**Minneapolis-St. Paul TGA Application for 2016 Ryan White HIV/AIDS Treatment Extension Act Part A Funding**

## PROJECT NARRATIVE

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***ii. Project Narrative***

▪ *INTRODUCTION*

The following application describes both the continuing and evolving needs of people affected by the HIV epidemic in the TGA including Minneapolis–St. Paul and the thirteen counties that surround them. In an era when effective treatments for HIV are available and adherence can significantly reduce HIV transmission, the TGA's Part A funds provide critical services that engage and retain in care the most affected groups including men who have sex with men (MSM), disproportionately affected communities of color, injection drug users (IDU), at-risk youth and immigrant populations. In collaboration with all of Minnesota's (MN) RWP parts and Minnesota Department of Health (MDH, CDC HIV prevention grantee), the Part A program ensures an integrated continuum of care and services in the Twin Cities metropolitan area where 85% (7,060) of MN's living with HIV reside, the vast majority (83%) in Hennepin and Ramsey Counties. Recent national, MN and TGA HIV Care Continua (HCC) make clear where the greatest needs arise in helping people to become aware of their HIV status and engage in lifetime HIV medical care and prevention. As implementation of the Affordable Care Act (ACA) continues to ease the financial burden of those who previous went without adequate insurance, the TGA's FY2017 Part A plan focuses on delivery of high quality services designed to promote: early identification of individuals who are unaware of their HIV status; linkage to the best-quality medical care; re-engagement in care; health education and literacy; retention in care and treatment adherence; and addressing social and cultural barriers for rapid movement along the HCC to achieve sustained viral suppression.

▪ *NEEDS ASSESSMENT*

**A. Epidemiological Overview**

**1) Geographical Region of the Minneapolis-St. Paul Transitional Grant Area (TGA)**

The Minneapolis-St. Paul Part A TGA comprises 11 counties in MN and two in western Wisconsin (WI) with Minneapolis and St. Paul the two largest cities at its center. The TGA was defined in 1995 when Hennepin County became eligible for a Title I (now Part A) Emergency Relief Project Grant under the Ryan White CARE Act and is equivalent to the Minneapolis-St. Paul Metropolitan Statistical Area as defined by the U.S. Office of Management and Budget. The estimated population of the TGA in 2015 is 3,456,257. The outer TGA counties are suburban or rural, and together with Hennepin and Ramsey counties comprise 63% of MN's population of 5,489,594. Hennepin and Ramsey counties comprise 32% of MN's population. The TGA's population is 78% White, 8% Black (with 70,600 African-born), 6% Hispanic, 7% Asian/Pacific Islanders (API), and 1% American Indian/Alaskan Native. In 2015, an estimated 403,545 Minnesotans (7%) were foreign born, 27% born in Latin America and 20% in Africa. The greatest concentrations of Blacks (both U.S. and African-born), Hispanics, American Indians, API, and MSM in MN reside in Hennepin and Ramsey Counties. The proportion of males estimated to be MSM throughout the TGA is 6% with higher percentages of males who are MSM in Minneapolis (11%) and in Hennepin and Ramsey Counties (8%). ***Attachment 14A*** presents a map of HIV prevalence in the TGA as of December 31, 2015. The TGA is home to 85% of people living with HIV (PLWH) in MN. Greater than 99% of the TGA's 7,060 diagnosed PLWH reside in the 11 counties in MN, with less than 1% residing in the two WI

counties. The greatest concentration of PLWH reside in the core urban center of the TGA with 63% residing in Hennepin County and 44% in Minneapolis alone.

**2) Sociodemographic Characteristics of Newly Diagnosed, PLWH and Persons at Risk**

***Attachment 3*** presents HIV incidence and prevalence data for the TGA from 2011 to 2015.

a) Demographic Data. *i) HIV Incidence*. In 2015, 259 new HIV diagnoses were reported in the TGA, representing a 6% decrease from 2014 (277 new diagnoses). Incidence declined by 2% over the past five years with an average of 266 new cases per year. The HIV epidemic in the state and TGA remains largely male, with 75% of new cases among males, 70% of whom are MSM, and MSM who also inject drugs (MSM/IDU). There were five diagnoses among male-to-female transgendered persons in 2015.

HIV disproportionately impacts people of color in the TGA, most notably Blacks, both African American and African-born combined comprised 45% of new diagnoses in 2015 while they make up only 8% of the TGA's population. Hispanics comprised 8% of new cases in the TGA in 2015. The HIV incidence rate is highest among African-born with a rate 28 times that of Whites. In the past five years HIV incidence increased among Blacks by 11% and 18% among African-born Blacks. If this trend continues, the disproportionate impact of HIV on Blacks, both U.S. and African-born in the TGA will continue to intensify. Although the annual number of new infections is comparatively very low among API, incidence more than doubled from 4 cases in 2011 to 9 cases in 2015. Among women, 81% of new diagnoses in 2015 were among women of color, most notably African-born (54%) and African American (19%). In three of the past five years (2011, 2013 and 2015), the number of new cases among African-born women increased.

Adolescents and young adults ages 13-24 years accounted for 22% of new infections in 2015, a 4% increase from 2011. Adults ages 25-34 years accounted for 32% of new diagnoses in 2015, also increasing by 4% since 2011. New cases among adults ages 50 and older increased from 30 cases in 2011 to 47 cases in 2015, rising 57% in five years.

Greater than half (53%) of new diagnoses in 2015 were among MSM and MSM/IDU. Among MSM, African American MSM accounted for 27% of new infections in 2015, a 14% increase from 2011. Between 2011 and 2015, HIV incidence among African American YMSM ages 13-24 years rose by 38% and by 50% among African American MSM ages 25-29. Although new cases are relatively low among API MSM, new infections more than doubled among API MSM since 2011 from 2 to 7 cases. Between 2014 and 2015, new infections among IDU jumped 79% from 14 to 25 cases, with MSM/IDU accounting for 73% of the increase.

Foreign born people diagnosed with HIV are more likely to test late which is defined as progressing to AIDS within a year of initial HIV diagnosis. In 2015, 38% of the newly diagnosed foreign born individuals tested late compared to 26% of all newly diagnosed cases overall. New foreign born cases were born in 28 different countries with Liberia, Ethiopia, and Mexico being the three most common countries of birth.

*ii) HIV Prevalence*. By end of 2015, there were 7,060 diagnosed PLWH in the TGA. From 2011 to 2015, overall HIV prevalence increased by 18%; an average of 3.5% annually. Of PLWH in the TGA, 3,278 or 46% had an AIDS diagnosis, while 3,782 or 54% had a non-AIDS HIV diagnosis. By gender, 76% of the TGA's PLWH are male and 24% are female. Among males living with HIV, 74% are MSM or MSM/IDU. Greater than 50% of PLWH in the TGA are people of color with 23% African American, 14% Black African-born, 9% Hispanic, 1% American Indian, 2% API, and 2% of multiple racial backgrounds. The HIV prevalence rate among African-born is the highest among racial/ethnic groups with 1,496 cases per 100,000

population or 16 times the rate among Whites. Among women living with HIV, 76% are women of color (34% African-born and 27% African American).

The largest age group among PLWH in the TGA are people 50 years or older comprising 44% of the population of PLWH. Ten percent of PLWH in the TGA are between the ages of 13 and 29, 19% between 30 and 39, and 27% between 40 and 49. People younger than 13 years comprise less than 1% of PLWH.

The population most disproportionately impacted by HIV among all demographic groups continue to be MSM with 57% of diagnosed PLWH, though MSM make up just 6% of the male population of the TGA. MSM have the highest prevalence rate of any demographic group with 5% of MSM estimated to be living with HIV. MSM are 73 times more likely to acquire HIV compared to non-MSM. Among MSM and MSM/IDU living with HIV, 67% are White, 18% African American, 9% Hispanic, 3% multiracial and 2% API. Forty-seven percent of MSM living with HIV are ages 50 and older, 34% are 35 to 49, 16% are 25 to 34 and 3% are 13-24.

*iii) Persons at Higher Risk*. The past five years of the TGA's HIV incidence and prevalence data indicate the demographic groups at higher risk of acquiring HIV are MSM and Black women. More specifically those at greatest risk are African American MSM, especially young African American MSM, MSM/IDU, and African-born women. These groups show increases in HIV incidence between 2011 and 2015 and are significantly over represented among PLWH based on their proportions in the TGA's general population. Although incidence and prevalence numbers are very low, a possible emerging risk population to watch are API MSM as indicated by high percent increases in both HIV incidence and prevalence between 2011 and 2015.

b) Socioeconomic Data. ***Table 1*** on page 46 presents income as percentage of Federal Poverty Level (FPL) and health insurance status of the TGA's population and population of PLWH.

*i) Income and Poverty*. Minnesota has fared better economically than the nation, according to the MN State Demographic Center, in 2015 an estimated 11.5% of Minnesotans were living below the FPL compared to 14.8% nationally. In Hennepin County the overall poverty rate was 12.2%. According to the U.S. Census Bureau's American Community Survey (ACS) the median income in 2015 for the United States was $56,516 and $63,488 in MN.

Despite these favorable numbers, poverty and income inequity have a striking impact on persons of color in MN and the TGA. Income inequality by race is more pronounced in MN and Hennepin County compared to the nation as a whole. According to the ACS, poverty varied greatly by race in Hennepin County with poverty rates for Whites at 8.1%, Blacks at 36.8%, American Indian/Alaskan Natives at 34.3%, and Hispanics at 23.6%.

*ii) Education*. Minnesota's emphasis on education is reflected in the low statewide percentage (7.7%) of people aged 25 years or older who have less than a high school education; the national average is 14.4%. The percentage of persons with less than a high school education is greater for persons of color in MN. According to the 2010-2014 ACS, 17% of Black men and 22% of Black women have less than a high school education compared to 6% and 5% of White men and women, respectively. High school graduation rates are even lower among Hispanics, with 38% and 33% of Hispanic males and females not having a high school diploma, respectively.

*iii) Health Insurance*. Overall, MN has one of the lowest rates of uninsured residents in the nation with 2015 posting the lowest recorded rates of uninsurance. According to the 2015 Minnesota Health Access Survey, 4.3% of Minnesotans were not covered by health insurance compared to 8.2% in 2013, 9% in 2011, 9% in 2009 and 7.2% in the 2007 survey. Though significant differences continue to exist by race/ethnicity, age, income and country of birth. Based on MNCAREWare data, among PLWH in the TGA who received a Ryan White Program

(RWP) Part A or B funded services in 2015, 5% were uninsured although many who are insured may have out-of-pocket costs that create economic barriers to accessing health care. In 2015, 34% of the TGA's 3,057 RWP clients accessed Part A funded Outpatient Healthcare Services (OHS) because they were uninsured or had high out-of-pocket deductibles, copayments or co-insurance.

**3) HIV Disease Burden**

Comparing demographics of the TGA's population with that of TGA's PLWH population along with HIV prevalence rates shows that people of color, primarily Blacks (African American and African-born), Hispanics, and MSM carry the greatest burden of HIV disease. According to the ACS, of the TGA's 3,356,082 residents in 2014, 8% were African American, 2% Black born in an African country and 6% Hispanic. An estimated 3% of the TGA's population are MSM (6% of the male population). ***Attachment 3B*** shows prevalence data for the TGA from 2011 to 2015. By December 31, 2015 there were 7,060 diagnosed PLWH in the TGA. The following table compares select demographic group representation in the TGA's population with representation among diagnosed PLWH and presents HIV prevalence rates in 2015:

| **Demographic Group** | **% of TGA Population** | **% of Diagnosed PLWH** | **HIV Prevalence Rate‡** |
|---|---|---|---|
| White | 80.9 | 47.9 | 124.6 |
| African American | 5.5 | 23.0 | 880.3 |
| Black, African-born | 2.1 | 14.5 | 1447.5 |
| American Indian/Alaskan Native | 0.6 | 1.2 | 427.7 |
| Asian/Pacific Islander (API) | 6.1 | 1.9 | 65.6 |
| Multiracial | 3.1 | 2.4 | 164.1 |
| Hispanic | 5.5 | 8.9 | 336.4 |
| MSM* | 2.9 | 52.0 | 3901.6 |

*Includes MSM/IDU. ‡Per 100,000 persons.

MSM including MSM/IDU have the highest prevalence rate followed by Black-African born, African Americans, American Indians, and Hispanics. Four percent of the TGA's MSM are living with HIV. African American MSM carry a relatively heavy HIV disease burden among MSM, representing 18% of MSM living with HIV in the TGA. New HIV infections continue to increase among African American MSM particularly among adolescents and young adults ages 13-29 years. The prevalence rate among Black African-born is almost 12 times that of Whites. Among African-born, women have a greater disease burden than men with the mode of HIV exposure being primarily through heterosexual contact. African-born is the only racial/ethnic group where the number of females (667) living with HIV exceeds the number of males (493). Foreign-born cases are also more likely to test late. In 2015, 38% of foreign born cases were late testers compared to 21% of US-born cases. Among the 21% of foreign born PLWH, 34% were born in Ethiopia, Kenya, Somalia or Sudan; 17% in Mexico; and 16% in Liberia or Cameroon. Geographically, HIV disease burden is greatest in Minneapolis (see ***Attachment 14A*****)** with prevalence highest in the central, south and north sectors of the city where African Americans, Black-African Born, Hispanics and MSM are more likely to reside.

**4) Indicators of HIV Risk**

a) Behavioral Surveillance**.** Minnesota Department of Health (MDH) collects some behavioral information as part of their HIV/AIDS surveillance, including information on drug use and sexual behavior. MDH collects behavioral data on specific populations as seen in the 2001 Minnesota STI Prevalence Study (ages 12-24), the 2004 and 2007 Twin Cities Men's Health Surveys (MSM 18 and older), and the 2011 MN Men's Health Study (MSM 18 and older). The

Twin Cities Men's Health Survey found that of those interviewed 88% had been tested for HIV, 63% used condoms, and 89% read prevention literature they received.

There are also recurring surveys conducted throughout MN, such as the SHAPE Survey (Survey of the Health of All the Population and the Environment) conducted by Hennepin County in collaboration with other jurisdictions within the TGA, an Annual Health Survey of the LGBTQ community conducted by Rainbow Health Initiative, as well as the Behavioral Risk Factor Surveillance Survey (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), and the Minnesota Student Survey (MSS) conducted by the MDH. MN is not one of the 22 project areas of the National HIV Behavioral Surveillance (NHBS) project, nor is it a state that participates in the Youth Risk Behavioral Surveillance System.

SHAPE provides an estimate of the population that identify as lesbian, gay, bisexual or transgender in Hennepin County, which is used to estimate the alarmingly high HIV incidence and prevalence rates among MSM in the TGA. Both SHAPE 2010 and 2014 indicate that young gay and bisexual men are less likely to have a primary care provider and are significantly more likely to binge drink alcohol compared to non-gay/bisexual peers. SHAPE also indicates that older gay and bisexual men are more likely to be heavy drinkers. In 2014, the BRFSS estimated the percentage of persons living in MN who had ever been tested for HIV to be 27%. In 2011, the PRAMS estimated that 47% of women received an HIV test during their most recent pregnancy, and 64% reported that a health care worker talked with them about an HIV test during their prenatal care visits. The MSS is conducted every three years across MN school districts asking high school students about sexual activity. Of students surveyed in 2013, 64% used a condom during their last sexual intercourse, a decrease from recent years, and 47% of students who very sexually active talked to their partner about protection from STIs or HIV.

b) HIV Surveillance and Testing Program Data**.** The Counseling, Testing and Referral (CTR) System consists of MDH-funded agencies that provide free or low-cost anonymous and confidential HIV testing to MN residents in clinical and office settings or during outreach. Most offer rapid HIV testing instead of the traditional blood draw. In 2015, 12 of the 14 funded sites were located in the TGA. Confidential tests are name-based and reported to MDH and added to the yearly surveillance statistics. Anonymous tests are code-based and are not included in yearly surveillance, although positive anonymous results are reported to MDH. An anonymous test may be linked to a surveillance case if the individual mentions a previous positive diagnosis and recalls the date and site of that test, as well as the code given. The number of tests CTR agencies conducted grew from 10,597 in 2005 to 13,828 in 2015.The positivity rate (percent of positive tests among all tests performed) ranged from 1.0% in 2010 to 1.5% in 2007. In 2015, the positivity rate dropped to 0.5%. The majority of those tested in 2015 were males (70.8%), between the ages of 20 and 39 (68.4%), and people of color (49%). Of the 13,828 tests conducted, 32.7% indicated male-to-male sex, and 5.7% indicated injection drug use in the past 12 months. Positivity rates in 2015 were highest among MSM/IDU (4%), MSM (1%), people ages 39 years and younger (0.5%), transgender individuals (0.8%), males (0.6%), and Hispanics (0.7%). Hennepin County Public Health Clinic's (PHC) Red Door Services, the largest publicly funded HIV testing site in the TGA and MN, receives RWP Part A funding to provide Early Intervention Services. Red Door conducted 8,660 HIV tests in FY2015 with 68 newly diagnosed HIV cases (26% of new cases in the TGA). The positivity rate was highest among MSM at 1.3%.

Clinical data presented in the most recent HIV Care Continuum shows little variation across populations that previously were disproportionally affected. Additionally, there has been a decrease in the proportion of the TGA's PLWH that are virally suppressed. Putting these

numbers in the context of previous years and seeing an increase in missing clinic data indicates that viral suppression numbers have not truly decreased and disparities have been eliminated but rather that clinical data is not being fully reported. The TGA RWP staff are currently embarking on a quality improvement project with MDH to improve data quality and completeness.

c) Ryan White Program (RWP) Data. Minnesota's RWP Parts A and B recipients use a centralized custom version of CAREWare to collect and report client-level data. In 2015, of the 3,534 of the TGA's diagnosed PLWH who received a RWP funded service, 99% reported their mode of HIV exposure. This represents 50% of the TGA's population of diagnosed PLWH. Forty-one percent reported MSM, 37% heterosexual, 2% IDU and 3% MSM/IDU as their mode of HIV exposure.

d) Hepatitic B and C, STI, and Tuberculosis Surveillance Data. In 2015, 19 cases of acute hepatitis B virus (HBV) infection were reported to MDH. Fifteen (79%) cases were residents of the TGA. Fifteen (79%) cases were male and 8 (42%) were between 13 - 39 years of age. Race was known for 14 cases: 9 were white; 2 were black; 2 were multi-racial, and 1 was Asian. Hispanic ethnicity was reported for 1 case. Incidence rates were higher among Asians (0.4 per 100,000) and blacks (0.6 per 100,000), than among non-Hispanic whites (0.2 per 100,000). In 2015, of the TGA's 20,098 persons with past or present with HBV infection, 281 (1.4%) were co-infected with HIV. In 2015, 37 cases of acute hepatitis C virus (HCV) infection were reported to MDH, 16 residing in the TGA. The median age of all cases was 29 years. Twenty-two (59%) cases were female. Race was known for 33 cases: 22 (67%) were White and 11 (33%) American Indian. There were 2,396 reports of newly identified anti-HCV antibody-positive or HCV PCR-positive persons in 2015, the vast majority of whom are chronically infected. Of the TGA's 28,388 persons with past or present HCV infection and 443 (1.5%) are co-infected with HIV.

In 2015, the number of reported bacterial STIs increased to 25,986 cases, a 6% increase in MN from 2014. The change in incidence rates varied by disease, with chlamydia increasing by 7%, gonorrhea remaining stable, and primary/secondary syphilis decreasing by 4%. In the TGA there were 14,260 cases of Chlamydia, 3,256 of Gonorrhea and 227 of Syphilis which combined account for 68% of reported STI cases in MN. In 2015, the chlamydia rate remained highest among women (528 per 100,000), Blacks (1,701 per 100,000), and 20-24 year-olds (2,336 per 100,000). The rates increased by 11% among males and 5% among females. Adolescents (15-19 year-olds) and young adults (20-24 year-olds) have the highest rates and are the majority of cases. In 2015, the gonorrhea rate remained stable at 77 per 100,000 compared to 2014, although from 2004 to 2015 the incidence of gonorrhea increased from 58 to 77 per 100,000 persons (33%). The rates have increased among American Indians (131%), Whites (132%), & API (100%) but decreased among Blacks (55%) while rates among Hispanics have remained stable. Despite the recent decline among Blacks, they continue to have gonorrhea incidence rates far higher than other racial groups. Adolescents and young adults continue to account for a disproportionate amount (47%) of all gonorrhea cases. The number of people in the TGA with primary and secondary syphilis infections in 2015 was 227 (53% of cases in MN). The number of early syphilis cases in MN increased from 49 in 2004 to 431 in 2015, with MSM accounting for 65% of all male cases males in 2015. The disparity in early syphilis rates between males and females remains large and reflects the greater burden within the MSM community. Fifty-two percent of syphilis cases in the TGA in 2015 were co-infected with HIV.

There were 112 cases of Tuberculosis (TB) reported to MDH in 2015, 75% of cases were in the TGA. TB incidence is disproportionately high among racial minorities in MN. In 2015, only 12 cases (8%) occurred among non-Hispanic whites. In contrast, among non-Hispanic persons of

other races, 56% occurred among Blacks and 27% among API. Nine cases were Hispanic of any race. The vast majority of Black TB cases (92%) and API TB cases (98%) were foreign-born. Foreign-born TB cases represented 26 different countries of birth; the most common region of birth was Sub-Saharan Africa (60% of foreign-born cases), followed by South/Southeast Asia (22%), East Asia/Pacific (10%), and Latin America (6%). In 2015, there were 7 cases of TB in the TGA that were co-infected with HIV.

e) Qualitative data. No recent additional qualitative data is available that further illuminates indicators of risk for HIV infection.

f) Vital Statistics. The number of births to HIV-infected women increased from 41 in 2005 to 59 births in 2015. The rate of transmission decreased from 15% between 1994 and 1996 to 1.6% in the past three years, with two HIV-infected babies born to HIV-infected mothers in MN in 2015. The number of deaths among all PLWH infection in MN and the TGA decreased dramatically between 1995 and 1997 and has remained relatively constant since 2001. In 2015, 89 deaths were reported among PLWH infection in MN. The total number of deaths reported in MN for those living with AIDS was 66 (74% of all deaths) in 2015.

g) Other Relevant Program Data. No recent additional program data is available that further illuminates indicators of risk for HIV infection.

**B. FY2017 HIV Care Continuum**

**1) HIV Care Continuum Depiction and Description**.

**Figure 1. Estimated percent of persons (ages 13 years or older) living with HIV in the Minneapolis – St. Paul TGA engaged in selected stages of the Care Continuum**

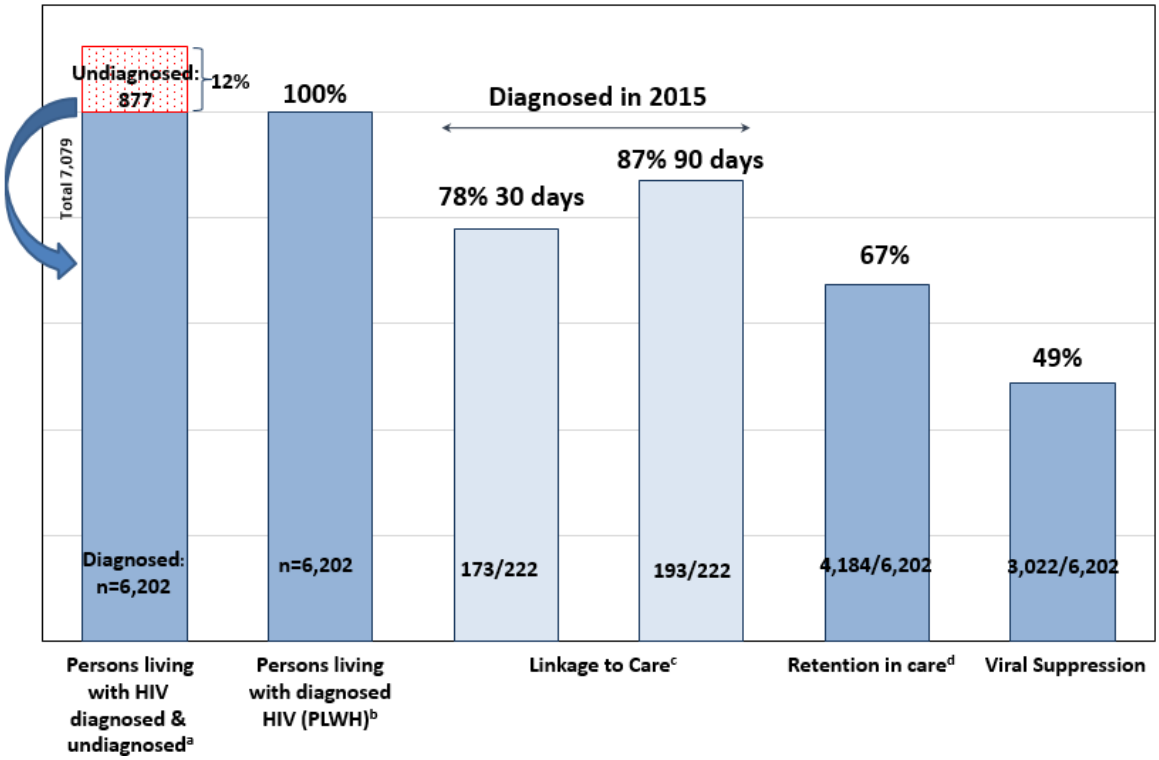



Figure 1 HCC Stage Definitions (numerator/denominator):

***a.*** *Persons living with diagnosed (6,202) and undiagnosed (877) HIV*. Defined as persons undiagnosed and persons diagnosed ages 13 years or older with HIV infection (regardless of stage at diagnosis) through year-end 2014, who were alive at year-end 2015.

***b.*** *Persons living with diagnosed HIV (6,202).* Defined as persons diagnosed ages 13 or more years with HIV infection (regardless of stage at diagnosis) through year-end 2014, who were alive at year-end 2015.
***c.*** *Linkage to care.* Calculated as the percentage of persons linked to care within 30 *(173/122)* and 90 *(193/222)* days after initial HIV diagnosis during 2015. Linkage to care is based on the number of persons diagnosed during 2015 and is therefore shown as a lighter color than the other bars with a different denominator.
***d.*** *Retention in care (4,184/6,202).* Calculated as the percentage of persons who had ≥1 CD4 or viral load test results during 2015 among those diagnosed with HIV through year-end 2014 and alive at year end 2015.
***e.*** *Prescribed antiretroviral therapy (ART*) is not included in MN's mandated HIV surveillance reporting rules and there are no reliable data sources to obtain this stage of the HCC for all persons living with diagnosed HIV in the TGA.
***f.*** *Viral suppression (3,022/6,202).* Calculated as the percentage of persons who had suppressed viral load (≤200 copies/mL) at most recent test during 2014, among those diagnosed with HIV through year-end 2014 and alive at year end 2015.

The prevalence-based HIV Care Continuum (HCC) for PLWH in the Minneapolis – St. Paul TGA (***Figure 1, p. 8***) was developed from surveillance data from MDH and WI Department of Health Service's (WDHS) electronic HIV Reporting Systems (eHARS). MDH uses ≥ 1 CD4 count or viral load test to calculate retention in care since the CDC methodology (≥ 2 documented medical visits, viral load, or CD4 tests three months apart in the measurement year) results in a retention rate lower than the viral suppression rate in MN. MDH's retention measure is in line with the revised U.S. Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (July 14, 2016) for patients with stable viral suppression. Prescribed antiretroviral therapy (ART) is not included in MN's mandated HIV surveillance reporting rules as there are currently no reliable data sources.

The FY2017 HCC that utilizes calendar year 2014 and 2015 HIV surveillance data for the TGA shows a drop of 5% in the rate of retention in care and a 14% drop in the viral suppression rate compared to the FY2016 HCC. Both retention in care and viral suppression had increased from the TGA's first HCC (FY2015) to the second (FY2016). The following table compares retention in care and viral suppression rates over the past three years:

| **HIV Care Continuum (HCC) Stage** | **FY2015 HCC** | **FY2016 HCC** | **FY2017 HCC** |
|---|---|---|---|
| Retention in care | 68% | 72% | 67% |
| Viral suppression | 62% | 63% | 49% |

MDH found that in 2015 fewer viral load tests were reported despite MN's mandatory HIV surveillance reporting rules and a 3% increase in the number of PLWH in the TGA. At least one large HIV medical care provider reported far fewer viral load tests than in 2014 although reporting of CD4 counts did not appear to decline. Incomplete reporting by some providers likely explains the declines in retention in care and viral suppression for the FY2017 HCC.

**2) Disparities in Engagement of Key Populations along the HCC.** HIV surveillance data from 2014 and 2015 on diagnosed PLWH in the TGA elucidates differences in linkage to care, care retention and viral suppression by geography (greater MN v. TGA), gender, race/ethnicity, age and HIV exposure category. Unfortunately, possible incomplete reporting of 2015 viral load tests may mask previously identified disparities along the HCC illuminated by the FY2015 and 2016 HCCs for the TGA. Based on the 2014 and 2015 data used to develop the FY2017 HCC, differences in engagement along the HCC were as follows based on each stage. *Linkage to care*

*within 30 days (78% overall)*: The lowest linkage to care rates were among Hispanics (75%) and PLWH ages 35-44 years (73%). The highest linkage to care rates were among PLWH ages 45-54 years (82%), IDU (83%), and MSM/IDU (100%). *Retention in care (67% overall)*: The lowest retention in care rates were among African born (65%), PLWH with unspecified HIV mode of exposure (65%), Hispanics (60%), and IDU (60%). The highest retention in care rates were among American Indians (77%), PLWH of more than one race (75%), Whites (71%), PLWH ages 13-24(82%), and Heterosexuals (72%). *Viral Suppression (49% overall)*: There were no demographic groups that had viral suppression rates that were more than 2% below the overall rate for the TGA. Women (52%) were more likely to have suppressed virus than men (48%). There were several that had viral suppression rates greater than 2% above the overall suppression rate for the TGA including American Indians (53%), API (54%), PLWH of more than one race (54%), PLWH ages 45-54 (51%), and PLWH 65 years or older (52%).

