Minneapolis-St. Paul TGA Application for FY 2022 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 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 care engagement, retention, and viral suppression for the people with HIV. The RWHAP seeks to advance health and racial equity with Black/African American and African-born, Latinx (Hispanic), and American Indian being selected as subpopulations of focus. Having taken a health and racial equity centered approach, additional analysis reveals people experiencing homelessness, men who have sex with men (MSM), people who inject drugs (PWID), at-risk youth, and immigrant populations experience additional barriers to advancement along the HIV care continuum. These issues are intimately tied to racial disparities. 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 84% (7,916) of Minnesotans living with HIV reside. The vast majority, 80% (6,307) 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. Despite improved access to and affordability of healthcare through full implementation of the Patient Protection and Affordable Care Act (ACA) with the percent of MSP-TGA residents uninsured at 4.5% in 2019 (most current data), near the all-time low of 4.3% in 2015, significant healthcare barriers remain for low-income people with HIV, especially those from disproportionately impacted communities. The MSP-TGA's FY 2022 Part A and MAI plan funds 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, as of Aug 19, 2021, an ongoing HIV outbreak among people who inject drugs (PWID) in the TGA's two largest counties accounted for 80 new cases since the outbreak was declared in December 2018 (including 7 additionally linked cases diagnosed prior to Dec 2018). As of Aug 25, 2021, the COVID-19 pandemic has infected *at least* 8% of Hennepin County (HC) RWHAP clients based on a probabilistic match between RWHAP data and COVID-19 surveillance available to HC. While the impact is not entirely quantified, the COVID-19 pandemic continues to affect 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 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 frameworks in our community engagement efforts, continuous improvement, and disparities elimination systemwide. The range of RWHAP Part A and MAI 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 $6,137,019 in Part A and MAI funds for FY 2022 to achieve these objectives.

- *NEEDS ASSESSMENT*

A. Demonstrated Need

1) Epidemiological Overview

a) Summary of the HIV epidemic in the Minneapolis-St. Paul TGA (MSP-TGA)

The Minneapolis-St. Paul 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 2019 American Community Survey (ACS) 5-year estimated population of the MSP-TGA is 3,519,502. To disaggregate by race/ethnicity for smaller counties in the MSP-TGA, the five-year estimate needed to be used due to data suppression rules of ACS. The outer counties are suburban and rural. The 11 MSP-TGA counties in MN, including Hennepin and Ramsey Counties, comprise 61% (3,388,793/5,563,378) of MN's population. Minneapolis and St. Paul are the MSP-TGA's and MN's two largest cities. Hennepin and Ramsey Counties alone comprise 32% (1,790,279/5,563,378) of MN's population. The MSP-TGA's population is 75% White (Not Hispanic), 8.5% Black or African American (including an estimated 124,556 African-born immigrants), 6.7% Asian/Pacific Islander (API), 5.9% Latinx, 3.0% multi-racial, 0.5% American Indian, and 0.2% other. 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. An estimate of the MSM population in the MSP-TGA's is not available, but an Emory study estimates the MSM population in Hennepin County to be 8.5% of the male population. The same study estimates the MSM population in Minnesota is 4.2% of the male population. The MSM population in the Minneapolis-St. Paul-Bloomington metropolitan statistical area is estimated at 5.7% of the male population.

There were 178 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 2020. MN's HIV epidemic is highly concentrated in the Minneapolis-St. Paul metropolitan area. Seventy-eight percent (177/226) of new cases in MN reside in the eleven MN counties of the MSP-TGA.

There were 7,969 diagnosed people with HIV (PWH) in the MSP-TGA as of December 31, 2020. The 11 MN counties represent 84% (7,916/9,408) of MN's HIV prevalence. The greatest concentration of PWH in the MSP-TGA is in the core urban center with 61% (4,850/7,969) residing in Hennepin County and 40% (3,187/7,969) in Minneapolis alone. Eighteen percent (1,456/7,969) live in Ramsey County, and suburban areas of the MSP-TGA account for 18% (1,418/7,969) of its living HIV cases. The remaining PWH in the MSP-TGA (3.1%; 250/7,969) reside in the six rural counties, with less than one percent (0.7%; 53/7,969) residing in the two WI counties. ***Attachment 14B*** presents a map of HIV prevalence in the MSP-TGA as of December 31, 2020 along with the locations of RWHAP services.

b) Socio-demographic characteristics

i. Demographic data

(1) Persons newly diagnosed. ***Attachment 3A*** presents HIV incidence data for the MSP-TGA from 2016 to 2020. Over the 5-year period, new cases declined 31% from 259 to 178. The substantial decline is mostly attributed to the lower number of HIV diagnoses in 2020 during the COVID-19 pandemic, and such a decline is not expected to continue as HIV testing opportunities increase in 2021. Though there was some evidence of a slight decline in HIV incidence before 2019, an HIV outbreak among people who inject drugs and/or experiencing homelessness began in December 2018. Hennepin County's RWHAP and epidemiology staff suspect diagnoses are underestimating HIV infections during an ongoing HIV outbreak and the reduction in testing and diagnoses during the COVID-19 pandemic. The HIV epidemic in the state and MSP-TGA remains largely male, with 80% of the 178 new cases in 2020 in the MSP-TGA among males, 63% (90/143) of whom are MSM or MSM who also inject drugs (MSM/IDU). There were eight 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. Minnesota's state health department attempts to determine the current gender identity through chart abstraction and disease investigation for all newly diagnosed and reported infections, but the information is not always available.

New HIV diagnoses are concentrated in young adults with 64.6% being 20-39 years old. There were no cases for those younger than 13, only 2.2% of the cases are 13-19, 19.1% are 40-49, and 12.9% are 50+.

HIV disproportionately impacts the Black/African American, including African-born immigrants, Latinx, and American Indian communities in the MSP-TGA. Blacks comprised 46% of new diagnoses in 2020, while they make up only 8.5% of the MSP-TGA's population. Among new cases of HIV infection in 2020, 14% were Latinx, 3.9% were API, 2.8% were American Indian, and 4.5% were multi-racial. The remaining 29% were White.

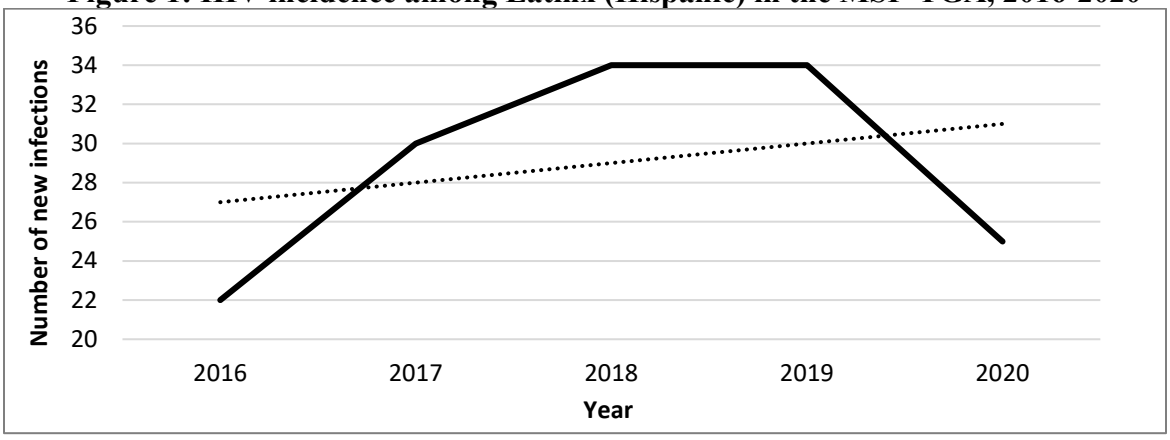
Among women, the majority of the 27 new diagnoses in 2020 were women of color, 37% among Black/African-born women and 26% among Black/African American (U.S. born) women. Since 2016, the number of new infections among Black/African American women averaged 9 new cases per year (high 11, low 7). Since 2016, the number of new infections among Black/African-born women averaged 24 infections. Black/African-born men peaked in incidence with 33 cases in 2016 decreasing to 9 cases in 2020. Overall, African-born incidence peaked at 66 cases in 2016 and declined to 20 cases in 2020. 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 168 cases in 2016 to 115 cases in 2020 is partially 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 35, 31, 31, 35, and 21 cases in 2016-2020, respectively. New foreign-born cases from 2016-2020 were from 60 countries with Liberia, Mexico, Ethiopia, Cameroon, Kenya, Nigeria, Somalia, and Vietnam having at least 10 cases within this five-year span.

HIV incidence among Latinx declined in 2020, along with most racial/ethnics groups. In 2016, 22 cases were reported. Annual number of cases peaked at 34 in 2019 and declined to 25 in 2020 (Figure 1: HIV incidence among Latinx in the MSP-TGA, 2016-2020**)**. This illuminates a troublesome trajectory as Latinx take on an increasing burden of the HIV epidemic. In 2016,

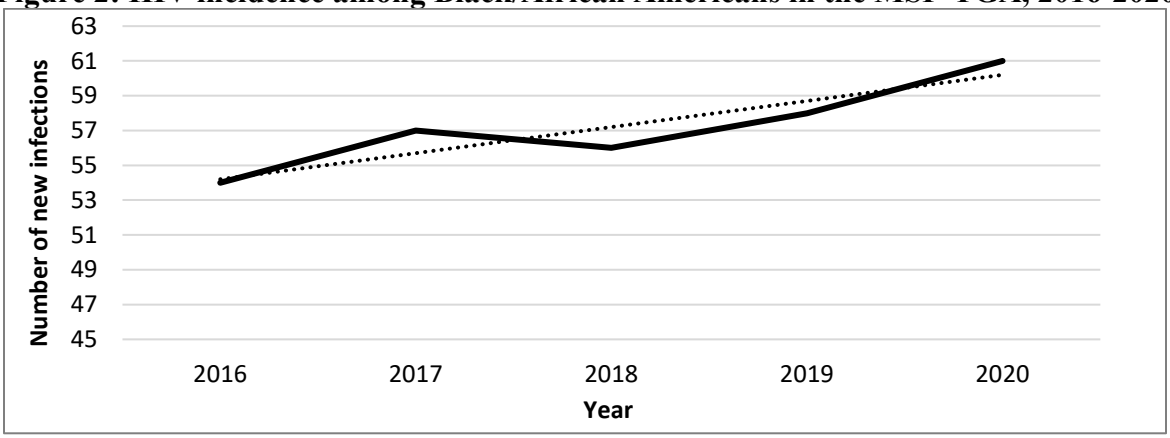
Latinx accounted for 8.5% of newly diagnosed cases, rising to 15% of new cases in 2019. Despite the decrease in 2020, Latinx cases accounted for 14% of new cases.

