Minneapolis-St. Paul TGA Application for 2018 Ryan White HIV/AIDS Treatment Extension Act Part A and MAI Funding

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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 Minneapolis-St. Paul Transitional Grant Area (MSP-TGA) including the cities of Minneapolis and St. Paul and the thirteen counties that surround them. In an era when highly effective treatments for HIV are available and adherence significantly reduces 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 RWHAP Parts and the Minnesota Department of Health (Minnesota's CDC HIV prevention grant recipient), the Part A program ensures an integrated continuum of care and services in the Twin Cities metropolitan area where 85% (7,339) of Minnesotans living with HIV reside, the vast majority (81%) in Hennepin and Ramsey Counties. Recent national, Minnesota and MSP-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 previously went without adequate insurance, the MSP-TGA's FY2018 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. Demonstrated Need

1) Epidemiological Overview

a) Summary of the HIV Epidemic the Minneapolis-St. Paul TGA

The Minneapolis-St. Paul Part A Transitional Grant Area (MSP-TGA) comprises eleven counties in Minnesota and two in western Wisconsin with the cities of Minneapolis and St. Paul 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 at that time. The estimated population of the TGA in 2016 is 3,482,752. The outer TGA counties are suburban or rural. The nine outer Minnesota counties together with Hennepin County (Minneapolis) and Ramsey County (St. Paul) comprise 63% of Minnesota's population of 5,528,630. Minneapolis in Hennepin County and St. Paul in Ramsey County are the TGA's and Minnesota's two largest cities. Hennepin and Ramsey counties comprise 32% (1,773,132) of Minnesota's population. The MSP-TGA's population is 77% White, 7.6% Black (including an estimated 90,072 African-born), 5.4% Hispanic, 6.2% Asian/Pacific Islander (API), <1% American Indian/Alaskan Native, and 2.8% other or Multi-racial. The greatest concentrations of Blacks (both U.S. and African-born), Hispanics, American Indians, API, and men who have sex with men (MSM) in Minnesota reside in Hennepin and Ramsey Counties. The proportion of males estimated to be MSM throughout the MSP-TGA is

6% with higher percentages of males who are MSM in the City of Minneapolis (11%) and in Hennepin and Ramsey Counties (8%).

There were 249 newly diagnosed cases of HIV infection in the MSP-TGA reported to the Minnesota Department of Health and Wisconsin Department of Family Services in 2016. Eighty-four percent of new cases in Minnesota resided in the 11 Minnesota counties of the TGA. ***Attachment 14B*** presents a map of HIV prevalence in the TGA as of December 31, 2016. The TGA is home to 85% of people living with HIV in Minnesota. Greater than 99% of the TGA's 7,339 diagnosed PLWH reside in the 11 Minnesota TGA counties, with less than 1% residing in the two Wisconsin counties. The greatest concentration of PLWH in the MSP-TGA reside in the core urban center of the TGA with 62% residing in Hennepin County and 43% in the City of Minneapolis alone. Suburban areas of the TGA account for 42% of its living HIV cases.

b) Socio-demographic Characteristics

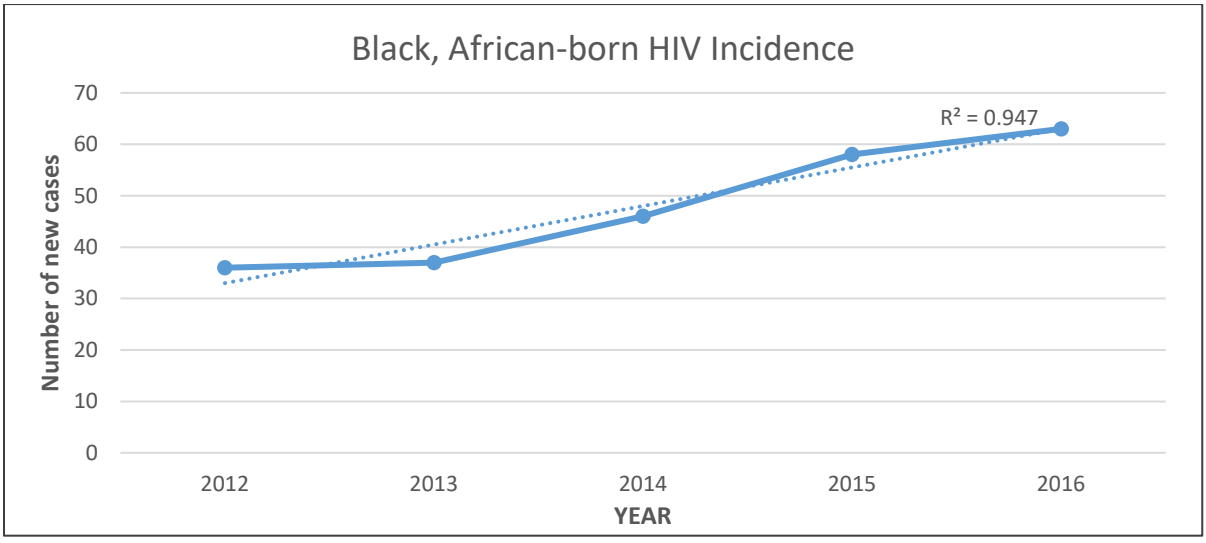
i. Demographic Data

(1) Persons newly diagnosed

Attachment 3 presents HIV incidence data for the TGA from 2012 to 2016. In 2016, 249 new HIV diagnoses were reported in the MSP-TGA. The HIV epidemic in the state and TGA remains largely male, with 76% of new cases among males, 64% of whom are MSM or MSM who also inject drugs (MSM/IDU). There were four diagnoses among transgender people in the TGA (2 Transgender-female to male and 2 Transgender-male to female).

HIV disproportionately impacts people of color in the TGA, most notably Blacks, both African American and African-born. African American and African-born Blacks combined comprised 47% of new diagnoses in 2016, while they make up only 7.5% of the TGA's population. The disparity among blacks becomes more pronounced when African-born are separated from African-American (US born). There were 63 new cases among African born, representing a quarter of new cases in 2016. The HIV incidence rate among African-born was 23 times that of whites. Moreover, the incidence rate has been rising since 2012 for African-born Blacks (Figure 1). If this trend continues, the disproportionate impact of HIV on Black African-born clients in the TGA will continue to intensify.

Figure 1. HIV Incidence Among Black, African-born in the MSP-TGA, 2012-2016

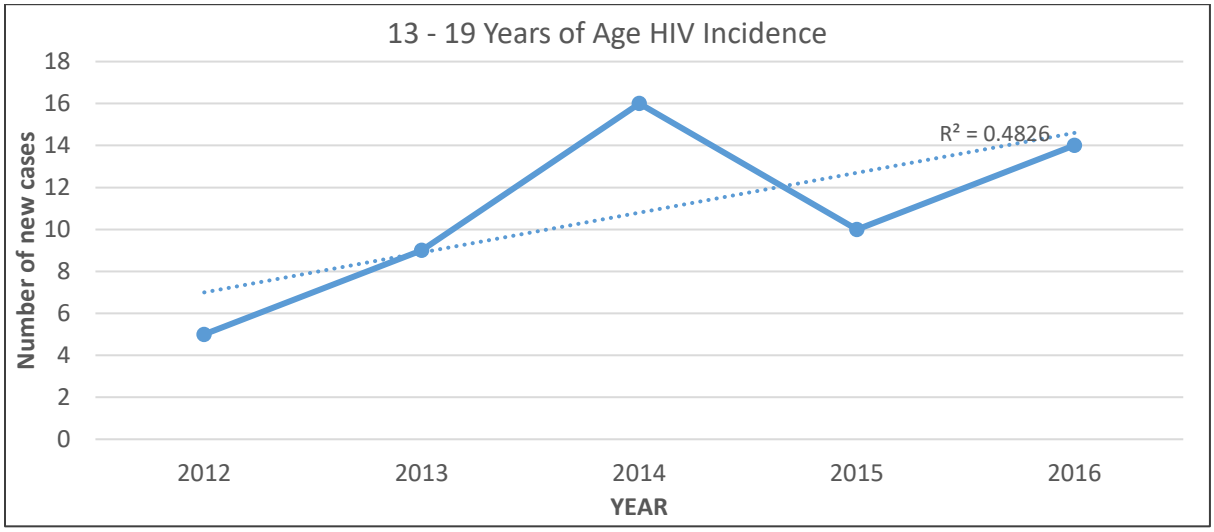


Among new cases of HIV infection in 2016, 7.6% were Hispanic, less than 1% were American Indian or Alaska Natives and 1.6% were multiracial. Although the annual number of new infections is comparatively low among Asian/Pacific Islanders (API), incidence more than doubled from 5 cases in 2012 to 12 cases in 2016. Of these 12 cases, seven of them were known to be foreign born, 3 cases were unknown, and 2 cases were US born. Additionally, 10 of the 12 cases were men, with six identifying as MSM or MSM/IDU.

Among women, nearly all new diagnoses in 2016 were among women of color, most notably African-born (56%) and African American women (20%). Since 2012, the number of new infections among African-born black women has increased from 19 to 31. This is similar to the increase among African-born black men, which increased from 17 to 32 cases between 2012 and 2016. This is the only population with significant increases in new infections in both its male and female populations in the past five years. Unlike other racial/ethnic groups, the primary mode of transmission among the African born community is through heterosexual contact, which is reflective of the predominant mode of transmission in Sub-Saharan Africa.

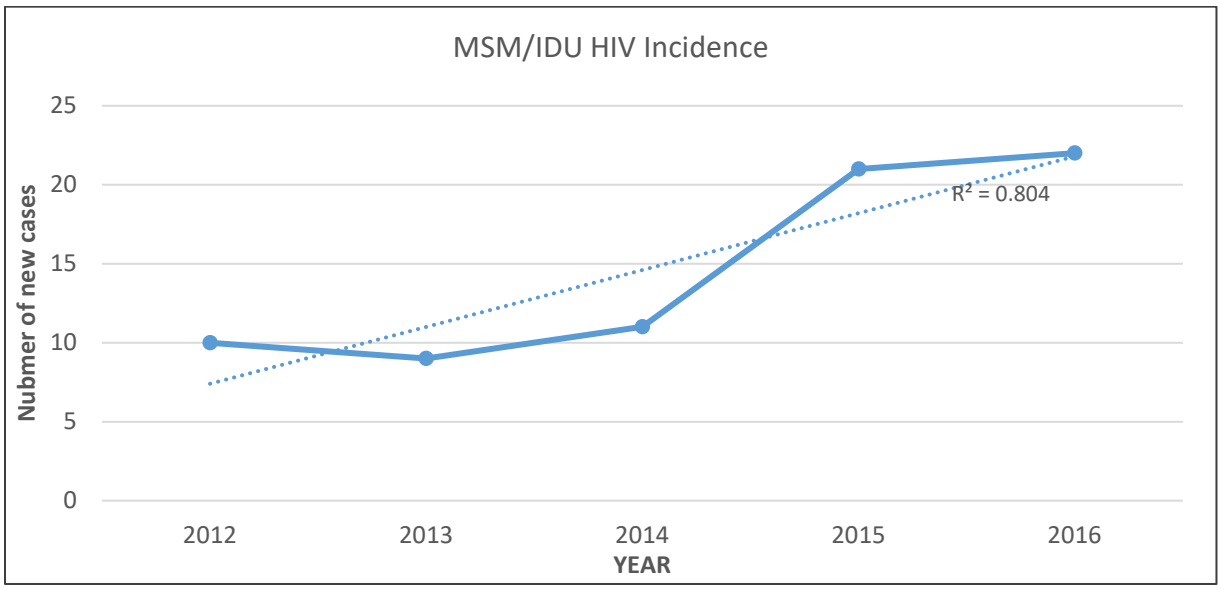
Adolescents and young adults ages 13-24 years accounted for 23% of new infections in 2016. While new infections in 20-24 years old has been relatively stable with an average of 43 cases per year since 2012 (low of 39, high of 49), new infections among 13-19 year olds has risen from 5 to 14 cases from 2012 to 2016 (Figure 2).

Figure 2. HIV Incidence Among Youth (13-19 Years) in the MSP-TGA, 2012-2016



Forty-eight percent of new diagnoses in 2016 were among MSM and MSM/IDU. Among MSM, 45% of new infections were among men of color with African American MSM accounting for 21% and Hispanic MSM accounting for 12% of new infections. Since 2013, new infections among IDU doubled from 13 to 26 cases. Most of these new infections are MSM/IDU, as illustrated below (Figure 3).

Figure 3. HIV Incidence MSM/IDU in the MSP-TGA, 2012-2016



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 2016, 34% of the newly diagnosed foreign born individuals tested late compared to 19% of all newly diagnosed cases overall. New foreign born cases were born in 28 different countries with Liberia, Ethiopia, Somalia, Mexico, and Kenya accounting for more than half of these cases.

(2) People living with HIV

Attachment 3 presents HIV prevalence data for the TGA from 2012 to 2016. By December 31, 2016, there were 7,339 diagnosed PLWH in the MSP-TGA. From 2012 to 2016, overall HIV prevalence increased by 13% (822 cases). Of the living cases in the TGA, 3,359 or 46% had an AIDS diagnosis, while 3,980 or 54% had a (non-AIDS) HIV diagnosis. By gender, 75% of the TGA's PLWH are male, 24% are female, and 1% are transgender. Among males living with HIV, 75% are MSM or MSM/IDU. Greater than half of PLWH in the TGA are people of color with 23% African American, 15% Black African-born, 9% Hispanic, 1% American Indian, 2% API and 2% of multiple racial backgrounds. Forty seven percent are White. Among women living with HIV in the TGA, 66% are Black, of which 56% are African-born. The largest age group among PLWH in the TGA are people 50 years or older comprising 46% of the population of PLWH. Nine percent of PLWH in the TGA are between the ages of 13 and 29, 19% between 30 and 39, and 25% between 40 and 49. People younger than 13 years comprise less than 1% of PLWH in the TGA.

Comparing demographics of the MSP-TGA's population with that of the population of diagnosed PLWH in the TGA along with HIV prevalence rates shows that people of color, including Blacks (African American and African-born), Hispanics, and American Indians, along with MSM, carry the greatest burden of HIV disease. According to the American Community Survey (ACS), of the TGA's 3,482,752 residents in 2016, 5% were African American (US born), 2% African-born Blacks, and 6% Hispanic. An estimated 3% of the TGA's population are MSM

(6% of the male population). The following table compares select demographic groups represented in the TGA's population with representation among diagnosed PLWH and presents 2016 HIV prevalence rates:

Table 1. Minneapolis-St. Paul TGA Population and HIV Prevalence Rates

Demographic Group	% of TGA Population (2016)	% of Diagnosed PLWH (2016)	2016 HIV Prevalence Rate‡
White	77.2	39.0	130.8
Black, African American	5.4	21.3	915.4
Black, African-born	2.2	25.3	1,525.3
Hispanic	5.6	7.6	353.6
American Indian/Alaskan Native	0.5	0.4	559.8
Asian/Pacific Islander	6.2	4.8	70.5
Multiracial	2.8	1.6	195.6
MSM*	2.9	55.9	4,064.3

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

Comprising just 6% of the male population of the MSP-TGA, MSM have the highest prevalence rate of any demographic group followed by Black-African born, African Americans, American Indians, and Hispanics. Fifty-six percent of diagnosed PLWH in the MSP-TGA are MSM or MSM/IDU with 4% of the TGA's 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, 46% are White, 19% Black, 9% Hispanic, 3% multiracial and 2% API. While representing a minority of MSM in the TGA, compared to their representation in the TGA's general population, African American MSM carry a relatively heavy HIV disease burden among MSM in the TGA. The incidence rate among African American MSM remains high particularly among adolescents and young adults ages 13-29 years. Forty-nine percent of MSM living with HIV are ages 50 and older, 32% are 35 to 49, 16% are 25 to 34 and 3% are 13-24.

The prevalence rate among Black-African born is almost 12 times that of Whites. Among African-born Blacks, women have a greater disease burden than men with the mode of HIV exposure being primarily through heterosexual contact. Black African-born is the only racial/ethnic group where the number of females (652 cases) living with HIV exceeds the number of males (493 cases). In 2016, 34% of foreign born cases were late testers compared to 19% of US-born cases. Geographically, HIV disease burden is greatest in Minneapolis (see ***Attachment 14B: HIV Prevalence and Services Map*)**. HIV prevalence is highest in the central, southern and northern sectors of the city where MSM, African Americans, Black African Born, Hispanics, and MSM are more likely to reside.