Previous TGA HIV Care Continua for FY2015 and 2016 indicated more significant disparities in engagement in care experienced by African Americans, African-born and Hispanics who were less likely to be retained in care and have suppressed virus compared to Whites. PLWH who had unidentified HIV exposure were least likely to be retained in care. IDU were least likely to have suppressed virus.

a) Utilization of the HCC to Plan, Prioritize, Target and Monitor resources**.** The Council's September 13, 2016 meeting included a presentation on MN's and the TGA's updated HCC by the MDH's HIV epidemiologist using 2014 and 2015 HIV eHARS data including care continua by gender, race/ethnicity, age, geography and mode of exposure to help identify potential disparities in movement along the HCC. The Council's Planning and Allocations Committee (PAC) uses a local version of this HCC framework developed by the recipient's Quality Management Advisory Committee (QMAC) showing RWP services superimposed on the stages of the continuum to provide greater focus on where resources will have the greatest impact on gaps in the continuum, especially between linkage to care and retention, and populations that are least likely to be retained in care and have suppressed virus.

MDH HIV epidemiologist developed MN's first HCC in 2013 based on 2011 and 2012 eHARS data. A draft was first presented to QMAC for vetting. In 2016, the Council reviewed the 2014 MN HCC prior to both determining their service priorities for FY2017 and 2018, and allocating funds for the FY2017 Parts A and B grant applications. Concerned about the 28% of diagnosed PLWH who are not retained in care, the Council allocated $80,800 for housing assistance to help alleviate waiting lists for the TGA's two HIV housing programs. In FY2016 and for 2017, the Council continued to allocate MAI funds to Medical Case Management (MCM) targeting African Americans and Latinos and OHS for Latinos to address disparities in retention and viral suppression. In 2016, the Council used the HCC to guide development of the 2017-2021 integrated HIV prevention and care plan's goals, objectives, and activities. The HCC based on 2013 and 2014 HIV surveillance data framed their work to reduce racial/ethnic and age disparities in movement along the continuum which is reflected in the integrated plan's third goal to "Reduce HIV-Related Disparities & Health Inequities."

In 2014 during the annual review of the Part A clinical quality management plan at the August QMAC meeting, committee members recommended four goals in line with the National HIV/AIDS strategy for the overall Part A FY2015 and 2016 quality plan that directly relate to the stages of the HCC with a primary focus on increasing retention in care. At least one quality improvement goal in each of the Part A provider quality plans in FY2016 addresses improving retention in care. Recipient staff also incorporates HCC related HHS and HAB linkage, gap in

medical visits, and viral suppression performance measures in monitoring and evaluating effectiveness of all Part A funded services including Early Intervention and Outreach services, OHS and MCM.

b) Utilization of the HCC to Improve Engagement and Outcomes at Each Stage. *Linkage to care*. Part A provides resources for Early Intervention Services (EIS) at the Hennepin County Public Health Clinic (PHC), the largest public health clinic in the TGA; diagnosing 25-30% of the TGA's HIV cases annually. All newly diagnosed PLWH meet with a nurse practitioner at the time of diagnosis and have their blood drawn for CD4 count and viral load tests. In addition, they meet with an HIV positive navigator to arrange follow up appointments and broker internal and external connections with services that support ongoing retention in care. The PHC has a cooperative referral agreement to have a medical appointment scheduled for a newly diagnosed individual within 48 hours at Hennepin County Medical Center's Positive Care Center (PCC), the largest HIV specialty clinic in the TGA. The PCC is a quick skyway walk from the PHC and both clinics share a clinical director. The PHC also has referral agreements with the other four largest HIV primary care providers in the TGA. The PHC provides confirmatory testing for many of the community-based organizations in the TGA that provide rapid HIV testing which broadens the reach of their EIS program. In addition, the PHC receives funding for Medical Transportation, Health Education/Risk Reduction and Psychosocial Support services that facilitate linkage to care and ongoing retention. In FY2015, 90% of the PHC's newly diagnosed clients were linked to care within 90 days. EIS was expanded in 2016 through subrecipient contracts with Full Proof Ministries, a faith-based organization, and North Point Health and Wellness Center, a Federally Qualified Health Center (FQHC). Both operate in north Minneapolis and its northwest suburbs where large populations of African Americans and African-born immigrants reside. These programs will expand testing, linkage to care, and health education activities to two hard to reach populations that have the highest incidence and prevalence rates in the TGA: African American MSM and African-born women.

*Retention*. Data from MNCAREWare suggest that PLWH receiving Part A services in 2015 are more likely to be retained in care (91%) and have suppressed HIV (78%) compared to the TGA's total population of PLWH (***Figure 1, p. 8***). MCM is a key facilitator to improvements across the HCC from linkage to suppressed virus, through its support of ART adherence and mitigation of economic and psychosocial barriers to care. The Council's largest allocation (45%) of Part A funds for services is to MCM. Part A funds provide MCM for patients at the three largest HIV medical specialty centers in the TGA and at Children's Hospitals and Clinics. In addition, Part A and MAI funds for MCM are allocated to a FQHC that provides care to a 25% of MN's Latinos living with HIV and to the African American AIDS Task Force that reaches African Americans experiencing significant barriers to health care access and retention. Through additional Part B and State funded MCM, six community-based organizations including the TGA's largest AIDS service organization, provide retention and treatment adherence interventions for the TGA's PLWH who receive their medical care at other HIV care providers. These resources combined enable any PLWH in the TGA who is RW eligible to receive MCM services until barriers to sustained viral suppression are mitigated. In FY2015, 2,288 or 32% of PLWH in the TGA received MCM services, with 94% retained in care.

In September 2016, Hennepin County PHC began to receive HIV surveillance data on PLWH living in Hennepin County from MDH to implement a data-to-care project. Fifty-five percent of the TGA's population of PLWH reside in Hennepin County. The surveillance data will enable PHC's disease intervention and service navigation staff to reach out to those who are

out of care (no evidence of CD4 count or viral load test in past year) to help them restart their movement across the HCC by connecting them to services they need to support retention and achieve viral suppression. In addition, in March 2016 the Part A grant recipient in collaboration with the MDH and DHS (Part B recipient) began to migrate CD4 counts and viral load values from MN's eHARS into MNCAREWare so these values are known for RWP clients in MN. This will improve MCM monitoring of retention and viral suppression of their clients so they can more effectively target treatment adherence interventions.

*Viral suppression*. With full implementation of the ACA only 4.3% of TGA residents are now uninsured (***Table 1, p. 46***), providing increased access to health care which ought to raise retention and viral suppression rates among PLWH; however, disparities in access to economic supports for health care coverage continue to exist among people of color, particularly those born outside of the U.S. To address these disparities, 15% of Part A and MAI funds combined are allocated to OHS for PLWH born in Latin American countries that do not qualify for Medicaid or Medicare and are unable to obtain a qualified health plan because of immigration status. These OHS programs fill gaps in medical care for those HIV patients who are newly diagnosed or re-entering care and uninsured, temporarily lose coverage, lose employer sponsored coverage, or are awaiting MN's insurance exchange open enrollment. Of the 1,232 PLWH who received a Part A funded OHS service in 2015, 77% had suppressed virus.

c) Evaluation of Efforts to Impact the HCC. HIV surveillance data on diagnosed PLWH in the TGA from MDH's eHARS provides information on linkage to care, care retention, and viral suppression by gender, race/ethnicity, exposure category, and age. The percentages at each stage on the HCC by demographic group provided by the MDH are based on diagnosed cases (the denominator) and are not estimated for the entire population of PLWH. Surveillance data are also used to estimate the proportion of the TGA's population of PLWH who remain undiagnosed based on the CDC's state-by-state estimates published in 2015 (Morbidity and Mortality Weekly Report Vol. 64 /No. 24). MDH develops annual prevalence-based HCCs (since 2013) for the TGA from these data to monitor changes in each stage from year to year. MNCAREWare collects client-level data for all Part A and B funded programs and is used to evaluate the impact of RWP services on client movement along the HCC. All Part A and B subrecipients are required to report twice a year whether their clients had an HIV medical appointment in the past six months and the date of last appointment. These data have been collected in MNCAREWare since 2009. In addition, Early Intervention and Outreach Service providers report if a client is newly diagnosed or previously diagnosed and if they provided linkage services, indicated by a confirmed medical appointment. OHS providers report medical visits, CD4 counts and viral load values quarterly for each of their Part A funded patients.

In 2016, as more eHARs data is brought into CAREWare, Hennepin County RWP staff are able to access more accurate and timely data along the HCC. With greater access to timely data, staff can begin to create, analyze, and share HCCs by gender, race, age, risk factor, and provider. The goal in FY2017 is to more readily share HCC with providers in aggregate and by disproportionally affected populations to understand where disparities exist, where performance is lacking, and to develop strategies to target gaps and disparities more precisely. Moreover, Part A grant recipient staff in conjunction with staff administering MNCAREWare hope to develop mechanisms, protocols, and training for providers to be able to log into CAREWare and analyze their own HCC at any point to empower them to understand their real time performance and develop strategies to help improve outcomes along the HCC for their clients.

d) Dissemination of HCC Planning and Evaluation Information. Each summer, MDH presents an updated HCC for both MN and the TGA to the Council. The Council includes at least 11 unaligned consumers and representatives from seven RWP Part A and B subrecipient agencies. The updated HCC includes breakouts by gender, race/ethnicity, age, and HIV exposure. The Part A Program Quality Management Coordinator (QMC) presents an annual QM update to the Council in the fall that includes HRSA/HAB retention in care, prescribed ART and viral suppression performance measures. MDH also presents the most current MN and TGA HCC at MN's annual All HIV Prevention and Care Provider meeting which includes over 100 staff from RWP Part A and B funded subrecipients and CDC HIV/AIDS Prevention Program funded agencies in MN. This meeting is jointly sponsored by Hennepin County (Part A recipient), DHS (Part B recipient) and MDH. In preparing for the Council's biennial RWP Part A and B service prioritization and funding allocations, the Council's Needs Assessment and Evaluation Committee (NA&E) prepares Service Area Review Summaries (SARS) for each of the funded service categories that includes the most current service specific HRSA/HAB and DHHS HIV performance measures used to evaluate service outcomes. The Committee presents the SARS to the full Council during their meetings two months in advance of their ranking of service priorities and allocations of Part A and B funds to the priorities. The Part A Quality Management Coordinator (QMC) also reviews HCC performance measures with QMAC is co-convened by the Part A and B grant recipients and includes representatives from all of MN's RWP funded service areas. In addition, the SARS and Part A annual grant applications are posted on the Council's website with notices of website postings on the Council's Facebook page.

**C. Demonstrated Need**

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

There are an estimated 877 PLWH who are unaware of their infection in the 13-county Minneapolis-St. Paul TGA as of the end of 2015. This estimate uses 2015 HIV surveillance data from the Minnesota (MN) and Wisconsin Enhanced HIV/AIDS Reporting Systems, and the CDC methodology for estimating the population of PLWH who are unaware of HIV infection as reported in of the CDC's Morbidity and Mortality Weekly Report Vol. 64 /No. 24.

The TGA's EIIHA data includes HIV testing data reported by the Ryan White Program (RWP) Part A Early Intervention Services (EIS) provider as well as EvaluationWeb data submitted by MN Department of Health (MDH) funded HIV counseling testing and referral (CTR) providers. Currently, there are 9 clinic and 3 community-based MDH funded CTR service providers in the TGA. Five of the CTR providers also deliver Part A, Part B, state or ADAP rebate funded services including Medical Case Management (MCM), Psychosocial Support and Medical Transportation Services. In FY2015 and 2016, Hennepin County Public Health Clinic's (PHC) Red Door Services, the largest publicly funded HIV testing site in the TGA and MN, received RWP Part A funding to provide EIS. In 2015, MDH funded CTR providers reported 12,879 HIV test events, identifying 37 newly diagnosed cases of HIV. Red Door, PHC Refugee Health Screening Program and Health Care for the Homeless conducted 9,789 HIV tests in FY2015 and identified 68 newly diagnosed cases of HIV. Combined, MDH's CTR funded programs and Red Door Services identified 41% (105/256) of newly diagnosed HIV cases in the TGA in 2015.

**FY2017 EIIHA Plan**

a) Process for Linking People Identified in EIIHA Data to Prevention and Care Services

All HIV CTR service providers funded by MDH and EIS service providers funded by RWP Part A in MN have protocols for linking newly and previously diagnosed PLWH to HIV medical

care and directly provide or refer high-risk testers for HIV prevention services. Linkage protocols adhere to the MN RWP EIS and Outreach services standards of care. Red Door's EIS program provides Fast Track and Concierge services for both newly and previously diagnosed patients. Any individual identified with HIV through their program is offered initial clinical services including a health assessment with a nurse practitioner, CD4 and viral load testing and STI screening upon receiving a fourth generation rapid reactive HIV antibody test. All EIS clients meet with a services navigator that schedules their first clinic visit, often within 48 hours, arranges transportation to the appointment if needed, and connects them to Medical Case management and other linkage and retention facilitating services. The navigator follows up until linkage to medical care is established and insurance is obtained if needed, and also provides ongoing risk reduction counseling, referral of partners to their PrEP program and information on HIV services and how to access them. In 2015, of the 37 cases newly diagnosed through MDH's CTR programs, 24 (65%) were confirmed linked to HIV medical care. Of the 38 individuals newly diagnosed through Red Door Services, 34 (90%) were confirmed linked to care.

The TGA's RWP Part A collaborates with MDH on EIIHA data collection and coordinates implementation of EIIHA activities including Part A funded Early Intervention and Outreach services with CDC and state-funded CTR programs. The Part A Program also coordinates its EIIHA activities and planning efforts with the Minnesota Department of Human Services (DHS), MN's Part B recipient. MN's Part B grant and ADAP rebate revenue fund additional EIS programs targeting disproportionately impacted communities including African American MSM and transgender women of color. The Part A Program serves as administrative agent for these funds to ensure uniform service standards, program monitoring, and to prevent duplication.

b) Planned MSP-TGA EIIHA Activities for 2017

*(1) Primary Activities*

***Promote and Assess Implementation of Routine HIV Testing among Hennepin County Operated Primary Care Providers***. Hennepin County operates the TGA's largest public health clinic, two Federally Qualified Health Centers including Health Care for the Homeless (HCH) and NorthPoint Health and Wellness Center, and Hennepin Health, a Medicaid accountable care organization. In addition, Hennepin County Medical Center (HCMC), is the only publicly managed health care facility in MN and has the largest indigent patient population in the state. In FY2015, Hennepin County's Part A Program convened a group of 50 key HIV care and community stakeholders to develop an HIV strategy for the County where 55% of MN's PLWH reside. Out of this strategy development process, HCMC established a plan to implement routine HIV testing through HCMC's electronic health record (EHR). As a result, the EHR now includes an HIV test on the health maintenance screen. This alerts primary care clinicians to include HIV testing as a routine procedure during primary care visits based on the CDC guidelines. HCMC began institution-wide routine testing based on EHR alerts on December 1, 2015. It is estimated that 30% of their client population had an HIV test by December 31, 2014. NorthPoint Health and Wellness uses the same EHR and also began providing their clinicians health maintenance alerts for HIV screening on December 1, 2015. NorthPoint's baseline assessment of HIV screening was at 53% as of December 31, 2014. Health Care for the Homeless implemented routine HIV screening in 2011 and as of December 31, 2015, 24% of their patients had been screened for HIV infection. In 2017, Hennepin County public primary care providers will continue to monitor HIV screening rates of their patient populations. In addition, the Part A coordinator has approached Hennepin Health about improving routine HIV screening rates as a quality goal in 2017. The Part A Program also promotes implementation of routine HIV testing

according to CDC guidelines and the U.S. Prevention Services Task Force's recommendation for HIV screening by the TGA's other major health care providers. Health Partners incorporated routine HIV screening into their EHR system in 2015.

***Early Intervention Services.*** In 2016, the Minnesota Council for HIV/AIDS Care and Prevention (Council) increased the Part A allocation for EIS from $41,300 to $158,400. In FY2017, two new EIS providers will be funded including an African American faith-based organization, Full Proof Ministry, and NorthPoint Health and Wellness Center that is located in the heart of Minneapolis' Northside neighborhood with the highest proportion of African American residents in the city. The faith-based organization will increase access to HIV testing among African American MSM and high-risk women in the community. NorthPoint Health and Wellness Center will increase testing opportunities through their Man Clinic that provides STI testing and treatment for uninsured African American men and through their community health outreach programs. Full Proof Ministry and NorthPoint established a partnership to ensure access to clinical care for newly diagnosed PLWH.

The Part A program will continue to fund the EIS Fast Track and Concierge services provided by Hennepin County's PHC, the TGA's largest public health clinic. Through Red Door services, the PHC has historically diagnosed 25-30% of the TGA's HIV cases. In addition to increased testing of EIIHA targeted populations, the program links clients to clinical services immediately instead of waiting for confirmatory results to become available. An on-site peer navigator provides immediate support and assistance with navigating the healthcare system. On-site Disease Investigators meet with newly diagnosed individuals to maximize opportunities for partner notification and testing. To achieve the goal of connecting clients to an appointment within 48 hours of their initial test, the program helps clients overcome any barriers to attending the appointment such as insufficient health insurance or transportation. This includes, for Fast Track clients (uninsured) who receive a positive rapid test result, meeting with an HIV nurse practitioner, performing a confirmatory test, initial CD4 count and viral load test, STI screening, and obtaining releases of information so that test results may be conveyed to their future HIV primary care providers. Clients receiving Concierge services are assessed for barriers due to transportation, stigma, or emotional support needs, and then receive services to address these barriers and assist them to follow up with medical appointments. Clients with a more complex needs are referred to a MCM program. In 2015, the Red Door's EIS conducted 6,880 HIV test events with 38 positive results. The EIS provider linked 34 of 38 newly diagnosed clients (90%) to HIV medical care. In 2016, the MN DHS allocated $170,000 from ADAP pharmaceutical rebate revenue to increase HIV testing opportunities among African American and Latino MSM and transgender women of color by expanding the capacity of EIS in TGA. The Part A Program will be the administrative agent for these funds to coordinate with Part A funded EIS activities. These funds will increase the capacity of Red Door services to test members of these communities and to employ their Fast Track and Concierge services to successfully link newly identified individuals with HIV to care.

***Enhanced Partner Services.*** MDH's CareLink program expands Disease Investigation/Partner Services to include testing, referral, and linkage to care services in addition to the usual scope of identifying and notifying partners of newly diagnosed PLWH. The program refers them to Parts A and C funded EIS or HIV primary medical care, Part A and state funded MCM programs, and follows up with PLWH and their identified partners to promote testing and linkage to care. Targeted populations include African-born women and men of color who have sex with men (MCSM) who were not linked to care within 90 days of diagnosis. The CareLink staff has had

some success by using a personalized, holistic, care-driven approach that enhances trust, decreases stigma, and motivates recently diagnosed individuals to help identify and reach partners who may have been exposed. Because of this success, an additional Disease Investigator was added to the program team at the Hennepin County PHC in 2014 to increase its capacity for Partner Services and will continue in 2017.

***Improved Outreach*:** The recipient will continue to implement and evaluate the TGA's local Outreach service standards of care to improve cost effectiveness. In late 2014, data collection began on the number of clients referred and linked to ongoing HIV medical care by Outreach services. In FY2015, the two Part A Outreach services providers reported 1,763 unduplicated client contacts, where at a minimum the Outreach worker had a conversation with the client about their HIV status, risk, and if HIV-positive, their care status. Of the 22 HIV cases of PLWH found in FY2015 who were not in care, 7 were newly diagnosed and the 15 who had been previously diagnosed had not received HIV medical care in more than six months. Informed by Outreach services data and annual site visit client chart reviews, recipient staff will provide technical assistance to outreach programs to develop strategies to increase the yield of contacts with people who are unaware of their HIV infection and those who are aware and are out of care.

***Data-to-Care Initiative***. Fifty-seven percent (57%) of new HIV diagnoses in MN in 2015 reside in Hennepin County. In September 2016, Hennepin County's PHC began receiving HIV surveillance data on PLWH in the County from MDH's electronic HIV/AIDS Reporting System (eHARS) to identify those who have been diagnosed and are out of care based on last date of CD4 count and viral load test. Adapting a protocol developed by the Seattle/King County Public Health Department, PHC epidemiology staff are now able to create an out-of-care line list from eHARS of PLWH residing in the County that the PHC's Disease Investigators and HIV health care navigator will use to contact and assist in re-engaging in HIV medical care. The PHC also has limited access to electronic health records of County residents receiving medical care at County operated health care facilities which may provide additional information on care status of those who did not have a CD4 or viral load result reported to MDH. The PHC will facilitate care re-engagement and connection to services to support on-going care retention for those contacted and not in care. An additional $85,000 in ADAP rebate income will support this effort in 2017.

***Convene Minnesota's EIIHA Workgroup to Coordinate Activities***. The Part A Quality Management (QM) Coordinator will convene MN's EIIHA workgroup in 2017 to continue to coordinate EIIHA activities throughout MN and the TGA. The workgroup was established in 2009 to ensure a collaborative and coordinated effort to decrease the proportion of MN's HIV infected population that is unaware of their status. The workgroup shares successful strategies, recommends target populations, EIIHA interventions, and outcome measures. Primary workgroup objectives include coordinating activities, fostering partnerships between providers, and to assess overall EIIHA progress in MN. The QMC maintains an annually updated matrix of EIIHA activities that includes services, target populations, providers, and recipients involved in the activities. At the March 2016 EIIHA workgroup meeting MDH presented an updated estimate of the population of PLWH in MN who are unaware of status using the CDC's 2015 state-by-state estimates. As a result, MDH committed to providing additional geographic data on those who may be unaware of their status.

*(2) Major Collaborations with Other Programs and Agencies*

***EIIHA Workgroup***. The Part A recipient continues to facilitate this collaborative effort with MN's Part B (DHS) and CDC HIV prevention (MDH) recipients. Its ongoing mission is to recommend coordinated strategies to identify, diagnose and link the HIV unaware with testing,

prevention resources, appropriate referrals and HIV medical care. Membership in the workgroup includes representatives from Council and MN's RWP Parts A, B, C, D and F recipients. Also active in the group are HIV care, prevention and testing providers, and consumers. The Part A Program establishes its EIIHA goals based on the workgroup's recommendations.

***Minnesota Department of Health (MDH).*** As the state's CDC prevention and testing grant recipient, MDH facilitates understanding of the relationship between prevention and RWP care services and their common goals to the Council. MDH reports to the Part A recipient and Council on changes in the state's HIV epidemiological data. RWP Part A EIIHA target populations are selected based on information provided by MDH staff in the EIIHA workgroup, eHARS, and EvaluationWeb. The Government HIV Administrative Team (MDH, DHS and Hennepin County) meet thrice annually to coordinate all state and local RWP and funded care programs with CDC and state-funded HIV testing and prevention programs to ensure efficiency, consistency, and coordination.

***Minnesota Council for HIV/AIDS Care and Prevention (Council).*** The Council first convened in February 2016 and serves as the single integrated HIV care and prevention community planning body for MN and the TGA. The new Council combines representatives from HIV prevention and HIV care programs in the TGA and state. The initial goals, target groups, and activities of MN's coordinated RWP EIIHA efforts were presented for input and approval to the former MN HIV Services Planning Council. Annual updates on EIIHA activities are presented during Council meetings. Council members, who represent consumers and providers receiving Part A and B and CDC HIV prevention funding, are also active participants in the EIIHA workgroup. EIIHA activities are incorporated in the Council's new 2017-2021 Integrated HIV Prevention and Care Plan. This integrated planning approach helps those working on care and prevention in MN to collaborate, improving EIIHA coordination and efficacy of activities.

***Minnesota Department of Human Services (DHS).*** As the state's Part B recipient and Medicaid agency, DHS' ADAP Coordinator is a member of the Council. In addition, DHS HIV Quality Coordinator is a member of the EIIHA workgroup and co-convenes the cross parts and HIV prevention Quality Management Advisory Committee with the Part A Program QMC. DHS funds additional EIS and Outreach services through Part B supplemental and ADAP rebate program income funding which is administered by the Part A Program to ensure coordination of RWP funded activities. Coordination of Part A and B funding in this manner provides comprehensive services to targeted populations that facilitate linkage to care and supports ongoing retention in care for those who are newly diagnosed or re-engaged.

***Providers***. MDH, MN's CDC HIV Prevention Program recipient, serves as the administrator of MN's joint Part A and B client-level database, MNCAREWare, enabling coordination with HIV surveillance data. On March 1, 2016, the Part A Program, MDH, and DHS embarked on a collaborate project to migrate CD4 count, viral load, HIV and AIDS diagnosis dates and vital statistics into MNCAREWare. The ultimate goal is to improve outcomes along the HIV Care Continuum through better performance measurement and evaluation of Part A and B funding. The Part A Program also works with the Hennepin County PHCs to increase routine HIV testing of patients presenting for STI tests and MSM through outreach and at the HCH and the refugee health clinics. Other EIIHA collaboration includes Part A Program efforts to increase routine HIV testing HCMC, NorthPoint Health and Wellness, Part A funded providers of Outreach, Food Bank and Onsite Meals, and Medical Transportation services. These programs are expanding HIV testing efforts, and increasing outreach, specifically to young gay and bisexual men, transgender women of color, and African Americans and African-born. All RWP funded

providers engaging in EIIHA activities, including those that do not provide EIS and Outreach services, participate in the EIIHA workgroup including the TGA's Part C and D recipient.
*(3) Anticipated Outcomes of Overall EIIHA Strategy.* The recipient will continue collaborating with MDH, DHS, and the EIIHA workgroup, to further define specific EIIHA objectives. Each activity will have baseline measures, data collection timelines, and improvement goals. Anticipated outcomes of the overall strategy are as follows:

1. Increase the proportion of HCMC and NorthPoint Health and Wellness patients screened for HIV.
2. Increase HIV testing of members of EIIHA target groups in the TGA including African American and Latino MSM, young MSM, transgender women of color and African-born.
3. Improved HIV and AIDS diagnosis date, CD4 count and viral load test data for Part A clients.
4. Increase the percentage of people in the target groups in the TGA linked to initial HIV medical services within 30 days of HIV diagnosis.
5. Increase the percentage of people in the target groups in the TGA who have a CD4 and/or viral load test reported to MDH within 30 days of HIV diagnosis from the 2015 30-day linkage percentage of 78%.
6. Increase in the proportion of PLWH in Hennepin County who are aware of their status and not in care who are re-engaged in HIV medical care within 30 days of initial contact.

c) <u>FY2017 EIIHA Plan Contributions to the National HIV/AIDS Strategy (NHAS) 2020</u>
*(1) EIIHA plan contributions to improving health outcomes along the HIV Care Continuum.* The Part A Program's EIIHA plan facilitates rapid linkage to HIV medical care for the newly diagnosed and allows for ongoing support for care retention and viral suppression. The EIIHA plan will help reduce the portion of PLWH in the TGA who are unaware of their status and decrease new HIV infections through increased opportunities for HIV testing and diagnosis among targeted populations in the TGA, including MSM (particularly young MSM, YMSM), African American, African-born and Latino. The EIIHA planned activities also focus on engaging partners and social networks of the newly diagnosed; late testers and high-risk and comorbid populations (e.g., substance abusers, Hepatitis C infected, and the homeless) to be tested and linked to care if found to have HIV.

The EIIHA plan's EIS create an easier-to-navigate continuum of services so unaware individuals can rapidly go from testing to diagnosis to care with minimal steps and barriers. EIS and Outreach services build and maintain formal and functional referral relationships with points of entry outside the RWP system as well as with primary care and MCM which increase opportunities for HIV testing, improved system navigation, and ultimately care access. Referrals to MCM for the newly and previously diagnosed helps assure ongoing support for retention through connections to other services that assist in overcoming barriers including mental health and chemical dependency treatment, medical transportation, and assistance with basic needs. Both Early Intervention and Outreach services' linkage protocols include referrals to MCM which is a key service in the continuum of care that serves as an "access hub" for clients with multiple unmet medical and basic needs. EIS navigators and Outreach staff follow up on MCM referrals to help ensure ongoing retention in medical and medication adherence support until viral suppression is achieved.

EIS at Hennepin County's PHC, help newly diagnosed individuals to gain confidence to navigate HIV care system, increase the likelihood that they will link to an HIV medical provider at the time of diagnosis, and adhere to treatment. This reduces risky behaviors while lowering

viral load, both of which will reduce new infections. In addition, the PHC has on-site disease investigation staff to reach out to partners and offer in-clinic and field HIV testing. The PHC also has the largest PrEP program in MN funded through an MDH HIV prevention grant. EIS navigators also assist with enrolling clients in ADAP and obtaining insurance coverage.

Outreach activities that re-engage in care those aware of their HIV infection also provide linkage services and access to partner testing. Outreach services utilize peer support models that simultaneously reduce stigma and promote communication among peers on the importance of early antiretroviral treatment to maintain good health, community resources to help access medical care, and other core medical and supportive services that support medical care retention.

The plan addresses HIV-related health disparities by targeting populations such MCSM, partners of late testers, African-born individuals, and other communities that are disproportionately represented in the local epidemic for testing and connection to care. Successfully engaging these populations in care earlier will help increase rates of linkage to care, care retention and suppressed virus. The EIIHA plan addresses HIV-related health disparities by increasing the capacity of the healthcare and social service system in the TGA to recognize clients at risk of HIV infection and facilitate their referral and access to RWP services. The EIIHA plan's capacity development activities promote routine testing among publicly funded health care providers in both community and clinic settings for high-risk African Americans, and the development of culturally appropriate sexual health assessments and prevention interventions for African-born individuals.

