accurately reflect the extent to which DOHMH's testing programs engage with previously diagnosed people. Of the previously diagnosed people encountered by funded programs, some may already be engaged in care. DOHMH reimburses programs for linkage services only if previously diagnosed people have not seen a medical provider for nine months or longer (out of care). Only successful linkages are reported to DOHMH. EIS providers are contractually required to report those previously diagnosed. During this time period (January 1-June 30, 2015), 109 Black, 36 Hispanic, and 64 MSM that self-identified as HIV-positive and out of care were not tested, but were re-engaged in care.

(ii) GY 2016 EIIHA Plan.

1. *Planned activities of the EMA EIIHA Plan for GY16.* Several sources of information were used to develop the GY16 EIIHA Plan. Information used includes the PC's Part A and Minority AIDS Initiative (MAI) EIS allocations, the updated NHAS, and the HIV Continuum of Care Initiative. The planned activities for GY16 are detailed below.

[9] DOHMH matches HIV positive persons identified through testing programs to the HIV Registry to determine the number of positives who were linked to care and accessed CD4/viral load testing. Providers and laboratories are required to report CD4 counts and viral loads to DOHMH. Providers vary in the timeliness of reporting. Most tests are reported to DOHMH within nine months of testing. Because of this data lag in reporting, the number of positives diagnosed or the proportion of them accessing CD4/viral load testing between January 1 and June 30, 2015 are unable to be determined.

• *An updated estimate of individuals who are HIV-positive and do not know their status*. The CDC recently revised its unaware estimate, which indicates that 12.8% of PLWHA in the U.S. are undiagnosed.[xi] Applying this percentage to NY EMA data suggests that, as of December 2014, the most recent year for which complete data are available, 15,932 people are infected but undiagnosed in the EMA. DOHMH is currently in the process of conducting a five-borough serostatus survey to update its estimate of the percentage of PLWHA who are unaware of their status in NYC.

• *Populations addressed by the EIIHA Plan*. The EMA has identified three primary target populations: Blacks, Hispanics, and MSM. In addition, all persons in the EMA are addressed through an approach described below that seeks to integrate HIV testing into primary and emergency medical care with targeted testing and linkage efforts for those most at risk. The EIIHA Plan aims to make HIV awareness accessible to the general EMA population. The EMA's target populations are included in the 2015 NHAS's prioritized communities, which include: 1) gay, bisexual, and other MSM of all races and ethnicities (particularly young MSM [YMSM] of color); 2) Black women and men; 3) Latino women and men; 4) people who use drugs, including injection drugs; 5) youth aged 13 to 24 years (particularly YMSM of color); and 6) transgender women (particularly transgender women of color).

• *Primary activities to be undertaken, including system-level interventions*. The EMA uses a two-tier approach to pursue the EIIHA goal to reduce the number of undiagnosed and late diagnosed individuals. The first tier promotes routine HIV screening programs in healthcare facilities to support sustainable access to HIV testing services for the general population citywide, while the second tier targets testing services to high-risk and historically underserved populations in non-clinical settings.

a) <u>*Tier 1.*</u> The first tier approach is consistent with 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 and service provision, and provides HIV testing to people who may be missed through targeted testing, especially those who do not perceive themselves to be at risk. A 2010 NYS legislative mandate required healthcare providers to offer testing to all clients aged 13-64 years in healthcare settings, with limited exceptions. A 2012 evaluation of the legislative change showed that testing volume increased by 13% in NYS.[xii] The EMA uses RW and other sources of funding to support, but not supplant, routine HIV testing programs in healthcare settings and to support the implementation of community-level initiatives that promote HIV testing and normalize the testing experience. To maximize the impact of funding, routine screening funded by RW is focused on clinical facilities that serve neighborhoods disproportionately affected by HIV and that are underserved, such as the South Bronx, Central Brooklyn, and East and Central Harlem.

To support the implementation of routine screening, DOHMH uses CDC, City Tax Levy (CTL), and other non-RW funds for outreach to the clinical community, from hospitals to private practices, to educate healthcare providers about current recommendations and legislative mandates, promote routine HIV screening, and provide TA. Additional CDC and CTL funds support social marketing campaigns to encourage routine testing. In the Tri-County region, Medicaid is the most significant payer supporting the implementation of the NYS routine testing law.

One approach the DOHMH has taken to engage hospitals and community health centers in routine HIV screening is through the city-wide HIV testing initiative, *New York Knows*. In 2008, DOHMH began working with Bronx providers on an initiative called *Bronx Knows* to increase voluntary HIV testing so that every Bronx resident is aware of his or her HIV status and has access to quality care and prevention services. DOHMH expanded on the success of *Bronx Knows* by launching *Brooklyn Knows* in 2010, and by launching *New York Knows* on World AIDS Day 2014. *New York Knows* also engages community providers to conduct targeted testing of high-risk populations. Approximately 2.18 million HIV tests have been performed collectively in these boroughs since 2008

through all three initiatives combined. The *New York Knows* initiative is a public-private collaboration using RW, CDC, Medicaid, and insurance reimbursements to support HIV testing efforts.

The NYC DOHMH Bureau of STD Control (BSTD) has been providing HIV testing services since early in the HIV epidemic. HIV testing is routinely offered to all STD clinic clients. Beginning in 2008, the DOHMH BSTD, Bureau of HIV (BHIV), and the Public Health Laboratory (PHL) launched a testing program using pooled nucleic acid amplification tests (pNAAT) to increase detection of acute HIV infections. pNAAT testing is limited to those individuals who are part of demographic and/or high-risk groups where acute infections have been identified, including MSM, people who have shared injection drug equipment, and people who exchange sex for money (or other material goods). From January 1 through June 30, 2015, 22 acute HIV infection cases were diagnosed in NYC STD clinics via pNAAT. Of those individuals, 73% were linked to HIV primary care within 90 days. Rapid intervention with this group is particularly important to prevent transmission during the high-viral load stage of acute HIV infection.

b) Tier 2. The second tier of the EMA's EIIHA approach aims to decrease disparities in HIV testing through targeted testing services in non-clinical settings for historically underserved and high-risk populations that might be missed by routine screening in clinical settings. Strategies used include targeted testing in venues where people at high risk for HIV can be found and engaged, with trained staff using evidence-based recruitment practices. Given finite resources, DOHMH preferentially funds agencies that provide services and testing to these groups. Agencies providing these services must demonstrate cultural competency and have a history of working with these populations.

For all DOHMH-funded testing programs in both tiers, DOHMH recommends the use of HIV testing technologies that enable the detection of acute and early HIV infections, such as combination antigen-antibody (4th generation) HIV tests. To support testing programs, DOHMH provides trainings for providers and publishes testing and prevention resources online. To ensure that individuals with a preliminary positive test result receive confirmatory testing, DOHMH requires programs conducting HIV testing in the field using rapid testing technologies to collect confirmatory specimens at the site. In addition, confirmatory testing is a discrete reimbursement point in HIV testing contracts. The additional reimbursement point and required on-site collection of specimens has resulted in a higher proportion of tested clients receiving confirmatory results among those who test preliminary-positive. Because DOHMH funds point-of-care and other rapid testing, very few individuals are not post-test counseled.

The GY16 EIIHA Plan also addresses the goal of increasing the number of HIV-positive individuals who are in medical care. All testing programs funded by DOHMH are required to link HIV-positive people to medical care and refer them to case management services. DOHMH has found that Case Managers help clients navigate the HIV system of care and improve durable linkage to medical care. MCM and HE/RR program clients also receive health education that engages and empowers them to connect to care, remain in care, and initiate treatment. Acknowledging the increased resources necessary to achieve prompt linkage to medical care, DOHMH provides higher reimbursement to agencies for clients who link to care within 90 days, consistent with the 2010 NHAS. Subrecipients are required to collect documented proof of successful linkage and must provide such documentation for verification, as part of the EMA's fiscal and administrative duties. DOHMH will seek to align contracts with the updated 2015 NHAS indicator of linkage within 30 days of diagnosis. To support testing programs with linkage to care, DOHMH provides training to subrecipients and other NYC agencies on Anti-Retroviral Treatment and Access to Services (ARTAS), an evidence-based intervention shown to increase linkage to and retention in HIV care.

The Contact Notification Assistance Program (CNAP) and FSU within DOHMH and the Tri-County region's health departments provide partner notification services to PLWHA and their sexual or needle-sharing partners. These programs elicit the names of potentially HIV-exposed partners,

confidentially notify these partners of their possible HIV exposure, and offer HIV testing and linkage to care for persons who test positive. The FSU was created in June 2006, based on the successful CDC field services model used by DOHMH STD Intervention Specialists to elicit and notify partners of New Yorkers who are diagnosed with STDs. In 2014, FSU provided partner services to all HIV testing facilities citywide. FSU interviewed 89% (1609/1802) percent of persons newly diagnosed with HIV in NYC, and elicited 1547 HIV-exposed partners. Seventy-five percent (890/1547) of partners with negative or unknown HIV status were notified and 38% (341/890) were tested, of which 18% (63) were newly diagnosed with HIV. In instances where people newly diagnosed with HIV do not return to receive their test results, FSU can assist testing providers in locating patients, notifying them of their results, and offering partner services. For people who consent, FSU assists in linking them to medical care. FSU also assists with re-engaging PLWHA who have been out of care for at least nine months, identifying them from the NYC HIV surveillance registry and checking against other data sources to verify that they have not died or moved out of the jurisdiction before efforts are made to locate and engage them in medical care. Westchester County, the largest in the Tri-County region, has a similar re-engagement program that utilizes surveillance data funded by NYS.

DOHMH has created and expanded programs and initiatives to support the goal of increasing the number of HIV-negative individuals referred to services that contribute to keeping them HIV-negative. Individuals who test negative and are at-risk for HIV are educated about and referred to prevention services, including PrEP and PEP. The DOHMH contracts with several clinical providers using non-RW funds to provide sexual and behavioral health services, including PrEP and PEP, to uninsured and underinsured clients and has created patient education and social marketing materials on PrEP and PEP to educate and promote these options. DOHMH has also taken steps to create and expand a network of PrEP and PEP providers and, in 2014 used the pharmaceutical detailing model to train staff to visit clinical practices in NYC to educate providers, and hold workshops.

- *Major collaborations with other programs and agencies.* Many DOHMH programs collaborate to identify individuals unaware of their HIV status, as detailed in the EIIHA Plan. Under the leadership of the BHIV's Prevention Program's Diagnostics Unit, all HIV testing programs have standardized service models and data collection across funding sources, enforced Payer of Last Resort (POLR) requirements, eliminated duplication of services across funding streams, and promoted coordination of monitoring and evaluation activities. The BHIV HIV Prevention and CTP staff meet regularly to coordinate activities. In 2014, CDC and the Health Resources and Services Administration (HRSA) held a joint meeting with the DOHMH and NYS to coordinate HIV testing resources across funding streams, informing the GY15 and GY16 EIIHA Plans.

BHIV also collaborates with other DOHMH programs that provide services to populations heavily impacted by HIV. Such programs include the Division of Mental Hygiene, BSTD, Bureau of Tuberculosis (TB) Control, PHL, the Office of School Health and the NYC Health and Hospitals Corporation (HHC), NYC's public hospital system. In 2015, the management of correctional health services in NYC jails was transferred from DOHMH to HHC. HHC Correctional Health coordinates comprehensive medical, MH, and dental services for inmates in NYC correctional facilities. Inmates are offered an HIV test during their medical intake. In addition, Correctional Health staff educate and engage high-risk inmates who refuse HIV testing through health promotion sessions. Once engaged, inmates are offered testing services again. HIV-positive inmates are linked to care while incarcerated and receive discharge planning and other services to support engagement in medical care in the community within 30 days of release.

The *Brooklyn and Bronx Knows* initiatives were expanded citywide in 2014, bringing new non-clinical and clinical community partners from Manhattan, Queens, and Staten Island. Collectively,

New York Knows has over 200 partner agencies that have pledged to support the goals of the initiative to: test every resident for HIV, link HIV-positive individuals to care, link HIV-negative individuals to prevention services including PrEP, and make HIV testing a routine part of healthcare in NYC. Steering committees have been created in each borough and for the initiative citywide.

- *Planned outcomes of overall EIIHA strategy.* The main planned outcomes of the overall strategy include more people within the EMA being aware of their HIV status, a higher proportion of PLWHA being promptly linked to medical care, and a higher proportion of populations at-risk for HIV receiving prevention services including PrEP *(see p.16 for specific objectives)*. With continued promotion of routine screening in clinical or community-based settings, a higher proportion of clients are expected to be offered HIV testing. The EMA proposes to monitor this outcome through a variety of mechanisms. Funded programs report client-level testing data; clinical facilities from borough-wide initiatives report aggregate testing data to DOHMH. Funded programs are also expected to report the aggregate number of total HIV tests performed at their facilities, regardless of funding source. DOHMH also monitors the testing data reported by testing programs in non-clinical settings that target high-risk populations. With broader implementation of routine screening and expansion of targeted testing, the volume of HIV tests reported to DOHMH should increase.[xiii]

As the EMA continues to promote and fund testing programs, the proportion of residents in the EMA that have ever been tested for HIV continues to increase. Through the annual Community Health Survey[10] (CHS), DOHMH tracks the percentage of NYC residents, aged 18 and older, who report ever testing for HIV. The 2013 survey found that 62.5% of adult NYC resident respondents have ever tested for HIV, up from 59.7% in 2010. DOHMH also expects the estimated HIV incidence to decline citywide and for priority populations. The 2013 HIV Surveillance Annual Report showed a statistically significant decline in estimated HIV incidence between 2009 and 2013. The DOHMH's Fall 2014 Sexual Health Survey found that 86% of MSM and 84% of women of color had an HIV test in the past year.

The EMA recommends and promotes prompt linkage to medical care. A planned outcome is an increased percentage of people with new HIV diagnoses initiating care. Currently, DOHMH tracks this indicator using HIV surveillance data and defines timely linkage as the first CD4 count or viral load drawn between eight and 91 days[11]after HIV diagnosis. Since 2006, there has been a steady increase in timely care initiation among people newly diagnosed, from 59% in 2006 to 72% in 2013. DOHMH will also begin to track linkage to care within 30 days of HIV diagnosis, based on the 2015 NHAS indicators.

As the EMA continues to promote and fund PrEP and PEP referral and care services, the proportion of at-risk residents, including MSM and transgender individuals, who are aware of and report using these services will increase. Data from the Spring 2015 Sexual Health Survey found a higher percentage of White MSM were aware of PrEP (91%) than Black MSM (78%) or Hispanic MSM (82%), with only 14.8% of MSM overall reporting use of PrEP in the past six months (18.4% of White MSM, 12.2% of Black MSM, and 15.7% of Hispanic MSM). The Fall 2014 Sexual Health Survey found that only 10% of women of color were aware of PrEP (data for women of color was not collected during the Spring 2015 survey), underscoring the need for intensive social marketing and education efforts which are underway at DOHMH using CDC resources.

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[10] Since 2002, DOHMH has conducted the NYC CHS, an annual telephone survey of approximately 10,000 adults (18 and older) from all five boroughs of NYC, in order to better understand the health and risk behaviors of New Yorkers and to track key indicators over time.

[11] The date range is set to account for time to complete lab draws, which the EMA does not count as linkage to care. All individuals must have a confirmation visit.

2. *GY16 EIIHA Plan contributions to achieving NHAS goals.* The EMA has employed the HIV Care Continuum as a tool to frame the planning and delivery of all services in the EMA to advance the goals of the NHAS: 1) reduce new HIV infections; 2) increase PLWHA access to care and improve health outcomes; 3) reduce HIV-related health disparities and health inequities; and 4) achieve a more coordinated national response to the HIV epidemic. By increasing HIV testing and linkage to medical care, the EIIHA Plan helps the EMA in achieving the first three goals. These activities address the crucial initial stages of the HIV Care Continuum, increasing the number of PLWHA who are aware of their status and linking them to HIV primary care. Because testing programs encounter people previously diagnosed with HIV who have fallen out of care, these programs can also re-connect people to care and could lead to an increase in the number who are retained in care. The provision of services designed to address the unique needs of target populations helps to reduce HIV-related disparities. These activities also support the NY EMA's Comprehensive Plan. DOHMH contributions to achieving the fourth goal include increased collaborations and provision of capacity building, training, and education to health departments and agencies across the country through two capacity building assistance (CBA) grants from the CDC. This involves sharing best practices from around the country, and leads to better coordination of the national response.

3. *GY16 EIIHA Plan contributions to achieving White House Continuum of Care Initiative goals.*

- *Innovative approaches.* In December 2013, NYC was highlighted as one of three metropolitan areas making strides to address the three goals of the White House's HIV Care Continuum Initiative to: 1) reduce new infections; 2) increase access to care, and 3) optimize health outcomes and reduce HIV-related health disparities.[xiv] The White House specifically cites the efforts of NYC in increasing the number of individuals tested for HIV, reducing the number of new infections, and increasing the percentage of PLWHA with an undetectable viral load. DOHMH proposes to further these efforts with the following innovative approaches to addressing barriers to accessing testing and treatment:

a) *"Status neutral" approach.* The DOHMH will continue efforts started in 2015 to integrate HIV prevention and care services. Many HIV-positive and negative individuals need similar services, particularly with the expanded adoption of PrEP and PEP, which include linkage to medical care, benefits navigation, and support to remain in care. As such, DOHMH is taking a "status neutral" approach—ensuring that all individuals, regardless of HIV status, receive these essential services. The CDC recently funded DOHMH to implement a demonstration project to increase PrEP support and to expand data-to-care capacity for HIV-negative and positive MSM. Through this project, DOHMH will expand the role of its STD clinics in supporting HIV prevention efforts, which will build internal capacity to administer PrEP and ARVs. Ultimately, the proportion of high-risk MSM receiving and adhering to PrEP will increase as will the proportion of HIV-diagnosed MSM who are virally suppressed. Further, in GY16, DOHMH plans to fund CBOs to expand access to PrEP and PEP.

b) *Enhanced community-level testing.* DOHMH will implement a demonstration project, funded through CDC, to enhance *Brooklyn Knows*, the Brooklyn-based HIV testing collaborative within *New York Knows*. The project aims to improve coordination of HIV prevention and care services, with a targeted focus on Black and Hispanic MSM. All Brooklyn-based, RW-funded CCPs will be integrated into the collaborative and their care coordination model will be adapted for HIV-negative persons, further expanding upon DOHMH's "status neutral" approach (described above). Participating agencies will conduct critical targeted outreach and navigation for HIV-positive and negative MSM of color. Ultimately, the enhanced *Brooklyn Knows* collaborative will address Brooklyn-specific challenges to implementing HIV prevention and care activities by improving coordination among providers and building providers' capacity to provide a wide-range of coordinated healthcare services.

c) *ETE.* In April 2015, the NY Governor's *ETE Blueprint* was released. The BHIV's Assistant Commissioner Dr. Demetre Daskalakis and Deputy Commissioner Dr. Jay Varma served as core

members of the Governor's Taskforce and its Prevention Sub-committee. The NY EMA continues to implement the *ETE Blueprint* by expanding HIV testing; improving HIV treatment engagement, retention, and adherence among PLWHA; and expanding the awareness and use of PrEP.

- *Collaborations.* As described previously, DOHMH collaborates with partners at the local and state level to implement EIIHA activities, all of which focus on achieving high retention across the HIV Care Continuum. Through *New York Knows*, DOHMH collaborates with over 200 NYC-based agencies to enhance coordination of HIV prevention and care. Further, DOHMH was actively involved in the development of NY's *ETE Blueprint*, which aims to reduce new HIV infections from 3,000 to 750 by 2020 by testing and linking individuals to HIV care and treatment or PrEP and other prevention services across the state. DOHMH will continue to be actively involved in planning and implementation meetings with HIV providers across the state and will incorporate the Blueprint's goals into all of its HIV prevention and care activities.
- *Gap analysis.* The DOHMH uses the first two stages of the HIV Care Continuum (HIV-diagnosis and linkage to care) as a means of targeting services and implementing continuous quality improvement (CQI) in all testing programs (*described on pp. 4-7*). Over the last few years, the percentage of individuals concurrently diagnosed with HIV and AIDS has remained stable while overall diagnoses declined, which indicates that while the EMA is not missing people, more must be done to identify people earlier. DOHMH utilizes this data to inform all testing, medical, and support services. In addition, DOHMH has begun to analyze retrospective data on PLWHA who die within 12 months of diagnosis to better understand system-wide barriers to testing and treatment.

4. *Unmet need estimate and activities and relation to EIIHA planned activities.* According to the New Unmet Need Methodology, based on the NYC HIV Care Continuum, (*p. 18*), 48% of PLWHA have unmet need. The EMA's unmet need data is used to inform the EIIHA Plan's activities including the geographic distribution of EIS programs, how the FSU engages those out of care, and how the CCPs employ return-to-care activities for clients disengaged from HIV primary care. TCC programs engaged homeless and unstably housed PLWHA while n-MCM programs work with those recently released from incarceration to support engagement in care. Findings from the Unmet Need estimate also helped to identify populations for the second tier of targeted testing activities (*pp. 10-12*).

5. *Influence of GY15 EIIHA Plan on development of the GY16 EIIHA Plan.* The implementation of the GY15 EIIHA Plan and its outcomes were critical to the development of the GY16 EIIHA Plan. In 2014, administrative oversight and program monitoring for all testing contracts was consolidated under the HIV Prevention Program's Diagnostics Unit. This has allowed for provision of focused TA across all testing contracts. As testing policies change and testing technology improves, all testing contracts benefit from the same policies, communication, and TA. Additionally, reductions in GY14 led to discussions with the PC and a decision to re-bid the entire category in GY16, with an emphasis on using RW funding to enhance linkage activities and targeted testing programs, while using CDC funding to expand HIV testing capacity for clinical facilities and hospitals.