(3) Persons at higher risk for HIV infection in the service area

The past five years of HIV incidence and prevalence data for the TGA indicate that broadly the demographic groups at higher risk of acquiring HIV are MSM, MSM/IDU, Black men (African American and African-born), and women of color. African born men, African born women, and MSM/IDU show increases in HIV incidence between 2012 and 2016 and are significantly over represented among PLWH based on their representative proportions in the TGA's general population. Younger people, specifically 13-19 year olds, have nearly tripled their incidence

since 2012. This increase is particularly noticeable among 13-19 year old MSM with 1 case in 2012 rising to 8 cases in 2016. Although both incidence and prevalence numbers are relatively low, a possible emerging higher risk population is Asian/Pacific Islander MSM as indicated by high percent increases in both HIV incidence and prevalence between 2012 and 2016. Additionally, lower rates of viral suppression, especially among American Indians (59%), African Americans (57%) and African born Blacks (60%) compared to Whites (69%), based on the MSP-TGA's most recent HIV Care Continuum, indicate that these populations may be at higher risk for HIV infection.

ii. Socioeconomic data.

Table 3 on page 10 presents income as a percentage of Federal Poverty Level and health insurance status of the MSP-TGA's population and population of diagnosed PLWH.

Income and Poverty**.** Minnesota overall has fared somewhat better than the nation as a whole economically. According to the Minnesota State Demographic Center, in 2015 an estimated 11.3% of Minnesotans were living below the Federal Poverty Level (FPL) compared to 15.5% nationally. In Hennepin County, where 63% of the TGA's diagnosed PLWH reside, 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 $53,889 and $61,492 in Minnesota.

Despite these favorable numbers, income inequality and the impact poverty has on persons of color in Minnesota and the MSP-TGA is striking. Income inequality by race is more pronounced in the TGA 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%.

Education**.** Minnesota's emphasis on education is reflected in the low statewide percentage (7.6%) of people aged 25 years or older who have less than a high school education; the national average is 13.3%. The percentage of persons with less than a high school education is greater for persons of color in Minnesota. According to the 2011-2015 ACS, 17% of Black men and 22% of Black women have less than a high school education compared to 6% and 4% of White men and women, respectively. High school graduation rates are even lower among Hispanics, with 37% and 33% of Hispanic males and females not having a high school diploma, respectively.

Health Insurance. Overall, Minnesota has one of the lowest rates of uninsured residents in the nation with the lowest rate on record for the state in 2015. According to data released from the 2015 Minnesota Health Access Survey, 4.3% of Minnesotans were not covered by health insurance compared to 8.2% in 2013, 9.0% in 2011, 9.0 in 2009 and 7.2% in the 2007 survey. The findings in this study suggest that significant differences continue to exist by race/ethnicity, age, income and country of birth.

Based on MN CAREWare data, among PLWH in the TGA who received a Ryan White Program (RWHAP) Part A or B funded services in 2016, 5.6% were uninsured, although many who are insured may have out-of-pocket costs that can create economic barriers to accessing health care. Greater than one in three (35%) of the TGA's RWHAP clients accessed Part A funded outpatient health care services in 2016 either because they were uninsured or had high out-of-pocket deductibles, copayments or co-insurance.

Language Barriers**.** With African-born Blacks and Hispanics being disproportionately impacted communities, language barriers exist for many PLWH. English is a second language for many of the MSP-TGA's foreign born PLWH and access to HIV health promotion information and where

to get tested and receive services is likely lacking especially for those who have not yet entered the RWHAP system of care.

c) Relative Rates of Increase in HIV Diagnosed Cases within New, Emerging and Disproportionately Impacted Populations

i. Emerging populations, unique challenges and estimated costs

A close examination of HIV incidence in the MSP-TGA between 2012 and 2016 shows the number of new HIV diagnosed cases rose among four distinct subpopulations including: African born Blacks (Figure 1), youth and young adults ages 13-19 years (Figure 2), MSM/IDU (Figure 3) and Asian/Pacific Islanders. The greatest rate of increase was among African born Blacks with an average of 7 new cases per year during the 5 year period. HIV incidence among African born Black men 30 years of age or older increased by almost 4 new cases per year and among African born Black women 34-39 years of age by almost 3 new cases per year. The population of African born PLWH in the MSP-TGA has been growing since the late 1990s when Minnesota became one of 6 states in the US to resettle HIV positive African immigrants from refugee camps in East Africa. Over 100 countries of birth are represented among the TGA's population of PLWH. Language barriers to accessing HIV medical care and other core medical and supportive services are significant for many African immigrants with an HIV diagnosis and limited English proficiency. HIV stigma is also high among the many African communities within the TGA.

Incidence also rose among youth 13-19 years of age. As highlighted above in Figure 2, the number of new infections rose from 5 to 14 cases since 2012. Young people are less likely to be in care. Additionally, the lifelong cost of HIV medical care and supportive services is higher among young people living with HIV. Incidence more than doubled among MSM/IDU from 9 to 19 cases with a doubling of new infections between 2014 and 2015 (Figure 3). This is another population that is less likely to be in care than the general population of PLWH because of co-occurring conditions such as substance use disorder, which is often accompanied by depression. If this trend continues, the burden among MSM will continue to rise in the TGA.

Although the numbers of new cases among Asian/Pacific Islanders is relatively small compared to most other racial and ethnic groups, HIV incidence in this population has more than doubled from 5 new cases in 2012 to 12 in 2016 with an average rate of increase of 2 cases per year. At least half of these cases are among MSM. The low number of cases combined with a general lack of recognition of Asians as a minority (invisible) population by the dominant culture and little or no culturally responsive targeted HIV prevention, testing and care information present significant challenges in effectively engaging Asian/Pacific Islanders at risk and living with HIV in testing and services. Additionally, the MSP-TGA's population of Southeast Asians experience significant disparities in access to care and achieving positive health outcomes.

Based on the proportion of PLWH in the TGA who utilize RWHAP funded services, estimating the annual cost of providing Part A and Part B services (including ADAP) combined for new clients that enter the HIV system of care is possible. In FY2016, 40% of PLWH in the MSP-TGA received Part A funded services at an average cost of $1,583 per service recipient. Fifty-one percent of the TGA's diagnosed population of PLWH received a Part A and/or Part B service in FY2016 at an average annual cost per client of $3,319. Individual client costs based on their need will vary. Part A costs for early intervention services to reach the undiagnosed and

outreach services to re-engage PLWH in care who are not receiving HIV medical care were $3,049 and $6,904, respectively. If 40% of the MSP-TGA's people newly diagnosed with HIV infection in 2016 (100) accessed Part A funded services, the cost incurred to deliver these services would be $158,300. If 51% of the MSP-TGA's new cases (127) needed both Part A and B funded services, the total cost would be $421,479. Given that the four subpopulations that had increases in HIV incidence in the last five years face significant challenges in accessing HIV testing and services, annual costs for each newly diagnosed member of one of more of these groups is likely higher.

ii. Increasing need for HIV-related services in the MSP-TGA

The number of diagnosed PLWH residing in the TGA increased by almost 3.5% (249 living cases) between 2015 and 2016. In the past five years, the number of diagnosed PLWH in the TGA increased by 822 with an average annual prevalence increase of 2.5%. The MSP-TGA's 2016 HIV Care Continuum based on 2015 and 2016 HIV surveillance data estimates that there are 972 undiagnosed PLWH in the jurisdiction (11.7% of the population of PLWH) and 1,986 diagnosed PLWH who are not retained in care (Unmet Need for medical care). Including the undiagnosed and diagnosed, the estimated total population of PLWH in the TGA is 8,311, 36% of whom are likely not receiving consistent quality HIV medical care that is necessary to achieve viral suppression.

In FY2016, 40% of diagnosed PLWH in the MSP-TGA received at least one RWHAP Part A funded service. The following table presents Part A funded RWHAP service utilization in the MSP-TGA including the proportion of the TGA's diagnosed population of PLWH that received each of the funded services and the cost per client:

Table 2. FY2016 Part A Service Utilization, Cost Per Client and Expenditure

Service Category	Unduplicated Clients Served	% of Diagnosed PLWH	Part A Cost per client	Total FY2016 Expenditure
Early Intervention	45	0.6%	$ 3,079	$ 138,542
Emergency Financial Assistance	303	4.1%	320	97,103
Food Bank/Home-delivered Meals	1,224	16.7%	507	620,430
Health Education/Risk Reduction	256	3.5%	313	80,245
Health Insurance Premium & Cost Share Assistance	75	1.0%	87	6,519
Home and Community-based Health Services	35	0.5%	3,419	119,675
Housing Services	14	0.2%	3,634	50,873
Legal Services (Other Support Services)	323	4.4%	294	95,024
Linguistic Services	3	0.0%	911	2,732
Medical Case Management	1,563	21.3%	1,452	2,269,082
Medical Nutrition Therapy	291	4.0%	145	42,136
Medical Transportation Services	40	0.5%	555	22,207
Mental Health Services	59	0.8%	2,148	126,746
Outpatient Health Care Services	1,237	16.9%	631	780,806
Psychosocial Support	239	3.3%	365	86,581
Outreach Services	23	0.3%	6,904	158,799
Substance Abuse Services: Outpatient	236	3.2%	599	141,361
Total Unduplicated	2,905	39.6%	$ 1,593	$ 4,838,861

Assuming the proportion of diagnosed PLWH in the MSP-TGA who utilize Part A funded services remained constant at 40% and with a five year average annual increase in HIV prevalence of 2.5%, the Part A Program would require an additional $233,820 in Part A funding (based on FY2016 service costs) for FY2018 to meet the increasing needs of the RWHAP eligible population in the MSP-TGA. In FY2016, 94% of Part A Program clients were retained in HIV medical care and 88% were virally suppressed. Eighty-six percent of those receiving early intervention or outreach services were linked to care within 30 days and 47% on the same they began receiving the service. Given that an estimated 75% of the TGA's population of PLWH are income eligible for RWHAP services (see **Table 3**, page), an even greater Part A Program capacity increase would likely improve the MSP-TGA's HIV Care Continuum if the Part A Program is successful in increasing access to the 8 core medical and 9 support services prioritized by the Minnesota Council for HIV/AIDS Care and Prevention for RWHAP Part A funding.

2) Co-occurring Conditions

Quantitative evidence describing conditions co-occurring with HIV in the Minneapolis-St. Paul Part A TGA is presented in ***Attachment 4.***

3) Complexities of Providing Care

a) Impact and Response to Reduction in RWHAP Formula Funding

The MSP-TGA received a 1.1% increase in Part A formula funding in 2017. Formula funding increased by $38,659; from $3,646,183 in FY2016 to $3,684,842 in FY2017.

b) Poverty and Health Care Status of PLWH in the MSP-TGA

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

Table 3. Poverty and Health Care Coverage for the MSP-TGA's Population and Diagnosed PLWH

	TGA	%	PLWH	%	Data Source
Total Population	**3,482,752**	**100%**	**7,339**	**0.2%**	ACS^, MDH*
Health Insurance					
Medicare	428,484	12%	1,007	14%	ACS^, MNCAREWare¥
Medicaid	796,730	23%	2,476	34%	DHS**, MNCAREWare¥
MinnesotaCare (Basic Health Plan)	110,428	2.9%	162	2.2%	DHS**, MNCAREWare¥
Qualified Health Plan (*MNSure*)	110,854	3.2%	157	2.1%	DHS**, MNCAREWare¥
Uninsured	156,724	4.5%	361	4.9%	MN Health Access Survey, MNCAREWare¥
Income as % of FPL (up to/cumulative)					
138% (Medicaid eligible)	487,593	14%	3,101	42%	ACS^, MNCAREWare¥
200% (MinnesotaCare eligible)	789,702	23%	3,907	53%	ACS^, MNCAREWare¥
300%	1,285,036	37%	4,900	68%	ACS^, MNCAREWare¥
400% (RWHAP and APTC[ł] eligible)	1,760,895	51%	5,521	75%	ACS^, MNCAREWare¥

^U.S. Census Bureau American Community Survey Public Use Micro sample (2016), *MN Department of Health eHARS, **MN Department of Human Services - Minnesota Medicaid Information System (MMIS), ¥State of MN and MSP-TGA RWHAP client-level database, [ł]Advance Premium Tax Credit.

Minnesota 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. Minnesota has taken full advantage of the ACA's provisions to expand health insurance and reform the health care delivery system to improve quality and value by protecting people with pre-existing conditions such as HIV, strengthening public health and health care access, improving the health care workforce and encouraging consumer and patient wellness in both the community and the workplace. Minnesota was an early Medicaid expansion state, established a state insurance exchange, *MNSure*, and a Basic Health Plan, MinnesotaCare. As a result, Minnesota now has one of the lowest rates of uninsured residents in the nation with 2016 showing 4.3% compared to 8.2% in 2013. The increase in health insurance coverage is primarily driven by enrollment in publicly funded state health insurance programs. The greatest benefit for the MSP-TGA's population of PLWH was the expansion of Medicaid primarily through the elimination of categorical eligibility and increase in the income limit. Currently, 1 in 4 MSP-TGA residents rely on Medicaid or MinnesotaCare. Coverage through *MNSure*, MN's state-based marketplace, covers 10% of Minnesotans on individual or small group coverage. Currently, there are an estimated 3,645 of the TGA's PLWH covered under Medicare, Medicaid or MinnesotaCare (Basic Health Plan) as of March 31, 2017. An additional 157 of the TGA's PLWH are enrolled in a Qualified Health Plan (QHP) through *MNSure*. Individuals with incomes up to 138% of the Federal Poverty Level (FPL) are eligible for Medicaid. Those between 139% and 200% of FPL are eligible for MinnesotaCare. Despite these overall changes, the uninsured rate among the TGA's RWHAP recipients has remained relatively unchanged at 5% since 2010.

Minnesota's ADAP covers premium costs and prescription deductible and co-payments for PLWH with incomes up to 400% of FPL for private health plans including QHP's obtained through *MNSure* and cost effective off-Exchange plans that provide comprehensive coverage. All of the QHPs that ADAP will purchase are Gold or Silver level plans that include all of the essential health benefits without restrictions on antiretroviral medication.

c) Factors That Limit Access to Health Care and Service Gaps

Factors That Limit Access

Complexity of health insurance system. Although full implementation of the ACA in Minnesota resulted in a significant increase in access to affordable health care for the broader community and PLWH, it created a more complex system of obtaining health care coverage especially for those struggling to meet their basic needs, experiencing homelessness or other hardship including substance use disorder and mental illness, and for immigrants with limited English proficiency. Limited open enrollment periods may exacerbate temporary loss of coverage and access to HIV medical care due to changing circumstances, including fluctuations in income, that impact eligibility for publicly funded or subsidized private health coverage. PLWH born outside the U.S. who are undocumented may be unaware of ADAP and health insurance premium assistance. PLWH who purchase insurance through *MNSure* experience annual plan changes, including changes in provider networks, along with dramatic premium increases (17% - 49% in

2017), although a recently received state innovation waiver to stabilize Minnesota's individual health insurance market will reduce premiums for consumers in 2018.

A more complex health insurance system for the TGA's PLWH, may make continuity of coverage more challenging, resulting in increased reliance of RWHAP services to assist PLWH in obtaining coverage and fill coverage gaps for short periods. The short annual open enrollment period for obtaining Qualified Health Plans through *MNSure* for PLWH with incomes between 201 and 400 of FPL who do not have employer sponsored health coverage may result in coverage gaps depending on when PLWH who don't qualify for Medicare, Medicaid, or MinnesotaCare (Minnesota's Basic Health Plan) 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 or result in the inability to continue care at their provider of choice. The Council's 2015 Comprehensive Needs Assessment (2015 CNA) indicates that a trusted health care provider plays a significant role in connecting PLWH to medical care. Of the 504 respondents to the needs assessment survey, the two most important factors in finding and connecting to HIV-related medical care were a knowledgeable medical professional or clinician (84%) and a sense that people at the clinic seem to care about them (70%).

State of residence. The MSP-TGA includes two counties in western Wisconsin; Pierce and St. Croix. According to HIV surveillance data from the Wisconsin Department of Health Services, there were 46 individuals known to be living with HIV in these two counties as of December 31, 2016. The State of Wisconsin has not fully implemented the ACA and has not expanded their Medicaid program so health care access may be more limited for Wisconsin residents in the TGA. Low income Wisconsin residents living with HIV without a disability determination who are not pregnant or 65 and older and without access to employer sponsored health insurance would need to enroll in a QHP through the federal health insurance exchange and would likely have higher out-of-pocket costs for their care. These individuals need to rely on Wisconsin's ADAP to cover premium and prescription drug costs and other RWHAP programs such as the MSP-TGA's Parts A funded outpatient health care services (OHCS) and Part C and D programs and Wisconsin's Part B, C and D funded health care services. Accessing Part A funded OHCS may be difficult for Wisconsin residents since the three Part A providers are located in the Twin Cities metro area requiring long distance travel to medical appointments.

