Minneapolis-St. Paul TGA Application for FY 2021 Ryan White HIV/AIDS Program Part A and MAI Funding

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- *INTRODUCTION*

The following application describes the continuing and evolving needs of people affected by the HIV epidemic in the Minneapolis-St. Paul Part A 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 leading to viral suppression prevents HIV transmission, the MSP-TGA's Ryan White HIV/AIDS Program (RWHAP) Part A and MAI funds provide critical services that advance HIV engagement, retention, and viral suppression for the people with HIV, focusing on men who have sex with men (MSM), disproportionately affected communities of color, people who inject drugs (PWID), at-risk youth, and immigrant populations. In collaboration with all of Minnesota's RWHAP parts and the Minnesota Department of Health (Minnesota's Centers for Disease Control HIV prevention grant recipient), the Part A program ensures an integrated continuum of care and services in the Twin Cities metropolitan area where 85% (7,836) of Minnesotans living with HIV reside. The vast majority, 80% (6,233) of the TGA's people with HIV (PWH) reside in Hennepin and Ramsey counties. Recent national, Minnesota, and MSP-TGA HIV Care Continua (HCC) make clear where the greatest disparities and needs arise in helping people become aware of their HIV status and engage in a lifetime of HIV medical care and prevention. While the Patient Protection and Affordable Care Act (ACA) has improved access to and affordability of healthcare, the percent of TGA residents who are uninsured increased to 6.4% in 2017 (the last time it was assessed) from an all-time low of 4.3% in 2015, and the future of the ACA is uncertain. As a result, the MSP-TGA's FY 2021 Part A and MAI plan continues to fund a spectrum of high-quality services to ensure that no one living with HIV goes without health care due to financial barriers. This and next fiscal year present many unknowns and uncertainties as the MPS-TGA as well as the rest of the country grapple with the dual public health crises of the COVID-19 pandemic and racism. Additionally, an HIV outbreak among PWID in the TGA's two largest counties was identified accounting for 26 new cases since December 1, 2018. The COVID-19 pandemic has infected 1.3% of the Part A MSP-TGA clients but also affects all RWHAP consumers, providers, and the greater community. Telemedicine is provided unless in-person medical appointments are required. Subrecipients are providing remote services as possible. COVID-19 has also caused unemployment rates to soar, economic devastation for many, as well as an increase in cases of depression. The effects of racism are seen in the social determinants of health as drivers of the disparities seen in health outcomes for Black/African American men and women in the MSP-TGA. The death of George Floyd in Minneapolis, at the center of the MSP-TGA, caused chaos and catalyzed critical conversations and changes to address the roots and effects of racism. The MSP-TGA continues to integrate data driven decision making, participatory processes, community engagement, continuous improvement, and disparities elimination systemwide. The range of services funded is designed to promote: early identification of individuals who are unaware of their HIV status; rapid linkage to the best-quality HIV medical care and antiretroviral treatment; re-engagement in care; health education and literacy; retention in care and treatment adherence; and address social and cultural barriers for rapid movement along the HCC to achieve sustained viral suppression. Hennepin County, the MSP-TGA's Part A recipient, is requesting $6,159,626 in Part A and MAI funds for FY 2021 to achieve these objectives.

- *NEEDS ASSESSMENT*

A. Demonstrated Need

1) Epidemiological Overview

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

The Minneapolis-St. Paul Part A Transitional Grant Area (MSP-TGA) comprises eleven counties in Minnesota (MN) and two counties in western Wisconsin (WI) with the cities of Minneapolis and St. Paul at its center. The estimated population of the MSP-TGA in 2019 is 3,584,879. The outer counties are suburban and rural. The 11 TGA counties in MN, including Hennepin and Ramsey Counties, comprise 61% of MN's population of 5,639,632. Minneapolis and St. Paul are the MSP-TGA's and MN's two largest cities. Hennepin and Ramsey Counties alone comprise 32% (1,816,164) of MN's population. The MSP-TGA's population is 74% white, 8.7% Black (including an estimated 128,357 African-born immigrants), 6.0% Latinx, 7.0% Asian/Pacific Islander (API), 0.4% American Indian, and 3.5% other or multi-racial. The greatest concentrations of Blacks (African American and African-born), Latinx, API, and men who have sex with men (MSM) in MN reside in Hennepin and Ramsey Counties, and Minneapolis has the third largest urban population of American Indians in the U.S. The proportion of males estimated to be MSM throughout the MSP-TGA is 6% with higher percentages of males who are MSM in Minneapolis (11%) and in Hennepin and Ramsey Counties (8%).

There were 227 newly diagnosed cases of HIV infection in the MSP-TGA reported to the MN Department of Health (MDH) and Wisconsin Department of Health Services in 2019. MN's HIV epidemic is highly concentrated in the Minneapolis-St. Paul metropolitan area. Eighty-two percent (226/275) of new cases in MN reside in the eleven MN counties of the MSP-TGA.

There were 7,836 diagnosed people with HIV (PWH) in the MSP-TGA as of December 31, 2019. The 11 MN counties represent 85% (7,788/9,193) of MN's HIV prevalence. The greatest concentration of PWH in the MSP-TGA is in the core urban center with 61% (4,804/7,836) residing in Hennepin County and 40% (3,167/7,836) in Minneapolis alone. Eighteen percent (1,429/7,836) live in Ramsey County, and suburban areas of the MSP-TGA account for 17% (1,358/7,836) of its living HIV cases. The remaining PWH in the MSP-TGA (3.1%; 244/7,836) reside in the six rural counties, with less than one percent (0.4%; 48/7,836) residing in the two WI counties. ***Attachment 13B*** presents a map of HIV prevalence in the MSP-TGA as of December 31, 2019.

b) Socio-demographic Characteristics

i. Demographic Data

(1) Persons newly diagnosed. ***Attachment 3A*** presents HIV incidence data for the MSP-TGA from 2015 to 2019. The HIV epidemic in the state and MSP-TGA remains largely male, with 70% of the 227 new cases in 2019 in the MSP-TGA among males, 72% (113/156) of whom are MSM or MSM who also inject drugs (MSM/IDU). There were nine diagnoses among transgender people in the MSP-TGA. The number of transgender individuals varies year to year partly due to inconsistent reporting from diagnosing facilities to state health departments. The state health departments attempt to determine the current gender identity (chart abstraction and disease investigation) for all newly diagnosed and reported infections, but the information is not always available.

HIV disproportionately impacts people of color in the MSP-TGA, most notably Blacks including African Americans and African-born individuals. Blacks comprised 41% of new diagnoses in 2019, while they make up only 8.7% of the TGA's population. Among new cases of HIV infection in 2019, 15% were Latinx, 4.0% were Asian/Pacific Islanders, 3.5% were

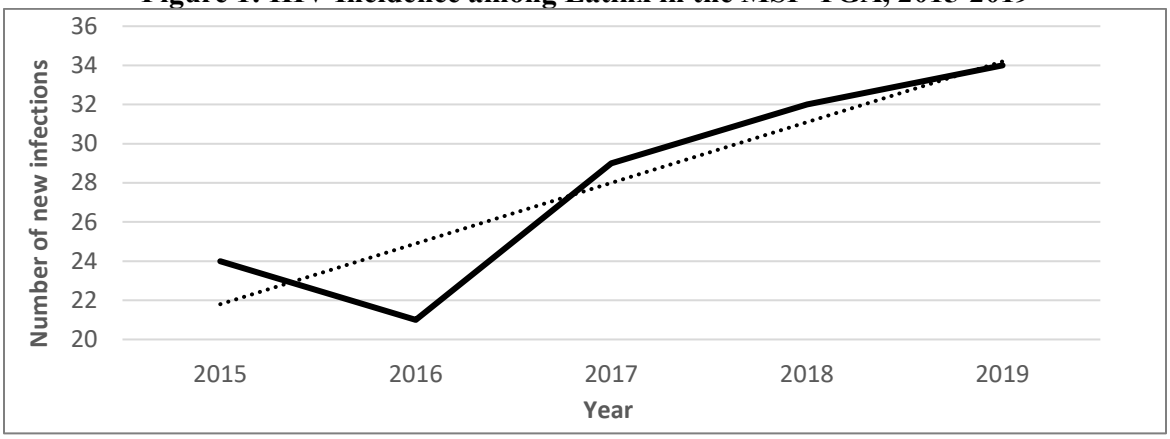
American Indian/Alaska Natives, 2.6% were multi-racial, and one case (0.4%) was an "other" or unknown race. The remaining 33% were White, non-Hispanic.

Among women, the majority of the 62 new diagnoses in 2019 were women of color, 40% among Black/African-born women and 16% among Black/African American women. Since 2015, the number of new infections among Black/African American women averaged 11 new cases per year (high 15, low 10). Since 2015, the number of new infections among Black/African-born women averaged 29 infections. Black/African-born men peaked in incidence with 33 cases in 2016 decreasing to 9 cases in 2019. Overall, African-born incidence peaked at 66 cases in 2016 and declined to 35 cases in 2019. Unlike other racial/ethnic groups, the primary mode of transmission among the African-born community is through heterosexual contact.

This decrease in incidence rates for the Black/African-born population is evaluated in the context of late testers among foreign-born individuals. While the decline in the number of foreign-born individuals diagnosed with HIV from 91 cases in 2015 to 66 cases in 2019 is largely due to the decline in African-born cases, the number of late testers (defined as a person progressing to AIDS within a year of initial HIV diagnosis) remained flat with 25, 23, 21, 16, and 22 cases in 2015-2019, respectively. New foreign-born cases from 2015-2019 were from 60 countries with Cameroon, Ethiopia, Kenya, Liberia, Mexico, Nigeria, Somalia, and Vietnam having at least 10 cases within this five-year span.

HIV incidence among Latinx increased from 2015 to 2019, with 24 and 21 cases in 2015 and 2016, respectively, followed by 29, 32, and 34 cases in 2017, 2018, and 2019, respectively (**Figure 1)**. This illuminates a troublesome trajectory as Latinx take on an increasing burden of the HIV epidemic. In 2015, Latinx accounted for 8.7% of newly diagnosed cases, rising to 15% of new cases in 2019.

Figure 1: HIV Incidence among Latinx in the MSP-TGA, 2015-2019



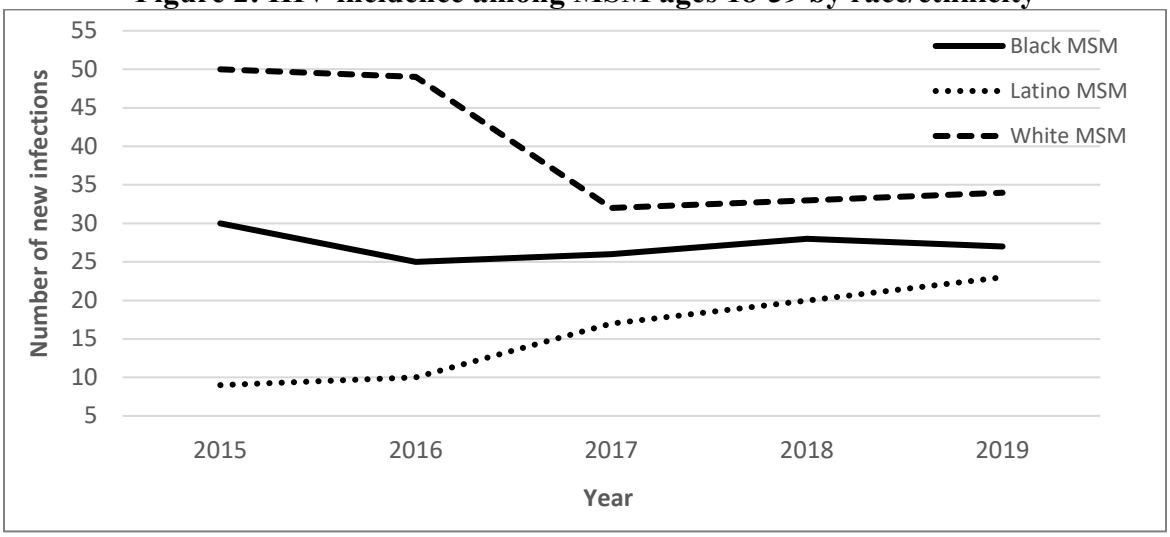
Incidence rates for Black/African American remained persistent at an average of 59 cases annually (low: 55, high: 65) in 2015 – 2019. HIV disparities for Latinx and Black/African Americans are significant compared to Whites. For White, non-Hispanics, 2015 represented a five-year high of 104, falling to 75 cases in 2019.

MSM ages 18-39 accounted for 81% (91/113) of all MSM cases in 2019. Similarly, younger adults (ages 18 - 39 years) accounted for 70% (160/227) of new infections. This contrasts with MSM ages 40+, where incidence has fallen from 38 cases in 2015 to 20 cases in 2019, with no incident cases among Blacks and 3 cases among Latinx in 2019.

In 2015 among MSM, men of color represented 44% (62/142) of new infections. In 2019, 54% (60/112) of new infections among MSM were men of color with Black/African American

accounting for 25% and Latinx accounting for 23% of new infections. Furthermore, Latino MSM have had rising incidence since 2015 (**Figure 2**). Incidence among Black/African American MSM is persistently at 31 cases (low: 28, high: 34) from 2015-2019. Much like race/ethnicity overall, this contrasts with white MSM ages 18-39 where incidence has fallen from 50 in 2015 to 34 in 2019. Examining the intersectionalities of race/ethnicity, age, and sexual behavior clearly shows that Latino MSM and Black/African American MSM ages 18-39 (**Figure 2**) continue to experience a disproportionate burden of new HIV infections in the MSP-TGA and are prioritized in the RWHAP's disparities elimination efforts.

Figure 2: HIV incidence among MSM ages 18-39 by race/ethnicity



Finally, in February 2020, the MN Department of Health (MDH) announced an HIV outbreak among people who inject drugs (PWID), most of whom were *not* MSM. These cases have all occurred within Hennepin and Ramsey Counties. In ***Attachment 3A***, there is a noticeable increase from 8 PWID cases in 2018 to 20 PWID cases in 2019. This ongoing outbreak, as defined by CDC surveillance methodology, began in December 2018. HIV DNA molecular cluster analysis is in progress which may help further identify networks where HIV is spreading rapidly. As of August 2020, there have been at least 26 cases (and an additional 2 probable cases) identified in this cluster.

(2) People living with HIV. ***Attachment 3B*** presents HIV prevalence data for the MSP-TGA from 2015 to 2019. As of December 31, 2019, there are 7,836 diagnosed PWH in the MSP-TGA. From 2015 to 2019, overall HIV prevalence increased by 11%. Of the living cases in the MSP-TGA, 44% had an AIDS diagnosis, while 56% had a (non-AIDS) HIV diagnosis. By gender, 74% of the MSP-TGA's PWH are male, 25% are female, and 1.3% are transgender. Among males living with HIV, 75% are MSM or MSM/IDU. Greater than half of PWH in the MSP-TGA are people of color with 22% Black/African American, 17% Black/African-born, 11% Latinx, 1.0% American Indian/Alaska Native, 2.3% Asian/Pacific Islander, 3.8% of multi-racial backgrounds, and 0.3% with an "other" or unknown racial background. Forty-three percent are White. Among women living with HIV in the MSP-TGA, 68% are Black with 25% Black/ African American and 42% Black/African-born. The largest age group among PWH in the MSP-TGA are people 50 years or older comprising 50% of the population of PWH. Eight percent of PWH in the MSP-TGA are between the ages of 13 and 29, 20% between 30 and 39, and 22% between 40 and 49. People younger than 13 years comprise less than 1% of PWH.

Comparing demographics of the MSP-TGA's population with that of the population of diagnosed PWH shows that people of color, including Blacks (African American and African-born), Latinx and American Indians, along with MSM, carry the greatest burden of HIV disease based on prevalence. According to the most recent American Community Survey (ACS), 5.5% of people in the MSP-TGA were Black/African American, 3.3% Black/African-born, and 6.0% Latinx. An estimated 3% of the MSP-TGA's population are MSM (6% of the male population). The following table compares select demographic groups represented in the MSP-TGA's population with representation among diagnosed PWH and presents 2019 HIV prevalence rates. In line with the MDH, these prevalence rates are calculated using 2010 Census population data.

Table 1. Minneapolis-St. Paul TGA Population and HIV Prevalence Rates in 2019

Demographic Group	% of TGA Population	% of Diagnosed PWH	HIV Prevalence Rate**
Hispanic (all races)	6.0	10.5	467
American Indian/Alaska Native	0.4	1.0	423
Asian/Pacific Islander	7.0	2.3	97
Black/African American	5.5	21.8	1,279‡
Black/African-born	3.3	17.2	
White	74.0	43.0	130
Multiracial	3.5	3.8	401
MSM*	9.2	62.0	2,770
Overall	100	100	239

*Includes MSM/IDU. For Hennepin County only. MSM population estimated using 2010 Hennepin County SHAPE data. ** Per 100,000 persons. Population denominators from 2010 Census. ‡Prevalence rate for all Blacks (African American and African-born) calculated together.

The MSM prevalence rate was calculated for Hennepin County only due to the stability of the county estimate compared to the estimate for the entire MSP-TGA. MSM have the highest prevalence rate of any demographic group. MSM have a HIV prevalence rate 16 times higher than non-MSM. The next highest prevalence rates (for the entire MSP-TGA) are Blacks, Latinx American Indians, and those that identify with multiple races. Whites and Asian/Pacific Islanders have a prevalence rate below the overall rate of 239 per 100,000. Fifty-five percent of diagnosed PWH in the MSP-TGA are MSM or MSM/IDU. Among all MSM living with HIV, 62% are White, 19% Black, 12%, Latinx, 2% Asian/Pacific Islander, less than 1% American Indian/Alaska Native, and 4% multiracial. Black/African American MSM carry a relatively heavy HIV burden among MSM in the MSP-TGA. Fifty-two percent of MSM living with HIV are ages 50 and older, 19% are 40-49, 20% are 30-39, 7.3% are 25-29, and 1.9% are 13-24.

The prevalence rate among Blacks is 9.8 times that of Whites. Among Black/African-born PWH, women have a greater disease burden with the mode of HIV exposure being primarily heterosexual contact. Black/African-born is the only racial/ethnic group where the number of females (812 cases) exceeds the number of males (534 cases). Geographically, HIV disease burden is greatest in Minneapolis (see ***Attachment 13B: HIV Prevalence and Services Map***). HIV prevalence is highest in the central, south-central, and northern sectors of the city where MSM, Black/African Americans, Black/African-born, and Latinx 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 MSP-TGA indicate that the populations at higher risk of acquiring HIV are MSM (particularly those MSM under 40, Latino, and/or Black) and people who inject drugs (PWID). While HIV incidence is declining among white MSM, it is increasing among Latino MSM while new cases among Black/African American MSM are persistently steady (**Figure 2, p 5**). Latino and Black/African American MSM are significantly overrepresented among PWH in the MSP-TGA. A similar trend exists for MSM ages 18-39

compared to MSM ages 40+. MSM ages 18-39 accounted for 81% of all new MSM cases in 2019. This is contrasted with MSM 40+ who have seen declining incidence in 2015 to 2019, including having no cases among Black MSM and 3 cases among Latino MSM 40+ in 2019. The low number of incident cases, while promising, should be considered in the context of the low number of publicly funded tests for Latino MSM and Black MSM who are 40+. In 2019, 32 tests were conducted with Latino MSM and 161 with Black MSM who were 40+. In low-to-moderate incident states like Minnesota, there are insufficient resources to find all people living with HIV but unaware of their status. Additionally, the RWHAP closely monitors populations experiencing lower rates of viral suppression. Based on the MSP-TGA's HIV Care Continuum in 2018 (the most recent year available), Black/African American MSM (56%) experienced lower viral suppression rates than White MSM (69%), indicating that this population may be at higher risk for HIV transmission. Although Latino MSM (70%) are virally suppressed at a comparable rate to White MSM, incidence continues to increase among Latino MSM.

Finally, in February 2020, an HIV outbreak was announced by the MN Department of Health among people who inject drugs (PWID) in Hennepin and Ramsey Counties. Twenty-six cases (with 2 additional probable cases) were identified in this ongoing outbreak from December 2018 to August 2020. Most PWID in this outbreak are experiencing homelessness. With increasing rates of homelessness in the MSP-TGA due to the COVID-19 pandemic and the related economic downturn, PWID are at high risk for HIV infection.

ii. Socioeconomic data.

Table 3 on page 12 presents income as a percentage of Federal Poverty Level (FPL) and health insurance status of the MSP-TGA's population and population of diagnosed PWH.

Income and Poverty**.** According to the American Community Survey (ACS), in 2019 (the most recent year available), an estimated 13% of the MSP-TGA were living below 138% of the FPL, the threshold to be Medicaid-eligible in Minnesota (MN). According to the US Census Bureau, the median household income in 2019 for the United States was $65,712 and $74,593 in MN.

Despite these favorable numbers, income inequality and the impact of poverty on persons of color in MN is striking. Income inequality by race/ethnicity is more pronounced in MN compared to rest of the nation. According to the ACS, the median household income for White Minnesotans is $77,311 compared to $41,570 for Blacks, $40,051 for American Indians, and $57,591 for Latinx.

Education. MN's emphasis on education is reflected in the low statewide percentage (6.4%) of people aged 25 years or older who have less than a high school education; the national average is 11%. The percentage of persons with less than a high school education is greater for people of color in MN. According to the 2019 ACS, 14% of Black men and 22% of Black women have less than a high school education compared to 4.6% and 3.4% of white men and women, respectively. High school graduation rates are even lower among Latinx, with 26% and 24% of Latinx men and women, respectively, not having a high school diploma.

Health Insurance. Overall, MN has one of the lowest rates of uninsured residents in the nation with the lowest rate on record in 2015. According to data released from the most recent Minnesota Health Access Survey (2017), 6.4% 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 2007. The findings suggest that significant disparities continue to exist by race/ethnicity, age, income and country of birth. Minnesota achieved its lowest percentage of uninsured residents in 2015 at 4.3%. The 2% increase in the percentage uninsured in 2017 is attributable to the roll back of

provisions of the Patient Protection and Affordable Care Act that began in 2017 including elimination of the individual mandate, which drove up insurance premiums in Minnesota.