With 65% of the TGA's 2015 newly diagnosed with HIV residing in Hennepin County, the TGA's Part A recipient, Hennepin County Public Health Department (PHD) began developing "HIV Free Hennepin" the Hennepin County HIV Strategy. The strategy, to be released on 2016 World AIDS Day, aligns all County HIV public health efforts with the NHAS goals. The strategy's goals are to reduce new infections, ensure access to and retention in care and improve health outcomes, and engage and facilitate the empowerment of disproportionately affected communities to prioritize the elimination of HIV. The strategy will integrate HIV care throughout the County's health and human services system and promote health equity to eliminate HIV health-related disparities.

*(2) Innovative EIIHA plan approaches*. The following EIIHA efforts in the TGA are innovative approaches to improving outcomes along the HIV Care Continuum (HCC):

- Integrating care and prevention efforts. In 2015 MN's Part A and B recipients joined with MN's CDC HIV prevention recipient, MDH, to create one HIV prevention and care community planning body for the state. The new Council convened in February 2016. One of its first tasks was to develop the TGA and State integrated HIV prevention and care plan for 2017-2021. By aligning and integrating HIV prevention and care efforts, as supported by NHAS' fourth goal and the White House Care Continuum Initiative, efforts to improve access to testing, linkage to care, and retention in care will be more coordinated and efficient across the state and the TGA. Duplicated efforts will be minimized, allowing for increased focus on areas of need, like reducing HIV-related health disparities and filling gaps along the HCC such as earlier identification of at-risk individuals, the unaware and those out of care.
- Routine HIV testing. Since 2011, Hennepin County PHCs have provided routine HIV testing for patients, but other providers in the TGA have not necessarily done so. HCMC, a subsidiary of Hennepin County, has the largest indigent patient population in the state. In FY2014, Hennepin County's RWP Coordinator and QMC met with leaders of Hennepin County Government's primary care clinics, including HCMC, and the County's Medicaid managed care program to

promote implementation of routine HIV testing according to the CDC guidelines across all County primary care facilities. As a result, HCMC began working with their electronic health record (EHR) administration staff to include an HIV test on the health maintenance screen in EPIC. This alerts HCMC primary care clinicians to include HIV testing as a routine procedure during primary care visits. In FY2016, Part A recipient staff have continued to work with leaders of the County's primary care organizations to promote implementation of routine HIV testing in all County operated primary care settings. HCMC's PCC along with NorthPoint Health and Wellness Center, the County's FQHC located in the heart of Minneapolis' African American Northside neighborhood, began routine testing based on EHR alerts on December 1, 2015. Currently, it is estimated that 30% of their patient population has had an HIV test, but that is expected to increase as the new program is implemented. Another RWP funded primary care provider, Health Partners, has also begun routine HIV testing for all patients. This expansion of HIV testing will likely identify new positives, reduce the number of PLWH who are unaware of their status, and allow for opportunities to link to HIV medical care. Improving linkage to care, and retention in care will ultimately lead to higher viral suppression rates in the TGA, which supports goals to improve outcomes along the continuum.

- Disparities Elimination Committee of the Council. As the new Council convened in 2016, the Disparities Elimination Committee (DEC) formed, composed of stakeholders with an interest and expertise in advancing HIV health equity for populations disproportionately impacted by HIV in the TGA and state. The EIIHA activities aimed at improving testing, Outreach services, CareLink, Fast Track and Concierge services and referrals to care for YMSM, MCSM, and African-born communities will include efforts to reduce HIV-related health disparities experienced by these communities along the HCC. The Council's DEC, Needs Assessment and Evaluation, Planning and Allocation Committees along with the EIIHA workgroup will monitor these efforts and their outcomes to ensure services and activities addressing disparities are prioritized, implemented and measured. DEC will address emerging disparities and to prioritize evidence-based solutions for emerging communities in the TGA in order to improve health outcomes for these populations. This innovative approach aligns with White House HIV Care Continuum Initiative goal to address barriers to testing and treatment for communities in need.

*(3) Collaborations to strengthen HCC outcomes*. Many of the RWP Part A and B funded providers of Outpatient Health Care, EIS, Outreach services, HE/RR, and more will be partners with both Part A and B recipients in EIIHA activities. The Part A Program works in partnership with Hennepin County PHCs to increase routine HIV testing for: patients presenting for STI tests; MSM prevention and care outreach programs; HCH, and refugee health clinics. The TGA's Part A Program also works with three community-based organizations that provide RWP Outreach, Food Bank and Onsite Meals, and Medical Transportation services to coordinate HIV testing. These programs are expanding outreach and HIV testing efforts, specifically to young MSM, African American and African-born individuals, and those with substance use disorders. All RWP funded providers engaging in EIIHA activities participate in the EIIHA workgroup including the TGA's Part C and D programs. The EIIHA workgroup will continue to meet annually to plan and assess EIIHA activities and outcomes. As the state's CDC prevention and testing recipient, MDH has a position on Council to facilitate understanding of HIV testing and prevention programs and outcomes. MDH also reports to the Part A recipient and Council routinely on changes in the state's HIV epidemiological data and HCC. Data from the state's eHARS and MDH's testing and Disease Intervention/Partner Services databases, informed the selection of the target populations for the recipient's EIIHA efforts. The Government HIV

Administrative Team (MDH, DHS and Hennepin County) holds three meetings annually to coordinate all state and local RWP funded care programs with CDC and state-funded testing and HIV prevention programs to ensure efficient use of resources and consistent policies and standards of care. The initial goals, target groups, and activities of the recipient's EIIHA efforts were presented for input and approval to the Council. Regular updates on EIIHA activities are presented during Council meetings. Council members, who represent funded providers and consumers, as well as Council staff, are active participants in the workgroup. EIIHA activities are incorporated in the TGA and MN's 2017-2021 Integrated HIV Prevention and Care Plan. As the state's Part B recipient and Medicaid agency, DHS's ADAP Coordinator is a member of the Council and DHS HIV Quality Coordinator is a member of the EIIHA workgroup. DHS funds additional Outreach services through Part B supplemental funding and ADAP rebate program income which is administered by the Part A Program to ensure coordination of RWP funded activities to identify the HIV unaware and link them to care. Coordination of Part A and B funding provides comprehensive services to targeted populations that facilitate linkage to care and supports ongoing retention in care and sustained viral suppression for those who are newly diagnosed or re-engaging in care.

*(4) Use of EIIHA data to analyze and address gaps along the HIV Care Continuum (HCC).* Evaluation of the TGA's progress in reducing the gaps between the HCC stages of HIV diagnosis and linkage to care is informed by eHARS data on the proportion of PLWH diagnosed each year that receive a CD4 count or viral load test within 30 and 90 days. (see ***Figure 1***, p. 8). Part A funded EIS and Outreach services outcome data collected through MNCAREWare provide information on the impact of EIIHA interventions including case finding, referrals, linkage to medical care, and health education and risk reduction counseling. Beginning March 1, 2016, HIV and AIDS diagnosis dates, CD4 count and viral load test values and vital statistics from eHARS began to be uploaded into MNCAREWare for RWP Part A and B clients who signed a release of information for transfer of their surveillance data. Through the development of data agreements between MDH, Hennepin County, and DHS, the need for RWP clients to sign a release of information is anticipated to be eliminated in 2017. This will result in more complete diagnosis date, CD4 count and viral load data for all Parts A and B funded service recipients. These data inform EIIHA service improvement efforts and innovative interventions to reduce the proportion of the TGA's PLWH are unaware of HIV infection and not engaged in care and increase the proportion of newly diagnosed cases linked to care within 30 days of diagnosis.

(d) Unmet Need Estimate and EIIHA Planned Activities. Using 2015 HIV surveillance data from MDH and WI Department of Health Services and using the CDC criteria for retention in care, 43.4% of the TGA's PLWH who were aware of their status were estimated to be retained in care. This is likely a significant underestimate of those retained in care given that an estimated 49% of the TGA's PLWH who are aware of their status are virally suppressed and it is unlikely that all PLWH retained in care are virally suppressed. Thus, the Unmet need estimate of 56.6% using the CDC's HCC methodology is likely an overestimate of jurisdiction's Unmet Need. In addition, the estimate of viral suppression of diagnosed the TGA's PLWH declined from 63% in 2014 to 49% in 2015. MDH is investigating the significant decline in viral load tests reported to MN's eHARS in 2015. Lack of complete viral load test reporting by some clinical providers is a possible cause of the 2015 declines in retention and viral suppression measures, limiting the ability to use the current Unmet Need estimate to inform EIIHA planned activities for 2017. Given these data limitations, the demographics of recent Unmet Need estimates helped select the 2016 and 2017 EIIHA activities' target populations.

The EIIHA activities of EIS and Outreach services focus on increased testing and linkage to care among African American and young MSM as 57% of PLWH out of care identified as MSM or MSM/IDU and 30% as Black (African American and African-born). Part A funding allocations for EIS activities in 2016 and 2017 increased by $117,100. These funds are supporting two new programs through a faith-based and clinic-based organization on the Northside of Minneapolis to expand testing and linkage services for African Americans and the African-born. Additional EIIHA activities including targeted outreach, routine HIV testing at Hennepin County PHCs, enhanced Partner Services, and a peer navigator model to facilitate linkage to care will focus on communities of color including African-born, YMSM, and MCSM. EIIHA services. Fast Track and Concierge, more focused Outreach services, and Health Education/Risk Reduction (HE/RR) are designed to address barriers to testing, receiving test results, navigating healthcare systems, and behavioral change to reduce HIV transmission. The Part A recipient is working collaboratively with MDH and DHS (MN's Part B recipient) to integrate RWP client-level data with surveillance data to improve estimates of linkage to- and retention in- care for all RWP Part A and B clients. One benefit of this project will be the ability to demonstrate the impact on viral load of PLWH of RWP clients compared to overall TGA and state viral load estimates. These data will inform further plans to target services to populations that are most prominent in the annual Unmet Need Estimate.

e) Influence of FY2016 EIIHA Plan on FY2017 EIIHA Plan. The expansion of EIS through the additional $117,100 Part A allocation in FY2016 will continue in FY2017 to increase testing and linkage services for African Americans, especially African American MSM and high risk women. Continuation of other EIIHA activities in 2016 into 2017 was informed by successful outcomes of FY2015 activities. The Fast Track and Concierge programs had a high linkage rate of 90% for newly diagnosed MSM including young MSM and MCSM. Continued success of routine HIV testing for patients screened and/or treated for chlamydia, gonorrhea and syphilis, along with the high positivity rate among STI clinic patients who are MSM necessitates continuation of this cost effective approach in 2017. The EIIHA workgroup will continue to ensure coordination of activities conducted by RWP and CDC prevention recipients and subrecipients, especially those not receiving RWP Part A funding for EIIHA interventions.

The data-to-care project that began in 2016 will continue into 2017. In 2016, the data agreement with MDH to share HIV surveillance data on Hennepin County residents living with HIV with the County's PHCs was executed and protocols were developed to create the case finding line lists of PLWH who had not had a CD4 or viral load test reported in the designated time period. The PHC's HIV Care Navigator was trained by CDC to serve as a disease intervention specialist in 2016. The first results of this data-to-care approach to care linkage and re-engagement will be available in 2016 and will inform 2017 improvement of program processes and interventions.

f) Plans to Remove Legal Barriers to Routine HIV Testing. MN has no state or local laws that present legal barriers to routine HIV testing.

g) Three FY2017 EIIHA Target Populations. Epidemiological and Unmet Need data, HIV testing data from MDH and Part A funded EIS programs, the TGA's 2015 HIV Care Continuum and the EIIHA Workgroup recommendations inform the selection of the following populations for focus in the 2017 plan: 1) Young MSM ages 13-29; 2) African American MSM and 3) African-born individuals. The Part A Program goals for disproportionately impacted populations include reducing new HIV infections and ensuring that people are diagnosed and in care early to improve individual and community health outcomes.

Young Men Who Have Sex with Men (YMSM)

*(1) Why YMSM were chosen*. In 2015, 66 of the 259 incident cases of HIV, or 25% of new cases in the TGA were among YMSM ages 13-29. Ninety-three percent of adolescent and young adult males diagnosed with HIV infection in 2015 identified as MSM or MSM/IDU. There was a slight increase of new infections among YMSM from 63 to 66 from 2014 to 2015; however, between 2011 and 2015 there was a 43% increase in new infections among African American YMSM. Of all MSM diagnosed in 2015, 49% were between the ages of 13 and 29 years. Among 2015 MDH funded HIV testing events, only 16% were among YMSM. The number of YMSM living with HIV in the TGA has doubled in the past five years and YMSM represented 11% of diagnosed MSM living with HIV in the TGA as of December 31, 2015. The TGA's 2015 HIV Care Continuum, indicates that MSM 13-24 years of age are less likely have suppressed virus (37%) compared to MSM overall (48%).

*(2) Specific challenges*. YMSM may be less likely to interact with the healthcare system, particularly if they have no connection to a clinical provider who is competent in caring for gay and bisexual men. Data from Hennepin County's 2010 Survey of the Health of All the Population and the Environment (SHAPE 2010) show that gay, bisexual, lesbian and transgender (GBLT) residents are significantly less likely to have a regular source of health care compared to their non-GBLT peers. Only 35% of gay and bisexual males had a physical exam in the past year compared to their non-gay or non-bisexual male counterparts (57%). Despite these challenges, in FY2015, EIS and Outreach services identified 37 new cases among YMSM and helped 32 (86%) of them engage in care, and identified 3 previously diagnosed YMSM and engaged all 3 (100%) in care. In the 2015 Comprehensive Needs Assessment (2015 CNA), which included responses of 504 PLWH in MN, 65% of MSM reported receiving EIS after diagnosis. Also, 82% percent of MSM reported having a case manager to coordinate HIV medical care and access to other services. Therefore, it is possible, though challenging, to identify MSM, and YMSM, who are in need of and benefit from EIIHA activities. Opportunities to reach this group likely lie in their access to, and comfort with, social media.

*(3) Specific activities for YMSM include*:

- Scale up targeted EIS testing by funding two new EIS providers on Minneapolis' Northside.
- HIV screening through the Hennepin County PHC's Red Door Services' STI and HIV testing, and PrEP program.
- Fast Track and Concierge services aimed at assisting YMSM who test positive to connect quickly with clinical services, often immediately after a rapid test, to begin linkage to clinical care and support, and to identify and address barriers such as having a substance use disorder, dependence on parental insurance, stigma and isolation, and concerns about confidentiality.
- HE/RR services to provide young men with accurate knowledge about their sexuality and HIV risk, and effective prevention and harm reduction strategies, will be provided with EIS for YMSM testing positive at the PHC.

*(4) Specific objectives for early identification of HIV/AIDS among YMSM:*

- Increase the number of YMSM testing by the end of FY2017 at Hennepin County's PHC and through Part A funded EIS and Outreach services through social media, enhancing partner services, routine testing of MSM receiving STI screening and treatment and HIV screening for PrEP enrollment by 10%.

- Provide Fast Track and Concierge services to ensure that by the end of FY2016: 100% of results are received through rapid testing and follow up by disease intervention staff; 95% or greater have an appointment for HIV medical care within 14 days of the test; and 90% complete an appointment.

*(5) Responsible parties include:*

- The Part A recipient will fund EIS and Outreach services; convene the EIIHA workgroup; communicate the FY2017 EIIHA Plan; coordinate data collection and dissemination; and facilitate outcomes evaluation.
- The Hennepin County PHC will deliver Partner Services, PrEP, EIS and Outreach services. The PHC will also employ data-to-care strategies to engage in medical care those who did not connect to care following diagnosis.
- Full Proof Ministry and NorthPoint Health and Wellness Center will increase HIV testing opportunities on the Northside of Minneapolis.
- MDH will fund and administer test sites and provide testing and surveillance data. It will also provide the CareLink (Enhanced Partner Services) program.

*(6) Planned outcomes:*

- By the end of FY2017, 90% of YMSM in the TGA will know their current HIV status.
- 90% of YMSM who are diagnosed with HIV in FY2017 will be linked to care (as evidenced by reported CD4 and/or viral load tests in MDH surveillance data) within 30 days

African American Men who have Sex with Men (MSM)

*(1) Why African American MSM were chosen*. MSM are disproportionately impacted by HIV and African American MSM are the most disproportionately impacted in the TGA and nationally. While 26% of new infections among males were among African American males, African American males comprised less than 10% of the TGA's male population in 2015. In the TGA, people of color comprised 58% of new HIV cases in 2015 with African Americans (not including African-born Blacks) alone comprising 25%. New infections among African American MSM increased by 14% between 2011 and 2015, one of only two racial/ethnic groups among MSM to show an increase in HIV incidence in the past five years. African American MSM in the TGA likely have the highest prevalence rates among all demographic groups. By the end of 2015, African American MSM comprised 18% of all diagnosed MSM living with HIV in the TGA. HIV prevalence among African American MSM increased by 21% from 2011 to 2015. The TGA's HCC for 2015 indicates that African Americans have the lowest rates of retention in care and viral suppression compared to other racial/ethnic groups. Among MSM, 64% of African American MSM were retained in care and 43% had suppressed virus, whereas 71% of White MSM were retained in care and 49% had suppressed virus.

*(2) Specific Challenges*. Data from Hennepin County's 2010 SHAPE show that gay, bisexual, lesbian and transgender (GBLT) residents are significantly less likely to have a regular source of health care compared to non-GBLT residents. In addition, only 35% of gay and bisexual males had a physical exam in the past year compared to their non-gay or non-bisexual male counterparts (57%). African Americans are disproportionately affected by issues of poverty and same-sex sexual orientation stigma. The priority of maintaining psychosocial and economic support from the community often trumps awareness of HIV status as a priority. Members of this target group are more likely to have fewer contacts with routine or preventive health care providers, making it more difficult to encourage routine testing. Fear of stigma associated with an even more pronounced level of homophobia within the African American community contributes to a greater sense of stigma and denial among African American MSM who do not

identify as gay or bisexual. In FY2015, only 43% of African American men identified as MSM to their RWP Part A provider compared to 84% of white and 61% of Latino men suggesting heightened same-sex sexual orientation stigma that can be a barrier to testing and seeking HIV care. Discrepancies between self-reporting of sexual orientation to providers and mode of exposure disclosure for HIV surveillance is greatest among African American males, with 76% of African American males reporting sex with males as their mode of HIV exposure. Data gathered from key informant interviews with African American gay and bisexual men, conducted by the Office of Minority Health Resource Center (OMHRC) in the TGA in 2014 and 2015, indicated a gap and need for culturally competent support groups, health education, health promotion campaigns, substance free social events and African American gay/bi/MSM-friendly churches and spiritual institutions, to better address the healthcare needs and stigma experienced by members of this community.

*(3) Specific activities for African American MSM include:*

- Scale up targeted testing by funding two new EIS providers on the Northside of Minneapolis where a large proportion of Minneapolis' African Americans reside.
- EIS at the Hennepin County PHC's Red Door Services including Fast Track and Concierge along with HE/RR are designed to address barriers to testing, receiving results, linking to care, and navigating health care systems as well as planning for prevention of transmission.
- HE/RR aimed at addressing knowledge barriers African American MSM may experience about their sexuality and HIV risk, and culturally appropriate prevention and harm reduction strategies as part of EIS and Outreach services.
- Continued meetings of the African American gay/bisexual/MSM workgroup that formed as part of the OMHRC technical assistance to engage in ongoing discussion and planning to address health disparities as part of the TGA's Part A program. The expertise of this workgroup will be utilized to help address service gaps and barriers to access that African American gay/bisexual/MSM at risk and living with HIV experience. They will also participate in the work of Council's Disparities Elimination Committee to address early identification of HIV/AIDS among African American MSM and to develop strategies to eliminate disparities in access to HIV testing, retention in care and viral suppression.

*(4) Specific objectives for early identification of HIV/AIDS among African American MSM:*

- Increase African American MSM tested for HIV through EIS and Outreach services by 20% by end of FY2017.
- Increase African American MSM linked to care through EIS and Outreach services by the end of FY2017, so that 95% or greater of those newly diagnosed with HIV have a medical appointment within 14 days of their test result; and 90% complete an appointment.

*(5) Responsible parties include:*

- The Part A recipient will fund Outreach services and EIS providers; convene the EIIHA workgroup; convene the African gay/bi/MSM workgroup; communicate the FY2017 EIIHA Plan; coordinate data collection and dissemination; and facilitate outcomes evaluation.
- Hennepin County PHCs will deliver Part A funded EIS, Outreach and Partner Services.
- Full Proof Ministry and NorthPoint Health and Wellness Center will scale up HIV testing on the Northside of Minneapolis and provide EIS.
- MDH will fund and administer test sites and provide testing and surveillance data. It will also provide the CareLink (Enhanced Partner Services) program.

*(6) Planned outcomes:*

- More African American MSM living with HIV will become aware of their infection early through testing at a Part A Program EIS or Outreach site.
- African American MSM newly diagnosed with HIV though EIS and Outreach services will receive HIV medical care including anti-retroviral treatment.

African-born (Black) Individuals.

*(1) Why African-born individuals were chosen*. There were 53 African-born Blacks diagnosed with HIV infection in the TGA in 2015; an increase of 15% from 2014. HIV incidence among the African-born in the TGA increased by 18% between 2011 and 2015. The number of new cases among African-born women in MN in 2015 was 36, accounting for 54% of all new diagnoses among women in Minnesota. In 2015, the number of African-born persons living with HIV in the TGA was 1,022; a 23% increase since 2011. While African-born residents of the TGA make up slightly less than 2% of the population, they represent 14% of PLWH in the TGA. African-born blacks have the highest HIV prevalence in MN with 1.5% of the population estimated to be living with HIV. Additionally, African-born women represent the largest proportion of women living with HIV in MN, at 34%. Women also account for 58% of the African-born living with HIV in MN. African-born individuals are more likely to test late and less likely to be in care with 32% Unmet Need in 2015 compared to 28% overall Unmet Need for Whites in the TGA.

*(2) Specific Challenges.* Among the top five countries of birth of immigrants living with HIV in MN, four are African countries including Ethiopia, Liberia, Kenya and Somalia. Immigrants from these countries speak different languages and represent many ethnic groups with a diversity of cultures and beliefs. Within these diverse communities there is an even greater level of stigma associated with HIV than in the TGA at large. This may compromise clients' willingness to be tested or to follow through with referrals to HIV prevention and care services for fear of loss of emotional and economic support from family and community. Africans living with HIV are often reluctant to utilize language interpreters for fear of disclosure of their HIV status to other community members. Linguistic barriers may also limit access to information about HIV testing opportunities and services available to PLWH. Culturally and linguistically specific EIS and Outreach services, especially for African-born women in the TGA are lacking.

*(3) Specific activities for the African-born Blacks include:*

- Enhanced Partner Services that broker referrals with RWP funded services such as MCM that are culturally competent to handle issues experienced by African-born PLWH, and are especially equipped to address language barriers and understand cultural norms.
- HE/RR services will address issues commonly found in the African-born communities such as the need for client education on how privacy practices protect them from disclosure within their communities, and the assumption that PLWH who are married don't need Partner Services. HE/RR service providers will use a sexual health assessment designed to address the beliefs and norms of African cultures to inform culturally appropriate HIV risk reduction interventions.
- Develop the capacity to culturally competently promote HIV testing and prevention education among African communities and improve clients' ability to navigate the healthcare system and self-advocate for best quality care. The national OMHRC will continue to provide capacity building technical assistance to an African health leaders group that will promote HIV testing events at African community health events. The Part A recipient will contract with an African HIV services provider to develop and deliver a training for Kenyan and Liberian faith-leaders to educate members of their faith communities on the importance of HIV testing and antiretroviral treatment and to reduce community and individual level HIV stigma.

*(4) Specific objectives for early identification of HIV/AIDS among Africans:*

- By the end of FY2017, increase the number of Africans receiving an HIV test by 10% with 95% or more of those who have tests informed of their results.
- Among Africans diagnosed with HIV, 95% or more will have an appointment for HIV medical care at a culturally competent clinic within 14 days of the test, and 90% will complete an appointment by the end of FY2017.

*(5) Responsible parties include:*

- The Part A recipient will fund the EIS and HERR providers to provide culturally appropriate health education services, convene the EIIHA workgroup, communicate the FY2017 EIIHA Plan, and collect and evaluate related program and outcomes data.
- MDH will fund and administer test sites and provide testing and surveillance data. It will provide the CareLink (Enhanced Partner Services) program targeting African women.

*(6) Planned outcomes:*

- More African-born individuals will receive an HIV test and be aware of their status in 2017.
- Africans diagnosed with HIV in 2017 will receive HIV medical care and ART.

h) Utilization of EIIHA Data in Services Planning. MDH annually presents a MN HIV Care Continuum (HCC) to the Council and the EIIHA workgroup. Beginning in 2015, the HCC included an estimate of the population of undiagnosed PLWH using the CDC methodology published in CDC's Morbidity and Mortality Weekly Report Vol. 64 /No. 24. The HCC includes demographic breakouts by geography (TGA and greater MN), gender, race/ethnicity, age and mode of exposure. MDH also provides the TGA's Part A Program staff with an HCC for the 11 MN TGA counties and additional data is obtained from WI Department of Health Services to complete an HCC for all 13-counties of the TGA. In addition, Part A Program staff provide the Council with an annual EIIHA update with results of EIIHA activities. MDH provides data on HIV tests funded through their HIV CTR program. These data inform the Council's work to prioritize RWP Parts A and B funded services, allocate funds to services that impact the population of undiagnosed PLWH, and recommend priority populations for HIV testing and prevention activities. The EIIHA workgroup uses the data to recommended activities designed to reduce the proportion of PLWH unaware of their infection and coordinate their EIIHA efforts.

i) Evaluation of Efforts to Identify Individuals with HIV/AIDS Early**.**

To monitor and evaluate the TGA's EIIHA progress, Part A Program staff including the Quality Coordinator, Data and Outcomes Coordinator, HIV Services Planner and Contract Analysts rely on the following data: eHARS; MNCAREWare EIS and Outreach Services client-level data on case finding, linkage, referral and health education, and risk reduction services provided; medical care status reported by all Part A subrecipients in MNCAREWare; EIS and Outreach Services subrecipient quarterly reports for number of HIV tests provided; EvaluationWeb data from their CTR providers; patient population HIV testing rates from Hennepin County operated primary medical care; and annual EIS and Outreach Services subrecipient site visit client record reviews. Surveillance data provide indicators of time to linkage to care and estimates of the population of PLWH in the TGA who are unaware of their HIV infection. MDH's annual estimate of the HIV-unaware population provides an overall picture of the impact of EIIHA activities. MNCAREWare services data indicate the number of new HIV cases identified, linked to care, and provided with HE/RR interventions through RWP services. Client record reviews during site visits provide information on the quality of EIS and Outreach Services provided based on

standards of care developed by the Part A recipient and Council. Client-level EIS and Outreach Services outcomes data along with annual client record reviews, informs the Part A program's efforts to improve the impact of these services. Client-level services data along with expenditures on EIS and Outreach Services measure cost effectiveness of Part A funded EIIHA activities.
j) Dissemination of EIIHA Planning and Evaluation Information. The Part A recipient will present the EIIHA Plan to the Council in the last quarter of FY2016 and provide regular updates on planned activities at monthly Council meetings. As plan outcomes data become available they will be presented at a Council meeting. The recipient will also convene the EIIHA Workgroup in early 2017 to inform other RWP recipients, HIV service providers, and other stakeholders of the Part A EIIHA plan. The Workgroup will also share outcomes of the TGA and MN's combined EIIHA efforts and update the Workgroup's EIIHA matrix to facilitate ongoing coordination. Early Intervention and Outreach data on case finding and linkage rates will be incorporated into the Services Area Review summaries that Council members receive in preparation for their biennial RWP funded services prioritization and allocations process.

**2) Unmet Need for HIV Medical Care**

Unmet Need estimates using both the current and new (HIV Care Continuum) framework methodologies are presented as ***Attachment 4***.

**Current Methodology: Unmet Need Framework Estimate**

a) Unmet Need Description

*(1) Estimation method*. The TGA's 2017 Unmet Need estimate (***Attachment 4A***) uses the current methodology based on the framework developed by the Institute for Health Policy Studies at the University of California, San Francisco in 2003 and adopted by HRSA/HAB. This framework defines Unmet Need as the need for HIV primary medical care by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care. More specifically, the measure of Unmet Need is that there is no evidence of any of the following three components for HIV primary medical care during the designated 12-month time frame: viral load testing; CD4 count; or prescribed ART. The data used in the TGA's current Unmet Need framework methodology are provided by MDH and WI Department of Health Services and come directly from electronic HIV/AIDS Surveillance systems (eHARS). As neither MN nor WI require medical care providers to report ART prescriptions, the definition of Unmet Need in the TGA using the current methodology is "no evidence of viral load testing or CD4 count between January 1 and December 31, 2015." According to eHARS, in 2015 there were 3,379 people living with AIDS 2,531 of them received HIV medical care services and 3,861 people living with HIV/non-AIDS 2,469 of whom received HIV medical care services in the 13-county TGA (11 counties in MN and 2 counties in WI). Using this methodology the Unmet Need estimate is 30.5% of diagnosed people living with AIDS and HIV non-AIDS in the TGA that did not receive the specified primary medical care services during the January 1 to December 31, 2015 12-month period. The methodology used to estimate Unmet Need for 2017 is identical to that used in 2016. The greatest limitation of using this methodology is completeness of CD4 count and viral load test reporting by medical care providers. Although MN communicable disease reporting rules requires reporting of all CD4 counts and viral load tests, it is difficult to assess and enforce. In 2015, provider viral load reporting to MN eHARS declined significantly compared to 2014. MDH is following up with providers whose viral load reporting declined to determine the extent of missing data. As a result, the 3% increase in the Unmet Need estimate from 2014 (27%) to 2015 (30%) may be an artifact of incomplete laboratory test reporting.