In the coming year, Project Officers (POs) will continue to provide TA to contracts with a focus on targeted outreach to those most at risk, identifying those who test positive, and linking them to care. In GY15, some testing contracts continued to have challenges with identifying PLWHA who are unaware of their status and with linking them to HIV primary care. Some agencies may need to broaden the populations that they target for testing while other agencies need to strategically focus on a higher-risk population. POs work with agencies to review the demographics and risk factors of those tested through targeted testing and to use this information to better target higher risk groups. Additionally, POs provide TA on data monitoring, which helps agencies evaluate their work. Agencies that have co-located HIV care generally have higher linkage to care rates than agencies that refer for care. TA is provided to CBOs on developing and maintaining strong Memoranda of

Understanding (MOUs) and protocols with clinics and hospitals that provide care. POs work with agencies on strategies to increase linkage, such as utilizing motivational interviewing and strengths-based counseling beginning at the preliminary positive test. In order to share best practices for both finding positives and linking them to care, POs will work with subrecipients to increase peer-to-peer consultation and share best practices at biannual subrecipient meetings.

6. Planned efforts to remove legal barriers to routine HIV testing. The EMA continues to work with the NYS DOH, NYS legislators, and regulatory agencies to remove legal barriers to routine HIV testing. In 2010, legislation was passed to expand the options available to obtain consent for HIV testing, including the use of documented oral consent with rapid testing (any HIV test that can produce results in sixty minutes or less), and/or integration of consent for HIV testing with the general consent for medical care. While these changes to the HIV testing law have resulted in an increase in testing volume,[xv] barriers to routine HIV testing still exist. In settings where multiple HIV testing technologies are used, providers can become confused when attempting to match the appropriate consent option with the HIV testing technology. Effective April 1, 2014, additional amendments to NYS Public Health Law were enacted that allow for documented oral consent for an HIV test, regardless of test type in settings other than correctional facilities. In 2015, the Public Health Law was further amended to remove the requirement of written consent in correctional facilities.

7. GY16 EIIHA Plan Target Populations. The three selected distinct target populations are: 1) Black men and women (including transgender women), 2) Hispanic men and women (including transgender women), and 3) MSM (including YMSM of color).

- *Populations targeted.* The three populations were chosen to align with national and local priorities, and make up three of the six targeted populations highlighted in the NHAS. In 2014, Blacks and Hispanics accounted for 75% (43% and 32%, respectively) of all new HIV (non-AIDS) diagnoses in the EMA. MSM, including Black and Hispanic MSM, made up 61% of all new HIV diagnoses in the EMA. In total, these three groups accounted for 95% of the 2,230 new HIV (non-AIDS) diagnoses reported in NYC in 2014.
- *Specific challenges with or opportunities for working with the targeted populations.*

a) Black men and women. According to the 2013 CHS, only 50.8% of Black adults in NYC were estimated to have had an HIV test in the past 12 months. In 2014 in the EMA, Black men and women made up 43% of the new HIV diagnoses, more than any other racial/ethnic group. These proportions indicate a continued need for targeted EIS including HIV testing services. The Black community is highly diverse, and several subpopulations within this community, including low-income individuals, substance users, MSM, transgender women, and individuals who are foreign-born have a higher risk of being diagnosed with HIV. Some of the challenges experienced by Blacks include stigma associated with HIV, cultural and language differences, and low self-perceived of risk for HIV. Substance users may experience additional stigma related to drug use and fear of law enforcement, impeding their willingness to seek testing and medical services and inhibiting their disclosure of risk behavior to service providers. People who are foreign-born, especially those who are undocumented, may delay seeking HIV testing and care services because of stigma associated with HIV, isolation, and fear of exposure and potential deportation, in addition to differences in culture and language. In the coming year, DOHMH will further develop partnerships with churches and other houses of worship to promote testing within the Black community.

b) Hispanic men and women. The 2013 CHS indicates that 41% of this population received an HIV test in the previous 12 months, with women more likely to have a test than men. In 2014 in the EMA, Hispanic men and women made up 32% of the new HIV diagnoses, just behind Black men and women. Similar to Black men and women, there is considerable diversity among this population, with certain subpopulations at greater risk for HIV acquisition. These subpopulations include

individuals who are foreign born, substance users, heterosexuals at high behavioral risk, transgender women, and MSM. Some of the challenges in seeking HIV testing and medical services experienced by this target population include HIV stigma, cultural and language differences, fear of deportation (for those undocumented), and lack of perceived risk for HIV. Hispanic substance users face similar challenges as other substance users (described above).

c) *MSM*. Sixty-three percent of new HIV diagnoses in the EMA in 2014 were among MSM, more than any other transmission risk group. National data indicate that young MSM (YMSM) ages 13-24 years old, particularly YMSM of color, are at the highest risk for acquiring HIV. This holds true in the NY EMA, making them a targeted subpopulation of the overall EIIHA Plan. Research has shown that stigma and discrimination due to race and sexual orientation and lack of access to culturally competent services among MSM of color are barriers to HIV testing and medical services.[xvi] Further, some YMSM experience homelessness/housing instability, lack of family support, and limited access to healthcare.

- *Specific activities that will be utilized with the target population.* The EMA's GY16 EIIHA Plan was designed to ensure that services provided to the target populations result in a reduction of the number of undiagnosed and late-diagnosed individuals, and that those diagnosed with HIV promptly access HIV care and treatment. The EMA plans to implement its two-tiered approach to achieve these objectives. As a result of Medicaid-funded and other third party-funded HIV screening in clinical settings and EMA programs supported by RW, CDC, and other funds, the EMA promotes and supports routine HIV screening in all healthcare settings. To maximize the use of funds and to comply with POLR requirements, DOHMH prioritizes RW and CDC HIV testing funding for uninsured clients in healthcare agencies that serve high numbers of Black, Hispanic, and/or MSM clients. Innovative approaches such as social network strategy testing and couples counseling and testing are utilized to reach high-risk populations. A recent qualitative study[xvii] of barriers and facilitators to HIV primary care among vulnerable populations (YMSM, African immigrants, recently released prisoners, and transgender women) in NYC supports the importance of this strategy, highlighting the essential role of CBOs in engaging vulnerable populations in care, specifically referencing their tailored and culturally competent services.

  DOHMH is also using private foundation funding to work with various Federally Qualified Health Centers in NYC to modify electronic health records and work flows to integrate HIV screening with other healthcare services. Best practices and lessons learned from this pilot program will be used to increase routine testing citywide.

- *Specific objectives for each component of EIIHA.*
  - *a)* *IDENTIFY*: Testing programs targeting MSM, Black and Latino women and men, and transgender individuals in non-clinical settings will achieve at least a 1% testing positivity rate for GY16.
  - *b)* *INFORM*: At least 95% of MSM, Black and Latino women and men, and transgender clients who test positive for HIV in GY16 will receive their HIV test result.
  - *c)* *REFER*:
    i. At least 85% of MSM, Black and Latino women and men, and transgender clients who test positive for HIV in GY16 will be referred to partner services and prevention services.
    ii. 8% of MSM and transgender of individuals who have not been diagnosed with HIV and have had sex with a man in the last 12 months will have used PrEP in the last 12 months.
  - *d)* *LINK TO CARE*: At least 85% of MSM, Black and Latino women and men, and transgender clients who test positive for HIV in clinical settings in GY16 will be linked to medical care within 90 days of diagnosis. *(DOHMH will begin working towards the updated NHAS indicator.)*

- *Responsible parties*. Multiple individuals and partners are responsible for the coordination and/or monitoring of the EIIHA Plan activities described below.

a) <u>*DOHMH.*</u> The Deputy Director of HIV Prevention oversees NYC testing-related activities within BHIV across all funding streams. Members of the Prevention Programs Unit and Contract Managers (CMs) from DOHMH's Master Contractor Public Health Solutions-Contracting and Management Services (PHS-CAMS) follow up on coordination, program implementation, and program evaluation. The Director of TA within the Prevention Programs Unit oversees the provision of TA to funded agencies and monitors program activities. The Director of TA coordinates with CMs to ensure funded programs are meeting contractual and programmatic requirements. BHIV POs and PHS-CAMS CMs conduct joint visits to funded agencies in NYC to verify that services are provided as contractually prescribed. The data analyst within the HIV Prevention Program team works with the Deputy Director of Prevention to create and implement a data monitoring and evaluation plan, engaging the PO team in its work with funded agencies.

For the borough-wide testing initiative *New York Knows,* the Deputy Director of Prevention and the *New York Knows* team coordinate with community partners to promote routine and targeted HIV testing. They will also coordinate the activities to support a CDC-funded pilot to promote HIV prevention and care among MSM of color in Brooklyn. The *New York Knows* team tracks the performance of these initiatives and provides TA as needed.

Members of the PO team coordinate with HHC Correctional Health staff on testing services provided on Rikers Island and other NYC jails. The PO team monitors data reported in eSHARE and reviews it with Correctional Health to ensure that eSHARE correctly captures services provided. Similarly, POs coordinate with the BSTD and the FSU and monitor services provided. BHIV staff regularly meets with STD programs to facilitate communication and TA provision.

b) <u>*Tri-County region.*</u> In GY16 Tri-County EIS services will be monitored by the PHS-CAMS (see *p. 51*) with one FTE on site at Westchester County Department of Health (WCDOH) responsible for quality management (QM) and serviced planning, with access to eSHARE linkage data. Tri-County service providers participate in region-wide linkage activities through the NYS *NYLinks* program which seeks to improve linkage and retention in care through regional learning collaboratives.

c) <u>*NYS.*</u> The BHIV regularly coordinates with the NYS DOH AIDS Institute (NYS AI) on efforts to engage PLWHA unaware of their status. DOHMH works with the NYS AI to provide TA to agencies that want to provide testing services in NYC. DOHMH was also an active participant in the discussion with key stakeholders on crafting the Governor's *ETE Blueprint*. DOHMH and the Tri-County health departments will coordinate with the NYS AI to implement the *ETE Blueprint* in the NY EMA.

- *Planned outcomes for target populations resulting from EIIHA Plan activities.* As a result of implementing the EIIHA Plan activities, the EMA expects to achieve outcomes including increased awareness of HIV status and improved linkage to care among the target populations, both HIV-positive and HIV-negative. CHS data will provide DOHMH with an estimate of the percentage of Black, Hispanic, and MSM residents in NYC who have ever tested for HIV. The percentage ever tested for HIV should increase each year for these target populations. Using HIV surveillance data on CD4 cell count and viral load test dates as proxies for medical visits, DOHMH can assess the outcome of linkage to care/initiation of care. DOHMH expects the percentage of those newly positive who initiate care within 91 days to increase for each of the target populations. The Sexual Health Survey will provide DOHMH with an estimate of PrEP awareness and utilization among MSM and transgender women.

8. <u>*Plans to present, discuss, and/or disseminate the EIIHA Plan and outcomes to planning bodies and others.*</u> In the January 2014 supplement of the *Journal of AIDS*, DOHMH and NYS DOH published a series of articles detailing the evaluation of the NYS 2010 HIV Testing Law Amendments. The articles

recount the evolution of HIV testing requirements in NYS and the evaluation of several data sources to assess the law's impact on HIV testing volume. DOHMH submitted an article to *Public Health Reports* on lessons learned in routinizing HIV testing through modifying electronic health records of Federally Qualified Health Centers. The article has been accepted and is pending publication.

In 2014 and 2015, the DOHMH presented the outcomes of the EIIHA Plan to the PC and discussed the future implementation of the EIS service category. Given the changes in insurance coverage and HIV testing, the Grantee and the PC have decided to rebid RW-funded and prevention-funded testing programs in 2016. In the restructuring, Prevention Program funds will support system-level changes to enable routine screening of clients in healthcare settings and RW funds will support the linkage of persons diagnosed with HIV to HIV primary care. Both RW and Prevention Program funds will be used to support testing of targeted populations in non-clinical settings. The GY16 EIIHA Plan and outcomes will be presented to the PC and the NYC HIV Prevention Planning Group (HPG).

b. Unmet Need (*see Attachment 4*).

Current Methodology: Unmet Need Framework

(i-ii) Unmet Need Estimate. In 2014, 36% of people diagnosed, reported, and presumed to be living with HIV/AIDS are not currently in care in the EMA. Unmet need is estimated at 40% among people diagnosed, reported, and presumed to be living with HIV (non-AIDS) and 33% among people diagnosed, reported, and presumed to be living with AIDS (*see Table 4).*

Table 4: Unmet Need Table: 2012-2014

Estimated number and percent of PLWHA with unmet need, NY EMA 2012-2014						
Year	**PLWHA**		**PLWH**		**PLWA**	
2012	38,241	36%	17,168	40%	21,073	33%
2013	38,526	36%	17,367	40%	21,159	33%
2014	39,550	36%	18,060	40%	21,490	33%

Sources: New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC DOHMH, HIV Epidemiology and Field Services Program: 2012 data as of 3/31/2013, 2013 data as of 3/31/2014, 2014 data as of 6/30/2015; Westchester, Rockland, and Putnam counties: NYS Dept. of Health, Bureau of HIV/AIDS Epidemiology: 2012 data as of 3/2013, 2013 case data as of 4/2014 and laboratory data as of 6/2014, 2014 case data and laboratory data as of July 2015.

The Unmet Need Estimate has remained consistent over the last three years due largely to a data lag on those who have died or incomplete data on those who have moved and are receiving care out of the jurisdiction. See *Attachment 4* for information on how the estimate is calculated.

New Methodology: Unmet Need Estimate based on the HIV Continuum of Care Framework

(i-iii) Changes in estimate, difference in estimates; alignment with Current Unmet Need Framework. The Current Methodology defines unmet need as the lack of any evidence of care in the past year, while the New Methodology defines unmet need as the lack of continuous care (at least two visits at least three months apart) in the year, which is a stricter definition of retention. The 36% Unmet Need estimate derived from the Current Methodology has been consistent from 2012-2014. The Unmet Need estimate derived from the New Methodology is higher at 48% (does not include data from the Tri-County region). The difference between the two estimates suggests that a higher percentage of PLWHA are not consistently engaged in care (per the Department of Health and Human Services (HHS) definition for the HIV Care Continuum), though they may be receiving care sporadically, as captured in the Current Methodology estimate.

(iv) Impact on approach to unmet need. The NY EMA has used the HIV Care Continuum to assess unmet need for several years. In the Needs Assessment, approved by the PC in March 2014, the EMA moved from defining unmet need and target populations based on demographic and behavioral risk groups towards exploring the needs of groups who had not moved to the next stage of the HIV Care Continuum, and assessing what approaches would be needed to address those needs. This is one of the many reasons the NY EMA has continued to seek a Core Medical Services (CMS) Waiver and to allocate more resources to support services such as SCF, FNS, and Housing services to meet basic survival needs of PLWHA who have access to primary care services and ARVs through the AIDS Drug Assistance Program (ADAP) or Medicaid, but have other barriers that prevent the consistent and sustained engagement in care and ARV adherence that leads to VLS.

Further, this shift in thinking resulted in the NY EMA's Undetectable Framework to address VLS. As described on *p. 6*, TSRs are sent to providers every six months to: 1) promote ARV initiation and adherence barriers discussions between each client not virally suppressed and their medical provider, and 2) to inform the client's treatment plan to address barriers to care (e.g., housing, MH, substance use, etc.). The vision for the system-wide effort is to ensure that each RWPA client has the resources they need to become virally suppressed.

(v) Data used in Unmet Need framework versus HIV Care Continuum framework. Data to derive the Unmet Need estimates for both the Current Unmet Need and HIV Care Continuum frameworks was pulled from the NYC HIV Surveillance Registry. In both cases, laboratory (CD4 and viral load) test dates are used as proxies for medical care visits.

c. Service gaps. As a component of the Needs Assessment, the PC was briefed on the latest data on unmet need for HIV primary care. The PC also received reports on unmet need in 2015.

(i) Identification of service gaps. Service needs and gaps in service utilization among CHAIN participants are assessed on an ongoing basis. Data from interviews conducted between 2011 and 2013 were analyzed for an updated (2014) report and presented to the PC. The PC triangulates findings from multiple data sources: HIV surveillance; eSHARE reporting on service category performance; eSHARE-surveillance merged analyses on outcomes by service category, client subgroup and overall/cross-portfolio; service utilization data from the RWPA annual Service Category Scorecards[12]; geographic mapping of funded service sites by service category (superimposed on the NYC HIV prevalence map); updates to the *POLR Tool*; CHAIN and DOHMH-conducted consumer surveys; and consumer focus groups, such as the 2013 listening sessions.

(ii) Prioritization of service gaps. Comparing these diverse and complementary data sources, and through dialogue with the analysts providing these reports, the PC is able to identify trends and service gaps that could be filled by RW. This process is used to identify service priorities to reduce unmet need. As part of a multi-year effort to address unmet need, the PC has taken steps in its GY16 Plan to improve linkage to and continuity of care.

(iii) Description of plan to address gaps. The PC's Integration of Care Committee (IOC) has worked diligently to continually update models of care to meet the needs of NY EMA PLWHA, address gaps in the HIV Care Continuum, and adjust to changes in the healthcare system resulting from Medicaid expansion and the ACA. The RWPA services portfolio is carefully designed to meet needs identified through surveillance, RW program evaluation, and CHAIN data. Needs that are identified are addressed through the incorporation of best practices and evidence-based interventions in service models to support effective diagnosis, linkage to and retention in care, and adherence to

[12] The RW Service Category Scorecards are annual summary reports that provide three years of data on spending, services, and client demographics in tabular and graphical format.

ARVs. Activities to address service gaps in the NY EMA, as described based on the stages of the HIV Care Continuum, include:

1. *Individuals diagnosed but not linked to care.* EIS programs work to identify and link newly diagnosed individuals to medical care. In 2014, persons who inject drugs were least likely to be linked promptly to HIV medical care in NYC than people in other transmission risk groups. The EMA dedicated almost 10% of Part A funding to meet the needs of substance users through HR programs in GY15. MH advocacy services also assist with engaging and keeping vulnerable clients in care. These programs address unique challenges of PLWHA less likely to be linked to care, including stigma and other competing issues.
2. *Individuals previously not retained in care and individuals who are not currently virally suppressed.* Among both RW clients in NYC (2014) and in Tri-County (2013), Blacks and Hispanics were more likely to be retained in care, while individuals aged 20-29 were less likely to be retained in care. In both NYC and Tri-County, VLS rates among RW clients were lowest among Blacks, individuals aged 20-29, and persons with likely exposure to HIV through injection drug use. See pp. 15-16 for unique challenges for these populations. Through successful tailoring and placement of services, these groups are highly represented among RWPA clients in the EMA. Additionally, in GY14, almost 52% of CCP clients were Black. The EMA's care coordination model provides a comprehensive set of services, including health promotion, patient navigation and accompaniment to appointments, re-engagement in care procedures, and DOT, to ensure engagement in care and ARV adherence for those presenting to the program as newly diagnosed, disengaged from care and/or virally unsuppressed. For GY16, the PC allocated 34.1% of funding to support MCM and n-MCM services. Navigation services are also offered through FNS programs, and EIS programs also provide some re-engagement activities. Outreach to disengaged PLWHA often requires specialized engagement efforts in non-traditional venues with unconventional strategies, especially for those with substance use and MH issues.

d. Minority AIDS Initiative (MAI)

(i) Identification of minority populations. As described in earlier narrative, low-income communities of color are disproportionately affected by HIV in the EMA. The EMA strategically uses MAI funding to reduce health disparities, increase service access, and improve health outcomes for underserved minority PLWHA including Black, Hispanic, and Asian men and women. In GY14, the populations served by the MAI program were 60% Black, 31% Hispanic, and approximately 1% Asian. Women (including transgender women) of color represent 55% of all MAI clients in the NY EMA. It should be noted that the entire RWPA grant in the NY EMA could be considered an MAI grant – 92% of all RWPA clients in the EMA identify as Black, Hispanic, Asian/Pacific Islander, Native American/Alaskan Native, and/or multi-race. The NY EMA strives to use all of its resources to address HIV health disparities associated with race/ethnicity – particularly among Black and Hispanic populations, who experience the greatest disparities, and account for 90% of all people served by RWPA (while making up 76% of PLWHA in the NY EMA).

(ii) MAI activity descriptions. The GY16 MAI funds have been allocated to program services in four service categories to reduce barriers to care among minority populations and engage them in care: Outpatient/Ambulatory Health Services (ADAP Plus), 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. The MAI program service models do not vary from the same service categories in the RWPA program portfolio; rather, the MAI program prioritizes communities where disproportionately burdened minority populations live. The EMA applies the eligibility criteria below to ensure that MAI funds are directed to high-need communities. Each MAI-fundable agency/program (except ADAP Plus) must:

- Direct its services to residents of ZIP code areas with 150 or more reported living HIV/AIDS cases among the MAI target 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 targeted populations; and
- Demonstrate that at least 75% of its current active clients who receive HIV/AIDS services are from the MAI target populations.