Based on MN CAREWare data, among PWH in the MSP-TGA who received a Ryan White Program (RWHAP) Part A or B funded service in 2019, 9.7% were uninsured, although many who are insured have out-of-pocket costs that can create economic barriers to accessing health care. More than 1 in 4 (27%) of the MSP-TGA's RWHAP clients accessed Part A funded outpatient ambulatory health services in 2019 either because they were uninsured or had high out-of-pocket deductibles, copayments, or co-insurance.

Language Barriers**.** With Black/African-born individuals and Latinx being disproportionately impacted communities, language barriers exist for many PWH. English is a second language for many of the MSP-TGA's 28% foreign-born PWH, and access to HIV 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. An examination of HIV incidence in the MSP-TGA between 2015 and 2019 shows the number of new HIV diagnosed cases rose among Latino MSM (**Figure 2, p 5**) and people who inject drugs. Latino MSM incidence nearly doubled (14 cases to 26 cases) from 2015 to 2019. Fifty-four percent of these Latinx cases were foreign-born in 2019 and may face additional barriers to care due to linguistic and cultural needs, and the impact of increasing anti-immigrant sentiment nationwide.

In February 2020, the MN Department of Health announced an HIV outbreak among people who inject drugs (PWID). This outbreak resulted in an increase from 8 IDU cases in 2018 to 20 IDU cases in 2019, as shown in ***Attachment 3A***. This ongoing outbreak in Hennepin and Ramsey Counties includes at least 26 cases (with two additional probable cases) between December 2018 and August 2020. There are underlying socioeconomic factors placing individuals at higher risk to acquire HIV as part of this outbreak. Most of the individuals in the HIV outbreak are homeless. Due to the COVID-19 pandemic and related economic downturn, the MSP-TGA has seen an increase in people experiencing homelessness. In addition to the lack of safe, affordable housing, the COVID-19 pandemic has complicated the efforts of public health departments to provide effective harm reduction services, including syringe exchange services. Disease investigators determined that persons likely to be at high risk include sex partners or syringe-sharing partners of outbreak related cases, PWID and their sex partners and needle/equipment sharing partners, and persons who exchange sex for income or other items they need. New cases continue to be identified. This population presents significant challenges in providing HIV medical care and supportive services needed to advance newly diagnosed individuals along the HIV care continuum, in turn preventing new HIV infections and ending the outbreak.

HIV incidence among Black/African American MSM remains disproportionately high with an average of 31 cases each year (**Figure 2, p 5**). The health inequities and public health challenges are amplified by the group's low rate of viral suppression (56%). Another critical issue is the 31% increase in HIV prevalence (1,026 to 1,346) among the MSP-TGA's African-born population between 2015 and 2019. The African-born population has been growing since late 1990s when Minnesota became one of six states in the U.S. to resettle African immigrants with HIV from refugee camps in East Africa. Over 100 countries of birth are represented among the MSP-TGA's population of PWH. The RWHAP works to ensure linguistically appropriate and culturally responsive services for the diverse African-born population. HIV related stigma among this population further complicates the RWHAP's efforts eliminate disparities.

Estimating the annual cost of providing Part A, Part B, and ADAP services for new clients entering the HIV system based on the proportion of the MSP-TGA's PWH who utilize RWHAP services is possible. In FY19, 41% of diagnosed PWH in the MSP-TGA received Part A funded services at an average cost of $1,641 per service recipient. Fifty-two percent of the MSP-TGA's diagnosed population of PWH received a Part A, Part B, or ADAP 340B rebate funded service in FY19 at an average annual cost per client of $2,549. Individual client costs based on their need will vary. Part A per client costs for early intervention services (EIS) to reach the undiagnosed or outreach services to re-engage PWH in care who are not receiving HIV medical care were $3,288 and $14,604, respectively. If 41% of the MSP-TGA's 227 people diagnosed with HIV infection in 2019 (92) accessed Part A funded services, the cost incurred for these services would be $150,972. If 52% of the MSP-TGA's new cases (119) needed Part A, B or rebate funded services, the total cost would be $303,331. Given the significant challenges in accessing HIV testing and services for the subpopulations that had increases in HIV incidence in the last five years, annual costs for each newly diagnosed PWH is likely higher.

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

In the past five years, the number of diagnosed PWH in the MSP-TGA increased by 774 with an average annual prevalence increase of 2.6%, and a 2.1% increase (164) in living cases in 2019.

The following table presents Part A funded RWHAP service utilization in the MSP-TGA including the proportion of the MSP-TGA's diagnosed population of PWH that received each of the funded services and the cost per client:

Table 2. FY 2019 Part A Service Utilization, Cost Per Client, and Expenditure

Service Category	Unduplicated Clients Served	% of Diagnosed PWH	Part A Cost per client	Total FY19 Expenditure
Early Intervention Services	77	1.0%	$ 3,288	$ 253,148
Food Bank/Home-delivered Meals	1,258	16.1%	616	775,454
Health Education/Risk Reduction	152	1.9%	755	97,469
Home and Community-based Health Services	27	0.8%	4,160	112,318
Housing Services	75	1.0%	3,537	265,263
Legal Services (Other Professional Services)	259	3.3%	362	93,826
Linguistic Services	3	0.04%	2,110	2,320
Medical Case Management	1,631	20.8%	1,290	2,104,428
Medical Nutrition Therapy	244	3.1%	166	40,451
Mental Health Services	298	3.8%	412	122,786
Outpatient Ambulatory Health Care Services	1,173	15.0%	831	974,452
Psychosocial Support	146	1.9%	571	83,304
Outreach Services	10	0.1%	14,604	146,038
Substance Abuse Services: Outpatient	276	2.6%	506	139,707
Total Unduplicated	3,178	40.5%	$ 1,641	$ 5,214,973

Assuming the proportion of diagnosed PWH in the MSP-TGA who utilize Part A funded services remains at 41% and a five-year average annual increase in HIV prevalence of 2.6%, a minimum increase of $342,992 in Part A funding (based on FY19 service costs) is needed for FY21 to meet the needs of the same proportion of RWHAP eligible population in the MSP-TGA that received services in FY 2019. In 2019, 97% of Part A Program clients were retained in HIV medical care and 90% were virally suppressed. Eighty-six percent of those receiving early intervention or outreach services were linked to care within 30 days. Given that an estimated 74% of the MSP-TGA's population of PWH are income eligible for RWHAP services (**Table 3, p 12**), an even greater Part A Program capacity increase would improve the MSP-TGA's HIV

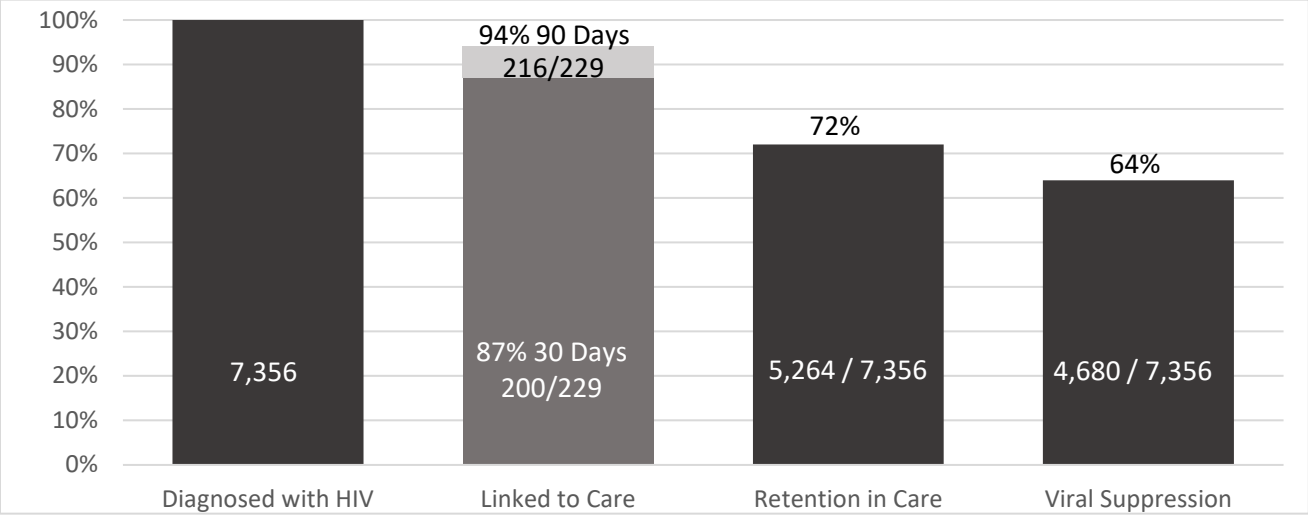
Care Continuum if a greater proportion of eligible PWH access the services allocated Part A funds by the Minnesota Council for HIV/AIDS Care and Prevention. Increasing the percent of diagnosed PWH in the MSP-TGA who access Part A funded RWHAP services by 10% (from 41 to 51% of PWH in the TGA) would cost an additional $1,285,887, using the average 2019 cost per client who accessed one or more Part A Program service. This would require a Part A grant award of $7,152,073 for the MSP-TGA in FY 2021.

2) HIV Care Continuum

a) Graphic Depiction of the HIV Care Continuum. The most recent estimate available (2018) of the population of PWH in Minnesota, both diagnosed and undiagnosed, is 9,662, with 90.1% of PWH aware of their status. For the HIV care continuum, diagnosed with HIV is defined as persons diagnosed with HIV through year-end 2017 who are 13 or more years of age and were alive at year-end 2018. The MN Department of Health (MDH) releases an estimate of the PWH who are undiagnosed statewide and not for a jurisdiction within the state, hence an official estimate of the undiagnosed population of people with HIV for the MSP-TGA is not available.

To develop an unofficial estimate, the Part A recipient used the following methodology. Eighty-five percent of Minnesota's prevalent cases reside in the 11 MN counties of the MSP-TGA. Using the undiagnosed estimate of 9.9% and applying it proportionally to the MSP-TGA's diagnosed prevalent cases 13 years or older included in the 2018 care continuum (n = 7,356) yields an undiagnosed estimate for the MSP-TGA in 2018 of 812. The following discussion uses a jurisdictional *diagnosis-based* HIV care continuum for the population of PWH residing in the MSP-TGA. **Figure 3** depicts the entire MSP-TGA including the Wisconsin counties. Demographic breakdowns later in the section were only available for the eleven Minnesota counties, where greater than 99% of the prevalent cases reside.

Figure 3: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2018



The linked to care denominator includes all PWH diagnosed in the MSP-TGA during 2017. The numerator is the number of PWH diagnosed in 2017 who were linked to care within 30 or 90 days of diagnosis indicated by a viral load test or CD4 count conducted within the designated period and reported to MDH or the Wisconsin Department of Health Service (WI-DHS). The retention in care and viral suppression denominator includes all PWH 13 or more years old diagnosed with HIV as of December 31, 2017, and still alive and living in the MSP-TGA as of December 31, 2018. The numerator for retention in care is all PWH 13 years of age or older

living in the MSP-TGA who had at least one viral load or CD4 count performed in 2018 and reported to MDH or WI-DHS. Finally, the numerator for viral suppression is all PWH 13 or more years old living in the MSP-TGA whose last reported viral load in 2018 was less than 200 viral copies/mL of blood. Prescribed antiretroviral therapy (ART) is not included in MN's nor WI's mandated HIV surveillance reporting rules, and there are no reliable data sources to obtain this stage of the HCC for all persons living with diagnosed HIV in the MSP-TGA.

For those diagnosed in 2017, linkage to care was 87% (200/229) within 30 days. Additionally, 94% (216/229) of all those diagnosed were eventually linked to care within 90 days. Denominators for subpopulations were not large enough to analyze disparities for linkage to care. Seventy-two percent (5,264/7,356) of diagnosed PWH in the MSP-TGA are retained in care, and 64% (4,680/7,356) are virally suppressed.

b) Viral Suppression Rates for Three Most Disproportionally Impacted Minority Populations. Analysis of surveillance data by race/ethnicity, gender, age, and mode of exposure reveal disparities among several subpopulations of PWH in the MSP-TGA. Three groups show the greatest disparity in relation to viral suppression: Black/African American MSM, Black/African-born men, and Black/African American women. For each of these subpopulations, retention in care and viral suppression is disaggregated by age. Age groups were combined, so the denominator/population sizes were greater than 100. This ensures the percentages are statistically reliable and protects the privacy of individuals in these groups.

Black/African American MSM experience one of the greatest disparities being retained in care below 70%, and virally suppressed at 56%. Despite being retained in care at similar rates across the age groups, viral suppression is significantly lower in those under 35.

African American MSM by Age Group	**Retention in Care**	**Viral Suppression**	**Population Size**
13-29	69%	50%	183
30-34	71%	51%	105
35-49	72%	59%	187
50+	67%	60%	265
African American MSM Overall	**69%**	**56%**	**740**

Among RWHAP clients, 11% of Black/African American MSM experience unstable housing compared to 6% of all MSP-TGA Ryan White clients. For Black/African American MSM, the RWHAP is adopting a community participatory approach to reduce the population specific unmet needs, including engagement with faith leaders, providing trauma informed care, and addressing the intersectionality of racism and homophobia. This work is made possible through a HRSA capacity development grant.

Black/African-born men also experience disparities in viral suppression. For Black/African-born men, the disparity is greatest for those ages 40-49.

African-born Men by Age Group	**Retention in Care**	**Viral Suppression**	**Population Size**
13-39	69%	59%	133
40-49	63%	55%	145
50+	66%	60%	217
African-born Men Overall	**66%**	**58%**	**495**

Black/African-born men receiving Ryan White services were uninsured at a higher rate (12%) compared to 9.7% for all Ryan White MSP-TGA clients. For African-born men and women, the RWHAP is working with civil society leaders, including public health scholars, to provide population specific culturally responsive trainings ranging from cultural health norms to mental health stigma. This work is made possible through the HRSA capacity development grant.

When women are stratified by racial/ethnic groups, Black/African American women have the lowest viral suppression rate at 60%. Among Black/African American women, viral suppression is lowest in teens and young adults (50%), with viral suppression improving with age.

African American Women by Age	Retention in Care	Viral Suppression	Population Size
13-39	71%	50%	149
40-49	69%	57%	121
50+	76%	68%	203
African American Women Overall	**73%**	**60%**	**473**

Black/African American women in the RWHAP have a higher uninsured rate (12%) compared to 9.7% for the RWHAP overall. Similar to Black/African American MSM, the RWHAP is adopting a participatory approach to identify specific needs for Black/African American women. This includes working with community faith leaders, ensuring Ryan White subrecipients are trained in trauma informed care, and addressing the intersectionality of racism and sexism.

3) Co-occurring Conditions. Quantitative evidence describing conditions co-occurring with HIV in the MSP-TGA are presented in ***Attachment 4.***

4) Complexities of Providing Care

a) Impact and Response to Reduction in RWHAP Formula Funding. i. Impact: The MSP-TGA's Part A formula funding decreased in FY20 by only 0.1% or $4,112 from $3,675,623 in FY19 to $3,671,511. All Minnesota Council for HIV/AIDS Care and Prevention allocations for services were sustained and no services were reduced or eliminated. ii. Response: Small decreases in grant administration and CQM budgets absorbed the slight decrease in funding. No cost containment measures were needed.

b) Poverty and Health Care Status of PWH in the MSP-TGA. The following table compares current estimates of: i) enrollment in publicly funded healthcare programs; ii) insurance status; and iii) income of the overall population and of people diagnosed with HIV (PWH) in the MSP-TGA. Insurance percentage totals for the overall population and for PWH exceed 100% because of dual enrollment in Medicaid and Medicare and insurance churning from one plan to another.

Table 3. Poverty and Health Care Coverage for the MSP-TGA Population and Diagnosed PWH

	TGA	%	PLWH	%	Data Source
Total Population	**3,584,879**	**100%**	**7,836**	**0.2%**	ACS^, MDH*
Health Insurance					
Medicare	575,783	16%	1,195	15%	CMS Dashboard^{c}, MNCAREWare¥
Medicaid	800,345	22%	2,937	37%	DHS**, MNCAREWare¥
MinnesotaCare (Basic Health Plan)	71,650	2.0%	621	7.9%	DHS**, MNCAREWare¥
Qualified Health Plan (*MNSure*)	70,223	2.0%	175	2.2%	DHS**, MNCAREWare¥
Other Private (Group & Individual)	2,034,164	57%	2,997	38%	MN Health Access Survey (2017) MNCAREWare¥
Uninsured	228,034	6.4%	635	8.1%	MN Health Access Survey (2017) MNCAREWare¥
Income as % of FPL (up to/cumulative↓)					
138% (Medicaid eligible)	478,293	13%	3,118	40%	ACS^, MNCAREWare¥
200% (MinnesotaCare eligible)	755,529	21%	3,972	51%	ACS^, MNCAREWare¥
300%	1,214,545	34%	4,994	64%	ACS^, MNCAREWare¥
400% (RWHAP and APTC^{t} eligible)	1,701,191	47%	5,828	74%	ACS^, MNCAREWare¥

^U.S. Census Bureau American Community Survey Public Use Micro sample (2019), *MN Department of Health eHARS (2019), ^{c}CMS/Office of Enterprise Data & Analytics Medicare Dashboard (2018), ¥State of MN and MSP-TGA RWHAP client-level database (2019), **MN Department of Human Services - Minnesota Medicaid Information System (2019), ^{t}Advance Premium Tax Credit.

Minnesota (MN) 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, 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, MN's rate of uninsured residents is lower than the nation with 6.4% uninsured in 2019 compared to eight percent in 2013. Minnesota's uninsured rate remained steady between 2018 and 2019. Increased enrollment in publicly funded state health insurance, primarily Medicaid, drove the increase in insurance coverage in MN following implementation of health care reform. MN's uninsured rate hit a low of 4.3% in 2016, and slowly increased since. The percentage of PWH in the MSP-TGA who are uninsured exceeds that of the general population by 1.7 percent.

The greatest benefit for the MSP-TGA's population of PWH was the expansion of Medicaid through the elimination of categorical eligibility and the increase in the income limit. Currently, one in four MSP-TGA residents rely on Medicaid or MinnesotaCare. Coverage through *MNSure*, MN's state-based marketplace, covers two percent of the MSP-TGA's residents on individual or small group coverage. In addition, 57% of the TGA's population relies on group insurance primarily through employers for their health care coverage. Currently, there are an estimated 4,753 PWH (61%) in the MSP-TGA covered under Medicare, Medicaid or MinnesotaCare (Basic Health Plan) as of December 31, 2019. An additional 175 of the MSP-TGA's PWH 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 in the health care landscape over the past 7 years, the uninsured rate among the MSP-TGA's RWHAP recipients remained relatively unchanged at five percent prior to 2017. This percentage increased to seven percent in 2017 and 2018, and increased again in 2019 to eight percent.

Minnesota's ADAP covers premiums, prescription deductibles, and co-payments for PWH with incomes up to 400% of FPL for private health plans including QHP's obtained through *MNSure* and cost effective off-Exchange plans that provides comprehensive coverage. All QHPs that ADAP purchased in 2020 are Gold and Bronze level plans that include all the essential health benefits without restrictions on antiretroviral medication (see **Table 4, p 36**).

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

Factors That Limit Access

Complexity of health insurance system. While the ACA in Minnesota resulted in a significant increase in access to affordable health care for the broader community and PWH, it created a more complex system of obtaining coverage. The complexity is especially challenging for those struggling to meet their basic needs, have limited English proficiency, or are experiencing homelessness, substance use disorder, or mental illness. Limited open enrollment periods exacerbate temporary loss of coverage and access to HIV medical care due to changing circumstances, including income fluctuation, that impact eligibility for health coverage. People with HIV born outside the U.S. who are ineligible for publicly funded or subsidized health care coverage may be unaware of ADAP and health insurance premium assistance. People with HIV who purchase insurance through *MNSure* often experience annual plan changes, including changes in provider networks and increases in deductibles and co-pays. Loss of employment and employer sponsored health insurance as a result of the COVID-19 pandemic may force some PWH to obtain a QHP through *MNSure* and that may increase out-of-pocket costs.

The complex health insurance system for the MSP-TGA's PWH makes continuity of coverage challenging, resulting in increased reliance on RWHAP services to assist PWH in obtaining coverage and filling gaps. The short annual open enrollment period for obtaining QHPs through *MNSure*, results in coverage gaps depending on when PWH need to obtain coverage. Beginning in 2018, the open enrollment period for coverage was shortened and in 2020 it is only seven weeks. Qualified Health Plan changes may require PWH to change their plan annually, increasing the risk of losing coverage or resulting in the inability to continue care at their provider of choice. The council's 2015 Comprehensive Needs Assessment (CNA) indicates that a trusted health care provider plays a critical role in access and retention in care. Of the 504 respondents to the CNA survey, the two most important factors were knowledgeable medical providers (84%), and a sense that clinic staff cared about them (70%).

Geography of residence. The MSP-TGA includes two counties in western Wisconsin (WI), Pierce and St. Croix. There were 48 individuals known to be living with HIV in these two counties as of December 31, 2019. Wisconsin has not fully implemented the ACA and is one 12 states that has not expanded Medicaid, so health care access may be more limited for the Wisconsin TGA. Low-income WI 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 WI's ADAP to cover premium and prescription drug costs and other RWHAP programs such as the MSP-TGA's Part A funded outpatient ambulatory health services and Part C and D programs, and WI's Part B, C, and D funded health care services. Accessing Part A funded OAHS may be difficult for WI residents since the three Part A providers are located in the Twin Cities metro area requiring long distance travel to medical appointments. One hundred ninety-six PWH in the MSP-TGA reside in the exurban Minnesota counties of the MSP-TGA, of which 62 received RWHAP in 2019, and live more than 20 miles from where services are concentrated (***see Attachment 13B***). Along with those living in the two WI counties, they are less likely to have the resources for transportation to access needed services.

