

Abstract.

- *Project Title: HIV Emergency Relief Grant Program - Part A.*
- *Applicant Name: City of New York*
- *HRSA Announcement Number 09-184*
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More than 9 million people live in the New York (NY) Eligible Metropolitan Area (EMA). The EMA has a much higher rate of poverty than the U.S. as a whole (18.5% compared to 12.5% nationally), a greater proportion of Black and Hispanic residents (51% versus 20%), more foreign-born (36% versus 12%), and more people without health coverage (28% of working adults versus 14%).

The EMA also has the country's largest and most complex HIV/AIDS epidemic. With less than 3% of the U.S. population, the EMA is home to 14.4% of living AIDS cases. More than 107,000 people are living with diagnosed HIV/AIDS. Blacks account for 45% of people living with HIV or AIDS (PLWHA) and 50% of new AIDS diagnoses, followed by Hispanics (32% of PLWHA) and non-Hispanic whites (21% of PLWHA). Women account for 31% of PLWHA. Men who have sex with men and injection drug users represent the two largest populations of PLWHA, although heterosexually-acquired infections are on the rise. Among PLWHA enrolled in the EMA's longitudinal client cohort study, 73% have incomes under \$10,000 annually, more than 90% report lifetime drug use, one in four is unstably housed, and more than one-third are experiencing a mental health disorder. As the epidemic evolves, the PLWHA population is becoming increasingly disenfranchised and more likely to suffer from substance addiction, mental illness, and housing instability, exacerbating the cost and complexity of the EMA's AIDS response.

The EMA includes the five boroughs of New York City, and Westchester, Rockland and Putnam counties north of NYC. Racial/ethnic minority neighborhoods in the South Bronx, Upper Manhattan, and Central Brooklyn have been most heavily affected, along with the largely white, heavily gay neighborhood of Chelsea in Lower Manhattan.

With vital support from Part A, the EMA has established an HIV care continuum that has been cited as a national model by the Institute of Medicine. Part A services are distributed throughout the EMA, but are heavily concentrated in the minority neighborhoods where needs are greatest. Primary medical care is supported in part by Medicaid and delivered through a network of AIDS clinical centers and New York's HIV Uninsured Care Program (also supported by Part A). Early intervention initiatives engage out-of-care PLWHA and link them to services, while treatment adherence initiatives work individually with patients to help them take medication regimens as prescribed. Part A supports mental health care, substance abuse services, housing assistance, and medical case management to strengthen linkage to care and improve medical outcomes. While those in care receive high-quality services – regardless of race, ethnicity, gender, or HIV exposure category – individuals battling acute poverty and associated co-morbidities are least likely to receive an HIV test, remain in care, and adhere to treatment regimens, underscoring the continued need for Part A support. In FY09, the EMA will use Part A funding to implement a new standard-driven, evidence-based care coordination program in the medical case management category.

The EMA has received continual Ryan White Part A support since 1991.

Pursuant to the FY2009 Ryan White Part A Program Guidance, dated July 14, 2008, the Department of Health & Mental Hygiene (DOHMH) of the City of New York (NYC), as Grantee for the Eligible Metropolitan Area (EMA) of New York, New York, submits this application for funding under Part A of the Ryan White HIV/AIDS Treatment Modernization Act (HATMA) of 2006.

Home to the country's largest, most diverse and most complex HIV epidemic, the New York EMA has implemented an HIV care continuum cited by the Institute of Medicine as a national model. (1) Building on this success, DOHMH in 2004 launched a campaign (*Take Care New York*) to achieve significant, measurable improvements in public health. A key component of this new public health strategy was the goal of reducing annual AIDS deaths by 42% within four years, bringing annual AIDS mortality below 1,000 for the first time since the epidemic's early years. As a long-term strategy to improve medical outcomes for PLWHA, the EMA is aggressively promoting early diagnosis of HIV infection, swift entry into HIV primary care for people who test HIV-positive, and preventing the progression of HIV disease by ensuring that PLWHA receive the high-quality medical and support services they need. The unique gap-filling role of Part A has played a key role in advancing NYC efforts to meet this goal. Through a multi-year re-evaluation and re-competition of the entire Part A portfolio, the EMA has reallocated substantial funds from support services toward HIV primary care and other core services that promote health care access, continuity in care, and treatment adherence. Part A providers of both clinical and non-clinical services are now required to monitor clients' primary care utilization and to intervene to address access barriers. The EMA has invested significant new resources in innovative programs to link out-of-care individuals to HIV primary care, promote maintenance in care, and increase treatment adherence.

These strategies have achieved remarkable results. Three years after the launch of the new NYC initiative, the EMA was more than halfway towards its goal of a 42% reduction in HIV-related deaths. (2) The decline in deaths among PLWHA since 2003 has been almost two times greater in NYC as for the U.S. as a whole. (2) As the EMA's early intervention and maintenance in care services have been intensified, estimated unmet need has steadily declined since 2004. (3) With Part A services prioritized for traditionally underserved minority communities, newly diagnosed Black and Hispanic PLWHA are now more likely than their white counterparts to be in HIV primary care. (1)

While significant progress has been made in reducing HIV-related illness and death, the EMA confronts considerable obstacles in achieving its vision of dramatically lower death rates for PLWHA. Demands on the HIV service system are increasing from year to year, as HIV prevalence in the EMA increases due to increased life expectancy for PLWHA. As the epidemic has evolved, the EMA's longitudinal cohort of low-income PLWHA has become poorer and more likely to suffer acute social and medical co-morbidities, such as substance abuse, mental illness, homelessness, and previous incarceration. (4) And the rate of new diagnoses among the foreign-born has nearly doubled in recent years. (2)

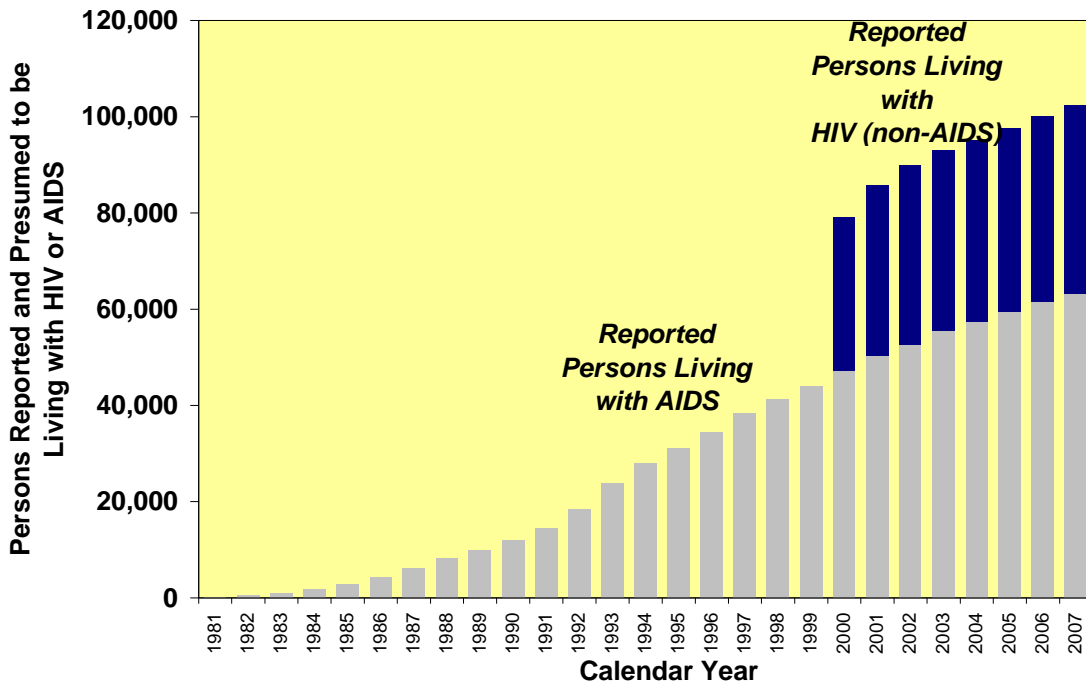
To meet such challenges, the FY09 plan allocates 78% of Part A funding toward core medical services. The FY09 plan recognizes that while life-preserving medical services are widely available to those most in need, critical barriers often interfere with the ability of PLWHA to make optimal use of these services. The FY09 plan consolidates funding from three separate service categories and reallocates funds from two others to create a new, evidence-based medical care coordination program to address the factors that prevent

existing services from achieving maximum public health impact. As in previous years, strong and continued Part A funding is vital to the EMA's efforts to manage its unequaled HIV epidemic.

1. Demonstrated Need. The impact of HIV/AIDS on the New York EMA has no parallel in the developed world. Since the beginning of the epidemic, roughly 200,000 New Yorkers have become infected with HIV. To date, more than 100,000 New Yorkers with HIV/AIDS have died. (2)

The EMA's epidemic is not only the country's largest but also the most complex. Over time, the epidemic has become concentrated in the EMA's most vulnerable communities – among the economically disadvantaged, racial and ethnic minorities, the homeless, the formerly incarcerated, and people suffering from mental illness and substance abuse.

Figure 1
People Living with HIV or AIDS (PLWHA), NYC, 1981-2007



As the epidemic has grown in magnitude and complexity – and as PLWHA are living longer due to improved treatments – HIV-related costs to the EMA have increased. In FY09, the EMA estimates that total public spending on HIV/AIDS care and treatment will exceed \$2.8 billion annually (excluding in-patient expenses). In addition to these financial costs, HIV/AIDS continues to cause incalculable injury to families and communities.

As this section describes, PLWHA in the EMA have an overwhelming and growing need for critical Part A funding:

¶ *Unmet Need.* One-third (33%) of PLWHA were not receiving HIV primary care in 2007. (3) While a decline from 37% in 2004 following intensification of early intervention and linkage services, the rate remains unacceptably high. Reducing unmet need represents a critical EMA priority.

¶ *Increasing Need for Services.* In an era of flat or declining Part A funding, the demand for services continues to increase, as PLWHA live longer and experience a wider range of

chronic conditions. Since 2000, the number of people living with AIDS in the EMA has risen almost one-third. (2) (Fig. 1.) At the same time, the growing prevalence of medical and social co-morbidities among PLWHA using Part A services has increased average service intensity for Part A clients. (4)

¶ *Relative Rates of Increase in HIV/AIDS Cases.* The proportion of HIV/AIDS cases among Asian/Pacific Islanders, men who have sex with men (MSM), and people with heterosexually acquired HIV has increased since 2001. PLWHA over age 50 experienced the sharpest increase in cases from 2001 to 2007. Among new diagnoses, the percentage among foreign-born New Yorkers increased from 17% in 2001 to 27% in 2006. (1)

¶ *Current HIV/AIDS Prevalence.* More than 107,000 people are living with diagnosed HIV or AIDS in the EMA (5), along with several thousand additional individuals who are infected but not yet diagnosed. (See Attachment 3.) With only 2.7% of the U.S. population (6), NYC accounts for 14.4% of all AIDS cases nationwide. (7)

¶ *Factors Affecting Cost and Complexity of Care.* The intensity and complexity of service needs for multiply diagnosed PLWHA greatly increase the costs associated with the EMA's HIV care system. (See p. 8.) Costs and difficulties of delivering HIV care services are further increased by the exceptional diversity of the EMA's PLWHA population and by the high cost of living in the EMA.

¶ *Impact of Co-Morbidities.* Despite recent progress on a number of fronts, NYC continues to have among the country's highest rates of tuberculosis, sexually transmitted infections, hepatitis, mental illness, and substance addiction. (See p. 8.) Co-morbidities increase health care costs associated with HIV disease management.

¶ *Prevalence Among Correctional Releasees.* An estimated 6.5% of male inmates and 13.9% of women in city jails are HIV-positive. (8) Several thousand PLWHA pass through NYC correctional facilities annually, including nearly 1,000 individuals with previously undiagnosed HIV infection. More than 40% of PLWHA participating in the EMA's longitudinal client cohort study* (CHAIN) have a history of incarceration. (4)

¶ *Homelessness.* Nearly one-third of all PLWHA participating in the CHAIN cohort were homeless or unstably housed in the 12 months prior to their HIV diagnosis. (4) People with HIV are 70% more likely than the general NYC population to suffer from chronic homelessness (i.e., at least five years' duration) and three times more likely to experience sporadic or short-term homelessness. (9)

¶ *Factors Limiting Health Care Access.* Utilizing essential medical services can be especially challenging for PLWHA who suffer from substance addiction, mental illness, and/or housing instability. Key populations – including women, MSM, immigrants and correctional releasees – confront unique and frequently overwhelming barriers to care.

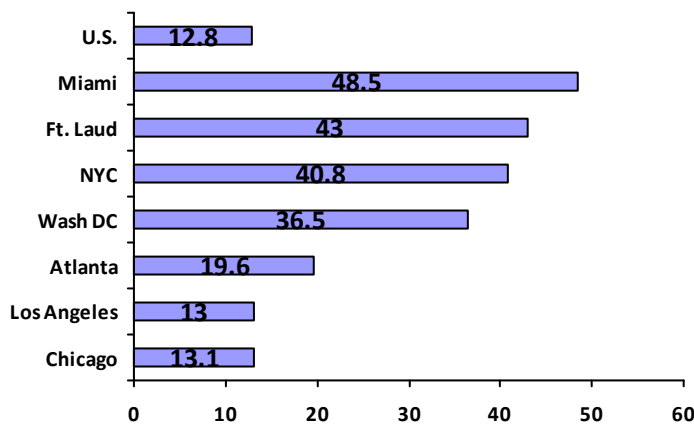
* Since 1994, the EMA has commissioned the Columbia University Joseph L. Mailman School of Public Health to undertake a longitudinal client cohort survey, the Community Health Advisory Information Network (CHAIN). CHAIN evaluators periodically survey PLWHA living in NYC and in Westchester, Rockland and Putnam Counties. The base cohort of 700 individuals, recruited in 1994-95, was replenished in 1998 and again in 2001-03. A cohort of more than 400 residents from Westchester, Rockland and Putnam Counties was recruited in 2000-2001. Recruited primarily in social service settings and safety-net medical clinics, the cohort broadly reflects the population of low-income PLWHA receiving Part A services, although it may not be representative of PLWHA in the EMA as a whole. CHAIN researchers interview participants to assess their perceived service needs, monitor service utilization, and track other key issues, such as frequency of homelessness, current and prior drug use, satisfaction with services, and the like. The survey completion rate has exceeded 90% in four of the seven rounds of follow-up interviews.

¶ *Impact of Funding Loss.* The EMA experienced no loss of formula funding in FY08. Each year, the EMA prepares in advance for the possibility of funding reductions by scoring individual service categories on a data-driven prioritization tool, facilitating timely reprogramming.

1.a. HIV/AIDS Epidemiology. One in 77 New Yorkers – 1.3% of the population – has been diagnosed with HIV/AIDS. (2) While no neighborhood in the EMA has been spared, HIV/AIDS is most prevalent along an arc that runs from the South Bronx, through Upper and Lower Manhattan, into Central Brooklyn. (See Fig. 4, p. 7.) In addition to the five boroughs of NYC, the EMA also encompasses three counties north of the City – Westchester, Rockland and Putnam Counties (collectively referred to as the “Tri-County region”) – where HIV infections are primarily concentrated in the portions of southern Westchester County that border on NYC.

AIDS is the *leading cause of death* among NYC males ages 25-44 and the third leading cause of death overall. (2) NYC’s rate of new AIDS cases is *more than 3 times higher than the national average.* (7) (Fig. 2.) The NYC metropolitan area had the nation’s third highest rate of

Figure 2
Rate of new AIDS cases (per 100,000) is more than 3 times higher in NYC Metro Area than in U.S. as a whole, 2006 (CDC, 2007)



new AIDS cases in 2006 and the *highest rate* of new AIDS cases for the last five years as a whole. (7)

One in four new HIV diagnoses in NYC occurs within 31 days by an AIDS diagnosis, indicating an initial recognition of HIV infection late in the course of disease, when available therapies are less effective and risk of death substantially greater. (2) Non-Hispanic Blacks^o and injection drug users (IDUs) are least likely to enter care soon after testing HIV-positive. (2)

HIV/AIDS Cases. The EMA remains the epicenter of

the U.S. epidemic.

¶ *People Living with HIV (non-AIDS).* Nearly 41,000 EMA residents are living with diagnosed HIV (non-AIDS). Men represent 68% of people living with HIV, and Blacks account for the largest share (45%) of such cases among racial/ethnic groups, followed by Hispanics (29%), whites (23%), Asian/Pacific Islanders (1.5%), and Native American (under 1%). MSM make up 34% of living HIV cases, followed by heterosexuals (19%) and IDUs (11%), with risk not identified for 33% of living HIV cases. Nearly 6,000 new HIV (non-AIDS) diagnoses occurred in 2006-2007; as with living HIV (non-AIDS) cases, new HIV diagnoses in 2006-2007 were more likely to be Black (49%), male (72%), and MSM (42%) or people with heterosexually acquired infection (24%). (5)

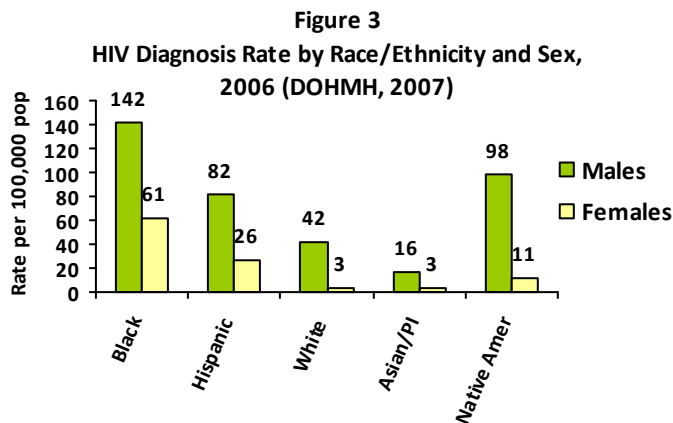
^o For purposes of simplicity, non-Hispanic Blacks are referred to in the application as “Blacks,” and non-Hispanic whites as “whites.”

¶ *Living AIDS Cases.* As an AIDS diagnosis indicates an advanced case of HIV infection, AIDS case reports provide important indications of more intensive service demands on the care system. As of December 31, 2007, almost 67,000 people in the EMA were living with an AIDS diagnosis. More than two-thirds of living AIDS cases were male (71%), and nearly half (46%) were Black, followed by Hispanics (33%), whites (20%), Asian/Pacific Islanders (1%), and Native Americans (under 1%). MSM represent the largest exposure category for people living with AIDS (28%), followed by IDUs (24%) and individuals exposed through heterosexual sex (18%). (5) *The number of AIDS cases in the EMA is larger than the total number in Los Angeles, San Francisco, Washington D.C., and Atlanta combined.* (7) Between 2000 and 2007, the number of people living with AIDS in NYC grew by more than 20%. (2)

¶ *New AIDS Cases.* Declines in AIDS incidence underscore the EMA’s success in preventing severe immune suppression through the delivery of life-preserving medical care. In 2006, the number of new AIDS diagnoses in NYC fell below 4,000 for the first time since 1985. (2) Despite such clear progress, however, the NYC metropolitan area has the country’s *third highest rate of new AIDS cases* (40.8 per 100,000 population), exceeded only by Miami (48.5) and Ft. Lauderdale (43.0). (7) (See Fig. 2, p. 4.) In 2006-2007, 7,381 new AIDS cases were reported, more than two thirds of them (69%) male. Blacks represent nearly half (49%) of new AIDS cases, followed by Hispanics (31%), whites (17%), Asian/Pacific Islanders (2%), and Native Americans (under 1%). More MSM were reported with AIDS in the last two years than any other exposure category (30% of new cases), followed by heterosexual exposure (23%) and IDUs (13%). (5)

¶ *Disproportionate Impact.* The epidemic continues to devastate the EMA’s poorest and most vulnerable communities. (Fig. 3.) In particular, the epidemic’s impact on minority communities has significantly increased over time.

¶ *Non-Hispanic Blacks.* Representing 25% of the EMA’s population, Blacks account for 46% of all PLWHA and 49% of new HIV (non-AIDS) diagnoses in 2006-2007. (5) Among Black men ages 40-54, one in 12 is living with HIV – a rate seven times higher than for New Yorkers as a whole. (2)



In 2006-2007, HIV-positive Blacks in NYC had an age-adjusted death rate almost twice as high as white PLWHA, and Blacks were 35% more likely than whites to be diagnosed with AIDS within 31 days of receiving an HIV diagnosis. Once diagnosed, Blacks are 17% less likely than whites to enter care within three months of diagnosis. (2)

¶ *Hispanics.* Hispanics, who make up 25% of the EMA’s population, account for 32% of all PLWHA and for 30% of new HIV diagnoses in 2006-2007. (5) In 2006-2007, Hispanics diagnosed with HIV were 35% more likely than white PLWHA to be diagnosed late in the course of infection and 10% less likely to enter primary care within three months of HIV diagnosis. The age-adjusted risk of death was 61% higher for Hispanic PLWHA than for whites in 2006-2007. (2)

¶ *Homeless or Unstably Housed.* Single adults who use the NYC shelter system are 16 times more likely than New Yorkers as a whole to be HIV-infected. (9) While homeless adults account for less than 0.5% of all New Yorkers, they represented 5.4% of new HIV diagnoses in 2001-2003, the most recent period in which comprehensive HIV surveys were undertaken among homeless adults. (9) In 2001-2003, HIV/AIDS accounted for approximately 0.3% of all deaths among New Yorkers as a whole but for 13.8% of deaths among homeless people. (9)

¶ *MSM.* MSM accounted for 42% of new HIV diagnoses in 2006-2007 (5) and for 50% of estimated new infections in 2006. (10) Young Black MSM (18-29) in NYC are nearly four times more likely than white or Hispanic MSM to be infected with HIV. (11) From 2001 to 2007, HIV diagnoses among young MSM (under age 30) in NYC increased by 42%, with the number of new diagnoses rising by 78% among MSM ages 13-19. (2)

¶ *Substance Users.* More than 20,000 IDUs are living with diagnosed HIV/AIDS in the EMA. (8) Following the implementation of targeted HIV prevention measures for injection drug users, the rate of new HIV infections declined almost 80% from 1990 to 2002. (12) IDUs living with HIV are significantly more likely to die than other PLWHA. In 2006-2007, HIV-infected IDUs had an age-adjusted death rate more than three times higher than among HIV-infected MSM and more than 2.5 times higher than for HIV-infected people as a whole. (2) In recent years, HIV prevalence among users of non-injection drugs appears to have exceeded HIV infection rates among IDUs (13), likely due to the role of non-injected cocaine, methamphetamines and other drugs in sexual HIV transmission in the EMA.

¶ *Formerly Incarcerated PLWHA.* Of more than 2,000 low-income PLWHA surveyed in NYC in 2004, 43% had a history of incarceration. (14) In 2006, an estimated 6.5% of males and 13.9% of females entering NYC correctional settings were HIV-positive. (8) Several thousand PLWHA pass through NYC correctional facilities annually, including almost 1,000 individuals with previously undiagnosed HIV infection. (8) In addition to the high prevalence of HIV in NYC correctional facilities, the EMA accounts for the large majority of inmates in the 69 correctional facilities of New York State (NYS), which has the highest HIV prevalence (7.0%) of any state system – nearly four times higher than the national average. (15) Among female inmates in NYS correctional facilities, HIV prevalence is 10 times higher among Hispanics than among whites and almost seven times higher among Blacks. (15)

¶ *Older Individuals.* The age profile of PLWHA has markedly shifted in recent years. In NYC, the percentage of HIV/AIDS cases among people over age 45 rose from 39% in 2001 to 55% in 2007. (5) PLWHA over age 45 now outnumber those between 20-44 in NYC. (2) In part, this is a reflection of the success of the EMA's HIV care continuum in ensuring broad coverage of life-prolonging treatments. However, older individuals also constitute a considerable proportion of new HIV infections, with people over 45 accounting for nearly one in four new HIV diagnoses in 2006-2007. (5) They are often diagnosed late in the course of infection; in 2006, 50% of individuals ages 50 and above who were newly diagnosed with HIV also received an AIDS diagnosis within 31 days. (2) In 2007, nearly 40% of PLWHA over 60 had no evidence of receiving HIV primary care – a higher rate of unmet need than for other age cohorts. (3) The EMA's longitudinal CHAIN study also indicates that older PLWHA tend to be more socially isolated and often lack a social support network. (4)

¶ *Heavily Affected Neighborhoods.* While fewer than one in four whites with diagnosed HIV/AIDS live in zip codes where 20% or more of households are in poverty, nearly two out of three HIV-diagnosed Blacks and Hispanics live in low-income neighborhoods. (2)

These heavily affected, minority neighborhoods in NYC – including Harlem in Upper Manhattan, the South Bronx, and Central Brooklyn – have the lowest health care coverage in the EMA, the fewest economic opportunities, and the highest rates of co-morbidities, such as drug use, mental illness, and housing instability. PLWHA living in the poorest, most underserved neighborhoods are almost twice as likely to die as PLWHA in more affluent neighborhoods. (2)

These socioeconomic and racial/ethnic disparities are vividly illustrated by a comparison of poorer neighborhoods with the affluent Manhattan district of Chelsea, the center of NYC’s gay community. (Fig. 4.) While poverty rates in the South Bronx, Harlem and Central Brooklyn are well above the average for NYC, Chelsea dwellers are one-third less likely to live below the poverty line than New Yorkers as a whole and are also more likely to have health insurance. Indeed, although Chelsea and Harlem are only five miles apart, the likelihood that a resident will live in poverty is 2.5 times greater in Harlem. While whites account for 65% of Chelsea dwellers and for 35% of EMA residents overall, they represent fewer than 10% of residents in the South Bronx, Harlem or Central Brooklyn. (16)

Although HIV prevalence in Chelsea is the highest in the EMA – 4.1% of its residents are living with HIV – the risk that a Chelsea resident living with HIV would die in 2006 was 50% lower than the City average and roughly half the risk of death for HIV-positive residents of the South Bronx, Harlem or Central Brooklyn. (2) People living in low-income neighborhoods in NYC are 25% more likely than Chelsea residents to be diagnosed with HIV late in the course of infection, and residents of poor neighborhoods who test HIV-positive are also nearly one-third more likely than Chelsea residents to delay entering HIV primary care following diagnosis. (2)

Percentage of persons living with HIV/AIDS by UHF Neighborhood in NYC, 2007

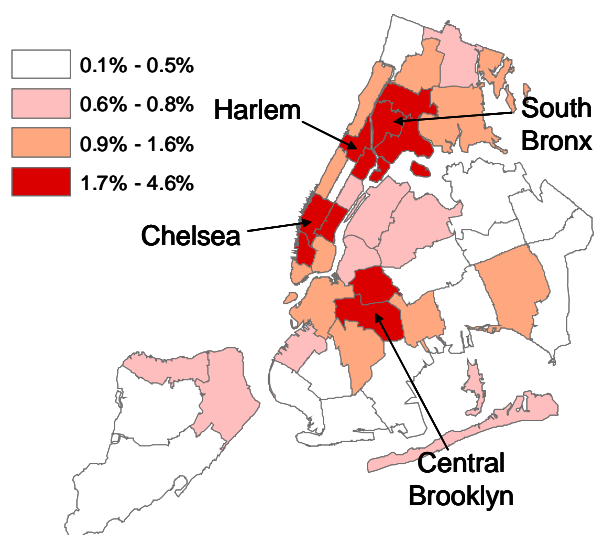


Figure 4

The contrast between the affluent Chelsea district and the three high-need neighborhoods starkly underscores the challenge facing the EMA’s efforts to promote equal access to life-preserving HIV treatments. While those with financial resources are able to obtain the health coverage and support needed to minimize the risk of HIV-related illness and death, PLWHA who are poor confront an array of barriers to health care access, treatment adherence, and favorable medical outcomes. The EMA’s Part A program is designed to address such gaps in health access.