(iii) Impact of MAI on improving health outcomes. The agencies/programs that receive MAI dollars are particularly well situated to provide services to MAI populations and have historic ties to the communities they serve. This is evident in the outcomes reported among these providers on standard measures. In GY14, MAI CCP clients showed high levels of retention in care (based on the 2010 NHAS definition: two visits at least 91 days apart, in the 12-month period), with 95% retained. Among clients on ARVs, optimal adherence was the norm, with 89% of clients showing at least 95% adherence at their last assessment in GY14. NY EMA testing programs are all required to provide and routinely report on linkages to HIV primary care for individuals newly diagnosed in the programs or entering the programs as known positives disconnected from HIV care. In GY14, MAI EIS programs linked 96%, and Base EIS programs linked 81%, of newly diagnosed clients to HIV primary care within three months of diagnosis. In addition, MAI EIS programs re-engaged 97% of known out of care PLWHA within three months.

e. Special Populations and Complexity of Providing Care. Many PLWHA in the EMA have co-morbid conditions that compromise health and increase the cost and complexity of their HIV care. Among PLWHA in the 2014-2015 CHAIN cohort in NYC, 93% percent suffer from at least one non-HIV-related chronic condition, and 77% report at least two additional conditions, such as hypertension, heart disease, or HCV. Having one or more co-morbid conditions increases the average number of annual ambulatory clinical and acute care visits (both inpatient and emergency department) among CHAIN participants, increasing the costs of healthcare. In a CHAIN mortality study, heart disease, substance use, and cancer were among the leading non-HIV-related causes of death. Non-HIV-related death rates in the CHAIN cohort remained in excess of those in the uninfected general population matched by age, gender, and race/ethnicity.[xviii]

In 2010, the DOHMH Division of Disease Control was funded by the CDC for Program Collaboration and Service Integration (PCSI) to enhance collaboration across DOHMH programs working on HIV/AIDS, viral hepatitis, sexually transmitted infections (STIs), TB, and later, the A1C (diabetes indicator) registry. Preliminary analyses of an October 2015 data merge suggest that 22.5% of RW clients served between January 2010 and December 2014 had a first positive antibody test or positive RNA test for HCV reported to DOHMH between January 1, 2000 and December 31, 2013; and 14.0% of RW clients with at least two A1C test results between January 1, 2006 and December 31, 2013 showed an A1C level of 6.5% or higher (indicating diabetes). This data can be used to: 1) target linkage and outreach efforts, 2) inform client health promotion materials; 3) design population-specific RWPA programs; and 4) inform trainings/TA for providers.

(i) Emerging Populations. As a jurisdiction with a widespread and mature epidemic, the EMA has observed a relatively stable demographic breakdown of PLWHA and those in need of RW services, over the past decade or more. The Grantee and PC regularly monitor HIV surveillance trends, service utilization trends, and other data sources that continue to show that HIV disproportionately affects low-income communities of color; gay, bisexual, and other MSM (with increased disparities among YMSM and MSM of color of all ages); and transgender women, particularly transgender women of color. As the impact of HIV on the above populations has been known to the EMA, none could be considered emerging. Thus, the NY EMA has not identified any new emerging populations for this application. Instead, the EMA has focused on shifts in the proportions (overall and in

subpopulations) achieving specific stages in the HIV Care Continuum, as indicators of where resources might need to be refocused.

(ii) Populations Under-Represented in RW System. In 2014 in NYC, Whites accounted for almost 21% of all PLWHA but represented less than 9% of all Part A clients. Additionally, the RW population includes a lower proportion of males, residents of Manhattan or Queens, and PLWHA with likely MSM transmission, as compared with the overall PLWHA population. The EMA has determined that these utilization patterns likely reflect sociodemographic differences in need and eligibility for local RW services, rather than gaps in the care system. White PLWHA have greater average household income and healthcare access resulting from coverage by other payers of HIV medical care services. Ongoing work through *New York Knows*, coordinated with NYS, seeks to further engage Manhattan and Queens PLWHA through regional testing, linkage, retention and adherence efforts coordinated with the RWPA program.

(iii) Profile of PLWHA with co-morbidities (see Attachment 5).

(iv) Effect of co-morbidities and co-factors on cost and complexity of HIV care.

1. *Sexually Transmitted Infections (STIs).* Untreated STIs increase the risk of sexual HIV transmission.[xix] In 2014, NYC's STI case rates were highest in neighborhoods with high HIV prevalence; Central Harlem and Chelsea have high rates of gonorrhea and primary and secondary syphilis, and chlamydia rates are high in the South Bronx. Key STIs are on the rise in NYC, though the rate of increase for some infections has slowed in recent years. In 2014, approximately 59,400 new chlamydia diagnoses were reported in NYC. There were 14,000 new diagnoses of gonorrhea reported in 2014; the largest increases in gonorrhea were seen among adolescent and young adult men of color. Since 2000-2001, primary and secondary syphilis has increased six-fold in NYC, with most new cases among MSM. In 2014, 97% (1,272 of 1,307) of primary and secondary syphilis diagnoses were among men, 79% of who were MSM. Among MSM with syphilis whose HIV status was known, 59% were HIV-positive.

STIs in Tri-County mirror patterns in NYC. In counties where there is an elevated HIV prevalence, the prevalence of STIs is also higher. In Westchester County, for example, the chlamydia rate has reached 337.2/100,000, almost eight and a half times the Tri-County rate of 40/100,000.

Average lifetime treatment costs are estimated at $709 (range, $355–$1064) for each case of syphilis and for gonorrhea, $79 (range, $40–$119) for each male case and $354 (range, $177–$531) for each female case.[xx] STIs increase future HIV treatment costs by facilitating the spread of HIV.

2. *Prevalence of homelessness.* The EMA has a longstanding history of 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.[xxi]A steady decline in the number of affordable rental apartments in NYC has been recorded in recent years. Between 2005 and 2012, after adjusting for inflation, rents rose by 11% while renters' incomes stagnated.[xxii] More than 116,000 unique individuals accessed the NYC shelter system in FY2014.[xxiii] Data from the annual HOPE Street Survey in 2015 suggests that an additional 3,183 homeless individuals were unsheltered.[xxiv] Studies show that the large majority of street homeless New Yorkers are individuals living with MH issues or other severe health problems.[xxv] Four out of five street homeless in NYC are men, and Blacks and Hispanics are disproportionately affected by homelessness: 57% of NYC homeless shelter residents are Black and 31% are Hispanic.[xxvi]

The prevalence of homelessness among PLWHA is especially high. In the most recent cohort surveyed (NYC, 2014-2015), 12% of CHAIN participants reported currently being homeless or in temporary/transitional housing, while an estimated 54% reported not having a regular place to live at some point in their lives; 55% experienced housing instability during the year in which they were diagnosed with HIV. Housing instability and homelessness were even more prevalent among HIV-positive RW clients served in 2014; 30% of those assessed reported unstable housing during the year,

and 24% met the definition of homelessness. Among those in HIV medical care, 66% of unstably housed clients were virally suppressed in 2014, compared to 79% of those with stable housing. When hospitalized, homeless individuals in NYC stay 36% longer than other hospital patients additional costs average more than $10,000 per hospitalized homeless individual.[xxvii]

The provision of housing assistance and support services significantly reduces the costs associated with homelessness and improves health outcomes. One study observed that the average monthly healthcare and public service costs for chronically homeless individuals fell more than 80% following the provision of housing, substance use treatment, and other needed services.[xxviii] Out of care PLWHA enrolled in CHAIN who receive housing assistance are more than three times as likely to enter HIV primary care as those not receiving assistance, and are 30% more likely than other unstably housed PLWHA to remain in care that meets clinical practice standards.[xxix] A recent study demonstrated that NY EMA Housing Opportunities for Persons with AIDS (HOPWA) clients enrolled in supportive housing programs experienced improved retention in care and viral suppression.[xxx] Additional funding for Part A Housing services was requested in GY16 to support engagement and maintenance in care and improve health outcomes.

3. *Formerly incarcerated individuals.* From 2012-2014, approximately 240,000 people were released from NYS prisons and local jails to the EMA. Of those released, an estimated 14,000 were PLWHA. Over two-thirds of NYS inmates return to NYC and reside in seven ZIP codes where new diagnoses and HIV prevalence are high.[xxxi] Nearly half (52% in NYC, 45% in Tri-County) of CHAIN participants report having ever been in jail or prison, with 9% in NYC (9% in Tri-County) experiencing incarceration during the year in which they were diagnosed with HIV. Individuals released from jails and prisons experience more chronic diseases and drug use compared to those who have not been incarcerated.[xxxii]

In 2014, over 2,700 people who report living with HIV were incarcerated in NYC jails; 2,300 received a discharge plan and about 75% (1,725) were released to the community with a plan.[xxxiii] In the first quarter of 2015, over 80% of those linked to care were maintained in care for at least 90 days. Three NYC districts identified as having the highest number of people returning home from NYC jail are the same areas identified by DOHMH as having among the highest rates of new HIV diagnoses: Central Brooklyn, Central/East Harlem in Manhattan, and the South Bronx. In 2014, approximately 80,000 people were released from NYS prisons and local jails to the EMA. Of those released, an estimated 3,760 (4.7%) were PLWHA and primarily returned to the same areas listed previously.

A recent cost analysis found that the mean annual cost to achieve HIV viral suppression among formerly incarcerated individuals is $8,432.[xxxiv] These high costs may be attributable to the challenges that formerly incarcerated people often face when released, including high rates of recidivism, 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.

4. *MH issues.* Approximately 24% of NYC CHAIN participants surveyed during 2014 and 2015 had very low scores on a standardized MH functioning measure (indicating MH issues). Among RW clients in NYC enrolled and served in 2014, nearly 29% of those assessed in the year had at least one very low MH functioning score (<37.0 out of 100), while 49% scored below the diagnostic cutoff for depression (<42.0 out of 100). According to CHAIN, of the 59% of sampled PLWHA in NYC who indicated a need for MH services, 25% were not receiving such services. In GY14, Part A spent $5.1 million on MH services for PLWHA, a reduction from GY13. This was not due to a decrease in MH service needs, but was instead due to an increase in services billed to Medicaid. In GY15 and in the spending plan for this application, the PC reduced the allocation to MH services, acknowledging the

significant investment by Medicaid of over $430 million for MH services for PLWHA on Medicaid. Additional funding sources, including RW Parts B and C and the Substance Abuse and Mental Health Services Administration (SAMHSA), infused millions of dollars for MH services into the EMA's healthcare system *(see Attachment 6)*.

5. *Substance use.* The EMA's efforts to manage its HIV epidemic are complicated by a high prevalence of drug and alcohol use (an estimated average of 8.2% in the EMA's general population).[xxxv] This appears to be higher in the RW population, with a significant impact on clinical outcomes. Among RW clients enrolled and served in 2014, 18% of those assessed in the year reported recent hard drug use; among RW clients with some evidence of HIV medical care, 60% of those who reported recent hard drug use during the year were virally suppressed, compared to 79% of those who did not report recent hard drug use. Part A funding supports HR services to engage those actively using substances, with the goal of reducing the harmful effects of substance use. In GY14, Part A spent just over $8 million on HR services for PLWHA. SAMHSA, Medicaid, and RW Parts B, C, and D supported substance use services in the EMA during the same period *(see Attachment 6)*.

6. *Hepatitis C Virus (HCV).* Incidence and prevalence of HCV are difficult to estimate because of the asymptomatic nature of the disease. The majority of new infections occur among people in high-risk groups with tenuous connections to healthcare including people who inject drugs and MSM who are co-infected with HIV. An estimated 50% of people with HCV are unaware of their infection, and roughly 16% of PLWHA in NYC are co-infected with HCV.[xxxvi] The HCV-HIV co-infection rate among RWPA clients is 22.5%. HCV-HIV co-infection can lead to higher viral loads and accelerate the onset of HCV-related complications, including cirrhosis and end-stage liver failure, particularly among those whose HIV is not well-managed. The newer HCV medications that are able to provide individuals with a cure are prohibitively expensive (upwards of $80,000-$100,000 for a course of treatment) to many middle and low-income individuals, even those with insurance. Currently, NYS ADAP covers only the older HCV treatments for HCV-HIV co-infected individuals, and none of the newer medications, leaving coverage for the newer, more effective HCV treatments to drug company assistance programs. DOHMH is reviewing the range of payers that help to cover HCV treatment costs (e.g., Medicaid, Patient Assistance Programs, public-private partnerships) to inform next steps.

7. Tobacco Dependency. Despite record low prevalence of smoking in NYC (less than 14%), pockets of heavy tobacco use and dependency persist among several populations, including PLWHA.[xxxvii] In addition to the commonly known negative health effects of tobacco use, PLWHA are at additional risk for HIV-specific negative health outcomes. A recent analysis conducted by evaluators at DOHMH found that recent tobacco smoking was reported by 40% (n=5,942) of a sample of 14,713 PLWHA enrolled in RWPA programs in NYC. Recent tobacco smoking was independently associated with low CD4 cell counts and unsuppressed viral load, even after controlling for several clinical and sociodemographic characteristics, including substance use and ARV prescription status. Further, previous studies that have found increased risk for some cancers and HIV opportunistic infections related to tobacco use, regardless of viral load and CD4 count. In studies exploring tobacco dependency and behavioral health, tobacco use is associated with worse substance use treatment outcomes and increased depressive symptoms. [xxxviii]

Despite mounting evidence of the poor health outcomes among PLWHA who smoke, studies show that tobacco smoking is not routinely addressed by HIV service providers, including support service providers such as those in RW-funded MH or HR services. Concurrently treating tobacco dependency along with medical and behavioral health can increase the cost and complexity of treating HIV, but provides significant short- and long-term health benefits. To this end, the EMA prioritized smoking cessation for PLWHA in GY14, GY15 and continuing in GY 16 by encouraging

providers to screen and refer PLWHA to appropriate tobacco dependency services and allow for the treatment of tobacco dependency concurrently with other MH and HR services to ensure the full needs of the client are met.

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

METHODOLOGY

(1) Impact of Funding.

a. Impact of the Affordable Care Act (ACA). Though NYS Medicaid covered individuals with incomes below 100% of the federal poverty level (FPL) before the implementation of the ACA, expanded health insurance coverage options provide further opportunities for PLWHA. These changes affect health insurance coverage options in the jurisdiction, as well as RW service needs, and how those services are provided. In addition, these new options require specific outreach and enrollment activities to ensure that people eligible for healthcare coverage are expeditiously enrolled and coverage is maintained.

(i) Table 5: NY EMA Uninsured and Poverty

Diagnosed and reported PLWHA in NY EMA (N = 124,471)	**# of PLWHA**	**% of PLWHA**
a1. PLWHA in the NY EMA enrolled in Medicaid	39,881	32.0%
a2. PLWHA in the NY EMA enrolled in Medicare and Medicaid/Medicare (dual eligible)	12,335	9.91%
a3. PLWHA in the NY EMA enrolled in marketplace exchanges	3,085	2.8%
b. PLWHA in the NY EMA without any insurance covered	13,705	11.0%
c. Active RW Clients in the NY EMA, GY14 (n=16,687)		
c1. PLWHA in the NY EMA living at or below 138% of 2015 FPL	14,860	89.1%
c2. PLWHA in the NY EMA living at or below 400% of 2015 FPL	16,311	97.7%
c3. PLWHA in the NY EMA living at or below 435% of 2015 FPL*	16,329	97.9%

Sources: Data in sections a. and b. provided by NYS DOH to NYC DOHMH. The numbers and corresponding percentages reflect insurance program enrollment and FPL available through June, 2015. Data in section c. derived from NY EMA Active RW Client Data collected in eSHARE. (RW provider-reported) FPL data available through February 2015.

* Residents with income under 435% FPL are eligible for RW services. This requirement for RW in the NY EMA remains unchanged. There are no income restrictions for EIS services or HE/RR.

(ii) Impact of Insurance Expansion. In the lead-up to the effective dates for provisions of the ACA, DOHMH underwent extensive work to assess which provisions might affect consumers and providers in the EMA and how to help them adapt to the changes. The CTP dedicated one staff person to assist providers and develop consistent communication (notices to providers, presentations, and a biweekly policy newsletter) on ACA-related issues relevant to RW-funded providers. Major provisions of the ACA were reviewed to assess whether they might impact the insurance status and/or the services available to consumers in the NY EMA, in light of the RW POLR requirement and RW provider requirements to ensure clients are appropriately enrolled in coverage, at intake and reassessment (every six months).

Regional breakdowns of reductions in Medicaid spending by service category are available but are based on the state's economic development areas. For the NY EMA, data are available for NYC, and information for Westchester, Rockland, and Putnam is combined with information from other counties that comprise the Mid-Hudson Valley. Through June 2015 of the current state fiscal year (SFY2015-2016), Medicaid state and county spending in NYC was $293.5 million higher than the previous state fiscal year.[xxxix] This increase is consistent with projections and trends among states that expanded Medicaid eligibility.[xl]

1. *Continued service to PLWHA covered under the ACA.* The PC began work to address changes in the healthcare system beginning in 2011, with the development of its first CMS Waiver application and directives for n-MCM and SCF service categories. Early predictions, since proven accurate, were that there would continue to be demand for RW and ADAP to fill gaps in Medicaid coverage for PLWHA in need.[xli] As such, additional shifts were made in funding allocations to Housing, FNS, and SCF, to address the anticipated increase in coverage of core medical services through other payers. Provisions of the ACA led to some increased insurance access for RWPA clients in two ways: 1) through Medicaid expansion and 2) through the availability of health insurance plans for purchase on the NYS of Health Marketplace (NYS of Health). Although there was greater access to insurance coverage due to Medicaid expansion, increases were relatively modest because NYS Medicaid previously covered people with income up to 100% of FPL. However, as anticipated, fewer people were served by the State's HIV Uninsured Care Program (HUCP) during the past year than in previous years because they achieved more rapid Medicaid enrollment, and thus had shorter gaps in Medicaid coverage, through web-based expanded Medicaid access.
2. *Health Insurance co-pay coverage.* The NYS AI's HUCP continues to be a resource for those who need assistance with health insurance premiums and copays. Approximately 3,085 participants have insurance coverage purchased through the NYS of Health. The PC and the Grantee continue to communicate with the HUCP to determine whether Part A funding is needed for this service; no funding is needed at this time.
3. *Major categories of service still provided under RWPA for those covered under ACA.* Table 6 below outlines the services that have been specifically designed to address gaps in the system of care that would otherwise be left out by the implementation of the ACA and expanded Medicaid.

Table 6: Service Gaps Filled (by service category)

Service Category	Service Provided	Gap Filled
MH Services (MH)	MH Advocacy	Services include engagement in MH care (including care funded by Medicaid and the health insurance exchanges) and coordination of MH care with medical providers.
Harm Reduction (HR)	All	Services to reduce the harm of substances for those using substances and those that are currently not reimbursed by Medicaid.
Medical Case Management (MCM)	Adherence Support Services	HIV treatment adherence-specific services to Medicaid Health Home clients (this service is not included in the Health Home program).
Non-Medical Case Management (n-MCM)	All	Services are not reimbursable by Medicaid.
Supportive Counseling and Family Stabilization (SCF)	All	Services are not reimbursable by Medicaid.
Oral Health Services	All	Services fill gaps in the Medicaid Oral Health Plan.
Food and Nutrition Services (FNS)	All	The majority of services are not reimbursable by Medicaid.
Legal Services	All	Services are not reimbursable by Medicaid.
Housing	All	Emergency rental assistance, housing placement and transitional housing assistance are available for those without another payer.

4. *Ways RWPA programs are serving individuals who were not previously clients.* Eligibility requirements for RW in the NY EMA remain unchanged, with residents with income under 435% FPL eligible for RW services. There are no restrictions on EIS services in order to reduce barriers to finding those who do not know their status, and no restrictions on HE/RR services to ensure that all PLWHA receive health education. A review of 2014 eSHARE data showed that 24% of clients who received a service were new to the RW Program, the majority of new clients were covered by Medicaid/Medicare (61%) followed by those uninsured (16%) and those with ADAP/ADAP Plus (13%). PLWHA may newly enter the RWPA program for a variety of reasons such as income changes, relocation to the EMA, a new HIV diagnosis, or a newly identified service need. The expansion of general n-MCM, which is a low-threshold client assistance and navigation service, may have brought previously eligible clients to RW for the first time.

(iii) Outreach and Enrollment. DOHMH worked closely with all providers to update them on *Policy Clarification Notices (PCN) #13-01* and *13-04* requiring subrecipients to pursue health insurance enrollment (including Medicaid) for all clients at intake assessment and reassessment (every six months) and to document enrollment efforts for all eligible clients. Since a subset of consumers (approximately 10% of RW clients) were expected to be newly eligible for Medicaid, DOHMH prepared a *Dear Colleague* letter advising providers that clients may be newly eligible for Medicaid and requiring clients to be referred to state-funded navigator programs to assist with enrollment. The letter was followed by presentations at all RW service provider meetings. The letter and presentations highlighted that non-enrollment could result in tax penalties for clients, and provided information on open enrollment and special enrollment periods. Finally, provisions requiring RW providers to assess possible client eligibility for expanded Medicaid and either assist clients with enrollment or refer clients to a navigator were added to all contracts, per HRSA policy.

In order to keep abreast of available outreach and enrollment resources, DOHMH kept close contact with State partners who were administering the state-funded navigator programs and trainings for Certified Application Counselors, as well as managers of the NYS of Health website. Further, DOHMH attended a variety of community forums sponsored by various community partners, including the National Black Leadership Commission on AIDS, and presented information about the effects of the ACA.

(iv) Marketplace Options. NYS is operating its own exchange for the purchase of Qualified Health Plans (QHPs) for eligible New Yorkers—the NYS of Health (nystateofhealth.ny.gov). Consumers with incomes from 138%-250% FPL may be eligible for some premium and cost-sharing assistance. According to GY15 NY EMA client income data, approximately 7% of NY EMA RW clients are potentially eligible to purchase a QHP. In January 2016, NYS will begin to offer a Basic Health Plan (BHP), which will be available to New Yorkers with incomes from 133% to 200% FPL. This plan will have the same actuarial value as a Bronze plan and will include all essential health benefits. The BHP premium is expected to be substantially lower than that for a QHP. According to GY15 NY EMA client income data, approximately 10% of NY EMA RW clients are potentially eligible to purchase a BHP. The NY EMA will monitor the effects of the BHP rollout on PLWHA in the jurisdiction.

Individual plans vary in terms of in-network providers and pharmacy benefits. As provider decisions to accept insurance products are subject to change, clients are encouraged to consult their current healthcare provider to determine if a plan that they are considering is accepted. Clients are also encouraged to check the plan websites to determine if their current medications are covered, and at which level. *Table 7* provides an overview of the plans available by county.