Poverty and out-of-pocket health care costs. The 2015 CNA also indicates that for some, poverty can still result in poor health care access despite expansion of affordable insurance options. Almost 10% of survey respondents reported being denied medical care because they were uninsured or couldn't afford their co-payment. Among the MSP-TGA's PLWH who received RWHAP services in FY2016, 79% had an income below 200% of the FPL. Among the 2015 CNA respondents, the RWHAP or the clinic covered the cost of care for 21% of those who received medical care in the past 12 months. In 2016, many of Minnesota's QHPs changed the structure of their deductibles so they no longer apply towards prescription drug costs, potentially resulting in higher out-of-pocket costs for RWHAP eligible PLWH for their outpatient health care visits since Minnesota's ADAP only covers deductible, co-insurance and co-payment costs for prescriptions.

Disparities among communities of color and the foreign-born. Notable disparities continue to exist among Minnesota's 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. Racial and ethnic disparities in access to health care are evident among the MSP-TGA's population of PLWH. Of the 2015 CNA respondents, 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. 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.

In addition, PLWH born outside the U.S. 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. Although Minnesota's ADAP will purchase a private health insurance plan on the off-exchange market for PLWH whose immigration status is undocumented, the one cost effective plan available in 2017 did not include two HIV specialty care providers of HIV who serve the majority of foreign-born PLWH who receive RWHAP services. One of these providers is a Federally Qualified Health Center in the heart of St. Paul's Latino community that provides linguistic and culturally responsive services. Limited English proficiency may also limit accessibility. Information on RWHAP services in languages other than English is sparse outside of the HIV system of care. Thirty-one percent of people living with HIV in the MSP-TGA who received RWHAP services in FY2016 (1,150) were born outside the U.S. People living with HIV born outside the U.S. are more likely to enter care late as indicated by the proportion of new diagnoses that progress to AIDS within a year. In 2016, 34% of Minnesota's new cases that were foreign born progressed to AIDS within a year of diagnosis compared to 18% of U.S. born cases. Lack of health care coverage for this population restricts access to HIV testing and services that facilitate early diagnosis and rapid linkage to care.

Service gaps for PLWH not in care

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 FY2015 and 2016 HIV Care Continua, RWHAP service utilization data, 2010 and 2015 HIV Comprehensive Needs Assessment (CNA) surveys, HIV 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. The Council's service priorities and allocations for FY2017 and 2018 (***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 are funded by sources other than the RWHAP are not always accessed by those in need due to eligibility criteria or insufficient capacity. Part A allocations for support services such as housing assistance, emergency financial assistance (EFA), and medical transportation are essential to maintaining health care access and retention by mitigating economic barriers.

The 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. The MSP-TGA continues to experience high rates of poverty among populations of color, particularly African American and African-born and Latino immigrants. United States Census data show that the Twin Cities metro area has one of the greatest income gaps between Blacks and Whites in the nation. Services that address basic needs such as food and nutrition, EFA, and housing assistance are crucial to continued access to HIV treatment for disproportionately impacted populations 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.

Access to healthcare. Despite Minnesota's successful health care reform efforts, gaps in health care still exist for those who are newly diagnosed or are not retained in care and are uninsured or under-insured. Of the 504 respondents to the 2015 CNA, 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. 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. According to the 2015 CNA, 31% of respondents reported that in the past year difficulty 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 or they could not afford a copayment.

Although most RWHAP eligible PLWH in the MSP-TGA will qualify for Medicaid, MinnesotaCare, or a QHP through *MNSure*, RWHAP funded medical case management and benefits counseling (non-medical case management) are critical services to maintain to provide assistance in negotiating the complex system of obtaining comprehensive affordable coverage and finding a trusted HIV specialty care provider. In addition, Part A funded outpatient health care services provide care until coverage is obtained. The Minnesota Council for HIV/AIDS Care and Prevention's FY2018 Part A allocations plan dedicates 15% of service funds to outpatient health care services ($757,800), 46% to medical case management ($2,304,500) and $10,600 to health insurance premium and cost-sharing assistance to cover MinnesotaCare premiums and other out-of-pocket medical care costs that are not covered by ADAP. In addition, the Council's MAI allocations are dedicated to outpatient health care services ($118,983)

targeting Latinos, many of whom are immigrants whose status is undocumented, and medical case management ($211,200) services targeting Latino, African American and African-born PLWH. Part B and ADAP rebate revenue will provide $500,000 in funding for benefits counseling in 2018. These programs also help ensure continuity of access to care for PLWH whose income and employment status changes can result in short term lapses in coverage. In addition, medical transportation services, allocated $25,100 in Part A funds and $351,160 in Part B funds provide needed rides to appointments particularly for those residing in the MSP-TGA's outlying suburban areas that are considerable distance from the major HIV specialty care providers that are located in the core urban centers of Minneapolis and St. Paul. **Attachment 8** (Service Category Plan Table) shows planned FY2018 Part A allocations for early intervention, home and community-based health, mental health, medical nutrition therapy and outpatient substance abuse services. These allocations will provide access to other core medical services for uninsured PLWH in the MSP-TGA and can help mitigate barriers to HIV medical care linkage and retention caused by untreated substance use disorder or mental illness.

In FY2016, 17% of PLWH (1,237) residing in the TGA received Part A funded outpatient health care services. In addition, 1,261 PLWH in the TGA received ADAP services; 1,208 received assistance paying for their medications, and 555 in paying for their insurance premiums. Twenty-eight percent (2,051) of the TGA's diagnosed PLWH received medical case management and 9% (646) received benefits counseling services. Furthermore, 85 received Part A and Part B funded health insurance premium/cost share assistance to pay medical expenses not covered by ADAP and 1,334 received Part A or Part B funded medical transportation to get to a health care or other core medical or support service appointment.

Housing. One of the biggest service gaps in the TGA is housing assistance. The Wilder Foundation's most recent *Homelessness in Minnesota* report indicates that on one night, October 22, 2015, there were 9,312 people experiencing homelessness in MN the majority of whom are in the MSP-TGA. 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. Minnesota CAREWare data shows that in 2016, 913 or 24% of the TGA's 3,722 RWHAP service recipients were living in temporary or unstable housing. In their newly developed HIV Housing Plan (2017), the Minnesota HIV Housing Coalition estimates that there are 1,096 PLWH in Minnesota who are unstably housed. The MSP-TGA lacks adequate affordable housing units and funding to meet the needs of the homeless and unstably housed. Several HIV housing providers in the TGA maintain waiting lists with over 400 people waiting for permanent housing. Additionally, 58% of PLWH receiving RWHAP services in 2016 have an annual income of less than $12,060 (100% of FPG) indicating that over half of the TGA's PLWH need housing and economic supports to sustain affordable stable housing. According to the 2015 CNA, 27% percent of PLWH 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.

The Minnesota Council for HIV/AIDS Care and Prevention's (MCHACP) 2018 allocations plan (see **Attachment 8)** includes $84,600 for housing services (rental assistance) and $121,800 for emergency financial assistance to prevent eviction or utility shut off. 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. In addition, Minnesota's Part B grant recipient will provide $473,139 in additional funding through ADAP rebate revenue for housing coordination and advocacy and rental and emergency housing assistance in 2018.

Mental Health Services. 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 3.3% of the TGA's population (114,769) has serious mental illness. SHAPE 2014 data indicate that LGBT respondents reported diagnosis of depression at a rate of 39.7%, compared to their non-LGBT counterparts at 21.7%. Similarly, LGBT respondents reported serious psychological distress at a rate of 5.4%, compared to 2.7% in non-LGBT respondents. Overall, LGBT respondents reported mental health distress nearly twice as often as their non-LGBT counterparts. According to the 2015 CNA, 60% of respondents reported receiving mental health services, an increase from 49% among 2010 CNA respondents and significantly higher for American Indian/Alaska Natives at 84%. Since diagnosis, 47% of the 2015 CNA respondents sought individual therapy with a psychiatrist for mental health treatment, 46% had psychiatrist prescribed medication, 50% had individual therapy with a psychologist, social worker, licensed professional counselor, nurse clinician or licensed chemical dependency counselor, and 40% sought help in an HIV-specific support group. Despite a decline in Part A spending on mental health services since 2014, psychiatric, rehabilitation, and support services still seem difficult to access for some PLWH. The 2015 CNA showed that 4% of respondents reported needing mental health services but were unable to access them and 3% needed psychosocial support but were unable to receive it. In 2016, 469 PLWH in the TGA who were enrolled in a Minnesota Health Care Program (MHCP) received outpatient mental health services at a total cost of $921,893.

In FY2016, $132,798 in Part A funds were spent on mental health services for 59 PLWH and $86,581 were spent on psychosocial support services for 237 PLWH. Planned Part A allocations for mental health and psychosocial support services in 2018 are $144,400 and $92,500, respectively. 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. This provider also offers culturally and linguistically specific psychosocial support for African-born women, especially for those women who fear repercussions from disclosure of HIV status, that can reduce isolation and stigma and increase knowledge of HIV treatment and services that ultimately improve retention in care. The third mental health program is at a Federally Qualified Health Center (FQHC) that provides primary care for 27% of the TGA's Latinos with HIV and employs mental health clinicians that are bilingual in English and Spanish. Three of the MSP-TGA's psychosocial support service

providers offer culturally responsive services for African Americans, African immigrants, Latinos and gay and bisexual men.

Substance Use Disorder (SUD) Services. A large proportion of clients receiving RWHAP 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, which is necessary to receive placement in a publicly funded treatment program, 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 RWHAP Part A clients accessing Part A Program Substance Abuse services in 2016 though they only make up 3% of RWHAP Part A clients and 1.2% 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 a Minnesota Health Care Program at a cost of $1,988,727 in 2016. In FY2016, $141,361 in Part A funds were spent on substance abuse (outpatient) services for 236 PLWH. Slightly more is allocated for FY2018 at $146,500 but may not be enough to fully meet the need that exists among the TGA's RWHAP eligible 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 problems 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 their insurance policy; being without health insurance for 3-months or longer since diagnosis; receiving health insurance premium assistance; 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 care can be mitigated by strong MCM programs. A large gap on the MSP-TGA's HIV Care Continuum is an 18% 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 connect to a trusted provider and stay in care. Five of the seven Part A funded MCM programs in the TGA are located at HIV specialty medical clinics that combined provide care to an estimated 62% of RWHAP eligible PLWH in the TGA. These clinic-based programs also staff Doctors of Pharmacy that provide treatment adherence and medication management counseling and tools. 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 FY2016, MCM services served 1,563 or 54% of Part A Program clients and 94% were retained in care. Eighty-seven percent of those receiving Part A funded MCM in FY2016 were below 200% of the FPG, suggesting a large need for the poor. MCM addresses gaps in services and barriers to care through care coordination that links PLWH to the core medical and support services they need. MCM receives the largest Part A allocation among the 17 service categories receiving Part A funds. In FY2016, $2,269,082, or 47% of Part A funds for services, were expended on MCM for PLWH, which included $191,800 of Minority AIDS Initiative (MAI) MCM funds targeting both African American clients and Latino clients. Planned allocations for MCM in FY2018 include $2,304,500 in Part A and $211,100 in MAI funds.

*Other Efforts to Address Service Gaps***.** To reduce the significant HIV-related health disparities that exist among racial and ethnic subgroups, age, and country of birth in the MSP-TGA, a number of approaches have been implemented or will be employed to fill gaps in services for the most disproportionately impacted communities in the MSP-TGA. The Minnesota Council for HIV/AIDS Care and Prevention's (MCHACP) Disparities Elimination Committee, which is dedicated solely to improving and reducing health disparities, continues to receive input from the League of Extraordinary Black Men, representing same-gender loving African American men, and the Latino Gay/Bi/MSM and Transgender workgroup on the needs of PLWH in these communities and strategies to improve their outcomes along the HIV Care Continuum. Beginning in 2017 and continuing in 2018, efforts to engage African faith and other community leaders to promote HIV testing, reduce HIV stigma and inform community members of HIV services through training and action planning are designed to increase access to HIV testing, early intervention and outreach services. If successful, this approach will hopefully reduce the proportion of African American PLWH who are late testers and are not benefiting from early antiretroviral treatment. The Part A grant recipient is investing $26,000 for expert consultants from disproportionately impacted communities for these community participatory engagement efforts.

Improved outreach utilizing a *Data to Care* protocol and EIS to reach and connect target populations to HIV medical care also facilitate entry into MCM services to address unmet PLWH needs for other core medical and support services. MCHACP allocated $218,000 for EIS and $155,600 for outreach services, respectively in FY2018.

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

There are an estimated 972 PLWH who are unaware of their infection in the 13-county Minneapolis-St. Paul TGA (MSP-TGA) as of the December 31, 2016. This estimate uses 2015 and 2016 HIV surveillance data from the Minnesota and Wisconsin Enhanced HIV/AIDS Reporting Systems (eHARS), and the CDC methodology for estimating the population of PLWH who are unaware of HIV infection as published in of the CDC's Morbidity and Mortality Weekly Report Vol. 64 /No. 24.

The MSP-TGA's EIIHA data includes HIV testing data reported by the Ryan White HIV/AIDS Program (RWHAP) Part A early intervention services (EIS) providers as well as EvaluationWeb data submitted by Minnesota Department of Health's (MDH) funded HIV counseling testing and referral (CTR) providers. Currently, there are 6 clinic and 6 community-based MDH funded CTR service providers in the TGA. Seven of the CTR providers also deliver

Part A, Part B, state or ADAP rebate funded services including medical case management (MCM), health education/risk reduction, psychosocial support, and medical transportation services.

In FY2016 and 2017, Hennepin County Public Health Clinic's (PHC) Red Door Services, the largest publicly funded HIV testing site in the TGA and MN, received RWHAP Part A funding to provide EIS. In 2016, MDH funded CTR providers reported 14,887 HIV test events, identifying 56 newly diagnosed cases of HIV. Red Door, PHC Refugee Health Screening Program and Health Care for the Homeless conducted 16,928 HIV tests in 2016 and identified 49 newly diagnosed cases of HIV. Red Door Services alone identified 19% (47/249) of newly diagnosed HIV cases in the TGA in 2016.

1) Planned MSP-TGA EIIHA Activities for 2018

a) Primary Activities

Increase HIV testing. Hennepin County operates the MSP- TGA's largest public health clinic in Minnesota, 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 remaining public care facility in Minnesota and has the largest indigent patient population in the state. In FY2016, Hennepin County launched Positively Hennepin, the County's strategy to end the HIV epidemic, the result of a process engaging a wide range of stakeholders and communities disproportionately impacted by the epidemic and the understanding that 55% of Minnesotans living with HIV reside in Hennepin County. Positively Hennepin has three goals: A) Decrease new HIV infections; B) Ensure access to and retention in care for people living with HIV; and C) Engage and facilitate the empowerment of communities disproportionately affected by HIV to stop new infections and eliminate disparities. Two actions have been identified in service of goal A: increasing routine testing and reducing barriers to testing for those at high risk for HIV. Positively Hennepin has an ambitious HIV testing milestone to reach by 2018 with 60% of HCMC and NorthPoint patients having had an HIV test and 90% of PLWH in Hennepin County knowing their status. To achieve these goals and to improve outcomes along MSP-TGA's HIV Care Continuum, the Part A RWHAP is working on multiple initiatives.

One is to increase testing through the programming of an alert in HCMC's electronic health record (EHR) health maintenance module that indicates that an HIV test is due all patients 15-65 years of age who have no record of receiving an HIV test. This alerts primary care clinicians to include HIV testing as a routine procedure during primary care visits based on the CDC "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings." 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. As of September 16, 2017, 46% of HCMC patient population (excluding Emergency Department patients only) had been tested for HIV. 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, 2016, 24% of their patients had been screened for HIV infection.

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. In addition to increased efforts at routine testing, the TGA is working on ensuring all RWHAP testing data is reported centrally to EvaluationWeb to analyze efficacy of testing to see if prioritized populations are being reached, and to coordinate testing efforts with partners at the Minnesota Department of Health and Department of Human Services.

The Minnesota/MSP-TGA EIIHA Work group met in April of 2017 and identified a number or priorities to explore for improving EIIHA efforts. One idea that came out of the work group meeting this year was how to integrate HIV testing with other routine health screenings across the TGA and the state. The Part A Coordinator is now bringing this idea to the state-wide HIV strategy workgroup to explore options for implementation.

Increased Early Intervention Services.

In 2017, the Minnesota Council for HIV/AIDS Care and Prevention (council) increased the Part A allocation for EIS from $158,400 to $233,350. In FY2017, two new EIS providers were 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 and two of the zip codes with the highest HIV prevalence in the state. Full Proof will increase access to HIV testing among African American MSM and high-risk women in the community. NorthPoint will increase testing opportunities through their community health outreach program for uninsured African American men, the Man Clinic, where STI testing and treatment is provided. Full Proof Ministry and NorthPoint established a partnership to ensure rapid 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 Public Health Clinic (PHC), the TGA's largest public health clinic. Through Red Door services, the PHC has historically diagnosed 20-25% 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, HIV testing and PrEP referrals. 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 more complex needs are referred to a MCM program. In 2016, the Red Door's EIS conducted 9,766 HIV test events with 47 new positives. Red Door linked 39 newly diagnosed clients (84%) to HIV medical care within 30 days and 47% on the

same day of diagnosis. In 2017, Red Door initiated three new projects that are assisting in identifying new diagnoses and in finding clients out of care.