¶ *Tri-County Region.* Nearly 5,000 individuals are living with diagnosed HIV or AIDS in the Tri-County region, with an additional 1,650 believed to be infected but undiagnosed. (17) The Tri-County region represents approximately 5% of the EMA’s HIV/AIDS cases. (5) The physical and social environment in the Tri-County region varies considerably, encompassing the high-density urban areas of southern Westchester County, the suburbs of

Westchester and Rockland counties, and the less populated rural areas in Rockland and Putnam Counties. PLWHA in the Tri-County region are more likely than their NYC counterparts to be Black, female, and exposed to HIV through injection drug use or heterosexual sex.

Rockland County exemplifies some of the challenges faced by the EMA in creating a seamless, comprehensive service system that meets the diverse needs of PLWHA. A county of nearly 300,000 residents – one in five of whom is foreign-born – Rockland County includes suburban and rural areas. (6) In the absence of Ryan White funding, the provision of HIV-related health care would be limited to a single local provider that lacks the capacity to offer comprehensive HIV care to women. A mobile van – upgraded through a collaboration between Part A, New York State, and local governments – provides HIV gynecological care locally, thus mitigating the need for women to travel to Westchester County or to forego seeking such care altogether. Part A also invests in transportation services to ensure that poor, isolated Rockland PLWHA obtain the services they need.

Populations Under-Represented in Care System. In comparison to their share of the EMA’s overall epidemic, white MSM are under-represented in the Ryan White service system, a reflection of white MSM’s increased likelihood of having private health insurance and thus reduced need for safety-net services. While MSM make up 30% of PLWHA in the EMA, they account for 10% of Part A clients. Non-Hispanic whites represent 21% of all PLWHA but only 8% of Part A clients. (2, 3)

Generally, older PLWHA are under-represented in the Ryan White service system. While people over 45 make up 55% of PLWHA in the EMA, they account for only 35% of NYC Part A clients. (2, 3)

Otherwise, demographic differences in service utilization are relatively modest. Men are slightly less likely than women to receive HIV primary care, and IDUs are more likely than other exposure categories to be out of care. (3) In 2007, Blacks and Hispanics were more likely to be in HIV primary care than whites, although racial and ethnic differences in unmet need are relatively modest. (3) A principal reason for the EMA’s success in ensuring health access for traditionally underserved populations is the lifeline provided by Part A. Blacks and Hispanics together represent 69% of PLWHA in the EMA but account for 85% of Part A clients in NYC.

Service Utilization Gaps. The EMA’s longitudinal CHAIN study uses subjective and objective measures (all via self-report in interviews) to assess clients’ need for specific services and the percentage of clients who are not receiving the services for which they indicate a need. According to the most recent round of surveys in 2005-2006, key utilization gaps included the following:

¶ *Substance Abuse Services.* More than one in four (27%) PLWHA enrolled in the CHAIN study say they need substance abuse services but were not obtaining them. (4)

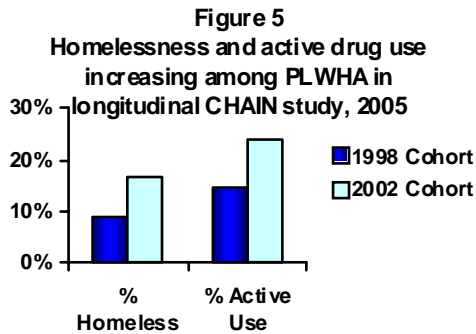
¶ *Financial Assistance.* Roughly one in five (21%) CHAIN participants report needing financial support but not receiving such help. (4)

¶ *Housing Assistance.* One in six (16%) PLWHA enrolled in CHAIN are experiencing unresolved housing problems. (4)

¶ *Mental Health Services.* One in seven (14%) CHAIN participants need psychological support services but were not obtaining them. (4)

1.b. Impact of Co-Morbidities on the Cost and Complexity of Providing Care. In addition to the extraordinary magnitude and severity of the EMA’s epidemic, PLWHA in the EMA are also increasingly likely to suffer other medical and social co-morbidities. (See Attachment 4.) Ninety percent of PLWHA in NYC enrolled in the EMA’s longitudinal

CHAIN study suffer from at least one non-HIV-related chronic condition, with 80% having at least two additional co-morbid conditions.



(4)

Many of these health and social conditions – such as substance addiction, mental illness, and housing instability – can interfere with service utilization, impede treatment adherence, and lead to severe illness or death. As Figure 5 illustrates, the prevalence of costly co-morbidities may be increasing over time; PLWHA enrolled in the CHAIN study earlier in the epidemic were

significantly less likely to have co-morbid conditions such as homelessness or active substance use than more recently enrolled PLWHA.* The multiplicity and intensity of needs in the EMA’s PLWHA population – combined with the high costs and urban complexity associated with the nation’s largest city – significantly complicate the delivery of life-preserving HIV services and greatly increase associated costs. On average, having one or more co-morbid conditions increases the average number of ambulatory clinical care visits per year among CHAIN participants. (4)

STI Rates. Untreated sexually transmitted infections (STIs) increase the risk of sexual HIV transmission by several orders of magnitude. (60) According to a CDC-sponsored study, each new syphilis-related HIV infection produces \$207,000 in lifetime medical costs. (61) In 2006-2007, the EMA’s STI cases were heavily concentrated in neighborhoods with elevated HIV prevalence; the Manhattan neighborhoods of Chelsea and Harlem, the parts of the EMA with the highest HIV prevalence, also have the highest case rates for syphilis and are among the top four neighborhoods in gonorrhea prevalence. (20)

The EMA is experiencing a surge in syphilis cases. In 2006-2007, almost 1,500 individuals in NYC were diagnosed with primary or secondary syphilis – 97% of them male – with an additional 201 cases in the Tri-County region. In the first six months of 2007, the number of primary and secondary syphilis cases in NYC doubled in comparison to the previous year. MSM account for 84% of new syphilis diagnoses, and 50% of syphilis diagnoses are in HIV-positive men. Among MSM with syphilis, the percentage co-infected with HIV increased from 20% in 1999 to 57% in 2007. (20)

Chlamydia diagnoses also increased by more than 22% from 2006 to 2007, with females accounting for more than two-thirds of new infections. Altogether, almost 92,000 chlamydia diagnoses were reported in the EMA in 2006-2007. The long-term decline in gonorrhea cases ended in 2006-2007, when gonorrhea diagnoses among men actually increased. For 2006-2007, 20,609 gonorrhea cases were reported in the EMA, with males accounting for more than 56% of infections. (20) Nearly 28% of adults in NYC are infected with herpes simplex virus type 2 (HSV-2), which is the STI most closely linked with increased risk of HIV infection; Blacks, Hispanics, women and MSM are most at risk of HSV-2 infection. (20)

Prevalence of Homelessness. Stable housing is essential for successful treatment of HIV/AIDS. As Figure 6, p. 10, demonstrates, NYC is experiencing a chronic housing crisis, reflected in a more than three-fold increase in the number of persons using the NYC shelter

* Some of the increase in prevalence of co-morbidities could be explained by differences in the selection of agencies across time at which CHAIN participants were recruited.

system since HIV was first recognized in the early 1980s. On any given night, more than 32,000 people would live on the streets of NYC but for the City's homeless shelters.

(21) In Manhattan, Staten Island and Brooklyn, 3,306 individuals live each day on the street, in parks, underpasses or in the subway system. (21) In response to the city's housing crisis, NYC is in the midst of implementing a multi-year action plan to enhance outreach, improve housing

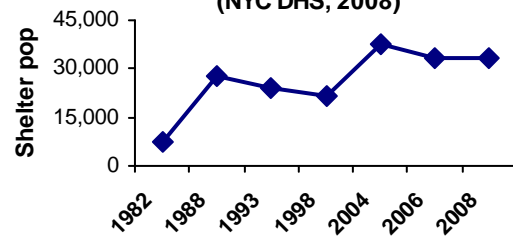
placement, and strengthen services to promote recovery, stability and ultimately independence for those who are homeless or unstably housed.

The EMA's housing crunch creates difficult and potentially life-threatening conditions for thousands of PLWHA. One in four PLWHA in the EMA's CHAIN cohort are either homeless or unstably housed at any given time, and 70% have experienced housing instability at some point since their HIV diagnosis. (4) In the year before they received their HIV diagnosis, 52% of PLWHA enrolled in the longitudinal cohort experienced at least one episode of homelessness. (4) Among homeless adults, Blacks are twice as likely as whites to be HIV-infected. (9) Homeless single adults are also 16 times more likely than New Yorkers with housing to be newly diagnosed with HIV. (7) According to CHAIN, housing vulnerability among PLWHA receiving Part A services appears to be increasing as the epidemic becomes more heavily concentrated among poor, multiply-diagnosed individuals. (3)

The high prevalence of homelessness significantly increases the cost and complexity of HIV care in the EMA. In FY08, the EMA is spending more than \$8.7 million in Part A funding on housing assistance, in addition to outlays from non-Part A public sources. In 2008, NYC's HIV/AIDS Services Administration contracts for more than 5,000 units of supportive housing and is planning to develop an additional 1,000 units in the near future. On average, a homeless individual with mental illness uses more than \$40,000 in public services annually, including medical care, housing assistance, and mental health and substance abuse services. (22) Homeless PLWHA enrolled in the CHAIN study are five times more likely to lack a primary care provider and more than twice as likely to delay entering primary care after a positive HIV test than their counterparts who are stably housed. (4) Homeless PLWHA enrolled in the CHAIN study are twice as likely to receive care that does not meet basic clinical standards, and half of homeless PLWHA enrollees do not adhere to HIV medication regimens, a rate almost twice as high as for stably housed PLWHA. (4) Because unstably housed PLWHA receive care that is episodic or below standard, they are 44% more likely than PLWHA with stable housing to be hospitalized, 26% more likely to use costly emergency rooms, and 26% more likely to experience an HIV-related opportunistic illness, according to CHAIN. (4) The average hospital stay for homeless adults is 36% longer than for those who are housed. (23)

Lack of Insurance. Nearly 1.7 million people in the EMA lack any form of health coverage, including Medicaid or Medicare. (24) While 31% of PLWHA nationally are covered by private health insurance (25), it is estimated that private plans cover no more than 13% of PLWHA in the EMA. Among CHAIN enrollees, 8% of Tri-County residents and 5% of PLWHA in NYC reported having lost insurance coverage in the prior six months in 2005-2006. (4) New York's Medicaid program is the most expansive in the country, although

Figure 6
Homelessness in NYC has more than tripled during the HIV epidemic (NYC DHS, 2008)



important eligibility gaps exist. For example, undocumented immigrants are not eligible for Medicaid services. Lack of private insurance significantly increases the financial burden on the public sector, requiring substantial investments in safety-net programs to care for the poor and uninsured.

Poverty. As Figure 7 reveals, nearly 1 in 5 NYC residents live below the federal poverty line – a rate 50% higher than the national average. (6) Black and Hispanic New Yorkers are more than twice as likely to be living in poverty as whites. (26) Roughly half (49%) of EMA residents, or 4.6 million, have annual incomes below 300% of the federal poverty line. (6) Poverty increases the likelihood of unfavorable health outcomes. Lower income is associated with poorer HIV treatment adherence. (27) People living in extremely poor neighborhoods in NYC are four times more likely to die of HIV-related causes as people who reside in affluent parts of the EMA. (2)

PLWHA in the EMA are overwhelmingly low-income. Only 15% of NYC PLWHA enrolled in CHAIN are employed, and the median annual income of CHAIN participants is below \$7,500.

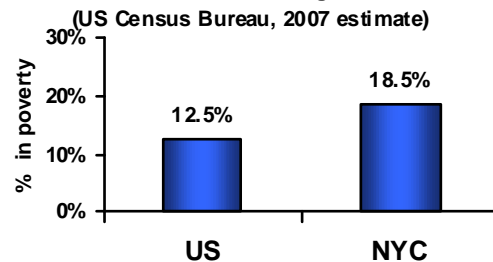
More recently diagnosed individuals enrolled in the cohort study tend to have fewer economic and social resources than cohort participants who were diagnosed earlier in the epidemic. (4)

The epidemic’s concentration among the very poor substantially adds to the cost and complexity of care, especially for the public sector. The EMA’s unit cost analysis (undertaken in 2005 by American Express Tax and Business Services Inc., as described on p. 52) found that intensity of Part A service utilization increases as the client’s annual household income declines. CHAIN cohort participants with an annual income under \$10,000 are 44% more likely to be hospitalized than non-poor PLWHA. (4) In the hard-hit Highbridge/Morrisania neighborhood of the South Bronx, where 42% of residents live in poverty, individuals are 4.5 times more likely than residents of other NYC neighborhoods to be hospitalized for HIV/AIDS, with most of these costs borne by the public sector. (16) The EMA concentrates its Part A services in neighborhoods where rates of HIV, poverty and comorbidities are highest. To further enhance and coordinate health services for high-need clients, DOHMH has designated District Public Health Offices that serve the poorest and most medically vulnerable neighborhoods, allocating concentrated and increased financial resources for health promotion, including HIV prevention.

The roughly two million people in the EMA who live in poverty are doubly burdened because they reside in a metropolitan area where the *cost of living is roughly twice the national average*. (28) Housing costs in Manhattan are more than four times the national average for metropolitan areas. Renters in NYC spend a higher percentage of their income on housing than anywhere else in the country; more than one in four renters spend more than half their income on rent in NYC. (14)

Tuberculosis. People with HIV are many times more likely to develop active TB than patients who are not HIV-infected. (29) Although NYC has made substantial progress in combating TB – recording fewer than 1,000 TB cases for the first time in 2005 – NYC still had a TB case rate in 2006 nearly twice as high as the national average (8.4 per 100,000

Figure 7
NYC poverty rate is 50% higher than U.S. average



versus 4.6 for the U.S. as a whole). (30) In 2005, NYC had the fifth highest rate of TB diagnoses among metropolitan areas with a population of 500,000. (31) In 2007, 914 TB cases were reported in NYC, including 116 (13%) among individuals co-infected with HIV. (30)

High TB rates increase the cost and complexity of HIV/AIDS care in the EMA. PLWHA who are co-infected with TB use 50% more medical case management services than PLWHA as a whole, nearly three times as many substance abuse services for active or relapsing users, and almost six times as many food and nutrition services. (32) To reduce TB incidence and prevent the potentially catastrophic growth of multi-drug resistance, NYC devotes more than \$26 million to TB control.

Former Prisoners. HIV prevalence among correctional inmates – 6.5% among male inmates and 13.9% among female inmates (8) – is several times higher than in the EMA’s general population. More than 40% of CHAIN participants have a history of incarceration. (4) As described in greater detail below in the discussion of emerging populations, former prisoners have more intensive service needs than other PLWHA and use a disproportionate share of Part A services. (See p. 20.) Because of the many access barriers faced by PLWHA released from correctional settings, Part A supports five targeted programs to link correctional releasees to care and to maximize favorable medical outcomes. (See p. 29.)

Drug and Alcohol Dependence. With less than 3% of the U.S. population, NYC accounts for at least 9% of the country’s 1.5 million injection drug users. (33) DOHMH estimates that roughly 138,000 people regularly inject drugs, and that 900,000 New Yorkers are problem drinkers. (34) An estimated 7% of IDUs are HIV-infected (35), and an even higher percentage of users of non-injection drugs are believed to be living with HIV. Age-adjusted death rates are more than three times higher among HIV-infected IDUs than among MSM living with HIV. (2)

Substance abuse significantly increases the cost and complexity of managing HIV/AIDS. The costs (in lost productivity, medical care and the like) associated with substance abuse in NYC is believed to exceed \$20 billion annually. (36) Medicaid spends roughly \$410 million annually to treat substance abuse and mental health disorders among PLWHA in the EMA. Medicaid covers outpatient substance abuse treatment for more than 13,000 PLWHA annually, providing inpatient services for an additional 9,598 PLWHA with chemical dependence. (18) In addition, Part A will provide targeted outreach and linkage services to more than 11,000 HIV-positive substance users and targeted counseling and education services to nearly 3,000 substance users in FY09. Despite the EMA’s enormous expenditures for substance abuse services, many PLWHA who need these services may not be presently receiving them. Although many programs offering medically supervised detox and drug treatment are enrolled beyond capacity, existing drug treatment capacity in the EMA is not sufficient to accommodate all those who need treatment. NYC is aiming – through the combination of methadone, buprenorphine, and other treatment alternatives – to increase the number of addicts in treatment to 100,000 by the end of 2008.

On average, PLWHA with drug or alcohol dependence used 48% more Part A services in 2006 than PLWHA as a whole. (32) In FY08, the EMA invested \$11.4 million in Part A funds on substance abuse services, as well as \$8.7 million on a range of housing services that serve significant numbers of PLWHA with substance abuse problems.

Mental Illness. Among CHAIN enrollees, more than one-third exhibit signs of severe mental disorders. (4) Mental health problems are associated with reduced treatment adherence and poor medical outcomes. In addition, mental illness significantly increases the risk that a patient will fall out of the HIV care system or fail to enter primary care in the first

place, with 91% of PLWHA currently out of care in the EMA exhibiting clinically relevant mental health symptoms. According to the EMA's longitudinal cohort study, provision of mental health services significantly improves the odds that PLWHA with mental illness will receive appropriate medical care and adhere to prescribed medication regimens. (4)

Mental illness increases the cost and complexity of managing HIV infection. Medicaid spends more than \$100 million annually to provide mental health services for PLWHA in the EMA, serving more than 8,500 PLWHA with outpatient mental health services and an additional 3,308 with inpatient services. Part A in FY08 will spend \$7.6 million to provide mental health services for PLWHA. Even with such heavy investment by the EMA in mental health services for PLWHA, 65% of participants in the EMA's cohort study who say they need mental health services are not currently obtaining them.

CHAIN study participants with low mental health functioning visit the EMA's ambulatory care settings 15% more often than the average PLWHA and are almost 20% less likely than other study participants to be on antiretrovirals. (4) PLWHA with serious and persistent mental illness used 48% more Part A services in 2006 than PLWHA as a whole. (32)

Hepatitis. More than 60% of HIV-infected IDUs, and an estimated 5%-30% of non-injection drug users, are co-infected with Hepatitis C (HCV). (37) Among CHAIN enrollees, 32% reported suffering from chronic hepatitis in 2005-2006.

The high prevalence of hepatitis among PLWHA increases the cost and complexity of HIV care. The cost of a standard 48-week antiviral regimen for HCV exceeds \$12,000. (38) HCV co-infection increases the risk of severe side effects from HIV medications, and co-infection accelerates the rate at which HCV-related liver disease progresses. (39)

1.c. Impact of Part A Funding: Funding Mechanisms and the Impact of the Decline in Ryan White Formula Funding. Although the magnitude of funding provided by Medicaid for HIV-related services outweighs amounts provided under Part A, 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 increasingly poor, multiply diagnosed PLWHA population.

i) Report on the Availability of Other Public Funding. As Attachment 5 indicates, more than \$2.8 billion in federal, state and local spending is anticipated to be available in FY09 for the six service categories listed in the HRSA program guidance. Because these categories do not capture in-patient medical care, total spending on HIV treatment and care in the EMA will substantially exceed \$2.8 billion.

ii) Coordination of Services and Funding Streams. By maximizing coordination among diverse service systems and funding streams, the EMA is able to maintain the most comprehensive and flexible HIV/AIDS care continuum in the country.

The Planning Council annually assesses available resources in all Part A service categories, identifying key gaps in the HIV care continuum. For development of the FY09 plan, this assessment was facilitated, in part, by a comprehensive payer-of-last-resort report on HIV-related services provided by non-Part A sources. Documenting more than 120 individual programs in 22 service categories, this mapping exercise aided the Planning Council in its needs assessment and in its efforts to ensure that Part A serves as the payer of last resort for all services. In addition, the Planning Council includes representatives from numerous NYC and State (NYS) agencies, as well as providers of a wide range of services funded by multiple payer sources, bringing to the planning process broad expertise on the full array of payment sources for HIV-related services and assisting the Council in maximizing the coordination of the Part A program with existing services. Close

coordination between DOHMH and NYS, long a mainstay of the EMA's planning process, is now stronger than ever, enhancing coordination, reducing duplication and facilitating the implementation of innovative strategies to address key service gaps. HIV care and housing programs are now overseen and administered by the same office in DOHMH, maximizing coordination of the various components of the HIV service continuum.

Medicaid. While the state share of Medicaid is exclusively borne by the state throughout most of the U.S., local governments contribute half of the state's share in NYS. Such cost-sharing enables NYS to offer the most comprehensive Medicaid coverage in the country. NYSDOH, which is represented on the Planning Council, provides ongoing updates to the Planning Council on changes in Medicaid policies, including reimbursement practices. Medicaid (strategically complemented by targeted Part A medical initiatives) spent nearly \$2.1 billion on HIV-related services for PLWHA in the EMA in 2007. (18) Medicaid covered physician services for more than 40,800 PLWHA in FY07 and provided HIV medications to 51,000 individuals. By remaining up-to-date on Medicaid policies, the Planning Council is able to allocate scarce resources toward high-priority services that are not covered by Medicaid. For example, because Medicaid in NYS covers most dental services for PLWHA, Part A funds for dental services have been reduced and instead directed toward critical services not included in the Medicaid package, such as early intervention, community-based treatment adherence support, housing assistance, and innovative models of outreach and counseling to reduce substance abuse. At the service delivery level, Part A contractors also participate in Medicaid, and the EMA rigorously enforces policies ensuring that Part A is the payer of last resort.

Medicare. From 2002 to 2006, the percentage of PLWHA in the CHAIN cohort who rely on Medicare increased from 17.7% to 21.6%. (4) NYSDOH assesses and reports on an ongoing basis on the impact of Medicare Part D prescription drug coverage on the demand for Part A-funded ADAP services. Because Medicare Part D has more restrictive drug formularies than Medicaid, NYSDOH ensures that its ADAP formulary includes important classes of drugs that are not covered by Medicare (e.g., atypical antipsychotics and antidepressants that are crucial for the care of PLWHA with chronic and severe mental illness). With support from the Planning Council, ADAP also covers costs for PLWHA who become liable for up to \$2,850 in out-of-pocket drug expenses as a result of the "donut hole" in Medicare Part D.*

State Children's Health Insurance Program. The EMA's planning process for FY09 was informed by an analysis of SCHIP coverage, including a list of relevant SCHIP-covered services.

Veterans Affairs. VA services to PLWHA were similarly factored into the payer-of-last-resort report, which the Planning Council used in its needs assessment for FY09. The VA has participated in Planning Council meetings with diverse federal partners to discuss service coordination and to share information regarding client needs and access gaps.

Housing Opportunities for Persons with HIV/AIDS Programs (HOPWA). The same unit of DOHMH that oversees Ryan White and HIV prevention services also administers AIDS housing programs. The close coordination between the Part A and HOPWA programs was

* Under the Medicare drug prescription law passed in 2003, Medicare temporarily discontinues payments for beneficiaries' drug purchases once an annual spending limit is reached, resuming them only after the patient has spent thousands of dollars out of pocket. This is popularly referred to as the Medicare "donut hole." Financial exposure is especially severe for individuals with HIV and other chronic diseases who need thousands of dollars in medications annually.

illustrated in FY07, when the EMA made a one-time transfer of \$1.5 million in MAI-funded transitional housing programs to HOPWA as a result of cuts in MAI funding. In coordination with the Mayor's initiative to create and preserve 65,000 new general housing units over five years, DOHMH has revised the HOPWA budget to emphasize the creation of new housing units. City plans for HOPWA were considered by the Planning Council in developing its FY09 plan, which provides for \$8.5 million in various forms of housing assistance for PLWHA.

CDC Prevention. HIV prevention programs are based in the same DOHMH bureau that oversees HIV care and housing. Over the last several years, DOHMH has significantly strengthened its prevention efforts, more than tripling condom distribution beginning in June 2005. DOHMH has consolidated oversight of all publicly funded HIV testing initiatives in a single unit and undertaken joint programming between HIV care and prevention programs to promote knowledge of HIV serostatus and linkage to care. DOHMH-supported testing programs yielded positive HIV test results for nearly 2,300 people in 2007.

Services for Women and Children and Other State and Local Social Service Programs. The 2008 service mapping took into account a range of social services programs, including programs specifically targeted to women and children. Participation on the Planning Council by various NYC agencies keeps the Planning Council up-to-date on policy developments related to the NYC HIV/AIDS Service Administration and other key NYC agencies. The NYS AIDS Institute reports regularly on changes in eligibility, policies and practices of State-sponsored social service programs, while representatives of NYC government agencies keep the Planning Council abreast of important developments regarding local assistance programs. In 2007, Medicaid spent \$626 million on HIV-related services for women, infants, children and youth in the EMA. (18)

Substance Abuse and Mental Health Services. Diverse funding sources support a wide array of substance abuse and mental health services in the EMA. In FY07, Medicaid expenditures exceeded \$398 million for substance abuse and mental health services for PLWHA in the EMA. (18) Part A services complement other services by addressing gaps arising from the unique needs of PLWHA who have substance abuse or mental health problems. To ensure coordination between Part A-funded low-threshold substance abuse programs and existing treatment services, the Planning Council remains up-to-date on the EMA's alcohol and drug treatment system and existing mental health services. The shortage of low-threshold substance abuse interventions among existing government-funded programs, for example, has long prompted the Planning Council to fund such approaches as a complement to existing treatment efforts. Planning Council members include staff from substance abuse and mental health treatment programs funded through diverse federal, State and local sources, and each year the Council takes these programs into account in its needs assessment, helping avoid programmatic overlap and duplication. To address gaps in non-Part A services, the EMA prioritizes substance abuse programs that provide on-site services in homeless shelters, soup kitchens, single-room occupancy hotels, and homeless drop-in centers.

Other Ryan White Funding. The Planning Council takes into account MAI-funded programs in developing service priorities and funding allocations for Part A base funding. The EMA uses MAI funds to support housing placement, early intervention and medical case management services in high-need minority neighborhoods. The Planning Council's efforts to coordinate base funding with MAI funding are informed by service utilization data from client-level reporting, which helps identify service trends and utilization gaps. Service

utilization statistics are presented for the Part A program as a whole, and separately for MAI and base-funded programs.