Poverty and out-of-pocket health care costs. The 2015 CNA indicates that for some, poverty still results in poor health care access despite expansion of affordable insurance options. Almost 10% of survey respondents were denied medical care because they were uninsured or couldn't afford their co-payment. Among the MSP-TGA's PWH who received RWHAP services in FY2019, 79% had an income at or below 200% of the FPL. For 21% of the 2015 CNA respondents, the RWHAP or their clinic covered the cost of their care. In 2017, many of MN's QHPs changed the structure of their deductibles so they no longer apply towards prescription drug costs, resulting in higher out-of-pocket health care costs for RWHAP eligible PWH since MN'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 MN's uninsured in the areas of race/ethnicity, age, and country of birth. According to the Minnesota Health Access Survey, whereas 4.6% of Whites were uninsured in 2017, the percentages among Latinx (21.8%), Blacks (12.8%), American Indians (10.6%), and Asians (10.3%) were considerably higher. Racial and ethnic disparities in access to health care are evident among the MSP-TGA's PWH. Of the 2015 CNA respondents, 31% reported difficulty signing up for insurance, with higher rates in racially and culturally specific populations including American Indian/Alaska Native (44%) and Latinx (41%). Twenty-eight percent of PWH reported that they didn't have health insurance for three months or longer since they

received their HIV diagnosis, with higher rates for American Indians (42%), API (33%), and Latinx (48%). Overall, 63% of PWH who participated in the CNA survey reported receiving assistance in paying health insurance premiums, while 66% of American Indian/Alaska Natives and 79% of Latinx reported receiving assistance for premiums. Nineteen percent of American Indian/Alaska Native and Latinx and 20% of API respondents reported they had been denied medical care because they could not pay for treatment due to not having insurance compared to only 3% of Black respondents and 2% of White respondents.

Minnesotans born outside the U.S. are uninsured at a rate three times higher than those born in the U.S. PWH without citizenship or permanent residency status are not eligible for publicly funded health care and need help navigating the private insurance market and enrolling in ADAP to cover premiums and out-of-pocket prescription costs. Minnesota's ADAP will purchase a private health insurance plan on the off-exchange market for PWH who are categorically ineligible for Medicaid, Minnesota Care, or a Qualified Health Plan through *MNSure.* In 2020, MN ADAP purchased Gold and Bronze private plans on the off-exchange market for 117 PWH. Information on RWHAP services in languages other than English is sparse outside of the HIV system of care. Twenty-seven percent of PWH in the MSP-TGA in FY2019 (2,151) were born outside the U.S. People with HIV born outside the U.S. are more likely to enter care late as indicated by the proportion of new diagnoses progressing to AIDS within a year. In 2018, 34% of MN's new foreign-born cases progressed to AIDS within a year of diagnosis compared to 22% of U.S. born cases. Lack of health care coverage for foreign-born people restricts access to HIV testing and services that facilitate early diagnosis and rapid care linkage.

Service Gaps for PWH Not In Care and Part A Funding to Address the Gaps. Service gaps and barriers to services were identified through the development of the 2016 statewide coordinated statement of need (SCSN) including analysis of epidemiologic data, the 2016, 2017 and 2018 HIV Care Continua, RWHAP service utilization data, Hennepin County's 2014 and 2018 Surveys of the Health of All the Population and the Environment (SHAPE), the 2010 and 2015 HIV Comprehensive Needs Assessment (CNA) surveys, and HIV resource inventories. The 2020 HIV Comprehensive Needs Assessment, originally scheduled to be completed by June 30, 2020, is delayed because of the COVID-19 pandemic's impact on data collection. Survey methodology was revised, and the survey will now close November 30, 2020, with results available in Spring 2021. The MN Council for HIV/AIDS Care and Prevention considered all relevant data sources in setting 2019, 2020 and 2021 service priorities and allocations. The council's service priorities and allocations for FY21 (***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 PWH who experience systemic, economic, linguistic, cultural, and personal barriers to accessing HIV services. The service priorities help provide economic stability so PWH do not need to choose between basic needs and accessing healthcare. Services needed by PWH funded by sources other than the RWHAP are not always accessed by those in need due to eligibility criteria, insufficient capacity, and lack of awareness. Part A allocations for housing assistance, food bank/home delivered meals, and medical transportation are essential to maintaining health care access and retention by mitigating economic barriers. In addition, the MSP-TGA's Part A COVID-19 CARES Act funding provides additional resources for food bank/home delivered meals to overcome barriers to accessing nutritious food imposed by COVID-19 preventive measures.

The MSP-TGA has high rates of poverty among populations of color, particularly African American, and African-born and Latinx immigrants, and among members of sovereign nations. 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. Culturally responsive services that address basic needs are crucial to continued access to HIV treatment and remain a top priority. Mental health and substance abuse treatment, while available through other funding sources, can be difficult to access which in turn becomes a barrier to achieving positive health outcomes.

Access to healthcare. Despite Minnesota's successful health care reform efforts, gaps in health care exist for those who are newly diagnosed or out of care, and are uninsured or under-insured. Of the 504 respondents to the 2015 CNA, 11% waited longer than a year to receive HIV medical care; a third of whom reported that they could not find a clinic where they felt comfortable. Respondents identified the following as most helpful in finding and connecting to an HIV medical provider: 1) an HIV knowledgeable clinician (85%); 2) a good relationship with their doctor (77%); and 3) clinic staff who cared about them (70%). In addition, 47% said that medical transportation was provided. According to the 2015 CNA, 31% of respondents reported that difficulty signing up for insurance or not 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 PWH 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 assist PWH with navigating the complex system of comprehensive affordable coverage and finding a trusted HIV care provider. In addition, Part A funded outpatient ambulatory health services provide care until coverage is obtained. The Minnesota Council for HIV/AIDS Care and Prevention's FY21 Part A allocations plan dedicates 15% of service funds ($757,700) to outpatient ambulatory health services and 42% to medical case management ($2,086,700) with the primary goals of access and retention in care. In addition, 38% of the Council's MAI allocations are dedicated to outpatient ambulatory health services ($136,096) targeting Latinx, many of whom are immigrants, and 62% to medical case management ($217,812) services targeting Latinx, African American and African-born PWH. Part B and 340B ADAP rebate revenue will provide $500,000 for benefits counseling in 2021. In addition, medical transportation services allocated $356,200 in Part B and rebate funds, provide rides to appointments for those residing in the MSP-TGA's outlying suburban and rural areas that are considerable distance from the major HIV specialty care providers located in the core urban center of the MSP-TGA. **Attachment 8** shows planned FY21 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 PWH 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 FY19, 15% of PWH (1,193) residing in the MSP-TGA received Part A funded outpatient ambulatory health services. In addition: 1,665 received ADAP services; 1,638 received assistance paying for their medications; and 550 in paying for their insurance premiums. Twenty-eight percent (2,179) of the MSP-TGA's diagnosed PWH received medical case management and 14% (1,092) received benefits counseling. Furthermore, 179 PWH received Part A and Part B funded health insurance premium/cost sharing assistance to pay medical expenses not covered by ADAP, and 1,319 (17%) received Part B funded medical transportation to get to a health care or other core medical or support service appointment.

Housing. One of the largest service gaps in the MSP-TGA for PWH is housing assistance. The Wilder Foundation's most recent *Homelessness in Minnesota, 2018* report estimates that on any

given night, there were 19,582 people homeless people in MN, the majority of whom reside in the MSP-TGA; an increase of 10% since 2015. Based on a single night count, 57% reported a chronic health condition, 24% substance use disorder, and 64% serious mental illness. 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 Indians (22%), and Blacks (24%). Minnesota CAREWare data shows that in 2019, 671 or 16% of the MSP-TGA's 4,105 RWHAP service recipients, whose housing status was reported, were temporarily or unstably housed. In their Housing Plan (2017), the Minnesota HIV Housing Coalition estimates that there are 1,096 PWH in MN 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 MSP-TGA maintain waiting lists with over 400 PWH waiting for permanent housing. Additionally, in 2019 55% of PWH receiving RWHAP services have an annual income of less than $12,490 (100% of FPL) and 51% of the MSP-TGA's population of diagnosed PWH (**Table 3, p 12**) have an annual income less than $24,980 (200% of FPG). These data indicate that over half of the MSP-TGA's PWH need housing and economic supports to sustain affordable, safe, stable housing. Compounding the housing crisis for the MSP-TGA's low income PWH, the median cost of rent in Minneapolis increased 12% in the past three years. According to the 2015 CNA, 27% of PWH reported paying more than 30% of their income toward rent in the past year. Inadequate resources to provide stable housing, combined with other complications for PWH, significantly increases the cost of care for homeless PWH. Many homeless PWH require intensive medical case management (MCM) 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) FY21 allocations plan (see **Attachment 8)** includes $275,800 in Part A funding for housing services (rental assistance) for up to two years, an increase from $80,000 in 2018. The council's housing services priority ranking for FY19 and FY20 moved up from third to first among supportive services. The Part A housing services are provided by the MSP-TGA's largest AIDS service organization. Their transitional housing program assists PWH to obtain safe and affordable housing and permanent resources to meet long-term housing needs. In addition, Minnesota's Part B recipient will provide $894,811 in additional funding through ADAP 340B rebate revenue for housing coordination and advocacy and rental and emergency housing assistance in 2020 and 2021.

Mental Health Services. PWH face stigma, anxiety, depression, homelessness, unemployment, lack of supports, low self-esteem, and low income. Data shows PWH suffer from depression and anxiety at higher rates. Based on the most recent National Survey on Drug Use and Health model-based prevalence estimates (2019), 3.4% of the MSP-TGA's population, 18 years of age or older, has serious mental illness (***Attachment 4)***, and 9% has a mental illness diagnosis. SHAPE 2018 data indicate that LGBT respondents were more than twice as likely to be depressed in the past two weeks (18.7%) than their non-LGBT counterparts (8.1%). Similarly, 14.1% of LGBT respondents reported serious psychological distress compared to 4.1% of non-LGBT respondents. Men who have sex with men comprise 55% of the MSP-TGA's HIV prevalence. According to the 2015 CNA, 60% of the 504 respondents reported receiving mental health services, an increase from 49% among 2010 CNA respondents and significantly higher for American Indians at 84%. Since their HIV diagnosis, 47 percent of the 2015 CNA respondents sought individual therapy with a psychiatrist for mental health treatment, 46% had psychiatrist prescribed medication, and 50% had individual therapy with a licensed mental health professional, or licensed chemical dependency counselor. In 2019, 1,755 PWH in the MSP-TGA

who were enrolled in a Minnesota Health Care Program (MHCP) received outpatient mental health services at a total cost of $1,178,293. In FY2019, $122,786 in Part A funds were spent on mental health services for 391 PWH. The planned Part A allocation for mental health services in FY21 is $133,900. There are three Part A Mental Health service providers. One provides psychiatric services, including medication management, at the MSP-TGA's largest HIV specialty medical care provider. Another provides culturally and linguistically responsive services for African-born PWH, many of whom were refugees who experienced trauma and carry severe stigma around HIV and mental illness. The third mental health program is at a Federally Qualified Health Center that provides primary care for 13% of the MSP-TGA's Latinx with HIV, and employs mental health clinicians that are bilingual in English and Spanish.

Substance Use Disorder (SUD) Services. According to the National Survey on Drug Use and Health (2019), 5.6% of the MSP-TGA's adult population has an Alcohol use disorder. In 2018 there were 407 drug related deaths in the MSP-TGA, 202 of which were from opioid overdoses. A large proportion of clients receiving RWHAP funded services in the MSP-TGA utilize SUD services. 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 in MN, while 56% of American Indian respondents and 40% of Latinx respondents reported the same. Eighteen percent of respondents reported receiving outpatient SUD treatment or counseling, with an even greater proportion of respondents who are Latinx (23%) and American Indian (28%). Two Part A funded programs in the MSP-TGA provide "just-in-time" connection to outpatient SUD services. These MSP-TGA programs, one housed at the largest HIV primary care clinic and the other at the 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, peer relapse prevention, and harm reduction support. In 2019, 381 PWH in the MSP-TGA received substance abuse treatment through a Minnesota Health Care Program, including Medicaid, a 61% increase compared to 2018. The treatment cost for this cohort was $2,153,006. In FY19, $139,707 in Part A funds were spent on substance abuse (outpatient) services for 308 PWH. Slightly more is allocated for FY21 at $146,400, but may not be enough to fully the need among the MSP-TGA's RWHAP eligible PWH.

Medical Case Management (MCM). Although the ACA has reduced some barriers for PWH to being insured, the complexity of the insurance marketplace and limited open enrollment periods cause persistent access and coverage problems for low income PWH. PWH who are categorically ineligible for publicly funded health care programs including advance premium tax credits and enrolling in QHPs through *MNSure*, often immigrants, need 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; 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, Latinx and American Indians. Strong MCM programs can mitigate challenges in accessing insurance and financial assistance for HIV care. A large gap on the MSP-TGA's HIV Care Continuum is a 28% drop in the proportion of diagnosed PWH who are retained in care. MCM provides comprehensive services that support treatment adherence and help secure stable housing, nutritional and economic supports, medical transportation, mental health, and substance abuse treatment. Five of the seven Part A MCM programs in the MSP-TGA are located at HIV specialty clinics that combined

provide care to an estimated 62% of RWHAP eligible PWH in the MSP-TGA. These clinic-based programs also staff Doctors of Pharmacy that provide treatment adherence and medication management counseling and tools. Three MCM programs, the Sub Saharan Youth and Family Services in MN, Hennepin Healthcare, and Minnesota Community Care, receive MAI funds to meets the needs of African American, African-born, and Latinx PWH who are at risk of not connecting or losing access to HIV medical care. In FY19, MCM services served 1,631, or 51% of Part A Program clients with 97% being retained in care, and 90% virally suppressed. Of those receiving Part A funded MCM in FY2019, 86% were at or below 200% of the FPL, suggesting a large need for PWH who are poor. MCM receives the largest Part A allocation among the 17 service categories receiving Part A funds. In FY19, $2,104,428 or 40% of Part A funds for services, were expended on MCM for PWH, which included $185,945 of Minority AIDS Initiative MCM funds targeting African American, African-born and Latinx clients. Planned allocations for MCM in FY21 include $2,086,700 in Part A and $217,812 in MAI funds.

Early intervention services (EIS), including data-to-care using HIV surveillance data to identify PWH in Hennepin County who are not in care, connect target populations to HIV medical care. In addition to linking PWH to HIV medical care, EIS facilitate entry into MCM to address the unmet needs for other core medical and support services that ensure re-engagement and retention in care. MCHACP allocated $373,800 in Part A funds for EIS in FY21.

Other Efforts to Address Service Gaps. To reduce the significant HIV-related health disparities that exist among racial and ethnic subgroups, age, mode of HIV exposure, and country of birth in the MSP-TGA, several approaches are being employed to fill gaps in services for the most disproportionately impacted communities in the MSP-TGA. In the summer of 2019, an intern from Lehigh University employed a disparities calculator, provided by the Center for Quality Improvement and Innovation and developed for use with CAREWare data, to identify disparities in viral suppression. His work identified significantly lower viral suppression rates among African American MSM and African American women in the MSP-TGA's RWHAP system of care. Results from the disparities calculator were presented to the Minnesota Council for HIV/AIDS Care and Prevention and its Disparities Elimination Committee. The Disparities Elimination Committee is dedicated to improving and reducing health disparities. The committee is using the calculator results to develop recommendations for resource allocation and service delivery approaches to eliminate disparities is viral suppression among African Americans.

In 2019, Hennepin County was one of 10 Part A jurisdictions to receive HRSA RWHAP funding for two years (2019-2021) to build capacity for HIV elimination in RWHAP Part A jurisdictions. This grant of $100,000 each year funds community engagement activities and targeted HIV awareness campaigns with the MSP-TGAs West African and East African immigrant communities, and African American MSM. The MSP-TGA's African immigrant communities are hit hard by the epidemic with black African-born immigrants comprising 17% of the MSP-TGA's HIV prevalence and 15% of new infections in 2019 (**Attachment 3**). Similarly, African American MSM comprise 10% of the MSP-TGA's HIV prevalence and 12% of new infections in 2019. Partners in this work include: the West African HIV Task Force (WAHTF), formed in 2017 and catalyzed by a Liberian immigrant intern with Hennepin County's Part A program; Sub-Saharan Youth and Family Services (SAYFSM), a Part A subrecipient receiving funding for medical case management, mental health and psychosocial support services for East African immigrants; Rev. DeWayne Davis, pastor of All God's Children Metropolitan Community Church and a recognized faith leader in the MSP-TGA African American MSM community; and Red Door Services, Minnesota's largest public health

STI and HIV testing clinic. WAHTF is implementing activities to achieve the objectives of their community action plan to increase West African HIV awareness and knowledge to promote testing, access to PrEP, and early care linkage and retention. SAYFSM recruited two community members with HIV to train and support them to tell their stories to engage East African and Muslim and Christian faith leaders to promote HIV testing, access to care and prevention services among their congregants. Rev. Davis is engaging African American faith leaders to assess their knowledge and attitudes towards PWH and African American MSM and facilitate efforts to increase their engagement in HIV elimination in their communities. Red Door Services will conduct focus groups in 2020 and 2021 with African American MSM to assess the cultural responsiveness of their services and develop a service delivery improvement plan to increase the effectiveness of their services in reaching and meeting the needs of African American MSM. Although COVID-19 preventive measures created unforeseen barriers to community engagement, all key partners are adapting their approaches to reach their communities through virtual platforms, social media, and physically distanced HIV education and testing events.

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

The 2018 estimate of the proportion of the total population of PWH in Minnesota (MN), who are diagnosed, is at 90.1%, thus the estimate of the proportion who are undiagnosed is 9.9% or 960 people, with a 95% confidence interval of 500-1400. This estimate, provided by the MN Department of Health (MDH), uses 2018 HIV surveillance data from the MN Enhanced HIV/AIDS Reporting Systems (eHARS), and the CDC methodology for estimating the population of PWH who are unaware of HIV infection as initially published in the CDC's Morbidity and Mortality Weekly Report Vol. 64 /No. 24. Minnesota effectively reached the National HIV/AIDS Strategy goal of 90% of the population of PWH aware of their status in 2017. Since 84.7% of Minnesotans with an HIV diagnosis reside in the MSP-TGA, the MN proportion of diagnosed Minnesotans living with HIV was applied to the MSP-TGA's population of PWH 13 years of age or older to develop an HIV-unaware estimate for the TGA. The estimate is 812 PWH in the MSP-TGA are unaware of their status as of December 31, 2018. The MDH will only release an estimate of the proportion of the population of PWH who are undiagnosed statewide hence, an official estimate for the MSP-TGA is not available. The MDH has not yet provided an updated estimate of the number of PWH in Minnesota who not aware of their HIV infection using 2019 HIV surveillance data, as the resources typically dedicated to HIV epidemiology have been utilized in the COVID-19 pandemic response.

The MSP-TGA's EIIHA data includes HIV testing data reported by Part A early intervention services (EIS) providers, Hennepin County operated clinics, as well as EvaluationWeb (EvalWeb) data submitted by MDH's funded HIV counseling testing and referral (CTR) providers. Currently, there are five clinics and seven community based MDH funded CTR service providers. Five of the CTR providers also deliver RWHAP Part A, Part B, or ADAP 340B rebate funded services.

In 2019, the trend of decreased publicly funded HIV testing in the MSP-TGA continued. In 2017, there were 14,184 publicly funded HIV tests, identifying 64 new cases of HIV; in 2018 there were 6,722 publicly funded HIV test events resulting in 16 new HIV case findings; and in 2019 only 5,182 tests resulting in 21 new case findings. Three factors may have caused the reduction in publicly funded HIV tests: 1) Prior to 2018 tests were entered into EvalWeb that were not funded by MDH; 2) MDH significantly reduced CTR funding in 2018 and 2019 for the public health clinic that administers the most HIV tests in the TGA; and 3) In late 2018, CDC

changed some fields in EvalWeb that resulted in some confusion in how to enter data which likely resulted in incomplete data. While 2020 will likely also show low HIV testing numbers due to the COVID-19 Pandemic, the MSP-TGA is committed to working with its government peers to counter the recent reductions in publicly funded tests.

Hennepin County is home to 61% of the TGA's PWH as well as the public health clinics that target and identify the most new HIV cases in the state. The Hennepin County Public Health (HCPH) Clinics including Red Door Services, Refugee Health Screening, Mental Health Center Primary Care, and Health Care for the Homeless, conducted 10,333 HIV tests in 2019 and identified 60 HIV positive cases. Red Door Services, the largest publicly funded HIV and STI testing clinic in the TGA and Minnesota, identified 57 newly diagnosed HIV cases. In 2019, both overall publicly funded HIV tests administered and HIV testing at HCPH Clinics increased over 2018 but are still not up to 2016 levels. A priority for 2021 will be to increase testing again.

1) Planned MSP-TGA EIIHA Activities for 2021

a) Primary Activities

Increase Publicly Funded HIV Testing. Hennepin County operates the MSP-TGA's largest public health clinic in Minnesota (MN), two Federally Qualified Health Centers including Health Care for the Homeless and NorthPoint Health and Wellness Center, and the county's Medicaid accountable managed care organization, Hennepin Health. 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. All these healthcare assets in Hennepin County are integrated into the County's strategy to end the HIV epidemic, *Positively Hennepin*. This strategy was the result of a process engaging a wide range of stakeholders and communities disproportionately impacted by the epidemic and the understanding that 52% of Minnesotans living with HIV reside in Hennepin County. *Positively Hennepin* has three goals: decrease new HIV infections; ensure access to and retention in care for people living with HIV; and engage and facilitate the empowerment of communities disproportionately affected by HIV to stop new infections and eliminate disparities. To achieve the first goal of decreasing new HIV infections, Hennepin County and the MSP-TGA are working to increase routine testing and reduce barriers to testing for those at high risk for HIV. To attain the targets and improve outcomes along TGA's HIV Care Continuum, the Part A RWHAP is working with HCPH Clinics, HCMC, Hennepin Health, MDH, and DHS to increase HIV testing and reduce the percentage of PWH in the TGA who are unaware of their status and rapidly link them care.