Figure 1: HIV incidence among Latinx (Hispanic) in the MSP-TGA, 2016-2020



Incidence for Black/African Americans (U.S. born only) increased slightly over the 5-year period with an average of 57 cases annually (low: 54, high: 61) in 2016 – 2020. Including an increase from 2019 to 2020 from 58 to 61 cases (Figure 2: HIV incidence among Black/African Americans in the MSP-TGA, 2016-2020) while overall HIV incidence declined. This continued increase in incidence highlights a clear HIV health and racial disparity in the MSP-TGA. In contrast, White, non-Hispanic cases declined by 45% over the same 5-year period from 95 to 52.

Figure 2: HIV incidence among Black/African Americans in the MSP-TGA, 2016-2020

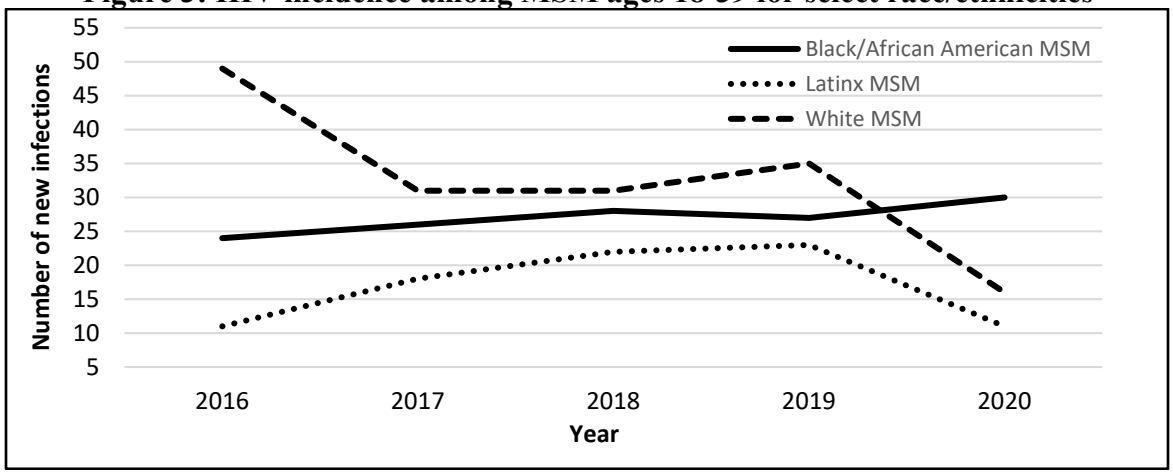


MSM ages 18-39 accounted for 78% (71/91) of all MSM cases in 2020. Similarly, younger adults, ages 18-39 years, accounted for 67% (119/178) of new infections overall. This contrasts with MSM ages 40+, where incidence has fallen from 40 cases in 2016 to 19 cases in 2020.

In 2016 among MSM, men of color represented 45% (58/128) of new infections. In 2020, 65% (59/91) of new infections among MSM were men of color with Black/African American accounting for 36% and Latinx accounting for 14% of new infections. Among young MSM ages 18-39, notable differences by race/ethnicity emerge. Until 2020, Latinx MSM had increasing incidence each year (Figure 3: HIV incidence among MSM ages 18-39 for select race/ethnicities**,** pg. 6). Incidence among Black/African American MSM has increased over the 5-year period from 20 to 32. Conversely, incidence among White, non-Hispanic MSM has decreased over the same time period from 46 to 15 cases. Examining the intersectionalities of race/ethnicity, age, and mode of transmission clearly shows that Latinx MSM and Black/African American MSM ages 18-39 (Figure 3: HIV incidence among MSM ages 18-39 for select race/ethnicities)

continue to experience a disproportionate burden of new HIV infections in the MSP-TGA and are prioritized in the RWHAP's disparities elimination efforts. There was an increase from 4 cases in 2019 to 14 cases in 2020 among Black/African American MSM ages 20-24. From 2016-2018, there were 3-6 cases in this demographic group. The RWHAP is working with epidemiological staff to determine if this represents a cluster and if this is continuing into 2021.

Figure 3: HIV incidence among MSM ages 18-39 for select race/ethnicities



Finally, in February 2020, the MN Department of Health (MDH) announced an HIV outbreak among people who inject drugs (PWID) in Hennepin and Ramsey Counties. In ***Attachment 3A***, there is a noticeable increase from 28 PWID cases in 2018 to 34 PWID cases in 2019 and 24 in 2020. 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 19, 2021, there have been 80 cases identified in this outbreak. The outbreak disproportionally affects individuals who are American Indian (25%, 20/80) , Black/African American (14%, 11/80), and people experiencing unsheltered homelessness (44%, 35/80).

(2) People with HIV. ***Attachment 3B*** presents HIV prevalence data for the MSP-TGA from 2016 to 2020. As of December 31, 2020, there are 7,969 diagnosed PWH in the MSP-TGA. From 2016 to 2020, overall HIV prevalence increased by 8.7%. 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, 24% are female, and 1.4% are transgender. Among males living with HIV, 74% 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, 4.0% of multi-racial backgrounds, 2.4% Asian/Pacific Islander, 1.0% American Indian/Alaska Native, and 0.2% with an "other" or unknown racial background. Forty-two percent are White. Among women with HIV in the MSP-TGA, 67% are Black with 25% Black/African American and 43% Black/African-born. The largest age group among PWH in the MSP-TGA are people 50 years or older comprising 51% of the population of PWH. Eight percent of PWH in the MSP-TGA are between the ages of 13 and 29, 19% 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 individuals who are Black (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), 5.0% of people in the MSP-TGA were Black/African American, 3.5% Black/African-born, and 5.9%

Latinx. An estimate of MSM population in the MSP-TGA's is not available, but an Emory study estimates the MSM population in Hennepin County to be 8.5% of the male population. The same study estimates that MSM in Minnesota comprises 4.2% 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 2020 HIV prevalence rates.

Table 1: Minneapolis-St. Paul TGA population and HIV prevalence rates in 2020

Demographic Group	% of TGA Population	% of Diagnosed PWH	HIV Prevalence Rate**
Latinx (all races)	5.9	10.9	492
American Indian/Alaska Native	0.5	1.0	423
Asian/Pacific Islander	6.7	2.4	102
Black/African American	8.5	22.2	1,312‡
Black/African-born		17.2	
White	75	42.2	130
Multiracial	3.0	4.0	425
MSM*	8.5	60.8	6,063^
Overall	100	100	243

*Includes MSM/IDU. ^For Hennepin County only. MSM population estimate from 2016 Emory estimate using 2010 Hennepin County Census 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 37 times higher than non-MSM. The next highest prevalence rates (for the entire MSP-TGA) are individuals who are Black, Latinx, multi-racial, or American Indian. Individuals who are White or Asian/Pacific Islander have a prevalence rate below the overall rate of 243 per 100,000. Sixty-one percent of diagnosed PWH in the MSP-TGA are MSM or MSM/IDU. Among all MSM living with HIV, 61% are White, 19% Black, 13%, Latinx, 4% of multi-racial backgrounds, 2% Asian/Pacific Islander, and 1% American Indian/Alaska Native. Black/African American MSM and Latinx MSM carry a relatively heavy HIV burden among MSM in the MSP-TGA, accounting for 31% of prevalence among MSM. Fifty-two percent of MSM living with HIV are ages 50 and older, 19% are 40-49, 21% are 30-39, 6% are 25-29, and 2% are 13-24.

The prevalence rate among Blacks is 10.1 times that of Whites. Among Black/African-born PWH, women have a greater disease burden with the mode of HIV exposure (when known) being primarily heterosexual contact. Black/African-born is the only racial/ethnic group where the number of females (821 cases) exceeds the number of males (544 cases). Geographically, HIV disease burden is greatest in Minneapolis (see ***Attachment 14B****: HIV Prevalence and Services Map*). HIV prevalence is highest in the central, south-central, and northern sectors of the city where individuals who are MSM, Black/African American, 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 data for the MSP-TGA indicate that the percent of prevalent cases by race/ethnicity is increasing among Latinx and Black/African American people. Males, including MSM, persistently have the highest incidence rates annually. The populations at highest risk of acquiring HIV are MSM (particularly those MSM who are under 40, Latinx, and Black/African American) and people who inject drugs (PWID). While a smaller racial/ethnic group, people who are American Indian are disproportionately impacted by the HIV outbreak among PWID. Data from the RWHAP suggests that people who are American Indian are the most likely racial/ethnic group to experience unstable housing, adding to their risk of HIV infection. While

HIV incidence has declined among white MSM, rates among Latinx MSM 18-39 (through 2019/before the COVID-19 pandemic) and Black/African American MSM 18-39 (Figure 3: HIV incidence among MSM ages 18-39 for select race/ethnicities, page 6) continues to increase. A similar trend exists for MSM ages 18-39 compared to MSM ages 40+. MSM ages 18-39 accounted for 78% of all new MSM cases in 2020. This contrasts with MSM 40+ who have seen declining incidence in 2016 to 2020 with greatest decline among MSM 40+ who are White. Additionally, the RWHAP closely monitors populations experiencing lower rates of viral suppression. Based on the MSP-TGA's HIV Care Continuum in 2019 (the most recent year data is available), overall viral suppression was 70%. However, certain groups achieve lower levels of viral suppression including American Indian/Alaskan Native MSM (63%) and Black/African American MSM (65%). Viral suppression is even lower for Black/African American MSM ages 18-39 (63%). Cases under 40 years of age consistently achieve lower viral suppression across all race groups. These populations may be at higher risk for HIV transmission. Although Latinx MSM (71%) are virally suppressed at a comparable rate to White MSM (71% and 74%, respectively), incidence increased four of the last 5 years among Latinx MSM.