ADAP covered medications for more than 13,000 PLWHA living in the EMA for the year ending February 29, 2008. (19) Senior representatives of the NYS AIDS Institute – which administers ADAP and other components of Part B, as well as a substantial HIV/AIDS service program funded by State tax levy – have been active participants on the EMA’s Planning Council since the beginning of the Ryan White CARE Act. *The close level of cooperation between the EMA and NYS* is reflected in the State’s management of the EMA’s quality management program and its extensive involvement in the recently completed service mapping exercise. Part A and NYS AIDS Institute staff convene regularly to discuss important developments and to coordinate efforts. In addition, Part A staff regularly attend meetings of the Part B CARE networks in the EMA and report on relevant developments to Planning Council committees. At the service level, more than one-third of Part A contractors also have Part B contracts.

The NYS AIDS Institute makes regular reports to the Planning Council on ADAP utilization and on changes in the Medicaid program and the ADAP formulary. Members of the Planning Council participate in the Statewide ADAP steering committee, which approves changes in the formulary and in ADAP policies. Each year, the Planning Council collaborates with the AIDS Institute to ensure the financial sustainability of ADAP, using unobligated and carryover funds to increase ADAP funding.

Representatives from Parts C- and D-funded programs are also active members of the Planning Council. Part A staff meet periodically with the EMA’s Part C and Part D programs to discuss strategies to enhance service coordination between titles. As Part F provides funding for 20 oral health programs for PLWHA in the EMA and Medicaid covered dental services for nearly 24,000 PLWHA in 2007, Part A supports oral health care only for the single HIV-specific dental practice in the Tri-Country region.

NYC Department of Correction. DOHMH spent more than \$166 million in FY08 on health care for individuals incarcerated in NYC correctional facilities, including more than \$7 million to purchase antiretrovirals for HIV-positive inmates. (39) As DOHMH has strengthened its HIV-related health protocols for inmates – offering rapid testing on intake and increasing capacity for HIV primary care – the Part A program has funded a transitional care linkage program for HIV-positive correctional inmates, ensuring that inmates who test HIV-positive on intake are connected to discharge planning to facilitate rapid linkage of released inmates to primary care and community-based HIV services.

1.d. Assessment of Emerging Populations with Special Needs. The exceptional prominence of high-need populations in the New York epidemic significantly increases the cost and complexity of the EMA’s response to AIDS. This section highlights the special needs, access barriers and associated service costs for six key populations.

Women. The prominence of women in the EMA’s epidemic has grown over time, with the number of AIDS cases among women rising from roughly one-quarter in 1992 to almost one-third in 2007. Women account for 31% of PLWHA in the EMA, including 31% of new AIDS diagnoses in 2006-2007. Nearly 33,000 women are living with diagnosed HIV/AIDS. (5) Nine out of 10 women with HIV are women of color. Among women of childbearing age (ages 15-44), Blacks are nearly 15 times more likely than whites to be HIV-infected. The densest concentrations of female HIV/AIDS cases are in the City’s most impoverished neighborhoods – Highbridge/Morrisania and other parts of the South Bronx, Central Harlem, and Central Brooklyn. (2)

Women face unique challenges to health care access and continuity. Nearly one-third (32%) of NYC women diagnosed with HIV/AIDS in 2007 failed to enter care within three months of their positive HIV test. (2) HIV-positive women enrolled in the EMA's CHAIN study are less knowledgeable than their male counterparts regarding primary medical providers and social service agencies in their neighborhood of residence. (4) Women with HIV have particular health care and social service needs not typically shared with men, such as the need for appropriate gynecological services, child care and family-centered services. Women enrollees in CHAIN are more than twice as likely as heterosexual male study participants to experience domestic violence, which is associated with poor treatment adherence. (4) In the Tri-County area, female PLWHA enrolled in CHAIN pay a *higher percentage of their monthly income towards housing* and are more likely than men to have a need for housing assistance. Compared with other groups of PLWHA, HIV-infected women in CHAIN are significantly more likely to report lacking sufficient money in the household for utilities, food and clothing. (4)

HIV-positive women enrolled in the CHAIN study experience acute utilization gaps for key services. Among HIV-positive women study participants who need professional mental health services, 54% are not receiving them. Nearly two-thirds (65%) of HIV-infected women in the study who require substance abuse services are not being served by such programs, and 38% of women who are unstably housed are not receiving permanent housing support. (4) Due to such factors that impede health care access and treatment adherence, women living with HIV have an age-adjusted death rate that is 17% higher than their male counterparts. (2)

The continued prominence of women in the EMA's epidemic increases the cost and complexity of the care system. Average annual inpatient costs for female PLWHA are 6% higher than for male PLWHA. (41) Women with HIV also typically require *more intensive services* than males. In 2007, HIV-infected mothers on average required nearly one-third more Part A mental health services than male PLWHA, more than one-third more housing assistance services, and nearly one-third more services associated with release from a correctional setting. As many HIV-positive women have childrearing responsibilities, women used two-thirds more food and nutrition services in 2007 than men. (32)

Because women with HIV experience unique barriers to health care, the EMA invests in a range of women-focused initiatives that expand access, including linkage, housing and substance abuse services specifically targeting women with a criminal justice history, mental health and support services for women and children, and other family-centered interventions. While females represent 31% of all PLWHA in 2007, they accounted for 39% of Part A clients.

Homeless and Unstably Housed. Among cohort participants, 70% have experienced housing instability at some point since their HIV diagnosis. In the 12 months before being diagnosed with HIV, 52% of PLWHA in the CHAIN cohort experienced at least one night of homelessness. (4) As described above (see p. 10), homeless adults are significantly more likely than other New Yorkers to be HIV-infected and to die of HIV-related causes.

More than 60% of HIV-positive enrollees in CHAIN who are unstably housed have substance abuse problems, 55% have mental health disorders, and nearly one in four has been hospitalized due to mental illness. Compared to CHAIN enrollees who are stably housed, homeless PLWHA are five times more likely to lack an HIV primary care provider, almost twice as likely to fail to receive medical care when they need it, and almost 50% more likely to drop out of care. According to the CHAIN study, homeless PLWHA are 47% less likely to receive antiretrovirals than PLWHA with stable housing and more than 80% less

likely to adhere to HIV medication regimens. In comparison to stably housed PLWHA, homeless PLWHA are 85% more likely to have a dangerously low CD4 count (below 200), and 76% more likely to have a high viral load. (4)

Homeless and unstably housed PLWHA face considerable access gaps for key services. Two-thirds of unstably housed PLWHA in CHAIN who need mental health services are not receiving them, and nearly half (48%) of PLWHA with both housing and substance abuse problems are not receiving services to address their chemical dependence.(4)

When PLWHA are homeless or unstably housed, the cost of delivering HIV care is significantly increased. Unstably housed PLWHA in CHAIN are 44% more likely to need hospitalization than PLWHA who are stably housed in their own place. (4) On average, homeless PLWHA used 40% more Part A outpatient medical services in 2007 than PLWHA as a whole, more than twice as many housing-related services for people with substance abuse problems, and 30% more medical services for people co-infected with HCV. (32)

Fortunately, the EMA’s experience indicates that many of the disproportionate costs associated with homelessness among PLWHA can be averted through investments in supportive services that stabilize the housing situation of PLWHA. Out-of-care PLWHA enrolled in CHAIN who receive housing assistance are more than 2.5 times more likely to enter HIV primary care. (3) PLWHA study participants who receive housing assistance are 23% more likely than other unstably housed PLWHA to remain in care. (3)

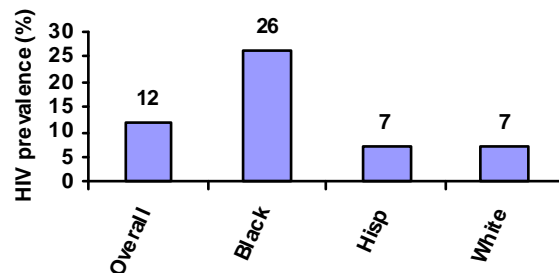
To achieve progress toward the EMA’s goal of reducing by one-half the number of AIDS deaths from 2003 to 2008, the EMA devotes substantial resources toward supportive services for homeless PLWHA. In addition to HOPWA’s support for additional housing units and housing placement services (\$57 million in 2008), the EMA allocated \$8.7 million in Part A funds (base and MAI) in the FY09 plan for targeted initiatives to stabilize the housing situations of vulnerable PLWHA. Part A funds emergency rental assistance, which provides unstably housed PLWHA with rental subsidies to avert homelessness. Many Part A housing service providers offer specialized services for key populations, such as women released from correctional settings, people over 50, and transgender individuals. One Part A program provides a safe drop-in center – operating 24 hours a day, seven days a week – to provide low-threshold HIV testing, substance abuse services, and linkage to HIV primary care for homeless people at high risk of infection.

MSM of Color. More than 18,000 MSM of color were living with diagnosed HIV/AIDS in 2007, including 8,810 Black MSM and 8,559 Hispanic MSM. Nearly 2,100 new HIV diagnoses among MSM were reported in NYC in 2006-2007. Between 2001 and 2006, the annual number of HIV diagnoses among young MSM (13-19) doubled, with Blacks and Hispanics accounting for more than 90% of such cases. (2)

According to an HIV serosurvey undertaken by DOHMH in 2004-2005, HIV prevalence among young Black MSM (18-29) in NYC is nearly four times more likely than among their white or Hispanic counterparts to be infected with HIV. (7) (Fig. 8.)

Among MSM diagnosed with HIV, Black and Hispanic men are more likely than whites to receive their AIDS diagnosis late in the course of

Figure 8
Young Black MSM (18-29) are nearly four times more likely to be HIV+ than whites and Hispanics (DOHMH, 2005)



infection. Compared to MSM overall, MSM of color are less likely to be in HIV care within three months of their HIV diagnosis and have an age-adjusted death rate that is 17% higher. (2)

MSM of color participating in the CHAIN study experience the widest service gap of any transmission risk category with respect to utilization of antiretrovirals, which are not reaching 33% of MSM of color who need them. (4) Three out of four (75%) MSM of color participants in the cohort study who need substance abuse services are not receiving them, while 69% of those requiring supportive mental health services are not utilizing such services. Forty percent of MSM of color who are homeless or unstably housed are not obtaining permanent housing assistance. (4)

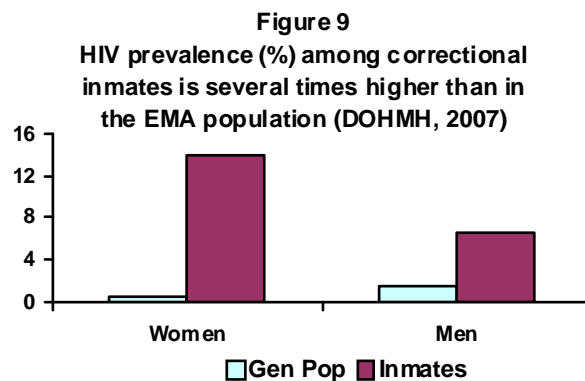
Among NYC MSM surveyed (88% non-white), 70% have used drugs in the last six months, including 39% who use at least weekly. (42) HIV-infected MSM are 2-5 times more likely than the general population to be co-infected with Hepatitis C. (43) MSM generally report high rates of depression and emotional distress and are more likely than the general population to have experienced violence or attempted suicide. (44) HIV-positive MSM participants in the longitudinal cohort study are nearly 40% more likely than heterosexual male PLWHA to experience interpersonal violence, which is associated with reduced treatment adherence.

High infection rates among MSM of color increase the cost and complexity of responding to HIV/AIDS in the EMA. In 2007, MSM of color accounted for 37% of all recipients of Part A-funded emergency rental assistance in NYC. (32) In the 12 months prior to February 2008, MSM of color accounted for 23% of ADAP and ADAP-Plus (HIV primary care) clients in the EMA. (19) In response to the unique needs of this population, the EMA uses Part A funds to support services specifically targeted to MSM of color. These include medical case management and early intervention programs for Spanish-speaking MSM, as well as a Brooklyn-based program serving MSM of color that integrates Part A funded early intervention and medical case management services with non-Part A-funded substance abuse and mental health services, primary care and education services.

Correctional Inmates and Releasees. The NYC Department of Correction has an average daily inmate population of 13,750 – a number larger than the entire prison system in 35 states.(45) As Figure 9 indicates, infection rates in the NYC correctional population are several times higher than in the non-incarcerated population. (8)

HIV-positive correctional releasees face considerable barriers to health care access. Incarceration in the previous 12 months is significantly associated with delayed entry to care for HIV-positive women enrolled in CHAIN. Most people released from correctional settings return to poor neighborhoods where economic opportunities are limited. (46) According to a DOHMH survey of male correctional releasees, only 45% had a job within 12 months of their release from jail. (8) Among CHAIN participants, PLWHA who are not in care are almost five times more likely to have been in jail during the previous six months than other PLWHA. (4)

Inmates and releasees are two to three times more likely than people



without a history of incarceration to be mentally ill or chemically dependent, which can interfere with health care access, treatment adherence, and housing stability. Their risk of tuberculosis is 5-15 times greater than the general public, and they are five times more likely to have hepatitis B and 10 times more likely to suffer from hepatitis C. According to a survey of NYC residents released from correctional settings in 2005, 77% report having used drugs in the last 30 days; 22% lived in a homeless shelter, single-room occupancy hotel, or on the street in the previous 12 months; and 15% reported severe depression. (62)

The concentration of HIV/AIDS among inmates and parolees adds to the cost and complexity of HIV/AIDS care. HIV-positive correctional releasees use more than three times more substance abuse services than the average Part A client, nearly three times as many mental health services, and almost 50% more transitional housing services. (32) In FY08, NYC spent more than \$7 million on antiretrovirals for incarcerated inmates. (40)

Notwithstanding the many impediments faced by HIV-positive correctional releasees, experience reveals that strong treatment adherence and favorable medical outcomes can be achieved through implementation of targeted initiatives that promote knowledge of serostatus, link infected individuals to care, and address social and medical comorbidities. Reflecting the strategic, gap-filling function of Part A, the EMA supports pre-release counseling, discharge planning and post-release care coordination for HIV-positive inmates that will reach 4,300 releasees in FY09. As a result of Part A services, 90% of inmates with self-identified HIV infection now have a post-release plan in place before their release.

Persons with Drug or Alcohol Dependence. More than 20,000 IDUs are living with diagnosed HIV/AIDS in the EMA, including nearly 1,000 who received an AIDS diagnosis in 2006-2007. Two percent of all people living with AIDS in the EMA are MSM who also have a history of injection drug use. (2)

While injection drugs have long been a major source of HIV transmission in the EMA, use of alcohol and non-injection drugs can also interfere with treatment adherence and efforts to maintain housing stability. Recent studies in NYC suggest that HIV prevalence may be higher among users of non-injection substances than among IDUs. (47) Nearly half (45%) of PLWHA CHAIN enrollees from the Tri-County region were using drugs at the time of their HIV/AIDS diagnosis. (4)

Substance users often experience severe barriers to health care access. Among participants in the longitudinal client cohort study, active drug use is independently associated with reduced odds of receiving appropriate HIV medical care. Drug users in CHAIN are more likely to delay seeking care after testing HIV-positive than other PLWHA. Once they are connected to care, they are more likely than other PLWHA to seek care in emergency rooms and to fall out of the HIV care system. According to CHAIN, drug users living with HIV are 71% more likely than HIV-positive MSM to be hospitalized in a six-month period. Those with a history of injection drug use are almost four times more likely to die of an HIV-related cause than MSM. Active drug users are at especially high risk of homelessness, which also increases the cost and complexity of care. Nearly one-third of PLWHA participants in the CHAIN study who have substance abuse problems in NYC – and 38% in the Tri-County region – also have mental illness. (4)

DOHMH estimates that more than 20,000 IDUs in NYC – including several thousand IDUs living with HIV – are receiving no services whatsoever. (35) Methadone maintenance programs currently reach only a fraction of NYC's heroin users. Most HIV-positive IDUs are co-infected with HCV, a potentially life-threatening infection that is exacerbated by HIV. (See p. 13.)

Among participants in the EMA’s CHAIN study who said they needed substance abuse treatment, 64% in NYC and 69% in the Tri-County region are not receiving such services. Half of HIV-infected substance-using cohort participants who are homeless or unstably housed are not receiving permanent housing assistance, and 59% of those needing professional mental health services are not currently being served. (4)

The high prevalence of substance use among PLWHA significantly increases the cost and complexity of the HIV/AIDS care system. PLWHA with drug or alcohol dependence used an average of 46% more Part A services than NYC PLWHA as a whole in 2007, including 21% more case management services and more than twice as many food and nutrition services. (32) PLWHA with substance abuse problems are three times more likely than PLWHA overall to be reached by early intervention assessment teams in hospital emergency care departments, more than twice as likely to access adult mental health services, and more than twice as likely to receive treatment adherence support. (32)

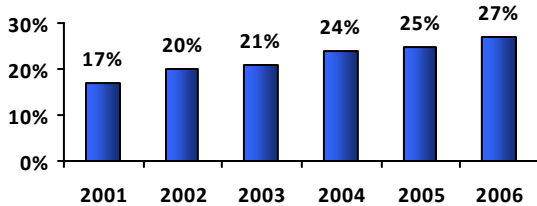
To reduce the negative impact of substance use on medical outcomes for PLWHA, the EMA has allocated \$11.2 million in Part A funds in FY09 to support a range of client-centered substance abuse services. In other service categories, the EMA requires providers to adapt their service models to address the multiple needs of PLWHA with substance abuse problems. EMA service utilization data indicate that clients with active or recovering alcohol or substance abuse problems are especially heavy users of medical services and housing referral programs based in single-room occupancy hotels and homeless shelters. One Brooklyn-based early intervention program for substance users is linked to more than 80 units of scattered site housing for PLWHA, while another Bronx-based Part A program integrates substance abuse services into a transitional housing program for HIV-positive clients with a history of substance abuse. Since 2007, buprenorphine therapy has been integrated into an increasing number of Part A substance abuse and mental health programs.

Immigrants. More than 15,600 PLWHA in NYC – nearly one in seven (14%) of PLWHA – are foreign-born. (2) Infections among immigrants are rapidly rising. As Figure 10 illustrates, the percentage of new HIV diagnoses among foreign-born New Yorkers increased from 17% in 2001 to 27% in 2006. (2)

Immigrants living with HIV often confront overwhelming barriers to care. Often discouraged from seeking services due to language barriers or fear of deportation, many immigrants lack access to basic HIV/AIDS information. Consumer focus participants in 2008 identified undocumented immigrants as an underserved PLWHA population in the EMA. In many immigrant communities, the stigma associated with HIV, homosexuality, and drug use deter many individuals from seeking counseling, voluntary testing, or HIV/AIDS

medical services. Accounting for 36% of NYC’s population, immigrants represent 63% of all uninsured people in NYC. As a result of these daunting barriers to health care utilization, foreign-born individuals newly diagnosed with HIV in 2007 were 46% more likely than their U.S.-born counterparts to receive an AIDS diagnosis within 31 days. Foreign-born PLWHA in NYC are also less likely than U.S.-born PLWHA to have entered HIV primary care

Figure 10
% Immigrants among new HIV diagnoses is rapidly growing (DOHMH, 2008)



within three months of their diagnosis and are significantly more likely to be co-infected with TB than their US-born counterparts. HIV-positive immigrants have an age-adjusted death rate nearly one-third higher than white PLWHA. (2)

The large number of HIV-infected immigrants in the EMA increases the cost and complexity of responding to the epidemic. On average, HIV-positive immigrants used 77% more Part A services in 2007 than PLWHA as a whole, including 17% greater utilization of medical case management, more than twice as many substance abuse services for active or relapsing users, and 67% greater utilization of mental health services in underserved neighborhoods. (32)

To address the multiple barriers to health care access and continuity faced by diverse immigrant communities, Part A funds a broad range of services focused on immigrants living with HIV. Part A, for example, funds a multi-disciplinary mental health program that serves HIV-positive Caribbean immigrants. Part A also supports medical case management services for African immigrants living in Upper Manhattan and the Bronx, HIV-positive individuals born in Central and South America, and immigrants from numerous Asian or Pacific Island countries.

1.e. Unique Service Delivery Challenges. Encompassing the country's most concentrated urban neighborhoods, as well as suburban and rural areas of the Tri-County region, the EMA confronts unique challenges to the delivery of HIV/AIDS care.

Late Diagnosis. One in four (25%) individuals newly diagnosed with HIV in the first half of 2007 also received an AIDS diagnosis within one month of their positive HIV test, indicating that HIV infection was first diagnosed late in the course of disease. Blacks, the foreign-born, older adults and people with unknown risk were more likely than other persons newly diagnosed in 2007 to be tested late in the course of infection. (2)

Individuals who are diagnosed with AIDS within one month of first being diagnosed with HIV (known as "concurrent" diagnosis) are *more than twice as likely to die* of an HIV-related cause over the next four months as individuals who first test HIV-positive earlier in the course of disease. (2) PLWHA diagnosed late in the course of infection are more likely to have multiple illnesses and more likely to require hospitalization than PLWHA who are diagnosed earlier. (48) Care costs in the year following an HIV diagnosis are twice as high for PLWHA diagnosed late (when CD4 count is under 200) than for patients who are diagnosed at an earlier stage of infection. (49)

Part A plays a critical strategic role in the EMA's efforts to ensure timely diagnosis of HIV infection and linkage to care for those who test positive. In FY07, Ryan White early intervention services linked more than 550 previously undiagnosed or out-of-care PLWHA to HIV primary care. (32) In addition, DOHMH has significantly increased non-Part A-funded efforts to expand use of rapid testing technologies in NYC correctional facilities, hospital emergency departments, City STI clinics, homeless shelters, and community-based organizations. DOHMH is also actively working with clinicians in diverse settings to ensure that HIV testing is a *routine component of medical care*. NYC's testing initiatives may be drawing people into care at an earlier stage of infection. From June 1, 2000 to December 31, 2004, the percentage of new HIV (non-AIDS) diagnoses that involved recent infections *increased from 14.6% to 32.3%*, with the percentage of new infections among MSM rising from 21.4% to 43.1%.*

* Although DOHMH only began routinely using the STARHS technology that differentiates recent from longstanding infections in 2005 for all HIV diagnostic tests, the Department was able to determine the percentage of new infections from earlier years by testing stored blood samples from NYC clinics and facilities.

Treatment Adherence. Failure to adhere to therapy is the *leading cause of treatment failure*, which in turn increases rates of HIV-related illness and death. (50) *HIV medical regimens require an unusually high degree of adherence*, with at least 85% adherence required to achieve optimal therapeutic benefit. While most PLWHA in the CHAIN study adhere to therapeutic regimens, many have difficulty doing so. (4) PLWHA struggling with substance use and mental illness have particular difficulty in adhering to prescribed regimens, as do individuals who are homeless or unstably housed. (51)

The EMA uses base Part A funding to support 28 treatment adherence programs, as well as services to address many of the underlying causes of poor treatment adherence, including \$11.4 million in FY08 for substance abuse services, \$7.6 million for mental health services, and \$8.7 million (including \$500,000 in MAI funding) in various forms of housing assistance. Ryan White-funded treatment adherence programs served nearly 4,000 PLWHA in 2007. In FY08, two Part A clinical treatment adherence programs are integrating daily directly observed therapy into program protocols. The FY09 plan incorporates treatment adherence supports, including directly observed therapy for high-need patients, into a consolidated medical care coordination program. As Section 6 explains, on pp. 59-60, outcomes evaluations have consistently demonstrated the effectiveness of the EMA's programs in improving adherence rates and medical outcomes. (52)

Fragmentation of Care. Many people who initially access care in the EMA drop out for extended periods. Among patients enrolled in the CHAIN study, 28% reported going on a "drug holiday" in the previous six months, with three out of four deciding to interrupt treatment on their own without consulting their medical provider. According to the cohort study, "drug holidays" are strongly associated with treatment failure. More than one in five (21%) PLWHA report having dropped out of care altogether for at least six months. (4)

Discontinuity of care significantly adds to the cost and complexity of HIV care. PLWHA in the EMA's cohort study who do not have a stable HIV primary care relationship are 3.3 times more likely than PLWHA in care to use costly hospital emergency rooms. Unsupervised drug holidays accelerate the development of drug resistance, which leads to treatment failure and often to costly hospitalization. (4)

The EMA uses Part A funds to support innovative, client-centered programs that aid multiply diagnosed PLWHA to remain in care. According to the EMA's outcome evaluation, more than 80% of high-need maintenance-in-care clients were receiving HIV primary care in 2007. (52)

Linguistic and Cultural Complexity of the EMA. NYC is not only the nation's most densely populated municipality, but it is extraordinarily complex. In the NYC borough of Queens alone, more than 120 different languages are spoken, and 46% of the population is foreign-born. Particularly for a disease that remains as stigmatized and complicated as HIV, effective service delivery demands that clients have access to providers that are equipped to provide culturally and linguistically appropriate services. Part A plays a critical role in delivering such services to those who need them, supporting a range of services that are available in dozens of languages, available to PLWHA who are hearing- and speech-impaired, and tailored to specific immigrant communities from all corners of the world.

Changes in the HIV Financing Environment. Enhanced Medicaid reimbursement rates for HIV care have been essential to the development of the EMA's HIV care continuum, persuading some of the world's most distinguished hospitals to establish outpatient HIV primary care programs for low-income New Yorkers. These payment policies, in place now for two decades, require medical centers to couple HIV clinical care with wraparound services that ensure care coordination and access to support interventions, such as food and

nutrition, treatment adherence support, and case management. New York State, however, recently announced that it intends to begin a three-year transition to a prospective payment system based on Ambulatory Patient Groups (APGs) for almost all services provided in hospital outpatient centers (beginning December 1, 2008) and freestanding diagnostic and treatment centers (beginning March 1, 2009). This policy change is intended to infuse additional funds into ambulatory care, as the APG methodology more appropriately recognizes the intensity and complexity of resources used in providing care. Most of the enhanced Medicaid HIV rates that have long attracted leading medical centers to serve indigent PLWHA will gradually be eliminated, although discrete reimbursement is being retained for providing such services as medical care coordination and treatment adherence in designated AIDS centers. As a consequence of this change, individual providers will need to decide whether reimbursement continues to give the financial incentive to provide the wraparound services that are critical to treatment success. At the same time, New York State is recommending mandatory enrollment of PLWHA in either the state's mainstream Medicaid managed care program or its HIV Special Needs Plans (SNPs). While HIV SNPs provide enrollees with access to comprehensive care and support services, mainstream Medicaid managed care plans also may not have the financial incentive to provide the comprehensive care and support services that low-income PLWHA need. As wraparound services possibly contract, the importance of Part A will intensify, as will the burdens on the EMA's care system.