*(2) Assessment of Unmet Need*. (a) Demographics and Geography. Based on 2015 race and ethnicity data from MN and WI eHARS, males have greater Unmet Need for HIV medical care (32%) than females (28%). Among racial and ethnic groups, Hispanics have the greatest Unmet Need at 36%. The following racial and ethnic groups also have greater Unmet Need than the overall population of PLWH who are aware of their status (30% Unmet Need): African-born Blacks (32%); and PLWH who identify as having multiple or unknown race (35%). Based on mode of exposure to HIV, IDU had the highest Unmet Need at 36% with PLWH whose risk is not reported or identified having 32% Unmet Need. Geographically (see ***Attachment 14B: Unmet Need Map)*** the concentration of PLWH who have Unmet Need for HIV medical care is highest in the TGA's urban center including the central, south and north areas of Minneapolis and somewhat in the areas of St. Paul closest to Minneapolis and on the east side of the Mississippi River and the northwest first ring suburbs of Minneapolis. These areas of the TGA are where MSM, Hispanic and African-born residents are most likely to reside.
(b) Unmet Need Trends. The following summarizes overall Unmet Need for HIV Medical Care of PLWH aware of their HIV infection in the TGA from 2011- 2015:

| Unmet Need Estimates CY2011-2015: Current Methodology, Minneapolis - St. Paul TGA | | | | | | |
|---|---|---|---|---|---|---|
| **Calendar Year** | **People Living with AIDS and not receiving HIV medical services** | | **People Living with HIV (non-AIDS) and not receiving HIV medical services** | | **Total People Living with HIV (AIDS and non-AIDS) and not receiving HIV medical services** | **Percent Unmet Need** |
| **2011** | 446 | 15% | 967 | 29% | 1,413 | 23% |
| **2012** | 594 | 19% | 1,134 | 33% | 1,728 | 26% |
| **2013** | 719 | 23% | 1,293 | 36% | 2,012 | 30% |
| **2014** | 668 | 21% | 1,205 | 33% | 1,873 | 27% |
| **2015** | 830 | 25% | 1,323 | 36% | 2,149 | 30% |

Based on the current Unmet Need methodology, it appears that between 2011 and 2015 Unmet Need increased by 7%. Prior to July 1, 2011, MN did not require medical care providers to report all CD4 count and viral load test results to MDH. From 2004 to 2011 two of the TGA's largest providers of HIV medical care submitted aggregate data that was used to supplement eHARS data to estimate Unmet Need in the TGA. This likely explains the increase in the Unmet Need estimate from 2011 to 2013. The greatest limitation of this Unmet Need estimate is the completeness of CD4 count and viral load reporting by medical providers and reporting of viral load test results in 2015 significantly declined. Fluctuations in Unmet Needs over the past five years may be the result of incomplete viral load data in MN's eHARS. Nevertheless, there are mentionable demographic trends in Unmet Need. Since 2011 African-born PLWH consistently had higher Unmet Need estimates compared to the overall population of PLWH. Similarly, since 2012 Hispanic PLWH had higher Unmet Need estimates compared to PLWH across all racial and ethnic groups. Although separate Unmet Need estimates by HIV exposure category were not calculated until 2013, the estimates for IDU has been greater than the overall estimate consistently over the past three years. While the exact cause of these differences is unknown, they underline the need for greater work on improving health disparities in the TGA, which will be a focus of activities in FY2016 and FY2017.
(c) Service Needs, Gaps and Barriers to HIV Medical Care. In FY2015, 1,207 (17% of) PLWH residing in the TGA received Part A funded OHS. In addition, 1,126 PLWH in the TGA received ADAP services, 1,072 received assistance paying for their medications, and 462 in paying for their insurance premiums. Furthermore, 74 received Emergency Financial Assistance to pay medical expenses and 1,290 received Part A or B funded Medical Transportation to get to a health care or other core medical or support service appointment. Of the 504 respondents to the

2015 Comprehensive Needs Assessment (CNA) of PLWH in MN, 11% waited longer than a year before receiving HIV medical care. A third of those who waited longer than a year reported that they could not find a clinic where they felt comfortable and a third chose alternative therapies or non-traditional medicine instead. Respondents identified the following facilitators as most helpful in finding and connecting to an HIV medical provider: an HIV knowledgeable clinician (85%); a good relationship with their doctor (77%); their questions were answered at their clinic (71%); and people at the clinic seemed to care about them (70%). In addition, 47% said that transportation was provided for them to get to their appointments. Although only 5% of PLWH who received RWP services in FY2015 were uninsured, many low income PLWH in MN have periods where they may temporarily lack health insurance because of changes in employment and/or eligibility for publicly funded insurance programs. Lapse in coverage can be exacerbated by the limited open enrollment period for MNSure, MN's health insurance exchange. According to the CNA, 31% of respondents reported that in the past year signing up for insurance or understanding their coverage negatively affected their medical care. Eight percent reported that in the past year they had been denied medical care because they didn't have insurance (5%) or they could not afford a copayment (4%).

**New Methodology: Unmet Need Estimate Based on HIV Care Continuum Framework**

a) Variances in Unmet Need Estimates: Current v. New Methodology. The 2017 estimate of Unmet Need for HIV medical services derived from the new HCC framework (presented in ***Attachment 4B)*** is 56.6%. This estimate exceeds the Unmet Need estimate of 30.4% based on the current methodology by 26.2% or almost two-fold.

b) Comparison of 2016 and 2017 Unmet Need Estimates Using the HCC Framework**.** The TGA's 2016 Unmet Need estimate was 51.9% of diagnosed PLWH in the jurisdiction did not receive the specified medical services within the 12-month period, a 4.7% increase from 2017's estimate of 56.6%. The increase is likely a result of a significant decline in viral load tests reported to the MDH in 2015 by some HIV care providers not consistently reporting all viral load tests to MDH's eHARS. Thus, the decline may be an artifact of incomplete viral load data.

c) Data Used to Determine Unmet Need Using the HCC Framework Methodology. The data sources for deriving the Unmet Need estimate using the HCC framework come directly from MN and WI's eHARS provided by the MDH and WDHS. The CD4 counts and viral load tests for diagnosed PLWH residing in the TGA's 13-counties, 11 in MN and two in Wisconsin, entered into each state's eHARS are used for the estimate. The prevalence, or number of persons living with AIDS (3,379 persons) and HIV/non-AIDS (3,681 persons) in the 13-county TGA in 2015 are the same as those used in the current framework. However, the number of PLWA (1,680) and PLWH/non-AIDS (1,381) who received the specified HIV primary medical care services during 2015, or the retention in care measure, is arrived at differently, due to use of CDC's definition of retention in care, which differs from that used by the MDH for the state and TGA HCCs. CDC defines retention in care as the number of diagnosed individuals who had two or more documented medical visits, CD4 count, or viral load tests performed at least three months apart in 2015. This retention in care outcome for the TGA in 2015 is 43%. When subtracting the retention in care percentage from the prevalence in the HCC Framework methodology, the Unmet Need for HIV primary medical services for PLWA is 1,699 persons and for PLWH/non-AIDS is 2,300 persons. Combined, the result is 3,999 persons or 57% of PLWA and PLWH/non-AIDS not receiving the specified primary medical services in 2015. This is a much higher estimate of the Unmet Need than that resulting from the current Unmet Need framework methodology. Using the HCC Framework methodology the retention in care measure ends up

being lower than the viral suppression rate of 49%, and therefore does not seem to be a good estimate of Unmet Need in the TGA.

d) Differences in Retained in Care Definitions. The definition of retained in care for estimating the TGA's Unmet Need using the current framework differs significantly from the HCC definition. Retained in care for the current methodology of estimating Unmet Need for 2017 is defined "as the percentage of persons who had ≥1 CD4 or viral load test results during 2015 among those diagnosed with HIV through year-end 2014 and alive at year end 2015." This is also the definition of retained in care that MN uses to derive retention in care estimates for the state and TGA HCCs. The definition of retained in care, used by the CDC to develop the national HCC and for estimating Unmet Need using the HCC framework methodology is "the percentage of persons who had ≥2 CD4 or viral load test results at least three month apart during 2015 among those diagnosed with HIV through year-end 2014 and alive at year-end 2015."

e) Challenges of Using the Retained in Care Measure. The challenge in using a retained in care measure for the Unmet Need estimate is the frequency of CD4 count and viral load tests in the defined 12-month period. In calculating retention in care for the TGA's HCC, the MDH uses the same retained in care definition as in the current methodology for estimating Unmet Need in the TGA which is ≥ 1 CD4 count or viral load test in the calendar year. MDH decided to use ≥ 1 CD4 count or viral load test in the specified year to calculate retention in care to develop the first HCC for MN in 2013 since using the CDC's method of calculating retention in care (≥ 2 CD4 or viral load tests at least three months apart in the specified year) resulted in a viral suppression rate significantly greater than the retention in care rate. The CDC formula for calculating the proportion of diagnosed PLWH retained in care that is used in the new Unmet Need methodology framework and for the developing the national HCC may no longer align with the federally approved guidelines for the treatment of adolescents and adults with HIV infection. The current Unmet Need framework methodology likely provides a closer estimate of true Unmet Need and retention in care rate for the TGA's HCC. Regardless of which formula is used to calculate retention in care, the accuracy of estimating Unmet Need and retention in care in the TGA is limited by completeness of CD4 count and viral load reporting to MDH. There may be two large HIV medical providers in the TGA that are not consistently reporting all of their patients viral load tests. MDH is currently contacting HIV medical care providers to further assess the completeness of HIV surveillance data reporting in 2015.

f) Impact of HCC Framework Derived Unmet Need Estimate. (1) Using the Unmet Need Estimate derived from the HCC Framework using the CDC definition for retention in care would prove problematic in the TGA. As community viral suppression levels improve over time fewer PLWH are seeking, or need, HIV medical care twice per year. HIV medical providers are now more often recommending one medical visit and/or lab test per year for patients who have been stably virally suppressed and do not require more than annual follow up for HIV treatment. In fact, the Positive Care Center at Hennepin County Medical Center, the largest provider of HIV specialty care in MN, determined that among their almost 2000 current patients, 15% do not need a viral load test more than once a year. Using the HCC framework methodology to estimate Unmet Need would include these PLWH resulting in an overestimate of TGA's Unmet Need. Large overestimates of Unmet Need could erroneously point to the need for more resources and efforts directed at linking and retaining PLWH who are already virally suppressed when those resources and effort may be better focused on other greater needs.

(2) Further demographic analysis of the Unmet Need estimate using the HCC framework using the CDC measure of ≥ 2 CD4 counts or viral load tests in the calendar year for retention in care

is required to determine the impact of strategies to reduce disparities in Unmet Need. Based on the TGA's 2013 and 2014 HCCs using ≥ 1 CD4 count or viral load in the calendar year to for retention rate calculation , Hispanic, African American and African-born people with diagnosed HIV have lower retention in care and viral suppression rates and greater Unmet Need.
(3) The primary means to link PLWH in the TGA who are aware of their infection to care and support ongoing retention in care is through Early Intervention (EIS) and Outreach services and a comprehensive accessible system of core medical and supportive services to mitigate barriers to connecting to an HIV medical provider and staying in care. Beginning in 2016, the Part A Program's Outreach services provided by the Hennepin County Public Health Clinic (PHC) will employ a data-to-care protocol using HIV surveillance data to identify PLWH who have not had a CD4 count or viral load test in the past year and reach out to them using a concierge model of patient centered contact and follow up. This intervention has been successfully employed by the PHC's Early Intervention program for the newly diagnosed.
g) Utilization of Unmet Need Estimate in Services Planning. As part of their biennial services prioritization and allocations process, the Council is provided with annual Unmet Need estimates along with other quantitative and qualitative information on the service utilization and needs of PLWH in the jurisdiction to inform direction of Part A and B resources to improve access to and retention in care. The Council Disparities Elimination Committee utilizes the Unmet Need estimates to determine the best use of MAI and regular Part A funds to address disparities along the HCC. The Part A recipient uses Unmet Need estimates to inform EIS and Outreach services standards of care and program development including how to best utilize data to improve engagement in medical care.
h) Evaluation of Strategies to Reduce Unmet Need. Part A recipient quality management, services planning, and contract management staff use client-level data collected in MNCAREWare, the TGA's HCC data, Part A Program subrecipient quarterly reports, and annual subrecipient site visit client record reviews to monitor and evaluate interventions to increase care engagement and retention. Both EIS and Outreach services providers log case finding, referral and linkage to care services in MNCAREWare. All Part A subrecipients are required to assess medical care status of clients and report the dates of last medical appointment in MNCAREWare.
i) Unmet Need Estimate Information Dissemination. Both the Minnesota Council for HIV/AID Care and Prevention (Council) and the EIIHA workgroup receive annual updates of both the Unmet Need estimate using the current framework and the MN and TGA HCC. Both RWP and CDC funded HIV care and prevention providers are presented with the HCC at the annual Minnesota All HIV Provider meeting where all publicly funded HIV prevention and care providers gather for a full-day meeting.

**3) Service Gaps**

a) Service gaps in the TGA. Service gaps and barriers to services were identified through the development of the 2017 statewide coordinated statement of need (SCSN) including analysis of epidemiologic data, the FY2016 and 2017 HCC, RWP service utilization data, 2010 and 2015 Comprehensive Needs Assessment Surveys, resource inventory, and Hennepin County's 2010 and 2014 Surveys of the Health of All the Population and the Environment (SHAPE). The Council considered all relevant data sources in 2017 and 2018 allocations. Part A allocations for support services such as housing assistance, emergency financial assistance (EFA), and medical transportation are essential to maintaining access and retention by mitigating economic barriers. SCSN participants consistently ranked culturally competent services as a high priority in all

categories, particularly support services, meaning culturally specific providers and interpreters who are knowledgeable about HIV and confidentiality of HIV status. MN continues to experience high rates of poverty among populations of color, particularly African American, African-born, and Latino immigrants. Services that address basic needs such as food and nutrition, EFA, and housing assistance are crucial to continued access to HIV treatment and remain a top priority. Mental health and substance abuse treatment, while available through other funding sources, can be difficult to access and in turn become barriers to achieving positive health outcomes.

*Housing:* One of the biggest service gaps in the TGA is housing assistance. Nearly 20% of respondents in the 2015 CNA said they were homeless or their housing was unstable in the last year; slightly higher for American Indian (22%), and Black (24%) respondents. Twelve percent of respondents had lived in a car, park, sidewalk, or abandoned building in the past year. Research has shown that for PLWH, lack of stable housing is strongly linked to inadequate HIV health care, high viral load, poor health status, emergency room visits hospitalizations, and early death (National AIDS Housing Coalition). The TGA lacks adequate affordable housing and funding to meet the needs of homeless and unstably housed. Wilder's recent report *Homelessness in Minnesota* indicates that on one night, October 22, 2015, there were 9,312 people experiencing homelessness in MN the majority of whom are in the TGA. The TGA's two largest HIV housing programs currently have long waiting lists of 382 PLWH needing affordable and supportive housing. Additionally, 54% of PLWH receiving RWP services in 2015 have an annual income of less than $11,880 (100% of FPG) indicating that over half of the TGA's PLWH need housing and economic supports. Twenty seven percent reported paying more than 30% of their income toward rent in the past year. When PLWH sought assistance, 7% reported being unable to access EFA to pay for rent or mortgage though they needed it, with higher percentages for American Indians (10%) and Asians (20%). Additionally, 9% of American Indian PLWH respondents were unable to access short-term assistance to support emergency, temporary or transitional housing. Inadequate resources to provide stable housing, combined with other complications for PLWH significantly increases the cost of care for homeless PLWH. Many homeless PLWH require intensive Medical Case Management (MCM) assistance to access mental health or substance use treatment, shelter, and supportive social services before successful treatment for HIV is likely. Providing services to the 30% PLWH out of care according to the Unmet Need estimate and homeless or unstably housed (664 PLWH in 2015), adds an additional $654,970 to the cost of rental assistance based on the affordable apartment unit cost in the TGA and $971,432 to provide MCM based on the per client cost of Part A MCM in 2015 ($1,463).

*Mental Health:* PLWH face stigma, anxiety, depression, homelessness, unemployment, lack of supports, low self-esteem, and low income. Many studies that show PLWH suffer from depression and anxiety at higher rates than the general population. DHS estimates that 5.8% of the TGA's population (202,385) has serious mental illness or serious and persistent mental illness. SHAPE data 2014 LGBTQ respondents reported diagnosis of depression at a rate of 39.7%, compared to their non-LGBTQ counterparts at 21.7%. Similarly, LGBTQ respondents reported serious psychological distress at a rate of 5.4%, compared to 2.7% in non-LGBTQ respondents. Overall, LGBTQ respondents reported mental health distress nearly twice as often as their non-LGBTQ counterparts. There are also shortages in mental health services, especially inpatient, psychiatric, rehabilitation, and support services. According to the 2015 CNA, 60% of respondents reported receiving mental health services, an increase from 49% in 2010 CNA and

significantly higher for American Indian/Alaska Natives at 84%. Since diagnosis, 47% of CNA respondents sought individual therapy with a psychiatrist for mental health treatment, 46% have had psychiatrist prescribed medication, 50% have had individual therapy with a psychologist, social worker, licensed professional counselor, nurse clinician or licensed chemical dependency counselor, and 40% have sought help in an HIV-specific support group. In 2015, 309 PLWH in the TGA who were enrolled in Minnesota Health Care Program (MHCP) received outpatient Mental Health services at a cost of $620,574. Culturally and linguistically specific Psychosocial support for African-born women, especially for those women who fear repercussions from disclosure of HIV status, can reduce isolation and stigma and increase knowledge of HIV treatment and services that ultimately improve retention in care. In FY2015, $187,330 in Part A funds were spent on Mental Health services for 157 PLWH and $85,316 were spent on Psychosocial Support services for 235 PLWH. Allocations for Mental Health and Psychosocial Support services in 2016 are $186,000 and $88,400, respectively.

*Substance Use Disorder (SUD) Services*: A large proportion of clients receiving RWP funded services in the TGA utilize SUD services and it remains an area of great need. In the 2015 CNA, nearly one third of respondents reported having a Rule 25 assessment for SUD services, while 56% of American Indian respondents and 40% of Hispanic respondents reported the same. Eighteen percent of respondents reported receiving outpatient SUD treatment or counseling, with an even greater proportion of respondents who are Hispanic (23%) and American Indian (28%). American Indian PLWH made up six percent of RWP Part A Clients accessing Part A Program Substance Abuse services in 2015 though they only make up 3% of RWP Part A clients and 1% of PLWH in the TGA. Two funded programs in this service area provide "just-in-time" connection to SUD services. These programs, one housed at the TGA's largest HIV primary care clinic and the other at the TGA's largest AIDS service organization, provide the Rule 25 SUD assessments required for placement in state-funded treatment programs as well as short-term counseling, treatment placement facilitation, peer relapse prevention, and harm reduction support. Three hundred and nine (309) PLWH in the TGA received substance abuse treatment through MHCP at a cost of $620,574 in 2015. In FY2015, $137,888 of Part A funds were spent on Substance Abuse (outpatient) services for 233 PLWH. Slightly more is allocated for FY2016 and FY 2017 at $139,900 but may not be enough to fully meet the need that exists among the TGA's RWP eligible PLWH.

*Oral Health:* Nationally anywhere between 32% and 46% of PLWH will have at least one HIV-related oral health problem during the course of their disease, and yet studies show that 58% to 64% of PLWH do not receive regular dental care (HRSA/HAB). Barriers PLWH experience in accessing oral health care include lack of insurance, low and limited incomes, perceived and real stigma, and lack of providers trained to treat PLWH. Access to high quality oral health care is a critical part of overall care for PLWH and is a service gap in the TGA just as it is nationally. In the 2015 CNA, 51% of respondents reported wanting or needing to see a provider for oral health care and not being able to do so. The need is even greater for communities of color, with 66% of American Indians and 65% of Hispanics reporting the need to see an oral health care provider and not being able to do so. In terms of actual service utilization, Black PLWH represent 37% of PLWH in the TGA and 44% of people in the TGA receiving RWP services, but only 26% of PLWH utilizing RWP funded Oral Health Care services were black. Though young clients between 13 and 39 years of age represent 29% of PLWH in the TGA and 34% of PLWH receiving RWP services in the TGA, only 21% of PLWH utilizing RWP funded Oral Health Care services were between the ages of 13-39. In the TGA, the DHS HIV/AIDS Program

administers ADAP and the state's RWP Parts A and B funded HIV Oral Health Care services through their centralized Program HH, providing services to 16% of Part A recipients. Oral health care is an important part of maintaining overall health for PLWH, and needs more attention in the TGA. In FY2015, $58,100 in Part A funds were used for Oral Health Care services for 447 PLWH.

*Medical Case Management (MCM) and Benefits Counseling:* Although the ACA has reduced some barriers for PLWH to being insured, the complexity of the insurance marketplace and limited open enrollment periods cause persistent access and consistent coverage issues for PLWH seeking insurance. PLWH without immigration documentation need additional help navigating the private insurance market and accessing ADAP to cover premiums and out-of-pocket costs. A significant percentage of the 2015 CNA respondents were impacted in all areas of access to health insurance including enrollment problems, understanding the insurance policy; being without health insurance for 3-months or longer since diagnosis; receiving health insurance premium assistance (HIPA); and denial of medical care because of lack of payment or insurance. Across the board the percentages of those impacted were higher for African Americans, Latinos, and American Indians. Challenges in accessing insurance and financial assistance for HIV/AIDS care can be mitigated by strong MCM programs. A large gap on the TGA's HIV Care Continuum is a 20% drop in the proportion of PLWH who are retained in care compared to the proportion of those linked to care within 90 days of diagnosis. MCM provides comprehensive services that assist in treatment adherence, securing stable housing, nutritional and economic supports, medical transportation, mental health, and substance abuse treatment services. In the 2015 CNA, 85% of respondents said a medical professional or HIV clinician was most helpful in finding and connecting to HIV-related medical care, further suggesting the importance of funding strong MCM programs that help clients find and stay in care. Part A funds support five clinic-based and one community-based MCM providers. Two MCM programs, the African American AIDS Task Force and West Side Community Health Services, receive MAI funds to focus on meeting the needs of African American, African-born, and Latino PLWH who are at risk of not connecting or losing access to HIV medical care. In FY2015, MCM services served 1,885 or 62% of Part A clients and 94% were retained in care. Eighty one percent of those receiving Part A funded MCM in FY2015 were below 150% of the FPG, suggesting a large need for the poor. Based on all these data, the need for MCM is great in the TGA. A significant amount of funding in the TGA is spent on MCM services. In FY2015, $2,165,782, or 45% of Part A funds, were spent on MCM services for PLWH, which includes $191,800 of Minority AIDS Initiative (MAI) MCM funds targeting both African American clients and Latino clients.

b) Method used to prioritize service gaps**.** The Part A recipient and Council use multiple approaches to assess the needs of PLWH and gaps in services. Service gaps were identified through careful analysis of 2015 service utilization data reported in MNCAREWare. If a certain subpopulation of PLWH receiving RWP funded services reported lower utilization of a service than that subpopulation's proportion of prevalence of HIV in the TGA, it was determined that it could indicate a potential gap. Although, this method was not the only prioritization method used because a lower proportion of service utilization may also indicate that that particular subpopulation simply did not have as great of a need for those services. In some cases, the proportion of a subpopulation using a particular RWP service was compared to the overall proportion of all PLWH receiving RWP services to look for differences. Service utilization data from 2015 was also compared to utilization data from 2014 in order to prioritize gaps. Service utilization by disproportionally affected populations of PLWH were carefully scrutinized and

considered for priority as well. Finally, the 2010 and 2014 SHAPE, as well as the outcomes of 2010 (502 respondents) and 2015 CNA's (504 respondents) were consulted to assess service gaps. CNA's provide self-reported demographics, socio-economic conditions, service utilization, and services that were not utilized in the previous year that participants reported needing. The data also included reasons for lack of access to services. If more than approximately 8% of respondents or a subgroup of respondents reported they were unable to access a particular needed service, these services were then considered as potential priorities. Combined, all of these strategies were compared and assessed for similarities and most frequently occurring service gaps, creating the methodology that is used for service gap prioritization.

c) How service gaps will be addressed**.** Significant HIV-related health disparities exist among racial and ethnic subgroups, age, and country of birth. A number of approaches have been implemented or will be employed to address and resolve these challenges, including the creation of a new Disparities Elimination Committee (DEC) in February 2016. DEC is dedicated solely to improving and reducing health disparities. Other efforts include improved outreach utilizing a *Data to Care* protocol, EIS, and MCM to reach and connect target populations to medical care. Part A efforts will focus on addressing special emerging, under-represented and co-morbid populations of PLWH, in order to reduce the disparities experienced by these groups. Finally, MAI programming will continue to address the health care and support service needs of African Americans and Latinos living with HIV in the TGA. The Council's service priorities and allocations for FY2016 and 2017 (***Attachment 8)*** are designed to achieve the four goals of the 2017 -2021 Integrated HIV Prevention and Care Plan by providing services to low income PLWH who experience system, economic, linguistic, cultural and personal barriers to accessing HIV services. The service priorities help provide economic stability so PLWH do not need to choose between getting their basic needs met and accessing healthcare. Services needed by PLWH that have finding sources other than the RWP are not always accessed by those in need them due to eligibility criteria or insufficient capacity. Part A funding helps fill these gaps.

*Housing Services.* In FY2016, the Council newly allocated $80,800 of Part A funds for Housing services to address the great need in the TGA. The TGA's largest AIDS service organization was selected to deliver housing assistance and is currently integrating these funds into their already established transitional housing program. In addition, $98,100 in Part A funds were allocated for EFA in FY2016 which can be used to provide services for clients to pay for rent and utilities. The State is allocating $69,500 in ADAP rebate funds for FY2016 and $1,075,000 over five years to housing assistance. The Part A Housing Services are provided by the TGA's largest AIDS service organization that provides multiple Part A and B funded services including a long established transitional housing program that assists PLWH to obtain safe and affordable housing and more permanent resources to meet long-term housing needs.

*Mental Health and SUD Services.* The Council allocated 9% of Part A funds ($446,700) for FY2016 and 2017 to SUD services (outpatient), Mental Health and Psychosocial Support services to address the mental health and psychosocial needs of PLWH whose mental illness, substance abuse, isolation and stigma preclude retention in care. Part A funded SUD services are housed at the TGA's largest HIV primary care clinic and at the TGA's largest AIDS service organization. They provide the Rule 25 SUD assessments required for placement in state-funded treatment programs as well as short-term counseling, treatment placement facilitation, and peer relapse prevention, and harm reduction support. There are three Part A Mental Health service providers. One provides psychiatric services, including medication management, at the TGA's largest HIV specialty medical care provider. One of the other two providers targets African-born

PLWH many of whom were refugees who experienced trauma upon leaving their countries of birth and carry severe stigma around both HIV and mental illness. The third mental health program is at a Federally Qualified Health Center (FQHC) that provides primary care for 26% of the TGA's Latinos with HIV and employs mental health clinicians that are bilingual in English and Spanish. Part A funds four Psychosocial Support programs targetting disproportionately impacted communities including African Americans, the African-born, Latinos, and MSM.
*Oral Health Care*. DHS will fully fund Oral Health Care Services for RWP eligible PLWH in the TGA in FY2016 and 2017 with an allocation of ADAP rebate funds of $117,100. RWP Oral Health Care is delivered through the DHS' Medicaid management claims system which allows RWP eligible PLWH in the TGA to access any qualified Medicaid provider and essential services not covered by Medicaid.
*Medical Case Management*. The FY2017 Part A allocations plan dedicates $2,247,900 to MCM services, including $191,800 of MAI MCM funds targeting African American, African-born, and Latino PLWH. The MCM allocation comprises 45% of Part A funds for services in FY2017. Five of the six Part A funded MCM programs in the TGA are located at HIV specialty medical clinics that combined provide care to an estimated 62% of RWP eligible PLWH in the TGA. These clinic-based programs also staff Doctors of Pharmacy that provide treatment adherence and medication management counseling and tools. MCM programs will work with both the newly diagnosed and PLWH who have multiple unmet health and socio-economic needs that unless addressed become barriers to retention in care and adherence to ART.

**4) Minority AIDS Initiative**

a) Minority Populations and Specific Sub-groups Targeted with MAI Funds. African American MSM, African-born women and their partners, and Latino MSM are minority populations disproportionately impacted by HIV in the TGA. The racial/ethnic barriers that prevent communities of color in TGA from achieving linkage to care, retention in care, and viral suppression are exacerbated by added social determinants of country of origin, gender and sexual identity. There were 1,622 U.S.-born African Americans living with HIV in the TGA in 2015; a 19% increase from 2011. There were 1,022 African-born PLWH, compared to 830 in 2011; a 23% increase. According to MDH, African Americans make up 23% of HIV prevalence and an additional 14% was African-born, whereas these two groups combined represent only 7.6% of the total population of the TGA. Latinos comprise 9% of PLWH though only are 5.5% of the TGA's population. Latinos are disproportionately impacted, comprising 8% to 14% of annual new HIV cases in the past five years. The need for culturally competent HIV services is underscored by the significant number of foreign-born individuals within these populations.