One strategy, implemented in 2015, was to increase routine HIV screening using Hennepin County's electronic health record's (EHR) health maintenance module to prompt alerts that all patients ages 15-65 are due for an HIV test if they have no record of an HIV test. All health care providers who access client EHRs as well as clients who access their EHR online though *My Chart* see the alert. This alerts 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" and the U.S. Prevention Services Task Force's grade A recommendation for HIV screening. While increases in testing have occurred since the implementation, annual rates of testing have varied significantly.

The Part A recipient, HCMC, NorthPoint, Hennepin Health, and HCPH Clinics are working to identify the cause for variation and factors that prevent meeting targets. *Positively Hennepin* staff are working with Hennepin Health to improve the HIV screening rate of their 24,000 patient members, the majority of whom receive their primary medical care at HCMC and Northpoint.

The aim is for this quality improvement initiative to serve as a model to be adopted by other Minnesota Health Care Program contracted managed care organizations delivering health care to Minnesotans enrolled in Medicaid and Minnesota Care, Minnesota's basic health plan.

In addition to increased efforts at routine testing, the MSP-TGA has successfully ensured that all RWHAP testing data is reported centrally to EvalWeb 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 (DHS, Part B recipient). Unfortunately, beginning in 2018 there was a significant drop in MDH funding of Red Door Services and therefore a drop in publicly funded HIV tests in the TGA. For FY20, the MSP-TGA Part A Program increased EIS funding by 33% to help ensure the number of publicly funded HIV tests administered increases in 2020.

The collaborative Minnesota/MSP-TGA EIIHA Workgroup met in July 2020 and identified several strategies for improving EIIHA efforts. A reoccurring priority among the workgroup, *Positively Hennepin*, and "End HIV MN", Minnesota's HIV strategy, is how to better target testing to reach populations that are at highest risk and use data to drive EIIHA interventions. The Part A Program Coordinator, the *Positively Hennepin* Strategy Coordinator, and the Part A Quality Management Coordinator are shepherding this strategy through various stakeholder groups to increase testing in Hennepin County, the MSP-TGA, and Minnesota.

More Targeted Early Intervention Services. Over the last five years the Minnesota Council for HIV/AIDS Care and Prevention (council) has increased the Part A allocation for EIS by 126% with an allocation of $357,250 in 2020. Along with increased funding for EIS, the RWHAP team is collaborating with MDH to improve reporting of HIV testing and case findings. The MSP-TGA team sought and contracted with a small population specific organization and one FQHC to reach areas of the TGA with populations particularly hard hit by HIV. One provider, despite over two years of technical assistance and training, failed to show results and thus was not successful in the 2019 RFP process. The FQHC is continuing to provide EIS funded by MDH.

The Part A program continues to fund the EIS "Fast Track" and "Concierge" services provided by the state's largest public health clinic, Hennepin County's Public Health Clinic (PHC). Through a combination of Part A and 340B ADAP rebate funding from the MN DHS, Red Door's EIS funding increased 93% from 2019 to 2020 in recognition of their effective work and the loss of funding from the MDH. Through Red Door Services, the PHC has historically diagnosed 20-25% of the TGA's HIV cases. In addition to increased testing of EIIHA target populations, the program links clients to clinical services immediately. An on-site peer care 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 services including, HIV testing, and linkage to PrEP and PEP providers. To achieve the goal of connecting clients to an appointment within 48 hours of their initial test and promote rapid initiation of antiretroviral therapy (rapid ART), the program helps clients overcome any barriers to attending the appointment such as insufficient health insurance or lack of 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 sent 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 2019, the

Red Door conducted 9,512 HIV test events resulting in 57 new HIV diagnoses. The overall positivity rate was 0.60%. Red Door linked 43 of their newly diagnosed clients (75%) to HIV medical care within 30 days.

Red Door continues to improve efforts to reach the most as risk populations most effectively. In collaboration with Hennepin County Public Health (HCPH) epidemiology team and Part A program staff, Red Door has better access to data to guide future programming and initiatives. The Part A grant 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. After testing three different processes and improving practice, Red Door's data-to-care (D2C) program is yielding results not previously seen. Since April 1st, 2018, 23 PWH who were not engaged in HIV medical were linked to care by Red Door care navigation staff with an average cost of $14,588 per case finding. Further analysis is required as well as improvement in data reporting and processes to link out of care clients to care.

Red Door has been working to identify PWH out of care through their D2C project by working with the state enhanced HIV/AIDS Reporting System (eHARS) since 2016. 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 PWH who reside in Hennepin County, where 62% of PWH in the MSP-TGA live, being sent to the HCPH epidemiologists. The county epidemiology staff then create a usable line list of PWH deemed not in care (NIC) based on last date of CD4 or viral load test. Red Door disease investigators then look up each person on the NIC list to identify if still reside in the county and if they have been seen anywhere in the county's health care network that shares an electronic health record. In 2019, Red Door received a list of 1,012 who had not had a CD4 or viral load test in the past 15 months, of which 960 were confirmed likely to reside within the county and not receiving medical care. Red Door care navigators match the list to the county's electronic health record to see if any had received HIV medical care at a county facility. For those for which there is no additional information that confirms receipt of medical care, staff try to find accurate contact info and reach out to individuals on this list. Of this group, 631 were found to be in care, 2 were deceased, and 52 were out of jurisdiction. Attempts were made to contact 149 individuals, 35 of whom were reached. Among the 35, there were 10 attempted linkages to an HIV specialty care provider and 11 were confirmed linked to care. The HCPH epidemiology team along with the MSP-TGA's Data and Outcomes Coordinator are working to improve data integration to increase the quality of the NIC list Red Door front-line staff use to engage people in care. The Red Door team documents the process to identify areas for quality improvement to make future efforts more effective and efficient.

Beginning in 2017, the Minnesota Department of Human Services began receiving Part B supplemental funding for EIS services. These funds are passed to the Minnesota Department of Health to administer to ensure coordination of Part B funded EIS with the state's CDC funded HIV counseling, testing, and referral. MDH currently funds nine providers located in the TGA's zip codes with the highest HIV prevalence for EIS targeting Black/Latino MSM, MSM/IDU, and the American Indian and West African communities. There has been discussion on coordinating Part A EIS services with HIV testing activities funded by Part B and administered by MDH through the work of Government HIV Administrative Team and EIIHA Workgroup meetings. One stumbling block is there is a great amount of staff turnover. Hopefully as EIIHA coordination improves among the government partners, this work can be institutionalized and continue regardless of staff transitions.

Innovating Services to Respond to an HIV and Hepatitis A Outbreak among People Who Inject Drugs (PWID). In January of 2020 the Minnesota Department of Health (MDH) notified the Hennepin County Public Health leadership and epidemiology about an HIV outbreak occurring in Hennepin and Ramsey Counties in the MSP-TGA. The outbreak was identified using a program that analyzes HIV surveillance data. The outbreak cluster case as defined by the CDC is any person who injects drugs who is newly diagnosed with HIV after December 1, 2018; residing in Hennepin or Ramsey Counties at the time of diagnosis; or is the sex or needle sharing partner of a person who is part of the outbreak; or person in their social network; or through HIV molecular linkage. The MDH has formed a collaborative HIV outbreak response group to coordinate among stakeholders engaging in activities to respond to the outbreak. Within Hennepin County, an incident command structure (ICS) has been established to organize efforts. The Hennepin County efforts are led by Healthcare for the Homeless.

The outbreak thus far has affected 26 individuals, the cases are split between men and women fairly equally, almost all have reported using injection drugs, 80% have a history of homelessness, nearly two-thirds of the women have a history of sex work, almost a quarter have a history of incarceration. Only one male case reports having sex with men. The population affected has complex unmet needs health care and social service needs that do and will affect their ability to link to care, stay retained in care, stay adherent to ART, and achieve sustained viral suppression. To address these needs, the Hennepin County ICS has developed a number of innovative approaches and wrap around services to meet the population where they are at and help them move along the care continuum to viral suppression. While the MSP-TGA RWHAP has researched and learned of promising practices in other jurisdictions that have worked with similar populations, the approaches need to be tailored specifically to this community and to also mitigate the risk of the spread of COVID-19. These approaches being used in the outbreak include: harm reduction with access to needle exchanges, chemical dependency programs, and medication assisted therapy for opioid addiction; Hepatitis A vaccination; easy access to PrEP for sex and needle sharing partners of those affected by the outbreak; ARV medications delivered to those who need them on the streets, homeless encampments, or wherever they may be; referral and linkage to services that enable linkage and retention to HIV medical care. This work is staff and supply intensive in a time when healthcare and epidemiological resources are already strained due the COVID-19 pandemic. All those involved in the effort are hopeful that through collaboration, coordination, and innovation that the work will be as efficient and effective as possible though additional are required to end to the outbreak, particularly to provide harm reduction services, and housing for those who are unsheltered.

Convene Minnesota's EIIHA Workgroup. The Part A Program Quality Management Coordinator (QMC) convened Minnesota's EIIHA workgroup in July 2020 through an online meeting 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 assessing overall EIIHA progress in Minnesota and the TGA. At the 2020 EIIHA workgroup meeting there were speakers on MSP-TGA and statewide HIV testing efforts and results, data on RWHAP efforts, and a participatory process for looking at the data and determining populations that should be prioritized for 2021 EIIHA work. The large groups discussed possible prioritized populations from the following populations/communities:

people who inject drugs (PWID), Black MSM, Latino/Hispanic MSM, young MSM, and African-born individuals. The large group broke into smaller groups by selected priority populations. The small groups discussed existing work and gaps in services for each population. The small groups also discussed best ways to reach the target populations, and the barriers and facilitators to reaching these populations.

Major themes that emerged from small groups include: data not current and does not reflect the concurrent crises of the COVID-19 pandemic and racism; input needs to come from the priority populations themselves not others conjecturing; solutions need to take into account social determinants of health and institutional racism, HIV stigma, inclusion of qualitative data, and the need for culturally and language specific outreach/materials to prioritized populations. Following the meeting there was an evaluation sent out and a debrief meeting was held. It was made clear that each government partner (MDH, DHS, and HC) needs to better define their participation and provide staff with a defined role in the EIIHA work. The Government HIV Administrative Team has taken up this work in the meantime to make intentional decisions on each government party's role and responsibility in EIIHA work.

Increasing Enrollment in RWHAP Services

At the end of 2019, 4,105 of the 7,836 (52.4%) MSP-TGA's population of diagnosed PWH received Part A, B or 340B ADAP rebate funded services. Based on income estimates of the TGA's overall population and income data on the TGA's PWH who received a RWHAP service in FY 2019, 74% of diagnosed PWH residing in the TGA ought to be eligible for RWHAP services (**Table 3**, **p 12**). The 2018 (2019 care continuum was not available due to COVID-19 pandemic utilizing epidemiologic resources otherwise used for HIV) MSP-TGA HIV care continuum shows that 72% of diagnosed PWH are retained in care and 64% are virally suppressed (**Figure 3**, **p 10**). People with HIV receiving RWHAP services have better health outcomes than the overall population of PWH in the TGA. In calendar year 2019, 97% of PWH receiving RWHAP services in the TGA were retained in HIV medical care and 90% were virally suppressed. Thus, increasing enrollment in the TGA's RWHAP program services through enhanced EIIHA efforts and interventions that re-engage those who are aware of their HIV infection in medical care will improve the TGA's overall HIV care continuum. Based on the population income estimates, there are an estimated 1,723 PWH in the TGA who are eligible but not receiving RWHAP services. To address this gap in access to RWHAP services in the TGA, the Minnesota Council for HIV/AIDS Care and Prevention (council) added an action to the 2017-2021 Integrated HIV Prevention and Care Plan to increase enrollment in Minnesota and MSP-TGA RWHAP services from 50 to 60%. With this data the cross-parts Quality Management Advisory Committee included increasing enrollment in RWHAP in the MSP-TGA to 60% by December 2023 as a quality improvement goal for their 2020 clinical quality management plan.

To develop new strategies to increase RWHAP enrollment, the Part A recipient convened a stakeholder summit on March 7, 2019. Thirty-two stakeholders attended including RWHAP recipients (Parts A, B, C, D and F), RWHAP program and CDC and state funded HIV testing providers, council members and staff. Summit participants reviewed Minnesota and MSP-TGA RWHAP service utilization data, RWHAP performance measures and a report on the RWHAP services that are most closely associated with high viral suppression rates. The summit included an idea generating process that identified five areas of focus to increase enrollment in RWHAP services. Summit participants coalesced into five action work groups around these areas: 1) Increase connections with non-HIV specific services as points of entry by educating 75

healthcare and social service professionals about the RWHAP service system and connecting PWH to care; 2) Address barriers to care identifying common characteristics among those who are out of care; 3) Develop culturally sensitive/appropriate services by providing training for HIV prevention and care providers on how to be culturally responsive to members of disproportionately impacted communities; 4) Implement a centralized RWHAP eligibility system by identifying barriers inhibiting the roll-out of a system to centralize eligibility determination for all RWHAP eligible clients; and 5) Align resources by developing a comprehensive current inventory of all HIV care and prevention resources to improve community and government planning processes. While the workgroups disbanded by the end of 2019, the QMAC and the Council are continuing to focus on these five areas to increase enrollment engage more people unaware of their status and those who are out of care in RWHAP services.

Improve 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 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; only those clients receiving Part A funded outpatient health care services. As of the end of CY 2019 viral load data was in MN CAREWare for 91% of RWHAP clients, an increase of 50%. Efforts with MDH to increase the proportion of RWHAP clients who have viral loads in CAREWare as well as timeliness of data continue. Once 90% of the RWHAP clients have viral load data in CAREWare for at least three months, subrecipient reporting of client retention in care will be simplified. This change will improve efficiency and data quality. Due to the COVID-19 pandemic, staff and resources at the MDH dedicated to administering MN CAREWare have been redirected to respond to the pandemic delaying the transition to a new MN CAREWare specific form designed to reduce subrecipient reporting burden. Plans are now to implement the streamlined reporting by the beginning of CY 2021, though all plans are tentative depending on the pandemic.

Migration of CD4 count and viral load data into MN CAREWare enables Red Door Services' Data2Care team to use CAREWare data to get more up to date information on PWH in Hennepin County deemed out of care. In addition, the Part A grant recipient data and outcomes coordinator is teaming up with Hennepin County Human Services data analysts to investigate access to Medicaid data systems to assist further in identifying and reaching out to PWH out of care.

Building Capacity for HIV Elimination in the MSP-TGA. In July 2019, the MSP-TGA was one of 10 Part A jurisdictions to receive a HRSA/HAB grant for "Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdictions." Grant activities focus on community engagement with three populations disproportionately impacted by HIV in the TGA that have been hard for the RWHAP service system to reach, and information dissemination and marketing to develop and implement targeted community awareness campaigns. The hard-to-reach target populations are African American same-gender-loving (AASGL) men – also known as MSM; East African-born immigrants; and West African-born immigrants. The grant provides $100,000 in funding for each of the grant period's two years for four key community partners (KCP) to engage these communities in activities to develop community driven strategies to eliminate HIV infections and develop targeted HIV awareness campaigns to promote routine HIV testing, early engagement in HIV medical care upon diagnosis, and access to prevention resources such as PrEP. The KCPs include the West African HIV Task Force, Sub Saharan Youth and Family Services of Minnesota, Rev. DeWayne Davis of All God's Children

Metropolitan Community Church, and Red Door Services, the MSP-TGA's largest publicly funded STI and HIV testing program housed within Hennepin County's Public Health Clinic. Grant activities will increase viral suppression and improve health outcomes by mitigating barriers which prevent RWHAP eligible members of target communities from utilizing program services. For example, grant work plan objectives include: 1) Building West African faith leader's and their follower's knowledge of the disproportionate impact of HIV on their communities and increase awareness of HIV care and prevention services available; 2) Decrease HIV stigma among East Africans through faith and community events that include PWH from the community telling their stories; 3) Engage African American religious and civil-society organizations to support the lives and health of AASGL men; and 4) Implement changes to improve cultural responsiveness to and trust with AASGL men. Each community partner will are implementing action plans to achieve the overarching goal of engaging and facilitating empowerment of each of these three hard-to-reach populations to stop new HIV infections in their communities. To make RWHAP services more responsive to the culturally-specific needs of AASGL men, East and West African immigrants, Hennepin County Public Health and the KCPs will use focus groups and surveys to evaluate the impact of the project activities and create plans to improve the responsiveness of RWHAP Services to these communities' needs.

b) Major Collaborations with Other Programs and Agencies

EIIHA Workgroup. The Part A recipient continues to facilitate this collaborative effort with Minnesota's Part B (DHS) and CDC HIV prevention (MDH) 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; Minnesota's RWHAP Parts A, B, C, D and F programs; HIV care, prevention and testing providers; and consumers. The Part A Program establishes its EIIHA goals based on the workgroup's recommendations. After the 2020 EIIHA Workgroup meeting the government partners saw the need to increase the clarity and improve the annual EIIHA process, therefore these collaborations are written as they are currently understanding that a quality improvement project is to be implemented in 2021.

Minnesota Department of Health (MDH). As the state's CDC HIV prevention and testing recipient, MDH articulates the common HIV prevention and RWHAP goals to the council. MDH reports to the Part A recipient and council on changes in the state's HIV epidemiological data annually including presentation of the state's HIV Care Continuum with estimates of the HIV unaware population. 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) meets every other month 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. MDH also serves as the administrator of Minnesota's joint Part A and B client-level database, MN CAREWare, enabling integration with HIV surveillance data.

Additionally, the MDH is the administrative agent for the DHS' Part B/rebate funded Early Intervention Services. Through this funding MDH has 15 grantees, nine of whom operate in the MSP-TGA. While the Part A Recipient team was provided with grantee name, target population of each grantee, dates of grants, geographic scope of each grantee, more data would be required for substantial collaboration. A primary goal of the more intentional collaborative EIIHA effort being instigated by GHAT is for the government partners to more freely share information on

contract amounts, contract goals, and contract outcomes to allow for more strategic, aligned, efficient and effective EIIHA funding, activities, and outcomes.

Minnesota Council for HIV/AIDS Care and Prevention (council). The council, established in 2016, serves as the single integrated HIV care and prevention community planning body for MN and the MSP-TGA. The 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 MN HIV Services Planning Council. Annual updates on EIIHA activities are presented during council meetings. Council members, who represent consumers and providers receiving Part A, Part B, and CDC HIV prevention funding, are active participants in the EIIHA workgroup. EIIHA activities are incorporated in the council's 2017-2021 Integrated HIV Prevention and Care Plan. This integrated planning approach helps those working on care and prevention in MN to collaborate, improving EIIHA coordination and efficacy of activities.

Minnesota Department of Human Services (DHS). As the state's Part B grant recipient and Medicaid agency, DHS Part B administrative staff serves as a member of the council. In addition, DHS' HIV Quality Coordinator and Data Coordinator are members of the EIIHA workgroup and are *ex-officio* members of the cross-parts Quality Management Advisory Committee convened by the Part A Program quality management coordinator. DHS funds additional EIS and outreach services through Part B supplemental and 340B ADAP rebate revenue which is administered by the Part A Program to ensure coordination of RWHAP funded activities. Coordination of Part A, B and rebate funding allocated to EIS and other RWHAP services in the MSP-TGA 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 at Red Door and the Aliveness Project. The Part A recipient also administers ADAP rebate EIS and Data2Care contracts for Red Door, Minnesota Community Care, and the Aliveness Project on behalf of DHS. DHS sends Part B supplemental funds to MDH to administer for EIS. MDH then funds fifteen EIS subrecipients, three of which Hennepin County RWHAP already funds. Although resources have increased for EIS to scale up testing of target populations, DHS' system of now sending funds to MDH in addition to Hennepin County to administer for EIS has created some contracting inefficiencies. More deliberate coordination on the part of the state is needed to mitigate duplication of efforts. Most of the EIS 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 the state and the 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. 75 newly diagnosed clients are identified through Part A EIS contracts
2. At least 75% of HIV tests are targeted to African American, Latino and young MSM, transgender women of color and African-born immigrants.
3. 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.

4. Use a proven methodology to establish an unaware of HIV status estimate for the TGA
5. Black and Latino MSM, African-born individuals, and people who inject drugs increase utilization of Ryan White services by a least 5%.
6. The viral suppression rate (within six months of diagnosis or initial contact with a disease investigator) among the HIV outbreak cases increases by 25% by the end of FY 2021.

2) Three FY 2021 EIIHA Target Populations

Epidemiological data, HIV testing data from MDH CTR and Part A funded EIS programs, the MSP-TGA's 2018 HIV Care Continuum and the EIIHA Workgroup recommendations inform the selection of the following populations for focus in the 2020 EIIHA plan: 1) Latino and Black/African American MSM ages 18-39; 2) Black/African-born individuals; and 3) People who Inject Drugs (PWID). The Part A Program goals for disproportionately impacted populations include reducing new HIV infections and ensuring that people are diagnosed, in care early and have the supports to stay in care to improve individual and community HIV health outcomes.

Latino and Black/African American MSM, ages 18-39

a) Why Latino and Black/African American MSM, ages 18-39 were chosen. Multiple identities and intersectionalities make some populations disproportionally affected by HIV.