Table 7: 2015 NYS of Health Plan Availability by County – Individual Market

County	Affinity Health Plan	EmblemHealth	Empire BlueCross-BlueShield	Fidelis Care	Healthfirst New York	Health Republic	MetroPlus Health Plan	MVP Health Plan	North Shore LIJ	Oscar Insurance	United Healthcare	Wellcare
Bronx	✕	✕	✕	✕	✕	✕	✕		✕	✕	✕	✕
Kings	✕	✕	✕	✕	✕	✕	✕		✕	✕	✕	✕
New York	✕	✕	✕	✕	✕	✕	✕			✕	✕	✕
Queens	✕	✕	✕	✕	✕	✕	✕		✕	✕	✕	✕
Richmond	✕	✕	✕	✕	✕	✕			✕	✕	✕	
Putnam		✕	✕	✕		✕		✕			✕	
Rockland	✕	✕	✕	✕		✕		✕		✕	✕	✕
Westchester	✕	✕	✕	✕		✕		✕	✕	✕	✕	

ACA implementation in NYS involved Medicaid eligibility expansion as well as the availability of health insurance through the NYS of Health. There have been numerous changes in the State's healthcare delivery system as a result of the ACA, as well as the State's broader Medicaid Redesign initiatives, which began before implementation of the ACA. NYS Medicaid Redesign initiatives include Medicaid Health Homes, community health clinic expansions and the five year, $8 billion Delivery System Reform Incentive Payment (DSRIP) program.

The State's Medicaid program had more generous eligibility features than most states before implementation of the ACA and has always been the primary payer of care for PLWHA. HUCP continues to bridge the gap between Medicaid coverage and private insurance for PLWHA in NYS, providing universal access to medications and outpatient care for PLWHA. The NYS of Health offers Medicaid and commercial health plans with a wide range of experienced safety net providers. The most significant roadblock to HIV care is that it is not possible to enroll in an HIV Special Needs Plan (SNP) through NYS of Health website. This is a major barrier because HIV SNPs are Medicaid Managed Care plans that specialize in HIV care and offer enhanced care management services for PLWHA. NYS of Health has been made aware of the issue and is in the process of developing a technological fix. In the interim, HIV SNP enrollment requires paper enrollment via local districts rather than the immediate enrollment provided by the NYS of Health. In addition to SNP enrollment barriers, both consumers and providers are experiencing confusion over navigating drug benefits in managed care. The NYS AI directs both groups to resources to better navigate drug formularies.

During webinars and trainings presented by the NYS AI on ACA implementation, providers and consumers have voiced several concerns:

- Difficulty understanding insurance eligibility and the application process
- Problems with increased out-of-pocket expenditures for co-pays

- Costs of dental insurance and/or unavailability of dental coverage as a stand-alone benefit (this is a problem raised by Medicare beneficiaries)
- Restrictions on accessing out-of-network providers
- Confusion over the interaction of various insurance products
- Need for assistance with understanding insurance terminology and navigation

Two of these issues, access to both out-of-network providers and stand-alone dental products, have been addressed with improved 2016 health plan options available via the NYS of Health.

Average HUCP enrollment has only slightly decreased, and early implementation of the ACA left many confused and some falling through the cracks in the QHPs due to issues such as requiring a change in primary care provider. As challenges with insurance coverage decrease, a growing number of PLWHA will be successfully insured. For Part A funds, ADAP Plus is a priority, as Part B funds are dedicated to health insurance premium assistance, which the NYS DOH reports is an increasingly highly utilized portion of the HUCP. As enrollment into expanded Medicaid and QHPs purchased on the NYS of Health continue, the Grantee will continue to monitor Part A client health insurance coverage and its effect on Part A-funded services.

1. *Proportion with discontinuous or uncoordinated care.* Any client could experience disruptions in care due to a broad variety of healthcare system and life circumstances. As such, there is no way to accurately capture the full proportion of clients with discontinuous or uncoordinated care caused by interruptions in insurance coverage. However, during early ACA implementation, many individuals, not just PLWHA, were confused about their health plan options, co-pays, and benefits. Active NYS ADAP enrollment at the end of February 2015 was 19,302 (down only slightly from a high of 20,500 in November 2012). While a proportion of ADAP enrollees moved onto Medicaid and a growing number are insured, many are in a transition period (e.g., eligible for insurance but missed the open enrollment period). The NY EMA will continue to monitor Medicaid and insurance enrollment and service utilization trends.
2. *Addressing discontinuous or uncoordinated care.* Although service disruption is possible for clients because of both healthcare system and various socio-demographic factors, DOHMH has established several safeguards to address discontinuous or uncoordinated care for RW clients. As mentioned in the *Service Gaps* section, DOHMH continues to provide n-MCM services. The allocation to this service category was increased to $6.6 million, $2.3 million of which is for general n-MCM services established, in part, to assist clients who are experiencing discontinuous or uncoordinated care. Clients are able to access low-threshold navigation assistance in a variety of settings to address or to prevent discontinuous or uncoordinated care. In addition, subrecipients are required to conduct intake assessments and re-assessments with clients and to provide all appropriate referrals, including to State-certified health insurance navigators.

(v) Successes/Outcomes. A major success of the DOHMH response has been that ACA changes have been incorporated into the regular expectations of the providers. Contractual language clearly states that providers are responsible for assessment of eligibility and connection to a navigator, whether the navigator is in-house or available by referral. As noted above, HUCP served fewer people in the last year because of expedited enrollment in Medicaid. Further, over 3,000 RW clients have purchased health insurance through the NYS of Health.

b. Impact of and Response to Reduction in RW HIV/AIDS Program Formula Funding.

(i) Impact and extent of decline in funding on services. While funding levels increased 1.2% in GY14, after a 14.75% reduction in GY13, the NY EMA once again received a reduction of 1.6% in GY15. That is a total reduction of 15.2% over the course of a three-year period. During this period

of reductions, the PC and the Grantee have acted to preserve to the greatest extent possible those services that most directly impact the health of PLWHA.

To accommodate the 1.6% percent reduction in GY15, the PC implemented its reduction scenario, which uses a data-driven tool that reduces service categories based on priority. Once the spending plan was approved, the Grantee sought to implement the reduction by first looking at historical service under-utilization and spending levels of the subrecipients.

Forty-nine out of 177 programs received reductions to their contract based on the PC's spending plan, and one contract was voluntarily terminated. This includes targeted reductions based on historical spending for established programs and proportional reductions to newly established contracts. In particular, when reprogramming between service categories, within service categories, and between service types, the Grantee seeks to preserve services where the reduction would be most immediately felt by clients, for example, housing assistance or FNS. In Housing contracts, greater reductions were made to housing placement assistance programs that were struggling to place people because of the low vacancy rates and high rents in NYC. This reduction allowed the Grantee to preserve short-term supportive and transitional housing services, thereby mitigating any housing loss for currently housed PLWHA. In FNS, one contract that provided nutritional counseling without directly providing food or meals voluntarily reduced its funding amount by the entire reduction to that service category to preserve food and meal provision in other contracts. The voluntary termination was an HIV testing contract that historically had low positivity rates. In the two service categories (MH and HR) that are going to be rebid in GY15, larger reductions were taken because many of the providers are performing below historic levels due to a variety of factors, including increased MH coverage through Medicaid and the health insurance exchanges.

(ii) Response of the PC. No cost containment measures connected to the reduction were implemented. The PC's response to the reduction in GY15 formula funding was to implement a reduction scenario which decreased service categories based on their rank on the prioritization and the leeway to reallocate up to 15% between service categories, in order to preserve essential services for PLWHA.

(2) Planning and Resource Allocation.

a. Description of the Community Input Process.

(i) Overall Structure of the Community Input Process. Consistent with legislative requirements, the EMA in GY15 used a systematic, evidence-driven, representative, and inclusive planning process to prioritize services and allocate resources for GY16. The PC and its Committees continued a multi-year process to reassess and modernize the directives of the Part A portfolio with the aim of ensuring that the EMA's service system addresses current needs and service delivery challenges. All PC Sub-committees include a diverse range of consumers, providers, and other stakeholders and provide extensive opportunity for public comment, as described throughout this section. The PC works closely with the DOHMH BHIV CTP throughout the planning process. This year, the PC accomplished the following:

- Utilized a data-driven planning tool to develop service priorities and determine funding allocations based on information regarding PLWHA needs, service utilization and gaps, including the EMA's Needs Assessment, Comprehensive Plan, Service Category Scorecards with three years' historical utilization data, and data analyses from the EMA's CHAIN study;
- Allocated 64% of Part A and MAI funding to core medical services for GY16;
- Allocated additional resources to promote access to and maintenance in care for newly diagnosed individuals and to re-engage people who had fallen out of care;

- Took further steps to reduce unmet need and address the needs of the changing service system, while also addressing gaps in the care continuum by revising the program guidance for Legal Services and EIS; and
- Approved targeted increases to Housing and FNS in order to address ongoing needs of PLWHA, based on data demonstrating the correlation between supportive housing, FNS and VLS.[xlii]

1. *Needs Assessment Committee (NAC).* In the winter of 2013-2014, the NAC reviewed a range of reports and presentations in order to identify populations that fall off the HIV Care Continuum at each stage. In GY14, with the assistance of the Grantee, the NAC produced a formal needs assessment for HIV services in the NY EMA, which identified and used key themes and information gaps to develop recommendations to assist Part A priority setting and resource allocation processes. In GY15, the NAC focused its efforts on analyzing data from CHAIN and eSHARE on HIV-HCV co-infection and housing and HIV.

2. *Integration of Care Committee (IOC).* The IOC guided the PC in reaffirming continuing models of care and creating new evidence-based models for two service category directives: EIS and Legal Services. These service category directives were identified as opportunities to adapt the RW portfolio to the altered coverage landscape due to ACA implementation and increased payment for HIV testing through Medicaid. The IOC uses the Comprehensive Plan objectives to develop all Part A service models in the EMA.

3. *Priority Setting and Resource Allocation Committee (PSRA).* The PSRA Committee used an objective, data-driven tool to determine service priority rankings and allocations, forwarding its recommendations to the full PC for consideration. The tool requires the committee to use data to score service categories on a prioritization grid, with four criteria (individually weighted for priority) for assigning scores to each service category, as described below.

- *POLR/Alternate Providers of Services (weight=15%).* The PSRA Committee used the *POLR Tool* to assess each service to determine if Part A is the primary funding source and whether other sources provide identical or equivalent services to PLWHA in the EMA. Highest value was assigned to services funded only by Part A and where existing provider capacity was found to be inadequate to serve PLWHA. The addition of new funding sources in NYS for HIV core medical services through Medicaid expansion, the NYS of Health, and the implementation of NYS Medicaid Health Homes was a critical factor in the PC's approval of the 2016 CMS Waiver request.
- *Access to Care/Maintenance in Care (weight=35%).* The PSRA Committee assessed 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. Highest value was 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.
- *Specific Gaps/Emerging Needs (Demographic/Special Population) (weight=25%).* The PSRA Committee assessed each service to determine the degree to which it reduces documented service gaps or meets the needs of special populations. The PSRA Committee reviewed updated data from the CHAIN study documenting the unmet need for key services. Highest value was assigned to services that promote healthcare access and re-engagement for out of care or underserved populations, including those who fail to engage in later stages of the HIV Care Continuum.
- *Consumer Priority (weight=25%).* The PSRA Committee scored services based on consumer input, as provided by the PC Consumer Committee, the CHAIN cohort study, consumer focus groups, and consumer listening sessions. Highest value was assigned to services identified by PLWHA as (a) significantly contributing to access to or maintenance in primary medical care, and (b) representing a

key consumer priority. In planning for GY16, the PSRA Committee scored each criterion for every service category in the Part A portfolio, resulting in ranked priorities. See *Attachment 8* for the list of funded categories.

- *Tri-County Steering Committee*. The Tri-County region receives 4.7% of the annual Part A award. A local Steering Committee functioning as a committee of the PC conducts service planning and makes resource allocation recommendations to the PC. Tri-County's 33-member Steering Committee includes 12 PLWHA and representatives from the NYS DOH. The committee utilizes the same PSRA tool that is described above to rank service priorities for the region. The Steering Committee reports to the Executive Committee and full PC to obtain final approval of its spending plan.

b. Description of Specific Prioritization and Allocation Process.

(i) Population needs considered.

1. *Needs of people not in care.* Identifying PLWHA not in care and linking them to outpatient primary medical care is a priority for all services in the EMA. The PC received the report on the needs of PLWHA not in care through a study by DOHMH, *Gaps in Primary Care: Client Perspectives from the Return to Care Survey*. The study reported on interviews with PLWHA who had recently been re-connected to care after a lengthy absence (≥ six months). Through the study, the PC learned about key factors that contribute to discontinuity of care including: depression, not experiencing symptoms, forgetting or accidentally missing appointments, not wanting to think about HIV, not wanting to take HIV medications, and using alcohol or other drugs. The study found that 69% of participating PLWHA who recalled having a recent gap in care had used health and social services while out of HIV primary care, and identified outreach services as one of the top mechanisms through which clients return to care, thus supporting the PC's decision to prioritize EIS case-finding and linkage services. Study findings correlating depression and substance use with gaps in primary care influenced the PC's decision to prioritize MH and HR services, allocating $4.35 million and $7.76 million, respectively. In addition, the PC ensured that navigation to medical care services for FNS clients disengaged from medical care are included in the service model.

The CHAIN cohort study analyses of food and nutrition needs demonstrated that food insecurity is widespread among CHAIN participants, with 88% exhibiting some need for food or relying upon food and nutrition programs. The study showed that food-insecure PLWHA report significantly more missed appointments for HIV primary care and more emergency room visits compared to those who do not report food insecurity. The food-insecure are also less likely to receive medical care that meets minimum clinical practice standards.[xliii] The PC thus arrived at a data-driven decision to assign a high priority to FNS, allocating $6.8 million.

Ninety-two percent of the CHAIN cohort in NYC (2014-2015) reported needing permanent housing placement or rental assistance. The unstably-housed and homeless PLWHA in the CHAIN cohort stand out as a subgroup with above average levels of service needs across multiple service areas, including ARV treatment support. The PC assigned a very high priority to housing services and allocated $11.4 million for those services.

2. *Needs of people unaware of their HIV status.* The PC continued its commitment to identifying individuals unaware of their HIV status and linking them to care. An estimated 15,932 people are infected but undiagnosed in the EMA in 2014. DOHMH analyzes geographic and demographic changes in new infections and concurrent HIV diagnoses to identify populations unaware of their status. The data were used by the PC to determine EIS and MAI allocations as well as to develop the EMA's EIIHA strategy. Significant non-RW resources available for HIV testing, combined with implementation of a new NYS law expanding availability of testing as a routine part of medical care, prompted the PC to revise the EIS service directive to focus Part A testing resources on non-clinical settings such as jails and CBOs, and allocating most EIS resources to programs that link those newly diagnosed and promote access to and retention in care for those who already know their HIV status

and are disengaged from care. The PC's revised EIS program also strengthens navigation and linkage to care for positive people, as well as adding referral to PrEP and PEP for those who are negative. The GY16 Plan's revised EIS component allocates $4.5 million in Part A funding, including $1.7 million in MAI funding targeting high-risk Black, Hispanic, and Asian individuals. Even with these shifts in the HIV testing landscape, the $4.5 million allocated to EIS shows the PC's commitment to continue case-finding of undiagnosed PLWHA in the EMA, concentrating Part A resources on populations and areas with the highest estimated prevalence.

3. *Needs of historically underserved populations.* The PC reviewed data highlighting the needs of historically underserved populations, including racial and ethnic minorities. Needs of PLWHA of color were assessed through an analysis of epidemiologic trends, utilization patterns by race/ethnicity, disproportionate service needs documented in the CHAIN cohort, and comparison of geographic distribution of HIV/AIDS cases with mapping of Part A services. Continued funding was allocated to MCM on the basis of outcome data indicating robust, statistically significant improvements in care engagement and VLS for high-need minority PLWHA in that program.[xliv]

For GY16, as part of its priority-setting process, the PSRA Committee reviewed available data on utilization of services by key underserved populations, including women of color, YMSM of color, PLWHA 50 or older, immigrants, substance users, and transgender individuals. Service Category Scorecards that track utilization of different services over a three-year period enabled PSRA Committee members to identify services that are heavily used by traditionally underserved populations. The PC also reviews ADAP and ADAP Plus demographic reports. For example, these reports provided evidence that MSM of color depend on the HUCP for healthcare access, which influenced the PC's decision to prioritize support for ADAP and ADAP Plus.

(ii) Involvement of PLWHA. The active, informed engagement of PLWHA is essential to the planning process and helps ensure that PC decisions address the needs of consumers. In 2015, PLWHA constituted 40% of the PC's 45 members. One-third of those members are PLWHA who are not aligned with a Part A agency, all of whom are people of color. PLWHA actively serve on all PC committees and make up 36% of the Tri-County Steering Committee. The governmental co-chair is a hearing-impaired PLWH. PLWHA were closely involved in feedback on service quality, needs, and priorities through consumer focus groups, the Fall 2014 Client Satisfaction Survey (CSS), and the ongoing CHAIN study.

The PC's Consumers Committee provides a forum for PLWHA to be actively engaged in the planning process. HIV-positive PC members and HIV-positive PC staff assist community members in understanding the priority setting and resource allocation process, the principles of HIV epidemiology, the HIV Care Continuum, community planning, group dynamics and decision-making, QM, and the ACA and its effects on RW services. Training is available during the planning cycle aimed at maximizing informed participation and decision-making. The Committee plays a key role in recruiting new members, advocating for consumer engagement in the planning process, and promoting, training, and mentoring new PC members. The Committee also developed a comprehensive set of recommendations based on a survey of Part A Community Advisory Boards (CABs) addressing the outreach, retention, input, and feedback processes of CABs, with the goal of maximizing CABs as a conduit for client feedback on service quality, delivery, needs, and priorities. To develop the GY16 Plan, the PC sought the Consumers Committee's input regarding special populations and geographic areas of the EMA that remain disproportionately affected by HIV.

(iii) Addressing funding increases or decreases. The PC's data-driven planning tool allows for advanced scenario planning for funding increases or decreases. The tool includes built-in weighted formulas, based on the prioritization rank of the services, which allow for automated calculations of funding increases or decreases for each service category based on the actual award. For GY15, there was a decrease of $1.8 million. In planning for GY15, the PC started with the carrying cost of

programs in GY14 and adjusted allocations based on expected need. Should the Part A award be further reduced in GY16, the PC will implement the same strategy. The PC is requesting additional funding to maintain services in the face of increased cost of service provision. Given the historic 14.75% reduction in the EMA's award in GY13, critical service levels will most certainly be additionally impacted if further reductions in the Part A award occur in GY16.

(iv) MAI Funding. Planning, including prioritization and allocation, for MAI funding is integrated into service planning for Part A funds. MAI funds are concentrated in three core medical service categories (ADAP Plus, MCM, and EIS) and one support service category (Housing), all of which target the most heavily-affected, minority, and high-need communities. Data shows continued gaps in these services for these populations, justifying the need for continued targeted programs. In particular, the PC sought to ensure that MAI funds were distributed to impact target populations at multiple stages across the HIV Care Continuum.

(v) Use of data in the priority setting and allocation process. The PC and its Committees considered diverse data sources to assess need, develop service models, prioritize services, and allocate resources for GY16. Data sources consulted include: surveillance data, the NY EMA RW Service Category Scorecards, CHAIN data, CSS results, HOPWA, and eSHARE data, among other sources.

1. *Service gaps and other findings from longitudinal cohort study.* Evidence of service gaps from the CHAIN study and surveillance data supported the PC's allocation of $24.7 million for MCM. CHAIN cohort members were defined as needing MCM if they reported interrupted HIV medical care, missed HIV medical care appointments, had no CD4 or viral load tests in the last six months, or reported any of those issues in the prior interview wave and were receiving MCM as of the current interview. In 2014-2015 interviews, 35% of CHAIN participants in NYC met the criteria for need for the service and of those, only 11% reported recent utilization of the service, defined as receiving referrals to medical services through a Case Manager during the past six months. Data also shows sizable service utilization gaps for n-MCM services. These gaps justify the EMA's allocation of $2.3 million to link people to medical and support services, to remove barriers to HIV primary care, and to assist enrollment of PLWHA eligible for the NYS pf Health plans and expanded Medicaid in 2015, and $4.3 million allocation to n-MCM for currently/recently incarcerated PLWHA ensures linkage to care upon release.
2. *Outcomes Data.* DOHMH-reported outcomes data showed program achievements during GY13 with respect to viral suppression, immunological improvement, and treatment adherence. A pre-post evaluation of CCP outcomes demonstrated significant post-enrollment improvements in engagement in care and VLS, which were robust across all client population subgroups examined in a 2015 updated analysis, including those enrolled with recognized psychosocial (MH, substance-related, and/or housing) barriers to optimal outcomes.[xlv] Additionally, annual assessments of the Comprehensive Plan indicators highlight trends over time in the achievement of outcomes across the RWPA portfolio. This information was utilized by the PC when considering the need for targeted support services and continued investment in the CCP.
3. *Service Utilization Trends.* The PC reviewed evidence that a notable percentage of newly diagnosed people (28% in 2013, an improvement from 31% in 2012) had not entered HIV primary care between eight to 91 days of diagnosis. In response, the EMA allocated $4.5 million to EIS in GY15 (including $1.7 million in MAI funding) for targeted outreach, testing and linkage to care as well as return-to-care services targeting individuals found to be out of care for at least six months. The PC also allocated $1 million under HE/RR to support HIV self-management education programs for people newly diagnosed with HIV and those with barriers to achieving VLS. For GY16, the PC has also revised the program model for EIS and Legal Services in order to support service coordination and to remove barriers to care.