The percentage of late testers is higher among foreign-born cases. Since 2005, approximately one third of all new HIV infections diagnosed in MN have either been AIDS at first diagnosis, or have progressed to an AIDS diagnosis within one year of initial HIV(non-AIDS) diagnosis. As with other epidemic characteristics, the proportion of late testers varies by demographic characteristics. The most significant differences occur by race/ethnicity, with the proportion of late testers in 2015 among African-born (33%), and Latino (29%) being higher than that among African Americans (15%). In 2015, 38% of foreign-born cases were late testers compared to 21% of US-born cases. An estimated 66% of Latinos living with HIV in the TGA receiving RWP services are foreign born.

Since the beginning, MSM have driven the epidemic in MN. In 2015, MSM accounted for 53% of all new infections (69% of males), with 137 cases diagnosed. MSM of color are more likely to contract HIV and have lower rates of retention in care and viral suppression. The HCC

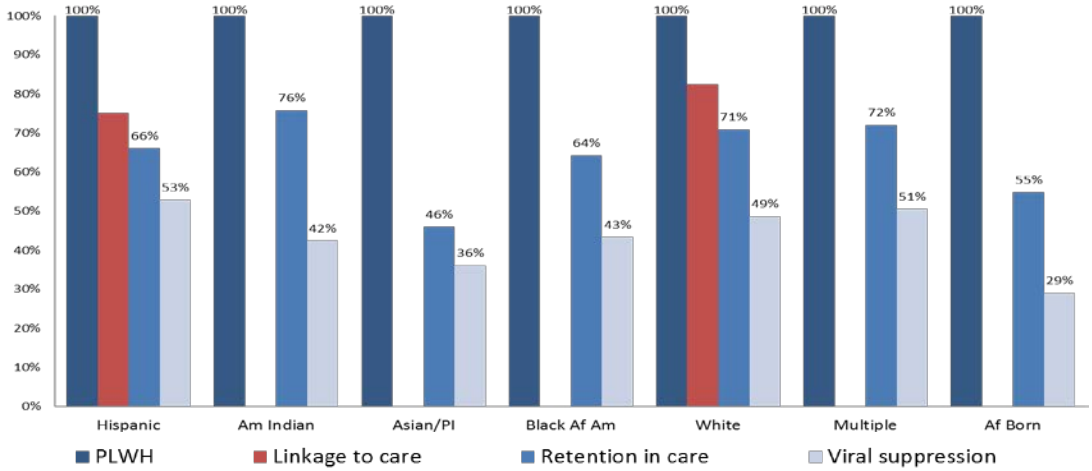
shown below for MSM by race and ethnicity shows African American, African-born and Hispanic MSM have lower retention rates 64%, 55% and 66% compared to White MSM at 71%. Similarly, African American and African-born MSM have lower viral suppression rates at 43% and 29% compared to White MSM at 49%. API MSM have the lowest retention rate at 46%. American Indian and API MSM also have relatively low viral suppression rates although each represent less than 2% of prevalence among MSM. The Part A recipient and Council will continue to monitor retention and viral suppression rates among MSM of color.

The epidemic looks different for the African-born communities. The largest number of women living with HIV/AIDS is among African-born women (672) followed by African-American (515). African-born persons have a higher proportion of HIV infections acquired through heterosexual contact than other racial/ethnic groups. It is estimated that 84% of new HIV infections among African-born males diagnosed between 2012 and 2014 were attributable to heterosexual sex; however, 12% of new HIV infections amongst African-born males were MSM.

HIV surveillance data from 2014 and 2015 on diagnosed PLWH in the TGA elucidates differences in linkage to care, care retention and viral suppression by geography gender, race/ethnicity, age, and HIV exposure category. Unfortunately, possible incomplete reporting of 2015 viral load tests may mask previously identified disparities along the HCC seen in the TGA's FY2015 and 2016 HCCs. Based on the 2014 and 2015 data used to develop the FY2017 HCC, differences in engagement along the HCC were as follows based on each stage. *Linkage to care within 30 days (78% overall)*: The lowest linkage to care rates were among Latinos (75%) and PLWH ages 35-44 years (73%). *Retention in care (67% overall)*: The lowest retention in care rates were among African-born (65%), PLWH with unspecified HIV mode of exposure (65%) and Hispanics (60%). *Viral Suppression (49% overall)*: No demographic groups had viral suppression rates that were more than 2% below the overall rate for the TGA.

Previous TGA HIV Care Continua for FY2015 and 2016 indicated more significant disparities in engagement in care experienced by African Americans, African-born, and Latinos who were less likely to be retained in care and have suppressed virus compared to Whites. PLWH who had unidentified HIV exposure were least likely to be retained in care.

**Percentage of MSM & MSM/IDU diagnosed with HIV/AIDS engaged in selected continuum of cares stages, by race – Minnesota TGA Counties**




Competency around race/ethnicity, country of origin, gender, and sexual identity is critical in order to address the social determinants such as racism, xenophobia, sexism, and homophobia in

order to eliminate the HIV related disparities experienced by African American MSM, African-born women and their partners, and Latino MSM.

b) MAI funded activities.

*(1) Planning process for MAI.* The Part A recipient and the Council established three workgroups and formed a Disparities Elimination Committee (DEC) to plan MAI funded activities. Principles of community-based participatory research (CBPR) were employed to form the three distinct workgroups: African American Gay/Bi/MSM; African Leaders; and Latino Gay/Bi/MSM & Latina Transgender. Participants include community leaders and HIV prevention and care recipient staff. The objectives are to analyze community engagement with planning, implementation, and evaluation efforts around reducing HIV disparities and identify and close culturally specific gaps in care and prevention services. The results inform the development of workgroup-specific strategic plans to eliminating racial disparities and cultural specific needs of subpopulations. Key activities of the workgroups include collecting and analyzing data from key informant interviews and health summits to gain insight on culturally specific needs of sub-populations. Another workgroup function is to advise the Council and certain grant administrative activities to ensure that processes and decisions are inclusive, free of racial bias, and do not have unintentional consequences for communities of color.

The new Disparities Elimination Committee (DEC) is responsible for developing strategies to ensure Council's priorities and allocations address and reduce disparities within underserved and disproportionately impacted populations in access to HIV prevention and care services, outcomes based on the stages of the HCC: awareness of diagnosis; linkage to care; retention in care; receiving ART; and achieving suppressed virus. In 2016, DEC reviewed the MAI plan and previous year's outcomes. Another responsibility of DEC is to propose to the Council how MAI funds will be used.

*(2) Culturally appreciative and population tailored interventions.* The goals and objectives of the MAI Plan is to reduce HIV-related disparities and health inequities by improving access to HIV medical care for African American, African-born and Latino individuals through MCM and OHS. All funds will be allocated to core medical services.

i. MCM-Black or African-American and Latino. The goal of MCM is to increase access to HIV primary medical care and support services for African American, African-born, and Latino PLWH. The objectives of MCM services are to address disparities by connecting clients to health care, psychosocial supports, and other services that address clients' barriers to accessing HIV medical care. MCM - Black or African American was allocated 30% of MAI service funds ($91,800) for FY2016. A community-based organization with a strong presence in South Minneapolis since 1995 focuses on providing culturally-specific MCM services to African American and African-born individuals. The agency has well-established relationships with clinical providers of HIV medical care and EIS in Minneapolis and St. Paul. The second MAI funded MCM program is provided by bilingual staff at a Federally Qualified Health Center located in St. Paul's Latino community and is fully coordinated with clinical services. Funds for this service are disbursed on a unit-rate basis through quarterly invoices. MCM- Latino was allocated 33% of MAI service funds for FY2016, with a budget amount of $100,000.

MAI funded MCM services emphasize addressing barriers to HIV care while incorporating specific cultural needs and health determinants of the client. Gaps are identified both through the client's individual service plan as well as from the HCC analysis. MCM includes prevention education for positive individuals to help address this disparity. The objectives of MCM for these populations are to link clients to health care, psychosocial supports, Medical Transportation,

Mental Health, and Substance Abuse services that address clients' barriers to consistently accessing HIV medical care.

ii. OHS - Latino. The goal of MAI funded OHS is to increase the number of Latino individuals diagnosed with HIV who are continuously engaged in quality HIV medical care. The goal is to improve health outcomes for Latinos living with HIV in the TGA who have no other sources of health care coverage and support a patient-centered long-term culturally appropriate continuum of care. This includes providing health care for individuals who are ineligible for publicly funded Minnesota Health Care Programs (including Medicaid and insurance accessed through the MN's health insurance exchange MNSure). This service targets and addresses barriers an ethnic group has to receiving HIV medical services. By providing funds to serve this population at a full-service medical clinic located in St. Paul's Latino cultural and economic center, the Part A recipient promotes care linkage and retention for consumers at risk of dropping out of medical services. Latino PLWH who are uninsured, under-insured, or unable to pay medical deductibles, co-payments or co-insurance for medical care are able to receive otherwise cost-prohibitive medical services and are retained in care. The clinical objectives for initial visits and routine care include coverage for all laboratory tests, vaccinations, and radiological imaging. OHS is budgeted to receive 37% of the MAI funds in FY2016, with a budgeted amount of $113,600.

*(3) Impact of MAI funded programs and activities on improving HIV health outcomes.* With African Americans and Latinos less likely than Whites to be retained in care and have suppressed virus, MAI funded OHS and MCM services are designed to reduce these disparities along the HCC. To determine the impact of MAI funded services on the target populations, data are collected by MAI funded agencies as they provide services and are reported through MN's CAREware. MAI funded providers also report specified data on MAI outcomes spreadsheets to ensure that they maintain a high priority on measuring outcomes of specific MAI funded activities. This allows both the Part A recipient and subrecipients to regularly evaluate the impact of those activities on meeting the 2017 MAI goals and to meet the HRSA requirement to report on client level health outcomes for all FY2017 MAI-funded services.

The planned client level outcomes for MCM are consistent with HRSA/HAB Performance Measures and the TGA's MCM standards of care: 1) 95% of clients retained in care, 2) 90% of clients with improved or a stable viral load. In FY2015, 76 African Americans and 95 Latinos received MAI funded MCM services. Eighty-nine percent of African Americans and 86% of the Latinos receiving MAI funded MCM services had suppressed viral loads. The planned client level outcomes for OHS are also consistent with HRSA/HAB Performance Measures: 93% of clients have improved or a stable viral load. FY2015 outcomes were 90% of Latino clients and receiving MAI funded OHS had suppressed viral loads.

**5) Special Populations and Complexity of Providing Care**

a) Emerging Communities. *How emerging populations were identified.* Epidemiological data, FY2015 MNCAREWare client-level service utilization data, survey data from the Hennepin County 2010 and 2014 Survey of the Health of All the Population and the Environment and data from the Council's 2015 Comprehensive Needs Assessment Survey (2015 CNA) were analyzed to identify emerging populations. Significant service delivery changes were noted for IDU, Male to Female Transgender, and American Indian/Alaskan Native. These three populations showed at least a 7% increase in overall utilization of RWP Part A services from FY2014 to 2015.

- IDU *Unique Challenges.* In 2015, IDU had the highest rate of being out of care (36%) and the lowest rate of viral suppression (47%), compared to an average of 30% and 53% respectively. IDU experience difficulties engaging and staying in care due to factors associated with substance

use dependency (SUD) and social determinants of health including homelessness, lack of insurance and incarceration. In 2015 CNA, 27% of respondents reported an assessment for SUD and 7% reported sharing needles. Additionally, 17% of CNA respondents reported unstable housing or homelessness over the past year and 46% received EFA for housing. According to a study cited by CDC "two out of five people who inject drugs and were diagnosed with HIV did not know they were infected" Moreover, a lack of federal funding for needle exchange programs puts IDU at greater risk. Despite these challenges there was an overall increase (16%) from 2014 to 2015 in utilization of Part A services by IDU. While IDU are a relatively small group, service utilization has increased disproportionately between 2014 and 2015 including Outpatient Care (+114%), Oral Health Care (+60%), Medical Nutrition Therapy (+33%) and Food Bank/Home Delivered Meals (+28%). However, IDU are less likely to have contacts with routine or preventive health care providers, making it more difficult to engage and retain in care. MNCAREWare 2015 data indicates that IDU did not access health education, HIP, waivered services, mental health, or service outreach pointing to possible retention in care challenges for this sub-population. These factors indicate the potential for even more RWP Part A funding for core medical and support services for IDU.

- IDU *Estimated costs.* Using service utilization data from MNCAREWare and year–end expenditure reports, the estimated cost of providing Part A and B base (not including ADAP) funded services to IDU in 2015 was $165,199, Part A funded services alone was $115,559.
- Male to Female Transgender (MtF) *Unique Challenges.* MN appears to attract a relatively large number of individuals who describe themselves as transgender due to access to hormonal and surgical sex reassignment. Studies by the University of Minnesota's Program in Human Sexuality identified specific risk factors such as sexual identity conflict, shame and isolation, secrecy, search for affirmation, compulsive sexual behavior, prostitution, and found that transgender identity complicates talking about sex. Stigma, funding and services targeting transgender and genderqueer people remains challenging, particularly people of color. For example, low testing rates among MtF transgendered individuals demonstrates the lack of recognition or lack of support from both their racial/ethnic communities and the gay community. While Transgender MtF are a relatively small group, service utilization has increased disproportionately, specifically between 2014 and 2015 include Nutrition Therapy (133%), Outpatient Medical (42%), Oral Health and Health Education (33%), and Food Supports (24%). Overall there was a 16% increase in utilization of Part A services by Transgender MtF clients. All of these factors indicate an even greater need for RWP Part A funding for core medical and support for transgender individuals.
- Male to Female Transgender *Estimated Costs.* Using MNCAREWare service utilization data and year–end expenditure reports, the estimated cost of providing Part A and B base funded services to transgender individuals in 2015 was $117,676. The estimated cost for Part A funded services alone was $82,316.
- American Indian/Alaskan Native *Unique Challenges.* Although American Indians account for only 1% of the TGA's population, according to MDH they have over twice the HIV prevalence rate compared to Whites (202 per 100,000 persons and 92 per 100,000 persons respectively). Notable differences also exist in social determinants of health among American Indians. Poverty and uninsurance rates vary greatly by race with Whites at 8.1% and 3.4%, American Indian were considerably higher at 34.3% and 8.7% respectively. Nearly 23% of all CNA respondents indicated that they were homeless or their housing was unstable in the last year with rates of 45% for American Indian PLWH. Many homeless PLWH will require intensive assistance through

MCM services to access mental health or substance use treatment, shelter and supportive social services before successful treatment for HIV is likely. American Indians accessed SUD assessments and SUD treatment at rates of 55% and 24% respectively, much higher than the overall rate of 29% and 18% respectively. MDH reports significant increases in the rates of Viral Hepatitis C, Chlamydia, Gonorrhea, and Tuberculosis for American Indians. Challenges in meeting basic needs and high levels of co-occurring SUD and STD's result in frequent connections with the social service and emergency medical care. Many Part A service areas increased in utilization by Native American from 2014 to 2015 including Psychosocial Support (100%), OHS (57%), Health Education (33%), HIPA(34%), Substance Abuse Services (outpatient) (15%) and Medical Nutrition Therapy (10%). Increased service usage in these areas suggests that Native Americans may need additional supports, programs and funding to assist them in access HIV medical care.

- American Indian/Alaskan Native *Estimated Costs*. Using service utilization data from the TGA's client-level database and year–end expenditure reports, the estimated cost of providing Part A and B base (not including ADAP) funded services to American Indian/Alaskan Native PLWH in 2015 was $201,407. The estimated cost for Part A funded services was $140,887.

b) Under-represented Populations in RWP Funded HIV Primary Medical Care**.** Comparing 2015 TGA client-level data (CLD) from MNCAREWare with HIV prevalence data by gender, race/ethnicity, age and mode of HIV exposure, it appears that males, Whites and MSM are most significantly underrepresented in the RWP funded system of HIV primary medical care. Men represent 66% of those utilizing primary medical care in 2015, though they represented 76% of the epidemic, while women, though 24% of the TGA's epidemic, made up 32% of those receiving RWP funded primary care. Whites comprise 48% of PLWH in the TGA, while they represented 42% of those receiving RWP funded HIV primary care. While MSM and MSM/IDU represented 57% of PLWH in the TGA, only 42% of those receiving RWP funded primary care services in 2015 were MSM. The 2015 RWP CLD represents only a partial picture of the HIV system of primary medical care in the TGA. Minnesotans have historically had access to health insurance through public programs or the purchase of health insurance for PLWH through MN's high risk pool, now replaced by Qualified Health Plans under the ACA. This has reduced the need to use RWP Part A funds to directly support primary medical care and allowed funds to be used to create a comprehensive system of services that support access to care, including MCM. The Council allocated 15% of Part A funds for OHS for 2016. Minority AIDS Initiative (MAI) funds support a primary care program that provides bilingual services to Latinos, with a resulting increase in this group's representation in utilization data. Thus for 2015, of those utilizing RWP funded primary care, 15% were Latino, though only 9% of PLWH in the TGA identified as Latino. The largest racial group utilizing Part A funded OHS was Black PLWH, both U.S. and African-born, at 50% of those accessing OHS in 2015. Since 2003, many immigrants, except pregnant women, are ineligible for publicly-funded MN Healthcare Programs, including Medicaid. While MN's expanded Medicaid program under the ACA increases income eligibility for state-funded insurance coverage for the working poor to 138% of FPL, immigrants without documentation are still excluded. These changes continue to disproportionately impede the ability of some new immigrants, particularly Latinos, to access HIV primary medical care.

c) Profile of PLWH with Co-morbidities. ***Attachment 5*** presents the levels of co-morbidities for PLWH in the TGA compared to the general TGA population.

d) Impact of Co-morbidities and Co-factors on the Cost and Complexity of Care

PLWH in the TGA who have sexually transmitted infections (STIs) or other co-infections including Hepatitis C, are homeless, were recently incarcerated, living in poverty, affected by substance use, have severe mental illness, face additional challenges to access services, address co-occurring conditions, attain economic self-sufficiency and stable housing, and adhere to medical care in a complex system. The Part A recipient has collected quantitative data on HIV co-morbidities and release of PLWH from incarceration from MDH, WDHS, the U.S. Census Bureau, local, state and federal correctional agencies, reports and service providers. MN's DHS data on unit cost of HIV primary care and testing, RWP client service utilization data and service expenditures are all used to provide a more detailed picture of the impact of co-morbidities on access to care and its costs. Although data are available for several co-morbidities, their rates among PLWH are difficult to determine because other service systems often do not collect HIV related data. Linkages between systems of care are limited and PLWH may remain undiagnosed or untreated for other conditions. Likewise, PLWH receiving treatment for co-morbidities may be unaware of their HIV status and opportunities for diagnosis may be missed. Data collected since 2009 through the TGA's client level data system (CLD), MNCAREWare, provides details about the following co-morbidities among PLWH accessing RWP funded services.

*(1) Hepatitis C Virus*. According to MDH, there were 28,388 prevalent cases of Hepatitis C infection (past or present) in the TGA with 444 PLWH in the TGA co-infected with Hepatitis C as of December 31, 2015. There was a 2% increase in Hepatitis C prevalence in the TGA from 2014 to 2015, although the number of PLWH in the TGA co-infected with Hepatitis C declined by 6 cases. American Indians and African Americans have starkly disproportionate rates of Hepatitis C prevalence that are 5.3 and 2.6 times that of whites, respectively. With 6.5% of PLWH in the TGA co-infected with Hepatitis C and the exorbitant cost of effective combination antiviral medications such as Harvoni® and Solvadi®, the treatment costs excluding OHS for this population are likely to exceed $40 million. MN's ADAP formulary includes Hepatitis C antiviral medications and will pay the full cost of treatment for uninsured PLWH and co-payments for those with cost effective insurance. With a 5% uninsured rate among PLWH in the TGA who received RWP services in 2015, the annual cost of OHS for those who are co-infected with Hepatitis C virus, uninsured and eligible for Part A services would be $316,572. Providing MCM would add $649,572 to the cost of care.

*(2) STIs***.** MDH reports that over the past decade, MN's chlamydia rates increased by 61% while the rate of gonorrhea has fluctuated it has shown an overall increase of 8%. Rates of primary/secondary syphilis have increased 246%. MN has seen a resurgence in syphilis since 2002, with MSM being especially impacted and the co-infection rate with HIV continues to remain high. The number of early syphilis cases (primary, secondary, and early latent stages) increased from 49 in 2004 to 431 in 2015, with MSM accounting for 65% of all cases among males in 2015. Disparity in early syphilis rates between males and females has remained large and reflects the greater burden within the MSM community; however the rates among females increased over the past two years. The number of cases among women increased from 41 cases in 2014 to 88 cases in 2015 with three cases of congenital syphilis reported in 2015. Early syphilis cases among men decreased from 374 to 341 (-9%). Of all early syphilis cases reported in 2015, 80% were among males and 65% of these were MSM. Of the MSM early syphilis cases 56% were co-infected with HIV. Minneapolis accounted for the majority of cases (52%).

STI rates continued to be highest in Minneapolis. Disparities in STIs persist with communities of color having the highest rates. Between 2014 and 2015, the chlamydia incidence rate

increased by 7%, while the gonorrhea rate remained stable. In 2015, incidence rates of chlamydia increased by 11% among males and 5% among females; gonorrhea increased by 7% among males and decreased 7% among females. Adolescents and young adults (ages 15-24) accounted for 64% of chlamydia and 47% of gonorrhea cases reported in 2015. African Americans had the highest Chlamydia incidence rate in 2015 at nine times that of Whites follow by American Indians and Hispanics at four and three times that of White, respectively. Gonorrhea infection rates in 2015 were 16 times higher among African Americans and seven times higher among American Indians compared to Whites. In 2015 the rate of primary/secondary syphilis increased 300% among American Indians.

Based on 2015 unit costs for laboratory tests and treatment from the TGA's largest HIV and STI testing clinic, the cost of screening for chlamydia, gonorrhea and syphilis averages $540 per patient. Antibiotic treatment costs range from $8–$51. Treatment for co-infections can be as much as $89. Costs are even higher for treatment of later stage STIs. One latent case of syphilis can cost $716 which includes comprehensive treatment and follow-up. With 840 PLWH in the TGA diagnosed with gonorrhea, chlamydia, or syphilis in 2015, co-infections with STIs may add up to $453,600 (screening and treatment) to the annual cost of care for PLWH in the TGA.

*(3) Homelessness*. According to *Homelessness in Minnesota* (Wilder Research Center, 2015) an estimated 6,711 homeless individuals lived in Minneapolis-St. Paul in 2015. There were 9,312 homeless adults, youth, and children counted on the night of the October 2015 survey, down 9% from 2012. People of color are vastly overrepresented among MN's adult homeless population, with 39% identified as African American and 10% American Indian. According to *Homelessness in Minnesota* (Wilder Research Center), mental illness and drug abuse are prevalent among homeless adults. The report estimates that 57% have a serious mental illness. Homelessness is often preceded by childhood trauma and abuse: 39% of adults age 18 and older were physically abused; 33% experienced an out-of-home placement; and 37% lived with a parent or guardian with mental health issues. These additional co-morbidities are significant barriers to entering and maintaining primary HIV medical care. Homeless patients are more likely to visit emergency rooms, be hospitalized more frequently, stay in the hospital for longer periods of time, and have poorer health outcomes. Eighty percent of respondents to the Wilder homelessness survey said they were not taking a needed medication, and 46% said they were not getting needed medical care due to financial issues. In 2015, RWP CLD indicated that 664 or 19% of service recipients in the TGA reported that they were living in either non-permanent or unstable housing. The two largest HIV housing programs in the TGA report a combined waiting list of 382 individuals or families needing either transitional or permanent affordable housing. For those living with HIV and unstably housed, adherence to antiretroviral treatment is likely to be a significant challenge. All of these factors, complicated by inadequate resources to provide stable housing, will significantly increase the cost of care for homeless PLWH. Many homeless PLWH will require intensive assistance through Medical Case Management (MCM) to access mental health or substance use treatment, shelter and supportive social services before successful treatment for HIV is likely. Providing MCM services to PLWH out of care and homeless or unstably housed (426) could add an additional $942,172 to the cost of care. This cost is based on the proportion of Part A service recipients who report temporary or unstable housing (19%) and the annual per client cost of Part A funded MCM in 2014 ($1,463).

*(4) Formerly Incarcerated PLWH*. According to the Federal Bureau of Prisons, 11 PLWH were released from federal facilities in MN in 2013, 5 in 2014, and 8 in 2015. The Bureau's Clinical Practice Guidelines in June 2013 stated that voluntary testing is done at an inmate's request,

mandatory testing occurs when there are indications of risk factors, and involuntary testing is performed when an exposure incident occurs.

The Minnesota Department of Corrections (MNDOC) reports 33 PLWH were released from state correctional facilities in 2013, 27 in 2014, and 27 in 2015. Since 2007 the MNDOC has routinely screened for HIV at its St. Cloud facility, a "pass through" center for all men entering the state correctional system. Screening began at the female state correctional facility in 2008. Estimating HIV-positive individuals detained in the county jail system is more difficult as an average length of stay is only six to seven days, routine screening is not part of the intake or discharge process and health screening forms do not ask about HIV status. While a detainee does have the opportunity to disclose HIV status, and individuals are asked if they have any medical or medication needs, there is little incentive for them to request screening or disclose status due to potential stigma and the transitory nature of their detainment. Based on staff estimates from Hennepin County and Ramsey County Adult Corrections 64 PLWH were known to be released from local correctional facilities in 2013, 11 in 2014, and 214 in 2015. Hennepin and Ramsey County residents comprise 52% of the TGA's population. In addition to these approximations, the Hennepin County Jail estimates three to four PLWH cycle through its facility each month and the Ramsey County Jail estimates 25 PLWH were provided with HIV medications each year for the last three years. MCM services can assist PLWH in maintaining or connecting to medical care at the time of release, a critical time to support PLWH as they reenter society. Estimating that a minimum of 249 PLWH were released from Federal, State and the TGA's two largest counties' facilities in 2015, providing MCM and Outpatient Healthcare Services (OHS) services to the formerly incarcerated would add a minimum of $364,287 and $177,537 to the annual cost of care, respectively. The annual per client cost for Part A funded OHS in 2015 was $713.

*(5) Mental Illness.* In its *Statewide Health Assessment: Part Two: The Health of Minnesota* (2012), MDH notes that individuals with serious mental illnesses are more likely to experience homelessness, be uninsured, and lack social support. These are all issues that complicate the ability of PLWH, if they are also affected by serious mental illness, to access regular HIV medical care. The MDH report also discusses that the difficulty of changing behaviors such as smoking or alcohol use in persons with serious mental illnesses is compounded by their mental status and their life circumstances. Added to this may be the challenges of making and sustaining behavior changes that will enable treatment adherence and prevention strategies for those living with HIV. Over 8% (350,000) of Minnesota's adult population experienced significant depressive symptoms in 2011; and 3% (about 125,000) had symptoms suggestive of serious psychological distress. According to Hennepin County's Survey of the Health of All the Population and the Environment (SHAPE) in 2014, frequent mental distress is 2 times more prevalent among gay and bisexual adult males than among their heterosexual counterparts. DHS estimates that 5.7% of the TGA's population (202,385) has serious mental illness and/or serious and persistent mental illness. In 2015, 402 PLWH in the TGA who were enrolled in a Minnesota Healthcare Program (MHCP) received outpatient mental health services covered by a MHCP at a cost of $461,094. An additional 141 RWP eligible PLWH in the TGA received a RWP funded mental health service in FY2015. According to the Council's 2015 Comprehensive Needs Assessment (CNA), 61% of respondents (433) reported that they received mental health therapy from a licensed clinical mental health provider in the past year and 46% had been prescribed medication for mental health treatment since their HIV diagnosis. In FY2015, $73,767 in Part A funds were spent on mental health services for PLWH in the TGA.

*(6) Substance Abuse***.** The Substance Abuse and Mental Health Services Administration (SAMSHA), in its 2009 *States in Brief: Minnesota* report; found that MN's rates of past-year alcohol dependence have generally been in the top ten of national rates. The rate of Minnesotans needing and not receiving alcohol treatment have generally been above the national rates. The 2013 National Survey on Drug Use and Health Prevalence Estimates show that 3.0% and 3.7% of MN's population 12 years of age and older have an alcohol and or illicit drug dependence, respectively. SHAPE 2010 found that an alarming 52% of young LGBT adults (ages 18-34) reported binge drinking and older LGBT adults were twice as likely to report heavy drinking as their non-LGBT peers. Given that 58% of the TGA's PLWH are MSM, rates of alcohol abuse are likely higher among PLWH. An estimated 151 PLWH enrolled in a MHCP received substance abuse treatment services in 2015 at a cost of $1,125,242. According to the 2015 CNA, 18% of PLWH who responded to the survey received outpatient substance abuse treatment in the past year. In 2015, 233 PLWH in the TGA received Part A funded outpatient Substance Abuse Treatment Services at a cost of $135,863.

**6) AIDS Pharmaceutical Assistance** – The Minneapolis-St. Paul TGA Part A grant does not fund a Local Pharmaceutical Assistance Program.

▪ *METHODOLOGY*

**A. Impact of Funding**

**1) Impact and Response to Reduction in RWHAP Formula Funding**

The TGA received a 1.2% increase in Part A formula funding in FY2016. Formula funding increased by $43,347 in FY2016 from $3,602,836 in FY2015 to $3,646,183 in FY2016.

**2) Impact of the Changing Health Care Landscape**

a) Uninsured and poverty. The following table compares current estimates of health insurance and income status for the Minneapolis-St. Paul TGA's overall population with estimates of insurance and poverty for the TGA's population of PLWH.