Incidence	2015	2016	2017	2018	2019
White MSM ages 20-39 (for comparison)	50	49	32	33	34
Latino (all races) MSM ages 20-39 + Black/African American, not Latino (not African-born) ages 18-39	39	35	43	48	50
Latino (all races) MSM ages 20-39 + Black/African American ages 18-39 as % of total MSP-TGA Incidence	14.4%	13.6%	18.6%	20.9%	22.1%

MSM are disproportionately impacted by HIV, African American MSM, Latino MSM, and younger MSM are all disproportionally affected by HIV. These disparities have been identified in the above incidence data but also widely in the USA by the end+disparities ECHO Collaborative, HRSA, NASTAD, among others. While 41% of new infections in 2019 were among Black/African Americans and Latinx these groups only made up 15.4% of the TGA's population. Of all new HIV case findings in 2019 among MSM, 48% were Black/African American and Latino MSM. In the TGA, people of color comprised 67% of new HIV cases in 2019 with Black/African Americans and Latinx alone comprising 41%. New infections among Latino and Black/African American MSM (all ages) averaged 51 new cases per year from 2015 to 2019. Black/African American and Latino MSM make up 30% of MSM with HIV in the TGA by the end of 2019. HIV prevalence among this population increased by 23.2% from 2015 to 2019 compared to a 1.2% decrease among white MSM. The TGA's HIV Care Continuum for 2018 indicates Black/African Americans have the lowest viral suppression rate compared to other racial/ethnic groups at 57% virally suppressed. Among MSM, 69% of Black/African American MSM were retained in care and only 56% had suppressed virus, whereas 75% of White MSM were retained in care and 69% had suppressed virus.

b) Specific challenges or opportunities. Data from Hennepin County's 2018 SHAPE show that gay, bisexual, lesbian and transgender (GBLT) residents are 45.7% more likely to delay or not receive medical care when it's needed compared to non-GBLT residents (21.0%). These data indicate that gay and bisexual males are more likely to have fewer contacts with routine or preventive health care providers, making it more difficult to access routine testing. Black/African Americans and Latinx are disproportionately affected by issues of poverty and same-sex sexual

orientation stigma. The priority of maintaining psychosocial, economic support from the community, and ties to faith communities often trumps awareness of HIV status. Fear of stigma associated with a pronounced level of homophobia within the African American community contributes to a greater stigma and denial among African American MSM who do not identify as gay or bisexual. While in the Latinx culture the family and societal gender roles of machismo, men as head of the family, and members of a church that may not accept them can stymie acceptance of GLBTQ people. Additionally, as barriers to care for Latino MSM population include: lower rates of health insurance, distrust of healthcare systems, and language barriers.

In FY19 only 57% of Black/African American men identified as MSM to their RWHAP provider compared to 90% of White and 71% 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 Black/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. The Office of Minority Health Resource Center conducted key informant interviews with Black/African American and Latino gay and bisexual men in the MSP-TGA in 2014-2015. The findings indicated a gap and need for culturally responsive support groups, churches and spiritual institutions, health education, health promotion campaigns, and substance free social opportunities that welcome and affirm Black/African American and Latino MSM to better address the healthcare needs and reduce HIV stigma.

c) Specific strategies for Black/African American and Latino MSM ages 20-39 include:

i. Early Intervention Services

a. Increase targeted HIV testing among Black/African American and Latino MSM ages 20-39 by 10% by end of FY 2021 through publicly funded EIS programs.
b. Increase the proportion of newly diagnosed Black/African American and Latino MSM linked to care by the end of FY 2020, so that at least 90% of those newly diagnosed are linked to care within 30 days.
c. Fund culturally specific EIS provider Minnesota Community Care (MCC). MCC has long been the provider of choice for Latino PWH in the MSP-TGA with its strategic location, its staff who share the identity and languages of the clients, and its great health outcomes for Latino PWH. This provider is the best choice for expanding EIS services targeted to this population. MCC is one of the TGA's largest FQHC's located in the heart of St. Paul's Latino community and receives Part A and 340B ADAP rebate funds to deliver culturally responsive outpatient health care, medical case management, mental health, psychosocial support, and medical transportation services. In FY2019 they provided RWHAP funded services to 51 Latino MSM. Among MCC's RWHAP patients in 2019, 100% were retained in care and 98% were virally suppressed.

ii. HIV Screening Through PrEP Services. HIV screening through Red Door Services' PrEP program. Red Door provides PrEP to 300 of the highest risk Black/African American and Latino MSM in the TGA and provides 90% of PrEP services in Minnesota funded through MDH's CDC funded HIV prevention program. Red Door's PrEP program coordinator is a Spanish-speaking Latino gay man with close connections to the TGA's Latinx GBLT community and their medical providers. All MSM who are screened for PrEP and test HIV-

positive work with a care navigator to link to HIV medical care. Doubling PrEP enrollment is a three-year goal of *Positively Hennepin,* Hennepin County's strategy to end the HIV epidemic.

iii. Build Community Capacity to Reach Black/African American and Latino MSM with Culturally Responsive HIV Services

a. Partner with Rev. DeWayne Davis, pastor of All God's Children Metropolitan Community Church, to engage Black/African American faith and civil society organization leaders and Black/African American same-gender loving (AASGL) men to achieve the following objectives: 1) Identify religious and civil-society organizations dedicated to improving the life and health of AASGL men; 2) Identify culturally-responsive approaches and opportunities to mitigate stigma and eliminate HIV; 3) Identify methods to sustain dialogue with faith and civil-society organizations to disseminate information and provide HIV education and training; and 4) Increase RWHAP service utilization among AASGL men. Rev. Davis will accomplish these objectives through community engagement sessions with pastors from at least five African American Churches, and leaders of two African American civil society organizations and community members. He will convene a summit featuring prominent national African American faith leaders who are engaged in eliminating HIV in African American communities across the country.

b. Fund Hennepin County Public Health Clinic's Red Door Services to conduct focus groups with AASGL men to inform efforts to create culturally responsive and trusted services. The aim is to deliver their EIS and Data2Care re-engagement services, so the TGA's AASGL find them welcoming and meaningful in meeting their sexual health and HIV care and prevention needs. Red Door services will engage an expert focus group facilitator from the target community and form a technical working group to develop the focus group questions and interpret qualitative data obtained from focus group participants. Based on the results of the focus groups, Red Door Services will create and implement a plan to improve the cultural responsiveness of their HIV services.

c. Improve cultural responsiveness of EIS providers to serve Black/African American and Latino MSM. In 2018 the MN Council for HIV/AIDS Care and Prevention approved the new Universal Standards that included new cultural responsiveness standards. When these revised standards were initially implemented there were readiness assessments, checklists, and training provided. As two years of site visits have occurred since implementation it is now clear that the cultural responsiveness standards require increased training and more tools for providers to be successful. Additionally, there was a realization that while there are assessment tools for providers to assess their own cultural responsiveness there is little input given by consumers apart from the ongoing consumer feedback and quality management structures. The Quality Management Advisory Committee (QMAC) has created a goal to develop tools for consumers to assess provider cultural responsiveness by 2023.

Black/African-born Individuals

a) Why Black/African-born individuals were chosen. There were 35 Black/African-born individuals diagnosed with HIV infection in the TGA in 2019, representing 15% of new cases. The number of new cases among Black/African-born women in the TGA in 2019 was 25, accounting for 40% of all new diagnoses among women. The gender profile of the epidemic among the TGA's Black/African-born population more closely resembles that of the epidemic in

Sub-Saharan Africa than it does the epidemic in the U.S. Black/African-born women comprised 71% of new diagnoses among African-born in contrast to the overall number of new diagnoses in the TGA in 2019 where 27% were among women. In 2019, the number of Black/African-born persons living with HIV in the TGA was 1342; a 31% increase from 2015. At the same time the overall prevalence on PWH in the MSP-TGA increased by only 11%. While Black/African-born residents of the TGA make up 3.6% of the population, they represent 17% of PWH in the TGA. Black/African-born have the highest HIV prevalence rate in Minnesota among racial/ethnic groups with 1.2% 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 42%. Women also account for 60% of the African-born people living with HIV in the TGA. African-born individuals are more likely to test late, less likely to be in care with 69% retained in care compared to 75% of whites retained in care in 2018. The viral suppression rate shows a similar disparity with 61% of African-born PWH virally suppressed while 68% of white PWH were virally suppressed in the TGA in 2018.

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 PWH. Cultural and religious beliefs about health and disease inform health seeking behaviors that may conflict with tenets of Western medicine that may delay HIV testing and antiretroviral therapy. Culturally and linguistically specific EIS, especially for African-born women in the TGA, are lacking. Funding through HRSA/HAB's "Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdictions" grant will create new opportunities to engage both West and East African communities in the development and implementation of community driven strategies to decrease HIV stigma and increase access to services. Targeted HIV awareness campaigns that promote early access to care, such as culturally responsive EIS and other services for African immigrants living with HIV result in early linkage to care, ongoing retention in care, and sustained viral suppression.

c) Specific strategies for Black/African-born Individuals include:

i. Early Intervention Services

a. Administer 340B ADAP rebate funds to expand testing and rapid linkage services provided by the TGA's second largest HIV services organization that employs EIS services staff from African communities.
b. Coordinate Part A funded medical case management, mental health and psychosocial support services with an EIS program at Sub-Saharan Youth and Family Services (SAYFSM) receiving Part B supplemental funding targeting East African immigrants. The Part A funded services at SAYFSM ensure that East African immigrants newly diagnosed through their EIS program will receive core medical services that provide culturally responsive support for access to HIV medical care and ongoing retention in care and

treatment adherence. East Africans receiving MCM services at SAYFSM were retained in care at a rate of 98%, and 92% were virally suppressed in 2019.

ii. *Build Community Capacity to Reach West and East African-born immigrants with RWHAP services.* The following capacity building activities will be funded through the Part A recipient's two-year HRSA/HAB "Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdictions" grant awarded in July 2019.

a. Provide funds for the West African HIV Task Force (WAHTF) to engage key West African immigrant community stakeholders, including faith leaders and civil society organizations, to mobilize the community to stop new HIV infections through information dissemination and marketing. Objectives of the community engagement activities are: 1) Build a targeted HIV awareness campaign that is culturally responsive to the TGA's West African immigrant communities; 2) Build Christian and Muslim West African faith leaders' and followers' knowledge of HIV's disproportionate impact on their communities and HIV testing, prevention and care services available; 3) Decrease HIV-related stigma through outreach and education at West African community events; and 4) Increase RWHAP service utilization through culturally responsive marketing of RWHAP services. The WAHTF will accomplish these objectives through a combination of outreach at community events and celebrations, HIV education sessions with West African faith and civil society leaders to increase HIV knowledge and health literacy, meetings with community members to develop culturally responsive messaging and materials to build a targeted HIV awareness campaign, and training of HIV service providers to be culturally responsive to the needs of West Africans. The WAHTF was founded in 2017 through the efforts of a Part A recipient Liberian American Doctoral intern. Through her engagement with community faith and civil society organizations to alert the community to the increasing incidence of HIV among Liberian immigrants, community leaders formed a task force to mobile West African communities to increase community HIV awareness and build collective capacity to increase opportunities in the community for HIV testing and access to care and prevention services.

b. Provide funds for Sub-Saharan Youth and Family Services of Minnesota (SAYFSM) to engage East African faith leaders to increase knowledge of the public health impact of HIV on the TGA's East African communities and promote non-stigmatizing healthy behaviors that increase HIV testing, access to HIV care and prevention services, and community support for PWH. The objectives of their capacity building actions include: 1) Build faith leaders' and their followers' understanding of HIV basics and its disproportionate impact on their communities; 2) Disseminate information on HIV, including RWHAP services, through a culturally-responsive targeted awareness campaign; 3) Decrease HIV related stigma through community discussions and events; and 4) increase RWHAP service utilization among East African PWH. To accomplish these objectives, SAYFSM staff will identify at least two East African immigrants with HIV who are willing to tell their stories publicly and support their leadership and visibility in the community. They will share their stories at East African faith-based organizations and at community events designed to reduce HIV stigma in the community. SAYFSM will also conduct conversations and education sessions and convene an annual forum on HIV with Muslim and Christian faith leaders and their followers. To evaluate their capacity building work, SAYFSM plans to survey faith-leader attitudes towards PWH and assess changes in their HIV knowledge from participating in the education

sessions and annual forum. SAYFSM currently receives Part A funds for medical case management, psychosocial support and mental health services. They also are receiving Part B funding for medical transportation and EIS. The number of SAYFSM clients has remained stable for the past three years and the organization's leadership is hoping that their planned capacity building actions will increase participation in their services.

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

a. Employ the RWHAP cultural responsiveness standards to increase subrecipient cultural responsiveness to Black/African-born RWHAP clients through training on intercultural communication, cultural intelligence, and development and dissemination of population-specific cultural tool kits. These efforts are designed to increase the effectiveness of the TGA's RWHAP services for Black/African-born residents and increase engagement of African-born PWH in EIS, and other core medical and supportive services that support lifetime retention in care.

People who inject drugs (PWID)

a) Why people who inject drugs were chosen. On January 9, 2020 the MDH notified Hennepin County Epidemiology of an HIV outbreak among people who inject drugs (PWID) as defined by CDC criteria. As of August 28th, 2020, the outbreak included 26 confirmed cases. In a typical year there are on average 0-3 new HIV cases among PWID (not MSM/IDU). To be defined as part of this outbreak the HIV cases must be: a newly diagnosed person who inject drugs after December 1, 2018 and residing in Hennepin or Ramsey Counties; or linked to cases of this outbreak as a sex partner or drug user partner. As a result of the outbreak, HIV incidence among PWID in the TGA, as seen below, has tripled since 2015, while non-PWID incidence has decreased by 23.04%.

MSP-TGA Incidence	2015	2016	2017	2018	2019	% change
Non-PWID	269	254	226	223	207	-23.04%
PWID (not including MSM/IDU)	6	5	5	8	20	233.3%

The cases are split nearly evenly between male and female. The races of those affected by the outbreak are white (7), black (7) and American Indian (9); including mixed race. The people infected in this outbreak were predominantly residing in Minneapolis, but a few were in the suburbs or in corrections. All but one reported using injection drugs. Over 80% of the people affected have a history of homelessness and over a third have a history of sex work. About a quarter of those identified in this outbreak have had a history of incarceration, and 6 cases have Hepatitis C co-infection.

b) Specific challenges or opportunities. The challenges of interrupting an outbreak of HIV in a largely unstably housed population that is largely experiencing substance used disorders or other co-morbidities during a pandemic are seemingly endless. Many of the outbreak cases have been living in tent encampments in Minneapolis, which are environments that can significantly increase risk of infectious disease transmission, including HIV, COVID-19, and Hepatitis C. Hennepin County established an incident command structure to respond to this outbreak and is utilizing several county assets and programs to reduce HIV transmission to stop new cases of HIV. The MSP-TGA Ryan White Coordinator is currently serving as the community organizations liaison but will soon be tasked with being the incident commander. This puts the Ryan White Program in a strategic position to ensure those affected by the outbreak are not only identified but also connected and retained to care. Other county programs/assets being engaged in the work of addressing this outbreak are: Emergency Preparedness, Epidemiology, Healthcare

for the Homeless, Human Services, Public Health Clinic & Syringe Exchange, and the County Jail. Each program has an important role to play in helping end this outbreak.

c) Specific strategies for PWID include:

i. Increase coordination between the Minnesota Department of Health and Hennepin County's HIV Outbreak Incident Commander as the Ryan White Program Coordinator takes over this role. Hennepin County Public Health staff, including the Ryan White Program Coordinator and the County's Healthcare for the Homeless outreach nurse participate in a collaborative outbreak response technical working group that includes representation from Minnesota's Part B administrative office at DHS, the Minneapolis Department of Health and Family Services, and several key community partners including the Native American Community Clinic and Southside Harm Reduction Services.
ii. Pilot mobile PrEP and ART distribution to housing insecure populations focused on homeless encampments, where the HIV outbreak is centered, and COVID isolation hotels.
iii. Increase HIV testing through Healthcare for the Homeless in the geographic areas where outbreak transmissions have been occurring.
iv. Offer syringe exchange through Healthcare for the Homeless, coordinating with community-based syringe services programs funded by MDH.
v. Provide post-exposure prophylaxis to sex and syringe sharing partners of confirmed cases.
vi. Identify and employ resources to increase capacity to provide safe shelter paired with harm reduction services.

3) Planned Efforts to Remove Legal Barriers to Routine HIV Testing

There are no Minnesota (MN) or Wisconsin (WI) state or local statutes, ordinances or regulations that impose significant barriers to routine op-out HIV testing in medical settings. In MN, the only statute that mentions consent specifically for HIV testing is MN Statute 144.74 which requires consent for testing for a communicable disease when emergency medical services personnel may have experienced a significant exposure from an individual harboring an infectious disease. In WI, statute 252.15 requires health care providers, blood banks, blood or plasma centers, to notify the person or the person's authorized representative that the person will be subjected to an HIV test unless the person or the person's authorized representative declines the test. The WI statute appears to support opt-out testing which is consistent with CDC guidelines and the U.S. Prevention Task Force's grade A recommendation for routine HIV screening. The greatest barriers to HIV testing in the MSP-TGA are low HIV health literacy, lack of health care access, and stigma particularly among disproportionately impacted communities including African Americans, African immigrants, and Latinx.

The TGA has several efforts to expand implementation of routine HIV testing. The Part A recipient works with the MN AIDS Training and Education Center to provide capacity building assistance to community health centers in the TGA to implement and improve routine HIV screening. *Positively Hennepin*, Hennepin County's strategy to end the epidemic, includes increasing routine HIV testing as one of three primary actions to decrease new HIV infections. Tactics include: 1) working with private and Hennepin County operated health care providers to develop plans to establish routine HIV screening as part of standard preventive screenings; 2) expanding the number and type of organizations that implement routine HIV testing by offering providers incentives and supports; and 3) conducting targeted public awareness campaigns, in partnership with communities disproportionately impacted by HIV, to emphasize the importance of routine testing. The *Positively Hennepin* implementation coordinator will continue to work with Hennepin Health, the county's managed care organization for Medicaid and

MinnesotaCare (Minnesota's basic health plan), to improve the rate of routine HIV screening among its 24,000 members, all of whom are Hennepin County residents.

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 PWH residing in the MSP-TGA.

- *METHODOLOGY*

A. Impact of the Changing Health Care Landscape

1) Health Care Coverage Options for PWH in the MSP-TGA. The Affordable Care Act (ACA) in Minnesota (MN) enabled PWH in the MSP-TGA to have a full range of health care coverage options. MN offers comprehensive affordable health care coverage through Medicaid, MinnesotaCare (MN's Basic Health Plan), a Qualified Health Plan (QHP) through MN's insurance exchange *MNSure,* or a private off-exchange plan or employer sponsored coverage. Table 3 (page 12) presents both the public and private health coverage options available through *MNSure* and the number of MSP-TGA's PWH estimated to receive coverage through each option. The MN Department of Human Services (DHS) administers all MN Health Care Programs and is MN's Part B recipient and ADAP administrator.

Medicaid. Medical Assistance (MA), MN's Medicaid program, provides comprehensive outpatient and inpatient health care benefits and covers all antiretroviral (ART) medications. MA health care services are provided on either a fee-for-service basis or through one of the five contracted managed care organizations that operate in the MSP-TGA. All major HIV specialty care providers in the MSP-TGA are qualified MA providers, ensuring that all eligible PWH can select their provider of choice. MA 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 MN'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 ART medications. MinnesotaCare monthly premiums are on a sliding scale based on household income that ranges from $0 for a recipient whose income is <35% of FPG to $80 for a recipient with an income of 200% of FPL. MN's ADAP provides premium payment assistance for all RWHAP eligible PWH enrolled in MinnesotaCare.

Qualified Health Plans. In addition to MA and MinnesotaCare, *MNSure* offers three levels of coverage (Bronze, Silver and Gold) through its QHPs and a catastrophic plan for enrollees under 30 years of age or meet other criteria. Table 4 compares relative costs and overall coverage among all three metal level QHPs.

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

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

MNSure QHP premiums range from $128 (bronze) to $295 (gold) per month, after a $94 advanced premium tax credit, for a single 40-year old with an income of $28,710/year (225% of FPL) living in the Minneapolis zip code that has the highest HIV prevalence rate in the TGA. Deductibles range from $900-$7,000 with out-of-pocket maximum costs ranging from $5,800-

$8,150 (not including premiums). Prescription co-payments range from $0 for generics (after deductible is met) to 30% co-insurance where the deductible does not apply. MN laws are more stringent than federal provider network requirements, requiring health plans to meet strict accessibility standards and offer contracts to all state-designated essential community providers in its service area. As a result, disruptions related to differences in provider networks are minimized. Unless categorically ineligible, most PWH 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.

ADAP. MN's ADAP is administered by the MN DHS. ADAP provides insurance premium assistance for cost effective private and employer-sponsored health plans (where the employee pays ≥50% of the premium cost) including QHPs obtained through *MNSure* and off-exchange private individual plans for PWH who are categorically ineligible to obtain health insurance, including a QHP, through *MNSure*. ADAP also covers prescription deductibles and co-payments. MN's ADAP is administered through DHS' Medicaid Management Information System which coordinates claims with all MN Health Care Programs, ensuring that the RWHAP is the payer of last resort. PWH whose income does not exceed 400% of FPL can receive additional assistance through MN's ADAP to cover their medication deductibles, co-payments, co-insurance, and the remainder of their QHP premiums (after the Advanced Premium Tax Credit is applied). This coverage further reduces any cost barriers to HIV medical care and treatment access. In 2020, ADAP provides premium and cost-sharing assistance for the following five QHPs available in the TGA: Blue Plus Metro MN Gold ($1350 deductible), Medica Applause Gold Copay ($900 deductible), Medica Applause Bronze HSA, ($1,600 deductible), HealthPartners Peak Individual Copay ($1,000 deductible), and UCareGold ($900 deductible).

ADAP selected these plans based on inclusion of comprehensive ART medications in all classes and access to all MSP-TGA providers that offer HIV specialty care. Prior to each open enrollment period HIV benefits counselors and medical case managers help DHS evaluate *MNSure*'s QHPs for affordability, health benefits, drug formularies, and provider choice. Benefits counselors, insurance enrollment assisters, and medical case managers help clients choose a plan that maximizes cost-effectiveness and provider choice. ADAP also pays premiums for Medicare C cost plans, which in 2019 covered 150 RWHAP eligible PWH in the TGA.

Part A and MAI Outpatient Ambulatory Health Services (OAHS). The Part A 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 PWH. Part A OAHS providers include Hennepin Healthcare, HealthPartners, and Minnesota Community Care. Located in downtown Minneapolis, Hennepin Healthcare's Positive Care Center (PCC) is the largest HIV specialty care clinic in the TGA. HealthPartners Specialty Clinics in St. Paul serves patients on the east side of the Twin Cities metro area. Metropolitan Community Care, a Federally Qualified Health Center, located on the west side of St. Paul in the heart of one of the Twin Cities' largest Latinx communities. Part A and MAI OAHS cover 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 MN Council for HIV/AIDS Care and Prevention (MCHACP) allocated $853,393 in Part A and MAI funds combined for OAHS in FY2020. Part A and MAI funded OAHS can also cover deductibles, co-insurance, co-payments for clinic visits, laboratory tests, and other outpatient services. Part A OAHS provided HIV outpatient care services to 1,173 PWH in the MSP-TGA in FY19.