4. *Populations with special needs.* The PC decided to continue supporting a MH service model that provides MH treatment navigation and supports MH treatment for PLWHA without another payer for services. This decision was based on presentations on unmet need and utilization of MH services among PLHWA in NYC. The Part A MH allocation will improve quality of life, MH functioning, and enable PLWHA to overcome barriers to engagement in MH care and adherence to ARVs and/or psychotropic medications. The PC allocated $4.35 million to MH services for GY16.

5. *Trends in healthcare financing and delivery.* The PC continues to prioritize investments in core medical services in the GY16 Plan during the implementation of NYS Medicaid Health Homes, the health insurance exchange, and expanded Medicaid coverage. Through discussions with HUCP on service utilization and projections for the uninsured care programs, PC members learned of continuing high demand for these programs, even with implementation of the ACA and Medicaid expansion. Active NYS ADAP enrollment at the end of February 2015 was 19,302 (down only slightly from a high of 20,500 in November 2012). However, while a proportion of ADAP enrollees moved onto Medicaid and a growing number are insured, many are in a transition period (e.g., eligible for insurance, but missed the open enrollment period). The PSRA Committee also learned from the NYS DOH ADAP Director that the first year of the ACA left many confused and some falling through the cracks in the exchange plans (e.g., some plans required a change in primary care provider). The PC's prioritization of core medical services was also supported by results from consumer focus groups identifying HIV medications and outpatient care as two of the top three priorities for core medical services.

(vi) Changes and trends in HIV/AIDS epidemiology. Epidemiologic data played an essential role in the development of the GY16 Plan. In response to the higher percentage of RW clients not attaining VLS in comparison to the NY EMA population, the PC identified HIV medications and ADAP Plus services as the top service priorities for GY16. MCM services were allocated ($24.7 million, including $4.2 million in MAI) to ensure that PLWHA are linked to medical services, stay connected to care, and receive support and tools for medication adherence. Service categories directly linked to positive health outcomes, including MH and substance use services, were supported to address barriers to care and VLS. Comparing epidemiologic mapping with service mapping, the PC directed Part A services to be strategically placed in the most heavily affected neighborhoods. The proportion of newly diagnosed individuals who receive an AIDS diagnosis within 31 days of their HIV diagnosis has slowly declined, comprising 18% of the newly diagnosed in 2014, compared to 20% in 2010. To encourage further declines, $4.5 million ($1.7 of which is MAI) has been allocated for EIS, including funding to identify and return to care individuals previously diagnosed with HIV infection not currently in care.

(vii) Cost Data. The PC carefully reviews expenditures in the Service Category Scorecards for each Part A service category, considering the original funding allocations and modifications for each service category over a three-year period along with client demographics and service units. The PC also reviewed unit costs for key services as they developed prioritized services for the GY16 Spending Plan. When considering allocations for ADAP and ADAP Plus, the PC considered cost data from the HUCP, which administers these services. The average cost for a prescription covered with Part A funds (ADAP) is $503/month. The average cost for a service unit of HIV primary care (e.g., primary care visit and laboratory monitoring) reimbursed by the HUCP is $134/encounter. Investing in these services aims to improve health outcomes, thereby reducing the costs for preventable and costly hospitalization and emergency department visits.

When considering the allocation for the revised EIS services, the PSRA Committee reviewed data on the average maximum reimbursable amount per client served for EIS services in different settings based on the current reimbursement rates. The cost analysis gave a more realistic depiction of the scale of need and the resources required to meet it. The approximate cost for providing

navigation, service checks, and linkage to a primary care provider is $1,760 per client. Using the HIV Care Continuum and the numbers of newly diagnosed, there are an estimated 376 people who will need EIS services (for a total of $661,760). Newly positive persons identified in clinical programs not linked to care through the existing system account for 298 people ($524,480). Re-engagement in care would be provided for a person who has been previously diagnosed and shows up at the clinical site for another test, for someone who is seeking clinical or emergency room care, or for someone identified by the FSU. Accounting for the inability to access everyone who is out of care, and people who may be re-engaged in other programs (e.g., Care Coordination), the new model would serve an estimated 300 out of 599 eligible people, for a total of $528,000. The estimated total annual cost to link and re-engage 974 persons ($1760/person) is $1,714,240. For testing and linkage services (navigation, linkage, and service checks) in non-clinical settings, potential clients include: persons with unknown HIV status; persons newly diagnosed with HIV and not linked to care; and PLWHA who have fallen out of care. In 2014, 19,050 rapid tests were provided by RW programs. The approximate cost of these services (based on a 1% positivity rate and 85% confirmed positive linkage rate) is $2,621,926.

The PC also develops an annual plan for unspent funds, directing the Grantee to reallocate funds based on need and service costs to ensure the EMA continues to spend more than 97% of its award.

(viii) Other federally funded HIV/AIDS programs (see Attachment 7). The PC and PSRA Committee use the *POLR Tool*, a database of funders of HIV services in the EMA, that includes federal payers (e.g., Medicaid; Medicare; RW Parts B, C, D and F; SAMHSA; HOPWA, etc.) as well as state and local funders to analyze service funding levels. The PC also communicates regularly with funders to stay abreast of funding changes. For example, the PC received an update from the DOHMH on reductions to the EMA's HOPWA award, which could result in a new influx of clients into RW-funded short-term housing programs. The NYS DOH also reported to the PC on changes in its HUCP program as a result of the NYS of Health and Medicaid expansion implementation. These reports informed the PC's priorities and service allocation.

(ix) Anticipated Changes Due to the Affordable Care Act. ACA-specific presentations were made to several planning committees, namely IOC, Policy, Executive, and the full PC, while discussion of the potential effects of changes from the ACA was incorporated into all relevant service category presentations. The PC also received data from the NYS HUCP on the impact of the ACA on utilization of ADAP and ADAP Plus. Increases in insurance coverage due to Medicaid expansion were relatively modest because NYS Medicaid previously covered people with incomes up to 100% of FPL. With the implementation of web-based expanded Medicaid access, fewer people were served by the HUCP during the past year than in previous years because they achieved more rapid Medicaid enrollment. Approximately 1,200 additional clients obtained insurance coverage purchased on the NYS of Health and had their premiums paid by the HUCP. As noted earlier, average HUCP enrollment has only slightly decreased and ACA implementation left many falling through the cracks in the exchange plans. As challenges with insurance coverage decrease, a growing number will be successfully insured. As enrollment into expanded Medicaid and QHP purchases on the NYS of Health continue, the EMA will continue to monitor Part A client health insurance coverage and its effect on Part A-funded services. These factors led the PC to continue to prioritize ADAP and ADAP Plus as the highest ranked service categories.

The PC allocated $6.6 million to n-MCM in GY16, $2.3 million of which is for general navigation assistance in n-MCM programs for clients who are not receiving more intensive MCM services. This allocation will increase the EMA's capacity to provide assistance with NYS of Health and Medicaid enrollment. With significant shifts in the system of care, the PC has funded this service to minimize confusion that could result in discontinuity of care for PLWHA.

(x) Integration of prevention and care planning. The chair and staff of the PC, the CDC-funded NYC HPG, and the NYS HIV Prevention Planning Group meet regularly in the NYC Supercommittee. The BHIV Assistant Commissioner, Director of CTP, Director of HIV Prevention Programs, grantees for the HRSA- and CDC-funded programs, along with NYS DOH representatives, also participate in the NYC Supercommitee. The group discusses collaboration and coordination between planning for prevention and care and is preparing for the joint *Comprehensive Strategic Plan for HIV Prevention and Care for 2016*. Specifically the NYS and NYC HIV Prevention and Care programs have agreed to develop a plan that is in-line with the State's plan to end the epidemic, allowing all HIV services, regardless of payer or governmental leadership, to be guided from the same document. This coordinated effort across prevention and care and between jurisdictions is an important step in implementing HIV status neutral services in line with the State's ETE plan.

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

c. Coordination of Services and Funding Streams. The flexibility of Part A funding has enabled the EMA to develop a range of innovative programs and service delivery strategies that respond to the specific access barriers faced by the EMA's PLWHA most in need of services.

(i) Availability of other public funding. As shown in *Attachment 7*, nearly $3.5 billion were available for HIV services in the EMA in 2015. As this figure does not include amounts spent on inpatient medical services and services funded through private insurance, Medicare, and the Department of Veterans' Affairs, it understates the total expenditures for HIV care.

(ii) How Part A funds are used to address gaps. By maximizing coordination among diverse service systems and funding streams, the EMA is able to provide a comprehensive and flexible system of HIV/AIDS care. The PC annually assesses available resources in all Part A service categories to identify key gaps in the HIV care system. For development of the GY16 Plan, this assessment was facilitated by a comprehensive *POLR Tool* that identifies and describes HIV-related services provided by non-Part A sources. Documenting 130 programs in 17 service categories funded by nearly 40 different sources, this tool helped the PC to ensure that Part A serves as the POLR for services while filling gaps in the system of care. Further, the PC includes representatives from numerous NYC and NYS agencies, as well as providers of a broad range of services funded by multiple sources, bringing expertise on the full array of sources for HIV-related services. Ongoing coordination between DOHMH and the NYS DOH increases efficiency, maximizes the number and accessibility of services available, reduces duplication, and facilitates implementation of innovative strategies to address service gaps.

1. *Services funded by other federal and local sources.* The HIV Care Continuum is supported by a variety of funding sources. Core medical and support services for PLWHA are supported by funding from the sources outlined in *Attachment 7*.

2. *How funds are used to address gaps.* The NY EMA ensures that low-income, under and uninsured PLWHA have the tools and resources necessary to fully engage in their medical care, and achieve VLS and other positive health outcomes by systematically coordinating services with the myriad of payers in the jurisdiction. The EMA has designed a system that: ensures RWPA resources are used as the POLR; is coordinated with other local, state, and federal funding streams; and ensures a continuum of services that is responsive to the needs of communities most heavily impacted by HIV.

- *RW HIV/AIDS Program funding.* The EMA coordinates extensively with the NYS AI, which administers more than $255 million in ADAP, RW Part B funds, and state tax dollars, in addition to $2.9 Billion for Medicaid services. Senior staff from NYS AI have been active participants on the EMA's PC since the beginning of the RW CARE Act. Close cooperation between the EMA and NYS is reflected in the NYS AI's collaboration on ETE and joint HIV service planning. *Gaps filled by*

RWPA: Each year, the PC collaborates with NYS DOH to help ensure the financial sustainability of ADAP using unobligated and carryover funds to provide ADAP and ADAP Plus support for NY EMA-residing PLWHA without any other source of reimbursement for medical care or HIV-related medications. The PC also includes members who are Parts C, D, and/or F grantees and consideration is given to these resources during prioritization and allocation.

- *Federal, state and local funding.* The NY EMA further coordinates with Medicaid and other federal programs funded through HRSA, SAMHSA, HOPWA, and CDC as well as Medicaid.

a) *Medicaid (HIV medical services).* With an investment of over $2.9 billion, Medicaid is the largest single payer of medical care for PLWHA in the NY EMA. The EMA coordinates services and ensures payer of last resort by designing a system that works in concert with, but does not supplant, Medicaid services. *Gaps filled by RWPA:* The EMA funds service categories, service models, and/or individuals that are not Medicaid reimbursable. This includes increasing the proportion of the award that is allocated to essential, support services that evidence has shown to increase retention in care – such service categories include Housing, FNS, SCF, Legal, and n-MCM. The EMA also funds models within core service categories that are not billable to Medicaid, but that the Grantee and PC have determined meet the needs of PLWHA, such as HR services in substance use and MH outreach, readiness, and re-engagement. The EMA has continued its commitment to core medical services such as ADAP, ADAP Plus, oral health, and MCM because, despite increases in Medicaid enrollment, as a segment of the RW eligible population continues to be ineligible for Medicaid. Payer of last resort is further enforced through contractual language that requires reassessment of client eligibility for Medicaid coverage and facility certification to bill Medicaid-eligible services to NYS with POLR site visits to ensure services are billed appropriately.

b) *CDC (HIV testing).* CDC-funded testing resources are particularly well coordinated with EIS in the 2015 directive approved by the PC. The EIS directive process reviewed both CDC and RWPA EIS service guidance to develop an overall plan to identify those unaware of their status. *Gaps filled by RWPA:* Through this process, the PC approved EIS funding to support targeted testing in CBO facilities and linkage and re-engagement activities in hospitals and clinics; CDC resources will be utilized to support clinical system transformation resulting increased routinized testing in hospitals and clinics.

c) *HOPWA (housing).* DOHMH ensures coordination with HOPWA through collaborative planning and administration within DOHMH, which also oversees the programs. Coordination between RW and HOPWA grants focuses on improving health and housing outcomes and increasing access to and maintenance in permanent, stable housing. The HOPWA grant supports permanent housing, housing placement assistance, and rental assistance. *Gaps filled by RWPA:* RW funding supports transitional short-term housing as well as housing placement assistance and rental assistance. HOPWA and RW housing programs are overseen by the DOHMH Housing Services Unit, and resource allocations and services are coordinated between the two programs to ensure optimal use of grant funds.

WORKPLAN

1. Funding for Core and Support Services. As a result of a public planning process conducted by the PC and documented availability of core medical services from the NYS AI (the authority for NYS Medicaid services for PLWHA) the NY EMA received a CMS Waiver for GY14 and GY15. (*GY16 CMS Waiver to be submitted to HRSA separately from this application.)*

a. GY 2016 Service Category Plan

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

(ii) Narrative. The GY16 Plan continues and strengthens support for RWPA services that have helped the EMA achieve reductions in AIDS-related mortality, increases in VLS, and improvements in service utilization. As in prior years, the GY16 Plan is focused on factors that support favorable health outcomes for the populations most in need. The plan reflects continued steps in a comprehensive, multi-year review and re-competition of the Part A portfolio. The EMA's portfolio reassessment is intended to ensure that services respond to emerging needs and are based on the latest scientific and public health evidence.

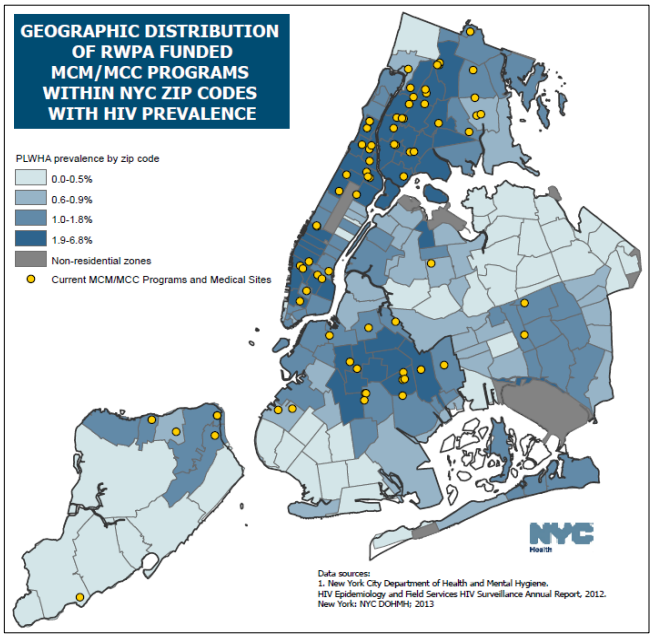
To develop the GY16 Plan, the PC, with DOHMH support, assessed and scored all services for their impact on access to and maintenance in HIV primary care. This process was undertaken using HIV surveillance data, program evaluation data, QM performance data, consumer survey results, including CHAIN, and published studies. The GY16 Plan has been designed to advance three major goals identified in the Comprehensive Plan: 1) increased awareness of HIV status, 2) early entry into primary care, and 3) optimal management of HIV infection. Additionally, all efforts aim to advance the fourth goal: 4) reduction of HIV/AIDS health disparities, especially among low-income minority PLWHA. Each of these goals can be linked to one or more stages of the HIV Care Continuum.

To bridge service gaps and meet clients' needs, the GY16 Plan allocates funding to services that have been proven effective in promoting equitable healthcare access and initial engagement and sustained retention in care, and addressing medical and social co-morbidities. In the GY16 Plan, 64% of program costs are allocated toward core medical services. The CMS Waiver will be submitted separately from this application. Using an objective planning tool informed by local NY EMA data *(see p. 32 for additional details)*, the PC prioritized the following services for GY16 (listed in order of priority with core medical services italicized): *ADAP*, *outpatient/ambulatory care services (ADAP Plus)*, housing services, case management, non-medical (n-MCM); *medical case management* (*MCM);* food bank/home-delivered meals (FNS); *substance abuse services – outpatient (HR)*; *MH services (MH)*; psychosocial support services (SCF); *home and community-based health services (HCBH)*; legal services; health education/risk reduction (HE/RR); *early intervention services (EIS); oral health services;* and medical transportation.

1. <u>*Unfunded Core Medical Services.*</u> The EMA's Part A plan prioritizes key services to address obstacles to healthcare access and favorable medical outcomes. Based on this approach, the GY16 Plan does not include the following core medical services:

- *Local AIDS Pharmaceutical Assistance Program (LPAP).* The EMA has no LPAP, but instead provides funding to NYS-administered ADAP.
- *Health Insurance Premium and Cost Sharing Assistance.* The NYS HUCP offers comprehensive assistance for insurance premium and cost sharing for PLWHA (including those on the health insurance exchange) with incomes below 435% of FPL, obviating the need for the EMA to allocate Part A funds for this purpose. In addition, insurance premium assistance for coverage purchased on the NYS health insurance exchange is available for PLWHA with incomes between 138-400% of FPL. PLWHA with incomes between 138% and 250% of FPL are also eligible for reduced cost sharing for plans on the exchange.
- *Home Health Care.* Medicaid and a NYS Home Health Program comprehensively cover services under this category. However, where coverage gaps still exist, HCBH services are included in the GY16 Plan.
- *Hospice Services.* Medicaid comprehensively covers hospice services, the demand for which has significantly declined because of reduced end-stage disease and mortality.
- *Medical Nutrition Therapy.* Although not separately prioritized, the GY16 Plan supports nutrition counseling in the broader category of FNS. In addition, the NYS Medicaid and ADAP programs cover a range of medical nutritional therapy services.

2. *Promoting parity of services.* In GY16, as in previous years, Part A services will be clustered in high-need, underserved minority communities, with consideration given to geographic distribution of Medicaid and RW-funded Parts A, B, C, D, and F services and providers' capacity to address health disparities. *Figure 3* illustrates the distribution of CCPs throughout NYC; concentrations of these programs can be seen in neighborhoods with high HIV prevalence. CCP clients obtain services co-located or closely linked with primary care providers, ensuring that case managers and primary care providers have access to clinically-relevant information and participate in joint case conferences. Part A-funded initiatives will continue to be complemented by targeted MAI programs that promote early diagnosis and linkage, adherence to treatment, and stable housing for PLWHA of color. Historically and presently, Part A serves Blacks, Hispanics, and women at a proportion higher than their representative portion of the EMA's population. In GY14, though eligibility criteria allows enrollment of PLWHA with incomes up to 435% of FPL, 79% of enrolled and served Part A clients had incomes below 100% of 2015 FPL. Service category- and agency-level results of a 2014 CSS were reported to providers to inform service quality. Additional service category-based quality indicators developed through the use of eSHARE data, in collaboration with funded providers, serve as objective means to measure quality improvement (QI) on core service elements (linkage to medical care or housing, for instance). Additional information on the quality of services can be found in the description of the EMA's QM program.



3. *Ensuring cultural and linguistic appropriateness.* The EMA contractually requires all Part A-funded agencies to demonstrate that they have policies and procedures in place that ensure access to care in a culturally and linguistically appropriate manner. The EMA promotes cultural competency by guiding providers on program model design, recruitment of culturally and linguistically-diverse staff, and related QI initiatives. Part A funds an array of services in more than 50 languages, and all Part A programs are required to have interpretation services available for non-English-speaking clients. Program materials for HE/RR and HR services have been translated to Spanish (the second most common language for RWPA clients in the EMA) and Care Coordination materials have additionally been translated into Mandarin Chinese and Haitian-Creole (the other most common languages in the EMA). In our most recent RFP, services that offer language interpretation are reimbursed at a higher level than those that do not, acknowledging the increased time and cost of delivering services that require language translation. MH and SCF services are especially tailored to the unique needs of key populations, such as women, MSM, unstably-housed individuals, and others who need specialized interventions. In addition, a large proportion of programs have experience working with specific demographic groups, including immigrants, individuals recently released from jails and prisons, homeless individuals, and members of the LGBT community. Cultural sensitivity/competency training is a requirement for all Part A providers.

4. *Factors contributing to changes in service category funding.* The greatest factor affecting service category funding has been Medicaid redesign and ensuring that RWPA remains the POLR. The GY16 Plan includes a reduction to MH, HCBH, and HR services; MH resulting from an increase in culturally competent MH service providers who are certified to bill Medicaid, HR as it is anticipated that

Medicaid will begin to reimburse for HR services, and HCBH because of increased access to long-term and home-based care services for those under Medicaid and Medicare. All other service category reductions have been proportionately calculated by the allocation tool, based on priority, as a result of reductions to the award over the past three grant years. The GY16 Plan calls for across-the-board increases to nearly all service categories (with the exception of HR, MH and HCBH) as a response to the increasing number of PLWHA in the EMA and the increased cost of providing services.

5. *Women, Infants, Children and Youth (WICY).* As Medicaid provides comprehensive coverage for HIV-affected WICY populations, the EMA will again join NYS to submit a retrospective WICY Waiver. Medicaid spending for WICY populations was over $542 million in GY14, far exceeding the EMA's required $29.6 million set-aside.