Challenges Specific to the Tri-County Region. The CHAIN study indicates that 69% of PLWHA in need of professional mental health services are not receiving them, potentially interfering with health care access and treatment adherence and resulting in avoidable illness that increases the costs associated with HIV primary care. (4) The dual stigma associated with HIV and a mental health diagnosis appears to deter many PLWHA from seeking the mental health services they require. Addressing these complex challenges entails expenditures on carefully tailored programs that increase the cost and complexity of the EMA's Part A program. One Part A community-based provider recently devised a successful strategy to help overcome the deterrent effect of stigma, merging with the staff of the local PLWHA advisory group and using PLWHA group meetings for outreach and educational sessions to reduce client resistance to services.

In the Tri-County region, which stretches from the urban neighborhoods of southern Westchester County to rural Rockland County, many PLWHA lack any means of transportation for medical appointments. Almost one in three (31%) Tri-County CHAIN participants require transportation assistance in order to see their clinical providers. (4) Transportation challenges hurt medical outcomes and increase the cost and complexity of HIV care, especially with concurrent unmet need for housing assistance. Among CHAIN participants who have an unmet need for both transportation and housing assistance, 40% obtain sub-optimal HIV care. However, high-need participants who receive Part A-funded assistance with medical transportation are 44% less likely than non-recipients to visit the emergency room and 37% less likely to be admitted to the hospital. (4)

1.f. Impact of a Decline in Ryan White Formula Funding. The EMA experienced no loss of Ryan White funding in FY08.

1.g. Unmet Need. The EMA estimates that one-third (33%) of all people with a diagnosis of HIV or AIDS are not currently in care. (See Attachment 6.) This includes 35% of persons living with HIV (non-AIDS) (PLWH) and 32% of people living with AIDS (PLWA).

Estimation Methods. Using public health surveillance data, the EMA compared the number of people with diagnosed HIV or AIDS with the number of people presumed to be in care based on mandatory reporting of all CD4 and viral load tests in calendar year 2007 to HIV/AIDS surveillance through June 30, 2008.

The DOHMH HIV Epidemiology and Field Services Program and the New York State Department of Health Bureau of HIV/AIDS Epidemiology provided the number of persons diagnosed and reported in the New York City EMA and presumed to be living with HIV or AIDS as of December 2006. The number of eligible cases not yet reported due to reporting lag was considered to be negligible. Cases reported to DOHMH (not the NYS DOH) were excluded if they 1) resided outside the five boroughs of New York City or had an unknown residence at the time of HIV/AIDS diagnosis (N=7,553) or 2) had evidence of residence outside of the five boroughs of New York City in 2007 based on interstate deduplication sponsored by CDC (N=5,849).

There were 36,478 PLWH and 57,106 PLWA who were diagnosed and reported and presumed to be living in the EMA at the end of 2006. Based on CDC estimates, as many as 25,000 additional persons may be living with HIV but are undiagnosed because they have never been tested.

To estimate unmet need, the EMA compared the number of PLWHA with the number of persons receiving HIV primary medical care in 2007 as documented by reportable laboratory tests. The percent not in care was defined as the percent of PLWH or PLWA who did not have at least one CD4 or viral load test reported in 2007. Receipt of antiretroviral therapy is not reportable to surveillance.

As Attachment 6 indicates, the EMA estimates that 35% of PLWH and 32% of PLWA are not in care. Unmet need may be overestimated due to the large number of PLWA diagnosed in NYC before 2000 (N=11,649) who are currently classified as living and not in care. An unknown number of these individuals may actually be dead or no longer living in NYC, but these facts are not yet known despite national death matches and CDC's interstate deduplication initiative. This limitation is common to older HIV/AIDS surveillance systems like New York City's.

Assessment of Unmet Need. Certain populations are more likely to be out of care than others, providing critical information used by the Planning Council in deciding on service priorities and allocations.

¶ *Demographics and Location of PLWHA with Unmet Need.* In 2007, male PLWHA in the EMA were 15% more likely to be out of care than female PLWHA. Among age groups, unmet need was highest among people over 60 with AIDS, with 39% of this population having no evidence of receiving HIV primary care in 2007. White PLWHA were somewhat more likely to be out of care than Black or Hispanic PLWHA.

People living with AIDS in the NYC borough of Queens were about 20% more likely than Bronx or Brooklyn residents to experience unmet need for HIV primary care. Unmet need in the poorest high-prevalence neighborhoods – in Harlem, South Bronx and Central Brooklyn – is actually lower than in the affluent Manhattan neighborhood of Chelsea, suggesting that the EMA is succeeding in addressing many of the access barriers posed by poverty and related conditions.

¶ *Assessment of Service Needs, Gaps and Barriers for PLWHA Not in Care.* In addition to using CHAIN findings and epidemiological data, the Planning Council also considered findings from a small, one-time “Return to Care Survey” of 51 clients in NYC Part A maintenance-in-care programs who had previously been disconnected from care. Altogether, CHAIN and epidemiological data indicate that out-of-care PLWHA are demographically

comparable (e.g., gender, race/ethnicity, age) to PLWHA who are in care. However, CHAIN study participants who are not in care are more likely to be actively using drugs, suffering from mental illness, homeless or unstably housed, recently incarcerated, and lacking strong social supports. Participants in the DOHMH return-to-care study cited a number of factors they perceived to contribute to their disconnection from care (multiple answers possible), including not wanting to think about or deal with HIV (48%), not being able to keep track of appointments (46%), feeling hopeless or overwhelmed (41%), not wanting to take HIV medications (39%), and using alcohol or other drugs (37%). Most CHAIN participants who are not in care had a primary care relationship at one time but subsequently dropped out of care (4), underscoring the importance of maintenance in care initiatives (part of medical case management). When asked which services were currently most helpful in keeping them in care, participants in the return-to-care survey most often highlighted their actual primary care for HIV, treatment adherence services, and case management. The FY09 plan prioritizes return-to-care and maintenance-in-care through its new care coordination model in the medical case management category.

¶ *Case-Finding and Linkage to Care Initiatives.* As described in greater detail below in Section 2, the EMA has significantly increased investments in early intervention services in recent years, in tandem with the multi-year re-competition of the full Part A portfolio. Early intervention initiatives undertake outreach, rapid testing and linkage services in community venues that are heavily used by hard-to-reach populations. The FY09 plan prioritizes early intervention initiatives. In addition, MAI funding supports nine programs to identify individuals with HIV infection and link them to care, including a program that links HIV-infected, newly released correctional inmates to HIV primary care and ongoing medical case management. In addition, the FY09 plan strengthens efforts to ensure continuity of care by increasing support for the new care coordination program, which will provide intensive, client-centered care to more than 10,000 PLWHA who are at high risk of falling out of the care system and provide return-to-care support for more than 4,600 PLWHA who have fallen out of regular care. By requiring Part A providers to monitor each client's utilization of primary care and to intervene to address access barriers, the EMA mobilizes the entire Part A portfolio to reduce unmet need.

¶ *Use of Unmet Need Estimate in Planning Process.* Over the last five years, the Planning Council has made concerted efforts to reduce the level of unmet need, building significant capacity for case-finding, linkage to care, and programs to assist PLWHA in remaining engaged in primary care. Data from the HIV/AIDS reporting system indicates that the percentage of PLWHA who are not in primary care has fallen in the last three years. Recognizing that the level of unmet need remains unacceptably high, the Planning Council increased support for medical case management and placed high priority on early intervention services.

2. Access to HIV/AIDS Care and the Plan for FY09. Timely, ongoing engagement in primary care is critical to public health efforts to reduce the number of HIV-related deaths. Risk of death for PLWHA dramatically increases for those who are diagnosed late in the course of infection, for those who are not in continuous care, and for those who develop drug resistance as a result of poor treatment adherence. By addressing the factors that impede health care access among poor, multiply diagnosed PLWHA, the EMA has established a care continuum that has been recognized by the Institute of Medicine as a national model. (1)

To enhance the public health impact of the EMA's HIV care continuum, the FY09 plan consolidates three local service priorities within medical case management and

reallocates \$11.6 million from outpatient medical care and medical transportation to establish a new multi-disciplinary model of care coordination in the service category of medical case management. This new initiative, co-located with HIV primary care and governed by rigorous standards of care, draws on extensive scientific evidence from HIV and non-HIV medical literature on the benefits of care coordination in improving health outcomes. (53) Through enhanced care coordination, the EMA will link PLWHA to care in a timely and coordinated manner, help maintain medical stability and a suppressed viral load, maintain PLWHA in care by aiding them with navigation and coordination of medical and social service needs, educate and support patients on treatment adherence, and train patients to become self-sufficient in order to manage their own medical and social service needs with autonomy.

2.a. The EMA's Established Continuum of HIV/AIDS Care and Access to Care.

Although Medicaid contributes more toward AIDS care and treatment in the EMA than Part A, the flexibility of Ryan White funding enables the EMA to close critical gaps in the health care continuum and to develop targeted initiatives to specifically address the needs of special populations and the factors that contribute to premature illness and death. In FY07, the EMA provided Part A services to 57,339 individual clients in NYC (including early intervention clients but not including individuals served by Part A-supported ADAP and ADAP-Plus services or clients served in the Tri-County region). Through a multi-year process of re-competing the entire Part A portfolio, the EMA has significantly reduced funding for program support and lower-priority services, reallocating savings toward high-priority core services, including treatment adherence, substance abuse and mental health services, and early intervention initiatives.

Trends in the health and longevity of PLWHA in the EMA constitute the ultimate test of the impact of the EMA's service continuum. From its peak in the mid-1990s, the annual rate of severe HIV-related immune suppression, as reflected in new AIDS diagnoses, has fallen by more than two-thirds – and the annual number of AIDS deaths in the EMA has declined even more sharply (by 75%). While deaths among PLWHA nationally declined by 15% from 2003 to 2006, the number of deaths among PLWHA in NYC dropped by more than 27% – evidence that the EMA's strategic use of Part A funds is saving lives and supporting public health objectives. (2)

Comprehensive Continuum of Care. The EMA's HIV/AIDS service system spans the country's most densely populated urban neighborhoods and the suburban and rural areas in the Tri-County region. NYC accounts for approximately 95% of all HIV/AIDS cases in the EMA and receives 95% of Part A funding. The EMA's care continuum focuses on three aims: (1) *early diagnosis* of HIV infection, (2) *early entry* into HIV primary care and *maintenance in care*, and (3) *ensuring treatment success* through the delivery of high-quality services needed to increase treatment adherence and promote favorable medical outcomes.

¶ *Early Diagnosis of HIV Infection.* The EMA offers free HIV counseling and testing. DOHMH-supported HIV testing in STD clinics, HIV testing centers, correctional settings and community-based organizations reached more than 178,000 people in 2007, including nearly 2,300 who tested HIV-positive. In 2007, the City's public hospitals also administered almost 144,000 HIV tests. (54) In an effort to further improve on its ability to ensure that people receive their test results, NYC has expanded rapid testing to STD clinics, HIV voluntary counseling and testing sites, correctional settings, homeless shelters, tuberculosis chest clinics, public hospital clinics, hospital emergency departments, and community-based organizations serving communities of color. In response to above-average HIV death rates in the Bronx borough of NYC, DOHMH in 2008 embarked on "The Bronx Knows"

initiative, which aims to achieve universal knowledge of HIV serostatus among residents of this heavily-affected, largely low-income part of NYC. In Westchester County, where 80% of PLWHA in the Tri-County region reside, the county department of health coordinates free rapid HIV testing in non-traditional settings, including housing projects, faith-based organizations, supermarket parking lots, recreational centers, family day picnics and cultural events.

¶ *Early Entry: Linking PLWHA to Care.* Testing sites refer individuals who test HIV-positive to primary care and medical case management services. To promote swift linkage to care for people who are newly diagnosed or otherwise identified through case-finding activities, the EMA integrates HIV prevention activities funded by city, state and federal sources, and is also actively encouraging formal partnerships and collaborations between community-based organizations and medical providers. The EMA invests more than \$7.3 million (base and MAI) in early intervention initiatives (including \$2.2 million in MAI-funded programs) that identify out-of-care individuals and facilitate their entry into care, linking more than 550 previously undiagnosed individuals to care in 2007. The EMA uses Part A funds to support the Rikers Island Transitional Consortium, which assists in the transition of HIV-infected individuals from jail to the community through discharge planning that begins as soon as the inmate enters the correctional system. Part A funds also support a discharge planning program for HIV-positive correctional releasees in the Tri-County region. The FY09 plan invests more than \$5 million in Part A base funding toward early intervention initiatives.

Medical case management is the linchpin of the EMA's efforts to promote health care access and continuity of care. The EMA's longitudinal client cohort study indicates that having a case manager *significantly increases health care access and favorable medical outcomes*. A 2006 analysis of 28 studies involving nearly 40,000 people with HIV indicates that receipt of case management services is associated with reduced mortality and increased likelihood of receiving antiretrovirals.⁽⁵⁵⁾ A 2007 study in NYC indicated that utilization of case management resulted in a statistically significant improvement in clients' access to safe housing. ⁽⁵⁶⁾

Part A supports HIV medical case management at 71 geographically targeted sites throughout the EMA. Like other Part A services, medical case management services are heavily clustered where they are needed the most – in the high-prevalence neighborhoods in the South Bronx, upper and lower Manhattan, central Brooklyn, and southern Westchester County. To avoid overlap and ensure that Ryan White functions as the payer of last resort, Part A medical case management services are coordinated with Medicaid-funded social service case management programs that in FY07 served more than 10,600 PLWHA in the EMA. Two-thirds of PLWHA in the EMA's CHAIN cohort receive case management services on an ongoing basis. Surveys of NYC PLWHA enrolled in the longitudinal cohort study in 2006-2007 indicate that 73.9% were "very satisfied" with their case manager. ⁽⁴⁾ The EMA requires all case management and out-patient care contractors to have formal referral arrangements in place with HIV testing centers and STD clinics to ensure early access for newly-diagnosed individuals.

In FY09, the entire EMA will consolidate the medical case management, maintenance-in-care and treatment adherence service categories into a single medical case management program. (The service category model was already consolidated and re-bid in the Tri-County region in FY08, resulting in 13 new programs.) With the aim of further strengthening the linkage between case management and HIV primary care, the EMA will require case management programs to be collaborative partners with HIV primary care

services. Medical criteria will govern reimbursement for case management services, and providers will be required to integrate treatment adherence and transportation services to enhance continuity of care and improve medical outcomes. Recent evidence indicates that integrated care coordination teams significantly increase the likelihood that PLWHA will be promptly diagnosed with underlying co-morbidities that may interfere with treatment adherence, reduce health care continuity, and worsen medical outcomes. (53)

Since responsibility for medical care for correctional inmates was transferred in 2003 from the NYC Department of Correction to DOHMH, the EMA has taken major steps to improve care linkages for HIV-positive inmates and releasees. Rapid testing is offered to all inmates upon entry, and the Part A-supported Rikers Island Transitional Care Consortium initiates discharge planning as soon as HIV-infected inmates enter the correctional system, ensuring that releasees are rapidly linked to HIV primary care, case management, housing assistance, and other essential services. A drop-in center serves as a “bridge” for correctional releasees to ensure a smooth transition from the point of release to community-based services. In FY07, the EMA provided transitional care and linkage services to more than 2,600 HIV-positive correctional inmates/releasees.

¶ *Early Entry: High-Quality HIV Primary Care.* Consumer focus group participants in 2008 reported that HIV medications and outpatient medical care were the two Part A core services with the highest client satisfaction. The EMA delivers high-quality primary medical care to low-income PLWHA through Medicaid and a network of 24 State-certified Designated AIDS Centers. These hospital-based centers primarily provide and coordinate out-patient care but also have the capacity to ensure continuity of care in case of hospitalization. Medicaid covers the medical costs for 85% of people diagnosed with HIV/AIDS in the EMA. In FY07, Medicaid covered HIV-related physician visits for more than 41,000 PLWHA in the EMA. For high-need clients who are either ineligible for Medicaid or who require specialized health services not covered by Medicaid, Part A in FY08 provides \$20.9 million in outpatient medical care, including funding for ADAP-Plus and more than \$600,000 to support two ambulatory care programs in homeless shelters and single-room occupancy hotels.

A key component of the EMA’s HIV/AIDS safety net is the HIV Uninsured Care Program (also known as ADAP-Plus). At the urging of the Planning Council, NYS created ADAP-Plus in the early 1990s. While ADAP in most other States provides only drugs, the visionary partnership between the State and the EMA’s Planning Council has permitted the program to be expanded to provide primary care for ADAP-eligible, uninsured people who have no other means of paying for clinical services. This unique approach to ADAP in New York is made possible by significant financial contributions by the EMA Planning Council, including more than \$7.1 million for ADAP in FY08, and \$7.1 million for ADAP-Plus for HIV uninsured care. As of February 2008, ADAP-Plus supported HIV primary care for more than 11,400 PLWHA in the EMA, more than 80% of whom belong to racial/ethnic minorities. The FY09 plan will support primary care services for 9,465 PLWHA served by ADAP-Plus. In the most recent round of interviews, 82% of participants in the EMA’s longitudinal cohort study said they were very satisfied with the HIV primary care they were receiving.

¶ *Early Entry: HIV Medications.* As a result of the 17-year financial and programmatic partnership between the EMA and NYS, New York’s AIDS Drug Assistance Program covers an expansive range of medications needed for the medical management of HIV disease. Consumers participating in the 2008 focus groups highlighted ADAP as a Ryan White core service achieving high levels of consumer satisfaction. PLWHA in the EMA have

access to all antiretrovirals, diverse treatments and preventive drugs for opportunistic infections, a broad array of medications for the treatment of mental illness, medications used to treat alcohol and chemical dependence, and drugs required for the management of co-morbid conditions. More than 2,000 PLWHA in the EMA enter ADAP for the first time each year. PLWHA of color account for 80% of the EMA's ADAP clients. Roughly 51,000 Medicaid-eligible PLWHA received HIV-related medications through Medicaid in FY07.

¶ *Ensuring Maintenance in Care.* While nearly 80% of people who test HIV-positive access primary care within 18 months of diagnosis, many patients subsequently drop out of the health care system for extended periods, often in response to substance addiction, mental illness, homelessness, or other personal crises. Interruptions in care significantly contribute to HIV-related illness and death. In FY08, the EMA supported maintenance-in-care programs (in the medical case management category) that provide intensive, client-centered services to patients who have missed appointments or who are identified at high risk of dropping out of care due to personal circumstances (i.e., unstable housing, co-morbidities, child care responsibilities, etc.). Some of these programs use culturally competent escorts to accompany high-need clients to medical appointments – an approach that has proven especially useful in promoting continuity of care for non-English-speaking PLWHA. An independent, EMA-funded evaluation found that clients enrolled in the EMA's maintenance-in-care programs are more likely to stay in medical care, to use antiretrovirals, and to have improved health. (52)

¶ *Ensuring Treatment Success: Promoting Treatment Adherence.* Recognizing that poor adherence is the primary cause of HIV treatment failure, the EMA supports 28 programs that provide client-centered services that help multiply-challenged PLWHA take medications as prescribed. In 2007, Part A supported treatment adherence services to more than 4,000 PLWHA in the EMA. Consistent with the latest information on successful strategies to increase adherence (55), Part A treatment adherence programs build practical medical management skills, provide ongoing support for adherence, and permit repeated reinforcement of messages and ongoing reassessment of client needs.

EMA evaluations indicate that nearly three-quarters (73%) of clients enrolled in MAI treatment adherence programs show reductions in their HIV viral load. (52) Among individuals who were not adherent to treatment at the time they enrolled in the Tri-County area's CHAIN cohort, those who subsequently entered a Part A treatment adherence program were nearly 20% more likely to be adherent at one year than patients who did not receive adherence support. (4)

¶ *Ensuring Treatment Success: Substance Abuse Services.* Federal, state and local funding combine to support a network of diverse alcohol and drug treatment services in the EMA. Such services include medically managed detox, adult outpatient services, intensive and community residential treatment, and drug substitution therapy (e.g., methadone, buprenorphine). Notwithstanding concerted efforts to expand the EMA's capacity for alcohol and drug treatment, available services are sufficient to address only a small fraction of needs. In particular, substantial unmet need exists for methadone maintenance, in-patient rehabilitation and residential services. In addition, many mainstream substance abuse treatment programs fail to address the unique medical and social needs of MSM, pregnant women, immigrants and other groups with high HIV prevalence. No validated medical intervention exists to address addiction to cocaine, crack or methamphetamines, and many treatment programs have only limited experience in treating individuals addicted to these and other stimulants.

To address the related epidemics of substance addiction and HIV/AIDS, the EMA in FY08 allocated \$11.4 million for client-centered, low-threshold substance abuse programs that are not covered by other payment sources, creating new substance abuse services in supportive AIDS housing programs and funding new initiatives to address the housing needs of substance-using PLWHA. Part A reaches more than 12,000 PLWHA with substance abuse services annually. More than three quarters (76.2%) of participants in the CHAIN study who received drug and alcohol treatment services in 2006-2007 reported being very satisfied with the quality of such care. For substance-using PLWHA enrolled in the CHAIN cohort, receipt of drug treatment is strongly associated with increased utilization of appropriate medical services. (4) The EMA in recent years has increased its efforts to co-locate substance abuse services in settings that provide other essential services, such as primary medical care, housing assistance, and mental health services. For example, Part A supports physicians to provide substance abuse assessments and referrals to PLWHA living in single-room occupancy hotels. To address the unique needs of key sub-populations, Part A programs have implemented a range of innovative service models; one Queens-based program, for example, has been specifically designed for young PLWHA with substance abuse problems, using recreational activities to attract clients to needed services.

¶ *Ensuring Treatment Success: Mental Health Services.* Ninety percent of participants in the EMA's 2008 consumer focus groups rate mental health as an essential service for PLWHA. Approximately 30% of clients enrolled in the CHAIN cohort study are experiencing clinically relevant mental health symptoms at any given time, and more than 90% have experienced a traumatic event in their lifetimes. Receipt of mental health services is strongly associated with entry into care and with continuity of care for PLWHA enrolled in CHAIN. (4)

To close access gaps in the mental health service system for PLWHA, the Planning Council directs significant Part A resources (\$7.6 million in FY08) toward mental health services tailored to the unique needs of PLWHA. In FY07, the EMA reached more than 2,200 PLWHA with mental health services as a result of Part A. Roughly four out of five PLWHA enrolled in the CHAIN study who receive mental health services in the EMA are "very satisfied" with the quality of such services. (4) The EMA requires all Part A mental health providers to provide comprehensive ambulatory and in-patient primary care or have in place a formal memorandum of understanding with such providers. Part A-supported mental health providers are also funded by Part A to provide buprenorphine for the treatment of substance addiction, as well as care coordination with primary care providers. The EMA prioritizes funding for mental health programs that provide on-site services in homeless shelters, soup kitchens, and single-room occupancy hotels.

¶ *Ensuring Treatment Success: Housing Assistance.* Housing stability improves medical outcomes for PLWHA and promotes more efficient use of scarce health resources. Among stably housed PLWHA in CHAIN, 95% have a relationship with an HIV primary care provider and 75% receive antiretrovirals. The longitudinal cohort study indicates that receipt of housing assistance doubles the likelihood that an out-of-care PLWHA will enter the care system. (4) Ninety-five percent of PLWHA participants in the EMA's 2008 consumer focus groups rated housing as an essential service for PLWHA.

NYC provides some form of housing assistance to nearly 30,000 people with HIV. (57) Part A funds transitional and emergency housing assistance, as well as wraparound social and medical services in AIDS housing sites to complement the \$57 million in support that NYC receives through the Housing Opportunities for People with AIDS program. Part A supports outstationed medical teams in single-room occupancy hotels, ambulatory and

outpatient care in AIDS supportive housing, and on-site substance abuse and mental health programs in AIDS housing sites. In 2007, Part A prevented more than 1,100 PLWHA from becoming homeless by providing housing assistance.

¶ *Ensuring Treatment Success: Supportive Services.* One of the great benefits of Part A funding, in comparison to Medicaid or Medicare, is its availability to support a range of non-medical services that improve quality of life and promote the utilization and success of medical services. In FY08, the EMA is spending \$6.3 million in Part A funding for food and nutrition services, which have an especially important role to play in antiretroviral management. In addition to meeting a basic health need, these low-threshold programs, which under the FY08 plan will feed more than 11,000 PLWHA and provide nutritional counseling to nearly 2,500 clients, also serve as gateways to medical care and an effective means to attract clients who need other services. As a result of Part A funding, the EMA's second largest provider of congregate meals to PLWHA integrates treatment adherence support into its mealtime activities. Another Part A food and nutrition program is housed in the EMA's largest HIV social service agency, facilitating rapid linkage to a broad range of case management and mental health services. Part A funding also supports legal services (\$4.0 million in FY08) to help stabilize housing in cases of discrimination, secure essential entitlements, and address life challenges associated with HIV infection. In FY08, the EMA also allocated \$1.9 million in Part A funding to provide psychosocial support services to stabilize the living circumstances of vulnerable HIV-affected families.

Enhancing Health Care Access. The large majority of newly diagnosed individuals (69%) have an HIV-related laboratory test within three months of testing HIV-positive, indicating the EMA's success in ensuring health care linkages for most newly diagnosed individuals. Nevertheless, a notable share of PLWHA delay entering care after a positive HIV test, with 21% of PLWHA lacking evidence of an HIV-related laboratory test within 18 months of their HIV diagnosis. (2) IDUs and Blacks are least likely to initiate care soon after diagnosis.

The flexibility of Part A has enabled the EMA to implement innovative service models that are specifically designed to promote health care access to PLWHA who confront obstacles to care. First, early intervention programs target hard-to-reach populations with rapid testing and linkage to care, focusing on key venues such as homeless shelters, soup kitchens and congregate meals programs, and shooting galleries. A national, multi-site study found that having nine or more outreach contacts in the first quarter of program enrollment reduced by more than 50% the risk of four-month primary care gaps in the following year. (58) In FY07, Part A early intervention programs made verified primary care linkages for 554 PLWHA.

Second, recognizing medical case management as the linchpin of the EMA's efforts to link newly-infected individuals to care, the EMA supports medical case management programs that are tailored to the needs of specific communities. In FY09, the EMA's medical case management program will consolidate funding from three service categories and reallocate funding from two others to establish a new comprehensive care coordination model to link PLWHA to care, help them remain in care, coordinate needed services, aid clients in navigating the medical and social service system, provide treatment adherence education and support, and promote patient self-care and self-sufficiency. Part A delivers targeted medical case management for deaf and blind PLWHA; MSM of color and drug users; for diverse immigrant communities from sub-Saharan Africa, Asia and Latin America; and in high-prevalence, underserved neighborhoods.

Third, the EMA requires providers to monitor clients' utilization of primary care. Where a client is not in ongoing primary care, providers are required to intervene to make referrals and to follow up to ensure actual linkage to care.

Finally, the broad array of Part A services – including professional and supportive mental health care, substance abuse services, housing assistance and critical support programs – addresses the factors that impede health care access.

Serving Communities of Color and Reducing Health Disparities. The EMA has demonstrated an unparalleled ability to reach communities of color with essential services, with Blacks and Hispanics together representing 85% of all Part A clients in NYC in 2007. For both Blacks and Hispanics, the percentage of Part A clients significantly exceeds their proportion of cases among PLWHA generally.