Red Door is constantly innovating and working on new initiatives to identify new PLWH and get them into care as seamlessly as possible. The MSP-TGA recipient directly supports these efforts with EIS Part A resources and hopes to scale up successes and share lessons learned to improve efficacy of EIS work throughout the jurisdiction. Red Door has taken on 3 new projects in the last year, 1) Just the Tip Campaign, 2) Grindr Survey, and 3) Data2Care Initiative.

The "Just the Tip" campaign is an advertising and outreach project to promote testing among African American MSM. Red Door is using targeted marketing techniques to reduce stigma and fear of getting tested for HIV. Secondly, this PHC is seeking to learn more about behavior and HIV health knowledge through a survey being advertised on the social networking apps for gay, bisexual;, curious, queer, and same gender loving men including "Grindr" and "Jack'd." Survey respondents who fit the target population, Latino and African American men who have sex with men, are invited for HIV testing, referred to PrEP if negative, linked to HIV care if positive, and for a follow-up interview for more qualitative data. Thus far, 900 surveys were completed (117 from the target population), 31 individuals were tested and referred to PrEP, 40 individuals were connected to HIV care, and 23 interviews were conducted.

Lastly, Red Door has been working to identify PLWH out of care through a Data2Care Project by working with the state enhanced HIV/AIDS Reporting System (eHARS). The project is utilizing protocols adapted from those developed by Seattle/King County Public Health Department. The process starts with state HIV surveillance data on PLWH who reside in Hennepin County (62% of PLWH in the MSP-TGA live in Hennepin County) being sent to the Hennepin County Public Health Department epidemiologists. The county epidemiology staff then create a usable line list of PLWH deemed out-of-care based on last date of CD4 or viral load test report. Red Door disease investigators then look up each person on the list to identify if they truly reside in the county and if they have been seen anywhere in the county's health care network that shares an electronic health record. Red Door initially received a list of 1,300 people, of which only 233 were confirmed to reside within the county. Red Door staff then try to find accurate contact info and reach out to individuals on this list. Of this group, 85 were found to actually be in care, 6 were deceased, 18 were attempted contacts but couldn't be reached, 8 refused to be linked to care, 2 failed to attend linkage appointments, and 2 confirmed linked to care. Cleaning the list has been more labor intensive than expected and additional staff would expedite efforts to contact individuals to begin care re-engagement efforts. This pilot project has highlighted some areas for improvement: limitations of the eHARS system with PLWH who have moved out of jurisdiction; the need to improve data integration across the state and county public health systems; and the time intensity of the work. The MSP-TGA Part A grant recipient is currently trying to promote solutions to integrate data systems and to increase staffing for this project.

Improved Outreach Services. The recipient continues to implement and evaluate the TGA's outreach services to improve efficacy of identifying PLWH who are unaware of their status and PLWH who are out of care. In late 2014, improved data collection began on the number of clients referred and linked to ongoing HIV medical care by outreach services. In FY2016, the two Part A outreach services providers reported 1,000 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 23 HIV cases of PLWH found in FY2016, 2 were newly diagnosed and the 21 who had been previously diagnosed had not received HIV medical care in more than six months.

Recipient staff are analyzing the relative efficiencies of outreach services versus early intervention services with sub-recipients that are funded for both. The goal of this analysis is to ensure funds spent to identify new HIV cases and out of care clients are coordinated and as efficacious as possible. Once analysis is complete, data will be presented to the Minnesota Council for HIV/AIDS Care and Prevention for discussion to inform future allocations to EIS and outreach services. Concurrently with this analysis, Part A grant recipient staff have been providing training and technical assistance to outreach and EIS providers on the services standards, on best practices, and on how to develop strategies and tactics to maximize impact of their work.

Convene Minnesota's EIIHA Work Group to Coordinate Stakeholder EIIHA Activities. The Part A Program Quality Management (QM) Coordinator convened Minnesota's EIIHA workgroup in March 2017 in an effort to continue coordination of EIIHA activities throughout Minnesota and the TGA. The workgroup was established in 2009 to ensure a collaborative and coordinated effort to decrease the proportion of Minnesota's HIV infected population that is unaware of their status. The workgroup shares successful strategies, recommends target populations, EIIHA interventions, and outcome measures. Primary work group objectives include coordinating activities, fostering partnerships among providers, and to assess overall EIIHA progress in Minnesota. The QMC maintains an annually updated matrix of EIIHA activities that includes services, target populations, providers, and CDC and RWHAP grant recipients involved in the activities. At the March 2017 EIIHA work group meeting there were speakers on HIV testing efforts and results, the HIV Care Continuum, the unaware estimate, integrating PrEP into EIS, and early linkage services for transgender PLWH. In addition to the presentations, the work group meeting included a structured conversation on ideas to improve EIS in Minnesota and the TGA. Major themes that emerged were increasing transgender responsiveness in EIS services, integrating data systems across Part A, B, and CDC funded prevention grant recipients for a more holistic picture of the state of need and impact, making HIV testing part of a bundle of regular health screenings, investigating social media usage to reach target populations for testing, increasing syringe exchange services, increasing awareness of available services among target populations, and developing and promoting a PrEP toolkit. Members of the workgroup are meeting quarterly to implement an action plan and give updates on the ideas that surfaced from the 2017 EIIHA workgroup meeting.

Data Integration and Access. On March 1, 2016, the Part A Program, MDH, and DHS embarked on a collaborative project to migrate CD4 count, viral load, HIV and AIDS diagnosis dates and vital statistics into MN CAREWare. With complete viral load and diagnosis data in MN CAREWare, the ultimate goal is to improve outcomes along the HIV Care Continuum through better performance measurement and evaluation of Part A and B funding. Prior to the beginning of this project, MN CAREWare had viral load data for 41% of RWHAP clients, primarily clients receiving Part A funded outpatient health care services. As of the end of FY 2016, viral load data was in MN CAREWare for 57% of RWHAP clients, an increase of 16%. Though this is progress, the RWHAP grant recipients require complete data for all RWHAP clients to improve

outcomes along the HIV Care Continuum. This desire coupled with intergovernmental data sharing agreements and orders from the Minnesota Commissioner of Health, a full match from eHARS shall occur for all RWHAP Part A and B clients by the end of the calendar year. With the migration of viral load data, the Part A grant recipient is advocating for subrecipient access to this data for most up to date information on their clients in care and viral suppression status. The MSP-TGA is especially interested in providing access to this data to the Red Door Services' Data2Care team to get more up to date information on clients deemed out of care through eHARS. In addition, the Part A grant recipient data coordinator is teaming up with the Hennepin County public health team to investigate access to Medicaid data systems to assist further in identifying and reaching out to PLWH out of care.

b) Major Collaborations with Other Programs and Agencies

EIIHA Workgroup. The Part A grant recipient continues to facilitate this collaborative effort with Minnesota's Part B (DHS), CDC HIV prevention (MDH) grant recipients, and subrecipients. 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 the Minnesota Council for HIV/AIDS Care and Prevention and Minnesota's RWHAP Parts A, B, C, D and F programs. 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 HIV prevention and testing grant recipient, MDH articulates the common HIV prevention and RWHAP goals to the council. MDH reports to the Part A grant recipient and council on changes in the state's HIV epidemiological data. RWHAP Part A EIIHA target populations are selected based on information provided by MDH staff in the EIIHA workgroup, and data from eHARS and EvaluationWeb. The Government HIV Administrative Team (MDH, DHS and Hennepin County) meet thrice annually to coordinate all state and local RWHAP and funded care programs with CDC and state-funded HIV testing and prevention programs to ensure efficiency, consistency, and coordination. In addition MDH serves as the administrator of Minnesota's joint Part A and B client-level database, MN CAREWare, enabling coordination with HIV surveillance data.

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 Minnesota and the MSP-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 Minnesota's coordinated EIIHA efforts developed in 2010 were presented for input and approval to the former Minnesota 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 Minnesota to collaborate, improving EIIHA coordination and efficacy of activities.

Minnesota Department of Human Services (DHS). As the state's Part B grant 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 and ADAP rebate revenue funding which is administered by the Part A Program to ensure coordination of RWHAP funded activities. Coordination of Part A and B funding (including ADAP rebate revenue allocated to EIS and outreach services) 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 in care.

RWHAP and HIV Prevention Service Providers. The Part A Program funds EIS and outreach services at Red Door, Full Proof Ministry, NorthPoint Health and Wellness Center and the Aliveness Project. The Part A recipient also administers Part B and ADAP rebate contracts for Red Door and the Aliveness Project on behalf of DHS (the Part B recipient) in service of administrative efficiency and project efficacy. In addition, DHS funds one other provider serving greater Minnesota with EIS. All of these providers along with additional organizations that receive funding from MDH for HIV counseling testing and referral are invited to the annual EIIHA workgroup meeting. The Part A Program is continuously working with these EIIHA providers to identify what is working, what isn't, and how to share those lessons and improve future EIIHA activities.

c) 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 EIIHA strategy are as follows:

1. The percentage of HCMC and NorthPoint patients screened for HIV increases by 10%.
2. The positivity rate of HIV testing administered by RWHAP Part A subrecipients is at least 1%.
3. At least 51% of total HIV tests are administered to targeted communities, including African American and Latino MSM, young MSM, transgender women of color and African-born.
4. Ninety percent of newly diagnosed people in the target groups in the TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis.
5. Ninety percent of PLWH in Hennepin County who are aware of their status and not in care are re-engaged in HIV medical care within 30 days of initial contact.
6. All RWHAP subrecipients report testing data to EvaluationWeb to enable centralized reporting across funding streams on testing by population, geography, and administering agency by the end of 2018.

2) Plans to Remove Legal Barriers to Routine HIV Testing

Minnesota has no state or local laws that present legal barriers to routine HIV testing.

3) Three FY2018 EIIHA Target Populations

Epidemiological and Unmet Need data, HIV testing data from MDH and Part A funded EIS programs, the MSP-TGA's 2016 HIV Care Continuum and the EIIHA Workgroup

recommendations inform the selection of the following populations for focus in the 2018 plan: 1) Young MSM ages 13-29; 2) African American MSM and 3) Black 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)

a) Why YMSM were chosen. In 2016, 66 of the 249 (27%) newly diagnosed cases of HIV in the MSP-TGA were among YMSM (including MSM/IDU) ages 13-29. Eighty eight percent of adolescent and young adult males diagnosed with HIV infection in 2016 identified as MSM or MSM/IDU. The number of new infections among YMSM remained relatively unchanged from 2012 to 2016 with an average of 66 new cases annually. Among YMSM in 2016, 26% of newly diagnosed cases were African American, 12% Hispanic, 48% White and 14% other men of color. Of all MSM (including MSM/IDU) diagnosed in 2016, 55% 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 increased by 67% in the past five years and YMSM represent 11% of diagnosed MSM living with HIV in the TGA as of December 31, 2016. The TGA's 2016 HIV Care Continuum, indicates that MSM 13-24 years of age are more likely to have suppressed virus (71%) compared to MSM overall (66%).

b) Specific challenges or opportunities. 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 2014 Survey of the Health of All the Population and the Environment (SHAPE 2014) 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. Gay and bisexual males were 10% more likely to delay or not access medical care compared to the rest of the Hennepin county population. Despite these challenges, in FY2016, 17 of 32 new HIV cases found though RWHAP funded EIS and outreach services were YMSM. Of the 17 new case findings among YMSM, 82% were linked to care in 30 days and 94% were linked to care in 90 days. Part A EIS subrecipients are finding effective strategies to reach this population through more responsive and relatable staff that make YMSM feel comfortable and employing tactics that resonate with YMSM. There could be even greater successes next year through sharing of lessons learned among subrecipients and from the End Disparities Exchange of the National Quality Center's interventions shared by populations, especially youth.

c) Specific strategies for YMSM include:

i. Early Intervention Services

a. Increase HIV testing of YMSM by at least 10% through the Public Health Clinic's Red Door Services by end of FY 2018 by continuing a successful social media outreach pilot project that reached 900 at-risk MSM in 2016-2017.
b. Increase Red Door Services' STI and HIV testing through the "Just the Tip" marketing campaign, and geo-social networking targeting MSM.
c. Increase the proportion by at least 10% of YMSM who are linked to care the same day as their positive HIV diagnosis through continued funding for the Public Health Clinic Red Door Service's "Fast Track" (for the uninsured) and "Concierge" (for the insured) EIS approach to rapid care entry.

ii. EIS and Outreach Services Provider Training

a. Conduct a workshop/seminar for RWHAP EIS and outreach services providers on strategies that work to reach, link and retain in care YMSM to increase cultural responsiveness and employ effective practices in serving YMSM populations.

African American Men who have Sex with Men (MSM)

a) Why African American MSM were chosen. MSM are disproportionately impacted by HIV and African American MSM (including MSM/IDU) are the most disproportionately impacted in the TGA and nationally. While 22% of new infections among males were among African American males, African American males comprised less than 6% of the TGA's male population in 2016. In the TGA, people of color comprised 61% of new HIV cases in 2016 with African Americans (not including African-born Blacks) alone comprising 21%. New infections among African American MSM remained relatively steady between 2012 and 2016, averaging 30 new cases annually. African American MSM in the TGA likely have the highest prevalence rates among all demographic groups. By the end of 2016, African American MSM comprised 18% of all diagnosed MSM living with HIV in the TGA. HIV prevalence among African American MSM increased by 18% from 2012 to 2016 compared to an 11% increase among White MSM. The TGA's HCC for 2016 indicates that African Americans have the lowest rates of retention in care and viral suppression compared to other racial/ethnic groups. Among MSM, 69% of African American MSM were retained in care and 57% had suppressed virus, whereas 75% of White MSM were retained in care and 71% had suppressed virus.

b) Specific challenges or opportunities. Data from Hennepin County's 2014 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. Gay and bi males were 10% more likely to delay or not access medical care compare to the rest of the Hennepin county population, meaning, 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. 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. 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 FY2016 only 44% of African American men identified as MSM to their RWHAP Part A provider compared to 84% of white and 64% of Latino men suggesting heightened same-sex sexual orientation stigma can be a barrier to testing and seeking HIV care. Discrepancies between self-reporting of sexual orientation identity on the anonymous 2015 Comprehensive Needs Assessment (CNA) survey and mode of exposure for HIV surveillance and mode of exposure disclosure to RWHAP service providers is greatest among African American males living with HIV. While 84% of African American males identified as gay or bisexual on the 2015 CNA, 63% reported sex with males as their mode of HIV exposure when diagnosed with HIV (HIV surveillance) and only 42% reported sex with males to their HIV services provider (all RWHAP funding sources). 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.

c) Specific strategies for African American MSM include:

i. Early Intervention Services

a. Continue to expand EIS to increase HIV testing among African American MSM by at least 10% by end of FY2018. Increased funding of early intervention services will scale up targeted testing in Minneapolis' Northside where a large proportion of Minneapolis' African Americans reside.
b. Increase the proportion of newly diagnosed African American MSM linked to care by the end of FY2018, so that at least 90% of those newly diagnosed are linked to care within 30 days of their test result. This aim is tied closely to increasing testing through EIS services targeting the African American community in Minneapolis. Any new diagnosis should be followed with rapid linkage services. New EIS providers have been and will continue to be provided with technical assistance and training to develop an organization climate that is culturally responsive to African American gay, bisexual and same gender loving men. All new case findings are partnered with confirmatory testing, referral to a trusted medical provider, and confirmation of medical appointment.
c. Repeat a social media survey through two social networking sites for gay and bisexual men to expand the Public Health Clinic's Red Door Services reach to African American MSM to promote testing and re-engagement in care for those who are aware of their infection and not receiving medical care.

ii. Community Engagement in Planning and Service Delivery

a. Continue the Part A Program's community participatory approach of engaging African American MSM in planning and service development by providing technical assistance and program development resources to support the League of Extraordinary Black Men's action planning to eliminate HIV-related health disparities among their peers. This work group will develop a culturally responsive brochure intended for an African American MSM audience on HIV services available, how to access prevention and testing services, and how to engage in the RWHAP service system. These brochures are one effort to increase African American MSM utilization of RWHAP services and engagement in RWHAP planning groups such as the Minnesota Council for HIV/AIDS Care and Prevention and its committees. Increased African American MSM engagement in planning and advising of RWHAP programming is key to improving the cultural responsiveness of RWHAP services and HIV health outcomes of African American MSM.