Prevalence data indicate that MSM, and Black (both African-born and African American), Latinx, American Indian, and multi-racial populations have the highest prevalence rates among PWH in the MSP-TGA (Table 1: Minneapolis-St. Paul TGA Population and HIV Prevalence Rates in 2020, page 7).

Finally, in February 2020, MDH announced an HIV outbreak in Hennepin and Ramsey Counties among people who inject drugs (PWID). This ongoing outbreak, as defined by CDC surveillance methodology, began in December 2018. As of August 19, 2021, there have been 80 cases identified in this outbreak. The HIV outbreak has disproportionately impacted people who are American Indian or Black/African American. The individuals in the HIV outbreak are likely to be currently experiencing unsheltered homelessness. With increasing rates of homelessness in the MSP-TGA due to the COVID-19 pandemic and the related economic downturn, a significant proportion of the MSP-TGA's homeless population remains at high risk for HIV infection.

ii. Socioeconomic data. Table 4 on page 16 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 2019 1-year American Community Survey (ACS) estimates (the most recent year available), 13% of the MSP-TGA population 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 Minnesota (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 Minnesotan households is $77,311 compared to $41,570 for Black Minnesotan households, $40,051 for American Indian Minnesotan households, and $57,591 for Latinx Minnesotan households.

Education. Minnesota'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 percentage is 11%. Clear racial disparities exist in educational attainment measured by the percentage of persons with less than a high school education. According to the 2019 ACS, 14% of Black men and 23% of Black women have less than a high school education compared to

4.6% and 3.4% of White men and women, respectively. Among those who are American Indian, 18% of men and 15% of women have less than a high school education. 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 (4.3%), yet Minnesota Health Access Survey (2019) disaggregated data shows significant racial/ethnic disparities. Overall, in 2019, 4.7% Minnesotans were not covered by health insurance compared to 6.3% in 2017, 8.2% in 2013, 9.0% in 2011, 9.0% in 2009 and 7.2% in 2007. While only 3.9% of Minnesotans who are white are uninsured, 4.4% of Minnesotans who are black, 9.7% of Minnesotans who are American Indian, and 15.5% of Minnesotans who are Latinx are uninsured.

Based on MN CAREWare data, among PWH in the MSP-TGA who received a Ryan White HIV/AIDS Program (RWHAP) Part A or B funded service in 2020, 3.7% were uninsured, although many who are insured have out-of-pocket costs that can create economic barriers to accessing health care. Almost half (49%) of the MSP-TGA's RWHAP clients accessed Part A funded outpatient ambulatory health services in 2020 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 27% of PWH in the MSP-TGA who are foreign-born. Furthermore, access to linguistically responsive HIV services is possibly lacking for those who have not yet entered the RWHAP system of care.

c) Relative rates of increase in HIV diagnosed cases within new and emerging populations

i. Emerging populations, unique challenges, and estimated costs.

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 21 IDU or MSM/IDU cases in 2017 to 28 IDU or MSM/IDU cases in 2018 and finally 34 IDU or MSM/IDU cases in 2019, as shown in ***Attachment 3A***. As of August 19, 2021, this ongoing outbreak in Hennepin and Ramsey Counties includes 80 cases. There are underlying socioeconomic factors placing individuals at higher risk to acquire HIV as part of this outbreak. Forty-four percent (35/80) of the individuals in the HIV outbreak are experiencing unsheltered homelessness. 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, and to effectively test individuals at risk of HIV infection in unsheltered homeless settings. Disease investigators determined that persons likely to be at higher 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. This outbreak has most disproportionally affected individuals who are American Indian who represent 25% of HIV outbreak cases while only being 0.5% of the MSP-TGA total population. Additionally, Black/African American individuals are overrepresented, accounting for 14% of cases while being 8.5% of the MSP-TGA total population.

HIV incidence among individuals who are Black/African American increased between 2016-2020, including during the COVID-19 pandemic, from 54 to 61 cases. (Figure 2: HIV incidence among Black/African Americans in the MSP-TGA, 2016-2020, pg. 5) Alarmingly, due to the reduction in testing during 2020, this increase may be an underestimation of new HIV infections. A little more than half of the cases among Black/African American individuals are MSM which also increased from 28 to 33 cases from 2016 to 2020. The increase from 4 cases in 2019 to 14 cases in 2020 among Black/African American MSM ages 20-24 is also concerning. From 2016-2018, there were 3-6 cases in this demographic group. The RWHAP is working with epidemiological staff to determine if this represents a cluster and if this is continuing into 2021. The health inequities and public health challenges are amplified by the low rate of viral suppression (63%) for this racial/ethnic group.

The number of new HIV diagnosed cases rose among individuals who are Latinx until 2019 (Figure 1: HIV incidence among Latinx in the MSP-TGA, 2016-2020, page 5). Latinx MSM incidence nearly doubled (14 cases to 26 cases) from 2016 to 2019. Fifty-three percent of Latinx cases from 2016-2020 were foreign-born and may face additional barriers to care due to linguistic and cultural needs, and the impact of increasing anti-immigrant sentiment nationwide. While there was a decrease in diagnoses in 2020, this may be due to the COVID-19 pandemic, and late diagnoses may be identified in the coming years.

Another concern is the 21% increase in HIV prevalence (1,129 to 1,368) among the MSP-TGA's Black/African-born population between 2016 and 2020. The Black/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 MSP-TGA RWHAP works to ensure linguistically appropriate and culturally responsive services for the diverse Black/African-born population. HIV related stigma among this population further complicates the RWHAP's efforts to 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 utilized RWHAP services is possible. In FY20, 40% (3214/7969) of diagnosed PWH in the MSP-TGA received Part A funded services at an average cost of $1,554 per service recipient. Fifty-two percent of the MSP-TGA's diagnosed population of PWH received a Part A, Part B, COVID CARES Act Part A and B, or ADAP 340B rebate funded service in FY20 at an average annual cost per client of $4,911. Individual client costs based on their need will vary. The Part A per client costs for early intervention services (EIS) to identify and link the undiagnosed to care or to re-engage PWH in care who are not receiving HIV medical care was $4,583. If 40% of the MSP-TGA's 178 people diagnosed with HIV infection in 2020 (71) accessed Part A funded services, the cost incurred for EIS would be $110,334. If 52% of the MSP-TGA's new cases (93) needed Part A, B COVID Cares, or rebate funded services, the total cost would be $426,219. Given the significant challenges in accessing HIV testing and services for the subpopulations with increased HIV incidence in the last five years, annual costs for each newly diagnosed PWH are likely higher.

The cost of care for those who delayed HIV medical care due to the COVID pandemic and whose health declined, or lost their housing as a result, will likely increase. The impact of COVID on the health and needs of PWH in the MSP-TGA will likely emerge more clearly during the next few years.

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 643 with an average annual prevalence increase of 2.4%, and a 1.7% increase (133) in living cases in 2020. The smaller increase in prevalence in 2020 is likely an artifact of the fewer number of new diagnoses resulting from significantly reduced HIV testing opportunities among those at highest risk during the first 15 months of the COVID pandemic.

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 2020 Part A Service Utilization, Cost Per Client, and Expenditure

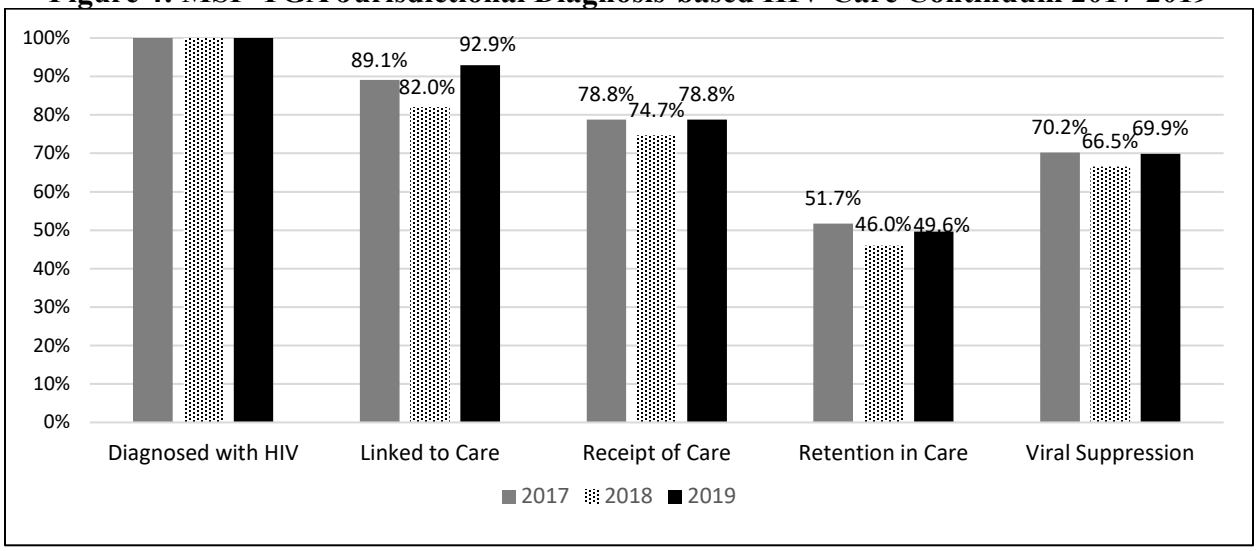
Service Category	Unduplicated Clients Served	% of Diagnosed PWH	Part A Cost per client	Total FY20 Expenditure
Early Intervention Services	70	0.8%	$ 4,583	$ 320,776
Food Bank/Home-delivered Meals	991	12.4%	827	819,546
Health Education/Risk Reduction	93	1.2%	1,188	110,516
Home and Community-based Health Services	32	0.4%	3,906	125,000
Housing Services	64	0.8%	4,113	263,261
Other Professional Services - Legal Services	217	2.7%	435	94,300
Linguistic Services	173	0.02%	309	5,259
Medical Case Management	1,562	19.6%	1,356	2,117,438
Medical Nutrition Therapy	198	2.5%	222	44,000
Mental Health Services	241	3.0%	518	124,772
Outpatient Ambulatory Health Care Services	1,945	24.4%	415	806,540
Psychosocial Support	101	1.3%	824	83,255
Substance Abuse Services: Outpatient	74	0.9%	1,076	79,652
Total Unduplicated	3,214	40.3%	$ 1,554	$ 4,994,315

Assuming the proportion of diagnosed PWH in the MSP-TGA who utilize Part A funded services remains at 40% and a five-year average annual increase in HIV prevalence of 2.4%, a minimum increase of $118,885 in Part A funding (based on FY20 service costs) is needed for FY22 to just meet the needs of the same proportion of RWHAP eligible population in the MSP-TGA that received services in FY20. Considering that utilization of most Part A funded services, except for outpatient ambulatory health, home and community-based health, and linguistic services, declined in FY20 because of the limitations to in-person service delivery to minimize COVID exposure, costs per client will likely increase in FY 2021 and beyond. In 2020, 98% of Part A Program clients were retained in HIV medical care and 91% were virally suppressed. Eighty-nine percent of those receiving early intervention services were linked to care within 30 days. Given that an estimated 74% of the MSP-TGA's population of PWH are income eligible (up to 400% FPL) for RWHAP services (Table 4, p 16), 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. Assuming an average annual prevalence increase of 2.4% and using the average FY 2020 Part A cost per client ($1,554), increasing the percent of diagnosed PWH in the MSP-TGA who access Part A funded RWHAP services by 10%, from 40.3% (3,214) to 50.3% (4,105) of PWH in the MSP-TGA, would cost an additional $1,384,614. This would require a Part A grant award of $7,229,394 for the MSP-TGA in FY 2022.