Part A services are placed in high-need neighborhoods with high HIV prevalence. As ongoing service mapping reveals, Part A services are heavily clustered in the poor, underserved, minority neighborhoods in the South Bronx, Harlem and Central Brooklyn. Base services are supplemented by, and coordinated with, MAI services that address specific service needs that affect access to care and treatment adherence.

Serving Emerging and Disproportionately Affected Populations. The Part A program provides life-saving care for emerging populations of PLWHA with special needs:

¶ *Women.* HIV-infected women accounted for 39% of Part A clients in 2007 (32) – a proportion well in excess of their share of PLWHA (31%). (5) Tailored services for women include housing assistance for women released from correctional facilities, mental health services specifically designed for women living with HIV, and family-centered substance abuse services.

¶ *Homeless and Unstably Housed.* Part A supports housing placement, transitional housing and emergency rental assistance to prevent homelessness, and on-site clinical care, substance abuse services and mental health care in AIDS housing programs. In FY08, Part A services will prevent more than 1,100 PLWHA from becoming homeless and provided core medical services to thousands of unstably housed PLWHA. More than one in six (17%) clients reached by early intervention services in health care facilities are homeless or unstably housed. (32)

¶ *MSM of Color.* Part A services reach thousands of MSM of color each year, including more than 3,300 MSM of color receiving Part A-supported medications and HIV primary care. (19) The EMA uses Part A funding to support services that are specifically targeted to MSM of color, including early intervention and medical case management services, and provides food and nutrition services to approximately 3,000 MSM of color. (32)

¶ *Correctional Inmates and Releasees.* In collaboration with correctional health officials, Part A provides transitional service planning and linkage for more than 2,600 HIV-infected correctional releasees annually, as well as a range of services delivered in community-based organizations that have expertise in addressing the HIV-related needs of correctional releasees.

¶ *Persons with Drug or Alcohol Dependence.* Part A provides substance abuse services for more than 15,000 PLWHA with drug or alcohol dependence. Part A also supports other vital services for PLWHA with substance abuse problems, including targeted housing assistance, co-located mental health services, and targeted clinical services for individuals co-infected with HCV.

¶ *Immigrants.* Part A supports culturally appropriate services for a broad range of immigrant communities from all parts of the world, with services available in 50 languages. One favorably evaluated Part A program has been specifically designed to deliver HIV

treatment and housing assistance to the heavily-affected, Creole-speaking population of HIV-positive Haitian immigrants in the EMA. In a five-month period in 2007, the EMA provided emergency rental assistance to 340 HIV-positive immigrants and outpatient medical care to 336 foreign-born PLWHA.

Reducing Unmet Need. The FY09 plan allocates \$5.1 million for early intervention services, which in FY07 linked more than 550 out-of-care PLWHA to HIV primary care. Part A services have contributed to a reduction in unmet need in the EMA. The percentage of newly diagnosed individuals who enter the primary care system care within 12 months of their diagnosis rose from 67% in 2001 to 77% in 2004 – a 15% improvement. (2) In addition, the CHAIN study has detected a steady decline over time in the percentage of PLWHA who need antiretrovirals but are not receiving them. (4)

2.b. Table: FY2009 Implementation Plan. See Attachment 7.

2.c. Narrative. The plan for FY09 reflects the latest step in a *comprehensive, multi-year review and re-competition of the entire Part A portfolio*. The EMA's comprehensive reassessment of its portfolio is intended to ensure that services in the EMA respond to *current* and *emerging* needs rather than to needs that may have prevailed earlier in the epidemic. With the EMA's testing initiatives bringing new PLWHA into the care system – and with the service-intensity of the PLWHA population increasing over time – the FY09 plan aims to maximize the accessibility, flexibility and comprehensiveness of the EMA's care continuum.

To develop the FY09 plan, the Planning Council assessed all services for their impact on access to care and maintenance in care. The FY09 plan continues funding for services that have proven effective in promoting equitable health care access, increasing treatment adherence, and addressing the medical and social co-morbidities that can lead to HIV-related hospitalization or death. Recognizing that available services are not being optimally used on a timely and consistent basis, the FY09 plan supports a robust new care coordination program in the medical case management service category, increasing overall funding for medical case management by \$11.6 million through reallocation of funds. Governed by clear standards of care, the new care coordination model will promote information sharing between service providers, avoid duplicative client assessments, and ensure that each patient has a *single* home for medical and care coordination services. The new care coordination program will ensure that PLWHA are linked to care in a timely and coordinated manner, maintain patients' medical stability and suppressed viral load, keep patients in care by helping them navigate and coordinate needed medical and social services, support treatment adherence, administer directly observed therapy where appropriate, and train patients to become optimally self-sufficient. This approach builds on extensive evidence that multi-disciplinary care coordination strategies significantly improve medical outcomes for PLWHA and patients with a wide range of other health conditions. (53)

In the FY09 plan, 78% of program costs are allocated toward core services. Using an objective planning tool informed by available data (see pp.48-49), the Planning Council prioritized these services for FY09 (with core services italicized): *AIDS Drug Assistance Program; Outpatient/ambulatory health services; Mental health services; Medical case management; Substance abuse services; Housing services, including emergency rental assistance, emergency transitional housing, and housing placement; Early intervention services; Legal services; Food bank/home-delivered meals; Home health care; Psychosocial support services; and Oral health care.*

Connecting Key Health Care Planning Elements. The EMA's multi-year reassessment of the Part A portfolio – including development of the FY09 plan – is guided by its *Comprehensive Plan for HIV/AIDS Services for the New York EMA, 2005-2008*. The strategic

goals in the *Comprehensive Plan* framed both this year's needs assessment by the Planning Council and the service priorities and allocations included in the FY09 plan. The EMA has now begun developing its *2009-2012 Comprehensive Strategic Plan for HIV/AIDS Services*, which will identify new and emerging strategies consistent with the three-part public health vision described above (early diagnosis, early entry, ensuring treatment success). As the 2009-2012 plan had not been finalized by the deadline for submission of this application, this section highlights the ways that the FY09 plan supports the goals set forth in the 2005-2008 comprehensive plan.

Comprehensive Plan Goal 1: Increase the number of HIV-infected individuals who know their HIV status.

Objective 1A: Expand testing at key points of entry into the health care system and expand access by at-risk populations. The unmet need estimate, as well as the large number of people who are concurrently diagnosed with both HIV and AIDS, indicate that substantial numbers of HIV-infected people are unaware of their infection. The FY09 plan supplements the EMA's considerable non-Part A efforts to promote knowledge of serostatus, allocating \$5.1 million to reach high-risk individuals through outreach, engagement and service linkage.

Comprehensive Plan Goal 2: Increase the proportion of people living with HIV/AIDS who receive timely, continuous, and quality HIV care.

Objective 2A: Ensure that programs serving as key points of entry into the health care system provide effective linkages to medical care, medications, and other necessary services needed by HIV-positive individuals. The EMA needs assessment indicates that significant numbers of PLWHA, especially those who are extremely poor and multiply diagnosed, do not access medical services in a timely manner. Supplementing existing initiatives that closely link HIV testing services to Part A-funded medical case management and to NYC's HIV/AIDS Services Administration, the FY09 plan includes support for early intervention initiatives. The EMA requires all Part A medical case management and ambulatory care programs to have formal linkages with HIV counseling and testing programs and STD clinics, and most contractors in other service categories maintain such linkages, as well. Part A supports comprehensive discharge planning for more than 4,300 HIV-infected inmates in EMA correctional settings annually, facilitating swift linkage to needed services.

Objective 2B: Reduce barriers to timely receipt of HIV care experienced by HIV-positive individuals. The EMA needs assessment underscores that multiply diagnosed patients frequently experience considerable difficulty in accessing, and remaining connected to, medical services. The FY09 plan reduces barriers to care by:

- (1) Reaching 16,849 PLWHA (including correctional releasees) with medical case management to promote health care access, continuity, and coordination;
- (2) Allocating \$5.1 million to early intervention services that link hard-to-engage PLWHA to care;
- (3) Allocating \$26.2 million toward medical case management, including treatment adherence;
- (4) Supporting substance abuse services with an allocation of \$11.2 million, reaching 2,865 clients with harm reduction or low-threshold assistance and counseling;
- (5) Preventing more than 1,500 PLWHA from becoming homeless;
- (6) Supporting mental health services to reduce barriers to care; and
- (7) Requiring that Part A service providers monitor clients' access to care on an ongoing basis and ensure appropriate linkage to service.

Objective 2C: Ensure availability of medical care, medications and other necessary services for people living with HIV/AIDS. According to the EMA needs assessment, need for medical services is rising as the number of low-income PLWHA increases. The FY09 plan reduces barriers to care by:

(1) Providing HIV medications to 8,355 PLWHA; (2) Delivering HIV primary care to nearly 12,000 PLWHA; (3) Allocating \$8.1 million toward mental health services tailored to the needs of PLWHA; (4) Supporting linkage to care through medical case management for more than 16,000 PLWHA (including treatment adherence support and directly observed therapy for 1,823 PLWHA); (5) Feeding more than 10,000 PLWHA (through meals and pantry bags) and providing nutritional screening and assessment services for more than 2,200 PLWHA; (6) Monitoring service utilization on an ongoing basis and intervening when waiting lists or other access bottlenecks emerge, typically through the reallocation of resources from underutilized contracts.

Objective 2D: Ensure that HIV services meet or exceed quality standards set by the HIV Quality Management Program. The needs assessment indicates that the EMA has significantly increased the number of Part A clients who receive medical and supportive services that meet the EMA's rigorous quality standards. As described in detail in Section 6, the EMA uses multiple strategies and rigorous monitoring to ensure that Part A contractors deliver the highest quality of service. Evaluation activities indicate that the quality of Part A services has improved over time, and outcomes monitoring reveals that PLWHA who receive Part A services have improved health care utilization and better medical outcomes. (52) The FY09 plan allocates \$3 million to support quality management activities.

Objective 2E: Coordinate care among providers of services to people living with HIV/AIDS. The FY09 plan enhances coordination of care by funding medical case management services for more than 16,000 PLWHA, and by furthering the EMA's longstanding commitment to co-location of key services. In addition, the EMA requires all mental health service providers to coordinate their care with the patient's primary care physician.

Objective 2F: Implement a mechanism to identify and re-engage people living with HIV/AIDS who are lost to care. The needs assessment indicates that many PLWHA fall out of the care system for varying periods of time, reducing the effectiveness of medical services. The FY09 plan incorporates proven return-to-care interventions in medical case management programs that will re-engage 4,610 clients who are at risk of falling out of care or who have fallen out of care. Early intervention services will engage undiagnosed and out-of-care PLWHA and link them with care. All Part A social and support service providers are required to monitor access to clinical care on an ongoing basis and take steps to link out-of-care clients to needed medical services.

Comprehensive Plan Goal 3: Ensure that the continuum of HIV/AIDS services is integrated, effective and comprehensive.

Objective 3A: Ensure that the continuum of HIV/AIDS services is integrated to the fullest extent possible. The EMA emphasizes the co-location of key services to ease access to comprehensive care and promote continuity of care. The FY09 plan continues funding for programs that co-locate key services, including HIV primary care, mental health, substance abuse services, and housing assistance.

Objective 3B: Evaluate the cost and impact of Part A services and the continuum of HIV/AIDS services. The EMA continues to make progress in estimating unit costs for Part A services. Client-level data reporting, the EMA's ongoing evaluation efforts, and continuation of the longitudinal client cohort evaluation will ensure the EMA's ongoing capacity to assess the effectiveness of Part A services. In addition, the EMA's implementation of performance fee-for-service billing for 84 contracts in 2007 represents cost-effectiveness in action. Performance-based contracting enables the EMA to place evidence-based cost-per-unit and

cost-per-client limits on Part A providers, preventing potential waste and maximizing the use of limited Part A dollars for the delivery of essential services.

Objective 3C: Address the capacity and infrastructure gaps in the system of care. The EMA will continue to monitor service utilization, waiting times, and consumer satisfaction on an ongoing basis. The EMA uses administrative funds to support research and evaluation projects, such as its CHAIN cohort study, and to deliver technical assistance to housing providers.

Non-Prioritized Services. Taking into account the unique nature of New York's health care financing system, the EMA's Part A plan prioritizes key services to address specific obstacles to health care access and favorable medical outcomes. The Planning Council has not prioritized certain core services that are either already provided by other payers or have a lower priority at this stage of New York's epidemic.

¶ *AIDS Pharmaceutical Assistance.* The EMA has no AIDS pharmaceutical assistance program of its own but rather provides financial support to ADAP, which covers medication costs for PLWHA in the EMA.

¶ *Health Insurance Premium and Cost Sharing Assistance.* NYS's HIV Uninsured Care Program offers comprehensive assistance for insurance premium and cost sharing for PLWHA, obviating the need for the EMA to allocate Part A funds for this purpose.

¶ *Home and Community-Based Health Care.* Services under this category are comprehensively covered by Medicaid. In the rare instances where coverage gaps exist, services are included in the FY09 plan under home care.

¶ *Hospice Services.* Hospice services are comprehensively covered by Medicaid. As Part A is the payer of last resort, the Planning Council does not prioritize hospice services.

¶ *Medical Nutrition Therapy.* Although not separately prioritized, the FY08 plan supports nutrition counseling in the broader category of food and nutrition.

Increasing Access to Continuum of Care for Minority Communities. Black and Hispanic PLWHA accounted for 89% of Part A clients in NYC in 2007. For both populations, their percentage among Part A clients substantially exceeds their percentage of PLWHA. CHAIN has consistently found equal access to antiretrovirals among racial/ethnic groups, and HIV-positive Blacks and Latinos are actually more likely to be receiving HIV primary care than white PLWHA. The FY09 plan continues and builds on these successes:

¶ The FY09 plan continues funding for early intervention services that in 2007 linked more than 550 previously undiagnosed or out-of-care PLWHA to HIV primary care. In 2007, Blacks and Hispanics together accounted for 90% of early intervention clients overall.

¶ The FY09 plan creates a new consolidated medical case management program that integrates case management, treatment adherence, and maintenance-in-care. Blacks and Hispanics together accounted for 85% of all Part A medical case management clients in 2007.

¶ Part A services are located in the high-need neighborhoods where most minority PLWHA live. Mapping of EMA services indicates that Part A providers of medical case management and supportive services are heavily concentrated in the South Bronx, Central and East Harlem, and a cluster of minority neighborhoods in Central Brooklyn.

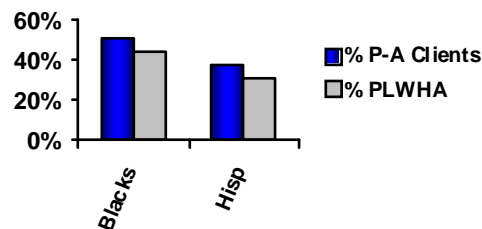
Addressing the Needs of Emerging Populations. The FY09 plan continues funding for the Part A continuum that has proven critical to key vulnerable populations and supports the consolidation of care coordination and treatment adherence services in a strengthened, redesigned medical case management program. The high-priority populations profiled in Section 1 are intensive users of the services that will be consolidated in the new medical case management model: women account for a majority of clients using medical case

management services in the Tri-County region; immigrants, MSM of color, and PLWHA with active or recovering substance abuse problems are especially heavy users of Part A medical case management. Treatment adherence programs served more than 360 homeless PLWHA in a five-month period in 2007.

Promoting Continuity of Care and Treatment Adherence. The FY09 plan will provide care coordination services for more than 6,100 PLWHA. These programs provide intensive follow-up and supportive services for PLWHA who are at high risk of falling out of care.

More than 1,800 PLWHA will receive treatment adherence counseling and support, including directly observed therapy where needed, under the redesigned medical case management program in the FY09 plan. As a key component of comprehensive, multi-disciplinary care coordination, Part A medical case managers will educate patients about the importance of rigorous adherence, help clients address their barriers to adherence, develop and periodically reassess individualized treatment adherence plans, and provide directly observed therapy where needed. As described in Section 6, Part A treatment adherence programs improve clients' adherence rates and medical outcomes.

Figure 11
Part A serves disproportionate share of Black and Hispanic PLWHA (PHS, 2008)



Promoting Parity of Services. As Figure 11 illustrates, Part A functions as a vital safety net for Black and Hispanic PLWHA, serving PLWHA of color in numbers that significantly exceed their share of the EMA's epidemic. Lab-based monitoring by DOHMH indicates that Black and Hispanic PLWHA were more likely to receive HIV primary care than white PLWHA in 2007. (2) In FY09, as in previous years, Part A services, including the new consolidated care coordination model, will be heavily clustered in high-need minority communities. These base-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.

The EMA has long been committed to ensuring that all Part A services are culturally appropriate. For foreign-born PLWHA, Part A funds an array of services in more than 50 languages. Mental health services are specifically tailored for the unique needs of PLWHA. Women living with HIV are afforded a broad range of services specifically tailored to address women's unique needs, including specialized programs in mental health, substance abuse services, and outpatient primary care. Part A services for MSM of color are delivered by agencies with extensive experience in serving this population.

Promoting Healthy People 2010. The EMA's plans to further reduce HIV-related illness and death in FY09 seek to maximize New York's contribution to national efforts to achieve the goals and objectives of Healthy People 2010.

Healthy People 2010 Goal: Prevent human immunodeficiency virus (HIV) infection and its related illness and death.

Objective 13-1. Reduce AIDS among adolescents and adults. Support for ADAP and for ambulatory and outpatient services, the two top priorities in FY09, help ensure timely access to life-preserving and disability-preventing medications and primary care. Medical case management services ensure full access to the range of interventions needed for patients to thrive, and early intervention services help prevent HIV infection from progressing to AIDS.

In 2007, Part A base funding provided early intervention, medical and support services to more than 57,000 individuals, serving as an anchor for the EMA's continued progress in reducing progression to AIDS, HIV-related illness and death.

Objective 13-2. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men. Support for ADAP and for ambulatory and outpatient services provides vital assistance in reducing the epidemic's toll among MSM, who account for 36% of all consumers of Part A-supported programs for HIV medications and clinical services for the uninsured.

Objective 13-3. Reduce the number of new AIDS cases among females and males who inject drugs. IDUs are heavy users of Part A medical and support services, accounting for 17% of all NYC clients in 2007 (and for more than 33% of NYC clients with an identified risk exposure category). Because active substance use significantly raises the risk of delaying care, discontinuing care, or non-adhering to medication regimens – increasing the likelihood that HIV-infected IDUs will progress to AIDS – the EMA will deliver substance-related counseling to more than 5,500 PLWHA in FY09 to help move them toward recovery.

Objective 13-4. Reduce the number of AIDS cases among adolescent and adult men who have sex with men and inject drugs. Part A funding plays a critical role in supporting an EMA-wide network of low-threshold substance abuse programs with the capacity and expertise to address the specific needs of MSM who inject drugs.

Objective 13-7. Increase the number of HIV-positive persons who know their serostatus. Supplementing extensive funding from non-Part A sources to promote and deliver HIV testing services, the FY09 plan includes funding for early intervention services and outreach that in 2007 reached more than 13,000 people at high risk and linked more than 550 previously undiagnosed or out-of-care PLWHA to HIV primary care.

Objective 13-13. Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment and prophylaxis consistent with current Public Health Service treatment guidelines. As noted, the FY09 plan will deliver HIV medications to 8,355 PLWHA and provide primary care services to 11,918 PLWHA (including ADAP-Plus). The EMA's quality management initiative monitors and promotes service quality on an ongoing basis, assessing Part A providers against clear performance indicators. Early intervention services promote knowledge of serostatus and early entry into care.

Objective 13-14. Reduce deaths from HIV infection. As a result of the EMA's comprehensive care continuum, cited by the Institute of Medicine as a national model, the reduction in AIDS deaths in the EMA has been notably sharper than for the U.S. as a whole. In an effort to further this progress, the FY09 plan continues funding for essential medications, primary medical care, and other core medical services. The FY09 will create a new consolidated, multi-disciplinary medical case management program that will improve care coordination, enhance treatment adherence, promote maintenance in care and individual self-sufficiency, and increase the accountability of Part A case managers for medical outcomes.

Objective 13-15. Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV. See response, above, to Objectives 13-1, 13-2.

Objective 13-16. Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death. See response, above, to Objectives 13-1, 13-2.

Ensuring Equitable Allocations for Women, Infants, Children and Youth (WICY Populations). Program monitoring data are analyzed annually, with information provided to the Planning Council on service utilization by gender and age. This enables the Planning Council to assess equity of allocations for WICY populations. As Medicaid provides comprehensive coverage for HIV-affected WICY populations, the EMA joins each year with NYS and with

EMAs/TGAs in the State in submitting a prospective WICY waiver for setting aside Part A funds for these populations. A year-end report summarizing Medicaid expenditures for WICY populations is submitted annually. Medicaid spending on WICY populations totaled \$626 million in FY07, significantly exceeding the required \$38.5 million set-aside for the EMA.

Data provided on client demographics in 2007 informed the Planning Council that, as in prior years, women were over-represented in the Part A care system. While women accounted for 31% of PLWHA in 2007, they represented 39% of Part A clients. Similarly, while infants, children and youth represented 2.1% of PLWHA in 2007, they made up 4.6% of Part A clients. In 2007, the EMA delivered mental health services for families, children and adolescents. Part A also allocates funding for medical case management services for perinatally-exposed children and adolescents, such as one program based in a major Bronx outpatient clinic that uses a multi-disciplinary team to anticipate service needs, link young people to services, and coordinate care.

Use of MAI Funding. Planning for MAI programming occurs in tandem with service prioritization and allocations for base Part A funding. Through coordinated planning, the EMA has crafted an MAI program that targets the communities most likely to lack access with innovative initiatives that address the specific needs of minority PLWHA. The EMA's MAI plan supports three categories of programs that promote health care access, continuity of care, and treatment adherence:

- *Early Intervention* – 10 programs among community-based organizations and health care organizations that provide outreach and HIV testing to clients who are unsure of their status and link them to HIV primary care.
- *Medical Case Management & Treatment Adherence* – 18 programs overall, including 13 specifically designed to help clients adhere to treatment, as well as five maintenance-in-care programs in key settings that provide intensive follow-up and supportive services to help members of the target population remain in care.
- *Housing Assistance* – one program to coordinate housing referrals and placement.

3. Grantee Administration. With the country's largest and most complicated epidemic, the EMA ensures, through the rigorous monitoring and accountability measures described below, that each Part A dollar is used as effectively as possible. When indicated, these procedures result in the timely termination of under-performing contracts and the efficient reprogramming of scarce Part A dollars. The EMA is near the completion of the transition of the entire Part A portfolio from cost-based grants to performance-based contracts, resulting in a new, results-oriented protocol for monitoring contracts that has increased efficiency and contributed to a more rapid mechanism for reprogramming dollars from under-performing contracts to higher-impact services. Through multiple strategies, the EMA ensures that Part A serves as the payer of last resort, using Part A funding only for services not covered by any other funding source.

3.a. Program Organization. The Mayor of New York serves as the CEO of the New York EMA. The Mayor has designated DOHMH as administrative and fiscal agent for Part A. As Attachment 1 illustrates, the EMA's Ryan White program is administered by the Ryan White Services program, part of the DOHMH Bureau of HIV/AIDS Prevention and Control, headed by an Assistant Commissioner of Health, who oversees 37 full-time equivalent positions under the Part A grant at DOHMH, including the Director of Care, Treatment and Housing, who ensures coordination of all Ryan White and HOPWA services. The Director of Ryan White Services oversees a professional staff that focus on fiscal,

program and administrative issues associated with the Part A program. The Director in charge of Planning Council support oversees a staff of 5.5 full-time professionals. A Director of Policy, Planning and Implementation supervises a professional staff of three program planners, a technical assistance manager, and three technical assistance coordinators that support the annual planning process for Part A and provide ongoing policy analysis to inform each year's needs assessment by the Planning Council. The Director of Public Health Practice heads a staff of three research scientists and oversees evaluation of the Ryan White portfolio. Over the last three years, DOHMH has consolidated oversight for planning and monitoring of HIV care, prevention and housing, ensuring a seamless, more coherent continuum of HIV services in the EMA.

DOHMH has executed *two master contracts* to administer subcontracts for the provision of HIV services throughout the EMA. DOHMH, the Part A Grantee, has designated Public Health Solutions, formerly the Medical and Health Research Association, as its master contractor for Part A services in the five boroughs of NYC. Public Health Solutions employs 60 staff to help administer the EMA's Part A program in NYC, including 33 monitoring staff, 15 contracts administration staff, and 12 planning and administrative staff. Subcontracts in the Tri-County region, which account for 5% of EMA funding, are administered by the Westchester County Department of Health (WCDOH), using procedures comparable to those administered by Public Health Solutions in NYC. WCDOH employs five budgeted staff to administer the Tri-County contracts and to conduct planning activities in the Tri-County region. With its much larger planning and administrative staff, Public Health Solutions performs several centralized functions on behalf of the Tri-County program, such as administrative trainings and the provision of technical assistance to providers regarding data collection. The EMA's Ryan White program benefits from the extensive clinical and administrative expertise of numerous unfunded staff of the Bureau of HIV/AIDS Prevention and Control and WCDOH's Division of Planning and Evaluation. In addition, DOHMH facilitates bi-weekly Part A coordination meetings for Public Health Solutions, WCDOH and Planning Council staff.

DOHMH currently has five administrative vacancies. Duties of these positions have been temporarily reassigned to other DOHMH staff. In addition, the newly created DOHMH technical assistance unit is recruiting to fill the three new positions in this unit by the end of this year. The existing evaluation staff are sharing responsibility to cover technical assistance responsibilities for evaluation until all positions are filled. Of the 60 staff positions allotted for Part A administration by Public Health Solutions, three positions are currently vacant. There are no administrative vacancies at WCDOH.

3.b. Grantee Accountability. Three important policy changes have affected monitoring of Part A contracts:

(1) *Performance-Based Reimbursement.* Over the last four years, the EMA has undertaken a *multi-year reassessment and recompetition of the entire Part A portfolio*. As part of the recompetition of the full Part A portfolio, the EMA is transitioning contracts to *performance-based reimbursement*. In 2007, the EMA launched 84 new contracts across five service categories (early intervention, maintenance in care, mental health, substance abuse, and housing placement assistance), transitioning these programs to a fee-for-service arrangement. Existing legal service contracts were also transitioned to performance-based reimbursement, and in 2008 supportive counseling contracts are being moved to performance-based reimbursement. The FY09 plan provides for competitive selection of providers under an integrated, performance-based category of medical case management, which will consolidate existing service categories of medical case management, transportation, treatment adherence,

and care coordination for ambulatory/outpatient care. The performance-based approach replaces prior practice, whereby the EMA reimbursed contractors for costs incurred in delivering services pursuant to approved budgets. Performance-based reimbursement ensures that the EMA pays only for specific services that are actually provided. This model also strengthens the EMA's ability to ensure that payments are made only for services not covered by a third-party payer and for services delivered by a properly credentialed individual who meets service-specific requirements.