Part C and D Health Care Services. Hennepin Healthcare is MN's sole Part C and D recipient. In addition to providing early intervention and ongoing outpatient health care services at their Positive Care Center, Hennepin Healthcare 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 (HIPCSA). The MCHACP allocated $26,700 in Part B funds in 2020 to provide additional assistance for out-of-pocket medical care costs that are not covered by MN's ADAP. In FY19, Part B funded HIPCSA helped 179 PWH residing in the TGA pay for medical costs.

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

After the full implementation of the ACA, Minnesota (MN) had one of the lowest rates of uninsured residents in the nation which was 4.3% as of December 31, 2015. The primary drivers of MN's record low uninsured rate were increased enrollment in publicly funded state health insurance programs through Medicaid expansion, the establishment of Minnesota Care as MN's basic health plan, and the availability of QHP's through *MNSure.* Prior to 2013, the only coverage option for RWHAP eligible PWH with incomes greater than 100% of the FPL who were not categorically eligible (pregnant, blind, disabled or 65 or older) for Medicaid and were unemployed or whose employer did not offer comprehensive health care coverage, was to obtain private insurance through MN's high risk pool. ADAP would cover the high-risk pool plan premium costs and prescription deductibles and co-payments. The removal of the categorical Medicaid eligibility requirements alleviated cost barriers that sometimes resulted in missed appointments or not picked up prescriptions for the TGA's poorest PWH. Deductibles and co-payments, particularly for outpatient health care services, continue to be cost barriers to health care access for RWHAP eligible PWH with incomes above 200% of the FPL or who do not qualify for Medicaid or MinnesotaCare. Although the QHPs that Minnesota's ADAP supports provide comprehensive coverage, changes in plan 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 PWH.

The proportion of the MSP-TGA's residents who are uninsured is now 6.4%. The rollback of some ACA provisions, including elimination of the individual mandate and the reduction in federal insurance subsidies, are likely causes of fewer Minnesotans retaining coverage. The estimated proportion of the TGA's population of diagnosed PWH who are uninsured is 8.1%, 2.3% higher than for the TGA overall (**Table 3, p 12**). Notable disparities continue among MN's uninsured in the areas of race/ethnicity, age, and country of birth (Minnesota Public Health Data Access, MDH 2017). For example, in 2017, while only 3.4% of Whites were uninsured, the rates among Latinx (21.8%), Blacks (12.8%), American Indians/Alaska Natives (10.6%), and Asians (10.3%) were considerably higher.

Currently, almost 25% of MSP-TGA residents rely on Medicaid or MinnesotaCare. Private insurance plans obtained through *MNSure*, MN's state-based marketplace, cover 2% of Minnesotans on individual or small group coverage. As of December 31, 2019, at least 3,733 (48%) of the TGA's PWH received coverage under Medicaid, MinnesotaCare or a 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. With full implementation of the ACA in MN and additional assistance provided by MN's ADAP, all RWHAP eligible PWH in the MSP-TGA who are U.S. citizens or have residency status ought to

qualify for comprehensive affordable health care coverage. According to the State Wide Coordinated Statement of Need, included in the 2017-2021 Integrated HIV Prevention and Care Plan for MN 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 PWH. With 51% of the TGA's PWH estimated to be at or below 200% of FPL (**Table 3**, **p 12**) and 84% of the TGA's RWHAP consumers at or below 200% of FPL, even small out-of-pocket costs for a clinic visit or a prescription co-payment could result in missing appointments or not adhering to an ART 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, food insecurity, HIV stigma, and HIV-related health disparities among disproportionately impacted communities in the current health care landscape. Without these resources, further improvements in rapid linkage to care, care retention, and ultimately viral suppression are unlikely. With continued rollback of ACA provisions, RWHAP resources will likely play a greater role in ensuring access to health care for eligible PWH, increasing the burden on the MSP-TGA's Part A program.

2) Effect of Changes in the Health Care Landscape

a) Service Provision and Complexity of Providing Care to PWH in the TGA. The council's 2015 Comprehensive Needs Assessment (CNA) survey of 504 PWH asked if participants had needed but not received HIV care and related core medical and support services in the previous 12 months. Nine percent of respondents reported being denied HIV medical care because they were uninsured or could not afford the co-payment, 23% reported waiting more than three months before receiving care, and 11% reported waiting more than a year. Of the respondents, 31% reported difficulty signing up for insurance, with higher rates in racially and culturally specific populations including American Indian/Alaskan Natives (44%) and Latinx (41%). Twenty-eight percent of PWH reported that they have been without health insurance for three months or longer since they received their HIV diagnosis, with higher rates for Latinx (48%), American Indians (42%), and Asian/Pacific Islanders (33%). 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, PWH 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. MN's ADAP works extensively each year to contact RWHAP eligible PWH who are categorically ineligible to obtain insurance through *MNSure* to purchase an off-exchange policy with comprehensive coverage. In 2019, 119 ADAP enrollees were covered by the off-exchange plans ADAP purchases for those unable to obtain a QHP through *MNSure.* Unfortunately, off-exchange plans often have a smaller network of HIV specialty care providers.

Overall, 63% of PWH who participated in the 2015 CNA Survey reported receiving assistance in paying for health insurance premiums, while 79% of Latinx, and 66% of American Indians reported receiving assistance for premiums. Twenty percent of Asian/Pacific Islanders and 19% of American Indian and Latinx respondents reported being denied medical care because they did not have insurance compared to only 3% of Black respondents and 2% of white respondents.

Overall, the ACA has facilitated access to health insurance, particularly for PWH with incomes at or below 200% of FPL. For PWH on Medicare, the Part D prescription drug benefit is also more affordable. MN's ADAP chooses Medicare supplemental health care or

"cost" plans with medication deductibles and co-payments that count towards out-of-pocket expenses. As a result, PWH get through the coverage cap (or donut hole) faster. As of December 31, 2019, 150 PWH in the TGA enrolled in Medicare received extra help from ADAP to cover their out-of-pocket prescription costs. ADAP also pays for open market off-exchange policies with comprehensive coverage for eligible clients who cannot qualify for subsidies due to immigration status. As of December 31, 2019, 119 of the TGA's RWHAP eligible PWH who are categorically ineligible to obtain insurance through MN's insurance exchange enrolled in one of these plans with ADAP covering premium and prescription deductibles 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 PWH, it created a more complex system of obtaining insurance for those struggling to meet their basic needs, experiencing homelessness or other hardship, or foreign-born. Limited open enrollment periods (7 weeks) have exacerbated temporary loss of coverage and access to HIV medical care due to changing life circumstances that affect eligibility for publicly funded or subsidized private health coverage. Foreign-born PWH comprise 28% of the TGA HIV prevalence, who are not citizens or permanent residents, face additional system barriers to health care access in the current health care landscape. The only insurance option for many of them is through the open market, and these off-exchange plans often have limited provider networks that may not include preferred HIV specialty care providers including those that are culturally responsive to foreign-born PWH in the MSP-TGA. The plans available change from year-to-year as do the provider networks. In 2018 and 2019, the off-exchange plans for PWH in the MSP-TGA who are categorically ineligible for Medicaid or Minnesota Care, did not include the two HIV clinical providers preferred by many foreign-born RWHAP eligible PWH in the TGA. One of the providers, Minnesota Community Care, located in the heart of St. Paul's Latinx neighborhood, is an FQHC that employs bilingual clinical and social service staff that provide linguistically specific services to their Spanish-speaking patients. Minnesota Community Care is known to the TGA's HIV community as being culturally responsive to immigrants living with HIV and has an HIV care retention rate that exceeds 90%. The recent escalation of anti-immigrant sentiment creates additional barriers to accessing insurance and ultimately health care. Immigrants living with HIV may be less likely to respond to public health early interventions such as partner services for fear of deportation, resulting in poorer HIV health outcomes, higher costs of care, and increased HIV transmission.

Similarly, PWH who obtain a Qualified Health Plan (QHP) through *MNSure* may experience annual plan changes, including different provider networks and out-of-pocket costs. Fortunately, in 2018 the Minnesota Legislature passed a state-paid $552 million reinsurance program to protect insurance companies from excessive loss that resulted in *MNSure* individual QHP premiums declining by 7 to 28% in 2019. 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 can 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 and Cost Sharing Assistance. The Part A Program coordinates with MN's Part B ADAP and HIV insurance assistance program to ensure coverage of health insurance premiums that are not covered by the Advanced Premium Tax Credits for PWH enrolled in *MNSure's* QHPs. ADAP pays for prescription deductibles, co-payments, and co-insurance for all RWHAP eligible PWH with an annual income up to 400% of the FPL. ADAP and its insurance assistance program also cover low-income PWH who are not eligible for other coverage because of their immigration status. Medical deductibles and co-payments are covered by Part A funded outpatient ambulatory health services (OAHS) at three HIV specialty clinics, one of which is the largest provider of primary care for PWH in the TGA. The Part A and MAI planned allocation for OAHS is increased by 4.7% to $893,796 in 2021 with the capacity to provide HIV specialty care for up to 1,003 un- or underinsured PWH. MN's Part B program also funds a health insurance premium and cost sharing assistance program delivered by MN's largest community-based HIV service organization, JustUs Health. In FY19, 550 PWH in the TGA received premium assistance through ADAP and an additional 179 received premium assistance for MinnesotaCare and help with other out-of-pocket medical costs through JustUs Health's program. Beginning in FY20 RWHAP eligible PWH may have ADAP pay for all insurance premiums for and JustUs Health's emergency financial assistance program, which was allocated $487,700 in Part B funds for emergency rent, utilities, and medical assistance, will pay for additional out-of-pocket medical costs, not associated with prescription co-payments or deductibles.

Part A and Part B funded services such as medical case management and benefits counseling (through Part B funded non-medical case management services) play critical roles in assisting the TGA's PWH to enroll in expanded Medicaid or QHP's through *MNSure.* In FY20, MCM is allocated 43% ($2,208,926) of Part A and MAI service funds which will increase to $2,304,512 in FY21. MCM along with Part B funded benefits counselling (neither are covered by insurance) ensure that the TGA's PWH continue to receive assistance in enrolling in Medicaid, MinnesotaCare, a QHP through *MNSure,* or a select private plan on the open market with premium and prescription co-payment assistance through ADAP.

The following core medical services, including the proportion of the $5,381,108 in Part A and MAI service funds allocated to each category in FY21, are provided for the TGA's PWH who are covered by Medicaid, MinnesotaCare, a QHP, or a select open market private, to assist with reducing out-of-pocket costs that can impose barriers to accessing medical care: 1) outpatient/ambulatory health services (OAHS) for uncovered services, deductible and co-payment coverage (17%); 2) MCM (43%); 3) early intervention services (7%); 4) mental health services not covered by insurance (2%); 5) medical nutrition therapy not covered by insurance (1%); and 6) 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 FY21, help meet basic needs to prevent RWHAP eligible PWH from having to choose between paying for medical expenses or being able to afford rent or food: housing services (5%); and food bank/home delivered meals (14%). In addition to ADAP and insurance premium and cost share assistance, Part B also provides resources for the TGA's PWH for MCM, oral health care, medical transportation, non-medical case management (benefits counseling), and referral for healthcare and supportive services. The Minnesota Council for HIV/AIDS Care and Prevention increased the Part A allocation for housing assistance in 2019 by $184,500, an increase of 120%, to specifically target RWHAP consumers in the MSP-TGA who

are unstably housed and are not virally suppressed to help them obtain stable housing, connect to a medical case manager, ensure access to insurance, and support retention in medical care.

Although covered by the ACA, Part A funded substance abuse outpatient treatment; Parts A, C, and D funded OAHS; Parts A and B funded mental health services; and Part B funded oral health care fill temporary gaps in coverage for uninsured or underinsured PWH between open enrollment periods. These RWHAP funded core medical programs provide "just in time" services to those where delays in obtaining insurance coverage 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, emergency financial assistance, housing services, and psychosocial support that are not covered by insurance, and address social determinants of health to stay engaged in care. Supportive services along with MCM combined comprise 69% of Part A allocations to services in FY20 and these programs will be sustained or increased in FY21.

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 joint community planning body for RWHAP Part A and B as well as for HIV prevention planning for the MSP-TGA and Minnesota (MN). The council meets all requirements under the federal RWHAP legislation, and the membership is reflective of the epidemic in the TGA. The council incorporates additional community input through consumer forums, its Community Voices Committee (CVC), and consumer needs assessments. The council completed its biennial priority setting for FY 2021 and 2022 in July 2020. The council's Planning & Allocations Committee (PAC) refined the priority setting process based on community and member feedback from past processes, and the full council approved the list of services to be prioritized. In addition, the council also approves the Minority AIDS Initiative (MAI) services to be prioritized and funded, and populations of color to be targeted with MAI funds. The MN Department of Health'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 decisions 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 priority setting process includes the council's Needs Assessment & Evaluation Committee reviewing data from a variety of sources, studies, and surveys, and creating a Service Area Review Summary (SARS) for each service area. The PAC designs the priority setting process and priorities are ranked separately for core medical and support services through a paired comparison process. Each member uses grids to compare the priority of each core medical service category to each of the other core medical services. Members 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 12 ranked core medical and 16 ranked supportive services to be considered for funding by Parts A and B grants. For FY21, Part A funds were allocated to seven core medical and seven support services, and, Part A MAI funds were allocated to two core medical services (see **Attachment 8**: Service Category Plan Table). The PAC also designs the resource allocation process. In creating a document that defines the resource allocation process, the committee included principles,

criteria, and guidelines for allocation decisions. The council-approved process keeps the importance of data-driven decision-making and consideration of the needs and input of PWH at the forefront. The council held two allocations meetings in August 2020. At the first meeting the council's resource allocation process was presented as well as the council's vision, values, and mission. The PAC presented the FY21 allocations proposal and the proposal was discussed and approved at the second allocations meeting. The council will consider allocation adjustments when the FY21 Notices of Grant Awards are received.

Minnesota's Integrated HIV Prevention and Care Plan informs the council's priority setting and resource allocation process and is interwoven in the council's and RWHAP Part A's activities. Many of the activities associated with each of the objectives of the integrated plan are based on the council's priorities and allocations.

i. PWH involvement in the planning and allocation processes. All populations identified as having severe need are represented on the council, including two African immigrants, and three Latin American immigrants. The council is currently composed of 28 members, 16 (57%) of whom have HIV. The council's CVC meets quarterly and includes council members as well as community members 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 PWH and feedback on priorities, allocations, and standards of care. During the priority setting process, committee members selected their top three service priorities using an online survey platform, and the results determined the community's priorities. Council members used the community's priorities and the two most recent needs assessment surveys of PWH to help determine the council's priorities. PWH are members and leaders of all council committees. 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 and CVC meeting.

ii. Community input into the process to address Part A award funding changes. The council planned for possible changes in the Part A award amount when it approved the priority setting and resource allocation process for FY21. The 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 2020 are automatically reduced by unspent amounts. If funding increases, allocations will be increased based on data, including the number and characteristics of clients, demand in the current year, HRSA performance measures, clinical outcomes data, and plans for bringing additional PWH into care. The council will also ensure core medical services are available to all eligible PWH.

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 consumer needs assessment, the annual HIV surveillance report, the HIV Care Continuum analysis by race, ethnicity, gender, age, and exposure category; and the results of the Center for Quality Improvement and Innovation's disparities calculator. 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.

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. The council reviews and considers the epidemiological data, the HIV Care Continuum (HCC), service utilization data, needs assessments, quarterly and annual recipient expenditure reports,

HIV care expenditures from other sources, and qualitative data from interviews conducted with Black/African American, Native American, and Latinx workgroup members in 2017, the Latino AIDS Commission study on Latino MSM in Minnesota (2014), results from interviews with African American MSM conducted by the Office of Minority Health Resource Center (2015), and reports from two Native American HIV Caucus action planning retreats conducted in December 2018 and March 2019 for setting priorities and allocating funds. The council examines HIV epidemiological trends from the previous five years, reviewing gender, age, race, ethnicity, country of birth and risk factor(s) in the HIV incidence and prevalence of the MSP-TGA and at each stage of the HCC. The council uses these data to consider allocations that address disparities, the needs of emerging populations, and fill gaps in services. The council decreased allocations to under-utilized services to maintain core medical services in FY19 in recognition of increased HIV prevalence and need for services to retain consumers in care as evidenced in the annual HCC update. The council makes every effort to ensure that Part A funds for women, infants, children, and youth (WICY) are proportionate to their representation in the epidemic.
v. Significant changes in the prioritization and allocation process from 2020 to 2021 and the rationale for those changes. Due to lower than anticipated utilization of mental health services, the council decreased allocations to mental health services for FY21 by $10,000. Linguistics services historically has received a small proportion of funding, but is an essential service for those who use it; and, in the current fiscal year, linguistics services is overspent by 300%. Accordingly, the council increased the funding for linguistics services from $1900 to $3600.

2) Administrative Assessment

a) Assessment of the grant recipient activities. The council's most recent assessment of the efficiency of the Part A recipient's administration of the FY 2019 Part A grant to ensure contracting of funds and timely payments to subrecipients used six measurement objectives. Results of the assessment are as follows:

MN Council for HIV/AIDS Care and Prevention Assessment of the Administrative Mechanism Part A FY19 (n=22)				
Objective	**Strongly Agree**	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
1. Part A funds are contracted quickly to subrecipients by signing contracts with subrecipients by 90 days of the beginning of Part A FY.	77%	14%	9%	0%
2. Part A subrecipients are selected through an open, public process to contract for services through a competitive RFP process.	68%	23%	9%	0%
3. The recipient secured sufficient subrecipients for all service areas receiving allocations. Per service area, sufficient number of subrecipients is based on: number of contracts that can be administered; amount of funding allocated for each prioritized service area; allocation requirements for populations with special needs; and availability of qualified providers.	59%	32%	9%	0%
4. Subrecipients are paid in a timely manner by Hennepin County and invoices were paid within the timetable indicated in contracts.	86%	5%	5%	5%
5. Part A funds are used to pay only for services that were identified as priorities by the council.	77%	14%	5%	5%
6. The amounts contracted for each service category are the same as the council's allocations. Awards per service area match the council's waiver request allocations plan completed in December 2018 and subsequent adjustments done through post award allocations, carryover plan, and reallocation plans in FY 2019.	77%	14%	5%	5%

The council completed their administrative assessment on September 11, 2020. Council members receive data from the Part A recipient as well as responses to a subrecipient (11) survey. 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. All but two (92%) council members completed the evaluation. Of those that completed the evaluation, 91% indicated that they strongly or somewhat agreed that objectives 1-6 were met. For the two members who somewhat or strongly disagreed that the objectives were met, no feedback, suggestions, or an explanation as to why the objectives were not met were included in the comment sections.

b) Deficiencies and corrective action. There were no deficiencies identified by the assessment and no corrective actions were recommended by the council.

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 Coordination of Services and Funding Table. **Attachment 5** presents the HIV prevention and care services available in the 13 county MSP-TGA along with their funding sources. A map of HIV prevalence in the TGA with Part A funded outpatient ambulatory health services, medical case management and other supportive services is presented as **Attachment 13B** and provides a sense of the geographic accessibility of RWHAP services in the 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 affect the HIV Care Continuum receive public funding, many of which are primarily funded by RWHAP funds. Two detailed analyses of the MSP-TGA's RWHAP client-level data were conducted in FY19 using logistic regression and a disparities calculator provided by the Center for Quality Improvement and Innovation. The analysis of the empirical evidence found that housing status was the independent predictor of viral suppression. Clients who are temporarily housed and receiving RWHAP services were more likely to be virally suppressed when medically case managed and enrolled in ADAP. As a result, a Part A implemented a housing pilot to help unstably housed RWHAP clients who are not virally suppressed achieve housing stability through a combination of medical case management, housing coordination, and rental assistance in order to reach viral suppression. Although the council increased the Part A allocation for housing services by $185,400 in 2019, additional resources, primarily for rental assistance, are needed to house the estimated 850 PWH in the TGA without a permanent stable home (MN Housing Coalition, 2018). Increased unemployment due to the COVID-19 pandemic will likely increase the need for rental assistance. Affordable housing in the TGA is becoming scarcer, making it harder to mitigate housing instability as a barrier to care. On July 1, 2020, MN will offer a new Medicaid benefit to help people with disabilities and seniors find and keep housing. Recipients of the new housing stability benefit must be 18 years or older with a disability or disabling condition.

The health disparities calculator identified Black/African American men who have sex with men (MSM) and Black/African American women as the only two groups of PWH larger than 100 and within the RWHAP system that continue to experience viral suppression disparities. As a result, the council's Disparities Elimination Committee has taken responsibility of conducting additional analysis and formulating recommendations based on the calculator results.

A critical goal of the MSP-TGA's RWHAP is to reduce or eliminate the gaps that prevent PWH from adhering the anti-retroviral treatment and reaching viral suppression. Currently, 96% of all demographic groups within the RWHAP system are retained in care. The most recent HIV Care Continuum (HCC) for all diagnosed PWH the TGA estimates that 72% of diagnosed PWH in the jurisdiction were retained in medical care, indicating that 2,092 of the TGA's diagnosed PWH were not receiving HIV medical care. The Minnesota Department of Health (MDH) estimates that 9.9% of PWH (960 PWH) in MN are undiagnosed. Eighty-five percent of MN's prevalent cases reside in the 11 MN counties of the MSP-TGA. Using the MN undiagnosed estimate of 9.9% and applying it proportionally to the MSP-TGA's 2018 care continuum yields an undiagnosed estimate for the TGA of 812. If 2018 HCC outcomes remain stable or improve, the national goals of 90% of PWH knowing their status and 85% of newly diagnosed cases being linked to care within 30 days are already met in the MSP-TGA. However, there are concerns about the increase in incidence among African American MSM and Latino MSM. Additionally, African-born communities have a disproportionately high incidence rate. Targeted EIS efforts will be needed to identify and link PWH among these and other communities disproportionately affected by HIV. With a total estimate of 2,904 PWH both diagnosed and undiagnosed in the TGA (36%) out-of-care, considerable additional resources would be needed to achieve key national HIV goals in the MSP-TGA where 90% of diagnosed PWH are retained in care and 80% of diagnosed PWH are virally suppressed.