African-born (Black) Individuals

a) Why African-born individuals were chosen. There were 63 African-born Blacks diagnosed with HIV infection in the TGA in 2016; an increase of 8.6% from 2015. HIV incidence among the African-born in the TGA increased by 75% between 2012 and 2016. The number of new cases among African-born women in Minnesota in 2016 was 31, accounting for 56% of all new diagnoses among women in Minnesota. In 2016, the number of African-born persons living with HIV in the TGA was 1,131; a 27% increase from 2012. While African-born residents of the TGA make up 2.2% of the population, they represent 15% of PLWH in the TGA. African-born blacks have the highest HIV prevalence in Minnesota among racial/ethnic groups with 1.7% of the population estimated to be living with HIV. Additionally, African-born women represent the largest proportion of women living with HIV in MSP-TGA, at 37%. Women also account for 58% of the African-born living with HIV in Minnesota. African-born individuals are more likely

to test late and less likely to be in care with 68% retained in care in 2016 compared to 74% of Whites retained in care 2016.

b) Specific challenges or opportunities. Among the top five countries of birth of immigrants living with HIV in Minnesota, 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.

c) Specific strategies for African-born Blacks include:

i. Engage African Faith Leaders in Efforts to Promote Testing and Early Treatment

a. The Part A grant recipient is contracting with an African HIV services provider to develop and deliver training for African 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. This training for both Christian and Muslim African faith leaders is aimed at increasing knowledge about HIV, altering attitudes about PLWH, and changing behavior toward PLWH all to reduce stigma, increase testing, and connect African-born people living with HIV to care.
b. Increase HIV testing of African born residents in the TGA by at least 10% through efforts to engage African faith leaders to mobilize their congregants to get tested, reduce stigma and support early entry into care and care retention.

ii. Early Intervention Services

a. Administer ADAP rebate funds to expand testing and early linkage services provided by Minneapolis' second largest HIV services organization that employs EIS and outreach services staff from African communities in the MSP-TGA. Coordinate this new funding stream with the Minnesota Department of Health's HIV counseling, testing and referral services.

iii. Develop Capacity of RWHAP Providers to Provide Culturally Responsive Services

a. Increase provider cultural responsiveness to meet the needs of African born RWHAP clients with new cultural responsiveness standards, training on intercultural communication and cultural intelligence and development population specific cultural responsiveness tool kits. These efforts are designed to increase the effectiveness the TGA's RWHAP services among African born residents, with the goal of increasing engagement of African born PLWH in RWHAP EIS, outreach and other core medical and supportive services that support lifetime retention in care.

C. AIDS Pharmaceutical Assistance – The Minneapolis-St. Paul TGA Part A grant does not fund a Local Pharmaceutical Assistance Program. Minnesota and Wisconsin ADAPs meet the

medication needs of all RWHAP eligible PLWH residing in the TGA and both ADAPs cover all HIV antiretroviral medications.

- *METHODOLOGY*

A. Impact of the Changing Health Care Landscape

1) Health Care Coverage Options for PLWH in the MSP-TGA

With full implementation of the Affordable Care Act (ACA) in Minnesota, PLWH in the MSP-TGA have the full range of health care coverage options available under federal and state statute. Minnesota offers comprehensive affordable health care coverage through Medicaid, MinnesotaCare (Minnesota's Basic Health Plan), a Qualified Health Plan (QHP) through Minnesota's insurance exchange *MNSure* or a private off-exchange plan or employer sponsored coverage. Table 3 (page 10) presents both the public and private health coverage options available through *MNSure* and the number of PLWH residing in the MSP-TGA estimated to receive coverage through each option. The Minnesota Department of Human Services (DHS) administers all Minnesota Health Care Programs and is also Minnesota's Part B grant recipient.

Medicaid. Medical Assistance (MA), Minnesota's Medicaid program, provides comprehensive outpatient and inpatient health care benefits and covers all antiretroviral medications. Medical Assistance health care services are provided on either a fee for service basis or through one of the state's five contracted managed care organizations. All major HIV specialty care providers in the MSP-TGA are qualified MA providers, ensuring that all eligible PLWH can select their provider of choice. Medical Assistance also provides home-based health care and supportive services to people with disabilities through the state's 1115 Medicaid waiver programs.

Basic Health Plan. MinnesotaCare is Minnesota's Basic Health Plan and provides similar benefits for working families and single adults with incomes at or below 200% of the Federal Poverty Level (FPL). MinnesotaCare enrollees receive their health care services through one of the state's contracted managed care organizations. As with MA, MinnesotaCare plans include all major HIV specialty care providers in the MSP-TGA and cover all antiretroviral medications. MinnesotaCare monthly premiums are on a sliding scale based on household income.

Qualified Health Plans. In addition to Medical Assistance (Medicaid) and MinnesotaCare, *MNSure* offers three metal levels of coverage (Bronze, Silver and Gold) through its Qualified Health Plans (QHP) and a catastrophic plan for enrollees under 30 years of age or meet other criteria. Table 2 compares the relative cost and overall coverage among all four metal level QHP's available through *MNSure*.

Table 4. Minnesota Qualified Health Plan Comparison (mnsure.org)

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

MNSure plan premiums range from $259 (bronze) to $537 per month for a single 40-year old living in the Twin Cities in 2018. Deductibles range from $0-$7,050 with out-of-pocket maximum costs ranging from $5,750 -$7,350 (not including premiums). Prescription co-payments range from $0 (after deductible is met) to 40% co-insurance where the deductible does

not apply. Minnesota 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, disruptions related to differences in provider networks are minimized. Most people living with HIV with incomes above 200% of FPL or who otherwise do not qualify for MA or MinnesotaCare can obtain coverage through a QHP and receive Advanced Premium Tax Credits to make their premiums more affordable, unless their immigration status is undocumented.

ADAP. Minnesota's ADAP is administered by the Department of Human Services. ADAP provides insurance premium assistance for cost effective private and employer sponsored health plans (where the employee pays ≥50% of the premium cost) including QHP's obtained through *MNSure* and off-Exchange private individual plans for PLWH who cannot obtain a QHP through *MNSure*, including immigrants whose status is not documented. ADAP also covers prescription deductibles and co-payments. Minnesota's ADAP is administered through DHS' Medicaid Management Information System which ensures claims coordination with all Minnesota Health Care Programs, ensuring that the RWHAP is the payer of last resort. PLWH whose income does not exceed 400% of FPL can receive additional assistance through Minnesota's ADAP to cover the remainder of their QHP premiums after the Advanced Premium Tax Credit is applied and medication deductibles and co-payments, further reducing any cost barriers to HIV medical care and treatment access. In 2017, Minnesota's ADAP provides additional premium and cost-sharing assistance for the following five QHPs:

- Blue Cross Blue Shield- Blue Access HSA Gold $2000 Plan 440
- UCare- UCare Choices Gold
- Blue Cross Blue Shield- Gold, a Multi-State Plan
- Health Partners- Key Embedded 3600 Plus (Silver)
- Medica- MN Applause Gold Co-pay

These plans were selected based on inclusion of comprehensive ART medications in all classes and access to all of the MSP-TGA providers that offer HIV specialty care. HIV benefits counselors and medical case managers help DHS evaluate *MNSure*'s QHPs for affordability, health benefits, drug formularies, and provider choice prior to each open enrollment period. Benefits counselors, insurance enrollment assisters, and medical case managers help clients chose a plan that maximizes cost-effectiveness and provider choice.

Part A and MAI Outpatient Health Care Services (OHCS). The Part A grant recipient contracts with three HIV specialty care providers to facilitate easy access to high quality HIV outpatient care for the MSP-TGA's un- and underinsured PLWH. Part A OHCS providers include Hennepin County Medical Center (HCMC). Located in downtown Minneapolis, HCMC's Positive Care Center is the largest HIV specialty care clinic in the TGA. HealthPartners Specialty Clinics are located in St. Paul and serves patients on the east side of the Twin Cities metro area. Part A and MAI also funds West Side Community Health Services, a Federally Qualified Health Center, located on the west side of St. Paul in the heart of one of the Twin Cities' largest Latino communities. Part A and MAI OHCS covers all HIV-related outpatient care services and other outpatient specialty care for co-occurring conditions that if untreated would result in poorer HIV-related health outcomes. The Minnesota Council for HIV/AIDS Care and Prevention allocated $876,783 in Part A and MAI funds combined for OHCS in FY2018.

Part A and MAI funded OHCS can also cover deductibles, co-insurance and co-payments for clinic visits, laboratory tests and other outpatient services. Part A OHCS provided HIV outpatient health care services to 1,237 PLWH in the MSP-TGA in FY2016.

Part C and D Health Care Services. HCMC is Minnesota's sole Part C and D grant recipient. In addition to providing early intervention and ongoing outpatient health care services at their Positive Care Center, HCMC contracts with HealthPartners Specialty Clinics to provide HIV care (Part C) on the east side of the Twin Cities metro area and with Children's Hospitals and Clinics to provide women, infants, children and youth with HIV health care (Part D) at both their Minneapolis and St. Paul clinics.

Part A and B Health Insurance Premium and Cost-sharing Assistance (HIPCA). The MCHACP allocated $10,600 in Part A funds and $16,600 in Part B funds to provide additional assistance for out-of-pocket medical care costs that are not covered by Minnesota's ADAP, including MinnesotaCare monthly premiums. Part A and B funded HIPCA provided assistance to 85 PLWH residing in the TGA in 2016.

a) Impact of Coverage Options on Direct Access to Health Care and Health Outcomes

Minnesota now has one of the lowest rates of uninsured residents in the nation showing 4.3% as of December 31, 2015. The increase in health insurance coverage is primarily driven by enrollment in publicly funded state health insurance programs. Currently, 1 in 4 MSP-TGA residents rely on Medicaid or MinnesotaCare (Minnesota's basic health plan). Private insurance plans obtained through *MNSure*, Minnesota's state-based marketplace, covers 10% of Minnesotans on individual or small group coverage. Notable disparities continue to exist among Minnesota's 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.

Currently, at least 2,795 of the TGA's PLWH are covered under Medicaid, MinnesotaCare or a Qualified Health Plan (QHP) obtained through *MNSure.* Individuals with an income below 138% of FPL are eligible for Medicaid. Those between 138% and 200% of FPL are eligible for MinnesotaCare. Despite the overall changes in Minnesota's health care landscape, the uninsured rate among the TGA's RWP recipients has remained relatively unchanged at 5% since 2010. The estimated proportion of the MSP-TGA's population of diagnosed PLWH who are uninsured is slightly higher than the TGA's overall population at 4.9% compared to 4.5%, respectively (Table 3, page 10).

With full implementation of the Affordable Care Act in Minnesota and additional assistance provided by Minnesota's ADAP, all RWHAP eligible PLWH in the MSP-TGA ought to qualify for comprehensive affordable health care coverage. The greatest impact of health care reform on HIV health care access in Minnesota since passage of the ACA is expansion of Medicaid to Minnesota's PLWH with incomes below 138% of the FPL who qualify. Prior to 2013, the only coverage option for RWHAP eligible PLWH with incomes greater than 138% of the FPL who were not categorically eligible (pregnant, blind, disabled or 65 or older) for Medicaid and were unemployed or whose employer didn't offer comprehensive health care coverage was to obtain private insurance through Minnesota's high risk pool and enroll in ADAP to cover the premium costs and prescription deductibles and co-payments. The removal of the categorical Medicaid

eligibility requirements alleviated cost barriers such as clinic visit and laboratory deductibles and co-payments for the poorest PLWH in the TGA that sometimes resulted in missed appointments or not picking up prescriptions. For RWHAP eligible PLWH with incomes above 200% of the FPL or do not qualify for Medicaid or MinnesotaCare, deductibles and co-payments particularly for outpatient health care services continue to be cost-barriers to health care access. Although the QHPs that Minnesota's ADAP supports provide comprehensive coverage, changes in deductibles where prescription costs no longer count toward the deductibles have increased the out-of-pocket cost burden for outpatient care services for some RWHAP eligible PLWH.

According to the State Wide Coordinated Statement of Need included in the 2017-2021 Integrated HIV Prevention and Care Plan for Minnesota and the MSP-TGA, unaddressed system, provider and personal barriers to health care access, as well as social determinants of health impact health care utilization and HIV health outcomes regardless of coverage options available to RWHAP eligible PLWH. With over 50% of the TGA's PLWH estimated to be at or below 100% of FPL and 79% of the TGA's RWHAP consumers at or below 200% of FPG, even small out-of-pocket costs of several dollars for a clinic visit or a prescription co-payment could result in missing appointments or not adhering to an antiretroviral treatment regimen. RWHAP Part A, B and ADAP rebate funded services continue to be critical to reduce barriers to health care access and address social determinants of health such as poverty, unstable housing, HIV stigma and HIV-related health disparities among disproportionately impacted communities in the new health care landscape. Without these resources, further improvements in rapid linkage to care, care retention and ultimately viral suppression are unlikely.

2) Effect of Changes in the Health Care Landscape

a) Service Provision and Complexity of Providing Care to PLWH in the TGA

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 respondents, 31% reported difficulty signing up for insurance, with higher rates in racially and culturally specific populations including American Indian/Alaskan Natives (44%) and Latinos (41%). 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 Indians (42%), Asian/Pacific Islanders (33%), and Latinos (48%). Among the 2015 CNA respondents, the RWHAP or their clinic covered the cost of care for 21% of those who received medical care in the past 12 months. In addition, PLWH without citizenship or permanent resident status 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. Minnesota's ADAP works extensively each year to contact eligible HIV-positive individuals who are undocumented to purchase an off-Exchange policy with comprehensive coverage.

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 Asian/Pacific Islander respondents reported having 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 younger PLWH ages 13-39 years represent 29% of those living with HIV and 34% of those utilizing RWHAP services in the TGA, only 5% of PLWH between the ages of 13 and 39 in the TGA utilized RWHAP Health Insurance Premium/Cost Sharing Assistance services.

Overall the ACA has facilitated access to health insurance, particularly for PLWH with incomes at or below 200% of FPL. For people with HIV who are on Medicare, the Part D prescription drug benefit is also more affordable. Minnesota's ADAP chooses Medicare supplemental health care 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. In FY2016, 145 PLWH in the TGA enrolled in Medicare received extra help from ADAP to cover their out-of-pocket prescription costs. ADAP also pays for an open market policy with comprehensive coverage for eligible clients who cannot qualify for subsidies due to immigration status. In 2017, 198 of the TGA's RWHAP eligible PLWH whose immigration status is undocumented were enrolled in this plan with ADAP covering premium and prescription deductible and co-payment costs. Preventive screenings at no cost are also a very important aspect of the ACA. Screenings aide in early identification of HIV infection, which has become increasingly important in achieving the best health outcomes and eliminating HIV transmission.

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. Foreign born PLWH who are not citizens or permanent residents face additional system barriers to health care access in the new landscape. Unable to obtain coverage through *MNSure*, the only available open market private plan in 2017 with cost effective coverage that Minnesota ADAP would support with premium and prescription deductible and co-payment coverage, did not include the two most preferred providers of the majority of the MSP-TGA's PLWH who were born outside the U.S. One of these providers, Hennepin County Medical Center's Positive Care Center, is the largest HIV specialty clinic in Minnesota. The other, West Side Community Health Services, located in the heart of St. Paul's Latino neighborhood, is an FQHC that employs bilingual clinical and social service staff that provide linguistically specific services to their Spanish speaking patients. Both of these providers are known to the TGA's HIV community as being culturally responsive to immigrants living with HIV and have retention rates that exceed 85%. PLWH who are undocumented and are not fluent in English may also be unaware of ADAP and other RWHAP services that can assist them in obtaining coverage. In addition, PLWH who purchase insurance through *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 MSP-TGA's continuum of HIV services continues to meet the needs of its residents living with HIV.

Part A and other RWHAP funded programs are essential care system components that are able to adapt to the changing health care landscape by increasing or shifting resources to mitigate the challenges inherent in an increasingly complex system of health care coverage.

b) Changes in Part A Allocations, Including Health Insurance Premium Assistance

The Part A Program coordinates with Minnesota'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 RWHAP eligible PLWH with an annual income up to 400% of the 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 deductibles and co-payments are covered by Part A funded outpatient health care services (OHCS) at three HIV specialty clinics, one of which is the largest provider of primary care for PLWH in the TGA, and through a health insurance premium and cost sharing assistance program delivered by Minnesota's largest community-based HIV service organization, the Minnesota AIDS Project (MAP). This program is also funded by Part B. In FY2016, 557 PLWH in the TGA received premium assistance through ADAP and an additional 85 received premium assistance for MinnesotaCare and help with other out-of-pocket medical costs through MAP's program. The Part A allocation for health insurance premium and cost sharing assistance increased from $7,300 in FY2015 to $10,100 in 2017 with a planned allocation of $10,600 for FY2018. The Part B contribution for this service also increased from $3,600 in 2015 to $16,600 in 2017 which will be sustained in FY2018.