2) HIV Care Continuum

a) Graphic Depiction of the HIV Care Continuum. The following section uses a jurisdictional *diagnosis-based* HIV care continuum for the population of PWH residing in the MSP-TGA. The definitions are the same as those used by the Centers for Disease Control and Prevention (CDC) in the *HIV Prevention Progress Report, 2019*. These data were provided by the HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Program (DMHAP) and uses 2017-2019 CDC surveillance data for each stage of the HIV care continuum. Figure 4: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019 is a graphic depiction of the HIV care continuum and Table 3: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019 provides the numerator and denominators for the percentages in the graphic depiction.

Figure 4: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019



Diagnosed with HIV is the number of persons aged ≥13 years with HIV infection in the jurisdiction at the end of the calendar year. This is depicted as 100% in the figure above.

Linked to Care is defined as the percentage of persons with newly diagnosed HIV infection who were linked to care within one month of diagnosis as evidenced by a documented CD4 count or viral load. The numerator is the number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented CD4 count or viral load test result. The denominator is the number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.

The denominator for *Receipt of Care*, *Retention in Care*, and *Viral Suppression* is the same. It is defined as the number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.

Receipt of Care is defined as the percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year. The numerator is the number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.

Retained in Care is defined as the percentage of persons with documentation of two or more CD4 or viral load tests performed at least three months apart during the calendar year. The numerator is the number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.

Viral Suppression is defined as the percentage of persons aged ≥13 years with HIV infection who had a viral load result of <200 copies/mL at the most recent viral load test during the calendar year. The numerator is the number of persons aged ≥13 years with diagnosed HIV infection whose most recent HIV viral load test in the calendar year showed a suppressed viral load.

Table 3: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019

Stage	2017	2018	2019
Diagnosed with HIV	6,978	7,199	7,430
Linked to Care	89.1% (204/229)	82.0% (187/228)	92.9% (209/225)
Receipt of Care	78.8% (5,312/6,741)	74.7% (5,200/6,963)	78.8% (5,672/7,195)
Retention in Care	51.7% (3,483/6,741)	46.0% (3,202/6,963)	49.6% (3,569/7,195)
Viral Suppression	70.2% (4,734/6,741)	66.5% (4,632/6,963)	69.9% (5,029/7,195)

3) Unmet need

a) Unmet need methodology. The required and enhanced methods were utilized to provide the Unmet Need Framework estimates. The required methods used HIV surveillance data provided by the Minnesota Department of Health (MDH) using the SAS code developed by the Centers for Disease Control and Prevention. In consultation with the MDH epidemiologist, the SAS code did not allow Black individuals to be separated by Black/African American and Black/African-born. Therefore, the unmet need framework will discuss the Black (both African American and African-born) subpopulation, even though the subpopulation of focus is more narrowly defined as Black/African American. MDH notes limitations with the Enhanced HIV/AIDS Reporting System (eHARS) in general: "Factors that impact the completeness and accuracy of HIV/AIDS surveillance data include availability and targeting of HIV testing services, test-seeking behaviors of HIV-infected individuals, compliance with case reporting, and timeliness of case reporting." Despite these limitations, the RWHAP believes the unmet need framework estimates are accurate among the overall population and reflect the health and racial disparities within the subpopulations of focus (with the caveat noted above about the Black subpopulation).

The enhanced method uses RWHAP data to estimate RWHAP clients in the MSP-TGA who received a late diagnosis, have an unmet need, or are in care and not virally suppressed. The Part A recipient for the MSP-TGA and the Minnesota Department of Human Services (Part B recipient for Minnesota) have a shared RWHAP CAREWare database (MN CAREWare). This shared database means clients residing in the MSP-TGA are included in the unmet need framework estimate whether the client receives services funded by the Minnesota Department of Human Services (DHS) or Hennepin County (HC). This ensures a more accurate estimate of unmet need in the MSP-TGA. DHS and HC work with MDH to conduct monthly HIV surveillance uploads on all RWHAP clients. This has improved the ability to estimate unmet need and viral suppression for RWHAP clients. In 2019, the most recent year available, 88.8% had documented viral load in CAREWare from the MDH HIV surveillance system. Therefore, the enhanced methodology uses both RWHAP and HIV surveillance data.

To assess the unmet need more accurately for RWHAP clients, a viral load, a CD4 count, a RWHAP funded OAHS medical appointment, or a reported HIV medical appointment by a RWHAP provider was considered evidence for retention in care. The reported medical appointment comes from a custom subform developed by DHS and HC in MN CAREWare. Twice a year, all RWHAP service providers must determine the last HIV medical appointment for their clients and report that in MN CAREWare.

b) Needs of PWH diagnosed late, not in care, or are in care but not virally suppressed

1) Late-diagnosed. In 2019, based on HIV surveillance data, there were 228 new HIV diagnoses in the MSP-TGA with 24.1% (55/228) having a late diagnosis. Evaluating the subpopulations of focus, the American Indian subpopulation accounted for 8 new diagnoses with 1 being a late diagnosis (12.5%). For the Black (both African American and African-born) subpopulation, there were 94 new infections with 25 being late diagnoses (26.6%). For Latinx individuals there were 34 new infections with 9 being late diagnoses (26.5%). In total, the three subpopulations of focus account for more than half of new HIV diagnoses (59.6%, 136/228) with a quarter of these individuals being late diagnoses (25.0%, 34/136).

The two race/ethnicities with the highest percentage of late diagnoses are Black (both African-born and African American) and Latinx. This suggests these populations are not receiving comprehensive, routine HIV testing even if they are at higher risk for HIV infection. While only 3.9% of Minnesotans who are white are uninsured, 4.4% of Minnesotans who are black and 15.5% of Minnesotans who are Latinx are uninsured. This lack of health insurance can contribute to the lack of HIV testing before diagnosis and the ability to access HIV medical care once diagnosed. Additionally, routine healthcare, which includes HIV testing, needs to be accessible. According to the 2020 HIV community needs assessment, 23.2% (146/630) of respondents put off HIV medical care, because they did not have a way to get there. This is higher for the Latinx subpopulation (33.3%, 21/63) and the Black/African American subpopulation (27.7%, 44/159). Reliable transportation for those that are newly diagnosed is critical as they attend follow-up appointments with their HIV healthcare provider to develop the best care plan to achieve viral suppression after a late diagnosis.

2) Unmet need. In 2019, based on HIV surveillance data, approximately 1 in 8 people with HIV (12.8%, 879/6,849) in the MSP-TGA had an unmet need. This means in the previous five years (2015-2019), they had an HIV-related lab reported to HIV surveillance, but they did not have a reported CD4 count or viral load test reported in 2019. The unmet need within the American Indian subpopulation was comparable to the overall unmet need at 12.9% (9/70). Two of the subpopulations of focus had slightly higher unmet need percentages with the Black subpopulation at 14.4% (381/2,641) and the Latinx subpopulation at 13.7% (95/695).

Within the RWHAP system, in 2019, the unmet need was significantly lower at 3.4% (139/4,090). The differences between the subpopulations of focus within the RWHAP system are not meaningfully different: American Indian at 3.6% (2/55), Black at 3.7% (68/1,827), and Latinx at 2.2% (11/493). The three subpopulations of focus account for 58.2% (81/139) of the unmet need within the RWHAP.

The significantly lower percentage of RWHAP clients with an unmet need compared to the overall population of people with HIV suggests the RWHAP system provides the medical and support services people with HIV need to attend HIV medical care appointments. In 2020, 49.1% of RWHAP clients accessed outpatient/ambulatory health services and 37.6% accessed the AIDS Drug Assistance Program. This suggests paying for healthcare and HIV medications is a high need among people with HIV. Enrolling more people with HIV in the RWHAP can ensure healthcare costs are not a barrier to retention in care. Basic needs were also heavily utilized in the RWHAP with 39.7% of RWHAP clients accessing food services, 26.5% accessing transportation, and 24.6% accessing emergency financial assistance in 2020. Meeting these basic needs and paying for healthcare costs can ensure those with an unmet need can be retained in HIV medical care. The RWHAP can help meet those needs. Culturally responsive mental health services are also needed as 24.0% (150/625) of respondents to the 2020 HIV community needs assessment reported mental health as a reason for missing an HIV medical appointment.

3) In care but not virally suppressed. In 2019, HIV surveillance data indicates 12.3% (737/6,849) of people with HIV in the MSP-TGA are in care but not virally suppressed. The American Indian and Black subpopulations are above the overall percentage at 13.1% (8/70) and 15.4% (348/2,641), respectively. The Latinx subpopulation has 10.2% (61/695) who are in care but not virally suppressed.

Within the RWHAP system, 16.9% (666/4,090) of clients were in care but not virally suppressed. Here, the racial and ethnic disparity for the American Indian subpopulation is apparent with 22.6% (12/55) in care but not virally suppressed. Black clients, as a subpopulation of focus, have a comparable percentage to the overall at 17.0% (299/1,827). The Latinx subpopulation had 18.3% (88/493) who were in care but not virally suppressed.