Forty-one percent of diagnosed PWH in the TGA received a Part A funded RWHAP service in FY19, 97% of whom were retained in care. Retention in care for Part A consumers is measured using a combination of CD4 count and viral load test data from the MDH's HIV surveillance system (uploaded into MN CAREWare monthly) and subrecipient reports of dates of client's medical appointments. Based on income estimates of diagnosed PWH in the MSP-TGA (**Table 3, p 12**), 74% (5,828) are eligible for RWHAP services, indicating that there are an estimated additional 2,650 RWHAP eligible PWH who might benefit from RWHAP services. With an average expenditure of $1,641 in Part A funds per client in 2019, $4,348,650 in addition to the Part A funds awarded in FY19 would be needed to provide comparable services to all RWHAP eligible PWH in the MSP-TGA.

The factors contributing to PWH unaware of their status not being tested and linked to care, and PWH who are aware of their status not remaining in care are complex. These factors include untreated co-occurring conditions such as mental illness and substance use disorders. Factors also include stigma, unfulfilled economic and social needs such as stable housing, income and food security, health literacy, and family and community support. The MN 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 ambulatory health services for the un- and underinsured, provide access to treatment for co-occurring conditions and meet the socio-economic needs of eligible PWH.

A full continuum of culturally responsive EIS, linkage, and retention support services are needed to engage and retain those not in care. Many steps are underway to ensure adequate resources are available to meet the needs of PWH, particularly for Blacks, Latinx, and other minority groups, such as men of color who have sex with men, and transgender and cis-gender women 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 (HCPH) Clinics, and the second largest community-based HIV service organization in the MSP)-TGA, both of which have referral agreements with the five largest HIV clinics that facilitate medical appointments within 48 hours of diagnosis. The MDH's Care Link Specialists use its

HIV surveillance data to help PWH who reside in the 10 Minnesota TGA counties outside of Hennepin County, to connect to and remain or re-engage in care. HCPH Clinics initiated a Data to Care project beginning in 2016 using HIV surveillance data provided by MDH that focuses on re-engaging and retaining Hennepin County's (where 61% of PWH in the TGA reside) diagnosed residents living with HIV in care. This program was expanded in 2018 with additional ADAP 340B rebate resources. PWH receiving RWHAP services are more likely to be in care and have suppressed virus compared to the TGA's total population of PWH. Services such as MCM significantly improve movement across the HIV Care Continuum from linkage to viral suppression, and support services such as housing, transportation, food supports, and EFA help mitigate economic barriers to care retention. Despite MN's low uninsured rate, disparities in health care coverage negatively impact people of color, particularly foreign-born individuals. The MSP-TGA's most recent HIV Care Continuum indicates that young African American MSM living with HIV may have the lowest rate of viral suppression among three-way stratified demographic groups. Part A and MAI funds are allocated to outpatient ambulatory health services (OAHS) provided by two of the largest HIV specialty clinics in the TGA and a Federally Qualified Health Center reaching PWH born in Latin American countries who are categorically ineligible for Medicaid or Medicare, or to obtain a subsidized Qualified Health Plan through *MNSure*. ADAP will cover health insurance premiums through the private market for many of these individuals but for others, OAHS programs fill gaps in medical care especially for PWH 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 the TGA's needs. The growth in both the epidemic and the number of PWH 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 (HCC) in the MSP-TGA and includes indicator baselines and target outcomes to achieve in FY 2021 at each stage of the HCC.

2) HIV Care Continuum Narrative

a) Utilization of the HIV Care Continuum to Plan, Prioritize, Target, and Monitor Resources. The Minnesota Department of Health's (MDH) HIV epidemiologists developed Minnesota's first diagnosed-based HCC in 2013 using 2011 and 2012 HIV surveillance data following the publication of the first national HIV treatment cascade. Both the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP or council) and the Part A recipient use the HCC extensively to set priorities, allocate resources, and develop effective service delivery models that facilitate HIV diagnosis, result in rapid linkage to care, support care retention and viral suppression, and address disparities in health outcomes along the HCC. In 2016, the Council used the HCC to guide development of the Minnesota/MSP-TGA 2017-2021 Integrated HIV Prevention and Care Plan's goals, objectives, and activities.

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 2018 HCC presented by MDH in September 2019 informed service priorities for FY21 and FY22. Due to the COVID-19 pandemic, MDH has not released the 2019 HCC.

MCHACP uses a version of the HCC developed by the council's Needs Assessment and Evaluation Committee that superimposes RWHAP services on the stages of the continuum to inform its work. 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 viral suppression.

On July 10, 2018, the RWHAP presented a report of client viral suppression rates based on 2017 housing status, which showed that those who are temporarily or unstably housed had significantly lower viral suppression rates of 63% and 73%, respectively, compared to those who are stably housing (86% virally suppressed). Concerned about the 28% of diagnosed PWH in the MSP-TGA who are not retained in care (**Figure 3**, **p 10)** and the lower viral suppression rates for RWHAP program clients who are not stably housed, the council increased its allocation for housing services by $184,500 for FY19 to help alleviate waiting lists for the MSP-TGA's HIV housing programs. Based on the state's estimate that 9.9% PWH are unaware of their status and disparities in care retention and viral suppression rates, the council allocated $50,000 in carryover funds to EIS for FY19 to sustain the level of EIS funding to continue targeted efforts to diagnose the HIV unaware and rapidly link them to care.

The 2016 HCC based on 2014 and 2015 HIV surveillance data framed MCHACP's work to reduce racial/ethnic, gender, mode of exposure, and age disparities in movement along the continuum towards rapid achievement of viral suppression, which is reflected in the integrated plan's third goal to "Reduce HIV-Related Disparities & Health Inequities." More recently, in November 2019, during the review of MN's integrated multi-parts (A, C, and D) clinical quality management (CQM) plan at the Quality Management Advisory Committee meeting, members approved the 2020 CQM plan goals that include eliminating disparities in health outcomes within the RWHAP system based on findings from the Center for Quality Improvement and Innovation's Health Disparities Calculator. This work was presented to the council in January 2020. While all populations examined were retained in care at 95% or above, Black/African American MSM and Black/African American women experienced disparities in viral suppression. The Disparities Elimination Committee of the council has taken on the task of making formal recommendations to address these disparities. For 2020, the council continued to allocate MAI funds to medical case management (MCM) targeting Black/African Americans, Black/African-born individuals and Latinx, and outpatient ambulatory health services (OAHS) for Latinx clients to address disparities in care retention and viral suppression.

Also informed by the annual review of the MSP-TGA's HCC, in 2016 Hennepin County's Public Health Clinic began receiving 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 15 months. Sixty-one percent of diagnosed PWH in the MSP-TGA reside in Hennepin County. Three clinic HIV services navigators, trained as HIV/STI disease investigators, work through the data to contact cases that have not received HIV medical care and offer person-centered care re-engagement services.

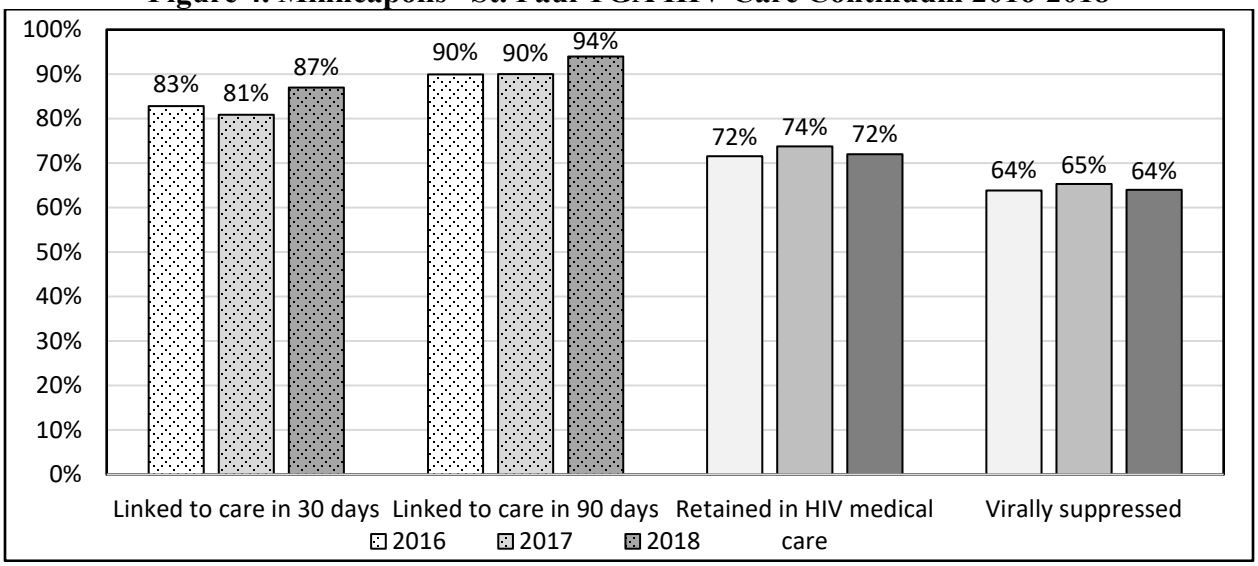
The Part A grant recipient staff incorporates HCC related HHS and HAB linkage, retention in HIV medical care, and viral suppression performance measures in monitoring and evaluating effectiveness of all Part A funded services including EIS, OAHS, and MCM. These performance measures, for both Part A RWHAP clients and all RWHAP clients residing in the MSP-TGA, are reviewed quarterly to monitor and evaluate the Part A annual clinical quality management plan.

b) HIV Care Continuum Changes, Program Impact and Response

Changes in the care continuum. **Figure 4** presents the most recent three years (2016-2018) of jurisdictional HIV care continuum data by stages along the continuum for the population of people in the MSP-TGA diagnosed with HIV infection. The MDH and Wisconsin Department of Health Services provide surveillance data to develop the MSP-TGA's annual diagnosed-based care continuum. Since neither the Minnesota nor Wisconsin's HIV surveillance system collects data on ART prescriptions, the MSP-TGA's HCC does not include prescribed ART as a continuum stage. The Part A program does collect prescribed ART data on clients who receive Part A funded OAHS, representing 16% of the population of diagnosed PWH in the MSP-TGA.

Linkage is calculated as the percentage of people linked to care within 30 and 90 days after initial HIV diagnosis during the previous year with the denominator being the number of new cases diagnosed in that year. A different denominator is used to calculate retention in care and viral suppression, hence the different shading of the linked to care bars. Retained in care is calculated as the percentage of people (≥ 13 years of age) who had ≥1 CD4 count or viral load test result during the designated year among those diagnosed with HIV through the end of the previous year and alive at the end of the designated year. Virally suppressed is calculated as the percentage of people (≥ 13 years of age) who had suppressed viral load (<200 copies/mL) at most recent test during the designated year, among those diagnosed with HIV through the end of the previous year and alive at the end of the designated year.

Figure 4. Minneapolis –St. Paul TGA HIV Care Continuum 2016-2018



The HIV care continuum data for the MSP-TGA indicate incremental progress in increasing the proportion of new diagnoses linked to care in 90 days, and a plateau of the proportion of diagnosed PWH who are retained in care and the proportion who are virally suppressed. As of 2018, 94% of the MSP-TGA's new HIV cases are linked to care within 90 days. Linking new cases to care within 30 days increased by 6% between 2017 and 2018 after a decline of 2% between 2016 and 2017. In 2018, retention in care and viral suppression decreased to the same percentages as in 2016, 72% and 64%, respectively. The increase in linkage to care between 2016 and 2018 surpassed the 2020 national goal of 85% of newly diagnosed PWH in the MSP-TGA being linked to care in 30 days. The rates of care retention and viral suppression need to improve significantly in order to meet the 2020 goal of 90% and 80%, respectively. Given the events of 2020, it is unlikely these goals will be met. The RWHAP and MCHACP are evaluating

how to drive improvement in the next iteration of Positively Hennepin (the county strategy to end the HIV epidemic), END HIV MN (the state strategy to end the HIV epidemic), and the Council's integrated plan.

MDH will only release an estimate of the proportion of the population of PWH who are undiagnosed statewide and not for a jurisdiction within the state, hence an official estimate of the undiagnosed population of people with HIV infection for the MSP-TGA is not available. The current estimate (2018) is that 90.1% of PWH in Minnesota are aware of their HIV status, meeting the national goal for 2020. This is an increase of 2.6% from the first estimate for Minnesota that was released by the CDC in 2015 based on 2012 national HIV surveillance data.

There continue to be large disparities in retention in care and viral suppression among Black/African American MSM, Black/African-born men, and Black/African American women. Because the linked-to-care percentages are based on the number of newly diagnosed cases in the designated calendar year, which is fewer than 300, the denominators for stratification by demographic groups including race/ethnicity, age and mode of exposure are too small to confidently assess disparities in linkage to care.

Impact of the care continuum on the Part A program and response to changes. Changes in the MSP-TGA's care continuum since 2013 impact service prioritization, resource allocation, population targeting, and capacity development to address the most persistent gaps along the continuum where improvement in health outcomes is slower, including retention in care and viral suppression. The MCHACP priority rankings for some services that directly impact stages of the care continuum moved up since 2013, including early intervention services (from 7 to 4 of core medical service), medical case management (from 4 to 1 of core medical service) and housing services (from 2 to 1 support service). Based on analysis of retention in care and viral suppression by housing status using MN CAREWare data that showed significantly poorer outcomes for RWHAP consumers who are either temporarily or unstably housed, the council increased the Part A allocation for housing services for FY19. These additional resources target PWH receiving RWHAP services that are unstably housed and are not virally suppressed to provide housing coordination and rental assistance for up to 24 months. This program aims to link clients to affordable permanent/stable housing with the goal of improving their HIV health outcomes during and after their time in the housing program. In addition, the council continues to target MAI funds to Blacks to support care retention and viral suppression by providing medical case management, which includes treatment adherence support, to close the persistent wider gap in these two stages of the care continuum that these populations experience.

Beginning in 2016, the Part A recipient began a collaborative project with MDH and the Minnesota Department of Human Services (Part B recipient) to migrate HIV and AIDS diagnosis dates, CD4 counts and viral load values from eHARS (the state HIV surveillance system) into MN CAREWare to develop a complete RWHAP HIV Care Continuum for Minnesota and the MSP-TGA that includes all diagnosed PWH that receive RWHAP services. The first complete match of eHARS with MN CAREWare data was completed in October 2017. Now, Hennepin County Part A program staff can access more accurate and timely data on each stage of the HCC. With greater access to timely data, staff can create, analyze, and share HCC data by gender, race, age, risk factor, service, and subrecipient. In 2019, 91% of Part A clients had a viral load in CAREWare. The integration of surveillance with client-level services data in MN CAREWare is positively impacting programs, and in turn, RWHAP clients. In 2019, Part A recipient staff along with staff administering MN CAREWare developed mechanisms, protocols, and training for providers to be able to log into CAREWare to develop and analyze their own agency or program

specific HCC to empower them to understand their real time performance and develop strategies to help improve outcomes along the HCC for their clients. Notably, beginning in FY2019, Part A medical case management programs are reporting on viral suppression rates on a quarterly basis as a contractual performance measure. This will enable them to more effectively monitor their clients' health outcomes including those from disproportionally affected communities to identify where along the HIV care continuum performance is lacking and where disparities exist.

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 allocated funds for FY 2020 and planned allocations for FY 2021 to meet the identified needs of PWH in the Minneapolis-St. Paul TGA. A core medical services expenditure waiver request for the MSP-TGA will be submitted separately prior to the commencement of FY 2021. The service category plan matches the intended waiver request.

b) MAI Service Category Plan Narrative. The goals and objectives of the FY21 MAI plan emphasize increasing access to HIV medical care and improving health outcomes along the HIV Care Continuum for Black/African American and African-born, and Latinx PWH through culturally responsive medical case management (MCM) and outpatient/ambulatory health services (OAHS). All anticipated FY21 MAI service funds ($353,908) are allocated to core medical services. The goals for the MAI-funded services are based on the 2018 HIV surveillance data used to develop the current TGA HIV Care Continuum (HCC). Disparities in engagement along the HCC pertains to the MAI goals are as follows. Comparative measures along the HCC were examined for the four largest racial/ethnic groups. Linkage to care within 30 days was consistently high at 87% overall across racial/ethnic groups. Overall, retention in care was 72%. The lowest retention in care rates were among Black/African-born (68%), Black/African Americans (69%), and Latinx (70%), compared to 74% for Whites. Overall viral suppression was 64%. The lowest viral suppression rates were among Black/African Americans (57%) and Black/African-born (61%), with Latinx (65%) and White, non-Hispanic (68%) individuals doing comparatively better. Therefore, the MAI plan focuses on retention in care and viral suppression for Black/African American and Black/African-born, as well as Latinx individuals.

The goal of MAI funded OAHS is to increase the number of Latinx, Black/African American, and Black/African-born PWH who are continuously engaged in quality HIV medical care, as a significant number have no other sources of health care coverage. OAHS includes providing health care for individuals who are categorically ineligible for publicly funded Minnesota Health Care Programs and individual Qualified Health Plans accessed through Minnesota's health insurance exchange, MNSure. The TGA's Cultural Responsiveness (CR) Standards are integrated into the programs to address culturally specific needs. One of the CR standards requires involving consumers in program development, implementation, evaluation, and quality improvement. The programs are located at a full-service Federally Qualified Health Center located in St. Paul and the largest HIV specialty clinic in Minneapolis; both are located in cultural and economic centers of the TGA. The clinical objectives for initial visits and routine care include coverage for all laboratory tests, vaccinations, and radiological imaging. OAHS is budgeted to receive 38% of the MAI funds in FY 2021 ($136,096). Part A funds will also support OAHS services in FY21.

The goal of MAI-funded CR MCM is to increase access to core medical and support services for Black/African American and African-born as well as Latinx PWH. MCM targeting

Black/African American PWH is funded by Part A. Sixty-two percent ($166,926) of Part A MAI funds are allocated in FY20 for CR MCM provided by bilingual and culturally responsive staff at a full-service Federally Qualified Health Center located in the heart of St. Paul. This is the same Community Health Center that receives MAI funding for OAHS. The second CR MCM organization receives 12% ($40,000) of Part A MAI funds and focuses on providing culturally responsive services to Black/African-born individuals. The agencies have well-established relationships with clinical providers of HIV medical care and early intervention services in Minneapolis and St. Paul. 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.

Black/African Americans (U.S. born) comprise 22% of the people living with HIV in the MSP-TGA, while 17% are Black/African-born (see Attachment 3B). Combined they make up 39% of all PWH in the TGA, but represent only 9% of the total population of the TGA. Latinx make up 11% of all PWH in the TGA and 6% of the TGA's population.

The Part A program has been successful at addressing several disparities highlighted above among PWH in the TGA. Among those receiving RWHAP services across all racial/ethnic groups, retention in care is at 96% or above. Disaggregated data shows positive retention in care outcomes for Black/African American (96%), Black/African-born (98%), Latinx (98%), and White (97%). However, there is a persistent disparity in viral suppression for Black/African Americans (87%) compared to Black/African-born (93%), Latinx (93%), and White, non-Hispanics (92%). Viral suppression, within the Ryan White system, uses the HRSA definition that only includes those with a documented viral load in the denominator.

With 75% of men living with HIV in the TGA identified as MSM (including MSM/IDU), it is important to examine the HIV Care Continuum for this high-prevalence population as well. MSM are the most common mode of HIV exposure among Black/African Americans and Latinos. In line with the disparities highlighted above, Black/African Americans MSM have a lower retention in care rate (69%) than White and Latino MSM, both who are retained in care at 75%. This disparity is more pronounced when examining viral suppression rates for Black/African American MSM (56%) compared to Latino MSM (70%) and White MSM (69%).

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 using MAI outcomes spreadsheets to ensure that they are prioritizing the measurement of outcomes for 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 2020 MAI goals and to meet the HRSA requirement to report on client level health outcomes for all FY 2020 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) 98% of clients retained in care and 2) 91% of clients with undetectable viral load. .

c) Core Medical Services Expenditure Waiver. A core medical services expenditure waiver request for the MSP-TGA for FY 2021 is not included in this grant application and will be submitted separately by March 1, 2021.

- *RESOLUTION OF CHALLENGES.*

The following table describes Part A Program approaches to resolving challenges and barriers in implementing the Part A Program and integrating the HIV Care Continuum into planning and programming.