**Table 1. Insurance and Income for the TGA's Population and Diagnosed PLWH**

| | TGA | % | PLWH | % | Data Source |
|---|---|---|---|---|---|
| **Total Population** | **3,456,257^** | **100%** | **7,060*** | **0.2%** | ^ACS, *MDH |
| **Health Insurance** | | | | | |
| Medicare | 488,724 | 14% | 954 | 14% | ^ACS, **MNCAREWare |
| Medicaid | 735,323 | 21% | 1,680 | 24% | DHS*, **MNCAREWare |
| MinnesotaCare (Basic Health Plan) | 90,109 | 2.6% | 127 | 1.8% | DHS*, **MNCAREWare |
| Qualified Health Plan (*MNSure*) | 63,057 | 1.8% | 112 | 1.6% | DHS* (Est), **MNCAREWare |
| Qualified Health Plan + APTC[ł] | 16,259 | 0.5% | 112 | 1.6% | DHS* (Est), **MNCAREWare |
| Uninsured | 148,619 | 4.3% | 458 | 4.7% | DHS*, **MNCAREWare |
| **Income as % of FPL (up to/cumulative) ^** | | | | | |
| 138% (Medicaid eligible) | 454,532 | 13% | 3,078 | 44% | ^ACS, **MNCAREWare |
| 200% (MinnesotaCare eligible) | 802,025 | 23% | 3,938 | 56% | ^ACS, **MNCAREWare |
| 300% (Ryan White eligible) | 1,277,270 | 37% | 4,624 | 65% | ^ACS, **MNCAREWare |
| 400% (APTCł eligible) | 1,747,453 | 51% | 5,332 | 76% | ^ACS, **MNCAREWare |

^U.S. Census Bureau American Community Survey 1-year population estimate (2014), *MDH eHARS, *Minnesota Department of Human Services - Minnesota Medicaid Information System (MMIS), łAdvanced Premium Tax Credit (All RWP eligible QHP enrollees qualify for an APTC), **Minnesota CAREWare

b) Impact of health insurance expansion. MN is a nationally-recognized leader in healthcare, improving resident's well-being, and public resources management. By coordinating patient-

centered care with the social determinants of health, the state is working to prevent and alleviate chronic illnesses, such as HIV and create health and prosperity for all. The intent of the ACA is to expand health insurance and reform the health care delivery system to improve quality and value. The ACA includes provisions to eliminate disparities in health care, protections for people with pre-existing conditions such as HIV, strengthen public health and health care access, invest in the expansion, improvement of the health care workforce and encourage consumer and patient wellness in both the community and the workplace.

*(1) Service Provision and the complexity of providing care to PLWH in the TGA.* MN has one of the lowest rates of uninsured residents in the nation with 2015 showing 4.3% compared to 8.2% in 2013. MN has enrolled 1,026,023 individuals in Medicaid and CHIP, a net increase of 17.52%. The increase in health insurance coverage is primarily driven by enrollment in publicly funded state health insurance programs. Currently, 1 in 5 Minnesotans rely on Medicaid or MinnesotaCare. Coverage on *MNSure*, MN's state-based marketplace, covers 10% of Minnesotans on individual or small group coverage. Currently, there are at least 1,807 of the TGA's PLWH covered under Medicaid, MinnesotaCare (Basic Health Plan) or by a Qualified Health Plan (QHP) through *MNSure.* Individuals with income below 138% of FPL are eligible for Medicaid. Those between 138% and 200% of FPL are eligible for MinnesotaCare. Despite these overall changes, the uninsured rate among the TGA's RWP recipients has remained relatively unchanged at 5% since 2010. However, notable disparities continue to exist among the uninsured in the areas of race/ethnicity, age, and country of birth. For example while only 3.4% of Whites were uninsured in 2015, the percentages among Hispanics (11.7%), American Indians (8.7%), and Blacks (8.4%) were considerably higher.

The Council's 2015 Comprehensive Needs Assessment (2015 CNA) survey of 504 PLWH asked if participants had needed but not received HIV care and related core medical and support services in the previous 12 months. Nine percent (9%) of respondents reported being denied HIV medical care because they were uninsured or couldn't afford the co-payment, 23% reported waiting more than three months before receiving care and 11% reported waiting more than a year. Of the 2015 CNA, 31% reported difficulty signing up for insurance, with higher rates in racially and culturally specific populations including American Indian/Alaskan Native (44%) respondents and Latino (41%) respondents. Twenty-eight percent of PLWH reported that they have been without health insurance for three months or longer since they received their HIV diagnosis, with higher rates for American Indian (42%) respondents, API (33%) respondents, and Latino (48%) respondents. In addition, PLWH without citizenship are not eligible for publicly funded health care and need help navigating the private insurance market and accessing ADAP to cover premiums and other out-of-pocket costs. Program HH (ADAP) works extensively to contact eligible HIV-positive individuals who are undocumented to purchase 220 off-Exchange policies annually. Among the 2015 CNA respondents, the RWP or the clinic covered the cost of care for 21% of those who received medical care in the past 12 months.

Overall sixty-three (63%) percent of PLWH who participated in the CNA survey reported receiving assistance in paying for health insurance premiums, while 66% of American Indian/Alaska Natives and 79% of Latinos participating in the survey reported receiving assistance for premiums. Nineteen percent (19%) of American Indian and Latino respondents and 20% percent of API respondents reported they had been denied medical care because they couldn't pay for treatment due to not having insurance compared to only 3% of Black respondents and 2% of white respondents. Though young PLWH ages 13-39 years represent 29% of those living with HIV and 34% those utilizing RWP services in the TGA, only 5% of

PLWH between the ages of 13 and 39 in the TGA utilized RWP Health Insurance Premium/Cost Sharing Assistance (HIP) services.

Overall the ACA has resulted in more people being able to access health insurance. For people with HIV who are on Medicare, the Part D prescription drug benefit is also more affordable. MN's ADAP chooses healthcare plans with medication deductibles and co-payments that count towards out-of-pocket expenses. As a result, a person living with HIV gets through the coverage cap (or donut hole) faster. ADAP also pays for open market policies for eligible clients who cannot qualify for subsidies due to immigration status. Preventive screenings at no cost are also a very important aspect of the ACA. Screenings aide in early identification which has become increasingly important to the elimination of HIV disease.

Although the ACA has many advantages for the community and PLWH, it created a more complex system of obtaining insurance for those struggling to meet their basic needs, experiencing homelessness or other hardship, and foreign-born. Limited open enrollment periods has exacerbated temporary loss of coverage and access to HIV medical care due to changing circumstances that impact eligibility for publicly funded or subsidized private health coverage. PLWH who are undocumented may be unaware of ADAP. PLWH who purchase insurance on MNSure may experience annual plan changes, along with dramatic premium increases (17% - 49%) in 2017. While the ACA has had a significant impact on eligibility for health insurance and thus who pays for the services needed, the continuum of HIV services has not changed because it is based on the needs of Minnesotans living with HIV.

*(2) Changes in allocations, including activities related to health insurance premium assistance.*

The Part A Program coordinates with MN's ADAP and HIV insurance assistance program to ensure coverage of health insurance premiums that are not covered by the Advanced Premium Tax Credits for PLWH enrolled in QHP's through MNSure. ADAP pays for prescription deductibles, co-payments and co-insurance for all RWP eligible PLWH with an annual income up to 400% of FPL. ADAP and the insurance assistance program also cover low income PLWH who are not eligible for other coverage because of their citizenship status. Medical co-payments are covered by Part A funded OHS at three HIV specialty clinics, one of which is the largest provider of primary care for PLWH in the TGA, and through EFA (funded by Parts A and B). Currently, 433 PLWH in the TGA receive premium assistance through ADAP. Part A and Part B funded services such as MCM and Non-medical Case Management/Benefits Counseling (Part B) played a crucial role in assisting the TGA's PLWH - who were previously covered under MN's high risk insurance pool because they were either ineligible for Medicaid or were shut out of the private market due to their HIV infection - to enroll in expanded Medicaid or QHP's through MNSure. MCM is allocated 45% of Part A funds in FY2016 and 2017 and along with Benefits Counseling funded through Part B, neither of which are covered by insurance, ensures that the TGA's PLWH continue to receive assistance in enrolling in Medicaid, MinnesotaCare or a QHP through MNSure or a select private plan on the open market with premium and prescription co-payment assistance through ADAP if ineligible to enroll through MNSure.

The following Part A funded services, including the proportion of Part A allocation to each category, are provided for the PLWH in the TGA who are covered by Medicaid, MinnesotaCare, a QHP or a select private plan on the open market to assist with out-of-pocket costs that can impose barriers to accessing medical care: OHS for uncovered services, deductible and co-payment coverage (17%); MCM (45%); Early Intervention services (EIS) (3%); Home and Community-based Health Services not covered by insurance (4%); EFA (2%); Food Bank/Home Delivered Meals (12%); Housing services (2%); Psychosocial Support Services (2%); Outreach

services (3%); HE/RR (2%); and Legal Services (2%). Part B also provides resources for PLWH in the TGA through ADAP to cover premium payments and prescription co-payments and deductibles; MCM; Oral Health Care; Medical Transportation; Non-medical Case Management (Benefits Counseling); and Referral for Healthcare and Supportive Services.

Although covered by the ACA, Part A funded Substance Abuse Outpatient Treatment, Part A and Part C funded OHS, and Part A and B funded Oral Health Care and Mental Health services fill temporary gaps in coverage for uninsured or underinsured, PLWH who are either newly diagnosed or are reconnected to care between open enrollment periods, and "just in time" services to those where delays might result in disengagement. In addition, MCM supports retention in medical care and treatment adherence, provides a gateway to Part A funded supportive services such as Food Bank/Home Delivered Meals, EFA, Housing Services and Psychosocial Support that are not covered by insurance and address social determinants of health to stay connected to care. Supportive services along with MCM combined comprise 70% of Part A allocations to services in FY2016 and these programs will be sustained in FY2017.

*(3) Costs including service costs, cost-sharing, cost savings.* Although MN is implementing health insurance expansion under the ACA, the impact on service costs is varied. The increased health insurance system complexity for the TGA's PLWH, makes consistent coverage more challenging, resulting in increased reliance of RWP services to fill coverage gaps for short periods. The short annual open enrollment period for obtaining QHP's through MNSure may result in coverage gaps depending on when PLWH who don't qualify for Medicare, Medicaid, or MinnesotaCare need to obtain coverage through private plans on the exchange. In Minnesota, since MNSure opened in 2013, the QHPs available have changed significantly each year requiring PLWH to change plans annually which may increase the risk of losing coverage. Dramatic increases in QHP premiums in 2016 and 2017 may increase out-of-pocket costs for PLWH, particularly for those whose income is above 200% of FPG. Large premium increases will also increase ADAP insurance premium assistance costs. Some costs of RWP services may be declining because of insurance expansion. MN's ADAP expenditures declined in FY2015 as did Part A expenditures on Mental Health Services. With more PLWH on Medicaid, Treatment Adherence service costs may also decline with Medicaid covering more medication treatment management for more PLWH.

c) Outreach and Enrollment.

*(1) Outreach and Enrollment Efforts.* DHS (Part B recipient) conducts a number of outreach and enrollment activities to ensure that both RWP eligible PLWH and RWP Part A and B recipients and subrecipients are informed about insurance enrollment opportunities. DHS' ADAP Coordinator provides regular updates for the Council and at MN's annual HIV care and prevention provider meeting that reaches over 100 RWP and CDC HIV prevention program service delivery staff on implementation of the ACA and how it impacts PLWH. DHS' HIV/AIDS Program administers ADAP, the state's Part B funded HIV Oral Health care services, and Part B and state funded MCM services through their centralized Program HH, providing services in 2015 to 1,279 or 42% of Part A program clients. MCM and benefits counselors also receive annual training on how to assist PLWH in enrolling in insurance through MNSure and the QHPs selected by the ADAP and its insurance assistance program to provide the most cost effective coverage. In collaboration with the Part A recipient, DHS also provides an annual core training for all new case managers in the state that includes information on MN Health Care Programs (including Medicaid). DHS provides funding for five HIV specific benefits counselors who are housed at the two largest Part A funded agencies; Hennepin County Medical Center's

(HCMC's) Positive Care Center, the state's largest HIV specialty medical care provider, and the Minnesota AIDS Project (MAP), the largest community-based AIDS service organization in MN. Combined, their MCM programs provide services to 25% of PLWH in the TGA.

DHS also conducts strategic client outreach and HIV service provider benefits training events. In addition to coordinated informational mailings to their Program HH clients about insurance enrollment and eligibility requirements, a series of four public meetings was held prior to the first open enrollment period in 2013 to help Program HH clients understand the ACA in MN. The personalized mailings included detailed information about how insurance changes would affect each client specifically. The public meetings consisted of an educational component along with time for questions and answers. The meetings were held at different locations in the TGA and one forum was held for the Latino community where interpreters were available for Spanish-speaking clients. Part A funded MCM programs are required to have at least one representative participate in DHS' annual all-day "Benefits Boot Camp" that provides case managers and benefits counselors with information about MNSure open enrollment, Minnesota Health Care Program policy changes and how to help clients enroll in a new plan through the MNSure. DHS also works closely with all RWP funded case management programs to ensure that the case managers have information on all of their Program HH clients who needed to enroll in an insurance plan through MNSure because they were eligible for expanded Medicaid, MinnesotaCare or a QHP with subsidized premiums or if they need to select a new QHP because the plans are changing.

*(2) Coordination with Partners.* MAP receives a MNSure outreach grant to target members of the LGBT community for insurance enrollment through MNSure. MAP receives Part A and/or B funding for Substance Abuse Treatment/Outpatient, Benefits Counseling, Medical Transportation, EFA, Food Bank/Home Delivered Meals, Health Insurance Premium and Cost Share Assistance and HE/RR services. MAP also receives state funding for MCM and provided various services to 1,759 PLWH in the TGA. MAP's MNSure outreach grant is a partnership with HCMC, Outfront Minnesota, Rainbow Health Initiative and the Rural AIDS Action Network (RAAN). HCMC's Positive Care Center provides HIV medical care to 1,800 PLWH in the TGA. Outfront Minnesota is MN's largest LGBT advocacy organization and Rainbow Health Initiative manages a statewide LGBT health coalition that organizes to eliminate LGBT health disparities in MN. RAAN provides Part B funded services to exurban areas of the TGA. MAP conducts MNSure enrollment outreach events at the Twin Cities Pride Festivals and employs two benefits counselors and eight insurance enrollment assisters to help members of the HIV and LGBT communities enroll in insurance through MNSure. Sub-Saharan Youth and Families Services (SAYFSM), a Part A subrecipient of RWP funding for Mental Health, Psychosocial Support and Medical Transportation services, also received a MNSure outreach grant. SAYFSM provides linguistically and culturally specific services to African-born PLWH and employs three assisters to help African immigrants obtain health care coverage through MNSure.

*(3) Major Challenges.* Annual changes in health insurance offerings, increases in premiums and technical difficulties accessing MNSure are major challenges to outreach and enrollment efforts. For the past two years the most popular plan option from the previous year is no longer available. This year insurance premiums on MNSure increased dramatically. MNSure continues to struggle with technical difficulties further exacerbate outreach and enrollment.

*(4) Major Facilitators.* The 12 PLWH and 10 service provider representatives who are Council members and are key information conduits to the TGA's HIV community are provided information on *MNSure* to share with their contacts and clients. The Part A Program Coordinator

also served on Hennepin County's Health Insurance Exchange and Systems Modernization advisory committee to bring HIV specific health insurance needs to the County and state as MN's health insurance exchange was being developed. The Part A recipient closely coordinates ACA enrollment information dissemination and activities with its 14 Part A subrecipient agencies, Hennepin County's Eligibility and Work Supports service area and DHS.

d) Marketplace Options. In addition to Medical Assistance (Medicaid) and MinnesotaCare, MNSure offers four levels of coverage (Bronze, Silver, Gold and Platinum) through its Qualified Health Plans (QHP) and a catastrophic plan for enrollees under 30 years of age or meet other criteria. DHS's ADAP program provides premium assistance and formulary drug co-payments and deductibles for RWP eligible PLWH - with incomes up to 400% of the FPL - enrolled in one of four gold level coverage QHPs if they are ineligible for Medical Assistance or MinnesotaCare. These plans were selected based on inclusion of comprehensive ART medications in all classes and access to all of the TGA providers that offer HIV specialty care. HIV benefits counselors help DHS evaluate MNSure's QHPs for affordability, health benefits, drug formularies, and provider choice prior to each open enrollment period. *MNSure* plan premiums range from $177 (bronze) to $480 (platinum) per month for a single 40-year old living in the Twin Cities. Deductibles range from $0-$7,000 with out-of-pocket maximum costs ranging from $5,750 - $11,000. Prescription co-payments range from $0 (after deductible is met) to $60. Benefits counselors, insurance enrollment assisters, and MCM help clients chose a plan that maximizes cost-effectiveness and provider choice. To date, DHS has not received reports of medication or HIV specialty care access problems from PLWH enrolled in a QHP.

**Plan Comparison** (mnsure.org)

| | **Bronze Plan** | **Silver Plan** | **Gold Plan** | **Platinum Plan** |
|---|---|---|---|---|
| Monthly Premium | $ | $$ | $$$ | $$$$ |
| Cost You Pay | $$$$ | $$$ | $$ | $ |
| Cost Plan Pays | 60% | 70% | 80% | 90% |

*(1) Plan Impact on Provider Accessibility*: The most significant challenge for PLWH in the TGA who are eligible for insurance through MNSure for 2017 is the premium increases between 17% - 49% and plan selection during open enrollment, particularly for those enrollees whose plan is no longer a QHP for 2017. For example, Blue Cross and Blue Shield of Minnesota (BCBS) is no longer selling Blue Cross individual health insurance plans in the state—both on and outside of MNSure. DHS HIV program staff, MCM, and benefit counselors routinely assist people to migrate from one plan to another and resolve provider accessibility issues. There have been no reports of discontinuous care as a result of the ACA. MN laws are more stringent than federal provider network requirements requiring health plans to meet strict accessibility standards and offer contracts to all state-designated essential community providers in its service area. As a result, few people experience disruptions related to differences in provider networks.

*(2) Plan Impact on Care and Medications*: DHS carefully selected four gold level plans for 2017 that ADAP supports with additional premium and co-payment assistance to provide continuity of client provider choice and comprehensive ART prescription coverage. Both Part A and B funded MCMs and Part B and ADAP rebate funded benefits counselors play a key role in helping all eligible clients enroll in new plans. Annually, new insurance information needs to be updated at pharmacies resulting from changes in QHPs. In 2016 DHS customer care staff resolved all of the issues thus preventing any delays in prescription dispensation. Part A and B funded MCMs and Part B funded benefits counselors work with their RWP clients during open enrollment periods to ensure that those eligible to enroll in insurance through MNSure receive assistance to maintain

continuity when client eligibility and plan changes occur. DHS also offers training for case managers, benefits counselors and MNSure assisters prior to open enrollment.

**3) Planning and Resource Allocation**

a) Description of the Community Input Process

*(1) Structure of the Community Input Process.* The Minnesota Council for HIV/AIDS Care and Prevention (Council) serves as the single community planning body for RWP Part A and B as well as for HIV prevention planning for the TGA and Minnesota (MN). The HIV epidemic is centered in the Twin Cities metro area with 85% of MN's HIV cases. MDH, DHS and Hennepin County Public Health created a joint integrated HIV care and prevention body to ensure coordination of funding streams, administrative efficiency, and coordinated evaluation of publicly funded HIV programs. The Council meets all requirements under sections 2602 and 2610 of the federal RWP legislation. Council membership is reflective of the epidemic in the TGA. The Council incorporates additional community input through consumer forums and needs assessment surveys. The Council completed its biennial prioritization process for FY2017 and 2018 in August 2016. The Council prioritizes services and allocates funds for both the Part A TGA and MN Part B. The Council's Planning & Allocations Committee (PAC) refined the prioritization process based on member feedback from past processes. The full Council then approved the list of services to be prioritized and the MAI services to be funded. MDH's HIV epidemiologist presents annually to the Council on MN's and the TGA's HCC by geography, gender, race, ethnicity and mode of HIV exposure to identify disparities. The degree to which each service impacts the HCC by facilitating early identification, linking to and retention in care, and ultimately viral suppression is a primary consideration in making allocations.

The Council's Needs Assessment & Evaluation Committee (NA&E) reviewed data from a variety of sources, studies, and surveys, and created Service Area Review Summaries (SARS) for each of services included on the final prioritization list. Council members received a SAR for each of service. Priorities are ranked separately for core medical and support services through a paired comparison process where each member uses grids to compare the priority of each core medical service category to all of the other core medical services. They then do the same for each support service. Members complete the paired comparison forms individually that result in a score for each service area. Aggregate scores provided a final list of ten ranked core medical and eleven ranked supportive services to be funded by Parts A and B in 2017 and 2018. Part A funds were allocated to eight core medical and nine supportive services (*See **Attachment 8**).* PAC developed values and guidelines for allocation decisions. The Council-approved values demonstrate the relative importance of data-based decision making and consideration of the needs and input of PLWH. At the Council's August meeting, allocations for FY2017 were presented, discussed, revised, and approved. The Council assumes flat funding each year and final notices of grant award usually are not issued until after the fiscal year begins. The Council will again consider allocation adjustments when FY 2017 Notices of Grant Awards are received.

*(2) Prioritization and Allocation Process*

(a) Consideration of those not in care, unaware, and historically underserved. To determine service category priorities and funding amounts the Council reviewed demographic patterns of service utilization, epidemiological data, Unmet Need Estimate, MN's HCC, RWP Part A and B expenditure reports, demographic reports for African American, Latino and African-born PLWH, 2010 & 2015 Consumer Needs Assessments (2010 & 2015 CNA), and the Latino AIDS Commission findings from interviews with Latino MSM (2014). Of the 504 PLWH who

completed the 2015 CNA, 23% did not have their first medical visit until four or more months after diagnosis, 11% reported that it was a year or longer before they saw a doctor. Two percent of the respondents indicated they had not visited with an HIV clinician in the past 12 months. Respondents indicated that lack of transportation, inability to find a physician they liked, and multiple service locations were contributing factors for being out of care. Six percent of all respondents indicated they had been denied medical care due to inability to pay. In November and December of 2013, representatives from Latino and African-born populations shared knowledge about barriers to care with the NA&E. Barriers to care among the Latino population included lack of transportation, stigma, and limited culturally appropriate treatment centers. Stigma, misinformation about HIV and AIDS, and limited understanding of the health care system were identified as main barriers to care among the African-born population. The Council used these data to prioritize services and allocate resources to service areas that connect people to community-based culturally appreciative services.

The needs of persons unaware of their HIV status were also considered. Council members and support staff serve on the EIIHA Workgroup, convened by the Part A and B recipients and MDH. Together with the Council, they formulate recommendations to identify persons unaware of their HIV status and facilitate their connection to care. Recommendations from this work group were presented to the Council during the development of the 2017–2021 Integrated HIV Prevention and Care Plan. These were also included in relevant SARS used in the prioritization process. The allocations approved by the Council for FY2017 included allocations to EIS, Outreach, and OHS. Assessing initial needs among persons recently diagnosed was considered a good indicator of service needs of persons who might be unaware of their infection. In consideration of needs of persons unaware of their status, RWP resources were allocated in ways that: 1) sustain "beacon services" that provide visible and accessible entry points to the HIV service system, and 2) develop the capacity of Outreach providers to use peers to provide information and support to those who have delayed HIV care.

The Council considered needs of historically underserved populations. The NA&E compared demographic patterns of client service utilization with epidemiological data, the Unmet Need estimate, expenditures on culturally appropriate services, and demographic reports for African Americans, Latinos and African-born PLWH from needs assessments, to prioritize service categories addressing needs of the underserved. The Council allocated $113,800 of Part A MAI in FY2017 for culturally appropriate OHS to assist Latinos with accessing and adhering to HIV medical care. Latinos in MN are also more likely to have AIDS at first diagnosis than other racial/ethnic populations. This program has reduced disparities in care access. Additional allocations of $191,800 in MAI funds to MCM and $158,800 in Part A funds to Outreach will increase access and reduce disparities for historically underserved populations.

(b) PLWH involvement in priority setting and allocation. All populations identified as having severe need are represented on the Council, including four African immigrants. The Council is currently composed of 30 members, eleven (36%) of whom identify as living with HIV. The Council's Community Voice Committee (CVC) meets quarterly and includes Council members as well as community members living with HIV. The CVC provides perspective on emerging service needs and problems associated with current service delivery. The group provides the Council with key insights on issues for PLWH and feedback on priorities, allocations, and care standards. During the current prioritization process, lists of service categories and activities developed by PAC were reviewed by the CVC for consumer input before going to the full Council. PLWH are members of all Council committees. They provide input on services,

allocations, data collection and analysis. Time allotted for community members to discuss service needs is a standing agenda item at each Council meeting. In addition to serving on the Council and its committees, PLWH participate in needs assessments and consumer surveys.
(c) Community input for Part A award funding increases or decreases. The Council planned for possible changes in the Part A award amount when it approved the prioritization and allocations processes for FY2017 and 2018 funding. PAC recommended allocations based on flat funding with scenario planning for an award increase or decrease. If funding decreases, allocations for service areas not fully expended in 2016 are automatically reduced by unspent amounts. All service areas are examined to maintain the 75% core medical expenditure requirement and reduced proportionately. If funding increases, allocations will be increased proportionately, while continuing to ensure core medical services are available to all eligible PLWH.
(d) MAI funding consideration to enhance services to minority populations. In evaluating the need to eliminate gaps and barriers in services for disproportionately impacted and underserved populations, the Council considered data from the 2015 CNA, HIV surveillance, Unmet Need estimate and the HCC on minority populations. The number of Latino consumers accessing medical care at the clinic receiving MAI funding has risen since funding inception. Based on the data, PAC determined it important to sustain two services: OHS (receiving $113,300) and MCM (receiving $191,800) that target African Americans and Latinos.
(e) Data use in priority setting and allocation to increase access to core medical services and reduce disparities. For priority setting and allocation processes, the Council reviewed and considered epidemiological data, the Unmet Need Estimate, service utilization data, needs assessments, quarterly and annual grantee expenditure reports, expenditures on HIV care from other sources, and qualitative data including the Latino AIDS Commission study on Latino MSM in MN. The Council examines trends in the epidemic from the previous three years, changes in epidemiologic data including demographics, emerging populations, the HCC, and estimates of Unmet Need. The Council used these data to consider allocations to services based upon prevalence and to determine resource allocations to address disparities and fill gaps in services. Part A recipient staff presented service utilization data including analyses of service utilization by population characteristics. Data from the 2015 CNA, which included information on number of persons who needed but had not accessed a particular service in the previous year, were used to inform the Council on service needs and were considered in the allocations process. The Council used data in many ways to establish priorities and allocations for core medical and support services. Increases in prevalence as evidenced in annual epidemiological updates mean more people need assistance to maintain health care. To address an influx of new consumers, the Council reduced allocations to previously under-utilized services to maintain those for core medical services in FY2017.
(f) Use of changes and trends in HIV epidemiology for priority setting and allocations. As the epidemic in the TGA has shifted, greater emphasis has been placed on services to people of color including men of color who have sex with men and African-born immigrants. PAC reviewed lists of services to be supported with MAI funds in FY2017. They determined culturally appropriate primary care and MCM should be included. The Council allocated funds to continue to support culturally appropriate primary care and MCM that target Latinos. Allocating MAI funds towards MCM for African Americans has continued since 2005. In 2015, MSM accounted for 56% of PLWH in the TGA. Though the proportions of new infections among MSM have remained relatively stable over the past decade, there is a small but constant increase of cases among African American MSM. The numbers of new HIV infections among females in MN in

2015 were higher than in 2014 with women of color exceeding their White counterparts, and African-born women disproportionately infected. In an effort to address these trends, the Council sustained FY2015 allocations to several services particularly those serving communities of color including Medical Transportation and Psychosocial Support for African women.
(g) Use of cost data for funding allocation decisions. To help determine service allocation levels, Council members were provided with service capacity data based on provider contractual goals, client utilization, units of service provided and quarterly expenditure reports. MCM, Medical Nutritional Therapy, Food Bank/Home Delivered Meals, Home and Community-based Health services and Substance Abuse Services Outpatient are procured on a unit rate basis. These data are used to estimate costs and along with client-level outcomes data to assess cost effectiveness.
(h) Use of data from federally funded HIV/AIDS programs for priorities **(*Attachment 7*).** NA&E reviewed data regarding other state and federally funded HIV programs and included those funding amounts on the individual Service Area Review Summaries. These data informed Council members of other funding sources for each service, allowing the Council to make informed decisions on more efficient and effective uses of RWP resources. When prioritizing and allocating funding for Housing services, the Council considered the availability of HOPWA for the housing needs of PLWH.
(i) Consideration of anticipated changes due to the ACA for developing priorities. The Council considered information on implementation of the ACA in MN that informed prioritization of services and allocation of funds for FY2017. Medicaid expansion along with MN's health insurance exchange provided additional options for access to quality healthcare. Council members considered these changes when comparing ADAP, OHS, Mental Health, Oral Health Care and Health Insurance Premium/Cost-share Assistance with other core medical services in their paired-comparison priority ranking grids. Anticipated ACA changes impacted rankings for FY2017 and 2018. Oral Health Care dropped in ranking while MCM and EIS increased in ranking. Through reports provided by Part B recipient staff, the Council monitors impacts of expanded Medicaid and Advanced Premium Tax Credits on MN's ADAP and HIV Insurance Program expenditures. The Council monitors trends in utilization of RWP Part A funded services anticipated to be impacted by the ACA such as OHS and Mental Health services. Once available, these data are used to make allocation adjustments to service areas experiencing lower or higher utilization because of health insurance expansion.
(j) Efforts to integrate prevention and care at the Part A level**.** Historically, MN has had two planning bodies responsible for segregated community planning for prevention and care services. With the evolution of rapid testing, pre-exposure prophylaxis (PrEP), quicker connection to care, medication benefits that lead to undetectable viral loads, and more people with HIV living longer lives, the differences between HIV prevention and care become indistinguishable. In 2015 planning began to integrate these separate planning bodies into one. Several activities were initiated to move to integration including reviewing CDC and HRSA communications on integrated planning, convening an integrated workgroup, and conducting a survey to assess willingness to have a single integrated planning body in MN for HIV prevention and care. Discussions between members of MN's two bodies and survey indicated a strong willingness to develop a single HIV prevention and care body for MN. With strong support from both bodies, the workgroup charged MN's federal grant recipient to develop a model body and a plan for implementation. In February, the integration was complete and the Minnesota Council for HIV/AIDS Care and Prevention convened to fulfill the legislative responsibilities for RWP Parts A and B and CDC HIV prevention funding in MN.

b) Letter of Assurance from MN Council for HIV/AIDS Care and Prevention Co-chairs. See ***Attachment 6*** for the Letter of Assurance from the Council Chairs**.**

c) Coordination of Services and Funding Streams

*(1) Financial Resources Inventory.*

(a) **Attachment 7** details the TGA's HIV Resource Inventory.