This cohort has been evaluated within the RWHAP to determine what services have the greatest impact on viral suppression once they are in HIV medical care. Based off this logistic regression model, housing status was found to be strongest predictor of viral suppression. If a RWHAP client is not virally suppressed and unstably housed, no service appeared to advance them along to viral suppression. Therefore, the RWHAP is increasing housing options for people with HIV who are experiencing homelessness. Moving along the housing continuum, RWHAP clients who are temporarily housed are more likely to be virally suppressed if they are medically case managed. These medical case managers can identify the needs of the individual and refer them to the needed resources, including medication adherence support. 50.8% of RWHAP clients accessed medical case management suggesting this service is a high need in the community. Housing and medical case management can help close the gap for those people with HIV that are attending HIV medical appointments but have not yet achieved viral suppression. Mental health is also a barrier to achieving viral suppression as 24.0% (150/626) of 2020 HIV community needs assessment respondents reported mental health as a barrier to remaining adherent to HIV medication.

4) Co-occurring Conditions. Quantitative evidence describing conditions co-occurring with HIV and estimated associated costs of care in the MSP-TGA are presented in ***Attachment 5***.

5) Complexities of Providing Care

a) Impact and Response to Reduction in RWHAP Formula Funding

i. Impact: The MSP-TGA's Part A formula funding increased in FY21 by $11,771 (+0.3%); from $3,671,511 in FY20 to 3,683,282 in FY21. As such, no prioritized services allocated formula funds by the Minnesota Council for HIV/AIDS Care and Prevention were eliminated or reduced.

ii. Response: A response was unnecessary as the FY21 formula funding slightly increased.

b) Health Care Coverage Options for PWH in the MSP-TGA. The Affordable Care Act (ACA) in Minnesota (MN) enables 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,* a private off-exchange individual plan or employer sponsored coverage. The MN Department of Human Services (DHS) administers all MN Health Care Programs and is MN's Part B recipient and ADAP administrator.

The following table presents both the public and private health coverage options available through *MNSure,* employers, the private off-exchange market, and Medicare. The table also shows the estimated number of people receiving coverage through each option, including the

uninsured, based on estimated income ranges (percent of the federal poverty guidelines) of the MSP-TGA's population at-large and of diagnosed PWH.

Table 4. Poverty and Health Care Coverage for the MSP-TGA Population and Diagnosed PWH

	TGA	%	PWH	%	Data Source
Total Population	**3,584,879**	**100%**	**7,969**	**0.2%**	ACS^, MDH*
Health Insurance					
Medicare	582,628	16%	1,310	16%	CMS Dashboardᶜ, MNCAREWare¥
Medicaid	747,160	21%	2,257	28%	DHS**, MNCAREWare¥
MinnesotaCare (Basic Health Plan)	70,342	2.0%	371	4.7%	DHS**, MNCAREWare¥
Qualified Health Plan (*MNSure*)	88,316	2.5%	261	3.3%	DHS**, MNCAREWare¥
Other Private (Group & Individual including employer sponsored)	2,171,774	61%	3,329	42%	MN Health Access Survey (2019) MNCAREWare¥
Uninsured	160,998	4.5%	322	4.0%	MN Health Access Survey (2019) MNCAREWare¥
Income as % of FPL (up to/cumulative↓)					
138% (Medicaid eligible)	478,293	13%	3,051	38%	ACS^, MNCAREWare¥
200% (MinnesotaCare eligible)	755,529	21%	3,936	49%	ACS^, MNCAREWare¥
300%	1,214,545	34%	4,994	63%	ACS^, MNCAREWare¥
400% (RWHAP and APTCⁱ eligible)	1,701,191	47%	5,869	74%	ACS^, MNCAREWare¥

^U.S. Census Bureau American Community Survey PUMS (2019), *MN Department of Health eHARS (2020), ᶜCMS/Medicare Enrollment Dashboard, Hospital and Medical (2020), ¥State of MN and MSP-TGA RWHAP client-level database (2020), **MN Department of Human Services - Minnesota Medicaid Information System (2019), ⁱAdvance Premium Tax Credit.

Medicaid. Medical Assistance (MA), MN's Medicaid program, provides comprehensive outpatient and inpatient health care benefits and covers all antiretroviral (ART) medications, without prior authorization. MA health care services are provided on either a fee-for-service basis or through one of the eight contracted managed care organizations, five of which operate in the MSP-TGA. All major HIV specialty care providers in the 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 in including a housing stabilization benefit added in 2021.

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, 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 <160% of FPG to $28 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 (QHP). In addition to MA and MinnesotaCare, *MNSure* offers four metal levels of coverage (Bronze, Silver, Gold, and Platinum) through its QHPs and a catastrophic plan for enrollees under 30 years of age or have a hardship exemption. Table 5 compares relative costs and overall coverage among all four metal level QHPs.

Table 5. Minnesota Qualified Health Plan Comparison (mnsure.org)

Relative Costs	Bronze Plan	Silver Plan	Gold Plan	Platinum Plan
Monthly Premium	$	$$	$$$	$$$$
Cost You Pay	$$$$	$$$	$$	$
Cost Plan Pays	60%	70%	80%	90%

MNSure QHP premiums range from $70 (Bronze) to $198 (Gold) per month, after a $204 advanced premium tax credit, for a single 40-year old non-smoker with an income of

$28,980/year (225% of FPL) living in the Minneapolis zip code with the highest HIV prevalence rate in the TGA. Deductibles range from $900-$6,700, with out-of-pocket maximum costs ranging from $7,200-$8,550 (not including premiums). Prescription co-payments range from $5 for generics (after deductible is met) to 20% co-insurance where the deductible does not apply. Depending on their income, enrollees may also be eligible for additional cost-sharing reductions which may lower their co-insurance, co-payment, and deductible costs. 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. Minnesota's AIDS Drug Assistance Program (ADAP) is administered by the Minnesota Department of Human Services. ADAP provides insurance premium assistance for cost effective private and employer-sponsored health plans (where the employee pays ≥50% of the premium cost) including seven QHPs obtained through *MNSure* and off-exchange private individual plans for PWH who are categorically ineligible to obtain health insurance, including a QHP. ADAP also covers prescription deductibles and co-payments. Minnesota'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 2021, ADAP provides premium and cost-sharing assistance for the following five QHPs available in the TGA: Blue Plus Metro MN Gold ($1,400 deductible), Medica Applause Gold Copay ($1,100 deductible), Medica Applause Bronze HSA, ($6,700 deductible), HealthPartners Peak Individual Copay ($1,000 deductible), and UCare Gold ($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 2020 covered 265 RWHAP eligible PWH in the MSP-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 with a patient population of over 2,500 PWH. 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, is 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 FY21. Part A and MAI funded OAHS can also cover deductibles, co-insurance, and co-payments for clinic visits, laboratory tests, and other outpatient services. Part A OAHS provided HIV outpatient care services to 1,945 PWH in the MSP-TGA in FY20.

i. Influence of coverage options on direct access to health care and health outcomes

After full implementation of the ACA, in 2015 Minnesota (MN) had one of the lowest rates of uninsured residents in the nation at 4.3%, which had fallen from 8%. 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.* The removal of the categorical Medicaid eligibility requirements alleviated cost barriers that prior to the ACA sometimes resulted in missed appointments or not picked up prescriptions for the TGA's poorest PWH who were categorically ineligible and relied on Minnesota's high risk insurance pool for coverage. 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 declined to 4.5% in 2020 from to 6.4% in 2019. Extension of ACA open enrollment periods in response to the COVID pandemic likely increased enrollment in Minnesota's publicly funded programs and QHPs. The estimated proportion of the TGA's population of diagnosed PWH who are uninsured is 4.0% (Table 4, p 16) and among the TGA's PWH who received RWHAP services in 2020, it is 3.6%. Notable disparities continue among MN's uninsured in the areas of race/ethnicity, age, and country of birth (State Health Access Data Assistance Center, 2019). While only 3.2% of Whites were uninsured in the MSP-TGA's largest county (Hennepin) comprising 61% of TGA's HIV prevalence, the uninsured rates among Latinx (21.9%), American Indians/Alaska Natives (13.5%), Blacks (7.5%), Asians (5.2%), and foreign-born (13.5%) were considerably higher.

Currently, 23% of MSP-TGA residents rely on Medicaid or MinnesotaCare (Table 4, p 16). Private qualified health plans (QHP) obtained through *MNSure*, MN's state-based marketplace, cover 2.5% of Minnesotans on individual or small group coverage. As of December 31, 2020, at least 4,188 (53%) of the TGA's PWH received coverage under Medicare (16%), Medicaid (28%), MinnesotaCare (4.7%) or a QHP obtained through *MNSure* (3.3%). Individuals with an income below 138% of FPL are eligible for Medicaid. Minnesotans with disabilities with incomes above 138% of FPL may also be Medicaid eligible if they are employed. 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 Statewide 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 49% of the TGA's PWH population estimated to be at or below 200% of FPL (Table 4, p 16) and 78% 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 340B 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 the potential negative impact of delayed HIV care due to the COVID pandemic, RWHAP resources will play an even more critical role in ensuring access to health care for eligible PWH, increasing the burden on the Part A Program in coming years. Ensuring access to comprehensive affordable health insurance continues to be challenging given the decline in the MSP-TGA's Part A program overall funding since 2017 along with the 6% increase in the TGA's HIV prevalence over the same period (see ***Attachment 3***).

c) Factors that limit access to health care

Geography of residence. The MSP-TGA includes two counties in western Wisconsin (WI), Pierce and St. Croix. There were 53 individuals known to be living with HIV in these two counties as of December 31, 2020. Wisconsin has not fully implemented the ACA and is one of 12 states that has not adopted Medicaid expansion, so health care access may be more limited for PWH in the TGA's Wisconsin counties. 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. Two hundred fifty PWH in the MSP-TGA reside in the exurban counties of the MSP-TGA, of which 77 received RWHAP in 2020, and live more than 40 miles from where services are concentrated (***see Attachment 14B***). They are less likely to have the resources for transportation to access needed services.

Complexity of the health insurance system. While full implementation of the ACA in Minnesota resulted in a significant increase in access to affordable health care for the broader community and PWH in the MSP-TGA, Minnesota's system of health care coverage remains very complex. 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 forced some PWH to obtain a QHP through *MNSure* that may increase their out-of-pocket costs.