Part A and Part B funded services such as medical case management and benefits counseling (through Part B funded non-medical case management services) plays a crucial role in assisting the TGA's PLWH to enroll in expanded Medicaid or QHP's through *MNSure.* MCM is allocated 43% of Part A and MAI service funds in FY2017 ($2,208,800) which will increase to 47% in 2018 ($2,525,600). Along with benefits counseling funded through Part B, neither of which are covered by insurance, MCM 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 and MAI funded core medical services, including the proportion of the $5,370,683 in Part A and MAI service funds allocated to each category in FY2018, 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 reducing out-of-pocket costs that can impose barriers to accessing medical care: outpatient health care services (OHCS) for uncovered services, deductible and co-payment coverage (16%); MCM (47%); early intervention services (4%); medical nutrition therapy not covered by insurance (1%); and home and community-based health services not covered by insurance (2%). The following support services, including the proportion of Part A and MAI service funds allocated to each category in FY2018, help meet basic needs to prevent RWHAP eligible PLWH from having to choose between paying for medical expenses or being able to afford rent or food: emergency financial assistance (2%); food bank/home delivered meals (11%); and housing 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 OHCS, and Part B funded oral health care and Part A and B funded 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 care 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 71% of Part A allocations to services in FY2017 and these programs will be sustained in FY2018.

B. Planning Responsibilities

1) Planning and Resource Allocation

a) Description of the Community Input Process

The Minnesota Council for HIV/AIDS Care and Prevention (Council) serves as the single community planning body for RWHAP Part A and B as well as for HIV prevention planning for the MSP-TGA and Minnesota (MN). The HIV epidemic is centered in the Twin Cities metro area with 84% of MN's living HIV cases. The MN Department of Health (MDH), Department of Human Services (DHS), and Hennepin County Public Health created a joint integrated HIV care and prevention body to ensure administrative efficiency, coordination of funding streams and evaluation of publicly funded HIV programs. The Council meets all requirements under sections 2602 and 2610 of the federal RWHAP legislation. Council membership is reflective of the epidemic in the TGA. The Council incorporates additional community input through consumer forums, its Community Voices Committee and consumer needs assessment surveys. The Council completed its biennial prioritization process for FY2017 and 2018 in August 2016. The Council prioritizes services and allocates both Ryan White Part A TGA and MN Part B funds. The Council's Planning & Allocations Committee (PAC) refined the prioritization process based on community and member feedback from past processes. The full Council approves 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 HIV care continuum (HCC) by geography, gender, race, ethnicity and mode of HIV exposure to identify disparities. A primary consideration in making allocations is the degree to which each service impacts the HCC by facilitating early identification, linking to and retention in care, and ultimately viral suppression.

The prioritization process includes the Council's Needs Assessment & Evaluation Committee (NA&E) reviewing data from a variety of sources, studies, and surveys, and creates Service Area Review Summaries (SARS) for each service included on the final prioritization list. Council members then receive a SAR for each service. Priorities are then 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. Scores are then aggregated resulting in a final list of twelve ranked core medical and sixteen ranked supportive services to be funded by Parts A and B. For FY 2018, Part A funds were then allocated to eight core medical and nine supportive services (*See* **Attachment 8**: Service Category Plan Table*).* PAC developed values and guidelines for allocation decisions to guide the process. The Council-approved values demonstrate the importance of data-based decision making and consideration of the needs and input of PLWH. At the August 2017 Council meeting, allocations for FY2018 were presented based on the following criteria: assumed flat funding; started with FY2017 Council allocations that met the 75% core medical services expenditure requirement; added the Council's increases that were approved at their July 2017 meeting based on the actual 2017 Part A award; reduced Home and Community-based Health Services by the same amount the Council reduced it in FY2017 based on expenditures; increased Food Bank/Home Delivered Meals to preserve at least part of the increase that was included in the core medical services expenditure waiver for 2017 but assuring the 75% core medical services expenditure requirement for 2018. The allocations proposal was discussed and approved. The Council will consider allocation adjustments when FY2018 Notices of Grant Awards are received.

How the Integrated HIV Prevention and Care Plan Informs the Process

Many of the activities associated with each of the objectives of the integrated plan are based on the Council's allocations. The Council is responsible for monitoring and carrying out all of the responsibilities of the integrated plan. The needs assessment portion of the plan informs the Council's evidence-based decision-making process which drives their priority setting and resource allocation process. Information in the integrated plan, including the epidemiological and HCC data in the needs assessment portion of the plan and the resource inventory are updated annually so the Council has the most updated data available to inform their decisions.

i. PLWH involvement in the planning and allocation processes and how their priorities were considered. All populations identified as having severe need are represented on the Council, including three African immigrants. The Council is currently composed of 30 members, thirteen (43%) 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 and those at risk. 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 last prioritization process, PAC developed lists of fundable service categories and activities to be considered for prioritization that were reviewed by the CVC for consumer input before going to the full Council to finalize for ranking. PLWH are members of all Council committees and represented in leadership on every Council committee. They provide input on services, allocations, data collection and analysis, including needs assessments and the integrated plan. 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 consumer forums, standards of care development, needs assessments and other consumer surveys.

ii. Community input into the process to adequately address 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 allocation 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 2017 are automatically reduced by unspent amounts. If funding increases, allocations will be increased proportionately, while continuing to ensure core medical services are available to all eligible PLWH. PAC uses data from consumer needs assessments to inform its allocations process. CVC recommended prioritizing all fundable service categories for 2016 and 2017 to allow consideration of funding of service categories not allocated funds for the Part A grant application if the Part A award increases. In 2017, Hennepin County Public Health was granted a core medical services expenditure waiver allowing the Council to allocate additional funding to support services based on the 2015 Consumer Needs Assessment (CNA), FY2015-2016 service category expenditures, and client utilization data.

iii. 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 of color, the Council considered data from the 2015 CNA, HIV surveillance data, Unmet Need estimate, the HCC on minority populations, and the past three years of MAI service expenditures. The Disparities Elimination Committee reviews MAI funded service expenditures, utilization, and client-level outcomes annually and proposes services to be prioritized and allocation amounts for MAI funding. 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 in FY2018: outpatient health care services (OHCS, allocated $118,983) and medical case management (MCM, allocated $211,100) targeting Latinos (OHCS and MCM) and African Americans (MCM). The integrated plan prioritizes reducing HIV-related disparities and health inequities so in addition to the MAI allocations, the Council funds services with Part A which provide culturally responsive EIS, mental health, outreach, health education/risk reduction and psychosocial support services to hard-to-reach African American, African-born, and Hispanic clients including: high risk heterosexuals, MSM, young MSM, and transgender women of color who are unaware of their status and/or out of care.

iv. Data use in priority setting and allocation process to increase access to core medical services, ensure access to services for WICY and reduce HIV health related disparities. For priority setting and allocation processes, the Council reviews and considers the 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 Minnesoa and results from interviews with African American MSM conducted by the Office of Minority Health Resource Center in 2015. The Council examines HIV epidemiological trends from the previous three years, reviewing gender, age, race, and risk factor(s) in the HIV incidence and prevalence of the MSP-TGA and in each stage of the HCC. The Council uses these data to consider allocations to

services based upon incidence and prevalence and to determine resource allocations to address disparities, the needs of emerging populations and fill gaps in services. Part A grant 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. The Council increased previously under-utilized services to maintain core medical services in FY 2017 in recognition of increased HIV prevalence and need for services to retain consumers in care as evidenced in annual epidemiological update. The Council makes every effort to ensure that Part A and B resources for women, infants, children, and youth (WICY) are proportionate to their representation in the epidemic. Once a waiver of the 75% core medical expenditure requirement was granted, and the Part A grant award was received, the Council was able to allocate an additional $26,000 to HE/RR to support women living with HIV and their partners to prevent mother-to-child transmission.

v. Significant changes in the prioritization and allocation process from 2017 to 2018 and the rationale for those changes. In May FY2017, the Part A recipient was granted a waiver of the 75% core medical services expenditure requirement. The decision to submit the waiver request was prompted by reductions in Part A core medical services spending since 2015 primarily due to increased access to outpatient health care and mental health services with the expansion of Medicaid in Minnesota and the increasing need for support services, especially those that help mitigate economic barriers to HIV care access. This allowed the Council to allocate additional funds to support services, particularly Food Bank/Home Delivered Meals, which was an activity defined in the integrated plan to meet basic needs to help increase the proportion of RWHAP African American, African-born, and Hispanic clients who are retained in care and prescribed ART. Following the waiver approval, the Council allocated 72% of Part A grant funds to core medical services and 28% to support services. The FY2018 allocations meets the 75% core medical service expenditure requirement but the Part A grant recipient plans to apply for a core medical services expenditure waiver in FY2018 following submission of the Part A grant application so the Council will be able to maintain additional funding to support services.

2) Administrative Assessment

a) Assessment of the grant recipient activities

The Council's most recent evaluation of the grant recipient's administration of the FY2016 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 2016 (N=26)		
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 (2016).	26	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 (2016).	24	2
3. Awards to service providers were determined according to established criteria.	25	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.	23	2
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.	26	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.	22	2
7. Award per service area/activity complies with Council prioritization (2016) and allocation amounts set by Council in August 2016 and subsequent reallocations.	23	1

The Council completed their administrative assessment on September 12, 2017. 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. One-hundred percent (26/26) of Council members returned the evaluation. All members that completed the assessment indicated that objectives 1, 3, and 5 were met. Twenty-four of 26 members (92%) indicated that objective 2 was met; twenty-three of 26 members (88%) indicated that objectives 4 and 7 were met; and 22 of 26 (85%) members indicated that object 6 was met.

b) Deficiencies and corrective action

There were no corrective actions recommended by the Council. One member commented on objective 2 that timeframes are unclear in the Part A response. The Part A grant recipient plans to address this by presenting a visual timeline that includes dates of award notifications, expenditure reports, Council allocations actions and contract actions. One member commented on objective 3 that it was unknown if awards to service providers were determined according to established criteria. In response, the results of the administrative assessment will be presented to the Needs Assessment & Evaluation Committee to inform the evaluation of Part A grant administration of FY2017 funds.

3) Letter of Assurance from Minnesota Council for HIV/AIDS Care and Prevention Chairs. See ***Attachment 6*** for the Letter of Assurance from the Council chairs.

4) Resource Inventory

a) Coordination of Services and Funding Streams

i. Minneapolis-St. Paul Transitional Grant Area HIV Resource Inventory Table

The HIV prevention and care services available in the 13 counties of the MSP-TGA along with their funding sources are presented in **Attachment 7.** A map of HIV prevalence in the MSP-TGA with Part A funded outpatient health care, medical case management and other supportive services is presented as **Attachment 14B** and provides a sense of the geographic accessibility of RWHAP services in the MSP-TGA.

ii. Needed Resources Not Being Provided and Steps Taken to Secure Them

The MSP-TGA's resource inventory indicates that nearly all essential core medical and support services that impact the HIV Care Continuum receive public funding, many of which are solely funded by RWHAP funds including medical and non-medical case management, food bank/home delivered meals, outreach services and psychosocial support. A key goal of the MSP-TGA's RWHAP is to reduce or eliminate the gaps in resources and services that prevent PLWH from entering into or remaining in care. The most recent HIV Care Continuum for the TGA estimates that 72% of diagnosed PLWH in the jurisdiction in 2016 were retained in care, indicating that 28% or 1,996 of the TGA's diagnosed PLWH were not receiving medical care for their HIV infection. The Minnesota Department of Health estimates that 11.7% of PLWH (972) in the 11 Minnesota counties of the MSP-TGA remain undiagnosed. With a total estimate of 2,968 PLWH in the TGA (36%) out-of-care, considerable additional resources would be needed to achieve key outcomes of the National HIV/AIDS Strategy in the MSP-TGA including: 90% of PLWH know their serostatus; 85% of the newly diagnosed linked to HIV medical care within 30 day; 90% of diagnosed PLWH are retained in care; and 80% of diagnosed PLWH are virally suppressed.

Forty percent of diagnosed PLWH in the TGA (2,903) received a Part A funded RWHAP service in FY2016, 94% of whom were retained in care. Retention in care for Part A service recipients is measured using a combination of CD4 count and viral load test data from the Minnesota Department of Health's (MDH) HIV surveillance system that is now uploaded into CAREWare quarterly and provider reports of dates their clients attended medical appointments. Based on income estimates of diagnosed PLWH in the MSP-TGA (see Table 3, page 10), 75%, or 5,521 ought to be eligible for RWHAP services indicating that there are an estimated additional 2,618 RWHAP eligible PLWH who could benefit

from Part A funded RWHAP services. With an average expenditure of $1,583 in Part A funds per service recipient in 2016, an additional $4,141,128 in Part A funds would be needed to provide comparable services to all RWHAP eligible PLWH in the MSP-TGA.

Factors contributing to why PLWH in the TGA who remain unaware of their infection are not getting tested and linked to care and why PLWH who are aware of their diagnosis are not retained in care are complex. These factors include untreated co-occurring conditions such as mental illness and substance use disorders and unmet economic and social needs such as stable housing, income and food security and family and community support. The Minnesota Council for HIV/AIDS Care and Prevention's plan for allocations of the TGA's Part A resources is designed to fill gaps in outpatient health care services for the un- and underinsured and provide access to treatment for co-occurring conditions and meet the socio-economic needs of eligible PLWH.

A full continuum of EIS, outreach, linkage and retention support services are needed, particularly culturally responsive 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

people of color, and eliminate gaps along the HIV Care Continuum. The council allocated Part A funds for early intervention services (EIS) provided by Hennepin County's Public Health Clinic (PHC), the county's Federally Qualified Health Center in North Minneapolis and an African American faith-based organization all of which have referral agreements with the five largest HIV clinics that facilitate medical appointments within 48 hours of diagnosis. The Minnesota Department of Health'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; 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 Public Health Clinic initiated a Data-to-Care project in 2016 using HIV surveillance data provided by MDH that focuses on re-engaging and retaining Hennepin County's diagnosed residents living with HIV in care. PLWH receiving RWHAP 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 HIV Care Continuum from linkage to viral suppression, and support services such as housing, transportation, food supports, and EFA mitigate economic barriers to care retention. Despite Minnesota's low uninsured rate, disparities in health care coverage negatively impact people of color, particularly the foreign-born. Part A and MAI funds are allocated to outpatient health care services (OHCS) provided by two of the largest HIV specialty clinics in the TGA and a Federally Qualified Health Center 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, OHCS 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. 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 RWHAP funded services in an atmosphere of flat funding presents a challenge to ensuring access to care.

- *WORK PLAN*

A. HIV Care Continuum Table and Narrative

1) HIV Care Continuum Table

Attachment 7 depicts how Part A funded service categories will improve indicators along the HIV Care Continuum in the MSP-TGA and includes indicator baselines and target outcomes to achieve in FY2018 at each stage of the Continuum.

2) HIV Care Continuum Narrative

a) Utilization of the HIV Care Continuum to Plan, Prioritize, Target and Monitor Resources

Both the Minnesota Council for HIV/AIDS Care and Prevention and the Part A grant recipient use the HIV Care Continuum (HCC) extensively to set priorities and allocate Part A resources and develop effective service delivery models that facilitate HIV diagnosis, rapid linkage to care and support care retention and address disparities in outcomes along the HCC. At the council's August 8, 2017 meeting, the Minnesota Department of Health's (MDH) HIV epidemiologist presented Minnesota's and the MSP-TGA's updated HCC using 2015 and 2016 HIV surveillance

data from the state's enhanced HIV/AIDS reporting system (eHARS). The MDH has been presenting an annual update of the HCC to the council since 2013 which includes 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 Part A grant recipient's Quality Management Advisory Committee (QMAC) that superimposes RWHAP services on the stages of the continuum. This framework provides 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 achieve suppressed virus. Beginning in 2017, the council's Needs Assessment and Evaluation Committee began presenting highlights of each prioritized service at council meetings that include data on service utilization, the proportions of diagnosed PLWH in Minnesota and RWHAP consumers who receive the service and a graphic depicting where the service impacts the HCC.

The Minnesota Department of Health's HIV epidemiologists developed Minnesota's first HCC in 2013 based on 2011 and 2012 eHARS data following the publication of the first national HIV treatment cascade. A draft was first presented to QMAC for vetting. In May 2016, the Council reviewed the HCC prior to both determining their service priorities for FY2017 and FY2018, and allocating funds for the FY2017 Parts A and B grant applications. Again, they reviewed the updated HCC in August 2017 to inform their allocations for the FY2018 Part A and B grant applications. Concerned about the 28% of diagnosed PLWH who are not retained in care, the council allocated $84,600 for housing assistance to help alleviate waiting lists for the TGA's two HIV housing programs. The council also increased its Part A allocation to EIS from $158,400 in 2016 to $218,000 in 2018 to target services aimed at the early identification of African American MSM with HIV, the only subpopulation of MSM showing an increase in HIV incidence in the past five years. In FY2017 and for 2018, the Council continued to allocate MAI funds to medical case management (MCM) targeting African Americans and Latinos and outpatient health care services for Latinos to address disparities in care 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 2014 and 2015 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 2017 during the review of Minnesota's first integrated multi-parts (A, B, C and D) clinical quality management plan at the May Quality Management Advisory Committee meeting, committee members approved the plan goals for 2018 that include improving care retention and viral suppression and developing the capacity of all RWHAP subrecipients to develop an HCC relevant to their own client population. Part A grant 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, OHCS and MCM.