(b) Interaction of Different Funding Sources. Flat or diminishing HIV public health resources and the blurring lines between prevention and care have created a demand for cost effective and integrated approaches to funding. MN is unique in that MDH administers CDC prevention funding, DHS administers RWP Part B, and Hennepin County is the Part A grant recipient requiring close coordination of funding sources among three government agencies. The TGA uses the HCC to coordinate funding, identify issues and opportunities, monitor emerging trends, prioritize populations, and improve service delivery. The Council receives various reports annually on PLWH and various health insurance and covered services including Medicaid and Medicare. These data ensure informed decisions are made in prioritizing and allocating funds and that RWP is the payer of last resort and not supplanting other funding. Funding integration ensures continuity of HIV prevention, care and treatment in the following ways: 1) MDH refocused funding to identify the estimated 12% of PLWH who are undiagnosed, ensure early linkage to care and implement highly effective prevention interventions including expanding PrEP access. 2) DHS uses ADAP rebate revenue for care linkage and epidemiological support to employ data-to-care strategies to increase retention in care. DHS also determines eligibility of PLWH who may qualify for state-sponsored insurance and RWP funded programs including ADAP. 3) Part B funds provide benefits counseling to help consumers identify the most comprehensive private and public healthcare programs for continued access to affordable HIV care. This helps those who are Medicare eligible to enroll in the Part D prescription drug plans and extra-help programs. 4) DHS also administers state and federally funded substance use disorder (SUD) services and provides key information for the Council about how SUD treatment services are funded. Treatment on demand is available for low income PLWH through MN's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant. The Council allocates Part A funding for chemical health assessment, treatment placement, short term counseling and follow up at the TGA's largest HIV specialty clinic and largest AIDS service organization. These programs facilitate access to SUD treatment funded through other public sources and ensure that a continuum of care exists for PLWH with SUDs. DHS also provides training for SUD treatment centers on appropriate care and resources for PLWH. 5) The DHS Part B Administrator apprises the Council of other state funded programs for persons with disabilities such as MN's Pathways to Employment program and the state's Medicaid waiver home and community support programs. Administrators of DHS' other state and local support programs, such as targeted case management, participate in the Council and in formulating the Statewide Coordinated Statement of Need. 6) Veterans Administration (VA) Medical Center in the TGA has an HIV specialty clinic that provides care to Veterans statewide. Veterans have access to the same comprehensive drug formulary as Medicaid offers. Veterans access and utilize other RW funded services that are not part of VA benefits, including MCM, Health Education, Food Bank/Home Delivered Meals, and Transportation. 7) The Part A and B recipients work closely with the MN Housing Finance Agency and the City of Minneapolis that receive Housing Opportunities for Persons with AIDS (HOPWA) funding to provide rental subsidies to coordinate Parts A and B with HOPWA in MN. 8) The Part A recipient office is co-located with Hennepin County's PHC which receives RWP

funding for services including: Early Intervention, Outreach, Health Education, Medical Transportation and Psychosocial Support services. The PHC also receives CDC funding through MDH for HIV counseling, testing and referral. As a result, CDC and Part A funds are coordinated in ways that would otherwise not be possible. 9) The Part A recipient coordinator, MDH's AIDS Director, and DHS' Part B Administrator meet monthly to coordinate local and state prevention and care funding and programming. This ensures coordinated administration of Part A, B, and state appropriations for HIV services with uniform reimbursement methods and standards of care for all RWP services and to prevent duplication of state and local funding.
(c) Resources that are not being provided, and steps taken to secure them. A key goal of the TGA's RWP is to reduce or eliminate the gaps in resources and services that prevent PLWH from entering into or remaining in care. Unmet need estimates produced by MDH approximates 30% of PLWH in the TGA know their status and out of care and 12% who are positive are not aware of their status. Factors contributing to why those who are unaware of their infection are not getting tested, linked, or retained into care are unclear. A full continuum of EIS, outreach, linkage and retention support services are needed, particularly culturally specific services, to engage and retain those who are not in care. Many steps are being taken to ensure adequate resources to meet the needs of PLWH, particularly for communities of color and eliminate gaps along the HCC: 1) The Council allocated Part A funds for Early Intervention Services (EIS) provided by Hennepin County's Public Health Clinic (PHC) that has referral agreements with the 5 largest HIV clinics that facilitate medical appointments within 48 hours of diagnosis. 2) MDH's Care Link Specialists use its HIV surveillance data to help PLWH connect to and remain or re-engage in care. Populations of focus are: HIV-positive pregnant women not in care or whose care status is unknown; newly diagnosed African women; PLWH who have not initiated HIV care within 90 days after initial diagnosis; and racial and ethnic minority MSM who have not been in care for more than 12 months. Hennepin County's PHC is also beginning a Data-to-Care project focused on re-engagement and retention. 3) PLWH receiving RWP services are more likely to be retained in care and have suppressed virus compared to the TGA's total population of PLWH. Services such as MCM significantly impact movement across the HCC from linkage to viral suppression, and support services such as Housing, Transportation, food supports, and EFA mitigate economic barriers to care retention. 4) Despite MN's low uninsured rate, disparities in health care coverage impact people of color, particularly the foreign-born. Part A and MAI funds are allocated to OHS provided by two of the largest HIV specialty clinics in the TGA and a Federally Qualified Health Center (FQHC) reaching PLWH born in Latin American countries who do not qualify for Medicaid or Medicare and are unable to obtain a subsidized Qualified Health Plan because of immigration status. ADAP is used to purchase health insurance through the private market for many of these individuals but for others, OHS programs fill gaps in medical care especially for PLWH who are newly diagnosed or re-entering care and uninsured or temporarily lose coverage due to changes in eligibility. 5) Although there are many linkage, engagement, and reengagement strategies, they are not adequate to meet all of the TGA's needs. The growth in both the epidemic and the number of PLWH eligible for RWP funded services in an atmosphere of flat funding presents a challenge to ensuring access to care.

- *WORK PLAN*

**A. Funding for Core and Support Services**

**1) Service Category Plan**

a) Service category plan table. ***Attachment 8*** presents the Part A and MAI core medical and support service expenditures in FY 2015, allocated funds for FY 2016 and planned allocations of funds for FY 2017 to meet the identified needs of PLWH in the TGA.

b) Service Category Plan Narrative

*(1) Prioritized core medical services not funded with FY2017 Ryan White Part A.* MN has an all-time low rate of uninsured individuals. Core medical services, a top priority, are covered by all MHCP, the anticipated ADAP award and drug rebates. ADAP solvency precludes allocating funds for a Local AIDS Pharmacy Assistance Program. The Council is confident that with their allocations plan for Parts A and B funding all core medical services are available to RWP eligible PLWH. As a result, no additional Part A funds are allocated at this time.

*(2) How the plan promotes parity of HIV services throughout the TGA.* The Part A service category plan activities center on moving all eligible PLWH in the TGA along the HCC by eliminating barriers to access and retention in care and reduce health disparities. Because the vast majority of PLWH in the TGA reside in Hennepin and Ramsey counties (82%), most of the funded services in the TGA are located in Minneapolis and St. Paul (see HIV Prevalence and Services Map in ***Attachment 14A***). Medical Transportation services are provided using a combination of Part A ($24,000) and B funds ($417,200) and include a cooperative process for PLWH to obtain rides, bus cards or taxi vouchers to medical appointments. The Part A grantee facilitates an annual meeting where contracted transportation providers plan together to make services available in all sectors of the TGA while avoiding duplication. The Medical Transportation policy and resource management tool ensures that all individuals have access to medical transportation for medical appointments. The $24,000 in Part A funds allocated to Medical Transportation provides rides to primary care and mental health appointments for African-born clients. A culturally appropriate primary care program is located in St. Paul in one of the largest Latino neighborhoods in the TGA. MCM programs, which receive Part B funding for transportation, are also located throughout the community and several of them serve specific populations, including African Americans, African-born, Latinos, youth, and MSM.

The MCM system in the Twin Cities includes 12 providers, 4 of which are culturally specific agencies located in the Twin Cities and in communities disproportionately impacted by HIV. Of the seven Part A funded MCM programs in the TGA, 5 are clinic-based and 2 are community-based. Two of the Part A MCM programs are MAI funded and target African Americans and Latinos. Among the providers of MCM, there are several multilingual African-born case managers serving the growing population of Africans living with HIV. One Part A funded provider agency's entire staff is bilingual in Spanish and English. All providers are assessed during annual site visits for their ability to facilitate access to no-cost interpreter services for clients who require them. Funded MCM programs are located in east and west metro areas where RWP eligible clients have easy access to services via public transportation. The allocation for MCM in FY2017 is $2,056,100 Part A and $191,800 Part A MAI to ensure that this critical service is available to all eligible PLWH in the TGA.

Part A funds three OHS programs. One is MN's largest HIV specialty care center serving over 1,800 patients and is located in Minneapolis. Two are located in St. Paul, one being a Federally Qualified Health Center that receives MAI funding and is located in the center of the east metro's Latino neighborhood. The goal of culturally appropriate OHS is to improve early

linkage, retention, and viral suppression for Latino PLWH whose rates of retention in care are comparatively low among PLWH in the TGA. Through an African specific agency and a Latino specific clinic, mental health individual and group counseling address HIV and MSM stigma, isolation, gender inequities, and other culturally specific social determinants to improve HIV health outcomes for African-born and Latino PLWH. African-born and Spanish-speaking immigrants are among the TGA's hardest to reach populations of special need and as such are targeted for MCM, Mental Health, OHS, Food Bank/Home Delivered Meals, Outreach, Health Education/Risk Reduction, Medical Transportation and Linguistics services. One provider of multiple Part A funded services is the largest AIDS service organization in MN that is centrally located in the TGA. They provide Emergency Financial Assistance for rent and utilities, Health Education/Risk Reduction, Housing, Psychosocial Support and Legal services and MCM funded by the State.

*(3) Planned activities to assure services are culturally and linguistically appropriate.* Additionally, agencies applying to be a Part A service provider must address the following to ensure culturally appropriate care: a) How their programs will target a clearly defined population that is underserved and/or over-represented in the epidemic, where at least 60% of its clientele is part of the target population; b) Plans to involve members of the target population in program development and evaluation; and c) Plans to maintain program staff that reflects the target population by at least 50%. Five Part A funded providers meet these criteria and collectively target African Americans, African-born immigrants, Latinos and MSM. Together these providers are expected to receive $1,554,400 of Part A funding for services in FY2017. In addition, during annual site visits, the Part A recipient contract managers and quality coordinator assess all Part A programs' ability to provide culturally appropriate services and cover free linguistic services, which receives a combined Part A and B allocation of $5,800.

*(4) Factors that contributed to changes in funding within service categories.* Since MN began full implementation of the ACA the uninsured rate dropped from 8.2% to 4.3%. By the end of *MNSure's* second open enrollment period, at least 2,295 of the TGA's PLWH were covered under Medicaid, MinnesotaCare (MN's Basic Health Plan) or by a QHP obtained through *MNSure.* MN's ADAP program expanded income eligibility from 300 to 400% of the federal poverty level on July 1, 2016 enrolling an additional 112 PLWH on ADAP and the State's HIV insurance assistance program. ADAP and the insurance assistance program also enrolled 223 low income PLWH who are not eligible for coverage under the ACA because of their citizenship status.

Part A and Part B funded services such as MCM and Benefits Counseling (Part B Non-medical Case Management) will continue to play a crucial role in assisting the TGA's PLWH to enroll in expanded Medicaid or QHP's through *MNSure* given the added complexity of navigating the new insurance landscape. MCM is allocated 45% of Part A funds in 2017 and along with Benefits Counseling funded through Part B, neither of which are covered by insurance, ensures that the TGA's PLWH sustain affordable coverage by continuing to receive assistance in enrolling in Medicaid, MinnesotaCare or a QHP through *MNSure* or a select private plan on the open market with premium and prescription co-payment assistance through ADAP if ineligible to enroll through *MNSure*. Insurance "churning" caused primarily by changes in income will continue for PLWH eligible for coverage through the ACA and sustaining allocations to these programs along with the Part A funded OHS and Mental Health services and Part B funded Oral Health Care will fill temporary gaps in coverage. These programs will also cover gaps for uninsured or underinsured PLWH who are either newly diagnosed or are

reconnected to care between *MNSure's* open enrollment periods. Part A funded Substance Abuse Treatment Outpatient services provide "just in time" MN Rule 25 chemical health assessments for PLWH who are ready to enter treatment to address chemical dependency that can delay entry into care or result in care disengagement.

For PLWH who qualify for coverage under expanded Medicaid, some services such as medication treatment management are more accessible. As a result, the Council reduced the allocation for medication adherence services under MCM by $15,000 for FY2017 reallocating funds to Health Education/Risk Reduction services to improve HIV health literacy among PLWH from disproportionately impacted communities including African Immigrants. Based on the service priorities for 2017, the Council allocated $80,800 in Part A funds to provide affordable housing to an additional 10 RWP eligible PLWH in the TGA. Funds were shifted by making very small across the board reductions in allocations to all other Part A services. The Council determined additional housing resources would support retention in care and not impact other priorities especially since increasingly core medical services are covered by insurance.

*(5) Ensuring that resource allocations to services for WICY are in proportion to their percentages of TGA AIDS cases.* Meeting the service needs of women, infants, children and youth (WICY) living with HIV continues to be a priority for the TGA. Infants, children and youth, however, make up a relatively small proportion of the TGA's epidemic. Women account for 24% of living HIV cases, while youth (age 13-24) make up 3%, and infants and children (age <13) make up less than one percent. Given these small numbers, the TGA requests data to assure that spending by the state's Medicaid and CHIP, as well as other federal and state spending, occurs in proportion to how these populations appear in the local epidemic. As such, the TGA along with the Part B recipient were granted WICY waivers for 2003 through 2015. The Part A recipient submitted a waiver request for FY 2015 for youth. Despite the waivers, MN's RWP recipients and Council make every effort to ensure that Part A and B resources for WICY are proportionate to their representation in the epidemic. Women are generally overrepresented in RWP funded services in the TGA; for example, in 2015, 33% of those accessing MCM services and Outpatient Healthcare Services were women. Emergency Financial Assistance, Food Shelf, Food Vouchers, Food Bank/Home-delivered meals address additional barriers to care by meeting women and children's basic needs. In 2017, $79,000 in Part A funds provides MCM for youth receiving their HIV care through Children's Hospitals and Clinics. Children's Hospitals also receives Part D funding to provide perinatal case management services for pregnant women living with HIV, the majority of whom are born outside the U.S.

*(6) How needs assessments and Unmet Need are linked to changes to service categories.* The 2015 CNA included information from 504 respondents living with HIV in MN on the number of persons who accessed services and the number of persons who needed but were unable to access a particular service in the previous year. 2015 CNA results indicated gaps potentially exist for PLWH in MN for Housing services, Oral Health Care, Mental Health, Psychosocial Support and Substance Abuse Outpatient services, particularly for communities disproportionally affected by HIV. The findings were considered in the Council's prioritization and allocations process in 2016 which set priorities and allocation proportions for FY2017 and 2018.

HIV surveillance data from calendar year 2015 for the TGA's current Unmet Need Estimate indicate that a total of 2,149 persons or 30.4% of PLWH and PLWH/A did not receive the specified primary HIV medical care services. The FY2017 Service Category Plan includes MCM to support retention in care and EIS and Outreach services to link the newly diagnosed and re-engage the previously diagnosed in care. Other objectives in the plan, including Mental Health

services, Substance Abuse Services Outpatient, Psychosocial Support and Food Bank/Home Delivered meals focus on facilitating access to care, addressing comorbidities and mitigating health-related consequences of poverty.

2015 CNA data and the Unmet Need Estimate informed the decision to focus on both EIS and MCM as priority service areas, in order to better connect PLWH who are out of care into primary care in an attempt to reduce the 30.4% estimated Unmet Need. The CNA 2015 and Unmet Need Estimate also informed the following: the EIIHA plan target populations, including those who are disproportionately affected by HIV; efforts to integrate RWP client-level data with state surveillance data to improve measures to monitor the HIV Care Continuum for RWP clients; revision of Outreach standards to increase the number of previously diagnosed who are relinked and re-engaged in care; and technical assistance from Seattle/King County Public Health for the Hennepin County Public Health Clinic, the TGA's largest HIV and STI testing site, to develop a local protocol to use HIV surveillance data and enhanced disease intervention to reach those who have not had CD4 or viral load test in the past year to re-engage them in care.

One service gap in the TGA that was identified in the 2015 CNA and that the FY2017 plan addresses is Housing assistance. Lack of stable and supportive housing is strongly linked to inadequate HIV health care, high viral load, poor health status, avoidable hospitalizations and emergency room visits, and early death (National AIDS Housing Coalition). The TGA lacks adequate funding to meet the needs of homeless and unstably housed PLWH. In FY2015, the Council allocated $80,800 of Part A funds for Housing services in the TGA to provide rent assistance to address this great need. The TGA's largest AIDS service organization was selected to deliver Part A funded Housing assistance and is currently integrating these funds into their already established transitional housing program, although they still have a waiting list. The program provides housing specialists to assist clients to obtain safe and affordable housing and more permanent resources for solutions to meet their housing needs. The Part A allocation for Housing services will be sustained in FY2017. In addition, $95,300 in Part A funds are allocated for EFA in FY2017 which can be used to provide services for clients to pay for rent and utilities to avoid eviction and service cut-offs.

c) Core Medical Services Expenditure Waiver**.** The Minneapolis-St. Paul TGA is not submitting a core medical services expenditure waiver at this time.

**B. Care Continuum Work Plan**

***Attachment 10*** depicts how the funded service categories will improve indicators along the HIV Care Continuum in the TGA.

- *RESOLUTION OF CHALLENGES*

The following table describes the approaches the Part A Program will use to resolve challenges and barriers in implementing the Part A Program and integrating the HCC into planning and programming.

| Challenge | Resolution | Outcome | Status |
|---|---|---|---|
| Part A Program | | | |
| Temporary insurance coverage gaps due to complexity of enrollment through insurance exchange and increasing insurance premiums and higher out-of-pocket costs. | Ensure adequate funding of core medical services to cover temporary gaps. Increase RWP Part A income eligibility from 300-400% FPG. Coordinate with Part B grant recipient ADAP and HIV Insurance Premium program to ensure continuity of coverage for RWP eligible clients. | FY2017 allocations plan ensures sufficient core medical services for RWP eligible clients. Minnesota ADAP is developing solutions that minimize out-of-pocket costs and maximize cost effectiveness of plans purchased for RWP eligible clients. | Qualified Health Plan premiums are increasing by 50-67% in 2017. Minnesota ADAP is considering changing plan selection criteria for RWP eligible clients for 2018. |
| Reducing HIV-related health disparities. | Target EIS, Outreach, OHS and MCM to African American MSM and women, African-born women and Latinos. | Increased engagement of PLWH from target populations in RWP services and advisory bodies. | RWP client retention rates far exceed the overall rate for PLWH in the TGA. Engagement of some target populations in RWP services is low. |
| Quality management coordination across RWP Parts. | Merge Part A and B Quality Management advisory committees and expand capacity for training and technical assistance. | Committees decided to merge in September 2016. | Committee is expanding to include Parts C, D, and F and representation from all funded service areas. Associated QM learning community forming. |
| HIV Care Continuum Integration | | | |
| Incomplete reporting of HIV CD4 counts and viral load tests to Minnesota's electronic HIV/AIDS Surveillance System (eHARS). Retention in care and viral suppression rate for the TGA decreased by 5% and 14%, respectively in the TGA in 2015. | Improved health care provider compliance with Minnesota's HIV/AIDS surveillance reporting rules. Training, technical assistance, and communication to support awareness and more complete reporting. RWP staff are seeking additional external technical assistance to assist in this effort. | Plans are beginning to improve feedback to providers on current viral load rates for their clients. RWP & MDH staff will more regularly look at data to spot check data reporting deficiencies and address them in a more timely fashion. | MDH is investigating the sources of missing CD4 and viral load counts and will follow up with medical providers that are not reporting all laboratory test results to improve reporting. |
| Retention in care | Additional funding for Outreach Services to support Data-to-care project at Hennepin County Public Health Clinic | Public Health Clinic is receiving surveillance data from MDH and hired new Outreach staff. | Public Health Clinic is developing out-of-care line list protocol in preparation to implement peer navigator model of care re-engagement intervention. |

EVALUATION AND TECHNICAL SUPPORT CAPACITY

**A. Clinical Quality Management (CQM)**

**1) Description of CQM Program Infrastructure**

(a) Staffing. The Clinical Quality Management (CQM) program's staffing includes 0.1 FTE RWP Coordinator, 1.0 FTE Quality Management Coordinator (QMC) and 0.9 FTE Outcomes and Data Coordinator.

(b) Staff Roles and Responsibilities**.** Part A Program leadership is provided by the RWP Coordinator and includes oversight and approval of the Part A annual CQM work plan and its integration into the overall Part A program; serving on QMAC and Quality Learning Community (QLC), providing RWP expertise, and supervising the Quality Management and Data & Outcomes Coordinators. The TGA has a full-time QMC who leads the TGA's Part A CQM efforts. The QMC works with other RWP parts and QMAC to establish annual quality goals and the Part A CQM plan. Implementation of this plan includes providing training and technical assistance for, obtaining and evaluating annual quality improvement plans and reports from, and annual site visits of contracted service providers. The QMC with the TGA's Contract Managers and HIV Services Planner perform annual site visits and review client records for compliance with eligibility requirements, National Monitoring Standards, service specific standards of care and contract goals. To ensure that CQM activities are coordinated across RWP Parts and that HIV care is provided in accordance with HHS treatment guidelines, the QMC acts as a quality liaison to the Council, subrecipients, consultants, DHS (Part B recipient), MDH (CDC prevention grant recipient), the QMAC, and QLC. The Part A recipient's Outcomes & Data Coordinator designs and manages the recipient's client-level data (CLD) reporting platform, assesses data completeness and validity, including CLD and outcomes evaluation data collected by subrecipients, analyzes data, and recommends ways to improve data collection and coordination and incorporate findings into CQM activities.

(c) Contractors**.** The CQM program contracts with A.J. Boggs and Company to host the secure central server for Minnesota (MN) CAREWare, MN's joint Parts A and B client-level database. The recipient also contracts with Community Consulting Group, LLC to facilitate and document proceedings of the QMAC, QLC, and the CLD workgroup (Part A, Part B, and prevention collaborative). The recipient also contracts as needed with jProg, the CAREWare programmer, to enable data importing from other client record systems used by subrecipients that have their own electronic client record systems.

(d) Coordination with Other Ryan White Grantees. The TGA's CQM program collaborates with DHS (Part B recipient) and MDH (CDC prevention recipient) to operate MNCAREWare. The CLD Workgroup, comprised of staff from all three government agencies, meets bi-monthly to ensure efficient operation of MNCAREWare, assure data quality, and integrate grant recipient data systems. The TGA's CQM plan and work are guided by the Quality Management Advisory Committee (QMAC), which is made up of representatives from RWP Parts A, B, C, D and F in MN, the Council, the Part A Outcomes and Data coordinator, HIV service providers, the MDH and consumers. The QMAC merged with Part B's Quality Improvement Committee to more closely align CQM efforts across parts. Activities and progress in quality improvement are reported at each meeting. Aggregate information about site visit findings is reviewed by the QMAC annually. The committee ensures that the consumer's voice is represented in all CQM efforts. The QMC seeks consultation from committee members as needed to complete annual work plan objectives. In addition to QMAC, the QLC recently formed led by RW Part A and B and open to all RWP recipients and subrecipients of RW funding or CDC prevention funding.

The goal of the QLC is to build the capacity of providers to meet the goals of the NHAS, Part A Program CQM plan, and CDC prevention priorities. QMAC will help set the work plan and curriculum of the QLC and the QLC will serve to prepare providers and consumers to participate more fully in improving quality of HIV care and prevention services.

**2) Description of CQM Program Performance Measures**

(a) Service Category Performance Measures**.** All subrecipients, regardless of the service they provide, are required to assess their clients' care status and report in MNCAREWare if they attended an HIV medical appointment in the past six months (yes/no) and the date of their most recent appointment, thus providing a universal medical care visit measure for the RWP care system. Part A funds 17 HRSA/HAB service categories. In addition to assessing HIV medical care status for all clients, subrecipients also indicate whether or not the clients who had not had an appointment in the last six months were referred for HIV medical care and if there was follow up to confirm appointment attendance. In addition to this universal performance measure, performance measures for each of the TGA's Part A funded services categories is as follows:

| **Performance Measure*** | **Service Categories** |
|---|---|
| HAB Systems-Level Measure: Linkage to HIV Medical Care | Early Intervention Services |
| HHS Common Indicator: Linkage to HIV Medical Care | Outreach Services |
| HAB MCM Measure: Gap in HIV Medical Visits | Medical Case Management |
| HAB MCM Measure: Care Plan | Medical Case Management |
| HAB Core Measure: Gap in HIV Medical Visits | Health Insurance and Cost Share Premium Assistance; Home and Community Based Health Services; Medical Nutritional Therapy; Mental Health; Substance Abuse Services Outpatient; EFA; Food Bank/Home Delivered Meals; HERR; Psychosocial Support Services; Legal Services; Linguistic Services; Medical Transportation |
| HAB Core Measure: Prescription of ART | Outpatient Healthcare Services |
| HAB Core Measure: HIV Viral Load Suppression | Outpatient Healthcare Services |
| HAB Adult Measure: Cervical Cancer Screening | Outpatient Healthcare Services |
| HHS Common Indicator: Housing Status | Housing Services |

*HRSA HIV/AIDS Bureau (HAB) Performance Measure or HHS Common Indicator for funded HIV Programs

(b) Frequency of performance measure data collection**.** Outpatient Healthcare Services (OHS) providers report CD4 counts, viral load, ART prescription and pap tests quarterly in CAREWare. Medical Case Management (MCM) providers report on medical visits biannually in CAREWare and care plan performance measure data are collected through client record reviews at annual subrecipient site visits. All subrecipients report in MNCAREWare if clients attended an HIV medical appointment in the last six months, the date, referral to medical care, and follow-up when appropriate twice per year.

(c) Outpatient HealthCare Services and Medical Case Management Performance Measures. Findings on the following HAB performance measures are monitored for funded OHS providers: CD4 tests performed one or more times in the measurement year; viral load suppression; and antiretroviral therapy (ARV). MCM programs are monitored for compliance with the HAB performance measures for medical visits and care plan. MCM care plan updates are reported in CAREWare and client records to allow for more complete tracking of this performance measure.

**2015 Outpatient Healthcare Services and Medical Case Management Data Summary**

| **Performance Measure** | **2013** | **2014** | **2015** |
|---|---|---|---|
| **All Part A Funded Services (N=all clients who received any Part A funded service)** | | | |
| Clients who saw a HIV medical provider in the last six months | 88% | 72% | 91% |
| Clients who did not see a HIV medical provider and were referred to care | 70% | 14%* | 20%* |

| | | | |
|---|---|---|---|
| **Outpatient Healthcare Services (N=patients who received Part A funded OHS)** | | | |
| CD4 counts (one or more tests in measurement year) | 81% | 90% | 79% |
| Viral Load suppression (% of patients with HIV with viral load less than 200 copies/mL at last HIV viral load test during the measurement year) | 85% | 73% | 78% |
| Antiretroviral Therapy (had RWP funded medical visit and received ARV) | 78% | 77% | 75% |
| Cervical Cancer Screening (females that had RWP funded medical visit and Pap test) | 47% | 61% | 55% |
| **Medical Case Management (N=clients who received Part A funded MCM)** | | | |
| Care plan updated two or more times in the measurement year in sample of audited MCM records | 96% | 98% | 98% |
| Gap in HIV Medical Visits (% of MCM clients with HIV who did not have a medical visit in the last 6 months of the measurement year) | 5.5% | 6.9% | 5.0% |

*Decrease could be due to reduced reporting of referrals and not an actual decrease in referrals; to be explored more in QI projects in 2016 and 2017.