The complex health insurance system for the MSP-TGA's PWH makes continuity of coverage difficult, resulting in increased reliance on RWHAP services to assist PWH in obtaining coverage and filling gaps including covering out-of-pocket costs. 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, without the special enrollment period due to the COVID pandemic, would have been only seven weeks in 2020. Qualified Health Plan changes may require PWH to change their plan annually, increasing the risk of coverage loss, or resulting in the inability to continue care at their provider of choice. In 2020, the MN Council for HIV/AIDS Care and Prevention, the MSP-TGA Part A and Minnesota's Part B recipients jointly conducted the 2020 HIV Community Needs Assessment (NA2020), with 814 PWH responding to the assessment survey. Thirty-nine percent of respondents accessed financial assistance to maintain continuity of health insurance coverage, and 11% who needed assistance were unable to access it.

Poverty and out-of-pocket health care costs. An estimated 49% of the MSP-TGA's diagnosed population of PWH have incomes at or below 200% of the FPL (Table 4, p 16). 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 prescription deductibles, co-insurance and co-payments. According to the NA2020, 53% of survey respondents accessed assistance obtaining and paying for HIV medications, and 8% needed assistance but didn't access it. Among survey respondents residing in the TGA (N=627), 33% reported having problems paying medical bills in the past 12 months, and 73% said that they were somewhat or very worried that they would not be able to pay their medical bills if they got sick or had an accident.

Disparities among communities of color and the foreign-born. Notable disparities continue to exist among MN's uninsured in the areas of race/ethnicity, and country of birth. According to the Minnesota Health Access Survey, whereas 3.2% of Whites in the MSP-TGA's largest county (Hennepin) were uninsured in 2019, the percentages among Latinx (21.9%), Blacks (7.5%), American Indians (13.5%), and the foreign-born (13.5%) were considerably higher. Racial and ethnic disparities in access to health care are evident among the MSP-TGA's PWH. The NA2020 showed that Black African-born (43.8%), American Indians (27.8%), Latinx (20.5%), and Black/African Americans (12.9%) were much more likely to need but not receive financial assistance to maintain continuity of health insurance coverage compared to Whites (6.6%). Similarly, the needs assessment survey showed that 14.5% of Black/African-born, 10.4% of Black/African Americans, 10% of American Indians, and 8.5% of Latinx needed but did not receive assistance obtaining and paying for HIV medications compared to 5% of Whites.

Minnesotans born outside the U.S. are uninsured at a rate four times higher than those born in the U.S. People with HIV 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 2021, MN ADAP purchased six Gold or Bronze private plans on the off-exchange market for 259 PWH who were categorically ineligible for Medicaid, MinnesotaCare or a QHP. Information on RWHAP services in languages other than English is sparse outside of the HIV care system. Twenty-seven percent of PWH in the TGA in FY2020 (2,115) 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 2019, 33% of MN's new foreign-born cases progressed to AIDS within a year of diagnosis compared to 21% 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.

Substance use disorder and homelessness. People with HIV who inject drugs and are experiencing homelessness are less likely to have health insurance and experience multiple

barriers accessing financial assistance to maintain continuity of health insurance coverage and access to antiretroviral medications. In February 2020, an HIV outbreak in Hennepin (Minneapolis) and Ramsey (St. Paul) Counties among people who inject drugs (PWID) was declared by the MN Department of Health. As of August 31, 2021, there are 80 cases associated with the outbreak. Among the outbreak cases, 44% are experiencing unsheltered homelessness, and the emergence of homeless encampments in the MSP-TGA during the summer of 2018 is correlated with the outbreak. Among PWH residing in the MSP-TGA who received RWHAP services in 2020 and were unstably housed, 15% were uninsured compared to 3% of those stably 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 majority of who reside in the MSP-TGA.

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

The 2019 estimate (most recent available) of the proportion of the total population of PWH in Minnesota (MN), who are diagnosed, is at 91.2%, thus the estimate of the proportion who are undiagnosed is 8.8% or 860 people, with a 95% confidence interval of 470-1,300. This estimate, provided by the MN Department of Health (MDH), uses 2019 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. If the MN proportion of diagnosed Minnesotans living with HIV was applied to the MSP-TGA's population of PWH 13 years of age and older to develop an HIV-unaware estimate for the TGA. The estimate is 778 PWH in the MSP-TGA are unaware of their status as of December 31, 2019. 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. An updated unaware estimate for 2020 isn't yet available for MN from MDH, as the resources typically dedicated to HIV epidemiology have shirted to the COVID-19 pandemic response.

The MSP-TGA's EIIHA data includes HIV testing data reported by Part A early intervention services (EIS) providers and Hennepin County operated clinics. In prior years, data on all publicly funded HIV tests administered in the TGA were shared including those funded by MDH and DHS. That data showed a clear trend of reduced number of HIV tests administered year over year due to changes in how HIV testing was reported into EvaluationWeb along with a significant drop in funding from the primary public funder of HIV testing, MDH. Now the numbers shared on testing will be only for contracts administered by the MSP-TGA Ryan White Part A program or administered by Hennepin County Public Health Clinics. In 2020, HIV testing, like most everything else, was affected by the COVID-19 pandemic. Agencies that administer HIV testing were closed for a time until they could determine how to keep both staff and consumers safe. When they were able to reopen, fewer people came to get tested as in general fewer people came to physical health centers and HIV agencies, opting to either do necessary appointments via telephone or video or delaying care or services. The numbers reflect the reality of fewer people testing in 2020. Partial data from 2021 show that HIV testing is increasing, and the number of publicly funded tests will likely be higher in 2021.

Hennepin County is home to 61% of the TGA's PWH as well as the public health clinics that identify the most HIV cases in the state. The Hennepin County Public Health Clinical Services including Red Door Services, Refugee Health Screening, Mental Health Center Primary Care, and Health Care for the Homeless, conducted 7,184 HIV tests in 2020 and identified 81 HIV positive cases. While these clinics administered fewer tests in 2020 than 2019 (10,333) the

number of case findings increased from 2019 (60), meaning they had a higher positivity rate in 2020 with 1.13% over 0.58% in 2019. From January to July of 2021 these clinics have administered 4,650 HIV tests and had 61 case findings resulting in a positivity rate of 1.31%, greater than the previous years. These recent numbers are more encouraging showing that despite reduction in HIV tests administered, people with HIV are being diagnosed, and efforts to reduce the percent of undiagnosed PWH in the MSP-TGA are progressing.

The early intervention services (EIS) contracts administered by the Hennepin County Ryan White Program have changed significantly from year-to-year, including changes in subrecipients from five providers to three, changes in data reporting from quarterly reports to EvaluationWeb, and changes from having both outreach and EIS contracts to only EIS contracts. MSP-TGA RWHAP staff use data to determine efficacy, efficiency, and disparities to inform contracting decisions to improve EIS results in identifying, informing, referring, and linking PWH to care. Two of the three EIS providers report number of HIV tests administered into EvaluationWeb, while all three report case findings in MNCAREWare. The third one collects data on the number of tests administered as a Hennepin County Public Health Clinic, which is reported in the previous paragraph. Therefore, the following data represents the two providers not already captured above. In 2020, HC funded EIS providers administered 422 HIV tests and found 19 cases resulting in a 4.5% positivity rate. In 2021 from January to May, 408 HIV tests had been administered with 9 case findings, resulting in a 2.2% positivity rate. While the reduction of the positivity rate is not ideal, the overall rates are more than twice the rate typically seen. Hennepin County contracted EIS providers and public health clinics, despite the COVID-19 pandemic, are continuing to administer HIV tests and find PWH, showing their resiliency and innovation to work towards the goal of ending the HIV epidemic.

1) Planned MSP-TGA EIIHA activities for 2022-2024

a) Primary activities

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 46% with an allocation of $391,250 in 2021. Overall funding administered by the MSP-TGA Ryan White Program has grown 76% to $939,124 in 2021 made possible from 340B ADAP rebate funding from the MN Department of Human Services (DHS). Paired with increased funding is better data collection, tracking, and analysis along with focus on the priority populations of people who inject drugs (PWID), American Indians/Alaska Native, Black/African Americans, Black/African-born, Latinx, people experiencing homelessness, and MSM, and MSM/IDU. The MSP-TGA Part A program EIS subrecipients are the Red Door Clinic, The Aliveness Project, and Minnesota Community Care. These providers have proven themselves effective to reach the prioritized populations and have strong partnerships with other organizations in the community to refer and link clients to needed core medical and support services to ensure clients have the best chance of being linked and retained in care and achieve sustained viral suppression.

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 112% from 2017 to 2021 in recognition of their effective work and the loss of funding from the MDH. Red Door Services has historically diagnosed 20-25% of the TGA's HIV cases. In addition, to increased testing of prioritized 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 2020, the Red Door conducted 6,208 HIV test events resulting in 30 new HIV diagnoses. The overall positivity rate was 0.61%. Red Door linked 26 of their newly diagnosed clients (87%) to HIV medical care within 30 days.

Red Door continues to improve efforts to reach the highest risk populations most effectively. Collaborating with Hennepin County Public Health's epidemiology team and MSP-TGA RWHAP staff, Red Door has better access to data to guide its initiatives. This team has increased collaboration, flow of information, and its continuous quality improvement efforts. The Part A grant recipient directly supports these efforts with EIS Part A resources and is scaling up successes and sharing lessons learned to improve EIS efficacy throughout the jurisdiction.

The other Part A funded EIS provider is the Aliveness Project, an organization that provides wrap around core medical and support services to PWH. In 2020, the Aliveness Project administered 374 HIV tests resulting in three new diagnoses, a positivity rate of 0.8%. In 2021 the goal is for them to administer 500 HIV tests, with 75% being done with Black/African American MSM, Latinx MSM, Black/African Born individuals, transgender individuals and people experiencing homelessness. The objective is to identify 10 new diagnoses. The Aliveness Project has staff and partners who provide culturally responsive services to the prioritized populations. They have a strong partnership with Hennepin County Public Health Clinic's Health Care for the Homeless to coordinate testing, linkage, and referral to continued HIV core medical and support services. The MSP-TGA RWHAP in coordination with Part A and rebate funded subrecipients, MN Department of Human Services, MN Department of Health, and the rest of the Hennepin County Public Health programs can reach those most at risk for HIV, link them to care within 30 days, and get them on the path towards sustained viral suppression.