(2) *Unified Monitoring Approach.* The shift to performance-based compensation has resulted in a new approach to contract monitoring that better suits the combined program-fiscal reimbursement model. All performance-based providers now have a *single point of contact* for each contract at Public Health Solutions, replacing prior practice that relied on separate monitoring teams for fiscal and programmatic functions. The revised approach simplifies communication between providers and monitoring staff and underscores the fact that programmatic achievement translates directly into payment. It also enhances the ability of Public Health Solutions to ensure the accountability of its contract monitors in providing a seamless, comprehensive assessment of the performance provided by contractors.

(3) *Primary Care Status Measures.* As service categories have been re-bid, language has been added to the resulting service contracts requiring contractors to *monitor the primary care status* of clients on an ongoing basis (e.g., regular utilization of primary care, receipt of antiretrovirals, CD4 and viral load lab values) and to intervene, where indicated, to link out-of-care clients to HIV primary care. This approach mobilizes providers from diverse service categories, including non-clinical social support services, to contribute to EMA efforts to reduce unmet need and maximize health care access. Relevant documentation relating to clients' primary care status is now a critical component of contract monitoring.

Tracking Funds. DOHMH separately tracks formula, supplemental and carryover funds. As part of standard quarterly reports, Public Health Solutions and WCDOH report to DOHMH on expenditures in each of these three funding streams, summarizing funding commitments per service category and spending to date. These periodic reports enable the EMA to identify unobligated funds and to plan for reallocation to high-priority services. Comprehensive year-end reports by Public Health Solutions and WCDOH attest to final expenditures for formula, supplemental and carryover funds.

Timely Redistribution of Unexpended Funds. During the course of the year, Public Health Solutions and WCDOH monitor contractor spending and likely underspending. Several times during the year, underspending contracts are reduced based on their rate of underspending. Savings from contract reductions are redistributed pursuant to the Planning Council's reprogramming plan. The shift to performance-based reimbursement has accelerated the ability of PHS and WCDOH to identify programs that are not performing up to expectations. In FY07, the EMA imposed contract reductions totaling \$7.4 million, rapidly reprogramming these funds to high-performing contracts and high-priority, high-impact services in accordance with the Planning Council's predetermined plans. In FY07, the EMA's spending reached an all-time high of more than 99%, a noteworthy achievement in an EMA that distributed over \$90 million among more than 200 contracts and more than 100 provider organizations.

Process for Fiscal and Program Monitoring. Public Health Solutions supplies all contractors (online and manually) with a copy of the *Contractor Desktop Reference Guide*, which outlines all expectations for Part A contractors and codifies in-person training conducted for new contractors. Following the shift to performance-based reimbursement, each contractor is now assigned a contract manager who is 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. The EMA's multi-faceted contract monitoring process includes monthly electronic data submissions (to Public Health Solutions or WCDOH, as appropriate) on client enrollment and service encounters, narrative reports, expense reporting for cost-based contracts, comprehensive quarterly reviews, multiple site visits each year, documentation reviews, and other meetings and site visits, as warranted. All Part A providers are required to maintain standardized client-level data records, with de-identified client-level extracts submitted monthly to Public Health Solutions for service utilization analyses. These procedures help assess programmatic capacity on an ongoing basis, ensure that Part A funds are used properly and most effectively, and permit timely intervention to correct problems that arise.

* *Fiscal Monitoring.* With the shift to performance-based reimbursement, contractors are paid a reimbursement rate per unit of service, making client-level data submitted each month the basis for payment. At the contract level, monitoring is limited to verification of claimed services and adherence to programmatic and contractual requirements.

With performance-based reimbursement, fiscal monitoring primarily occurs at the organizational level, as Public Health Solutions verifies that systems are in place to properly manage federal funds. Each year, contractors are required to complete an Internal Controls Questionnaire outlining their fiscal policies and procedures and identifying any possible internal control challenges. Annual fiscal site visits, conducted by fiscal analysts assigned to each contracting organization, review agency infrastructure, including segregation of contract expenditures and income on contractor ledgers; time and effort recordkeeping; tax filings and payments; and data back-up procedures.

(See p. 44 for a discussion of fiscal site visits and p. 45 for a discussion of fiscal audit requirements.)

* *Program Monitoring.* Each Part A contract specifies the nature of services to be delivered, eligibility requirements for clients, licensing or other requirements for staff who deliver services, and contractual expectations (e.g., reporting, training requirements, etc.). Contractors set forth the number of clients to be served and units of service to be delivered. Providers are required to budget a minimum of five hours of face-to-face client contact per day for all direct-service, full-time-equivalent staff. Each contractor providing Part A services must have meaningful grievance procedures in place and a functioning community advisory board.

Each contractor must collect and maintain *client-level data* (with a unique, anonymous identifier for each client, using a secure algorithm developed by HRSA) in accordance with the EMA's reporting requirements. Using software developed by the NYS AIDS Institute, contractors collect demographic information, documentation of HIV status, primary exposure category, co-morbid conditions or special needs, insurance status, housing status, and other information on clients served by Part A.

Contractors must submit a *program report each month*. The monthly report includes a program narrative that describes and quantifies the services being provided, service levels, characteristics of clients served, service barriers, staff vacancies, changes to the program's physical plant, and difficulties with any feature of the program. In addition, providers must provide client-level data on services provided during the reporting month. Public Health Solutions and WCDOH program staff review monthly reports, flag any potential problems, and require under-performing contractors to articulate and adhere to a corrective action plan.

Corrective Action. In the fourth quarter of FY07, 85% of Part A contracts were fully compliant with contractual requirements. *Corrective action* may be required in response to findings from site visits, from review of monthly reports, or from quarterly compliance reviews. Examples of programmatic corrective action plans include unacceptably low service levels (i.e., less than 85% of projected services), failure to adhere to required program elements, persistent failure to document services or to serve the target population, or failure to follow payer-of-last-resort regulations. Fiscal issues that may merit corrective action include audit irregularities, unreasonably low spending levels, deficient fiscal record-keeping, and persistent reporting problems (e.g., consistent late reporting, inaccurate or incomplete reporting, etc.).

Where corrective action is merited, the program coordinator (at Public Health Solutions or WCDOH) sends the contractor's senior administrator a letter detailing deficiencies that must be addressed. Contractors must articulate a corrective action plan within 15 days, clearly specifying the actions that will be taken to correct deficiencies, timeline, and precise and specific outcomes that are anticipated. Public Health Solutions and WCDOH must approve any plan for corrective action. Twenty-two Part A contracts (or 10.4% of the Part A portfolio) developed corrective action plans in the fourth quarter of FY07 in response to deficiencies identified through the EMA's contract monitoring. In the second quarter of FY08, two additional contracts (or 1% of the portfolio) were required to develop corrective action plans.

Public Health Solutions and WCDOH place contractors on *conditional status* when they fail to submit a satisfactory corrective action plan or fail to successfully implement agreed-on corrective action. Where contracts are placed on conditional status, senior management of the agency must meet in person with Public Health Solutions (or WCDOH) staff and submit a compliance plan within 15 business days. In FY07, 14 contracts (or 5% of the Part A portfolio) were placed on conditional status; through the first two quarters of FY08, 13 contracts (or 6.5% of the portfolio) were placed on conditional status. Failure of contracts on conditional status to correct their deficiencies may result in termination.

To ensure effective use of Part A funds, the EMA maintains guidelines for the termination or reduction of under-performing non-fee-for-service contracts.* These guidelines ensure that all contracts on conditional status for four or more quarters, and whose corrective action plan has not been successfully completed in the required timeframe, are recommended for budget reductions or termination. Persistently low-performing contracts (i.e., those with performance under 85% of contractual service levels in 50% or more of their service deliverables) may receive permanent funding reductions or be terminated. In FY07, five contracts were terminated, resulting in the reprogramming of \$633,000 toward high-priority services. (Contractors may occasionally relinquish their contracts voluntarily.)

Fiscal and Programmatic Monitoring Visits. With the move to performance-based contracting, *the EMA is increasing the number of annual site visits* (both programmatic and fiscal) to verify the actual delivery of the services for which Part A funds are being used. Under the new approach, monitors make at least two programming site visits each year per contract, with up to four site visits for under-performing contracts.

* Under-performance on fee-for-service is largely self-correcting, in that contractors are paid only for services actually provided. Funding from under-spending contractors is periodically reallocated to higher-performing providers.

During site visits, Public Health Solutions and WCDOH staff review documentation that reported services have been delivered and that all services were delivered and provided in accordance with the contract's scope of services. Monitoring activities undertaken during site visits include client chart reviews, reviews of quality assurance documentation (such as advisory group meetings, supervisory notes, and case conference findings), observation of service delivery, and documentation of staff training. Public Health Solutions and WCDOH staff summarize findings and recommendations from site visits in written reports that are provided to contractors.

Site visits also confirm that equipment purchased with Part A dollars has been appropriately logged and tagged. As services are transitioned to performance-based reimbursement, site visits focus on contractors' administrative infrastructure. In addition to standard periodic site visits, Public Health Solutions conducts fiscal site visits in response to reporting problems, extensive staff turnover, questionable costs, and/or audit findings.

Site Visits in FY08. For the 201 contracts held by 107 Part A contractors in NYC in FY07, the EMA conducted 498 site visits, including 160 program visits, 154 fiscal site visits, and additional administrative site visits. Through August 2008, 47% of 201 base-funded contracts in NYC received at least one site visit. In the Tri-County region, five site visits were conducted, with 25% of Part A agencies receiving a site visit.

Technical Assistance. Although contracts are terminated when warranted, the goal of the EMA's contract monitoring process is, whenever possible, to work with contractors in whom investments have been made to bring them into compliance. In FY07 and in the first two quarters of FY08, every Part A contractor received some form of technical assistance to increase compliance with contract requirements.

Contractors have access to several forms of technical assistance to improve performance and address problems. First, one-on-one technical assistance by telephone or e-mail is available from PHS and WCDOH. In FY07, the EMA's contract monitors provided more than 3,400 instances of remote technical assistance. Second, more intensive in-person technical assistance is provided to Part A contractors. In FY07, 25 different contracts received intensive technical assistance on various aspects of fiscal and programmatic performance, with seven resulting in signed workplans. Third, a broad array of information, guidance and downloadable compliance tools is readily available on the PHS website for Part A providers. Fourth, in the follow-up to site visits, contract monitors discuss and address all technical assistance needs and aid agencies in improving their compliance. Fifth, Public Health Solutions' Part A-funded technical assistance division – Fiscal and Infrastructure Technical Assistance – provides customized, in-depth assistance on important aspects of contract performance, as well as one- and two-day workshops. In 2007-2008, workshops focused on the policies and practices associated with the move to performance-based contracts, strategies to improve client data collection and reporting, implementation of performance management strategies, as well as on program performance and adherence to standards of care. Sixth, DOHMH has established a technical assistance unit to specifically aid contractors in improving their programmatic performance. All maintenance-in-care contractors will receive a DOHMH technical assistance visit by the end of October 2008.

Expenditure Reports. For performance-based contractors not reporting expenditures each month, Public Health Solutions requires the submission of a mid-year expenditure report. This report, along with the program's year-to-date general ledger, serves to flag any expenditure that appears to violate spending requirements from HRSA or the city's Office of Management and Budget, which is disallowed and recouped. The year-end report helps ensure that contractors' administrative costs do not exceed their contractual maximum.

Audited Financial Statements. Consistent with *OMB Circular A-133*, all Part A providers are contractually required to submit an A-133 audit report, where applicable. If A-133 is not applicable to the contract, the provider is mandated to submit a letter of explanation from its auditor. In addition, the EMA requires all contractors to provide agency-wide audited financial statements, including the management letter issued by the auditor. A provider that fails strictly to adhere to the EMA's audit submission requirements is immediately deemed to be out of compliance, and all payments to the provider are placed on hold until appropriate submission is made. Public Health Solutions and WCDOH staff carefully review all audit reports.

In FY07 (ending February 29, 2008), all (100%) of the 127 contractors required to submit an A-133 audit report had done so. For contractors that failed to submit a timely A-133, PHS and WCDOH withheld payment until receipt of either a corrective action plan from the contractor or written proof of an approved extension for submission of the report from the auditor.

Audit Findings and Corrective Actions. Review of the A-133 audit reports found that nine of the reports for Part A contractors identified material weaknesses. All had a management response that addressed the deficiencies identified in their report. Audit findings for six agencies had "going concern" issues; contracts for these agencies were placed on conditional status, and agencies were required to submit a compliance plan and be subject to additional documentation and monitoring.

3.c. Third Party Reimbursement. The EMA uses a *multi-step process* to ensure that all Part A funds always serve as the payer of last resort. From the standpoint of service planning, the Planning Council undertakes a comprehensive analysis of all other funding and service delivery systems in the process of establishing priorities and allocations for funding. State health officials, for example, serve on the Planning Council and provide data each year on Medicaid utilization, including covered services, coverage restrictions, and program developments. The Planning Council uses an objective priority-setting tool that consists of five criteria, with one criterion being "Payer of Last Resort/Alternate Providers of Service." Through use of this tool, the Planning Council specifically designed the FY09 Part A plan to address gaps in Medicaid, Medicare and other systems, prioritizing core services that are not covered by Medicaid/Medicare (such as individualized access-to-care, maintenance-in-care and treatment adherence support, and innovative, low-threshold service models designed to reduce substance abuse). Notwithstanding these efforts, continuous changes in reimbursement policies, especially under the Medicaid program, prompted the Planning Council to commission a comprehensive Payer of Last Resort study of all non-Part A services in the EMA; this study was used to develop the FY09 plan.

Process for Monitoring Third Party Reimbursement. Contractual provisions also require contractors to carefully monitor third party reimbursement. As each service category is competed, the *initial Request for Proposal* (RFP) expressly provides that Part A is the payer of last resort. As provided in the RFP and in the eventual contract, all Part A programs must participate in all applicable NYS Medicaid and state-funded uninsured care programs. Providers must submit verification of pending approval for Medicaid or other relevant programs, or application for appropriate certification, to be considered for funding.

During *contract negotiations*, Public Health Solutions identifies all potentially reimbursable services and thoroughly explores all possible sources of third party payment. During negotiations, providers must submit "Reimbursement Worksheets" that demonstrate 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 Ryan White. These statements become part of the provider's contract, which also explicitly provides that Part A funds "will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made . . . under any State compensation program, under any insurance policy, or under any Federal or State health benefits program . . . or by an entity that provides health services on a prepaid basis." Public Health Solutions monitors contracts against their statements in the worksheets.

Subcontractor Documentation. All contractors are required to *document the screening of every client for Medicaid, Medicare or other third party insurance eligibility* and to assist clients to apply, when eligible. The EMA's uniform reporting system (the AIDS Institute Reporting System, or AIRS) for data collection requires input of insurance status for both new and continuing clients, prohibiting use of other data fields until such questions are answered. AIRS captures insurance provider type, effective date of coverage, and whether Medicaid or ADAP applications are pending. During site visits, monitoring staff review log systems, client chart reviews, and other data sources that may indicate potential eligibility for third-party coverage, including NYS Child Health Plus or other programs. Contractors that provide potentially reimbursable services, such as mental health services, perform quarterly reassessments and must document insurance status in progress notes.

Program Income. Part A funding supports services that, for the most part, are not reimbursable by any other payer. For programs that provide potentially reimbursable services such as licensed mental health services, use of grant funds is limited to payment for clients who are not eligible for any third party payer. Thus, no income is generated that can be attributed to the grant program. Part A programs promote access to, and maintenance in, HIV primary care, which may generate income, primarily from Medicaid for non-grant funded programs. The only income generated by Part A programs is related to the authorized sale of assets, such as equipment or vehicles. Proceeds from any such sales are reported as income and returned to the grant-funded program.

3.d. Administrative Assessment. Consistent with legislative mandates, the Planning Council assesses the efficiency of the EMA's administrative mechanism on an ongoing basis.

3.d.1. Results of Administrative Assessment. The Planning Council's Finance Committee is charged with assessing the efficiency of the administrative mechanism in rapidly disbursing Part A funds according to the Council's priorities. In both FY07 and FY08, the Finance Committee met quarterly with DOHMH (the Grantee) and the EMA's master contractor to assess spending rates and trends for all individual service categories, reporting findings to the Planning Council. The Finance Committee took particular efforts to monitor utilization and spending under new performance-based contracts. Responding to encouragement from the Finance Committee to address underspending early in the fiscal year, DOHMH, Public Health Solutions and WCDOH achieved the highest spending rates in the EMA's history – more than 99% for the final FY07 award of \$103.5 million. The Finance Committee and the Planning Council determined that no corrective action was needed for this year. The Finance Committee recommended to the Planning Council that DOHMH be given greater flexibility to move funds between service categories to ensure optimally effective expenditure of funds. The Committee also recommended that Public Health Solutions meet with contractors to hear their experience to date with performance-based reimbursement to inform future planning; this meeting took place in September 2008.

4. Planning and Resource Allocation. Since the beginning of the Ryan White CARE Act, the New York EMA has demonstrated its strong commitment to the community planning mandates of the Act. Planning for FY09 was based on an evidence-based, quantitative tool

used to rank services and make allocation decisions. In planning for FY09, the Planning Council continued a multi-year process to reassess and rebid the entire Part A portfolio, with the aim of ensuring that the EMA's service continuum addresses the most current needs and service delivery challenges.

This year, the Planning Council:

- Used a data-driven planning tool to agree on service priorities and funding allocations,
- Relied on up-to-date information regarding PLWHA needs, service utilization and service gaps – including seven new analyses of data from the EMA's longitudinal CHAIN cohort study – to agree on service prioritization and allocation,
- Allocated 78% of Part A funding to core medical services,
- Heeded emerging evidence of the critical importance of care coordination for high-need clients by increasing funding for medical case management through reallocation of funds from other services, helping reduce unmet need, and
- Relied on the latest, refined estimate of unmet need and on results from the CHAIN cohort study to prioritize early intervention services that linked more than 550 previously undiagnosed or out-of-care PLWHA to care.

4.a.1. Letter of Assurance from Planning Council Chair(s). See Attachment 2.

4.a.2. Description of Priority Setting and Resource Allocation Processes. The FY09 plan was developed following a thorough, data-driven planning process undertaken by the EMA's Planning Council. The Planning Council used the following step-wise, evidence-based process to develop the FY09 plan:

¶ *Needs Assessment Committee:* This committee analyzed epidemiological and other data, identified unmet need and service gaps, and assessed overall systemic capacity for HIV/AIDS care in the EMA.

¶ *Integration of Care Committee:* Using the EMA's *model of comprehensive HIV/AIDS care*, which charts client pathways through the care system to achieve the best possible medical outcomes, the Integration of Care Committee guided the Planning Council in FY09 in defining individual service categories, including approving the new consolidated model of co-located medical case management. To be eligible for Part A funding, *all* services must be determined, based on available data, to promote either access to, or maintenance in, primary medical care, and to promote improved health outcomes.

¶ *Priority Setting and Resource Allocation Committee:* Using data assembled by the Needs Assessment Committee and service model definitions and client pathways agreed to by the Integration of Care Committee, the Priority Setting and Resource Allocation Committee used an objective, evidence-based tool to agree on service priority rankings and financial allocations, forwarding its recommendations to the full Planning Council for its endorsement. The tool requires the committee to use available evidence to score various service categories on a service prioritization grid, with five individually weighted criteria for assigning scores to each service category. Higher-priority items are accorded greater weight.

(1) *Payer of Last Resort/ Alternate Providers of Services* (weight factor = 15%). The Planning Council assessed each service to determine if Part A is the sole funding source and whether other sources provide identical or equivalent services. Highest value was assigned to services funded only by Part A and where existing provider capacity was found to be inadequate to serve PLWHA.

(2) *Access to Care/Maintenance in Care* (weight factor = 35%). The Planning Council assessed each service to determine the degree to which it contributes to

access to, or continuity of, HIV primary care. Highest value was assigned to services that clearly and significantly contribute to health care access or maintenance in care.

(3) *Specific Gaps/Needs (Demographic/Special Population)* (weight factor = 15%). The Planning Council assessed each service to determine the degree to which it reduces documented service gaps or meets the needs of special populations. Highest value was assigned to services that promote health care access and continuity for PLWHA who are not in care and/or are part of underserved populations.

(4) *Core Services* (weight factor = 10%). The tool provides for the assignment of highest value to core medical services, as defined by HATMA. All other services were assigned no value.

(5) *Consumer Priority* (weight factor = 25%). The Planning Council scored services based on consumer input, as provided by the standing Consumer Committee (described below), the CHAIN cohort study, consumer focus groups, and the EMA's consumer survey. Highest value was assigned to services identified by PLWHA as (a) significantly contributing to access to, or maintenance in, primary medical care, and (b) addressing an important service gap.

¶ *Tri-County Steering Committee.* With respect to the 5% of the EMA's award allocated to services in the Tri-County region, a committee conducts service planning and makes resource allocation recommendations to the Planning Council. One-third of the members of the Tri-County steering committee are PLWHA, and two (including one consumer) are voting members of the Planning Council.

Involvement of PLWHA. Since the inception of the Planning Council, the EMA has been strongly committed to an inclusive planning process that encourages the meaningful involvement of PLWHA. The active engagement of PLWHA in the planning process helps ensure that decisions on service prioritization, resource allocations, and development of service models address the actual needs of consumers. In addition, as each PLWHA is part of one or more social networks, involvement of diverse PLWHA from all parts of the EMA broadens community awareness of Part A services.

PLWHA represent 40% of Planning Council members, including one Co-Chair, and 33% of members are PLWHA who are not aligned with a Part A agency. All non-aligned PLWHA are people of color (10 Black, 3 Hispanic, 1 Asian/Pacific Islander). PLWHA actively serve on all Planning Council committees. PLWHA make up one-third of the Tri-County steering committee.

A standing *Consumer Committee* which meets monthly, collaborates with the Rules & Membership Committee in recruiting new members, advocates for appropriate support for consumer engagement in the planning process, and promotes orientation, training and mentoring of new Council members. To develop the FY09 plan, the Planning Council specifically sought the Consumer Committee's input regarding special populations and on geographic areas of the EMA that are disproportionately affected by HIV/AIDS. In addition, DOHMH in 2008 sponsored five focus groups with three distinct groups of PLWHA (men, women, and young adults) to obtain consumer input on service and funding priorities.

As in prior years, the Planning Council benefited from the input of an independent *PLWHA Advisory Group*. With staff support from DOHMH, the Advisory Group held monthly meetings throughout the EMA. Similarly, a local consumer advisory group meets monthly in the Tri-County region, with WCDOH support. In addition, the EMA undertook a survey of Part A consumers to inform service planning and resource allocations.

Use of Data in Priority Setting and Allocation Processes. With guidance from the Needs Assessment Committee, the Priority Setting and Resource Allocation Committee considered all available data to assign scores to all service categories in the Council's planning tool. In addition to periodic written and oral reports from various data sources throughout the planning process, development of the FY09 plan was informed by key epidemiological, utilization, consumer survey, quality management, focus group results, and cost data, which were presented to the Planning Council during a "data day" to inform service planning and prioritization.

¶ *Changes in Epidemiology.* As in prior years, changes in HIV/AIDS epidemiology played a critical role in the development of the FY09 plan. A professional in the DOHMH epidemiology branch provides ongoing epidemiological support to planning for HIV care and prevention services. This ensures not only that the Planning Council has access to essential epidemiological data, but also that the Council benefits from technical assistance regarding interpretation and use of such data. In developing the plan for FY09, the Planning Council relied on *epidemiological trends* in reallocating resources toward medical case management and other high-priority services. The continued decline in AIDS deaths motivated the Planning Council to continue funding for the broad array of Part A HIV services, with 78% of FY09 spending directed toward core medical services. The significant decline in recent years in the number of PLWHA with TB co-infection prompted the Planning Council to eliminate funding for specific stand-alone programs for HIV/TB co-infection management. In recognition of the high prevalence of HCV co-infection, HCV-specific programs were eliminated, as HCV-related services were incorporated as a critical component of all HIV treatment programs. Continuing high levels of unmet need, as reflected in the large number of people with diagnosed HIV who have no evidence of a CD4 or viral load test, justified the Planning Council's decision to reallocate funding to establish a new model of medical case management that will link PLWHA to care in a timely and coordinated manner, help maintain medical stability and a suppressed viral load, maintain patients in care by aiding with navigation and coordination of medical and social services, and promote treatment adherence and patient self-sufficiency.

¶ *Medications and Primary Care.* In response to the significant numbers of newly diagnosed PLWHA – a one-third increase since 2000 – the Planning Council identified HIV medications and outpatient medical services as the top two service priorities for FY09, allocating roughly one-fifth of all financial resources to these two items. The Planning Council's prioritization of these medical services was also supported by results from consumer focus groups, which identified medications and HIV primary care as two of the top three priorities for core services. The continued decline in HIV deaths clearly demonstrates the ability of timely delivery of high-quality medical care to significantly reduce the risk of HIV-related illness and death. Given that the median annual income of CHAIN enrollees is under \$7,500 (see p. 11), maintenance of a strong safety net for medications and primary care is essential to reduce HIV-related illness and death. Because many patients with severe social or medical co-morbidities may not always be ready or medically eligible for intensive clinical services, the Planning Council allocated \$2.4 million in FY09 for primary care programs in single-room occupancy hotels and substance abuse programs to engage multiply diagnosed individuals in bridging services and to ease their eventual entry into more intensive primary care. In prioritizing HIV medications, the Planning Council was also conscious of the fact that many PLWHA may be exposed to thousands of dollars in prescription costs due to the Medicare Part D donut hole. (See p. 14.)

¶ *Medical Case Management.* Increasing medical case management spending to \$26 million (from \$14 million in 2008) by reallocating funding from other service categories (i.e., treatment adherence, maintenance-in-care, and outpatient medical care), the Planning Council relied on a summary of the scientific literature from professionals from DOHMH and the New York State AIDS Institute. Data from both HIV and non-HIV scientific literature indicate that care coordination is optimally effective when it uses a multi-disciplinary approach, promotes service integration, empowers patients to assume responsibility for self-care (including treatment adherence), and involves strong and ongoing case management. (53) In the Tri-County region, 40% of FY09 funding will support care coordination. The increase in FY09 funding for medical case management is also supported by evidence from CHAIN associating receipt of medical case management with reduced mortality and increased likelihood of receiving antiretrovirals. (4) Prioritization of treatment adherence in the new medical case management model is also consistent with evidence that treatment adherence programs increase adherence rates. (See pp. 59-60.) The high prevalence of HIV infection among NYC correctional inmates (7% among males and 14% among females) encouraged the Planning Council to prioritize correctional transitional planning and linkage services as a component of medical case management.

¶ *Mental Health Services.* More than one-third of CHAIN enrollees suffer from mental illness. The high priority placed on mental health services in the FY09 plan is supported by results from consumer focus groups, which identified mental health services both as one of the top three most important core services and as an unmet service need in the EMA. In line with evidence of the beneficial effects of care coordination, the FY09 requires all Part A mental health service providers to coordinate service with each client's primary care provider. The strong improvement seen among Part A mental health providers in the quality of care provided, as documented by the EMA's Clinical Quality Management program (see Section 6), also supported the Planning Council's decision to prioritize mental health services.