Also informed by the annual review of the MSP-TGA's HCC, beginning in 2016 the Part A grant recipient provided resources through the council's outreach services allocations to support a data-to-care approach to increasing the proportion of the TGA's PLWH who are retained in care. Hennepin County's Public Health Clinic now receives HIV surveillance data from MDH on Hennepin County residents living with HIV who have not had a reported CD4 count or viral load test in the past 12 months. The clinic HIV services navigator, who is trained as an HIV/STI

disease investigator, works through the data to contact cases that have not received HIV medical care and offers person-centered care re-engagement services. Sixty-two percent of diagnosed PLWH in the MSP-TGA reside in Hennepin County.

b) Evaluation of Efforts to Impact the HIV Care Continuum

HIV surveillance data on diagnosed PLWH in the MSP-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 MSP-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 RWHAP 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. Outpatient health care services providers report medical visits, CD4 counts and viral load values, and prescribed antiretroviral therapy quarterly for each of their Part A funded patients.

Beginning in 2016, the Part A grant recipient began a collaborative project with MDH and the Minnesota Department of Human Services (Part B grant recipient) to migrate HIV and AIDS diagnosis dates, CD4 counts and viral load values from eHARS into MNCAREWare to develop a more complete RWHAP HIV Care Continuum for Minnesota and the MSP-TGA. Through the development of data agreements among the three government agencies, RWHAP clients no longer need to sign a release of information for their eHARS data to be imported into MNCAREWare. The first complete match of eHARS with the MNCAREWare population was completed in October 2017. Now, Hennepin County RWHAP staff are able to access more accurate and timely data on each stage of 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.

B. 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 2016, allocated funds for FY 2017 and planned allocations of funds for FY 2018 to meet the

identified needs of PLWH in the Minneapolis-St. Paul TGA. A core medical services expenditure waiver for the MSP-TGA has not yet been submitted.

b) Service Category Plan Narrative – *MAI Initiatives*

The goals and objectives of the FY 2018 MAI plan emphasize increasing access to HIV medical care and improving health outcomes along the HIV Care Continuum for African American, African-born, and Latino individuals through medical case management (MCM) and outpatient health care services (OHCS). All anticipated FY2018 MAI service funds ($330,083) are allocated to core medical services. The goals for the MAI-funded services are based on the 2015 and 2016 HIV surveillance data used to develop the current HIV Care Continuum (HCC) for the MSP-TGA. Disparities in engagement along the HCC among racial and ethnic groups as it pertains to the MAI goals were as follows based on each stage. Linkage to care within 30 days (82.8% overall): The lowest linkage to care rates were among African Americans (72.7%) and PLWH ages 45-59 years (63.6%). Retention in care (71.6% overall): The lowest retention in care rates were among African-born (68%) and Hispanics (68.4%). Viral suppression (63.8%) overall: The lowest viral suppression rates were among African American (56.5%) and African-born (60%) individuals.

The goal of MAI funded OHCS 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 to support a patient-centered long-term culturally responsive 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 Minnesota's health insurance exchange, *MNSure*). This service targets and addresses barriers Latinos experience while trying to receive HIV medical services. By providing funds to serve this population at a full-service Federally Qualified Health Center located in St. Paul's Latino cultural and economic center, the Part A grant 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. OHCS is budgeted to receive 36% of the MAI funds in FY2018 ($118,983). Part A funds will also support this program with an additional $88,250 in FY2018.

The goal of MAI funded MCM is to increase access to HIV primary medical care, other core medical 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 and other core medical services, psychosocial support, and other services that address clients' barriers to accessing and being retained in HIV medical care. MCM targeting Black or African American PLWH is allocated 31% of MAI service funds ($102,325) for FY2018 and is provided by a community-based organization with a strong presence in South Minneapolis since 1995 that focuses on providing culturally-specific MCM services to African American and African-born individuals. The agency is located in the TGA's zip code with the highest number of prevalent HIV cases and has well-established relationships with clinical providers of HIV medical care and early intervention services 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. This is the same Community Health

Center that receives MAI funding for OHCS. Funds for MCM are disbursed on a unit-rate basis through quarterly invoices. MCM targeting Latino was allocated 33% of MAI service funds for FY2018, with a budget amount of $108,775.

MAI funded MCM services address social determinants of health in ways that are culturally responsive to their client's health care and support service needs. Gaps are identified both through the client's individual service plan as well as through an analysis of disparities along the HCC. MCM includes prevention and HIV care education for positive individuals to help address these disparities. The objectives of MCM for these populations are to link clients to health care, psychosocial support, medical transportation, mental health, and substance abuse treatment services that address clients' barriers to consistently accessing HIV medical care.

African Americans (U.S. born) comprise 23% of the people living with HIV in the MSP-TGA and 15% are African-born (see ***Attachment 3B)***. Combined they make up 38% of all PLWH in the TGA. African Americans and African born combined represent only 7% of the total population of the TGA. Latinos make up 9% of all PLWH in the TGA and 6% of the TGA's population.

With Black and African-born individuals as well as Latinos less likely than Whites to be retained in care and have suppressed virus, MAI funded OHCS and MCM services are designed to reduce these disparities along the HCC. In 2016 in the TGA, 96.7% of Latinos diagnosed with HIV were linked to care in 30 days, 68.4% were retained in care, and 62.2% were virally suppressed. Among African Americans living with HIV, 72.7% were linked to care, 69.1% retained in care, and 56.5% were virally suppressed. African-born PLWH were linked to care at the rate of 79.7%, retention at 68% and viral suppression at 56.5%. Comparing these percentages across the treatment cascade to Whites living with HIV in the TGA (87.3% linkage to care, 74.1% retention 69% virally suppressed), Black and African born individuals as well as Latinos have lower rates of retention and viral suppression.

With 73% of men living with HIV in Minnesota identified as MSM, it is important to examine the HIV Care Continuum for this high-prevalence population as well. Additionally, sex with men is the most common mode of HIV exposure among men of color. Latino and African American MSM in the TGA have lower retention in care (66% and 64%, respectively) than White MSM, 71% of whom are retained in care.

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 CAREware. MAI funded providers 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 grant recipient and subrecipients to regularly evaluate the impact of those activities on meeting the 2018 MAI goals and to meet the HRSA requirement to report on client level health outcomes for all FY2018 MAI-funded services.

The planned client level outcome targets for MCM are consistent with HRSA/HAB Performance Measures and the TGA's MCM standards of care: 1) 95% of clients retained in care and 2) 90% of clients with improved or a stable viral load.

c) Core Medical Services Expenditure Waiver

A core medical services expenditure waiver request for the MSP-TGA is not included in this grant application.

- *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 HIV Care Continuum into planning and programming.

Challenge/Barrier	Resolution	Outcome	Status
1. HIV-related health disparities	a) Utilize End Disparities Exchange's Health Disparities Calculator to identify disparities. b) Review FY2017 performance measures and health outcomes disaggregated by disproportionally impacted population. c) Share the above data with the Council's Disparities Elimination Committee for discussion and action planning. d) New guidance is given to sub-recipients on annual quality improvement plans needing to address disparities. e) Continue to target disproportionally affected communities of African American and Latino/a through MAI funded services. f) Work with EIIHA work group on making Ryan White services more transgender (MTF) responsive. g) Implement new cultural responsiveness standards with training and technical assistance organized by the Part A Program.	• New plan to address disparities identified at the council or grant recipient level. • Sub-recipients address disparities in their client population in their annual quality improvement plans. • Increased sub-recipient outcomes and accountability of reaching those outcomes in contracts to ensure targeted populations are being served. • Increased focus on health outcomes for disproportionally affected communities. • Increased cultural responsiveness of the council, recipients, and sub-recipients.	• The TGA recipient staff have begun the process of examining outcomes of RWHAP clients through the disparities calculator, on hold until full eHARS to MN CAREWare match happens later in CY 2017. • The Part A grant recipient has begun drafting population and funding specific goals for FY 2018 sub-recipient contracts. • The 2018 guidance on sub-recipient quality improvement plans will be shared with sub-recipients in February of 2018 with direction on identifying disparities. • Cultural responsiveness standards are currently being drafted and shall be reviewed by the council in early CY 2018.
2. Incomplete and inaccurate Ryan White system level data.	a) By the end of CY2017 there shall be a full match between eHARS and CAREWare for all RWHAP Part A and B clients for data on viral load, diagnosis date, date of last appointment and more. This match will continue to occur monthly. This match will resolve issues of incorrect diagnosis date, increase completeness and accuracy of linkage to care, retention, and viral suppression rates. b) In 2018 contracts with sub-recipients there will be increased specification of contract guidance on data completeness. c) For 2018 site visits, recipient will compare units of service to service records in client files for all services areas. This increased auditing	• Recipient and sub-recipients have accurate and up-to-date diagnosis date, in-care status, and viral load for their clients. This data will inform sub-recipient, service area, and population specific care continua to aid in quality improvement efforts and improved health outcomes for Part A consumers. • Increased accuracy and timeliness of client utilization data by service area. • Improved program planning by the council and grant recipient with	• The first complete eHARS to CAREWare match is planned for October, 2017 along with training for sub-recipients. • The Part A recipient has begun drafting the 2018 contract language changes to include matching of utilization data prior to invoice payment. • The Part A recipient site visit process manual has been updated to match utilization data with client files. • The Part A data and outcomes coordinator has begun creating PowerBI reports to aid in reporting and report visualization.

Challenge/Barrier	Resolution	Outcome	Status
	will help ensure more accurate reporting of utilization by service area. d) The Part A recipient is currently piloting new software to aid in better data utilization, more audience friendly dashboards, and increased understanding of data. e) The Part A recipient is increasing the frequency of collection and analysis of performance measures.	more accurate, frequent, and user-friendly data on service utilization, performance, and health outcomes.	• The 2018 Clinical Quality Management plan is being drafted currently with stipulations of quarterly tracking of performance measures. The 2018 quarterly report format for sub-recipients will follow the new more frequent reporting of performance measures.
3. Ryan White sub-recipient level data completeness, access, and quality.	a) Building of reports and performance measures modules in CAREWare partnered with subrecipient training and updated manuals on generating reports. b) Increased contract expectations of sub-recipients in reporting through CAREWare and quarterly reports.	• Increased sub-recipient capacity in reporting and analysis of service and performance measures. • Sub-recipients will be able to see RWHAP client level health outcomes including care continuum stages of linked to care, care retention, ART, and viral suppression.	• The Part A Data and outcomes coordinator is working with the MN CAREWare administration team to identify all reports that need to be built and which ones are already available and accurate. Next steps include: participation in HRSA sponsored training on CAREWare performance measures; build new reports; and train sub-recipients on how to use reports in MN CAREWare. • The Part A grant recipient has begun drafting the 2018 contract language changes to include matching of utilization data prior to invoice payment.
4. Duplicative and uncoordinated HIV related funding and programming across funding streams, grant recipient and subrecipient agencies as new resources have become available for clinic and community-based HIV care service delivery. New resources include ADAP rebate	a) The Governmental HIV Administration Team, including Hennepin County (Part A), DHS (Part B and MDH (CDC HIV prevention grant recipient) develop and apply common principles for coordination and administration of funding. b) Continue to improve alignment of administrative funding processes through an intergovernmental work group. The work group consists of leadership staff from all Part A, Part B, and CDC prevention grant recipients and will receive guidance and "buy-in" executive leadership of the three agencies.	• Reduced administrative and contracting burden for recipients and sub-recipients. • More effective coordination of HIV funding and programming across recipients and sub-recipients. • Government agencies will consult the HIV funding administration inventory when making funding decisions and will coordinate with each other to the extent regulations allow.	• Created and compiled an accessible comprehensive HIV funding administration inventory of all funding sources, how funds are allocated to services and providers, which agency administers the funds and contracts and the service capacity (number of unique individuals planned to be served). • All three government agencies are developing presentations on different stages of the funding process to educate all government administrators and

Challenge/Barrier	Resolution	Outcome	Status
revenue and Part B supplemental funding		• Present a united front through a streamlined and coordinated funding and programming system for sub-recipients to access different funding sources	streamline the service procurement process.
5. Recruitment and retention of council members from disproportionally affected communities: Black, African American & African-born.	a) The Part A recipient is seeking TA from HRSA to increase consumer engagement. b) Utilization of a survey developed by the council's Disparities Elimination Committee to inform recommendations to Membership & Training Committee on improving engagement of members from disproportionally affected communities. c) The council continues to be more active in community events where recruitment is likely to happen, including engagement with work groups that target African American gay, bisexual, and men who have sex with men.	• Increased engagement of PLWH from target populations in RWHAP services and planning groups including the council. • Increased number of applications received from individuals who are members of disproportionally affected communities.	• A request for TA has been submitted to the Part A grant recipient's Project Officer. • A survey has been drafted and conducted of current and past members to identify barriers to engagement for members from disproportionally affected communities. • The council added 3 African American members in August 2017. Recruitment efforts are ongoing to fill one additional spot with an African American or African-born individual.
6. Increasing data, analysis, and programming responsiveness for male-to-female transgender HIV+ Ryan White Program Clients.	a) The Part A and Part B recipients in Minnesota are working to implement centralized eligibility for all RWHAP eligible PLWH. A part of this project is having a common application for all RWHAP applicants that includes both gender at birth and current gender identity. b) The MN Dept. of Health's HIV surveillance program is collecting information on transgender people in a better way through recent changes in reporting definitions of gender identity.	• Through inclusion of gender at birth and current gender fields on the common RWHAP application, the client level database will now more accurately be able to track transgender clients, their needs, their service utilization, and their health outcomes. • Greater data completeness of HIV surveillance data with the MN Dept. of Health on transgender PLWH.	• A centralized process for determining RWHAP eligibility is currently in development, applications are being piloted. • Estimated go live date of June, 2018.

- EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM)

1) Performance Measure Data Analysis and Actions Taken to Eliminate Disparities

Currently, the Part A CQM program and the Minnesota Council for HIV/AIDS Care and Prevention utilize HIV Care Continuum data for MSP-TGA's population of diagnosed PLWH provided by the Minnesota Department of Health to determine differences in linkage to care within 30 days, care retention and viral suppression among demographic categories including gender, race/ethnicity, HIV exposure category and age. In addition, current client-level data in MN CAREWare provides measures of care retention for all Part A clients including linkage to care for newly diagnosed clients receiving Part A funded early intervention or outreach services, and antiretroviral therapy and viral suppression for clients receiving Part A outpatient health care services. Care retention data for Part A service recipients has been collected since 2009 via custom fields in MN CAREWare where subrecipients report biannually if their clients have had an HIV medical appointment in the past six months and the date of the appointments. As with the TGA's HCC data, MN CAREWare performance measure data are analyzed by demographic characteristics.

The 2016 Minnesota and MSP-TGA HIV Care Continuum demographic data informed the development of the cross-Parts CQM plan and Part A quality goals developed by Minnesota's joint Parts A, B, C and D Quality Management Advisory Committee (QMAC). Goal 5 of the FY2017 CQM plan is to "identify any disparities that exist in health outcomes for Ryan White Part A & B clients and share information with stakeholders to inform action,"

The MSP-TGA's CQM staff is preparing to utilize the National Quality Center's End Disparities Exchange's Disparities Calculator to identify disparities that exist in the RWHAP client population of the TGA. The Part A staff are waiting until there is more client level data in MN CAREWare, prior to running the disparities analysis. Part A staff along with Part B and MN CAREWare administrators will be importing the date of HIV/AIDS diagnosis, current HIV status, dates and results of CD4 count tests, dates and results of viral load tests, and vital status (alive or deceased) and date of death once deceased from eHARS into CAREWare, so all clients receiving RWHAP services will have reported values for these variables. The first complete match from eHARS to CAREWare is expected occurred in October, 2017 with subsequent monthly data imports. The findings from running the disparities calculator will be shared with the MN Council for HIV/AIDS Care and Prevention's Disparities Elimination Committee and QMAC for discussion and action planning. Their recommendations would then be shared with the full Council, who would provide guidance to the recipients as to what actions to take.