Tailored Approaches for reaching the Black Gay community in Hennepin County. In 2020, the Hennepin County Public Health Clinical Service's Red Door Clinic conducted focus groups with African American men who have sex with men. This effort was supported by resources from the Hennepin County Ryan White Program's HRSA/HAB funded "Building Capacity for HIV Elimination in RWHAP Part A Jurisdictions" cooperative agreement to identify barriers experienced by Black/African American MSM to utilization of Red Door services. The participants in the focus groups shifted the focus away from Red Door services specifically to the larger context of issues that Black/African American MSM experience, such as stigma that result in less utilization of Red Door services. While it is important for RWHAP providers to have Black staff, there needs to be greater investment in the partnership with the Black Gay community. This partnership can be fostered by engaging grassroots Black/African American MSM leaders by providing incentives, refreshments, and meeting space. By investing in this leadership, these leaders can in turn create a place and opportunities to host Black Gay men. When these groups gather, a supportive community can form where information can be shared,

and services can be accessed. By partnering with, welcoming, and investing in Black Gay leaders and community, HIV health literacy and access to HIV related services will likely increase.

The Red Door Clinic has taken the recommendations as well as the input received from the focus groups to develop a cultural responsiveness quality improvement plan. Their staff are participating in cultural responsiveness training convened by the Hennepin County (HC) Part A recipient staff as well as other technical assistance and training opportunities. A network of Black/African American same-gender-loving (SGL) men has been established from the focus groups who help inform Red Door Clinic and are connecting with their community to bridge the gap between this provider and the community.

The Red Door Clinic, with support and resources from the MSP-TGA's Part A recipient staff are rolling out a "Stay Ready," campaign specifically tailored to Black/African American SGL men. This campaign includes having participants from the focus groups host events for their networks in the Black/African American MSM community to address stigma and barriers to accessing HIV services. In addition, banners and ads have been purchased for the campaign with imagery that is more representative of the Black/African American SGL community. The Red Door Clinic featured the "Stay Ready," campaign banners at their tent at the 2021 LGBTQ Pride Festival and will continue to be used at future events such as People of Color Pride Festival.

In addition, HC Part A recipient staff is working with Rev. DeWayne Davis, a gay African American pastor of a large congregation in Minneapolis. His work is to engage and facilitate the empowerment of Black/African American SGL men to stop new HIV infections. Objectives include: (1) identify religious and civil society organizations committed to improving the lives and health of AASGL men; (2) identify culturally responsive approaches/opportunities to reduce HIV stigma; (3) identify methods to build partnerships with faith and civil society organizations to disseminate information, provide education, and training; and (4) increase Black/AASGL utilization of Ryan White services. This work will support more Black/African American MSM knowing about and engaging in HIV prevention, testing, and care services, to prevent the spread of more HIV infections in their community.

Improving Cultural Responsiveness. In 2018 the Ryan White Universal Standards for Minnesota and the MSP-TGA were updated. These standards apply to all RWHAP funded services in Minnesota and the MSP-TGA, regardless of the recipient who funds them, or the services provided. This process began with the cross RWHAP parts quality management body led by Hennepin County and DHS. A task force was created with consumer, subrecipient, and recipient members to review previous Universal Standards. In addition, a separate taskforce was created to develop cultural responsiveness standards as a section of the Universal Standards. After the Universal Standards were approved by QMAC and the MN Council for HIV/AIDS Care and Prevention, HC Part A recipient staff worked on the development of readiness assessments, tools, and training for subrecipients to learn, understand, and comply with the new standards.

After a year of training and readiness assessments, subrecipients shared their need for more training, population specific awareness, and data. Part A recipient staff provided data and training on how to access data and disaggregate data to see what populations they are serving, to identify if those populations are changing, and if there are any disparities in viral suppression being experienced by any community. Once the providers received their data, they began making quality improvement plans to increase viral suppression of a particular client population experiencing disparities, to address compliance with a particular part of the cultural responsiveness standards, and to improve their cultural responsiveness to a particular population.

More efforts are underway to increase the capacity of providers to better serve PWH who are experiencing disparities. The HC Part A recipient's quality manager aided subrecipients in

actualizing their QI plans with training and technical assistance on quality improvement approaches. The Part A recipient staff organized trainings for all providers, sought feedback from subrecipients on the Cultural Responsiveness Standards, and provided one-on-one training, and technical assistance at the request of subrecipients. Subrecipients will be given guidance and training on how to examine their service utilization data to see if there are some populations they are not reaching and how to reach them. Part A recipient staff are hosting quarterly cultural responsiveness community of practice meetings to share tools, provide technical assistance, and work on how to measure cultural responsiveness. The feedback provided by subrecipients and subject matter experts will be used to continuously improve and revise the Cultural Responsiveness Standards to better serve PWH, especially those experiencing disparities.
Increasing Capacity and Community Engagement. While incidence is declining and viral suppression is high for the African-born HIV community, the percentage of late diagnoses among this population continues to be concerning.

Year	Prevalence (growth rate)	Incidence	Viral Suppression	Late Diagnosis (% of late diagnoses)
2016	1,128	66	89.8%	17 (25.8%)
2017	1,206 (6.91%)	48	90.1%	9 (18.8%)
2018	1,289 (6.88%)	42	92.5%	11 (26.2%)
2019	1,342 (4.11%)	36	91.8%	10 (27.8%)
2020	1,365 (1.7%)	20	n/a	6 (30%)

Based on these data, the MSP-TGA's RWHAP is engaging African immigrant communities to determine the barriers to getting diagnosed and into care sooner. The MSP-TGA RWHAP is partnering with two community specific agencies to connect with specific cultural communities. The Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) provides RWHAP funded services to East African immigrant communities and the West African HIV Taskforce (WAHTF) conducts HIV awareness and testing activities in West African immigrant communities. Hennepin County RWHAP's HRSA/HAB funded "Building Capacity for HIV Elimination in RWHAP Part A Jurisdictions" cooperative agreement supports these partnerships.

SAYFSM is the RWHAP subrecipient who provides early intervention, medical case management, non-medical case management, mental health, medical transportation, and psychosocial support services to African immigrant community members. The partnership the Part A program recipient has with SAYFSM has four objectives: (1) Build faith leaders' and the communities they serve understanding of HIV basics and how it affects their community; (2) Share information on HIV and RWHAP services in a culturally responsive awareness campaign; (3) Decrease HIV-related stigma through community events; and (4) Increase East African-born immigrant utilization of RWHAP services. They have completed a great number of effective efforts towards these objectives despite incredible challenges faced during the COVID-19 pandemic. The SAYFSM staff are making great strides working with Christian and Muslim East African Faith leaders. They have distributed brochures and monthly newsletters. They held virtual HIV awareness and education presentations on their YouTube channel, on their Facebook page, on community radio, and on TV outlets. SAYFSM staff provided capacity building training to nine other organizations also working on eliminating health disparities. In addition, SAYFSM conducted focus groups and small group discussions to assess community perception and knowledge of HIV/AIDS.

Going forward, SAYFSM will continue to be a leader in the East African Community around health and HIV. They continue to hold HIV education sessions with East African-immigrant faith leaders and communities and connect them to culturally responsive HIV testing and services. SAYFSM will annually assess faith leaders' knowledge on HIV basics and referral to

services process. They will hold annual HIV forums to share HIV information and assess knowledge and attitudes about HIV. From feedback they receive from their consumers and faith leaders they will tailor future campaigns and events to increase HIV knowledge, reduce HIV stigma, and increase HIV testing among community members, and link those who test positive to care easily and rapidly.

The HC RWHAP partnership with WAHTF has similar objectives as the partnership with SAYFSM to: (1) Build a culturally responsive HIV awareness campaign; (2) Increase West African-born faith leaders' and followers' knowledge on HIV and how it disproportionally affects the West African-born immigrant community in Minnesota; (3) Decrease stigma around HIV and people with HIV; and (4) Increase West African-born immigrant community utilization of RWHAP services. WAHTF has held eight HIV education, awareness, and testing events reaching 447 community members. In addition, they have hosted two Facebook live events with West African-immigrant influencers and two events on Zoom covering the importance of HIV testing, sharing resources and information on HIV services, and how to access them.

WAHTF will continue this effort to reach the West African-born immigrant community in the MSP-TGA to promote HIV awareness, break down stigma, encourage routine HIV testing, and link those who test positive to care easily and quickly. They will do this by holding at least four events a year within West-African immigrant faith and civil society organizations. They will assess, then train and campaign to address the findings of their assessments to ensure their messages are culturally responsive, effective, and efficient. Hennepin County is also providing organizational capacity building support to prepare WAHTF to receive funding to begin delivering early intervention services in 2022.

Reducing Barriers from Diagnosis to Linkage. 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 Healthcare's 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: 1) decrease new HIV infections; 2) ensure access to and retention in care for people living with HIV; and 3) 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 the TGA's HIV Care Continuum, the Part A RWHAP is working with HCPH Clinics, HCMC, Hennepin Health (the county's Medicaid managed care organization), 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 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 MyChart 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. *Positively Hennepin*'s implementation coordinator is 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 that deliver health to Minnesotans Medicaid and MinnesotaCare (basic health plan) enrollees.