6. *Links with Needs Assessment and Unmet Need Analysis.* The PC finalized its Needs Assessment in March, 2014, which was drawn from a wealth of information in a range of reports and presentations made available to members of the PC NAC between 2009 and 2013. Information included epidemiological summaries, survey results on service needs and utilization, findings from studies of clients' service experiences, and routine reports on key HIV health outcome indicators, among other data sources. These documents provided insight into the intersection between program and policy and summarized the most recent quantitative and qualitative data regarding the profile and needs of PLWHA in the NY EMA. As previously stated, the Part A population is predominantly lower income and includes a higher proportion of females, Blacks and Hispanics, and Bronx residents, and a lower proportion of Whites and Queens or Manhattan residents, than among PLWHA in NYC overall. Regarding modes of transmission, the proportion of Part A clients with likely MSM transmission is smaller (and the proportion with likely IDU or heterosexual transmission is larger) than among PLWHA overall.

The GY16 Plan prioritizes funding for Part A services that promote healthcare access and favorable health outcomes for minority PLWHA. While 79% of all PLWHA living in the EMA are people of color, 94% of PLWHA receiving Part A EIS, HR, Housing, and MCM services are people of color. All of these services are prioritized in the GY16 Plan. Part A services are located in high-need neighborhoods with high concentrations of minority PLWHA.

The EMA's estimate of unmet need led the PC to continue support for its highest funded category – MCM – providing patient navigation and adherence support to promote continuity of care. The persistence of unmet need also prompted the PC to develop service models that verify engagement in primary care for those previously out of care. The EMA also developed strategic reimbursement points for performance-based providers who link clients to care. Funding was continued for EIS, which also brings out of care PLWHA into care.

b. Allocation Table. The NY EMA plans to submit the complete GY16 CMS Waiver separate from this application, in accordance with *Policy Number 13-07*. The approved Allocation Table does not differ from the Service Category Plan (*Attachment 8*). A signed letter from the Director of the PC/Governmental Co-Chair and the Director of CTP that confirms that Service Category Plan and Allocation Table are aligned and that describes the process for submission of the GY16 CMS Waiver is included in *Attachment 9*, along with the Allocation Table.

(2) 2016 HIV Care Continuum Workplan ***(see Attachment 10).***

RESOLUTION OF CHALLENGES

Healthcare system changes and barriers. With ongoing changes in the NYS healthcare system such as the continued enrollment of Part A clients in Medicaid Managed Care and Health Homes, and reductions in the NY EMA's HOPWA award, continual monitoring of the healthcare and support services environment is required. In anticipation of the ACA, Medicaid expansion, and NYS Medicaid program changes, the Grantee has dedicated 0.5 FTE of a healthcare policy analyst to proactively

plan for healthcare system changes affecting RWPA as the POLR. Through continued engagement with NYS Medicaid policymakers, this dedicated staff person works to inform the PC and providers on changes in healthcare policy to ensure continuity of services to PLWHA. The PC, through its priority setting process and annual review of service category allocations based on service utilization and changes in the healthcare system environment, ensures funded services continue to meet the needs of marginalized PLWHA in the EMA through recent increases in funding to Housing, FNS, and SCF. Additional efforts on the part of the Grantee include the ongoing use of performance-based payment, which reimburses subrecipients for services delivered and POLR site visits to ensure RW pays for services that cannot be paid by other payment sources. To keep all parties aware of changes in the healthcare system, the Grantee sends a biweekly policy newsletter to the PC, providers, and other stakeholders that highlights changes in Medicaid, health insurance exchanges, and the healthcare funding environment.

Integration of HIV Care Continuum into planning and implementation of Part A program. DOHMH was a part of the 2011 CDC-funded Enhanced Comprehensive HIV Prevention Planning (ECHPP) grant through which NYC incorporated the HIV Care Continuum framework into planning and implementation activities. Coordination of these activities by DOHMH, CDC, and HRSA gave the EMA a head start in the integration of the HIV Care Continuum framework into EMA-wide HIV prevention and care programs.

While the NY EMA was early to incorporate the use of the HIV Care Continuum in planning, this important tool, it is not currently sufficient on its own for planning purposes. As described earlier *(p.7)*, a single HIV Care Continuum for the entire EMA cannot be developed due to differences in available data in NYC and Tri-County. Thus, other data sources must be used in conjunction with the HIV Care Continuums in order to identify barriers, strategize on design and operationalization of services, or determine funding allocation amounts to improve health outcomes. The NY EMA relies on CHAIN, surveillance and eSHARE data analysis, and the PC's priority setting and resource allocation process to plan for and implement the Part A program. The review of all data ensures that the EMA's priorities address the gaps identified in the HIV Care Continuum and address one or more stages where improvements are warranted.

Based on the HIV Care Continuums roughly three-quarters (NYC) and two-thirds (Tri-County) of RW clients have achieved VLS. As a means of engaging this complex, high need population of PLWHA, the NY EMA has developed the Undetectable Framework (*p. 6*) to ensure that each RW-funded provider engages with each RW client not on ARVs and/or not virally suppressed to ensure they have the support needed to achieve VLS. The entire RWPA service system is engaged in the Framework, including the REU Data Analysts who develop TSRs for RW providers, the DOHMH TA and QM teams, NYS AI staff who support implementation of CQI tools at RW-funded agencies, and PHS-CAMS who incorporate contractual language requiring the collection of Primary Care Status Measures (PCSM) data.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

(1) Clinical Quality Management (CQM). The CQM program is a collaborative effort that involves the DOHMH CTP TA Unit and REU, NYS AI, WCDOH, PHS-CAMS, the PC, consumers, and providers.

In late 2013, the CQM program was restructured to prepare providers for changes in the healthcare system resulting from implementation of the ACA and the NYS Medicaid Redesign. Both the ACA and the NYS Medicaid Redesign require health and service providers to collaborate more effectively across funding streams to address the needs of PLWHA. The RW TA Unit was integrated

into the CQM program in order to: (a) strengthen Part A providers' quality efforts; (b) support the needs of Part A providers and the consumers they serve by aligning programmatic TA more closely with QM support; and (c) more effectively address improving care across the continuum. The objectives of the CQM program are to build capacity for QM among Part A providers, to increase collaboration between RW and Medicaid-funded providers, to provide opportunities for peer learning among Part A providers, and to ensure the continuation of quality services for PLWHA.

BHIV is also expanding its efforts to support VLS citywide by drawing on NY HIVQUAL and the NYC surveillance-based HIV Care Continuum Dashboards (CCDs) to address care quality at the clinic level. The CQM program will collaborate in these efforts by ensuring that Part A services support engagement in high-quality clinical care. The CQM program is inspired by the Institute for Healthcare Improvement's (IHI) model. CTP staff is receiving training in the IHI model to more fully integrate this work into the provision of TA and the development of quality metrics for RWPA services.

a. Description of the CQM Program Infrastructure.

(i-ii) CQM FTEs, Staff roles and responsibilities. A total of 20.7 FTEs, inclusive of DOHMH and NYS AI-contracted QM staff, provide a comprehensive QM program for Part A providers. Several processes are in place to support the assessment of the EMA's CQM program. First, the DOHMH Part A QM Director (1.0 FTE) oversees the CQM program, including the CQM contract with NYS AI, by ensuring plan deliverables are met, identifying gaps in the RW system, and evaluating the program. The QM Director also oversees the DOHMH TA team comprised of one Program Manager and five POs that support providers in their QM work. DOHMH TA POs, with REU staff, NYS AI staff, and the Part A QM Director, are responsible for improving the coordination of CQM activities and providing DOHMH-led TA with an emphasis on using data to improve care, in collaboration with funded providers. More specifically, the QM Director and the DOHMH TA team develop and implement trainings for Part A providers to improve service quality and support QM activities; plan and implement provider meetings to facilitate peer learning among Part A providers; provide one-to-one TA in program implementation and QI; and work with NYS AI staff to plan and deliver an annual QI conference for the NY EMA.

WCDOH staff utilize a similar TA model to support QM efforts with Tri-County providers. DOHMH REU Evaluation Specialists are responsible for analyzing eSHARE data, as well as consumer survey and supplemental evaluation data, to produce and present service category- and agency-level quality performance indicator reports for the EMA.

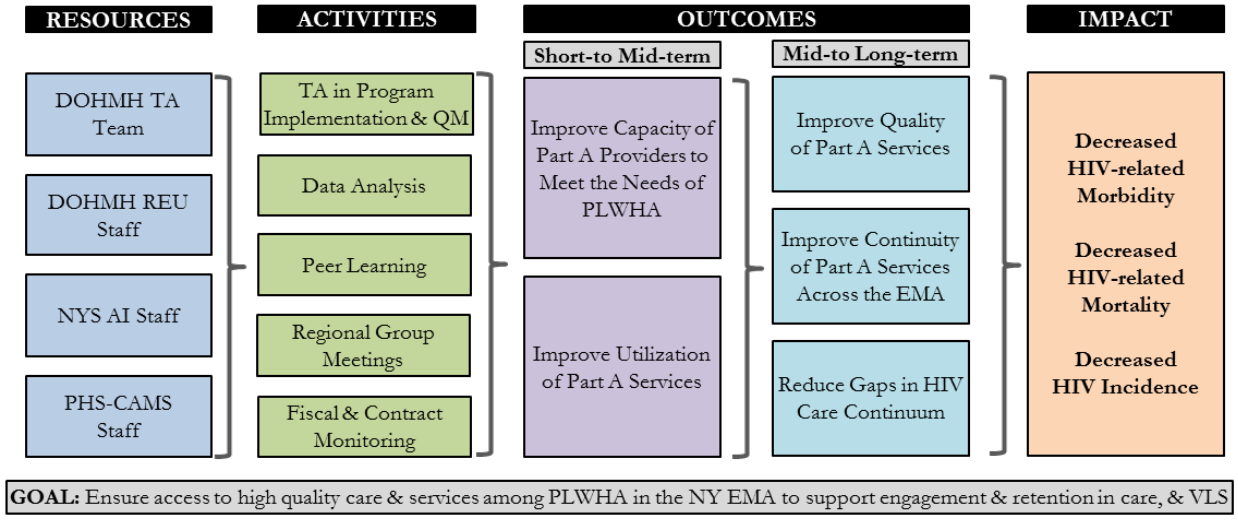
In GY16, the DOHMH TA team will assume responsibility for activities formerly undertaken by NYS AI consultants (known as QM Leads). This QM program transition will reduce provider burden, as Part A QM program efforts will be incorporated into the DOHMH's provision of TA. The NYS AI program staff will continue the CQM work of the National Quality Center while strengthening the collaborative system-wide effort between NYS AI and DOHMH to increase linkage to and retention in care and VLS across the HIV healthcare system. The NYS AI will also provide peer learning support through the Power of QI Conference, coordinate Part B and Medicaid clinical organizational assessments with the Part A program, participate in a cross-part QM committee, and assist with ongoing QM trainings for providers. The DOHMH TA staff will assume the new scope of QM work in August 2016, once they have completed IHI QM trainings.

CTP REU staff (supported by 8.75 FTEs in QM funding) manage eSHARE specifications, testing/troubleshooting of modifications, documentation of reporting requirements, data quality assurance, end user training, and general data support for all RW programs. REU Analysts also conduct routine reporting across service categories, and provide service category-level and agency-level analysis and reporting of quality performance measures for monitoring, evaluation, QM, and TA purposes. In addition, REU staff along with an eSHARE analyst, based in the BHIV Administration

Program, coordinate RW Services Report (RSR) submissions, and ensure that eSHARE remains aligned with federal reporting requirements. eSHARE Programmer Analysts (supported by 1.7 FTEs in QM funding) oversee eSHARE administration, manage system configuration and maintenance, and provide more technical application support/TA to external users.

The EMA has multiple systems in place to monitor and assess the CQM program: 1) an interagency steering committee comprised of senior staff from DOHMH, PHS-CAMS, WCDOH, the PC, and NYS AI monitors progress on a monthly basis; 2) the DOHMH TA team engages in QM planning for the CQM program and monitors performance; 3) CTP staff present CQM data and progress reports to the PC; 4) the NYS AI QM Leads review funded providers' QM plans to identify TA needs (will shift to DOHMH in GY16); and 5) PHS-CAMS monitors NYS AI contractual and fiscal requirements. *Figure 3* shows the logic model for the CQM program.

Figure 3: CQM Program Logic Model



(iii) QM Contractors. The GY16 Plan allocates $3 million to CQM, of which approximately $680,000 will support the NYS AI QM contract. As noted above, in August 2016, the DOHMH TA team will assume the TA activities currently provided by the NYS AI QM Leads. The NYS AI CQM program currently includes 4.5 FTEs; the total number of FTEs will be reduced upon completion of the transition in mid-GY16. NYS AI staff is led by a Medical Director who works closely with the DOHMH CTP to ensure that QM addresses the RWPA program goals. The NYS AI Project Director, who reports to the NYS AI Medical Director, is responsible for guiding the program's activities, and oversees the Program Managers and administrative staff who are responsible for day-to-day CQM program implementation. NYS AI fiscal staff oversees all fiscal aspects of the contract. The NYS AI also engages staff with specific QM expertise as needed.

Following the QM program transition, NYS AI will provide continued support for the development and implementation of the annual Power of QI Conference. This will include working with DOHMH TA to develop the conference theme and agenda; issuing the call for, evaluating, and selecting abstracts; facilitating sessions and panels as needed; and coordinating all logistics (i.e., securing space, catering, conference registration, etc.). NYS AI staff will also continue to coordinate NYS AI and DOHMH QM efforts, including comparing the State's CQM data (eHIVQUAL) with the CCDs (which are based on NYC surveillance data on engagement in care and VLS for those clinics with 150 patients or more). The NYS AI and DOHMH have begun a system-wide CQM effort with plans to address the lowest performing city clinics as measured by population-based VLS.

Additional work covered under the NYS AI QM contract includes coordinating clinical organizational assessments and participation in a cross-Part QM committee.

(iv) Efforts to coordinate CQM activities with other RW grantees in the jurisdiction. In addition to the NYS AI collaboration mentioned above, the CQM program continues to explore ways to improve the delivery of QI training and coaching. Collaborative models, like regional groups, combine clinical and non-clinical providers across multiple funding streams to focus on the area's broad public health needs to improve the continuum of care. These groups foster a collaborative approach to addressing current regional challenges in HIV care and develop strategies to meet or exceed the NHAS goals. CTP and WCDOH staff participate in regional groups, facilitated by the NYS AI in the Lower Hudson Valley and Upper Manhattan, which focus on linkage to and retention in care and VLS. DOHMH's *New York Knows'* regional efforts in the Bronx, Brooklyn, and Staten Island have expanded beyond testing and linkage to care to include retention in care and VLS (*see pp. 9-10*) and include Part B, C, and D grantees. *New York Knows'* regional efforts in Queens and Manhattan focus on testing and linkage.

b. Description of CQM Program Performance Measures.

(i) Performance measures for each service category. In general, performance is evaluated based on linkage to care, ARV utilization and VLS proportions, which demonstrate how well services in the EMA address the latter stages of the HIV Care Continuum (*Table 8*).

Table 8: Performance Indicators by Service Category

Service category	Indicator	Stage of HIV Care Continuum			
		Linkage	Retention	ARV	VLS
EIS	Increase in linkage to care among PLWHA who know their status (%)	X			
HE/RR	Increase in clients prescribed ARVs at most recent status report (%)	X	X	X	X
HCBH			X	X	X
Legal Services			X	X	X
n-MCM			X	X	X
ADAP Plus	Increase in clients with suppressed viral load at most recent measurement (%)		X	X	X
ADAP				X	X
Oral Health Care			X	X	X
MH			X	X	X
MCM		X	X	X	X
FNS			X	X	X
HR			X	X	X
Housing			X	X	X
Medical Transportation			X	X	X
SCF			X	X	X

Data from funded programs are drawn primarily from client-level PCSMs, which are collected at each agency. PCSMs record client utilization of primary care, receipt of ARVs, viral load and CD4 count tests and values. DOHMH TA staff routinely review PCSM data to identify areas for TA and to monitor client linkage, engagement in care, ARV initiation, and VLS. In GY16, DOHMH will further develop the Undetectable Framework (first described on *p. 6*) whereby TA staff will improve their capacity to use PCSM data, through REU routinized analyses, to support population health management activities among providers through use of the TSRs.

The performance indicators are closely aligned with both program activities and expected patient outcomes, and are based on data collected via eSHARE. REU staff provides eSHARE-derived reports that show aggregate performance across the service category as well as reports for each provider. Using eSHARE data allows the Grantee to measure performance among all eligible RW clients, rather than just a sample. This gives a more complete population-based picture of performance, which creates buy-in for evaluation and QI activities at the provider level and informs QM-related TA activities. Additional indicators are used to measure service delivery and utilization; enrollment patterns and demographics; and outcomes from the MAI Plan, Implementation Plan, and Comprehensive Plan. The standardization of eSHARE forms and data entry screens (as compared to disparate paper charting systems and electronic health record systems) facilitates appropriate reporting and recognition of indicator results.

Beginning in GY12, DOHMH staff, in collaboration with NYS AI, facilitated category-specific workgroups to develop quality indicators using a Nominal Group Technique (NGT). These indicators reflect program activities that are aligned with patient outcomes. NGT emphasizes achieving consensus and ensuring that quality measures reflect program priorities. By November 2013, quality indicators were developed for MCM Tri-County, NYC CCPs, HR, FNS, MH, and SCF services. More specific information on *ambulatory medical care* and *MCM* performance and quality measures and data collected are provided in *section (iii)* below.

(ii) Frequency of performance measure data collection. Data are collected and entered by providers throughout the contract year. TSRs are circulated to providers twice a year. Quality indicator data is analyzed and reported by DOHMH REU at least annually, with more frequent updates provided, as requested. Many providers are tracking their quality indicator data more frequently as a part of their QM workplan.

(iii) Ambulatory medical care and medical case management performance and quality measures. Over 100 EMA clinical providers of ADAP Plus services participate in the NYS HIV Quality of Care Program's eHIVQUAL data collection effort, which routinely evaluates multiple aspects of HIV clinical care through self-reported provider performance and quality data. Data collected include indicators such as clinical visits, clinical and psychosocial screenings, VLS, and ARV management. Results are used as a guide to the quality of clinical HIV care being provided in the EMA and NYS. The Director of CTP participates in the NYS Quality of Care quarterly meetings focused on clinical quality care initiatives and service delivery in NYS. eHIVQUAL data reports for 2014 are expected in December 2015 results will be coordinated with the RWPA QM program.

1. *Medical Case Management – CCP.* Developed in Spring 2012 and revised in Spring 2014, the NYC MCM (CCP) program quality indicators cover four measures of service quality: 1) Health Promotion: Percent of CCP clients who received the appropriate number of health promotion services in a quarter as indicated by track[13] assignment (*see Figure 4*); 2) Case Conferences: Percent of CCP clients with at least one case conference service in a quarter (defined as a face-to-face meeting between the CCP staff and the Primary Care Provider (*see Figure 5*); 3) Adherence Assessments: Percent of CCP clients who received at least one adherence assessment in a quarter (*see Figure 6*); and 4) Home/Field Visits: Percent of CCP clients who received the appropriate number of home-or-field-based service in a quarter as indicated by track assignment (*see Figure 7).*

[13] The frequency of encounters for each track are defined as follows: A/B: quarterly encounters; C1: monthly encounters; C2: weekly encounters; and D: DOT services.

Figure 4: CCP clients with minimum # of health promotion sessions in the quarter, GY13–14

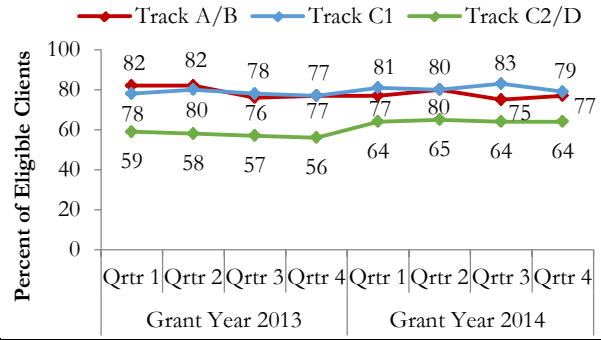


Figure 5: CCP clients with at least 1 case conference in the quarter, GY13–14

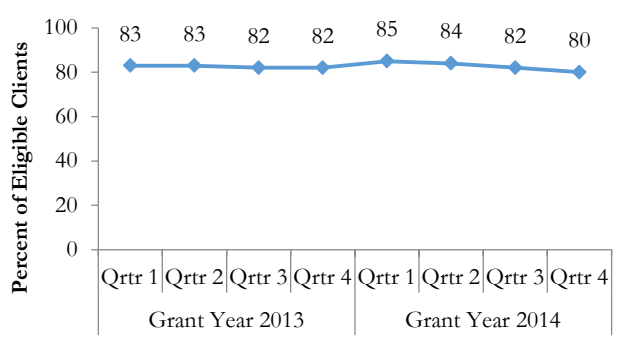


Figure 6: CCP Clients with at least 1 adherence assessment in the quarter, GY13–14

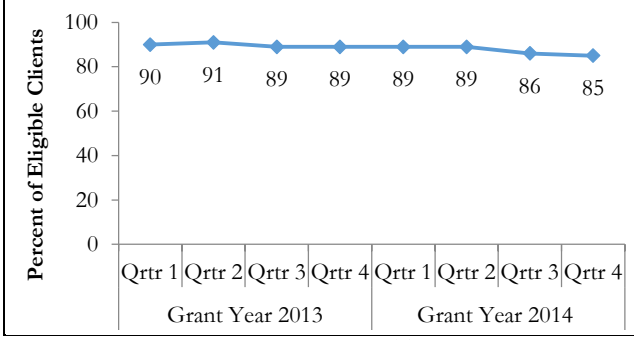
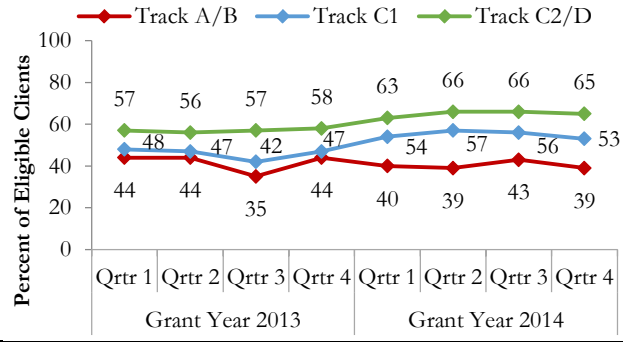


Figure 7: CCP clients with minimum # of home/field visits in the quarter, GY13–14



Source: NYC DOHMH. HIV Care and Treatment Program. eSHARE data as reported by April 19, 2015.