(d) Analysis of Performance Measures to Evaluate Disparities**.** The TGA's Minority AIDS Initiative (MAI) funds are allocated to OHS and MCM targeting Latino and African American PLWH. Performance measurement data for MAI funded OHS and MCM services are compared with performance measures from Part A (non-MAI) funded programs. Data are compared across providers and demographic groups and reported back to providers and the Council. At the subrecipient level, performance measures are used to evaluate specific quality improvement projects to increase retention in care, antiretroviral therapy, pap tests and viral suppression. For example, the subrecipient providing MAI funded OHS and MCM to Latinos, Westside Community Health Services identified a need to improve the percentage of clients with improved or stable viral load test results and increase the percentage of clients retained in care. The percentage of their OHS clients that were virally suppressed increased from 74% in 2014 to 86% in 2015. They increased their clients retained in care rate from 85% in 2014 to 92% in 2015.
(e) Stakeholder Participation in Selection of Performance Measures. The QMC drafts the TGA's CQM plan and list of priority performance measurements data based on the most recent outcomes data, the Council's integrated plan, the National HIV/AIDS Strategy, and feedback from consumers and providers. This plan and data list are then presented to the QMAC for review using the National Quality Center's (NQC) "Quality Management Plan Review Checklist." QMAC members provide recommendations on goals across RWP parts for the next fiscal year and for both system-wide and service specific performance measures to evaluate progress towards achieving the goals. QMAC members include representatives from all RWP Parts, consumers, subrecipients, a Council Needs Assessment & Evaluation Committee (NA&E) Co-Chair, and a Council Co-Chair. The QMC reports on quality improvement progress to the NA&E, which compiles all data for Council members' use in prioritizing services and allocating both Part A and Part B funds. In addition, the QMC delivers a presentation on performance measurement data to the full Council annually.

**3) Description of CQM Program Quality Improvement**

(a) Quality Improvement Approach. The QMC along with QMAC base their work on the Model for Improvement and the PDSA method. Currently, the QMC is identifying opportunities to use other techniques such as Lean and Agile in the TGA's quality improvement work. The QMC uses the Council's Integrated HIV Prevention and Care Plan, HRSA/HAB's Performance Measures, NHAS goals, and the TGA's CQM plan to identify performance indicators to be collected, analyzed, and measured. Data collected on these indicators are compared to targets established. Next, QMAC takes the comparative performance data, the previous year's QI projects list and outcomes, and discusses what QI priorities are feasible for the following year. Best practices and guidance is sought from NQC, the Target Center, and HRSA/HAB about what

has worked in other jurisdictions and could be tested in the TGA. Once QI priorities are set, each subrecipient drafts a QI plan. The goals of these QI plans are shared at QMAC.

*QI Project Examples*. The Minnesota AIDS Project (MAP), a Part A subrecipient for six service categories, identified a need to improve its documentation of eligibility. In 2014, only 62% of clients showed current RWP eligibility, by the end of 2015 98% of clients had documented eligibility. MAP updated its tracking system so that client documentation of RWP eligibility requirements could be tracked more easily. All staff attended a training on the new process. The Program Assistant (PA) checked a list of clients seen in the previous six months and reviewed eligibility. If documentation was missing, staff worked with clients to collect and document eligibility. The program assistant re-checked active clients for eligibility and notified staff what, if any information was needed. Once all documentation is obtained, the PA reviews to ensure completeness. Supervisors were notified if a specific staff person had client data consistently missing from the file. A supervisor then followed up with staff to assist staff in developing a plan so that the client's files are in compliance. Reports were generated every six months to establish percentage of client files in compliance. This process is now standard procedure at MAP.

Another provider, Children's Hospitals and Clinics of Minnesota, prioritized retaining their clients in care for their QI project. In 2014, 79% of their clients had a medical appointment in the last 6 months, which increased to 89% in 2015. They did this by having medical case managers (MCM) become more involved in scheduling client appointments. Medical case managers, nurses and medical assistants met with each family/patient during their clinic visit to schedule a follow-up appointment before the family leaves the clinic. MCMs were granted access to the scheduling software to help schedule patient appointments. The Program Coordinator tracked any issues related to appointment availability and reported them to the clinic manager. In this process staff found that families wanted to book appointments closer to the date needed to accommodate their work schedules. In response, the program coordinator added columns to the tracking sheet to track next appointment due and appointment scheduled. At monthly patient rounds, patients that had not been scheduled and were due for appointments were flagged then staff were able to contact those patients and schedule the appointment on time.

*Monitoring and Support of Subrecipient QI Projects*. Implementation of the CQM program is closely tied to the review and approval of each subrecipient's required annual QI Plan. Providers receive the Part A recipient's annual QM Plan and goals at the start of each contract year; the providers' plans are due one month later. A standard set of criteria is used to review their individual plans, and approval is tied to how well they support the Part A QM Plan; they receive technical assistance as needed to meet this expectation. All Part A subrecipients collect and submit semi-annual data on the progress of their QI plans and also, through MNCAREWare.

(b) Efforts to Improve Viral Suppression**.** The CQM program has a three-pronged approach to improving viral suppression among Part A funded clients: 1) monitoring of medical care status and referrals for clients across all Part A funded services and following-up with subrecipients falling below targets; 2) Ensuring at least one part of the subrecipient's contract outcomes grid targets viral suppression; and 3) Moving clinical data into CAREWare from MN's eHARS to enable monitoring and improvement of rates of clients virally suppressed. From 2014 to 2015, the percentage of clients who saw a HIV medical provider in the previous six months increased slightly from 90.8% to 91.8% but referrals of clients who had not seen a medical provider in the previous six months did not improve. This may be due to issues with reporting rather than clients out of care. In FY2017 there will be a quality improvement goal to increase accuracy, completeness, and timeliness of data in CAREWare. The TGA's three OHS subrecipients report

viral load test data in MNCAREWare on a quarterly basis. In FY2015, 1,235 PLWH received Part A funded OHS services, representing 40% (1,232/3,057) of Part A funded service recipients. The rates of viral suppression increased from 73% of OHS clients virally suppressed to 78%. Despite moderate gains, there is a persistent challenge of missing values for viral load but there was a slight improvement with a decrease in missing values from 19% in 2014 to 16% in 2015. As the project of importing eHARS information into CAREWare continues, missing values will decrease improving data accuracy. In FY2016, improving data reporting and quality assurance is a priority of the QMC and QMAC with a data quality improvement project launching in 2016.
(c) Use of CQM Data to Improve and/or Change Service Delivery**.** The Part A recipient's QMC and HIV Services Planner, in collaboration with the Council's Planning & Allocations committee, implemented a service analysis process to develop and update standards of care for all Part A funded services based on a recommendation from a HRSA/HAB monitoring site visit in December 2012. The process assesses the effectiveness of each service area, identifies service goals and related objectives, sets standards of care, develops process and outcomes measures related to goals and objectives, analyzes how costs vary among providers and determines more effective models of delivery. The process uses client-level data, performance measures, and needs assessment data to determine effectiveness and identifies service area gaps. In FY2015, service analysis processes were completed to develop new standards of care for Home and Community-Based Health Services, Housing Services and Health Education/Risk Reduction. In FY2016, new standards of care were developed for Substance Abuse Treatment Outpatient and Medical Nutrition Therapy. Currently CQM data is being analyzed for accuracy and completeness. Once the data is complete and accurate, analysis will begin on interventions and/or services that are helping achieve targets more effectively and efficiently than others. Better data will then inform quality improvement activities to improve RWP services.
(d) Stakeholder Contributions to QI Activities. The QMAC has taken steps to increase provider and consumer engagement through merging Parts A and B quality committees and inviting prevention grant subrecipients as well. Through simplifying these bodies and developing a clearer charge for QMAC, who would make a good member, and a concerted effort at recruitment and retention – increased stakeholder participation is expected. The QMC is working with other recipients and subrecipients on strategies to ensure greater consumer participation. In addition to QMAC, a Quality Learning Community is being developed with the purpose of building capacity, training, and creating a space for collaborative learning on quality HIV care and prevention. While QMAC has a limited number of seats, QLC is open to all and will serve as a venue to train consumers and providers on concepts of HIV/AIDS quality management and prepare them to advocate for improving HIV services.

**4) Data for Program Reporting**
(a) Data System. The RWP management information system is MNCAREWare, a shared database for Part A and B client-level data (CLD) collection and reporting. Housed on a secure, dedicated central server, data are available to providers in their individual domains and to the Part A and B recipients in aggregate. The MDH serves as the system administrator. Reporting responsibilities are maintained by each recipient for planning, policy and grant development. Contracted providers receive training and regular updates about CLD requirements and data reports to monitor HAB performance measures, and how to incorporate these measures into their annual QI work plans. Part A recipient staff uses the data to assess achievement of annual quality goals in collaboration with the QMAC as it completes its annual review of the Part A QM Plan.

(b) Client Level Data (CLD) Collection and Reporting Capabilities. Since 2010 all CLD elements required for the RSR have been submitted by 100% of Part A subrecipients into MN CAREWare. In 2015 only one subrecipient had 10% or greater missing entries for federal poverty level, health insurance status, and/or housing status in the RSR. Two of the three OHS providers had 10% or greater missing entries for viral load test and/or prescribed ART. This low number of providers with missing values in the RSR is progress though for jurisdictional required reporting there still persists too great a percentage of missing entries, with three of the 13 providers having missing values of 10% or higher. Increased communication, training, and collaboration is occurring across RWP recipients and subrecipients to understand the root cause of data challenges and to devise strategies to increase completeness. A trainer is currently being hired by MDH to assist in subrecipient capacity and data quality. Before RSR data are submitted to HRSA from MNCAREWare, subrecipients implement a data quality assurance (QA) protocol with a series of steps to identify missing data elements identified by QA reports from MN CAREWare, clean up missing data and resubmit as needed. This process is completed twice a year to allow time to identify and address issues with individual provider data systems or processes ahead of the RSR submission deadline. This process is currently being reviewed and will be revised to better meet current RSR requirements and training needs of subrecipients.

- *ORGANIZATIONAL INFORMATION*

**A. Grant Administration**

**1) Program Organization**

a) Administration of Part A Funds. The staffing plan is presented as ***Attachment 1*** and the organizational chart as ***Attachment 11***. The Chief Elected Officer, the Chair of the Hennepin County Board of Commissioners, designates Hennepin County PHD responsible for administering the TGA's Part A grant. The PHD is accredited by the Public Health Accreditation Board. The RWP is within the Public Administration and Practice area of the PHD. The RWP Supervisor oversees the daily operations of grant administration and reports to the Public Health Administration and Practice Administrative Manager. In addition to the RWP Supervisor, the grantee administrative team includes: an HIV Services Planner; 2 Contract Managers from the centralized Contract Administration area; a QMC; an Outcomes Evaluation & Data Coordinator and program support staff. The administrative team procures services, manages provider contracts, provides fiscal and program monitoring and oversight, prepares annual grant applications and reports, meets conditions of award, and takes the lead on quality management. The Part A grant supports 2.75 FTE administrative staff and 2.0 FTE CQM staff (see ***Budget Narrative Attachment*** and ***Attachment 1*** for detail). All grant administration and quality management positions are currently filled. When a staff vacancy occurs, the RWP Supervisor hires new staff using the County's Human Resources hiring procedures. The Part A grant also supports 50% of the costs of the Council Coordinator (.5 FTE) and Administrative Specialist (.5 FTE). The Council is a single integrated HIV care and prevention community planning body that fulfills the planning council responsibilities for the Part A grant, community input for MN's Part B grant and serves as the HIV prevention community planning group for MN's CDC HIV prevention funding. DHS (Part B recipient) provides funding to cover the other half of the Council's operating costs. (*see* ***Budget Narrative Attachment*** *for detail).* Council staff are employees of PHD and are supervised by the RWP Supervisor. The Administrative Specialist position is currently vacant. New staff will be hired by December 31, 2016.

b) Process and Mechanism for Distinguishing Client Funding Streams. Client-level data (CLD) entry and subrecipient fiscal controls are the primary mechanisms by which different funding streams (Parts A, B, and state) are distinguished for each unique client. MNCAREWare centralized application serves as the joint Part A and MN Part B CLD system where all Part A, B and state funded MN providers enter their required CLD. Contracts in CAREWare are set up to distinguish between funding streams including Parts A, B, Part A MAI, ADAP MAI and state funded HIV services. When providers enter CLD into CAREWare, they are required to select the contract which indicates the source of funding for the service. For each distinct CAREWare service unit entered, only one source of funding can be selected so providers must assign each unique client to a single source of funding for each specific service delivered. Part A grant recipient staff generates service unit reports from CAREWare that monitor provider assignment of funding sources to ensure that each client service is reimbursed through only one source. Part A provides funding for OHS at HCMC's Positive Care Center (PCC) that also receives Part C and D funding. In FY2014, Part A grant administration staff through provider contractual agreements implemented a new billing procedure for OHS requiring providers to include detail of all service expenditures claimed on Part A invoices by CPT code. The PCC's billing procedure to separate charges for Part A funded services from their Part C and D grant funds are reviewed during their annual Part A fiscal site visit. All Part A contracted subrecipients are also required to submit semi-annual program revenue and expense statements on September 30 for the period March 1 through August 31 and on March 31 for the period September 1 through February 28 showing all sources of funding and expenditures for each program by budget line.

**2) Grant Recipient Accountability**

a) Program Oversight

*(1) Update on implementation of the National Monitoring Standards (NMS).* The Part A Program's recipient administrative staff (Contract Managers, HIV Services Planner and Quality Management Coordinator) continued to ensure implementation of the RWP NMS in FY2016 through annual site visits including client record review, review of subrecipient invoices and annual invoice audits, and twice-annual program revenue and expenditure reports. In FY2016, implementation of the NMS focused on client eligibility documentation and recertification and reporting of program revenue and expenditures. Part A recipient staff determine areas where subrecipients can improve based on the previous site visit corrective actions and on the initial assessment of the Part A recipient and subrecipient capacity to meet the NMS conducted in 2010. This initial assessment identified areas to improve to better meet the NMS including eligibility recertification and documenting program income and allowable administrative and indirect costs. The TGA's RWP Universal Standards were revised by the Quality Management Advisory Committee in May of 2013 to align with the NMS. Each spring the Part A Program site visit team reviews and revises the Part A site visit protocol based on any changes in HRSA requirements and an evaluation of the previous year's site visit results. Changes for FY2016 site visits included clarifying acceptable documentation for income determination and implementation of newly developed standards of care for Substance Abuse Services Outpatient and Medical Nutrition Therapy. The site visit protocol also included review of client records for documentation of insurance and residency status every six months to ensure high levels of compliance with the payer of last resort and eligibility determination requirements of the NMS. Insurance verification had previously improved from 90% of records reviewed that met the requirement in 2014 to 96% of records that met the requirement in 2015. Similarly, residency verification improved from 92% to 97%. Grant recipient administrative staff also conducted its

annual Part A subrecipient meeting on April 20, 2016. The meeting agenda included a review of changes in contract language, the FY2016 reporting schedule, data reporting requirements, quality improvement plan and activity reporting, HRSA/HAB clarification on allowable services and a high level review of the new Uniform Administrative Requirements, Cost Principals and Audit Requirements for HHS awards under Title 45 of the Code of Federal Regulations Part 75. *(2) Process used to conduct subrecipient monitoring.* Subrecipient scopes of work, process and outcome measures, and program budgets are negotiated according to HRSA and Hennepin County contracting policies. Budgets reflect HRSA defined line items and are linked to measures for unit rate contracts for ease of reporting and satisfying conditions of award. Contract Managers review MNCAREWare service reports to ensure that subrecipient expenditures are congruent with services delivered. A resource management tool was implemented to better monitor and account for units of bulk-purchased bus passes for Medical Transportation. Invoices are not approved for payment if there are unaddressed programmatic or fiscal issues. If a programmatic problem is identified, RWP recipient staff meets with the subrecipient to discuss solutions and determine if technical assistance is needed.

To improve subrecipient accountability and better assess cost effectiveness of services, the grant recipient procures OHS, MCM, Medical Nutrition Therapy, Substance Abuse Treatment Outpatient, Home and Community-based Health Services, Food Shelf/Home Delivered Meals and EFA on a unit rate basis. Most subrecipients submit invoices for expenditures monthly or quarterly (larger health care organizations). Subrecipients must enter monthly numbers of clients served and service units provided in MNCAREWare. Subrecipients are also required to submit quarterly narrative progress reports that include case studies, relevant staffing changes or administrative challenges, and a description of unmet client needs. Subrecipients are required to generate monthly client service reports from MNCAREWare to assess progress toward contract process goals. Grant recipient staff review subrecipient quarterly reports and compare invoices to monthly service reports to ensure that expenditures are congruent with services delivered. *(3) Number of subrecipients funded in FY2016, monitoring site visits and reporting.* Recipient staff conducted annual site visits at all 14 Part A contracted agencies in FY2016. Invoice audits were also conducted at all 14 subrecipient agencies in 2016 without any significant findings. All Part A subrecipients will receive at least one program site visit and invoice audit in FY2017. The site visits combine fiscal and programmatic areas to assess: compliance with contractual goals and objectives; soundness of fiscal management; compliance with client eligibility determination requirements; that RWP funds are the payer of last resort; that progress toward QI goals is made; and adherence to the grant recipient's service specific standards and Universal Standards of care along with HRSA/HAB's NMS occurs. The site visit format allows the team to evaluate organizational structure, personnel management capacity, compliance with client utilization and outcomes data reporting, and to assess emergent needs of PLWH and technical assistance needs. Prior to the site visit, the RWP Contract Managers review: subrecipient's most recent financial statement and audits, including single audit reports if applicable; internal financial controls including policies and procedures for separating RWP dollars from other funding sources and monitoring of third party reimbursement; tracking of RWP-funded staff time and effort; quarterly reports; spending to date, client-level utilization and outcomes data reporting. *(4) Process and time line for corrective actions related to fiscal or programmatic concerns.* A report summarizing findings and any indicated corrective action is sent to the subrecipient. If a programmatic concern is identified, the Contract Manager develops a corrective action plan (CAP) with the subrecipient and communicates in writing expectations for meeting the plan

goals. The CAP must be agreed upon within 30 days. The HIV Services Planner assists the Contract Manager in assessing TA needs and identifying appropriate interventions if needed. By the end of the quarter following the identification of the problem, the Contract Manager follows up to assess progress toward meeting the plan's goals. Of the fourteen Part A contracted agencies that received a site visit in FY2016, six subrecipients were required to take corrective actions. Although 96% of records reviewed met Universal Standards requirements, including eligibility documentation, ten subrecipients did not meet the 100% requirement for eligibility verification. The Contract Manger provides support to ensure that the agencies fulfill the action plan. All agencies took corrective action and met follow up requirements.

*(5) Number of subrecipients that received technical assistance (TA) in FY2016.* All 14 Part A subrecipients received TA or training in FY2016. In April 2016, grant recipient staff including contract management staff convened a meeting of all Part A subrecipients to review changes in contract language, standards, resource management policy, and HRSA/HAB's policy clarification on allowable services. The recipient's local TA consultants, Community Consulting Group, provided individual subrecipients with service specific TA on meeting Home and Community-based Health Services, Housing, Medical Transportation, and Substance Abuse Outpatient standards of care. Contract Managers, the HIV Services Planner and the QMC provided TA on: fiscal monitoring standards; service specific standards; Medical Case Management services components and measures; Medical Transportation resource management; indirect cost rate approval process; and creating annual quality improvement plans.

b) Fiscal Oversight

*(1) Process used by program and fiscal staff to coordinate activities.* Part A Program staff play the lead role with assistance from analysts in Human Service and Public Health Financial Analysis and Accounting (*see **Attachment 11B***) to provide fiscal oversight of the Part A grant. Contract Managers monitor spending through invoice review and entry into the RWP financial workbook before they approve payment. Invoices are scanned into a document database and once approved by the Contract Manager are assigned a receipt number. Accounts payable staff then enter invoice amounts into the County's financial management system for payment through electronic transfer to subrecipient financial institutions. Support staff reconcile actual payments to subrecipients with invoice amounts monthly and enters all administrative and CQM expenditures in the RWP financial workbook. The RWP Supervisor completes Part A budgets, monitors overall spending, presents quarterly expenditure reports to the Council and works with the analysts to prepare grant Federal Financial Reports (FFR). A Financial Analyst completes and submits quarterly HRSA Payment Management System disbursement reports for grant payment drawdowns and copies the RWP Supervisor. At least one invoice audit is conducted for each subrecipient annually to ensure that documentation properly supports all units billed. Invoices are not approved for payment if an agency has outstanding fiscal issues. Hennepin County internal audit staff periodically conduct comprehensive fiscal audits of RWP Part A subrecipients. The RWP Supervisor meets with the financial analysts to resolve contract payment problems or discrepancies discovered during the invoice/payment reconciliation process. The RWP Supervisor also meets with fiscal staff prior to submission of the final FFR to reconcile any discrepancies between the RWP financial workbook and the County's payment system.

*(2) Process to separately track formula, supplemental, MAI, and carryover funds.* Because of the penalties for unobligated formula funds established by the federal RWP legislation, budget allocations for administration, CQM and services are each divided based on the proportion of the grant award that is formula and supplemental. Carryover funds are obligated separately in

subrecipient contracts, and expenditures are tracked accordingly. A separate MAI administration and CQM budget is developed and MAI funds for services are obligated separately in MAI subrecipient contracts. At the end of the fiscal year, once all subrecipient invoice payments have been disbursed, the amounts of unobligated funds for administration, CQM and services are multiplied by the proportion of the award that is comprised of formula and supplemental funds to determine the amounts of unobligated formula and supplemental dollars. Data systems utilized to track expenditures include a RWP master financial management and subrecipient invoice MS Excel workbook that is maintained by recipient staff. The Hennepin County Office of Budget and Finance uses APEX (PeopleSoft) for its accounting system. Separate project numbers are assigned to Part A administration and contracted services, Minnesota Council for HIV/AIDS Care and Prevention (Council) and CQM.

*(3) Process used to ensure timely monitoring and redistribution of unexpended funds.* The Council's allocations process is designed to avoid unobligated balances. At the August 2016 meeting to allocate funds for FY2017, the Council assumed that the Part A award would be the same as in FY2016. At the March 2016 meeting, the grant recipient informed members that the award would be received in two parts, the first being 55% of the FY2016 award. This enabled the grant recipient to obligate all funds allocated in subrecipient contracts by the start of the fiscal year. The final award notice was received on May 28, 2016 with an overall 2016 Part A award increase of 2%. At the June 14, 2016 Council meeting the Council approved their final FY2016 allocations plan based on the final award. Allocation to four service categories were increased. Budgets and expenditures for HIV services, administration, Council support and CQM are assigned separate project numbers in the County's financial management system to separately track expenditures ensuring that administrative and CQM caps are not exceeded. All subrecipient contracts include a reallocation policy. If 40% of a subrecipient's program budget isn't expended by the end of the first half of the fiscal year or if 70% of the budget hasn't been spent by the end of the third quarter, budgets can be reduced and funds allocated to other subrecipients. RWP staff review spending and consider expected temporal trends in expenditures before identifying opportunities for fund reallocation. If other programs within a prioritized service area can utilize funds, the recipient amends subrecipient contracts to redistribute the funds through an expedited ministerial adjustment. If utilization patterns or cost increases do not indicate a need for redistribution within a service area, the Council reallocates funds to another prioritized area. Contract Managers then adjust contracts to deliver the expanded services.

*(4) Process to review subrecipient compliance with the single audit requirement.* Prior to site visits, subrecipients are required to submit copies of their most recent annual audit including their single audit report, if they receive at least $750,000 in Federal funds. Contract Managers review all audits and financial statements to assess subrecipient fiscal stability and compliance with the HHS Uniform Guidance single audit requirement. In FY2016, all seven subrecipients receiving $750,000 or more in Federal funds complied with federal single audit requirement.

*(5) Single audit findings.* There were no material findings of subrecipient single audits.

*(6) Process for reimbursing subrecipients.* Subrecipients submit invoices on a monthly or quarterly basis. Only four health care institutions submit invoices quarterly. The grant recipient uses a standard electronic invoice form, which reflects contracted budget line items, to assist providers in managing their budgets. Subrecipients are expected to submit invoices electronically to Accounts Payable by the 15th of the month following the period during which services were provided. Final invoices for the fiscal year are due by April 15. Invoices and unit tracking spreadsheets are reviewed by the RWP Contract Managers for accuracy, compared to program

budget and service delivery reports from MNCAREWare, entered in the RWP financial management invoice workbook and submitted to the Financial Analysis and Accounting area (*see* ***Attachment 11B***) for payment. If invoices are inaccurate or show overspending of 10% or more on a budget line item, the Contract Manager works with the subrecipient to mitigate the problem. Any shift in budget line item amounts must be requested in writing and approved by the RWP Supervisor. Once payment is made, the payment amount from the monthly financial reports is reconciled with the invoice amount and entered into the financial workbook.

**3) Administrative Assessment**

a) Assessment of the recipient activities. The Council's most recent evaluation of the grant recipient's administration of the FY2015 Part A grant to ensure contracting of funds and timely payments to subrecipients used seven measurement objectives and is summarized as follows:

| **MN Council for HIV/AIDS Care and Prevention Assessment of the Administrative Mechanism Part A Fiscal Year 2015 (N=27)** | | |
|---|---|---|
| **Objective** | **Met** | **Unmet** |
| 1. Implementation of a process that utilizes the Council's priorities and allocations as a basis for securing services; 75% of newly awarded funds are initially obligated within 90 days of the grant award, and 100% of such funds are initially obligated within 120 days of the grant award (2015). | 27 | 0 |
| 2. Implementation of a process to monitor spending and reallocate funds which aims to limit the amount of unspent Part A to not more than 10% at the end of the fiscal year (2015). | 26 | 1 |
| 3. Awards to service providers were determined according to established criteria. | 27 | 0 |
| 4. Determination of non-competitive funding was appropriately justified based on established criteria: provider selected through past RFP; record of quality service delivery; demonstrated HIV competency; established infrastructure; cost effective; and continuity of client care. | 27 | 0 |
| 5. Redistribution of funds within a service category was based on the following: provider demonstrated ability to utilize additional funds; provider capacity; impact on unmet need; sustainability of service after redistribution of funds; and specific Council directives. | 27 | 0 |
| 6. Per service area/activity, sufficient number of providers is based on: number of contracts that can be administered; amount of funding allocated for each prioritized service area/ activity; allocation requirements for populations with special needs; availability of qualified providers. | 26 | 1 |
| 7. Award per service area/activity complies with Council prioritization (2014) and allocation amounts set by Council in August 2015 and subsequent reallocations. | 27 | 0 |

The Council completed their administrative assessment on September 25, 2016. The results of the assessment affirm that the recipient's activities ensured timely allocation of funds and procurement of services and payments to contracted subrecipients. Ninety-three percent (27/29) of Council members returned the evaluation. All members that completed the assessment indicated that objectives 1, 3, 4, 5 and 7 were met. Twenty-six of 27 members (96%) indicated that objectives 2 and 6 were met.

b) Deficiencies and corrective action. There were no corrective actions recommended by the Council. One member commented that more information is needed for members to assess achievement of objectives one through four. One Council member commented on objective 6 that more "actual data is needed to make sure services are delivered fairly and accurately" and "many questions remained unanswered." Neither comment articulated what type of information they would need to better assess achievement of the objectives. The results of the administrative assessment will be presented to the NA&E Committee to inform the evaluation of Part A grant administration of FY2016 funds.

**4) Third Party Reimbursement**

a) Monitoring third party reimbursement**.** To ensure that RWP funds are the payer of last resort, subrecipients are asked at each site visit to demonstrate how they determine RWP eligibility and

track other sources of reimbursement. The Part A grant recipient's instrument for OHS provider site visits assesses whether processes are in place to ensure that all third party funding sources have been exhausted prior to the utilization of RWP funds. The site visit team reviews a statistical sample of client charts to verify client insurance status and that RWP eligibility was determined. To ensure that all Medicaid-eligible providers are certified, the Part A recipient's contract managers check with the DHS to verify that each OHS provider receiving RWP funds has an active Medicaid provider number. All RWP subrecipient contracts identify the funding source and contain the following language: "*Third party payments must be exhausted prior to accessing Ryan White grant dollars. The provider must ensure that Ryan White program funds remain the payer of last resort*." All Part A subrecipients are also required to submit semi-annual program revenue and expense statements on September 30 for the period March 1 through August 31 and on March 31 for the period September 1 through February 28 showing all sources of funding , including third party reimbursement for each program by budget line.

b) Eligibility determination and ensuring RWHAP is the payer of last resort. Upon intake and every six months, all clients are asked about: income, residence and health insurance status including private insurance, Medicare, Medicaid, MinnesotaCare, veteran's health care benefits, ADAP, or the HIV Insurance Program and other public programs. Subrecipients are required to report these items in MNCAREWare in January and July. Insurance information is also documented in client charts. All Part A OHS providers have onsite caseworkers, including Medicaid enrollment workers, social workers, medical case managers, and benefits counselors, that review client eligibility for third party reimbursement. In addition, agencies ask about changes in insurance status at each appointment or as part of the billing requirement; however, many of the TGA's Part A funded programs cannot bill third parties for services such as Food Bank/Home Delivered Meals, most HIV MCM, HE/RR sessions, Psychosocial Support or Legal services. HIV diagnosis documentation is also obtained at intake or by the second appointment if not available upon first contact. Documentation of income and residence are obtained annually, and reassessed every six months. If no changes have occurred at the six month mark, self-attestation is noted in the client record. At annual site visits, a sample of client records based on HRSA/HAB recommendations for numbers of charts are reviewed for documentation of RWP eligibility including HIV diagnosis, income, residence in the TGA and insurance. In 2016, 610 client records were reviewed for eligibility determination documentation. Any subrecipient that does not demonstrate 100% documentation for each of the four elements of eligibility determination is required to take corrective action.

c) Tracking of program income**.** All Part A funded services are delivered by subrecipients. The Part A grant recipient does not generate program income. Since no Part A funds are allocated to a Pharmacy Assistance Program, no rebates are received. Subrecipient program income tracking methodology is reviewed during annual fiscal site visits. Each subrecipient is required to submit semi-annual agency-wide and program-specific line item revenue and expense statements and administrative allocation schedules (including methodology used), in March and September. Statements are reviewed by contract managers who follow up with subrecipients if revenue and expenditure information is incomplete.

**E. Maintenance of Effort (MOE)**

***Attachment 12*** presents a table that identifies the Minneapolis-St. Paul Part A TGA's MOE budget elements and the amount of expenditures for fiscal years 2014 and 2015.