¶ *Substance Abuse Services.* Prioritization of substance abuse services is needed to address the utilization gap for such services in NYC and the Tri-County region. Substance abuse services were cited as one of the top services by consumer focus groups. With the emergence of buprenorphine as an office-based addiction treatment alternative to methadone, the FY09 plan incorporates buprenorphine into Part A substance abuse programs. Substance abuse services also supports client engagement in HIV primary care, helping reduce the level of unmet need.

¶ *Housing Services.* As nearly one-third of PLWHA in the EMA's longitudinal client cohort experienced homelessness in the year before their diagnosis, the FY09 plan prioritizes housing services. This decision was also supported by evidence that prevalence of housing instability is increasing among PLWHA, according to CHAIN. Consumer focus groups also supported the Planning Council's prioritization of housing services, citing housing as the most important/essential non-core service in the EMA. Evidence that most public sector expenses for the homeless can be offset or contained through the delivery of supportive services (see p. 10) also supported the Planning Council's prioritization of housing assistance. The high rates of co-morbidities among homeless or unstably housed PLWHA, as documented in CHAIN, supported the decision to continue and restore funding for clinical, substance abuse, mental health, and medical case management services in homeless shelters or specialized AIDS housing.

¶ *Early Intervention Services.* The persistently large percentage of PLWHA who are tested late in the course of infection, as well as disproportionate mortality rates among Black

PLWHA, prompted the Planning Council to continue funding for early intervention services. The high priority for early intervention services in FY09 is supported by program utilization data from 2007, indicating that Part A early intervention programs successfully linked more than 550 out-of-care PLWHA to ongoing HIV primary care.

¶ *Support Services.* The public funding analysis found that Part A support services are generally not covered by other payers, including Medicaid. The severe need of many PLWHA for medical transportation, especially acute in the Tri-County region, supported the allocation of \$239,000 to such services in the Tri-County region. The increase in food costs led the Planning Council to increase the allocation for food programs in 2008, and this level of funding was continued in the FY09 plan.

¶ *Use of Cost Data.* The Planning Council's decision to establish a new care coordination model in the medical case management category was supported by evidence that interventions that improve treatment adherence and maintain patients in care are cost-effective. (59) In using costs to inform decisions on service prioritization and budget allocation for the FY09 plan, the Planning Council also relied on *unit cost analyses* undertaken on its behalf in 2005 by American Express Tax and Business Services Inc. American Express conducted a four-week study that included a broadly representative sample of Part A agencies, taking into account geography, agency types, and other factors. Using the relative value unit approach relied on by the Medicare program for its fee schedules, the study determined the cost of delivering a relative value unit of service in six service categories – case management, food and nutrition, substance abuse services, housing, mental health, and outreach.

The analysis determined that housing assistance had the highest cost per relative value unit, with food and nutrition having the lowest. Although costs, in general, did not vary significantly depending on the demographic status of the client population, the study determined that costs were higher for immigrants, people dually diagnosed with mental illness and chemical addiction, and the correctional population. Within service categories, differences in costs per relative value unit of service stemmed primarily from service volume (rather than service intensity), with high-volume providers having lower unit costs than providers serving fewer clients.

In addition to results from the unit cost analysis, the EMA's client-level reporting permits the Council to compare relative service costs with clients served and to assess variations in service intensity among 12 special populations of Part A clients who have comorbidities. The EMA *fee-for-service, performance-based reimbursement* approach, implemented for 84 new programs in FY07 in five service categories, is improving cost-related data for future planning and provides flexibility to reallocate funds to where they are most needed throughout the budget year.

¶ *Unmet Need.* The estimate of unmet need underscored the unacceptably large number of PLWHA who are out of care, prompting the Planning Council to prioritize funding for early intervention services and maintenance-in-care initiatives that assist PLWHA who are at high risk of falling out of the care system. According to the EMA's outcomes evaluation, these programs significantly improve adherence rates, as well as CD4 count and viral load. (See p. 60.) CHAIN, as well as recent trends in the timeliness of HIV diagnoses (see p. 33), indicates that the EMA may have reduced unmet need in recent years.

Planning for Funding Increase or Decrease. An important advantage of the Planning Council's objective, data-driven planning tool is that it encourages rational planning for funding increases or decreases. The Planning Council's scoring of each service category provides advance guidance on the extent to which specific services should be cut in the

event of significant variance between the FY09 award and the amount required to fund the plan. As occurred in FY07, when a funding loss necessitated budget and service cuts, the tool would be used to implement weighted cuts to all service categories, with steepest cuts reserved for lower-priority categories. As in prior years, the Planning Council will begin planning for funding scenarios in December 2008, with the goal of ensuring that a plan is in place by March 1, 2009.

4.c. Funding for Core Medical Services. FY09 allocations are summarized in the following table.

Service Categories	FY09 Planned Allocation	% Allocation
1. Core Medical Services Sub-total	\$72,277,544	78%
Outpatient / Ambulatory Health Services	\$9,837,793	11%
AIDS Drug Assistance Program (ADAP)	\$10,253,647	11%
Oral Health Care	\$118,249	0%
Early Intervention Services	\$5,140,505	6%
Home Health Care	\$1,396,525	2%
Mental Health Services	\$8,109,725	9%
Medical Case Management (& Treatment Adherence)	\$26,252,177	28%
Substance Abuse Services – outpatient	\$11,168,923	12%
2. Support Services Sub-total	\$20,542,422	22%
Food Bank/Home-Delivered Meals	\$5,851,270	6%
Housing Services	\$8,582,813	9%
Legal Services	\$3,971,779	4%
Medical Transportation Services	\$239,068	0%
Psychosocial Support Services	\$1,897,492	2%
3. Total Service Dollars	\$92,819,966	87%
4. Clinical Quality Management Activities	\$3,000,000	3%
5. Grantee Administration	\$10,646,663	10%
6. Total Allocations	\$106,466,629	100%

5. Budget and Maintenance of Effort (MOE). The EMA continues to exhibit commitment to the health and well-being of PLWHA. Local expenditures for the HIV services that are tracked for MOE remain relatively constant.

5.a. Budget. The EMA’s budget for FY09 is submitted with this application, pursuant to the HRSA guidance.

5.b. Maintenance of Effort. The table below summarizes the EMA’s maintenance of effort in FY07.

Agency and Services Provided	FY06 Local Expenditures	FY07 Local Expenditures
<i>NYC Human Resources Administration HIV/AIDS Services Administration (HASA) - Case management (CM) and housing assistance (HA) provided to HASA clients.</i>	CM: \$8,834,127 HA: \$61,069,000	CM: \$12,104,000 HA: \$52,881,000
<i>NYC DOHMH - HIV/AIDS surveillance, education, counseling and testing and outreach services.</i>	\$25,858,451	\$34,065,029
<i>Westchester, Rockland and Putnam Counties - Medicaid expenditures for HIV/AIDS services.</i>	\$15,488,207	\$14,367,848
<i>Total Expenditures</i>	\$111,249,785	\$113,417,877

Sources: New York State Department of Health, Federal, and City FY 2006 and FY 2007 Medicaid HIV/AIDS Claims File. 2006/2007 New York City Department of Health and Mental Hygiene, Division of Financial and Strategic Management, Tax Levy Funds; New York City Office of Management and Budget, Tax Levy Funds with corrected 2006 expenditures.

The maintenance of effort for receipt of Part A of the Ryan White HIV/AIDS Modernization Treatment Act of 2006 funds is monitored by analyzing and reporting local, non-grant funded expenditures for HIV/AIDS services for the New York City fiscal year, July through June for the services listed below. For the Tri-County portion, local Medicaid expenditures for HIV/AIDS services are monitored and reported since they represent the most consistent expenditures that can be tracked for these three counties. The Tri-County region does not have a local program comparable to the New York City HIV/AIDS Services Administration program, which provides specialized services to individuals and families living with AIDS or advanced HIV illness. HIV services provided by the NYCDOHMH were expanded in 2005 to include a city-wide condom distribution program, and rapid testing services in NYC correctional facilities, hospital emergency departments, City STD clinics, and homeless shelters. In FY 07 additional funds were allocated for rapid HIV testing for the City’s public hospital system and for outreach services increasing local expenditures in that category \$8.2 million. Local Medicaid expenditures for HIV/AIDS services in Westchester, Rockland and Putnam Counties decreased as a result of reduced inpatient expenditures in 2007. Annual expenditure reports are submitted to the Director of Ryan White Services by September 15.

6. Clinical Quality Management. The EMA’s strategic use of Part A funding not only maximizes access to HIV primary care and support services but also ensures that services delivered to Part A clients are of the highest quality. As described below:

- *The EMA’s model Clinical Quality Management (CQM) plan is fully implemented.* In addition to the ongoing assessment of individual providers afforded by results from service-specific CQM indicators, the EMA also ensures that each Part A agency has a comprehensive quality improvement program in place. EMA-sponsored learning networks and targeted CQM technical assistance help build the capacity of Part A providers to monitor and continually enhance the quality of Part A services.

- *Care standards that govern the award and monitoring of Part A contracts meet or exceed treatment guidelines issued by the U.S. Department of Health and Human Services.* The EMA not only has mandatory care standards for clinical services, but has developed quality indicators and standards for non-clinical services, as well.
- *Quality-related expectations are incorporated into Requests for Proposals (RFPs) and resulting Part A contracts.* All RFPs and contracts mandate a quality improvement plan and require providers to collect and provide to the CQM program with client data needed for ongoing quality assessment.

6.a. Description of Clinical Quality Management Program. The EMA’s CQM program is a *national model*, using standardized indicators to assess provider performance on an ongoing basis.

Structure, Vision and Goals of CQM Program. By agreement with the EMA and under the guidance of DOHMH, the NYS AIDS Institute provides a multi-level quality management program to evaluate and improve the quality of services delivered through the Part A program. The AIDS Institute is a national leader on HIV/AIDS quality improvement, having developed the Statewide HIVQUAL initiative on which the HRSA-funded National Quality Center project is based.*

¶ *Overall Purpose and Goals.* The EMA’s quality management program focuses on *systemic quality improvement* rather than exclusively on individual providers, which are the focus of the protocols for fiscal and program monitoring described in Section 3. As described below, the quality management program uses comprehensive performance measures to assess the quality of Part A programs and seeks to build the skills of Part A providers to enhance the quality of their services on an ongoing basis. The EMA aims to have a quality management program that adapts to the epidemic’s changing demands and improves health outcomes and quality of life for PLWHA.

The EMA requires all Part A agencies to have a quality improvement program. This mandate is set forth in all Requests for Proposals and in all Part A contracts. Using a standardized form, AIDS Institute staff assess the organizational capacity of Part A providers with respect to quality improvement. Key areas of inquiry include whether:

- Providers have a quality improvement plan,
- A quality improvement committee has been convened,
- Management is actively involved in quality improvement, and
- Quality improvement projects are currently underway.

The AIDS Institute provides Part A agencies with a written assessment of their organizational capacity and with recommended next steps to bring organizational practices into line with the EMA’s quality improvement standards.

The EMA has established *quality learning networks* for providers of Part A case management, mental health services, treatment adherence, food and nutrition, and substance abuse services. In FY08, the EMA established a new learning network for medical case management providers in the Tri-County area. In each of these service areas, DOHMH (or WCDOH for the Tri-County learning networks) and the AIDS Institute convene providers on a regular basis to provide training and discuss strategies for improving the quality of services, including use of performance data to inform quality improvement efforts. Learning

* Funded by HRSA’s HIV/AIDS Bureau in September 2004, the National Quality Center provides technical assistance on quality improvement to Ryan White grantees throughout the country, building capacity to improve the quality of HIV/AIDS care and services.

networks afford providers the unique opportunity to meet and interact with peers in an environment that promotes the application of quality management strategies and techniques. The AIDS Institute also consults with providers on periodic conference calls and has engaged several consultants with extensive experience in quality improvement to provide one-on-one support to providers in implementing quality improvement methods.

The EMA aims for a *steady improvement* in the quality of services provided to Part A clients. Based on the assessments of organizational CQM capacity, results from monitoring of CQM indicators, and the work of the quality learning networks, the AIDS Institute provides targeted technical assistance to correct quality problems and build CQM capacity at individual agencies. AIDS Institute staff meet one-on-one with agencies that have deficiencies in organizational capacity on quality management or with organizations that yield unsatisfactory findings against standard indicators for service delivery. In addition, the EMA has placed quality improvement information, including criteria for strong organizational standards for quality management, on the Planning Council's web site (www.nyhiv.org), permitting organizations to access AIDS Institute guidance on an ongoing basis. Web-based guidance on quality improvement is currently available for medical case management, mental health, treatment adherence, and other service areas. The web site also includes examples of tools to improve provider documentation in client records.

¶ *Staff and Committee Roles.* Within the AIDS Institute, the CQM program is overseen by the Medical Director. Reporting to the Medical Director, the CQM director oversees staff who analyze indicator data, assess organizational CQM capacity, and convene the quality learning networks. In addition, the CQM director oversees a small roster of consultants who provide targeted CQM technical assistance to Part A agencies, as well as two technical contractors who conduct client record reviews on the EMA's behalf. As described below, the CQM director reports regularly on CQM results to the Planning Council and participates in quarterly meetings of the CQM steering committee for the EMA's Part A program, along with DOHMH staff and representatives of Public Health Solutions and WCDOH. Through individual learning network planning groups, DOHMH and AIDS Institute staff, together with CQM consultants, direct the activities of the learning networks – setting goals and objectives, roles and responsibilities, tasks and timelines, and also agendas and speakers for particular learning network meetings. The FY09 plan allocates \$3 million to CQM activities.

¶ *Internal Quality Processes.* Two formal mechanisms ensure close and ongoing oversight of the EMA's quality management program. First, senior officials from DOHMH, Public Health Solutions, WCDOH and the Planning Council meet regularly with the director and key staff of the AIDS Institute's CQM program to review data, identify and address important policy issues, and assess progress. Over the last year, CQM and DOHMH staff have strengthened their collaboration on quality improvement, focusing particular attention on guiding and maximizing participation in the service-specific learning networks. Monthly inter-agency CQM meetings ensure continuous, shared oversight of the CQM program and ongoing momentum on quality-related initiatives. In addition, the CQM has a *steering committee*, which includes representatives from DOHMH, the master contractors (PHS and WCDOH), the Planning Council, and service providers, as well as PLWHA. Meeting on a quarterly basis with the AIDS Institute, the steering committee reviews methodologies and processes used in assessing contractor performance, evaluates the effectiveness of quality management technical assistance provided by the AIDS Institute, and communicates with the full Planning Council regarding the results of the EMA's quality management activities.

CQM Indicators. The EMA monitors CQM indicators for both clinical and non-clinical services that support the delivery and success of HIV primary care. CQM results derive from ongoing review and analysis of Part A client records.

¶ *Outpatient and Ambulatory Health Services.* Clinical care is governed by regularly updated guidelines that address a comprehensive range of clinical issues, including HIV specialist care (e.g., HIV specialist visit every four months, in addition to clinical visits), antiretroviral therapy management (e.g., at least once every four months), treatment education (e.g., education for any patient who initiates treatment or changes class of drugs), adherence (e.g., clinical discussion with patient, quantitative measurement of adherence at least once every four months); annual gynecology exam; annual dental exam; timely provision of appropriate prophylaxis for key HIV-related opportunistic infections; ophthalmologic care; screening for TB, STIs, HCV, mental health, substance use, tobacco use, and colon cancer; and pneumococcal vaccination.

¶ *Medical Case Management.* In FY08, indicators for medical case management were streamlined to avoid redundancy in data collection and to increase the focus on care coordination. Client records must clearly document a comprehensive client assessment within 30 days of initial client contact, development of a service plan within 45 days of initial client contact, subsequent follow-up and reassessment, and periodic case conferences and other measures to ensure coordination of care. In addition, client records should indicate a primary care visit at least every six months, receipt of antiretrovirals, viral load and CD4 counts, and follow-up on all referrals within 30 days to ensure that the appointment was kept or that laboratory tests were performed.

¶ *Treatment Adherence.* Client records must document provision (at least every quarter) of treatment education that addresses key topics (e.g., laboratory results, antiretroviral side effects, importance of adherence, adherence tools and techniques, etc.); quarterly assessment of the client's antiretroviral regimen; development and periodic communication regarding the client's individualized treatment plan; assessment at least every four months of the client's adherence to prescribed medication regimens; assessment (every three, six or 12 months, depending on the specific variable) of potential barriers to adherence (e.g., mental illness, access to primary care and medications, social support, substance use, inadequate or unstable housing, etc.); and discussion at least every six months of antiretroviral side effects and strategies for managing them. In addition, client records should indicate a primary care visit at least every six months, receipt of antiretrovirals, viral load and CD4 counts, and follow-up on all referrals within 30 days to ensure that the appointment was kept or that laboratory tests were performed.

¶ *Other Service Categories.* In addition to the above-noted services, the EMA also monitors performance in other service categories. Select indicators for other categories include the following:

- *Mental Health:* Annual cognitive assessment and multi-axis diagnosis; monthly assessment of whether client has experienced side effects from psychiatric medications; and quarterly documentation of coordination of care with client's primary care provider.
- *Substance Abuse Services:* Comprehensive assessment (within 30 days of initial contact); annual comprehensive assessment; provision of individual or group-level counseling.
- *Food Bank/ Home Delivered Meals.* Baseline nutritional screening within 30 days of intake; documentation of client's HIV medications; baseline screening of food security; monthly provision of nutritional education; specific community food and nutrition services provided to client.

Data Collection. As noted, each Part A contract collects standardized data with respect to each client service event. Agencies are trained in the collection of data on CQM indicators and are aware that their performance will be measured against these indicators. Technical medical records experts retained by the AIDS Institute, who are bound by rigorous provisions of confidentiality, review on an ongoing basis the client records of Part A-funded agencies. Results for each indicator are tabulated for the overall Part A portfolio and for each Part A agency, with performance trends identified over time for individual providers and for overall service categories. Technical assistance provided by the CQM program has aimed at preparing agencies to implement a new web-based data collection system, which will avoid the prior need to tabulate and analyze paper records and permit immediate assessment of an agency's performance against standard quality indicators. This new web-based system also permits more rapid identification of trends in quality of Part A services, enabling the CQM program, DOHMH evaluation and technical assistance personnel, contract monitors and the Planning Council to intervene more quickly to address problematic patterns in service delivery. This new data collection system will also benefit Part A service providers, who will obtain immediate feedback on how their service record fares in comparison to the average for all providers on a particular indicator.

Demonstrating Impact of Part A Services on Clinical Outcomes. As the EMA's CQM system has now been in place since 2001, performance trends are beginning to emerge, especially for service categories whose CQM indicators have been in place for several years. These trends, which are submitted to the Planning Council to inform their service prioritization and allocations, enable the EMA to assess the success of Part A services over time in enhancing health care access and improving service quality.

Over the last three years, as individual service categories have been re-bid, the EMA has added (for CQM and contract monitoring purposes) specific primary care status indicators that measure clients' utilization of primary care, receipt of antiretrovirals, viral load, and CD4 count. In FY08, data collection on the primary care status indicators was added to the contractual requirements for additional service categories that will be re-competed in the next year. These primary care indicators will enable the EMA (a) to determine whether specific services increase access to and continuity of primary care for Part A clients, and (b) to track the virologic and immunologic outcomes of clients over time. As monitoring of these primary care status indicators matures, the Planning Council will be better able to account for the clinical impact of interventions in the priority-setting and resource allocation process.

In addition to CQM, other initiatives by the EMA are helping document the impact of Part A services on clinical outcomes. As described below, the Planning Council's longitudinal client cohort study demonstrates that clinical outcomes for Part A recipients are consistently more favorable than for PLWHA who do not receive Part A services. Also described below in Section 6.b are results of the EMA's longstanding outcomes evaluation for the MAI portfolio, which uses the same program models in relevant service categories as those used for base-funded Part A programs. Beyond the MAI services and their base-funded counterparts, the EMA has applied outcome indicators to every service category in the FY08 spending plan, from ADAP to psychosocial support services.

6.b. Description of Data Collection and Results. As described above, all Part A contractors are contractually required to collect standardized data for each client encounter and to make these records available to the EMA's medical records evaluators. All Part A providers are trained in data collection methods and requirements. Client data are tabulated, disaggregated by a number of variables, and analyzed against quality indicators developed for

each service category. The AIDS Institute regularly reports to the Planning Council on CQM data results.

Preparation for Client-Level Data Reporting. The EMA has required Part A service providers to collect client-level data for the past three years. Providers use unique identifiers to collect and report complete demographic data on Part A clients. Master contractors track trends in service utilization, and EMA evaluators review records to assess performance against quality indicators, completeness of reporting, and program outcomes. The shift to client-level data reporting has already improved quality management and service planning. Through the use of unique identifiers, the EMA now has reliable data on the number of unique clients being served by the Part A program and within individual service categories, strengthening the Planning Council's ability to compare the relative impact of different service categories. In the last year, EMA evaluators have specifically tracked providers' documentation of clients' primary care utilization, providing enhanced technical assistance to providers with sub-optimal records documentation. In addition, tracking of service utilization by emerging populations enables the Planning Council to assess and compare service access and intensity of service utilization among different client groups. To maximize provider proficiency in collecting and reporting client-level data, Public Health Solutions and DOHMH meet every two weeks to discuss data issues, identify shortcomings, pursue data system improvements, and devise technical assistance strategies.

Process for Reporting Client-Level Data to HRSA. The EMA is in the advanced stages of preparing a tool to convert client-level data reporting by service providers into regular reports for submission to HRSA. This tool will use electronic data reporting formats already in widespread use by EMA service providers.

CQM Data Results. Ongoing monitoring of Part A programs has confirmed that the EMA delivers high-quality services to low-income PLWHA.

¶ *Medical Case Management.* In 2006, 86% of Part A case management clients were making at least one primary care visit every six months. Between 2005 and 2006, significant improvements were documented in the regular assessment by case managers of each and every major component of HIV care planning for Part A clients. The percentage of Part A case management clients whose initial service plan was in place within 45 days of intake rose from 87% in 2005 to 100% in 2006. The percentage of case management plans that included specific goals for all documented needs increased from 75% to 95%, and documented follow-up every 120 days on all goals rose from 55% to 86% of client charts reviewed.

¶ *Treatment Adherence.* Among clients of Part A treatment adherence programs, 89% visit an HIV primary care provider within six months of enrollment, and 93% of clients have had a CD4 or viral load test within the previous six months. CQM monitoring indicates a need for more frequent reassessment by treatment adherence providers of clients' antiretroviral status.

¶ *Mental Health.* In 2007, the CQM program reviewed records for 535 clients at 14 Part A-funded sites. On 19 of 24 CQM indicators, scores were 90% or greater for the mental health portfolio.

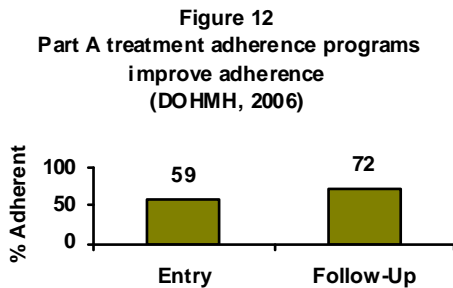
¶ *Substance Abuse Services.* Performance monitoring indicates that more than 95% of Part A substance abuse service providers document the development of an initial service plan and update the plan periodically. CQM surveys indicate that improvement is needed in the frequency of follow-up to referrals to HIV primary care for Part A substance abuse service clients.

¶ *Primary Care Status Measures.* To reduce unmet need and strengthen the linkages between Part A support services and primary care access, the EMA now requires Part A

providers to regularly assess clients' primary care utilization and to intervene to address access barriers. CQM monitoring of diverse service categories has noted a steady improvement in the rate of primary care status documentation since 2004.

Other Data Relevant to Quality Evaluation. In addition to the CQM program, numerous other data sources provide information that is relevant to assessment of the quality of Part A services. Like the CQM data, these data sources are carefully studied by the Planning Council and by the Grantee, MHRA and WCDOH to inform service planning and improve service delivery.

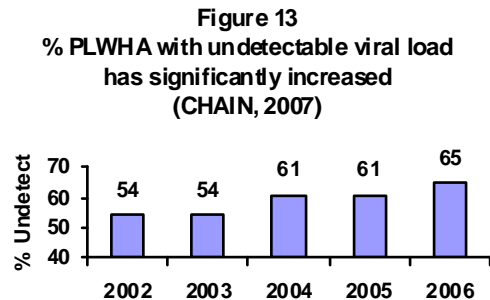
¶ *Outcomes Evaluation.* Since FY99, the EMA has conducted a comprehensive outcomes evaluation of its MAI treatment adherence programs. This MAI-focused outcomes evaluation has now been transitioned to the broader base-funded portfolio of services. As Figure 12 demonstrates, adherence rates among Part A MAI treatment adherence clients, as measured by an undetectable viral load, rose from 59% at baseline to 72% at three-month follow-up, with 94% of those who had an undetectable viral load at three months remaining undetectable at their next test later in the year. CHAIN indicates that patients enrolled in Part A treatment adherence programs are nearly 20%



more likely to be adherent to antiretroviral regimens at one year than patients who are not enrolled. Most recent results from the EMA's portfolio-wide outcomes evaluation indicate that 88% of treatment adherence clients have lab-based evidence of receiving HIV primary care services in 2007.

Similarly, the EMA's early intervention and maintenance-in-care programs (part of medical case management) support appropriate health care utilization. In 2007, for example, more than 80% of Part A maintenance-in-care clients were receiving HIV primary care within four months of their enrollment in the program.

¶ *Longitudinal CHAIN Cohort.* The CHAIN cohort study is not designed to measure quality of services, but it nevertheless vividly illustrates the benefits of services provided under Part A. Among the CHAIN cohort, the percentage of in-care PLWHA with undetectable loads (i.e., maximum treatment success) increased from 54% in 2002 to 65% in 2006. (Fig. 13.) The percentage of PLWHA in CHAIN who are disconnected from care has declined over the last 10 years.



PLWHA study participants who do not receive Part A services are more than one-third more likely than Part A recipients to report emotional or psychological problems or actively use drugs. Those in care are more than seven times more likely than out-of-care PLWHA to be taking antiretrovirals, roughly half as likely to be hospitalized, and more than one-third less likely to have a CD4 count below 200.