2. *Transitional Care Coordination (TCC).* The four measures of service quality include: 1) percent of clients who received a housing linkage; 2) percent of clients who received a case management linkage; 3) percent of clients who received a primary care linkage; and 4) percent of clients who received three health promotion services within the first three months of enrollment. In GY14, 49% of TCC clients were successfully linked to a housing program, up from 42% in GY13, and 25% of clients were linked to a case management program, up from 20% in GY13. Primary care linkage increased slightly from 56% in GY13 to 58% in GY14. Among clients enrolled within the first nine months of the grant year, 78% received at least 3 health promotion sessions within the first three months.

3. *Medical Case Management –Tri-County.* Tri-County MCM quality indicators cover: 1) percent of clients receiving an intake assessment or reassessment (e.g., needs assessment), 2) percent of clients receiving at least one treatment adherence assessment, 3) percent of clients receiving at least one care plan/service plan, and 4) percent of clients receiving one health education/health promotion service. Two review periods were selected for comparison of MCM indicators in the Tri-County region: September 1, 2013 – February 28, 2014 (first) and March 1, 2014 – August 31, 2014 (second). Indicators were presented to providers in March 2015. In comparison to the last six months of GY13, far more clients received a needs assessment during the first six months of GY14 (48 vs. 81%); the proportion of clients receiving at least one adherence assessment was similar for the two periods, around 82%; the proportion of clients who received at least one care plan in a 6-month period was slightly higher for the first half of GY14 than for the last half of GY13 (64% vs. 60%).

(iv) Use of performance measures to evaluate for disparities in care. All performance and quality indicators are service category-based, and data collected on clients include demographic, health, and service utilization data. Thus, the NY EMA is able to easily evaluate a range of disparities in care, including those related to race/ethnicity, gender, transmission risk category, and geographic

location, among others. Further, in 2014, as part of the EMA's Undetectable Framework, the DOHMH CTP began providing TSRs to each provider agency. The TSRs identify clients who are not virally suppressed to inform TA efforts, improve communication and coordination among RW service providers, and contribute to reductions in gaps in the HIV Care Continuum. In June 2014, 77 agencies received their first TSR and 74 agencies received a new report in January/February 2015. A monthly refreshable Excel version of the report was developed and tested in 2015, and is now provided to 74 unique agencies holding 94 unique contracts. In GY16, DOHMH TA staff will expand their work to include coaching in population health management using these data.

In late 2014, a multi-program, web-based CSS was conducted to gather client feedback on services in a standardized and comparable manner, and to identify barriers and facilitators to service utilization. The web-based Audio Computer-Assisted Self-Administered Interview (ACASI) tool was revised from the 2012 pilot (paper-based) survey, and was designed to be more accessible to all literacy levels and more focused on the client-provider relationship. The survey was available in English, Spanish, and French, and was offered in a confidential format (allowing linkage back to eSHARE and the HIV Registry) and an anonymous format. The survey was administered across service categories and among 80 service providers. More than 4,100 survey responses were received, yielding a 49% response rate, an improvement over the 30% pilot (hard copy) survey response rate. Ninety-two percent of clients surveyed were very or mostly satisfied with services overall. Agency-specific quantitative findings were shared at the end of March 2015 and service category-specific findings were shared at provider meetings in May to inform planning, TA, and QI projects. Open-ended responses are still being analyzed and will be used to guide GY16 focus group discussions.

(v) Stakeholder involvement in the selection of performance measures. As previously described, DOHMH staff, in collaboration with NYS AI and providers, used NGT to develop service category quality indicators. Analysis is based on data reported by providers, which facilitates their buy-in to evaluation and promotes a greater sense of ownership of the data and the results. Monthly QM Interagency meetings with key representatives from DOHMH, WCDOH, NYS AI, PHS-CAMS, and the PC (including PC consumer members) allow for presentation and discussion of performance on quality indicators to improve the CQM program, TA, and service delivery.

c. Description of CQM Program Quality Improvement.

(i) Process to Determine Priorities for QI Projects. Part A providers work with their DOHMH POs to prioritize performance improvement areas, examining available data and considering service impact and project feasibility. DOHMH TA staff will improve their capacity to coach for QI through application of the IHI's model for improvement. Further, providers within each service category meet to review and discuss performance and present QI projects to share successes and challenges in performance improvement, which promotes peer learning.

1. *Specific QI projects currently being implemented in EMA.* Providers across the EMA are implementing QI projects developed in their QM plans and workplans. Examples include:

- Improve the utilization and implementation of DOT services in CCPs.
- Improve VLS within a variety of service categories (SCF, HR, MCM).
- Improve performance on specific program activities such as reassessment in FNS, graduation in TCC, and referrals to healthcare services overall.
- Enhance organizational capacity for QI and better coordinate QM for RWPA and non-RWPA programs across service categories.
- Improve the client experience by creating an orientation protocol for new patients or fostering a transgender-friendly culture.

- Improve testing and linkage to care among HIV-positive persons who are unaware of their status through protocols to systematically offer HIV testing or that focus on PLWHA aged 40 and older.

In addition, the NY EMA will host its 2nd Annual Power of QI conference in November 2015, which will allow RWPA programs to engage in peer learning and share their QI projects. Posters and oral presentations at the upcoming conference will include such projects as "Reaching out for reassessments" (FNS), "Meeting the needs of people of Trans experience" (MH), and "Case conferencing to viral load suppression" (CCP). Over 31 posters and oral presentations are scheduled.

(ii) Efforts aimed at improving VLS within the EMA. As previously described, the CQM program reviews PCSMs as a means of measuring clients' utilization of primary care, receipt of ARVs, disease progression, viral load tests and values, and CD4 count tests and values. The PCSMs, reported on each active client at least every 120 days by all service categories providing post-linkage services, enable DOHMH to: 1) evaluate whether specific services increase access to and continuity of primary care for Part A clients; 2) track virologic and immunologic outcomes over time; and 3) assist providers in improving service quality and clinical outcomes. Data entry forms in eSHARE reinforce Part A program expectations by guiding the timely conduct of assessments and services for improved service quality. Other EMA initiatives also leverage Part A data and services to impact clinical outcomes. For example, as mentioned previously, the Grantee's TA staff use the Undetectable Framework's TSRs to work with all providers to identify clients not reported as virally suppressed and, among those, clients not recorded as being prescribed ARVs. Materials have also been distributed to providers to promote ARV initiation among their clients. In GY16, TA staff will expand their work to include coaching in population health management using these data.

(iii) Use of CQM data to inform service delivery. Trends identified through the CQM program enable the PC to assess Part A services over time. Indicators are often used to inform provider QM plans, which serve to improve service delivery. As the indicator data mature, the data can be reviewed for trends to inform long-range service delivery planning. CQM data reviewed and discussed in the QM Interagency meeting allow the PC to incorporate data-based changes in the service system upon careful consideration with the Grantee.

(vi) Stakeholder involvement in the selection of quality improvement activities. As noted above, the CQM program utilized NGT to develop service model-specific indicators, which are reported to providers at least annually, with adjustments to the indicators as appropriate. This enables TA staff to address program performance and provide TA to address QI. CQM data are reviewed service category by service category in the QM Interagency meeting, which includes PC members. This monthly meeting allows time for policy-level discussions on service delivery improvements. In addition, CQM data and program progress are presented annually to the PC and committees. This year's presentation will focus on the CQM Program's plans to expand its efforts to support VLS citywide, to address care quality at the clinic level, and improve referral pathways among medical care, Part A, and services funded by other payers.

Providers are required to incorporate input from consumers into their QM programs through CABs, ensuring that consumers are involved in quality activities, and verifying that each QM plan incorporates consumer input. In addition, as described previously, in GY14, the DOHMH REU implemented the multi-program CSS; initial findings have been shared with service providers and data will be analyzed and disseminated further in 2015. This tool was revised from a 2012 pilot survey, taking into account feedback from brainstorming sessions with RWPA providers and PC members. In preparation for survey implementation, presentations were given that highlighted changes in survey format and explained the value of conducting a largely confidential, non-

anonymous survey, which would enable linkage of survey results back to demographic characteristics, service utilization information, and health outcomes.

d. Data for Program Reporting. All Part A providers are contractually required, trained, and prepared to collect standardized data with service category-specific forms for each client profile, intake/baseline assessment, reassessment, and service encounter in eSHARE. RW eligibility in the EMA is based on HIV status, income, residency, and medical insurance status. DOHMH eligibility protocols require documentation at enrollment and each six-month reassessment in the client's chart and in eSHARE. Data reporting elements are closely monitored each reporting year.

(i) Information/Data System. All NY EMA Part A programs report client-level data in eSHARE, which has been designed with skip patterns, auto-populations, validations, and update rules to streamline and guide data entry for end users. With eSHARE, BHIV has greater ability to: 1) ensure client eligibility; 2) evaluate program impact; 3) monitor service delivery according to standards of care; 4) de-duplicate and track clients across Part A programs; and 5) match clients with the BHIV Registry for merged analyses with surveillance data. Regularly required PCSMs form the basis for several core indicators (i.e., linkage to care, HIV/AIDS concurrency, retention in care, receipt of ARVs, immune health, and viral suppression) that allow BHIV to evaluate programs in accordance with the NHAS, EIIHA, and the Comprehensive Plan. In 2014, over 1,200 users at 126 agencies used eSHARE to enter over 1,200,000 Ryan White, Prevention, or HIV testing forms representing services provided to more than 130,000 clients.

(ii) RSR. In 2014, all Part A client-level data were reported from eSHARE. By March 2014, eSHARE forms were modified to collect the new RSR data elements: Sex at Birth, HIV Diagnosis Year, and Race and Ethnicity Sub-categories. Beginning in May 2014, preparations were made for the 2014 RSR, including presentations at sub-recipient meetings and regular email communications to designated RSR contacts at each sub-recipient agency. In late 2014, the RSR Validations Report within eSHARE was updated to remove obsolete data elements including AIDS Diagnosis Year, Death Date, and Geographic Unit Code. The code to create the RSR client level data files from eSHARE (in XML format) was also modified to include the new data elements, including disability status. For the 2014 RSR, the NY EMA Part A Grant included 122 subrecipients, 110 of which were required by HRSA to submit client-level data in the RSR. All 110 subrecipients used the XML generator feature in eSHARE to create the client-level file for upload to the HRSA website.

Preliminary analysis comparing 2014 and 2013 shows a significant decrease (from 12% to 5%) in the proportion of Part A NY EMA service providers exceeding the 10% threshold for missing data on at least one of HRSA's five targeted (core) RSR indicators: 1) FPL; 2) health insurance status; 3) housing status; 4) viral load; and 5) ARV. This 5% represents six providers; of these, two had missing values for housing status, due to a service model limitation within eSHARE that has been corrected for 2015 RSR reporting; two providers provided satisfactory explanations of missing data and submitted 2015 action plans to HRSA; and one provider will be provided with TA to improve data completeness for the 2015 RSR reporting period. For the added data element 'Sex at Birth', for which there were no RSR validations in 2014, and for which HRSA expected some missing data, the overall completeness rate for RWPA subrecipients was 80%; this percentage will be improved in 2015.

The 2015 RSR will include an update of validations in the RSR Validations Report based on HRSA's updated validations. TA will be provided to providers on the use of the 'Test Your XML' feature in the HRSA HIV/AIDS Bureau's (HAB) RSR Web Application, which will generate data completeness reports for providers prior to upload of final RSR client-level data.

ORGANIZATIONAL INFORMATION

(1) Grant Administration. Through the rigorous monitoring and accountability measures described below, the EMA ensures that Part A funds are used effectively to address the country's largest and most

complex HIV epidemic. Eighty-six percent of the NY EMA's 2015 Part A contacts are paid based on performance, with subrecipients being paid for meeting service thresholds on a fee-for-service basis and achievement of specific deliverables, rather than by cost-based reimbursement. Transforming the portfolio into a results-oriented reimbursement model has increased efficiency and contributed to effective resource management with timely reallocation of dollars to higher-impact services. Through multi-pronged efforts, the EMA ensures that Part A serves as the POLR.

a. Program Organization. With nearly 25 years of experience as a Part A grantee, the EMA is committed to efficient program administration, aiming to maximize the effectiveness of HIV services. In GY14, the EMA spent more than 98.7% of its Part A formula award and 98.4% of its MAI award.

(i) Part A Administration (see Attachment 11). The Mayor of New York serves as the CEO of the EMA. The Mayor has designated DOHMH as the administrative and fiscal agent for Part A. As *Attachment 10* illustrates, the EMA's RW program is administered by the CTP in the DOHMH BHIV. The BHIV is headed by an Assistant Commissioner, who oversees 243 staff including 52.6 FTEs under the Part A grant as well as large HIV Prevention and Surveillance programs**.**

The Director of CTP oversees all staff responsible for service planning, TA, QM, research and evaluation, RW grant administration, and RW fiscal oversight in collaboration with the Director of Administration. There are 35.3 FTEs in the CTP and Administrative units. The Deputy Director of CTP collaborates with fiscal, program, TA, and administrative staff to ensure adherence to all applicable HRSA grant reporting and monitoring requirements. The Deputy Director oversees and coordinates the activities of two Program Planners and serves as an alternate to the Director of CTP for PC business. The Director of QM oversees one Program Manager and five POs as described in the CQM section. The Deputy Director of HIV Prevention oversees the TA provided to the EIS providers, in coordination with HIV Prevention. The two CTP Program Planners and one Evaluation Specialist, from REU, are responsible for working with the PC to develop needs assessments, evidence-based service directives, and program planning documents. The Deputy Director of Business Systems, under the leadership of the Director of Administration, oversees contract administration, including eSHARE data system implementation across Prevention and RW.

RW funds 9.6 FTEs in the REU of CTP overseen by the Director of REU. Using multiple methods, including merged analyses of provider-reported, HIV surveillance, and survey data, REU staff evaluates Part A client and program needs, service utilization, and health outcomes. REU staff track progress on Comprehensive Plan goals, analyze and prepare eSHARE data for site visits and provider meetings, report on performance indicators at the service category and agency levels for QM, elicit consumer input through surveys and focus groups, support service providers' use of the web-based data system, and improve completeness of RSR submissions.

The PC Director reports to the DOHMH Deputy Commissioner for the Division of Disease Control and oversees 5.0 FTEs to support the planning and administrative functions of the PC. The PC and Grantee meet regularly through a weekly meeting of the PC Director and the Director of CTP, pursuant to a detailed MOU approved by HRSA in 2012, to coordinate planning activities.

Because of reduced administrative funds with each declining award, administrative functions related to monitoring provider contracts are being consolidated. The WCDOH Master Contract will be assigned to PHS-CAMS in December 2015, thereby consolidating the work of both Master Contracts under one roof, resulting in increased administrative efficiency and reduced administrative burden. All contracts, and corresponding contract and fiscal monitoring, will move to PHS-CAMS; one FTE will remain in WCDOH to ensure continuity of services and provision of local services planning and support to the Tri-County Steering Committee. PHS-CAMS employs 42.72 FTEs to help administer the Part A program in NYC, including 21.6 FTE monitoring staff, 4.45 FTE contract administration staff, and 16.6 FTE planning and administrative staff. DOHMH facilitates a monthly

coordination meeting with PHS-CAMS and WCDOH and a monthly Data Workgroup with PHS-CAMS.

Recruitment for vacant Grantee positions, involving widely distributed postings and a competitive process, is in progress and will be completed at the start of GY16.

(ii) Avoiding service duplication. eSHARE generates the electronic Unique Client Identifier required by HRSA for the annual RSR and for the purpose of de-duplication across RW Program parts. In addition, the EMA's performance-based reimbursement system ensures that programs are paid for discrete services. Currently, 86% of subcontracts in the EMA are paid on the basis of performance (with the balance based on submitted expenditures). POLR monitoring ensures that Part A services are not reimbursed by other payers – including other RW Programs within the same organization. Some clients may be served by multiple RW program parts if services are not duplicative and are consistent with the client's treatment plan. For example, a client may receive Part C-funded MCM services and Part A-funded FNS. All Part A providers are required to describe how they assess for, identify, and resolve any duplication of services in their Scope of Service. The Grantee reviews all information to ensure that RWPA is the POLR.

b. Grant Recipient Accountability. Close and continual monitoring of Part A contracts ensures compliance with all applicable federal requirements and maximizes the return on Part A investments. As described below, monthly contract-level fiscal reports and annual TA and CM site visit reports are reviewed and kept onsite at PHS-CAMS and the DOHMH.

(i) Program Oversight. PHS-CAMS CMs are responsible for both fiscal and programmatic monitoring, ensuring that costs and activities are allowable and appropriate within the contract's budget and scope of services. In addition, providers in NYC, in most service categories, are assigned a DOHMH PO with expertise in the relevant programmatic content. POs provide one-on-one technical support and convene provider meetings to facilitate peer-led discussions of best practices. CMs and DOHMH POs 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 program challenges. While DOHMH POs focus on the programmatic elements and quality management of services, CMs at PHS-CAMS monitor contract deliverables and service documentation, conduct fiscal monitoring, and ensure compliance with relevant eligibility and administrative requirements, including client-level reporting. POs and CMs collaborate and ensure that consistent advice is provided to Part A subrecipients through joint site visits.

1. *National Monitoring Standards (NMS).* The NY EMA is compliant with all aspects of the NMS. After the initial release of the NMS, DOHMH, PHS-CAMS, and WCDOH met regularly to review policies and ensure compliance with all NMS with specific attention to client eligibility, Medicaid certification, and contract advances. The Deputy Director of CTP is responsible for ensuring that the NMS and associated HRSA and HHS policies are addressed throughout the EMA portfolio. The NMS are incorporated into contract language and into the service directives developed by the PC. In addition, the Grantee develops EMA-wide policies, as necessary; examples include policies on the *use of incentives*, *program income*, and the *use of indirect rates*. In GY14 and, to date, in GY15, the Grantee has undertaken the following activities to further implement the NMS and other federal policies:

- *Implementation of New OMB Circular.* To ensure that the EMA is compliant with the new uniform administrative requirements outlined in Title 2 of the Code of Federal Regulations (2 CFR), commonly referred to as the Omni-circular, the Deputy Director of CTP attended a grants management conference where the Federal Office of Budget and Management (OMB) gave multiple lectures on the changes and updates codified in 2 CFR. Upon return, the Deputy Director of CTP held an in-service for all RW contract and fiscal management staff on the impact of the regulation changes. In addition, responsible staff has attended multiple webinars on the subject. Contract

language has been updated throughout EMA contracts and further updates will be made, as necessary, after the release of the revised NMS and HHS Grants Policy Statement.

• *Implementation of HAB Policy Notice #15-01.* After attending the HRSA/HAB webinar for *Policy Notice #15-01*, the Grantee and Master Contractors acted swiftly to implement the policy. The NY EMA released a subrecipient bulletin that outlined the changes, provided guidance on calculating program space rent costs appropriately, and clarified how to correctly apply the new indirect rate policy for agencies that did not previously have a federally negotiated indirect cost rate. Since the notice came out after contracts had been negotiated for most subrecipients, a timeline and schedule was developed for re-negotiating budgets that would reduce administrative burden on contract management staff and service providers.

2. *Program Monitoring.* Each Part A contract specifies the nature of services to be delivered, eligibility requirements for clients, licensing or other requirements for staff, and contractual expectations. Contracts specify the number of clients to be served and service delivery targets. Each subrecipient providing Part A services must have operational grievance procedures in place (including whistleblower policies) and, in NYC, a CAB (Tri-County providers share a cross-portfolio consumer advisory group). Each subrecipient must collect and maintain client-level data in accordance with the EMA's reporting requirements. Using eSHARE, subrecipients collect demographic information, HIV status, primary exposure category, sexual risk information, co-morbid conditions, income, residency, insurance status, housing status, service utilization, clinical outcomes, and other information on Part A clients. Documentation of semi-annual assessments of residency and income are maintained in the client record, as is client HIV status and program-specific eligibility criteria; all are documented in eSHARE. Client-level data are used for program monitoring and evaluation and reimbursement of performance-based contracts.

3. *Number of contractors in 2015 and 2016 and site visits.* In GY15, Part A funding supports 177 contracts in the EMA in GY15 at 93 different agencies. In NYC, 62% of contracts have received site visits between March 2015 and July 2015. By the end of GY15, all NYC contracts will have had at least one site visit, and most will have two, from PHS-CAMS and/or DOHMH, with most receiving a joint PHS-CAMS and DOHMH TA visit. In Tri-County, all providers receive one programmatic and one fiscal site visit for each contract annually and, in cases where corrective action plans are required, a follow-up visit may be scheduled. All GY15 Tri-County programmatic site visits are complete; through August 2015, 86% have received a fiscal site visit. In GY16, plans to conduct approximately 234 site visits, with all contractors having at least one site visit, and most having two.

• *Fiscal and program monitoring process and frequency of reports.* PHS-CAMS supplies all subrecipients with a copy of the *Contractor Desktop Reference Guide*, which details expectations for Part A subrecipients, and WCDOH distributes its *Contract Monitoring Protocol.* Updates to the guide are published regularly, most recently in August 2013; the protocol was revised in May 2014. In addition, PHS-CAMS and DOHMH developed and provided subrecipients with the *Guide to Requirements for Services: Payability and Data Reporting* (the Payability Guide), which PHS-CAMS updates routinely. The Payability Guide provides guidance on submitting data for performance-based contracts. While the major emphasis is on requirements for payment, it also covers requirements for contract compliance, provides information on data reporting and evaluation, and outlines staff credentialing requirements for services. The current version is available on the PHS-CAMS website.