Challenges and Barriers	Proposed Resolutions	Intended Outcomes	Current Status
1. Ending an HIV Outbreak among People Who Inject Drugs (PWID): In October 2019, The Minnesota Department of Health (MDH) identified an HIV outbreak among PWID in Hennepin and Ramsey Counties, the two largest counties in the MSP-TGA. Twenty-one of the 26 cases reside in Hennepin County (HC). Most of the HIV cases are among people who are homeless, many of whom are unsheltered.	a) Scale up HIV testing among PWID, targeting people on the street, homeless encampments, and people in shelters. b) Provide contact tracing and partner services by Hennepin County disease investigators and test needle sharing and sexual partners of new outbreak cases. c) Provide early intervention services (EIS) including linkage to HIV medical care, care coordination, and referrals to medical case management, and other core medical and supportive services. d) Provide harm reduction services to PWID including access to syringe services programs, referrals to chemical dependency treatment programs, and medication assisted therapy. e) Provide stable transitional housing for homeless PWH who inject drugs who are identified through the outbreak response. f) Provide low-barrier PrEP services in the field for needle sharing and sexual partners of PWH connected to the outbreak. a) Provide low-barrier antiretroviral treatment in the field for homeless unsheltered PWH connected to the outbreak who are living in encampments or on the street.	• Homeless PWH connected to the outbreak are sheltered and linked to the MSP-TGA's HIV transitional housing program or another program that provides stable, safe housing. • New cases connected to the outbreak are linked to HIV medical care and other core medical and supportive services to support retention in care within 30 days of diagnosis. • PWH connected to the outbreak who remain unstably housed have a care coordinator (EIS navigator, medical case manager, or Healthcare for the Homeless case assistant) to help them meet their immediate medical and social service needs. • PWH connected to the outbreak achieve viral suppression within six months of diagnosis or first contact with a disease intervention specialist. • Needle sharing and sex partners of PWH connected to the outbreak have access HIV testing and harm reduction services including syringe services and low-barrier PrEP.	• Hennepin County Public Health (HCPH) employs an incident command structure to respond to the dual outbreak of Hepatitis A and HIV among PWID in Hennepin County. The ICS is in its ninth operational period. • A HC public health disease investigator is following all HIV outbreak cases, contact tracing, and offering partner services, and linkage to HIV medical care. • A HC Healthcare for the Homeless public health nurse is providing outreach, including HIV, syphilis and Hepatitis C testing, Hepatitis A vaccinations, and syringe services in the field at homeless encampments and on the street. • A Part A funded EIS navigator partners with the public health nurse to provide care coordination, including linkage to HIV medical care and other essential core medical and supportive services. • Needle sharing and sex partners of PWH connected to the outbreak receive HIV testing, and Hepatitis A vaccinations. • Hennepin County's syringe services program (SSP) and other SSPs funded by the MDH are providing sterile syringes and HIV testing in homeless encampments and to people on the street in Hennepin and Ramsey Counties.

Challenges and Barriers	Proposed Resolutions	Intended Outcomes	Current Status
2. <u>Understanding and responding to RWHAP consumer needs during the COVID-19 pandemic</u> The COVID-19 pandemic and associated economic downturn created barriers for RWHAP consumers to maintain access to HIV medical care and key support services. Furthermore, the pandemic resulted in a communication gap between RWHAP subrecipients and their clients, so client needs were not fully understood.	a) Design a survey for RWHAP consumers that is accessible, brief, and follows survey best practices to understand emerging client needs during the COVID-19 pandemic. b) Analyze the results quickly to leverage Coronavirus Aid, Relief, and Economic Security (CARES) Act funds to meet emerging client needs. c) Work with the Part B recipient (Minnesota Department of Human Services) to leverage state resources to meet client needs that cannot be met through CARES Act funding.	• How a client's housing, HIV medication adherence, and insurance have changed since the COVID-19 pandemic began is determined. • Client needs not being met due to the COVID-19 pandemic are identified. • Resources are provided that meet emerging client needs during the COVID-19 pandemic. • Clients have the core medical and support services needed to maintain viral suppression. • Fewer PWH acquire COVID-19 infections by ensuring their needs are met and they are protected.	• In May 2020, medical case managers collected 645 responses to a client survey designed to assess client needs during the COVID-19 pandemic. • Food, masks, and cleaning supplies were identified as needs addressable through the CARES Act funding, and were included in the Part A CARES Act budget. • As of September 2020, additional food services, gift cards for cleaning supplies, and masks are being distributed to clients. • The Minnesota Part B recipient is using 340b rebate funds to address emergency housing assistance and insurance needs that are exacerbated by pandemic. • Part A program recipient staff provided information to clients on safer transportation options and receiving HIV medication by mail. • The Part A program is monitoring service utilization, viral suppression, and COVID-19 infections to ensure these resources are meeting client needs and helping RWHAP consumers maintain their best health.
3. <u>Ending the Epidemic through Addressing Disparities in Health Outcomes</u>: Black/African American MSM and Black/African American women who receive RWHAP services in the MSP-TGA have lower rates of viral suppression compared to Whites, indicating the existence of health inequities in the RWHAP system of care.	a) Identify the percent of Black/African American MSM and Black/African American Women Ryan White consumers not receiving medical case management services and develop a plan to enroll these populations in MCM. b) Identify and implement a tool to assess the cultural responsiveness of RWHAP services for Black/African American MSM & Black/African American women. c) Hold focus groups with Black/African American MSM to identify barriers to	• Reduce the disparity for the identified subpopulation(s) year over year. o 92% viral suppression for Black/African American Women by 12/31/23 o 92% viral suppression for Black/African American MSM by 12/31/23 • Detailed implementation plan included in QMAC's 2021 CQM on addressing these goals.	• Health Disparities Calculator identified Black/African American MSM and Black/African American women as the two subpopulations larger than 100 people experiencing disparities in viral suppression for years 2014-2018. • These results have been presented to the MCHACP and QMAC. QMAC made these goals part of its 5-year CQM Plan • The Disparities Elimination Committee has taken on the responsibility of making formal recommendations based on the Calculator results.

Challenges and Barriers	Proposed Resolutions	Intended Outcomes	Current Status
	viral suppression and brainstorm ideas for addressing these barriers. b) Monitor health disparities by running the Health Disparities Calculator each year.		• Once the recommendations are made, HC, MDH, and DHS leadership will assess feasibility of solutions based on resources.
4. Ensuring RWHAP services are Culturally Responsive (CR): CR Standards were finalized and implemented in FY17 to advance health equity through quality care and services that are responsive to the cultural and linguistic needs of RW diverse client populations. Initial subrecipient compliance with CR standards was found lacking, additional guidance and tools are needed to support subrecipient successes with the CR goal.	c) Assess subrecipients' barriers to meeting CR standards requirements. d) Conduct CR standards overview/training. e) Conduct training on accessing and analyzing data to identify CR improvement opportunities. f) Convene regular subrecipient meetings to share successes and challenges. g) Provide evidence-based community engagement TA/capacity building assistance including participatory engagement and board development. h) Provide regular population-specific CR training. c) Monitor and evaluate subrecipients' CR initiatives and population advancement along the Care Continuum.	• Subrecipients understand the critical role of CR. • Subrecipients understand the conceptual frameworks of health equity and social justice. • Subrecipients are competent in accessing and analyzing quantitative and qualitative data to identify CR and health equity opportunities. • CR quality care and services are advancing health equity and eliminating disparities.	• Conducted CR Standards readiness assessments and provided a brief overview of CR Standards in FY17. • Assessed progress in meeting CR Standards during site visits and quarterly report reviews in FY18. • Assessed subrecipients' planned CR activities and training needs in FY19. • Conducted CR Standards and data access trainings in FY20. • In progress: coordinating CR and Black/African-born communities training scheduled for winter FY20. • In progress: coordinating CR, Black/African-born and mental health training. • Ongoing: monitor, evaluate, and improve subrecipient and systemwide CR efforts.

- EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM)

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

The Part A CQM program and the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) utilize HIV Care Continuum (HCC) data for the MSP-TGA's population of diagnosed PWH provided by the MN Department of Health (MDH) to determine differences in linkage to care within 30 days, retention in care, viral suppression; among demographic categories including gender, race/ethnicity, country of birth, HIV exposure category, and age. In addition, current client-level data in MN CAREWare provides the following data for Part A clients: linkage to care for newly diagnosed and reconnected to care clients; retention in care for all clients; prescribed antiretroviral therapy for clients receiving outpatient ambulatory health services (OAHS); and viral suppression for all Part A clients with a match from Minnesota's Enhanced HIV/AIDS Reporting System (eHARS). As with the MSP-TGA's HCC data, MN CAREWare performance measure data are analyzed by demographic characteristics as well as by subrecipient and service area.

The 2018 MN and MSP-TGA HCC as well as demographic data informed the development of the cross-parts Clinical Quality Management (CQM) plan and Part A quality goals developed by MN's joint Parts A, C, and D Quality Management Advisory Committee (QMAC). In 2019, MSP-TGA Part A staff took on the use of the Center for Quality Improvement and Innovation's Disparities Calculator. Through much analysis and community input, the most glaring disparities identified were as follows:

Viral Suppression Rates Among Ryan White Populations in the MSP-TGA			
	All Populations	**Black/African American MSM**	**Black/African American Women**
2014	87%	84%	84%
2015	86%	76%	81%
2016	88%	82%	84%
2017	90%	80%	86%
2018	90%	80%	86%

Three of the five 2020 CQM Goals were informed by these findings, specifically: increasing the viral suppression rates of RWHAP consumers who are Black/African American men who have sex with men and Black/African American women, as well as providing more culturally responsive services to both of those populations. This work is being done collaboratively with various stakeholders including the MN Council for HIV/AIDS Care and Prevention and its Disparities Elimination Committee.

The utilization of the Disparities Calculator was made possible by an intergovernmental project that transfers data from eHARS into MN CAREWare. Part A Program staff along with Minnesota's Part B recipient (DHS) and MN CAREWare administrators at the Minnesota Department of Health (MDH) are importing the dates and results of CD4 count tests and viral load tests from eHARS into CAREWare, so all clients receiving RWHAP services will have values for these variables in CAREWare. The first complete match from eHARS to CAREWare occurred in October 2017 with subsequent monthly data imports. As of the end of 2019, the target of 90% for Part A funded RWHAP consumers having imported data from eHARS in CAREWare was exceeded by 1.4%.

In preparation for subrecipients developing their quality improvement plans for FY20, subrecipients were trained on the quality management Model for Improvement using the Plan-Do-Study-Act cycle. Providers were also given one-on-one remote trainings on running

demographic-specific reports so they can disaggregate health outcomes by population. In the subrecipient quality improvement plan guidance this year it was stipulated for providers to address corrective actions from site visits, goals in contracts, as well as addressing disparities, in particular those experienced by Black/African American MSM and Black/African women. The quality management coordinator (QMC) then worked one-on-one with subrecipients to help identify and prioritize quality improvement goals and projects to improve their HIV Care Continuum performance measures.

HIV care retention and viral load performance measures inform the MSP-TGA Minority AIDS Initiative (MAI) programming. The MSP-TGA's MAI funds were allocated to OAHS ($129,293) and MCM ($206,926) targeting Latinx, Black/African-Born, and Black/African American PWH in FY20. Performance measurement data for MAI funded OAHS and MCM services are compared with performance measures from Part A (non-MAI) funded programs. Data are compared across subrecipient and demographic groups and reported back to the council. At the subrecipient level, performance measures are used to evaluate specific quality improvement projects to increase retention in care, antiretroviral therapy, and viral suppression. Over 90 percent of MAI consumers have been retained in care and virally suppressed since 2017. As of the end of 2019 MAI clients were 99% retained in care and 93% virally suppressed.

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

The Part A recipient's quality management coordinator (QMC) and data and outcomes coordinator (DOC) both advise the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP). The DOC is the Part A recipient representative on the MCHACP's Needs Assessment and Evaluation Committee (NAE) and the QMC is the Part A representative to the MCHACP's Membership and Training Committee. The QMC is lead convener and a member of the MN HIV/AIDS Integrated Quality Management Advisory Committee (QMAC), while the DOC and Part A Program Coordinator participate in advisory non-voting roles. Through their roles, these staff update the council's five-year Integrated HIV Prevention and Care Plan and the cross-parts Integrated Clinical Quality Management (CQM) Plan quarterly with performance measurement data for RWHAP clients in the MSP-TGA including: 1) linkage to care for both new case findings and out of care case findings within 30 days; 2) retention in HIV medical care; 3) ART prescription for OAHS clients; 4) viral suppression; and 5) housing status. This process assesses the effectiveness of each service area, brings forth any disparities, identifies service area goals and related objectives, sets standards of care, develops process and outcome measures related to contractual goals and objectives, analyzes how costs vary among subrecipients 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 identify service area gaps. These plans, the updates, and the discussion around them help the MSP-TGA served by Part A as well as all other RWHAP Parts understand the impact of funding, specific service efficacy, and where disparities exist. With this information the council and QMAC make informed allocations decisions and recommends areas of focus for quality improvement at both the grant recipient and subrecipient level for better outcomes for PWH in the MSP-TGA.

The NAE implements a process to review each service area along with five 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 are equipped to make data informed decisions to improve services and health outcomes for RWHAP clients. The NAE and the RWHAP recipients developed an interactive public-facing data dashboard that allows council and other community members to see service utilization and expenditure data.

The Part A Program's DOC has worked with the Hennepin County Epidemiological staff the to develop internal dashboards (in Power BI) to assess data completeness, performance measures, health outcomes, and utilization by subrecipient, population, and service area quarterly. Beginning in FY17, the QMC and DOC used the first dashboard to review the final number of unduplicated clients served versus targets along with data on expenditures and cost per client, and each subsequent year the dashboard has improved. The DOC presents an updated dashboard quarterly to the Part A recipient team, allowing more in-depth analysis and seamless updating of data, and better data visualization. This allows improved monitoring of subrecipient performance during the fiscal year and informs strategic long-range service delivery planning. The disaggregation of data both for all PWH in the MSP-TGA and for RWAHP client level data is becoming more sophisticated and readily available with the build out of various Power BI applications.

The MSP-TGA Part A recipient applies continuous improvement to access more complete data and analyze it with better tools. Therefore, in preparation for the FY20 fiscal year, the MSP-TGA team along with internal Hennepin Country resources sought to overhaul the subrecipient reporting system. The reporting burden had been lessened in 2017 when reports were combined and streamlined, leading to a reduction of over 100 reports submitted the MSP-TGA team. Even with the improvement, the quality of reporting was highly variable depending upon subrecipient and staff. The processing of reports on the Part A Program staff side was also cumbersome going through too many handoffs and seen as wasteful using the 8 Wastes approach. Therefore, the DOC suggested building out online reporting system using Qualtrics (an online survey and data collection platform) that would automatically notify contract managers of reports submitted, would be exportable in usable formats for the QMC to review and share at monthly Part A Programmatic meetings. While some stumbling blocks occurred, as is common in standing up a new technology, the benefits are eagerly anticipated by subrecipient and recipients alike.

- *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 Hennepin County Public Health (HCPH) responsible for administering the MSP-TGA's Part A grant. The Part A RWHAP is within the Public Health Protection service area of the HCPH. The RWHAP Supervisor oversees the daily operations of grant administration and reports to the Public Health Protection Manager. The HCPH Director ensures that all aspects of Part A grant administration are carried out and supervises the Public Health Protection Manager. In addition to the RWHAP Supervisor, the recipient administrative team includes: an HIV services planner; two contract managers and their supervisor from the county's centralized Health and Human Services Contract Administration area; a quality management coordinator; and a data and outcomes coordinator. 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 develops and implements the annual clinical quality management plan. Hennepin County Health and Human Services assigns a grant accountant from their Financial Analysis and Accounting area to prepare monthly fiscal expenditure reports for fiscal monitoring, submission of quarterly HRSA Payment Management System reports for

Part A fund draw down, and preparation of the final Federal Financial Report. The Part A grant supports 4.1 FTE administrative staff, including council staff, and 1.7 FTE CQM staff (see ***Budget Narrative Attachment*** and ***Attachment 1*** for detail). All grant administration and quality management positions are currently filled.

The Part A grant 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 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 HCPH 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 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. Hennepin County does not use an outside administrator or fiscal agent. All Part A grant administration activities are performed by the MSP-TGA grant recipient.

2) Grant Recipient Accountability

a) Monitoring

i. Three most common program and fiscal subrecipient findings for 2020 project period to date**.** Due to the COVID-19 pandemic, site visits were done remotely and were abridged. There were very few findings. The most common findings were incomplete documentation of the insurance, income, and residency verifications needed for determination of eligibility to receive RWHAP services. Four percent of files reviewed did not meet the requirement for insurance verification every six months. Two percent of files did not meet the requirement for income verification every six months, and 1% of files did not meet the residency verification requirements. One of the main challenges is that a number of RWHAP clients are homeless, have unstable housing, or are at risk for homelessness. Some clients have difficulty following-up with required eligibility documentation. Subrecipients also report that clients often do not have documentation on hand at initial early intervention services contact. If clients cannot be reached after that, documentation cannot be obtained. Part A recipient staff have implemented a policy that explains that services are not billable until annual eligibility certification and six-month recertification are met. The corrective actions for subrecipients who did not meet 100% of client eligibility requirements include reviewing client files and obtaining missing documentation prior to billing for services. Additionally, recipient staff provided technical assistance for improving eligibility verification and provided a template detailing approved language for when clients have no insurance and no income. The Part A recipient has also implemented a site visit policy that includes selecting all files for active clients that had missing eligibility documentation the previous year.

ii. Ensuring subrecipient compliance with the single audit requirement. Prior to the annual subrecipient program and fiscal site visits, subrecipients submit copies of their most recent annual audit including their single audit report if they receive at least $750,000 in Federal funds. All MSP-TGA Part A contracts with subrecipients contains detailed language on single audit requirements and submission for reports. Contract Managers review all audits and financial

statements to assess subrecipient fiscal stability and compliance with the HHS Uniform Guidance single audit requirement. In FY19, all six Part A subrecipients receiving $750,000 or more in Federal funds complied with federal single audit requirement. One subrecipient is in the process of completing their single audit requirement.

iii. Audit findings and corrective actions. An outpatient/ambulatory health services (OAHS) and medical case management provider had one deficiency with their single audit. The first was some billed units could not be substantiated. Additionally, the external audit identified material weakness related to adjustments made to patient accounts receivable, contributions receivable, accounts payable, and supplies and other costs. This provider will maintain a registry for invoicing Minority AIDS Initiative (MAI) and non-MAI hours until CAREWare has reporting capability to tabulate itemized hours. The subrecipient continues to work with TMG Health to strengthen and maintain core operational processes. Additionally, the subrecipient continues to control and manage the overall delegation, oversite activities, and assess and identify improvement opportunities through automation tools, policy refinement, and streamlining processes.

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 demonstrate how they determine RWHAP eligibility and track other sources of reimbursement at annual site visits. The Part A recipient's instrument for OAHS 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 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 OAHS provider receiving RWHAP funds has an active Medicaid provider number. All RWHAP subrecipient contracts identify the RWHAP as the funding source and contains language requiring that subrecipients ensure that their RWHAP funding is the payer of last resort. OAHS subrecipients submit all service claims to any third-party payer of record for each insured patient before invoicing the Part A recipient for any charges. Only when third-party claims are denied for RWHAP allowable OAHS services, will the subrecipient invoice the Part A grant recipient for charges. All Part A subrecipients are also required to submit annual program revenue and expense statements on March 31 for the Part A fiscal year that just concluded showing all sources of program income, including third-party reimbursement.

ii. Screening and eligibility 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, 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 and sign 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 ambulatory health services 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 providing core medical services ask about changes in insurance status at each appointment. In 2020, the Minnesota Department of Human Services (DHS), Minnesota's Part B recipient, plans to launch a centralized RWHAP Part A and B eligibility certification system that will simplify and standardize eligibility determination for all RWHAP Part A and B funded clients. This process will streamline eligibility documentation requirements, increase accuracy of client records, and reduce administrative burden of ensuring the RWHAP is the payer of last resort.

At annual subrecipient site visits a sample of client records, based on HRSA/HAB recommendations, are reviewed for documentation of RWHAP eligibility including HIV diagnosis, income, residence in the MSP-TGA and insurance. In 2019, 761 client records were reviewed for eligibility determination documentation. Of the 761 records reviewed, 99% had documentation of HIV infection, 95% had documentation of income, 95% had documentation of health insurance, and 96% had documentation of residence. Any subrecipient that does not demonstrate 100 percent documentation for each of the four elements of eligibility determination is required to take corrective action.

iii. Tracking and monitoring program income. Subrecipients deliver all Part A funded services. The Part A recipient does not generate program income. Since no Part A funds are allocated to a Pharmacy Assistance Program, no 340B pharmaceutical rebates are received. Subrecipient program income tracking methodology is reviewed during annual fiscal site visits. Each subrecipient is required to submit annual agency-wide and program-specific line item revenue and expense statements and administrative allocation schedules (including methodology used) in March. Statements are reviewed by contract managers who follow-up with subrecipients if revenue and expenditure information, including program income, is incomplete.

c) Fiscal Oversight

i. Process used by program and fiscal staff to coordinate activities. The Part A staff play the lead role with assistance from analysts in Hennepin County's Health and Human Services Financial Analysis and Accounting Area (*see **Attachment 10B***) to provide fiscal oversight of the grant. Contract managers monitor spending through invoice review and entry into the RWHAP financial MS Excel ledger 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, which triggers the county's accounting system to issue payment via electronic transfer to subrecipients' financial institutions. Part A staff reconcile actual payments to subrecipients with invoice amounts monthly and enters administrative and CQM expenditures in the RWHAP financial ledger. 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). 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 expenditures billed. Invoices are not approved for payment if an agency has outstanding fiscal issues or documentation of services provided is not aligned with program goals and expenditures. 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 ledger and the County's payment system. Hennepin County Audit, Compliance and Investigative Services staff conduct comprehensive fiscal audits of at least two RWHAP Part A subrecipients annually.
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 subrecipient contracts. At the close of the fiscal year, 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 MS Excel workbook ledger where contract managers enter subrecipient invoice amounts by budget line item and a master Power BI report that pulls data from the ledger to summarize expenditures by funding source, service category and subrecipient. The Hennepin County Office of Budget and Finance currently uses 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 recipient uses a standard electronic invoice form, which reflects contracted budget line items that correspond to the HRSA object class categories. 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 ambulatory health services subrecipients have until June 15 to submit final invoices for the fiscal year to provide enough time for them to ensure that RWHAP funds are the payer of last resort through insurance claims processing. Invoices are reviewed by the RWHAP contract managers for accuracy, compared to program budget, and service delivery reports from MN CAREWare, entered in the RWHAP MS Excel invoice ledger, and submitted to the county's Office of Budget and Finance for payment. If invoices are inaccurate, or not reflective of the number of client served and/or units of service provided, the contract manager works with the subrecipient to correct possible errors or resolve discrepancies. Any shift in budget line item amounts must be requested in writing and approved by the RWHAP contract manager.

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 actual expenditures for fiscal years 2019 and budgeted amounts for 2020.

iii. Budget – *See form SF424.*

iv. The ***Budget Narrative Attachment*** presents a project budget that clearly details and justifies all grant costs.