On the grant recipient level, internally, the Part A data and outcomes coordinator is building dashboards for planning staff to review performance measures monthly by service area, by sub-recipient, and by population. The performance measures by population will be disaggregated by sex, gender identity, race/ethnicity, country of birth, age, and risk factor. Planning staff in particular are interested in examining the health outcomes and care continuum for young men who have sex with men (YMSM), Black (African American) men who have sex with men, male-to-female transgender, and African-born communities. Current MSP-TGA HIV surveillance data show that African and Latin American-born populations tend to be later testers and progress to AIDS faster and YMSM, Black MSM, and male-to-female transgender populations have lower rates of viral suppression. After the full match of all Ryan White Part A client data from eHARS to MN CAREWare, staff will examine these outcomes again to see if the data indicate similar

disparities among RWHAP service recipients. The Part A program team will examine data quarterly to identify if interventions and programming are reducing disparities and how to change strategies if disparities are not being eliminated. The data will be shared with sub-recipients along with efforts to increase sub-recipient capacity training on how to disaggregate population specific performance measures through MN CAREWare to aid in addressing disparities in their RWHAP populations through quality improvement activities.

HIV care retention and viral load performance measures inform the MSP-TGA MAI programming. The TGA's Minority AIDS Initiative (MAI) funds were allocated to OHCS ($113,800) and MCM ($201,800) targeting Latino and African American PLWH in FY2017. Performance measurement data for MAI funded OHCS and MCM services are compared with performance measures from Part A (non-MAI) funded programs. Data are compared across provider and demographic groups and reported back to and the council. At the sub-recipient 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 sub-recipient providing MAI funded OHCS 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 OHCS clients that were virally suppressed has increase 2.5% over the last two years and they increased their clients retained in care rate from 85% in 2014 to 96% in 2016. As viral load data becomes available for their full client population, not only those receiving OHCS, West Side hopes to disaggregate health outcomes and performance measure data by MAI targeted populations and identify areas for quality improvement initiatives for their other RWHAP programs including MCM, health education/risk reduction, mental health services and psychosocial support.

2) Use of CQM Data to Improve and/or Change Service Delivery

The Part A grant recipient's quality management coordinator (QMC) and data and outcomes coordinator (D&OC) both advise the Minnesota Council for HIV/AIDS Care and Prevention and its Needs Assessment and Evaluation Committee. In addition, both the QMC and D&OC sit on the integrated Quality Management Advisory Committee (QMAC). Through these roles these staff update the council's Integrated Plan and the cross-Parts Integrated Clinical Quality Management (CQM) Plan quarterly with performance measurement data including: 1) HIV test positivity rate; 2) linkage to care within 30 and 90 days; 3) retention in HIV medical care; 4) referral to medical care rate for those not retained in care; 4) prescribed ART for PLWH receiving RWHAP OHCS; 5) viral suppression; and 6) MCM current individual care plan. This 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 contractual goals and objectives, analyzes how costs vary among providers and determines more effective models of service delivery. In addition to performance measures, the process uses other client level and needs assessment data to determine effectiveness and identifies service area gaps. These plans, the updates, and the discussion around them will help not only the TGA but all RWHAP Parts and CDC-funded prevention efforts understand the impact of funding, specific services efficacy, and where disparities, if any, exist. With all of this information the Council and QMAC can make more informed allocations decisions and recommend specific quality improvement initiatives at both the grant recipient and subrecipient level for better outcomes for people living with HIV in the MSP-TGA.

In FY2016, the Needs Assessment and Evaluation Committee implemented a process to review each service area along with three years of performance measure, utilization, and needs assessment data. This work is to build the numeracy and data comprehension capacity of council members so that they in turn make more data informed decisions to improve services and health outcomes for RWHAP clients. The D&OC develops a services area presentation for each council meeting that is first reviewed by the Needs Assessment and Evaluation Committee, then one member of this committee presents all of the service information to the full council.

At the Part A grant recipient level, the QMC and the D&OC are working with the Part A HIV service planners and contract analysts to develop dashboards looking at data completeness, performance measures, health outcomes, and utilization by sub-recipient, population, and service area quarterly. With the upcoming improvement in data completeness with the monthly eHARS to MN CAREWare match for all RWHAP clients in the TGA, staff will be able to monitor the efficacy of specific service areas and/or sub-recipients on the care continuum. This match means that for all RWHAP clients in MN CAREWare, date of HIV/AIDS diagnosis, current HIV status, date(s) and result(s) of CD4 count test(s), date(s) and result(s) of viral load test(s), vital status (alive or deceased) and date of death once deceased are known. In addition the D&OC is working to change the software currently being utilized for data reporting and analysis to assist with clarity and timeliness of reports to improve the Part A grant recipient and subrecipients' ability to monitor current performance measures disaggregated to hone in on what services have the greatest impact on client HIV health and how to improve services for better outcomes for the TGA's PLWH.

- *ORGANIZATIONAL INFORMATION*

A. Grant Administration
1) Program Organization
a) Administration of Part A Funds

The staffing plan for Hennepin County's Part A grant administration is presented as ***Attachment 1*** and the organizational chart as ***Attachment 10***. The Chief Elected Officer, the Chair of the Hennepin County Board of Commissioners, designates the Hennepin County Public Health Department (PHD) responsible for administering the MSP-TGA's Part A grant. The PHD is accredited by the Public Health Accreditation Board. The Part A RWHAP is within the Public Health Administration service area of the PHD. The RWHAP Supervisor oversees the daily operations of grant administration and reports to the Public Health Administration Administrative Manager. The PHD Director ensures that all aspects of Part A grant administration are carried out and supervises the Public Health Administration Manager. In addition to the RWHAP Supervisor, the grant recipient administrative team includes: an HIV Services Planner; 2 Contract Managers from Hennepin County's centralized Health and Human Services Contract Administration area; a Quality Management Coordinator; 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 3.8 FTE administrative staff and 1.6 FTE CQM staff (see ***Attachment 13-Line Item Budget*** and ***Budget Narrative Attachment*** for detail). All grant administration and quality management positions are currently filled.

The Part A grant also supports 50% of the costs of the Minnesota Council for HIV/AIDS Care and Prevention 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 MSP-TGA's Part A grant, community input for Minnesota's Part B grant and serves as the HIV prevention community planning group for Minnesota's CDC HIV prevention funding administered by the Minnesota Department of Health (MDH). The Minnesota Department of Human Services (Part B grant recipient) provides funding to cover the other half of the Council's operating costs which is passed to Hennepin County through a receivable contract. Council staff are employees of Hennepin County's PHD and are supervised by the RWHAP Supervisor. When an administrative or council staff vacancy occurs, the RWHAP Supervisor hires new staff using the County's Human Resources hiring procedures. In hiring the Council Coordinator, the council co-chairs and representatives from Minnesota's Part B (DHS) and CDC grant recipient (MDH) offices are invited to serve on the interview panel and participate in evaluation and selection of final candidates for the position.

b) Administrative Agency

All Part A grant administration activities are performed by the MSP-TGA grant recipient. Hennepin County does not administer the MSP-TGA's Part A grant by a contractor or fiscal agent.

2) Grant Recipient Accountability

a) Monitoring

i. Three most common program and fiscal subrecipient findings for 2017**.** The three most common subrecipients' findings in 2017 are annual income and insurance verifications related to eligibility determination, updated individual service plans for medical case management (MCM) and substance abuse treatment-outpatient (SAO) clients. Six and a half percent (6.5%) of files reviewed did not meet the requirement for income verification every six months. Similarly, 7.6% of files did not meet the requirement for insurance verification every six months. Nine percent (9%) of charts reviewed for MCM and SAO standards did not have an updated individual service plan (ISP). One of the main challenges for meeting eligibility requirements every six months is that a number of Ryan White clients are homeless, have unstable housing, or at risk for homelessness. Some clients have difficulty following-up with subrecipients with required eligibility documentation. Part A grant recipient staff have implemented a policy that explains that services are not billable until all eligibility certification and twice annual recertification are met. The corrective actions for subrecipients who did not meet 100% of client eligibility requirements include reviewing clients' files and obtaining missing documentation prior to billing for services. Additionally, grant recipient staff provided technical assistance for improving eligibility verification every six months and provided a template detailing acceptable language for no insurance and no income certification. The corrective action for not having an updated ISP includes technical assistance and training on programmatic standards and developing ISPs. One SAO subrecipient reported all clients that receive a chemical health assessment, even the ones without an ISP. The subrecipient has been informed that all SAO eligible clients have been identified through referrals and require coordination, follow-up, and an ISP in addition to the chemical health assessment required by the state for placement in a treatment program.

ii. Ensuring subrecipient compliance with the single audit requirement. Prior to the annual subrecipient program and fiscal 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. The following language is included in all MSP-TGA Part A contracts with subrecipients that receive $750,000 in federal funding: "*Providers who meet the threshold of federal expenditures as set forth by the Federal Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Grant Guidance), must submit a copy of their independent financial statement audit report(s) and a 'Single Audit', within thirty (30) days after receipt of the auditor's report(s), or nine (9) months after the end of the audit period, whichever occurs first*." Contract Managers review all audits and financial statements to assess subrecipient fiscal stability and compliance with the HHS Uniform Guidance single audit requirement. In FY2017, all nine Part A subrecipients receiving $750,000 or more in Federal funds complied with federal single audit requirement.

iii. Findings and corrective actions**.** Grantee staff conducted annual site visits at all 14 Part A contracted agencies in FY2017. Invoice audits were also conducted at all 14 subrecipient agencies in FY2017. One of the pilot projects, a faith based organization providing EIS to African American MSM, had significant fiscal findings that require corrective action. The first finding was a lack of adherence to generally accepted accounting principles (GAAP). The institution does not have an accounting system of journals, ledgers or spreadsheets to track and report on expenditures. The agency is not using the accrual basis of accounting per contract requirements. The second finding was incomplete bank reconciliations. The subrecipient was missing an accounting policy and procedure manual and a system for allocation of shared cost. This subrecipient also gave 1099 and paid fringe benefits directly to two employees. The corrective actions include: subrecipient will set up a sound financial accounting system based on generally accepted accounting principles (GAAP). The system must also include a program specific Accounting Policy and Procedure Manual. Subrecipient is required to establish an adequate payroll system where taxes are withheld and fringe benefits are paid on behalf of employees. Part A grant recipient staff is providing technical assistance and additional funding for the organization to contract with an accountant and fiscal consultant to develop an accounting system that meets GAAP and Hennepin County contractual requirements.

One outpatient health care services subrecipient had a single audit finding, with two out of thirty-three reviewed files missing income eligibility documentation. These two clients were identified as ineligible and resulted in a $79.42 overpayment for services rendered in FY2016. This subrecipient has completed their corrective action plan, which included the following procedures: income eligibility mapping; staff re-training on income eligibility determination requirements; a review of over 800 client files for proper income documentation; and implementation of client-level data systems changes to ensure that the Part A Program is not billed for client services without required RWHAP eligibility documentation.

b) Third Party Reimbursement

i. Process to ensure subrecipient pursuit of third party reimbursement. To ensure that RWHAP funds are the payer of last resort, subrecipients are asked at each site visit to demonstrate how they determine RWHAP eligibility and track other sources of reimbursement. The Part A grant recipient's instrument for outpatient health care services (OHCS) 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 RWHAP funds. The site visit team reviews a statistical sample of client charts that meets HRSA/HAB recommendations based on the number of clients the agency serves to verify client insurance status and that RWHAP eligibility was determined. To ensure that all Medicaid-eligible providers are certified, the Part A recipient's contract managers check with the Minnesota Department of Human Services to verify that each OHCS provider receiving RWHAP funds has an active Medicaid provider number. All RWHAP subrecipient contracts identify the RWHAP Part A as the funding source and contain the following language: "*Federal Ryan White HIV/AIDS Treatment Extension Act of 2009. Public Law No. 111-87 CFDA # 93.914. Third party payments must be exhausted prior to accessing Ryan White grant dollars. Provider must ensure that Ryan White program funds remain the payer of last resort.*" Outpatient health care services subrecipients submit all service claims to any third party payer of record for each insured patient before invoicing the Part A recipient for the charges. Only when third party claims are denied for RWHAP allowable OHCS services, will the subrecipient invoice the Part A grant recipient for charges. 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 program funding, including third party reimbursement for each program by budget line.

ii. Screening and eligibility determination to ensure RWHAP is the payer of last resort. Upon intake and every six months, subrecipient staff ask all clients about their 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. HIV diagnosis documentation is 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. If a client reports no income, they must complete a form that indicates how they receive economic support. All eligibility documentation is placed in the client file. Subrecipient staff are required to report these items in MN CAREWare in January and July. All Part A outpatient health care 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 medical case management and health education/risk reduction sessions, psychosocial support or legal services (other supportive services). In 2018 a centralized RWHAP eligibility certification system will be implemented in which eligibility shall be collected and shared amongst subrecipients who share that client. There will be central eligibility workers who will track and update eligibility records semi-annually and sub-recipients will be alerted to changes in eligibility status. This process will streamline eligibility documentation requirements, increase accuracy of client records, and reduce administrative burden of ensuring Ryan White is truly the payer of last resort.

At annual subrecipient site visits, a sample of client records based on HRSA/HAB recommendations for numbers of charts are reviewed for documentation of RWHAP eligibility including HIV diagnosis, income, residence in the MSP-TGA and insurance. In 2017, 812 client

records were reviewed for eligibility determination documentation. Of the 812 records reviewed, 99% had documentation of HIV infection, 93% had documentation of income, 92% had documentation of insurance, and 96% had documentation of residence. Any subrecipient that does not demonstrate 100% documentation for each of the four elements of eligibility determination is required to take corrective action. That corrective action plan must be implemented prior to the following year site visit and must be addressed in their annual quality improvement plan.

iii. Tracking and monitoring 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.

c) Fiscal Oversight

i. Process used by program and fiscal staff to coordinate activities**.** Part A Program staff play the lead role with assistance from analysts in the Human Service and Public Health Department's Financial Analysis and Accounting Area (*see* ***Attachment 10B***) to provide fiscal oversight of the Part A grant. Contract managers monitor spending through invoice review and entry into the RWHAP financial workbook before they approve payment. Prior to invoice payment approval, contract managers review subrecipient and program specific client level-data reports in MN CAREWare to confirm that services billed were reported. Invoices are scanned into a document database and, once approved by the contract manager, are assigned a receipt number. Once the receipt is created, accounts payable staff then enter invoice amounts into the County's financial management system for payment through electronic transfer to subrecipients' financial institutions. Support staff reconcile actual payments to subrecipients with invoice amounts monthly and enters all administrative and CQM expenditures in the RWHAP financial workbook. The RWHAP Supervisor completes Part A budgets, monitors overall spending, presents quarterly expenditure reports to the Minnesota Council for HIV/AIDS Care and Prevention and works with the financial analysts to prepare grant Federal Financial Reports (FFR), including separation of formula, supplemental and MAI expenditures, and unobligated balances. A financial analyst completes and submits quarterly HRSA Payment Management System disbursement reports for grant payment drawdowns and copies the RWHAP 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 RWHAP Part A subrecipients. The RWHAP Supervisor meets with the financial analysts to resolve contract payment problems or discrepancies discovered during the invoice/payment reconciliation process. The RWHAP Supervisor also meets with fiscal staff prior to submission of the final FFR to reconcile any discrepancies between the RWHAP financial workbook and the County's payment system.

ii. Process to separately track formula, supplemental, MAI, and carryover funds**.** Because of the penalties for unobligated formula funds established by the RWHAP legislation, expenditures on 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 provider 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 subrecipients contracts. At the end of the fiscal year, once all subrecipients 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 RWHAP master financial management and subrecipient invoice MS Excel workbook that is maintained by grant recipient staff. The Hennepin County Office of Budget and Finance currently 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 and CQM.

iii. 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 that correspond to the HRSA object class categories 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 for most subrecipients. Outpatient health care services subrecipients have until June 15 to submit final invoices for the fiscal year to ensure enough time for them to ensure that RWHAP funds are the payer of last resort through insurance claims processing. Invoices and unit tracking spreadsheets are reviewed by the RWHAP contract managers for accuracy, compared to program budget and service delivery reports from MN CAREWare, entered in the RWHAP financial management invoice workbook, and submitted to the Financial Analysis and Accounting area (*see* ***Attachment 10B***) 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 RWHAP contract manager. Once payment is made, the payment amount from the monthly financial reports from the APEX general ledger is reconciled with the invoice amount and entered into the financial workbook.

B. Maintenance of Effort (MOE)

Attachment 11 presents a table that identifies the Minneapolis-St. Paul Part A TGA's MOE budget elements and the amount of expenditures for fiscal years 2016 and 2016 and budgeted amounts for 2017.

iii. Budget

Line Item Budget

The Minneapolis-St. Paul TGA's FY2018 Part A and MAI line item budget is presented by funding type, program cost categories and object class categories as ***Attachment 13.***

iv. Budget Narrative – See ***Budget Narrative Attachment.***