In CHAIN, out-of-care PLWHA who receive housing assistance are more than 2.5 times more likely to enter HIV primary care. PLWHA in the study who receive housing

assistance are 23% more likely than unstably housed study participants to remain in care. Mental health services, substance abuse treatment, and medical case management also significantly increase the likelihood that homeless or unstably housed PLWHA in the cohort will enter HIV primary care. (4)

¶ *HIV/AIDS Surveillance.* Dramatic declines in AIDS deaths that exceed the national average suggests that the continuum of HIV care provided by Part A and other payers is having a major impact on the EMA's public health and on the well-being and longevity of PLWHA. From 2003 to 2006, as deaths among PLWHA nationally declined by 15%, the annual number of deaths fell by 27% in NYC. Laboratory reporting also indicates that the EMA has improved its success in rapidly linking newly-diagnosed individuals to care. The percentage of newly diagnosed individuals who have entered the primary care system within three months of their diagnosis rose from 49% in 2001 to 69% in 2007. Lab-based reporting also indicates that Black and Hispanic PLWHA were more likely to be receiving HIV primary care in 2007 than white PLWHA, underscoring the role of Part A in reducing longstanding health disparities. (2)

Use of Data to Improve Priority Setting and Resource Allocation Process. To help ensure that CQM data are available to assist the Planning Council in prioritizing services and allocating funds, the CQM director attends monthly Planning Council meetings. Discussion of CQM results and processes was an agenda item at several of this year's Planning Council meetings. CQM results were presented this year to the Planning Council during "data day" that informed development of the FY09 plan. Each month, staff from DOHMH, Public Health Solutions, WCDOH, and other government agencies and funders meet to discuss CQM, including the design and revision of indicators, indicator results, their impact on planning for Part A, and strategies to enhance CQM coordination. Each quarter, the CQM director participates in meetings of the Part A steering committee, which include attendees from the monthly CQM meetings, as well as consumers and special invitees. These quarterly meetings allow CQM staff to present CQM data, explain methods used to collect and analyze the data, and discuss future projects and initiatives to improve CQM. CQM data played an important role in development of the FY09 plan, as the need to bring current medical case management practices more into line with DOHMH's care continuum standards led the Planning Council to allocate \$26 million to create a consolidated, standard-driven medical case management program to support return to care and retention in HIV primary care.

Use of Data to Improve Service Delivery. Through the quality learning networks and through Part A-sponsored technical assistance, the CQM program contributes to improved quality in the delivery of Part A services.

¶ *Primary Care Status Monitoring.* As noted, the EMA in recent years began requiring Part A providers, including those providing non-clinical services, to monitor clients' HIV primary care utilization and to intervene to address access barriers. CQM staff studied experience in the various service categories to identify program characteristics associated with strong performance by providers in addressing primary care barriers. CQM and DOHMH staff are now working together with the various learning networks to implement delivery strategies for non-clinical providers that promote health care utilization.

¶ *Medical Case Management.* As a result of targeted technical assistance provided to agencies with substandard CQM scores in the last year, the large majority (72%) of Part A medical case management programs have refined their process for individualized client assessments and consultations to ensure quick response to changes in client circumstances.

¶ *Substance Abuse Services.* The CQM program worked with the quality learning network for substance abuse services to produce a manual for improving the quality of services provided to individuals with alcohol or chemical dependence.

¶ *Mental Health Services.* CQM staff have worked closely with the quality learning network for mental health services to improve program performance, with demonstrable results. From 2002 to 2005, the percentage of Part A mental health service providers assessing all aspects of mental health increased from 84% to 94%, while the percentage conducting a comprehensive substance abuse assessment rose from 74% to 94%.

¶ *Treatment Adherence Services.* In 2008, the collaborative network planning group for Part A treatment adherence providers developed a comprehensive workplan to improve organizational CQM infrastructure and program performance. Informed by results on quality indicators for the service category, the joint planning group developed a grid of activities, with specific timelines and staff responsibilities, to increase the capacity of Part A providers to improve service quality. To improve performance, DOHMH and AIDS Institute staff summarized for Part A providers the scientific literature on treatment adherence and health literacy, collected network input on assessment and intervention strategies, and reported back to providers on state-of-the-art techniques to increase patient self-care for chronic disease management.

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FY 2009 Ryan White HIV/AIDS Treatment Modernization Act of 2006
Part A Grant Application
New York, NY

Attachments

Attachment 1: Organizational Chart

Attachment 2: Planning Council Letter & Compliances and Assurances

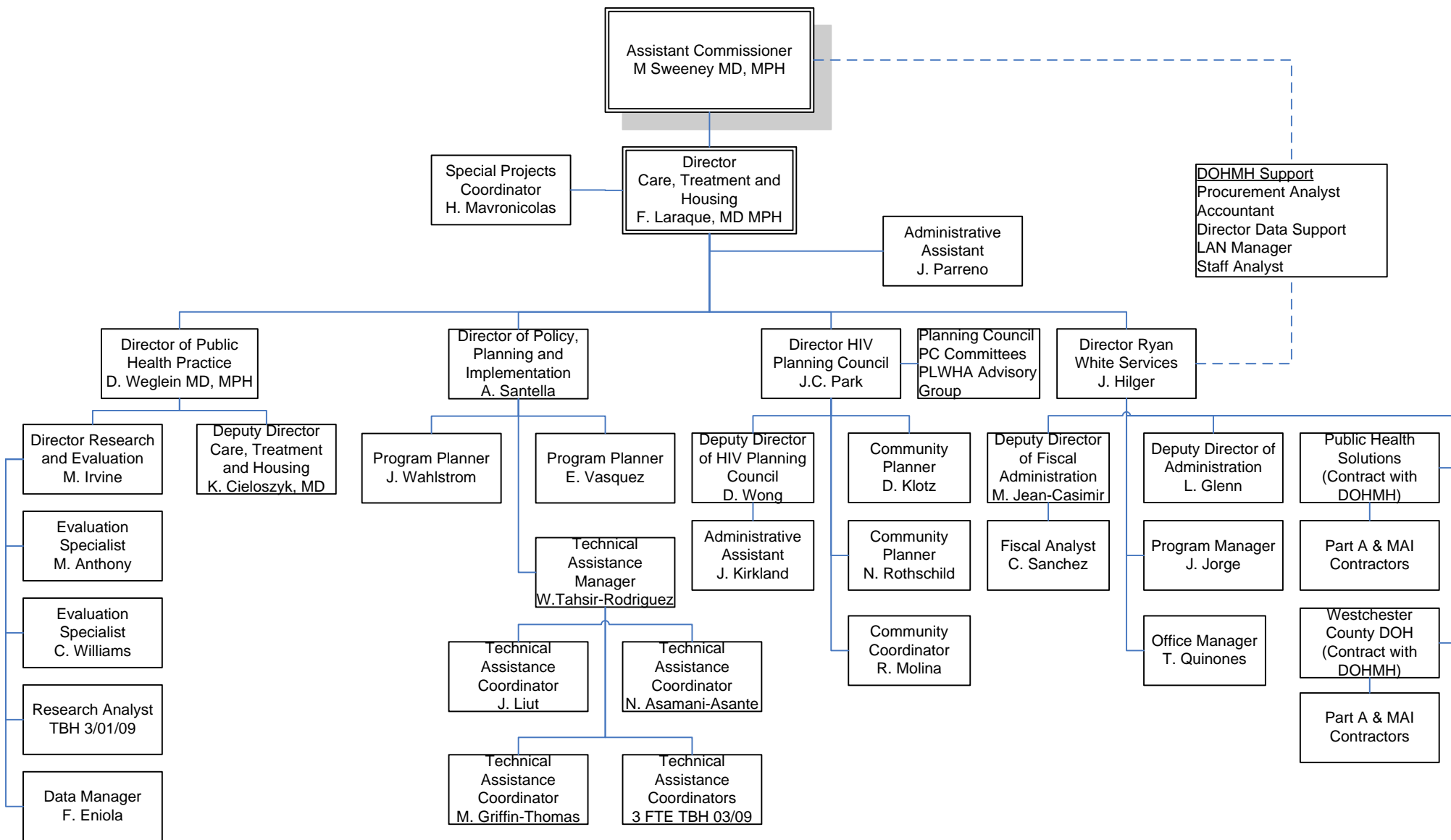
Attachment 3: HIV/AIDS Epidemiology Table

Attachment 4: Co-morbidities, Cost and Complexity Table

Attachment 5: Other Public Funding for HIV Related Services

Attachment 6: Unmet Need Estimate

Attachment 7: FY 2009 Implementation Plan



Attachment 2: FY 2009 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Treatment Modernization Act of 2006 Part A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area New York, NY (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)^{1,2}

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)

The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2603(c)

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604 (a)

The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

Pursuant to Section 2604(c)(3), Section 2604(d)

The EMA/TGA will expend not less than 75% of service dollars for core medical services, unless waived by the Secretary, and support services shall be those necessary for individuals with HIV/AIDS to achieve medical outcomes.

Pursuant to Section 2604(f)(A)

The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3)

The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)

The EMA/TGA will establish a Clinical Quality Management Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5% of program funds or \$3 million.

Pursuant to Section 2604(i)

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)

With regard to the use of funds,

- a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
- b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease;

¹ All statutory references are to the Public Health Service Act, unless otherwise specified.

² The five new TGAs (Baton Rouge, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in Section 2609(d)(1)(A).

- c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV-related services as required in the above paragraph; and
- d. documentation of this maintenance of effort will be retained.

Pursuant to Section 2605(a)(3)

The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)

The EMA/TGA will participate in an established HIV community-based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)

Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance policy, or any Federal or State health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)

Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)

The EMA/TGA has participated in the Statewide Coordinated Statement of Need process initiated by the State, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)

The EMA/TGA will submit audits every two years to the lead state agency under Part B of Title XXVI of the Public Health Service Act.

Pursuant to Section 2605(e)

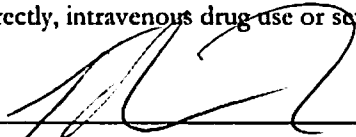
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)

Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684

No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.



Signature

Date: September 26, 2008

Title: Commissioner, New York City Department of Health and Mental Hygiene

Address: New York City Department of Health and Mental Hygiene
125 Worth St.
New York, NY 10013



Djuana Gibson
Grants Management Officer
HRSA, Division of Grants Management Operations
5600 Fishers Lane, Room 11A-02
Rockville, MD 20857

September 22, 2008

Dear Ms. Gibson:

We are writing this letter to provide assurance that the HIV Health and Human Services Planning Council of New York ("Planning Council") has fulfilled all mandated conditions of award. Through regular reports from the administrative agency, the Planning Council is assured that FY 2008 Part A funds are being rapidly allocated and disbursed efficiently according to the priorities and allocations established by the Planning Council.

We also provide assurance that the FY 2009 priorities and allocations listed in the New York EMA's FY 2009 grant application were determined by the Planning Council according to the Planning Council's established priority setting and resource allocation process. The priorities and resource allocations were adopted by the Planning Council at its July 24, 2008 meeting. The process used to determine the priorities is as described in Section Four of the grant application, Planning and Resource Allocation.

Finally, we also provide assurance that the membership of the Planning Council is representative and reflective of the demographics of the epidemic in the EMA, and that Planning Council membership training took place as planned. There are no vacancies on the Planning Council, and the demographics of the non-aligned consumers on the Planning Council reflect the demographics of the local epidemic.

Yours truly,

Jan Carl Park, MPA
Governmental Co-Chair

Soraya Elcock
Community Co-Chair

Attachment 3: Reported persons living with HIV/AIDS as of December 31, 2007, and HIV and AIDS diagnoses occurring 01/01/2006 through 12/31/2007 in New York, NY, EMA

	(1)		(2)		(3) PLWHA as of 12/31/07 (Diagnosed and Reported)					
	HIV (non-AIDS) Diagnoses 01/01/06 to 12/31/07		AIDS Diagnoses 01/01/06 to 12/31/07		Total		PLWH		PLWA	
	New HIV (non-AIDS) cases, diagnosed and reported		New AIDS cases, diagnosed and reported		Persons living with HIV or AIDS		Persons living with HIV (not AIDS)		Persons living with AIDS	
	N	%	N	%	N	%	N	%	N	%
Total	5,914	100.0%	7,381	100.0%	107,350	100.0%	40,757	100.0%	66,593	100.0%
Race/Ethnicity										
White, not Hispanic	1,054	17.8%	1,226	16.6%	22,439	20.9%	9,341	22.9%	13,098	19.7%
Black, not Hispanic	2,897	49.0%	3,653	49.5%	48,717	45.4%	18,234	44.7%	30,483	45.8%
Hispanic	1,778	30.1%	2,320	31.4%	33,865	31.5%	11,942	29.3%	21,923	32.9%
Asian/Pacific Islander	126	2.1%	123	1.7%	1,366	1.3%	602	1.5%	764	1.1%
American Indian/Alaska Native	10	0.2%	9	0.1%	107	0.1%	48	0.1%	59	0.1%
Multi- Race	49	0.8%	50	0.7%	327	0.3%	123	0.3%	204	0.3%
Unknown	0	0.0%	0	0.0%	529	0.5%	467	1.1%	62	0.1%
Gender										
Male	4,282	72.4%	5,076	68.8%	74,621	69.5%	27,652	67.8%	46,969	70.5%
Female	1,632	27.6%	2,305	31.2%	32,728	30.5%	13,104	32.2%	19,624	29.5%
Unknown	0	0.0%	0	0.0%	1	0.0%	1	0.0%	0	0.0%
Age group (Years)										
<13 years	24	0.4%	6	0.1%	686	0.6%	586	1.4%	100	0.2%
13 - 19 years	331	5.6%	139	1.9%	1,620	1.5%	904	2.2%	716	1.1%
20 - 44 years	4,183	70.7%	4,190	56.8%	46,280	43.1%	21,990	54.0%	24,290	36.5%
45+ years	1,376	23.3%	3,046	41.3%	58,761	54.7%	17,275	42.4%	41,486	62.3%
Unknown	0	0.0%	0	0.0%	3	0.0%	2	0.0%	1	0.0%
Adult/Adolescent Total	5,889	100.0%	7,372	100.0%	106,597	100.0%	40,145	100.0%	66,452	100.0%
Exposure Category										
Men who have sex with men	2,482	42.1%	2,194	29.8%	32,439	30.4%	13,785	34.3%	18,654	28.1%
Injection drug users	321	5.5%	934	12.7%	20,462	19.2%	4,209	10.5%	16,253	24.5%
Men who have sex with men and inject drugs	72	1.2%	127	1.7%	2,210	2.1%	569	1.4%	1,641	2.5%
Heterosexuals	1,390	23.6%	1,695	23.0%	19,733	18.5%	7,603	18.9%	12,130	18.3%
Other/Hemophilia/blood transfusion	0	0.0%	94	1.3%	2,095	2.0%	840	2.1%	1,255	1.9%
Risk not reported or identified	1,624	27.6%	2,328	31.6%	29,658	27.8%	13,139	32.7%	16,519	24.9%
Pediatric Total	25	100.0%	9	100.0%	753	100.0%	612	100.0%	141	100.0%
Exposure Category										
Mother with/at risk for HIV infection	24	96.0%	6	66.7%	728	96.7%	598	97.7%	130	92.2%
Other/Hemophilia/blood transfusion	0	0.0%	1	11.1%	2	0.3%	0	0.0%	2	1.4%
Risk not reported or identified	1	4.0%	2	22.2%	23	3.1%	14	2.3%	9	6.4%

Sources: New York, Kings, Queens, Bronx, and Richmond counties (New York City): New York City Department of Health and Mental Hygiene, HIV Epidemiology and Field Services Program, data as of June 30, 2008; Putnam, Rockland, and Westchester counties: New York State Dept. of Health, Bureau of HIV/AIDS Epidemiology, data as of August 8, 2008

Attachment 4: Co-morbidities, Poverty and Insurance Status – New York, NY

<u>Co-morbidity</u>	Prevalence within General population (2007)	Prevalence within HIV/AIDS population (2007)	Data Source and Date
Tuberculosis	10.3/100,000	0.11%	DOHMH (2008); Tri-County Health Departments Westchester, Rockland and Putnam Counties), 2008.
Syphilis (<i>Primary & Secondary</i>)	10.2/100,000	Data not collected	DOHMH (2008); Tri-County Health Departments, 2008.
Gonorrhea	112.3/100,000	Data not collected	DOHMH (2008); Tri-County Health Departments, 2008.
Chlamydia	563.5/100,000	Data not collected	DOHMH (2008); Tri-County Health Departments, 2008.
Intravenous Drug Users	1,549/100,000	19.2%	DOHMH (2008); NYS OASAS, 2004 (Tri-County IDU stats); Tri-County Health Departments, 2008(Tri-County HIV epi data)
Other Substance Abuse	7,197/100,000	Data not collected	DOHMH (2006); NYS OASAS, 2004 (Tri-County) <i>(Other substance use includes alcohol, Methamphetamine, cocaine, inhalants)</i>
Homelessness	39/100,000	1.5%	NYC Dept of Homeless Services, 2008; DOHMH (NYC, 2008); Tri-County HUD Applications, 2008 (Tri-County) <i>(Homelessness does not include individuals with unstable housing at high risk of homelessness)</i>
Severe Chronic Mental Illness	10.2%	33+% (CHAIN cohort only); EMA-wide information not available for all PLWHA	DOHMH, 2006 (NYC, community mental health estimates); Westchester County Community Mental Health Report, 2000 (community mental health estimates); CHAIN, 2005 (prevalence of mental illness in PLWHA population). Information not available for Putnam and Rockland counties.
Hepatitis C (<i>Tri-County only</i>)	86.8/100,000	Data not collected	Tri-County Health Departments, 2008. Information unavailable for NYC.

Attachment 4: Co-morbidities, Poverty and Insurance Status – New York, NY

<i>POVERTY AND INSURANCE STATUS</i>					
	General population		HIV/AIDS population		Data Source and Date
	Number	%	Number	%	
Poverty *	4,747,885***	50%	This information is not collected, although 83.3% of ADAP recipients in the EMA have annual incomes below \$30,000		U.S. Census Bureau, 2007 American Community Survey; NYS AIDS Institute, 2008 (income stats for ADAP recipients).
Uninsured**	1,680,000	17.0%	This information is not collected, although NYSDOH estimates that only 13% of PLWHA in the EMA have private insurance.		United Hospital Fund, 2007 (NYC general population); NYS Expanded Behavioral Risk Factor Surveillance System, 2003, Core Table 2 (Tri-County general population); NYSDOH AIDS Institute, 2005 (PLWHA population).
Medicaid	2,600,000	27.7%	85%		NYC Dept of Planning, 2004 (NYC); NYSDOH and U.S. Census Bureau, Census 2000 (SF 3), (2005 estimates) (Tri-County); NYSDOH, 2006.

* Persons in EMA below 300 percent of the Federal Poverty Level

** Persons in EMA without insurance coverage, including those without Medicaid or Medicare. Thirty-one per cent of NYC residents, or approximately 2.7 million people, are covered by Medicaid or Medicare (United Hospital Fund, 2007).

*** Data are based on a sample and are subject to sampling variability.

Attachment 5: Report on the Availability of Other Public Funding

EMA: New York, NY												
Services	Amount and Percent of Public Funding Source											
	RW Part A		MAI		Other Federal		State		Local		Total	
	Funds	%	Funds	%	Funds	%	Funds	%	Funds	%	Funds	%
Home & Community Based Support Services	\$42,001,592	5%	\$8,035,429	87%	\$160,172,336	19%	\$309,354,512	37%	\$306,335,407	37%	\$825,899,276	29%
Ambulatory/Outpatient Medical Care	\$20,904,073	2%			\$495,358,848	49%	\$250,777,656	25%	\$235,243,169	23%	\$1,002,283,746	36%
State AIDS Drug Assistance Program	\$7,114,413	4%	\$1,225,445	13%	\$87,282,182	44%	\$104,589,072	52%	\$0	0%	\$200,211,112	7%
Other Outpatient & Community Based Primary Medical Care Services	\$0	0%	0%		\$192,028,663	50%	\$156,845,484	41%	\$35,831,627	9%	\$384,705,774	14%
Oral Health	\$118,249	1%	0%		\$8,961,058	51%	\$4,565,162	26%	\$4,086,644	23%	\$17,731,112	1%
Substance Abuse/Mental Health Services	\$19,048,858	5%	0%		\$184,120,448	47%	\$97,012,547	25%	\$87,850,777	23%	\$388,032,631	14%
Total Funds	\$89,187,185	3%	\$9,260,874	0.3%	\$1,127,923,535	40%	\$923,144,433	33%	\$669,347,624	24%	\$2,818,863,651	100%

Sources:

1. New York City Office of Management and Budget FY 2007 Estimated Actual Expenditures
2. New York State Department Health FY 2007 Medicaid HIV/AIDS Claims and Payments Report for New York City and Lower Hudson
3. New York State Department of Health AIDS Institute
4. 2008 MAI Part A and MAI Allocations Report as submitted to HRSA

Note: Home & Community Based Services include: case management, home health care, transportation services, food bank/home delivered meals, legal services, psychosocial support services, early intervention, housing related services.

Attachment 6: Unmet Need Estimate - New York, NY

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		Value		Data Source
A	Number of persons living with AIDS (PLWA), 12/31/06.	57,106		HIV/AIDS Reporting System (HARS) for New York City (NYC) and New York State (NYS). Reports to NYC (not NYS) were excluded for persons residing outside NYC or whose residence was unknown at time of diagnosis, and persons with evidence of residence outside NYC in 2007.
B	Number of persons living with HIV (PLWH)/non-AIDS/aware, 12/31/06.	36,478		HARS - see A
C	Total number of HIV+aware, 12/31/06.	93,584		
Care Patterns		Value		Data Sources
D	Number of PLWA who received the specified HIV primary medical care in calendar year 2007.	39,106		HARS - see A
E	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care in calendar year 2007.	23,612		HARS - see A
F	Total number of HIV+/aware who received the specified HIV primary medical care in calendar year 2007.	62,718		
Calculated Results		Value	Percent	Calculation
G	Number/percent of PLWA who did not receive the specified HIV primary medical care in 2007.	18,000	32%	Value = A - D. Percent = G/A
H	Number/percent of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care in 2007.	12,866	35%	Value = B - E. Percent = H/B
I	Total number/percent of HIV+/aware who did not receive the specified HIV primary medical care in 2007.	30,866	33%	Value = G + H. Percent = I/C

Attachment 7: FY 2009 Implementation Plan with Highest Funded Core and Non-Core Services - New York, NY

The time frame for all objectives is 3/1/09 – 2/28/10	Service Unit Definitions	Planned Number of Service Units	Planned Number of Clients	FY 2009 Funds
Core Service Priority : AIDS Drug Assistance Program (ADAP):				\$10,253,647
Service Goal/s: Improve health outcomes of uninsured and underinsured PLWHA.				
Objective/s: 1. Increase access to medications through New York State ADAP for the treatment of HIV/AIDS and opportunistic infections.	Prescriptions	294,797	8,355	\$10,253,647
Core Service Priority: Outpatient/Ambulatory Health Services:				\$9,837,793
Service Goal/s: Improve health outcomes of PLWHA. (16 programs)				
Objective/s: 1. Increase access to HIV primary medical care services in high-need communities. Some programs target PLWHA living in marginalized housing such as SROs who are not ready to engage in HIV care in traditional medical care settings.	Medical care visits	19,495	2,453	\$2,701,613
2. Increase access to HIV primary and specialty care in various clinical settings by reimbursing service providers through the NYS HIV Uninsured Care Program.	Visits reimbursed by NYS HIV Uninsured Care Program	51,508	9,465	\$7,136,180
Core Service Priority: Medical Case Management (incl. Treatment Adherence):				\$26,252,177
Service Goal/s: Improve health outcomes of PLWHA by ensuring that clients are linked to medical care at the time of diagnosis and are provided with all clinical and psychosocial support needed to stay engaged in care. Provide treatment and medication adherence support and coordinate all medical and non-medical care. (83 programs)				
Objective/s: 1. Connect or reconnect individuals to an HIV primary care provider.	Care coordination visits	146,760	6,115	\$9,258,062

Attachment 7: FY 2009 Implementation Plan with Highest Funded Core and Non-Core Services - New York, NY

The time frame for all objectives is 3/1/09 – 2/28/10	Service Unit Definitions	Planned Number of Service Units	Planned Number of Clients	FY 2009 Funds
2. Maintain client engagement with HIV primary care provider. 3. Connect the client who is not connected to HIV primary care within 90 days of enrollment to other services that may be needed including mental health, substance abuse and housing. 4. Support client adherence to antiretroviral therapy through coaching, health education or directly observed therapy.	Care Coordination visits for recent releasees (NYC only)	9,024	4,301	\$1,469,598
	Number of visits by clients returning to care or at risk of falling out of care	26,799	4,610	\$9,767,061
	Treatment adherence sessions and DOT	170,788	1,823	\$5,757,456
Core Service Priority: Substance Abuse Services – Outpatient:				\$11,168,923
Service Goal/s: Increase the number of HIV+ active and recovering AOD users who are aware of their status and reduce morbidity and mortality of substance users living with HIV. Increase access to care for PLWHA with a history of alcohol or other drug use and are outside the traditional network of services. (28 programs)				
Objective/s 1. Connect clients to HIV primary care and help them stay engaged in care. 2. Link clients to substance use services based on need and readiness for engagement. 3. Help clients reduce HIV risk behaviors, and reduce substance abuse behaviors.	Medical outreach sessions in SROs (including buprenorphine)	1,441	960	\$596,120
	Successful rapid testing outreach & referral	11,128	11,128	\$1,680,173
	Harm reduction counseling & education sessions	34,378	2,865	\$5,605,037
	Low threshold AOD counseling sessions	32,626	2,719	\$3,287,593
Non-Core Service Priority: Housing Services:				\$8,582,813
Service Goal/s: Reduce homelessness, and improve housing access for PLWHA. Reduce HIV-related morbidity for homeless				

Attachment 7: FY 2009 Implementation Plan with Highest Funded Core and Non-Core Services - New York, NY

The time frame for all objectives is 3/1/09 – 2/28/10	Service Unit Definitions	Planned Number of Service Units	Planned Number of Clients	FY 2009 Funds
or unstably housed PLWHA. Increase access and engagement in medical care for target population. (13 programs)				
Objective/s: 1. Provide housing placement assistance and transitional housing for PLWHA who are unstably housed, homeless and in targeted communities so that they can access and stay in HIV primary care. 2. Permanent housing placement for those individuals who request it.	Long term and transitional housing placement.	894	894	\$5,219,874
3. Provide emergency rental start-up assistance, short-term rental assistance, and emergency utility payments for PLWHA who are not eligible for any other rental assistance.	Rental and utility assistance payments	5,587	649	\$3,362,939
Non-Core Service Priority: Food Bank/Home-Delivered Meals				\$5,851,270
Service Goal: Improve health outcomes and enhance treatment adherence of PLWHA by optimizing nutrition status, immunity and overall well-being. Prevent nutritional deficiencies, and loss of weight and lean body mass. (14 programs)				
Objective/s 1. Provide nutritional screening and periodic reassessment of nutritional status. 2. Increase availability of culturally appropriate meals 7 days per week through home delivered meals, congregate meals, and/or pantry bags.	Client meals	268,461	7,047	\$4,469,283
	Pantry bags	30,395	3,249	\$979,318
	Nutritional screening and assessment visits (NYC only)	8,381	2,273	\$396,648
	Food vouchers (Tri-county only)	1,512	81	\$6,021