The EMA's multi-faceted contract monitoring process includes monthly electronic data submissions, comprehensive quarterly reviews, multiple on-site visits each year, documentation reviews, frequent telephone and email contact, and other meetings, as necessary. All Part A providers are required to maintain standardized client-level data records with de-identified client-level extracts reviewed monthly by PHS-CAMS or WCDOH for reimbursement and by DOHMH for service

utilization analysis. Using eSHARE, subrecipients finalize client-level data entry by the 15th of each month, the point at which PHS-CAMS and DOHMH consider subrecipient-reported data to be ready for assessment for reimbursement and performance. In addition, PHS-CAMS and WCDOH require 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-CAMS, DOHMH, and WCDOH in advance of reimbursement. To ensure shared subrecipient information between PHS-CAMS and DOHMH, PHS-CAMS CMs and DOHMH POs hold regular joint monitoring meetings to review progress and discuss subrecipient concerns, including reviews of corrective actions. In addition, PHS-CAMS CMs prepare a comprehensive report twice per year on any significant subrecipient contracting issues, including salient programmatic, fiscal, and administrative challenges and successes. WCDOH provides DOHMH with a quarterly report on such issues.

- *Fiscal monitoring: performance-based contracts.* Fee-for-service subrecipients are paid a reimbursement rate for each reported unit of service, making monthly client-level service data the basis for reimbursement. Reimbursement rates are developed by DOHMH and PHS-CAMS, and factor in the cost of providing the services and assumptions about staff productivity. CCP contracts are paid a per-member, per-day rate for each enrollment, which serves as a summary of required activities; each day of enrollment is automatically assessed to ensure that required services have taken place. At the contract level, monitoring focuses on on-site verification of claimed services and adherence to contractual requirements; payment is withheld if subrecipients fail to submit required documentation. PHS-CAMS conducts thorough reviews of subrecipients' audited financial statements, single audit reports (formerly A-133), and management letters, securing written responses regarding any problem identified by auditors. Persistently delinquent audit packages are cause for withholding of reimbursement and can be cause for termination.

Beginning in GY14, as per the recommendation of the HRSA Comprehensive Site Visit team, PHS-CAMS standardized its collection of contract expenses to inform the process of reimbursement rate adjustments. Such information is obtained through Year End Cost Reports, which replaced the mid-year expense reports that PHS-CAMS formerly reviewed to substantiate allowable costs. In addition, beginning in 2015, PHS-CAMS resumed the biennial submission of the Infrastructure Self-assessment Questionnaire. Performance-based subrecipients are required to complete the Questionnaire outlining their fiscal policies and procedures and identifying any possible internal control challenges. Subrecipients that identify infrastructural deficiencies are referred for TA. Certain deficiencies, such as outstanding tax liability, are cause for further investigation and may result in withholding of payment and other disciplinary action.

- *Fiscal monitoring: cost-based contracts.* For contracts that remain cost-based, PHS-CAMS and WCDOH (all WCDOH contracts are cost-based) require subrecipients to submit monthly line-item expenditure reports. CMs review reported spending and withhold reimbursement if subrecipients fail to submit required monthly programmatic reports, external audit packages, and/or if reports are incomplete or contain unbudgeted or unallowable costs. Written protocols direct CMs on how to handle incomplete or inappropriate submissions of support documentation. PHS-CAMS and WCDOH conduct annual fiscal site visits for all Part A cost-based contracts to review subrecipients' fiscal and administrative operations. During the site visit, staff review documentation for at least three months of reported expenditures. The support documentation reviewed is sampled using a methodology that conforms to the NMS. The fiscal site visit also includes review of personnel files, allocation methodologies for shared costs, time and effort recordkeeping, and, as required, a review of equipment inventories and single audit report submissions. Subrecipients with a history of fiscal

monitoring deficiencies are required to submit supporting documentation of reported expenses with greater frequency.

- *Frequency of fiscal and program monitoring site visits.* CMs and Contract Coordinators make at least one routine site visit each year per contract, with more for under-performing contracts or contracts on conditional (disciplinary) status. During routine site visits, monitoring staff review documentation to verify that services have been delivered in accordance with the contract's scopes. Monitoring activities undertaken during site visits include: client chart reviews to verify that eligibility has been ascertained, services are documented and consistent with the approved scope of services, and staff are appropriately credentialed; reviews of quality assurance documentation; observation of service delivery; and documentation of staff training. All new contracts have an initial site visit in the first three months of operation to monitor start-up activities, which is one of two visits for the year. For service categories that have a DOHMH PO assigned, DOHMH and PHS-CAMS jointly conduct the annual routine site visit for each program. At annual routine site visits, subrecipients attend an entrance conference, after which activities are divided with POs conducting TA and CMs conducting contract monitoring, and ending with all staff attending an exit conference. PHS-CAMS staff summarizes findings and recommendations from site visits in written reports and provide the reports to subrecipients within 60 days.

4. *Corrective action.* Corrective action may be required in response to findings from site visits, review of monthly reports or audited financial statements, or semi-annual compliance reviews. Examples of matters requiring programmatic corrective action plans include low service levels; failure to adhere to required program elements; or persistent failure to document services, serve the target population, or follow POLR regulations. Issues that require corrective action are clearly outlined in materials provided to subrecipients. When corrective action is warranted, the CM sends the contract's senior administrator a letter detailing deficiencies that must be addressed. Subrecipients must present a corrective action plan within 15 (NYC) or 30 (Tri-County) days, clearly specifying the actions to be taken, responsible parties, timeline, and anticipated outcomes. PHS-CAMS and WCDOH approve all corrective action plans.

In NYC, DOHMH and PHS-CAMS conduct a comprehensive compliance review panel twice a year. Contracts are placed on conditional status when they fail to submit a satisfactory corrective action plan or fail to successfully implement the agreed-on corrective action. In such cases, senior management of the agency must meet with contract monitoring staff and submit a compliance plan within 15 business days. In the current fiscal year, three contracts were placed on conditional status. Failure of contracts on conditional status to correct deficiencies may result in contract reduction or termination. To ensure effective use of Part A funds, the EMA maintains guidelines for the termination or reduction of under-performing contracts. These guidelines ensure that all contracts on conditional status for four or more quarters, and whose compliance plan has not been successfully completed in the required timeframe, are recommended for reductions or termination. Persistently low-performing contracts may receive permanent funding reductions or be terminated. The most prevalent types of non-compliance among NYC contracts were low levels of service or related programmatic issues (92% of non-compliant contracts) and issues with reporting client-level data (5% of non-compliant contracts). Contracts may be cited for more than one problem area.

- *Improper charges or other findings and corrective actions.* Contracts requiring corrective action are assessed at the end of semi-annual review periods, although egregious findings can initiate corrective action at any time. The first review for the current year (GY15), covering the period March through August, will take place in October. In 2014, 10 NYC contracts were on conditional status for low service levels. In 2014, 38 NYC RW contracts, or 24% of all contracts, had corrective action or compliance

plans in place for some part of the contract year; no Tri-County contracts were on conditional or watch status during the first half of GY15.

5. Technical Assistance. The DOHMH programmatic TA staff work with contracted providers in key service categories to improve the health and well-being of Part A clients. Programmatic TA optimizes program performance, improves the accuracy of reporting and utilization of performance data, and enhances the capacity of programs to provide services in line with the contracted model (e.g, CCP, EIS, etc.). In the 2013 HRSA Comprehensive Site Visit Report, the HRSA/HAB site visit team acknowledged the TA team as a best practices model. DOHMH POs conduct site visits, conference calls, provider meetings, workshops and trainings, and participate in contract negotiation and program monitoring.

To date in GY15, programmatic TA has been provided to CCP, TCC, MH, HR, n-MCM, SCF, and FNS providers; 28 of the 97 assigned contracts received TA during 28 routine and/or targeted TA site visits dedicated to ensuring fidelity to service models, and improving documentation of program services and accuracy of eSHARE reporting processes. A total of seven provider meetings have been held thus far in GY15, and an additional two are scheduled for the remainder of the year. Additional TA activities in GY15 included 20 group trainings for over 200 staff from 60 provider agencies; training topics included service documentation, eSHARE, care coordination, health promotion, clinical supervision, and evidence-based interventions for HR services.

In 2014, the HIV Prevention Programs Diagnostics Unit conducted 120 site visits to 31 EIS contracts. Funded agencies conducted testing under three different models: routine testing, priority populations testing, and social network testing. Six provider meetings were held. In 2015 to date, 80 EIS site visits have been conducted, and three provider meetings have been held. In addition to quarterly site visits, POs conduct monthly check-in calls to each agency.

(ii) Fiscal Oversight.

1. Fiscal staff accountability. The EMA ensures the efficient use of funds for their intended purpose through fiscal monitoring and accountability protocols. Fiscal staff are supervised by senior managers at PHS-CAMS, WCDOH and DOHMH. Spending is recorded and tracked in the PHS-CAMS data and payment management systems which are reconciled with the PS-CAMS financial accounting system on a quarterly basis. PHS-CAMS staff prepare and submit quarterly spending reports to DOHMH, as well as the PC, for review. Formula, Supplemental, and Carryover funds and expenditures are tracked and reported separately. On a quarterly basis, PHS-CAMS, WCDOH, and DOHMH staff meet with the PC Finance Committee to review and discuss the 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 high-priority services. At the end of the contract term, subrecipients are required to calculate and report the aggregate amount of program income generated and costs covered by it. The EMA's aggregate program income and costs covered by program income are then reported to HRSA in the Federal Financial Report (FFR). The Director of Finance and Operations at PHS-CAMS manages fiscal tracking and reporting and reports directly to the Vice President for HIV Programs and Special Initiatives, who is part of PHS-CAMS's senior management team. The Financial Manager at the WCDOH will support the transition of contracts and other financial documentation to PHS-CAMS in the last quarter of GY15. At DOHMH, the Grant Fiscal Administrator, a Fiscal Analyst, and the Deputy Director of CTP, all overseen by the Director of CTP and the Director of Administration in the BHIV, are responsible for fiscal oversight and reporting on the RW grant, including implementation of the NMS.

- *Roles and responsibilities of fiscal staff.* With the EMA's shift to performance-based reimbursement, PHS-CAMS's organizational fiscal monitoring of programs primarily takes place through the review, by a Fiscal Manager, of the organization's audited financial statements and single audit reports. CMs

are responsible for fiscal monitoring of cost-based contracts. CMs verify that expenditures adhere to subrecipients' approved budgets.

At WCDOH the Accountant has primary responsibility for fiscal oversight. The Accountant reviews all monthly claims against the contracted budgets as well as all budget modifications. The Accountant also completes audits of every subrecipient's supporting documentation. DOHMH assists with fiscal monitoring by reviewing subrecipients' financial statements and annual audits, advising WCDOH of any findings requiring corrective action.

DOHMH fiscal staff, in collaboration with the Master Contractors, prepares and submits to HRSA: administrative budgets, allocation and expenditure tables, OMB forms such as the SF424A and the FFR, unobligated balance and carryover requests, and other fiscal documents required under the conditions of award. In addition, the Grant Fiscal Administrator and the Deputy Director of CTP interpret and summarize the fiscal monitoring standards into policies and procedures for the EMA, seeking clarification from HRSA as necessary.

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

At WCDOH, the two CMs work as a team with the Accountant before any payments are made. The CMs collect the monthly narrative, statistical, and expense reports. The CMs review the narrative and statistical reports for performance and accuracy and, only once approved, pass on the expense reports to the Accountant. The Accountant accompanies the CMs on all site visits where documentation supporting expenses is reviewed. Payments are made with the final sign-off of the program administrator who, together with the CMs and Accountant, meet weekly to discuss any program and fiscal irregularities requiring additional documentation or added site visits.

- *Fiscal Staff Organizational Chart (see Attachment 10).*

2. *Tracking Funds.* DOHMH separately tracks formula, supplemental, MAI, and carryover funds through a PHS-CAMS data system, PAMS, and AMS Advantage. As part of standard quarterly reports, PHS-CAMS and WCDOH report expenditures to DOHMH in each funded service category, outline funding commitments per service category, and summarize spending rates. These reports are presented to the PC to monitor expenditures, allocate funding for the following year's spending plan as well as develop a carryover plan for unspent funds at closeout.

3. *Timely monitoring and redistribution of unexpended funds.* DOHMH, PHS-CAMS, and WCDOH continuously monitor subrecipient spending and projected underspending. Underspent contracts are considered for reduction based on their rate of year-to-date and projected spending for the remainder of the contract. Underspent funds are redirected pursuant to the PC's reprogramming plan.

The discrete financial value of reported services in performance-based contracts facilitates PHS-CAMS's ability to identify programs that are not performing as projected. Likewise, reported over-performance makes clear which subrecipients are suitable candidates for enhancements. Such enhancements reimburse subrecipients for any incremental costs associated with the provision of additional services and allow for efficient use of Part A funding. In GY14, 85 Part A contracts were reduced (a total of $3.69 million) and 64 high-performing contracts received budget enhancements (for a total of $4.69 million). PHS-CAMS is able to amend contracts quickly to reflect these changes. In GY14, the EMA spent more than 98% of its award, a remarkable achievement in a grant exceeding $103 million.

4. *Subrecipient compliance with audit requirements.* Consistent with the new Uniform Administrative Requirements, Part A subrecipients are contractually required to submit a single audit report, where applicable. If a single audit is not applicable to the contract, the subrecipient must submit a letter of explanation from its auditor. PHS-CAMS communicates any material changes in federal and state reporting requirements. The NYS Nonprofit Revitalization Act as well as federal OMB updates are the topic of an upcoming "Newsflash" for subrecipients, as PHS-CAMS seeks to ensure compliance with up-to-date audit rules. Subrecipients that fail to adhere to the EMA's audit submission requirements are immediately deemed to be out of compliance, and their reimbursements are placed on hold until appropriate submission is made. PHS-CAMS staff carefully review all audit reports. In GY14, PHS-CAMS contracted with 87 agencies; however, only 70 audit packages were required to be submitted. In these cases, the financials of the agencies were consolidated into one audit package. All 70 audit packages were submitted in GY14; 38 (54%) were submitted late. Delinquent audit reports result in delayed payments, at a minimum. In the Tri-County region, all 14 fiscal organizations submitted audit reports in 2014 with four (29%) received late.

5. *Addressing subrecipient audit findings.* Thirty-four percent of NYC Part A subrecipients' audit reports contained issues noted in GY14. Issues ranged from general observations to auditor recommendations, some of which were unrelated to the Part A programs or the agencies' infrastructure. Of the issues noted, only 2% 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 OMB 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. No Tri-County audits had findings in GY14 that required corrective actions. For subrecipients with audit findings, PHS-CAMS and WCDOH request quarterly updates on corrective measures implemented. In cases where management provides an inadequate or no response, the agency may be placed on corrective or conditional status and PHS-CAMS and WCDOH request a corrective action or compliance plan to resolve the audit deficiency, during which agency reimbursements are placed on hold.

6. *Subrecipient reimbursement.* PHS-CAMS reimburses subrecipients monthly. Monthly reports are due to PHS-CAMS on the 15th of the month for NYC subrecipients or on the 30th for Tri-County subrecipients, including a monthly Program Narrative Report. The PHS-CAMS contract management system logs and time-stamps receipt of monthly reports and automatically uploads expenditure data. In addition, DOHMH extracts data from the client-level database (eSHARE) on the 16th of each month, transmitting it to PHS-CAMS for payment processing and compliance monitoring.

- *PHS-CAMS Payment System.* CMs review reports to determine payment. For cost-based contracts, reported expenditures must be consistent with approved budgets and allowable per the RW 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 modification to shift projected services between service types or a request for enhancement funding is approved. In addition, many services have utilization restrictions for payment, such as frequency limits, minimum group size or prerequisites. Many of these rules are enforced electronically, through the payment system database, while others are found only through site visits.

In the second half of each month, PHS-CAMS 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 Contract Coordinators. Some problems may be correctible while others may result in recoupment during closeout.

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

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

All Tri-County programs are reimbursed on a cost or line-item budget basis. A monthly expense report (with claim voucher) is due 30 days after the month of services reported for actual costs incurred. Each expense report must be accompanied by a statistical and narrative report citing number of clients served, service units provided, and a description of services delivered. The Program Administrator reviews and initials the voucher for payment by the Accountant, who scrutinizes each claim for accuracy and unallowable costs, and then processes each for payment by electronic transfer of funds to the agency's account.

A final report is due from each subrecipient at the end of the year. At that time, cost-based subrecipients may request budget or service modifications equal to up to 20% of the value of the contract to reimburse actual costs incurred to deliver services. 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, which in the past four years has allowed for reallocation between service categories up to 15%. Such enhancements reimburse subrecipients for any incremental costs associated with the provision of additional services.

c. Administration Assessment.

(i) Narrative. Consistent with legislative mandates, the PC assesses the efficiency of the administrative mechanism in timely allocation of Part A funds to areas of greatest need in the EMA.

1. *Assessment of Grantee's activities.* The PC's Finance Committee leads the assessment process. In GY14, the Finance Committee received quarterly commitment and expenditure reports for all Base- and MAI-funded service categories in NYC and the Tri-County region. The Finance Committee produced a checklist of measures including: contract executions and renewals, procurement, sub-subrecipient payments, and spending. The Finance Committee reported its findings to the Executive Committee and full PC, which approved the GY14 Assessment of the Administrative Mechanism on July 30, 2015.
2. *Deficiencies.* The Finance Committee determined that there were no deficiencies in the administrative mechanism and no corrective action was needed for GY 2015.

d. Third Party Reimbursement.

(i) Narrative. During GY15, the EMA has expanded its already robust process to ensure that all RW funds serve as the POLR. As previously discussed, the PC undertakes a comprehensive analysis of all other 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 criterion being "Payer of

Last Resort/Alternate Providers of Service." This tool helped the PC to specifically design the GY16 Part A Plan to address gaps in Medicaid, Medicare, and other reimbursement systems.

Beginning in GY11 and continuing through GY15, DOHMH and PC staff has been engaged in ongoing monitoring of changes due to the ACA and related NYS Medicaid Redesign efforts. This includes review and analysis of resources released by HRSA/HAB and the NYS Medicaid Redesign Team, as well as items published by national policy organizations and the media. This information was shared with stakeholders through presentations to committees of the PC and a monthly policy newsletter. Information gleaned through these efforts was incorporated into the *POLR Tool*. The EMA requires agency certification to bill Medicaid in all applicable service categories.

1. *Monitoring Third Party Reimbursement.* Contractual provisions define RW 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 payer sources. Contracts require subrecipients to carefully monitor third party reimbursement. Each service category RFP expressly provides that Part A is the POLR. As mandated in the RFP and in the eventual contract, all Part A programs must participate in applicable NYS Medicaid and State-funded uninsured care programs for those services reimbursed by Medicaid.

During contract negotiations, PHS-CAMS identifies all potentially reimbursable services and explore all sources of third party payment. Providers must submit "Reimbursement Worksheets" with the projected number of reimbursable services for the budget period and the amount of Part A funding that may be offset by third party payment. Providers are required to articulate why such services are not reimbursable from a source other than RW. These statements, ultimately part of the provider's contract, expressly prohibit the use of RW funding for otherwise covered activities. PHS-CAMS monitors contracts against their statements. MCM service design and contracts have expressly taken into account other case management services such as those reimbursed through Medicaid, mandating coordination with NYS-funded case management programs and providing lower reimbursement for dually enrolled patients based on services that are *not* covered by Medicaid.

In 2010, PHS-CAMS introduced a new level of verification to ensure that services billed to RW have not been billed elsewhere. Contracts that include services that are potentially reimbursable by Medicaid and other payers are subject to an annual review of all billing records associated with a patient visit. This review forces coordination between grants management and Medicaid billing staff.

2. *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 and effective date of coverage.

Many PLWHA with incomes between 100 and 400% of FPL are eligible for discounted premiums for plans on the NYS health insurance exchange (with exceptions based on insurance and immigration status), resulting in more PLWHA with health insurance. Based on the guidance issued by HRSA/HAB regarding ACA-related outreach and enrollment activities, the EMA sent a letter to providers in funded eligible service categories (EIS, MCM, n-MCM, and HE/RR) to notify them of their obligation to provide outreach, enrollment, and/or benefits counseling. 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 PLWHA who are eligible for other sources of assistance access those resources before accessing the RW care system, and that PLWHA are receiving enrollment assistance from application counselors who understand the HIV care system.

3. *Tracking and use of program income.* DOHMH and PHS-CAMS began implementing program income requirements in 2012 with subrecipients of the EIS category. Sliding fee schedules and caps on charges as well as full implementation of program income began in June 2013 for all service categories with potential program income. PHS-CAMS and WCDOH provided definitive guidance, through policy notices and a webinar, to subrecipients on the collection, use, and reporting of potential program income, with actual program income reported at closeout. In addition to reporting the amount of program income earned, programs also report how they have or will use the income to improve RW programs. The most common use of program income is to pay for administrative costs that were not covered under the 10% administrative cap. The EMA reports aggregate program income to HRSA on its annual FFR.

Because of the safeguards designed to ensure that RW funds remain the POLR, there are very few instances when a program might earn program income from RW activities, or clients. The primary instance, leading to why program income reporting was implemented in EIS first, is when a clinical program performs an HIV test on an uninsured person, after which the individual becomes enrolled in Medicaid; the clinical provider is allowed to back-bill Medicaid for any service, including HIV testing, which occurred during the three months prior to enrollment. The payment from Medicaid is considered program income and is reported to the Grantee as explained above.

e. Maintenance of Effort (MOE). (1), (2) and (3) ***(see Attachment 12).***

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