The work does not end at testing though. The clinic that tests and identifies the most new HIV diagnoses in the state is the Hennepin County Public Health Clinical Services' Red Door Clinic. While being incredibly successful at testing and working to improve results of their Data-to-Care program they have found that one of the challenges is the waiting time and barriers for clients to go from diagnosis to first appointment which is most often at HCMC's Positive Care Center. To address this issue *Positively Hennepin* staff are working with Red Door to explore their ability and capacity to diagnose and provide the first HIV medical appointment, ART prescription and viral load testing the same day as diagnosis. This will reduce the waiting period and barriers to getting in to that first appointment. These clients would then be linked to longer term care at an appropriate and accessible outpatient ambulatory healthcare service provider.
Using Data informed Approaches to Reconnect PWH to Care. Red Door has been working to identify PWH out of care through their Data to Care (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 61% of PWH in the MSP-TGA live, being sent to the HCPH epidemiologists. The state does this by assigning cases of PWH who are believed to be living in Hennepin County and are out of care to the Red Door team via the Minnesota Electronic Disease Surveillance System (MEDSS). These cases are checked for matches in the electronic medical record system Epic and Minnesota's RWHAP joint Part A and B CAREWare database to see if they are truly out of care, where they last received care, and for any notation of recent contact information. Red Door disease investigators then look up each person to identify if they 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 2020, Red Door received 913 cases who had not had a CD4 or viral load test in the past 15 months. For those for which there is no additional information that confirms receipt of medical care, staff try to find accurate contact information and reach out to individuals on this list. Of this group, 53 were found to be in care, 3 were deceased, and 53 were out of jurisdiction. Attempts were made to contact 144 individuals, 40 of whom were reached. There were numerous attempted linkages to an HIV specialty care provider and 12 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 data Red Door front-line staff use to engage people in care. In addition, this approach is helping stem the current HIV outbreak in the MSP-TGA as Red Door staff are seeing an overlap between the populations they are serving and those that Healthcare for the Homeless is serving in homeless encampments that have been the epicenter of the outbreak. The Red Door team documents the process to identify areas for improvement to make future efforts more effective and efficient.
Convene Minnesota's EIIHA Workgroup. Hennepin County's RWHAP, along with the Part B Program at MN DHS and the CDC Prevention Grantee MDH, convened Minnesota's EIIHA workgroup in July 2021 through an online meeting to continue coordination of EIIHA activities

throughout Minnesota and the MSP-TGA. The workgroup was established in 2009 to ensure a collaborative and coordinated effort to decrease the proportion of Minnesota's PWH population that is unaware of their status. The workgroup shares successful strategies, recommends priority populations based on epidemiological data, EIIHA interventions, and outcome measures. Primary workgroup objectives include coordinating activities, fostering partnerships among providers, and assessing overall EIIHA progress in Minnesota and the TGA. At the 2021 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 recommending EIIHA priorities for 2022. Small groups discussed existing work and successes as well as gaps in services for each priority population. The small groups also discussed best ways to reach populations disproportionally affected by HIV, especially Black/African American, Latinx, and American Indian individuals. This ongoing collaboration between Hennepin County's RWHAP, DHS, MDH and community partners promises to yield improved EIIHA outcomes.

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 linkage to 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, this resulted in the 2021 decision to integrate EIIHA work into the HC and DHS RWHAP respective quality management advisory bodies. This change increases frequency of updates on EIIHA data, goals, and progress to consumers, subrecipients, and other partners. With more frequent updates, accountability and transparency are improved that will hopefully result in continuous improvement of EIIHA work in the future.

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 priority populations are selected based on information provided by MDH staff in the EIIHA workgroup and data from eHARS, EvaluationWeb, and MN CAREWARE. The Government HIV Administrative Team (MDH, DHS and Hennepin County) meets every other month to coordinate all state and local RWHAP 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 an administrative agent for the DHS' 340B ADAP rebate funded Early Intervention Services. Through this funding MDH has 13 subrecipients, 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 MDH EIS subrecipient, more data would be required for substantial collaboration. A primary goal of the

more intentional collaborative EIIHA effort being instigated by the Government HIV/AIDS Team is for the government partners to share information more freely 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, a DHS Part B recipient 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 recipient's quality management coordinator. DHS funds additional EIS and outreach services through 340B ADAP rebate revenue, some of which is administered by the Part A recipient 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 priority 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 340B ADAP rebate funded EIS and D2C contracts with Red Door and Minnesota Community Care on behalf of DHS. DHS sends 340B ADAP rebate funds to MDH to administer for EIS as well. MDH then funds 13 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 fund duplication and 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. Each EIIHA activity will have baseline measures, data collection timelines, and improvement goals. The Part A program will continue collaborating with MDH, DHS, and the EIIHA workgroup to annually review activity progress and measures, including testing and linkage data, jurisdictional unaware estimates, and epidemiological data to identify emerging populations and trends. This process will inform adjustments to objectives and activities to respond to the needs of priority populations and those at highest risk. The following describes the anticipated outcomes of the overall EIIHA strategy for each of the four EIIHA components.

1) *Identify individuals who are unaware of their status:*
- In person rapid HIV tests are administered to 500 individuals at high risk for HIV who are unaware of their status.
- At least 75% of HIV tests are administered within the following populations: men of color who have sex with men; transgender individuals; people who inject drugs (PWID); people experiencing homelessness; African-born and American Indian individuals.

2) *Inform individuals who test positive of their HIV diagnosis:*
- All individuals tested for HIV with rapid HIV tests are informed of their results and assessed for needed prevention, including PrEP (if negative), or care services (if positive) at the same visit.

3) *Refer newly diagnosed individuals to care*
- 90% of newly diagnosed individuals are assessed for needs and potential barriers to linkage and retention in care, then referred to HIV medical and other necessary core medical and support services.

4) *Link newly diagnosed individuals to HIV medical care*
- Ninety-five percent of newly diagnosed people in the MSP-TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis.

An additional overall EIIHA anticipated outcome for FY22 is to identify and use proven methodology to establish an HIV unaware estimate for the MSP-TGA. This will hopefully provide a more specific estimate for the TGA than what is provided for the State of Minnesota by MDH, with improved potential to disaggregate the estimate by race/ethnicity for those subpopulations with high enough incidence to meet a confidence threshold.

2) Planned efforts to remove legal barriers to routine HIV testing. In Minnesota (MN) and Wisconsin (WI) there are no state or local statutes, ordinances, or regulations that impose significant barriers to routine opt-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 MSP-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 31 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 and improve 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, including capacity building; 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. In response to the HIV outbreak among PWID in Hennepin and Ramsey counties, Hennepin County Healthcare for the Homeless is scaling up its capacity to test people experiencing homeless through pop-up testing and harm reduction events in homeless encampments in Minneapolis in collaboration with community-based providers, two of which is a Part A funded EIS subrecipients. Through June 30, 2022, the Part A program is supporting targeted HIV awareness campaigns in East and West African immigrant communities, and among African American same-gender-loving men with its HRSA/HAB "Building Capacity for HIV Elimination in RWHAP Part A Jurisdictions" cooperative agreement funding.

C. Subpopulations of Focus

1) Description of subpopulations of focus. The Part A RWHAP focused on outcomes along the HIV care continuum, including unmet need, incidence and prevalence trends, and social determinants of health to determine the subpopulations of focus. Data was stratified by race/ethnicity, gender, age, transmission category/HIV risk factor, sociological factors (housing status, income), and geography to identify disparities. Viral suppression, receipt of care, and retention in care were evaluated using the most recent HIV care continuum and the unmet need framework. Furthermore, incidence was evaluated, including late diagnoses using the unmet need framework. When gaps were identified, services that impact social determinants of health were evaluated using RWHAP data in MN CAREWare and the 2020 HIV community needs assessment (NA2020). It became clear that a racial equity approach best captures the disparities in health outcomes. Access to HIV medical care, housing, harm reduction for substance use disorders, preventative HIV measures for men who have sex with men, and basic needs are shaped by racial inequities. While other subpopulations experience health and racial disparities, individuals who are American Indian, Black/African American, or Latinx have the greatest disparities in health outcomes in the MSP-TGA. RWHAP data and the NA2020 show these disparities in health outcomes are driven by inequitable access to and receipt of culturally responsive health and social services and supports that influence social determinants of health. The Minnesota Council for HIV/AIDS Care and Prevention was a partner in development of the NA2020 survey instrument. The council receives recurring updates on all the data discussed above and participates in disparities reduction planning. The council's Disparities Elimination Committee along with Planning and Allocations committee sets MAI service priorities and allocations and develops directives to assure that RWHAP services are culturally responsive to subpopulations of focus.

a) Subpopulation of focus: American Indian. Among American Indian individuals who have a documented viral load, only 87.7% were virally suppressed compared to 92.6% for the entire MSP-TGA PWH population according to the 2019 MSP-TGA HIV surveillance data. This subpopulation has a comparable receipt of care rate (78.1%) as the overall population (78.8%), although a slightly lower retention in care rate (47.9%) than the overall population (49.6%). Despite obtaining HIV medical care, the American Indian population is less likely to be virally suppressed. These health and racial disparities also exist within the RWHAP system of care, where American Indian clients are virally suppressed at 72.2% vs. 91.2% for all RWHAP clients.

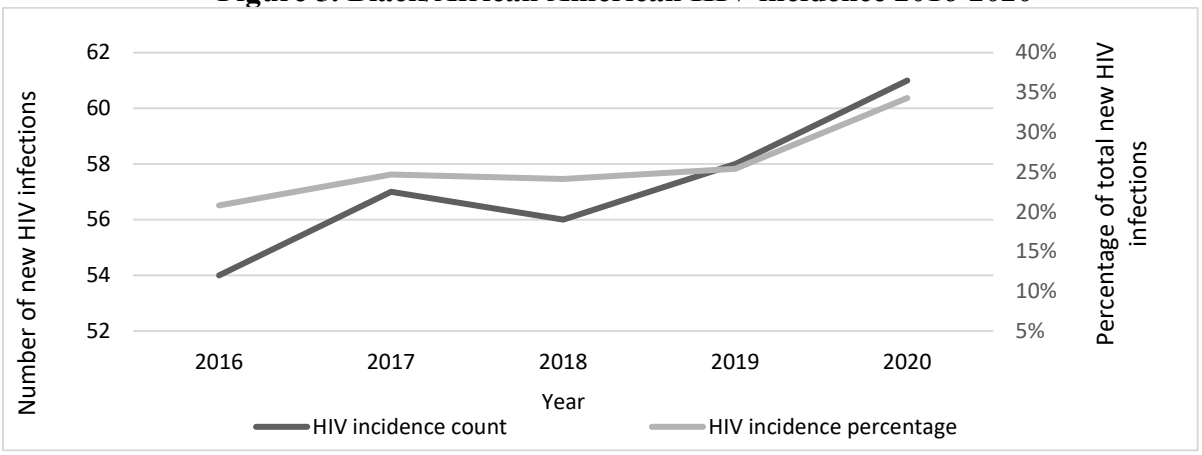
HIV incidence has risen among the American Indian subpopulation with 1 case in 2016, 2 cases in 2017, 4 cases in 2018, 8 cases in 2019, and 5 cases in 2020. Only 3 of these cases from 2016-2020 were late diagnoses. Unlike most racial/ethnic groups, the primary mode of transmission is injection drug use (IDU). Thirteen cases were IDU or men who have sex with men who inject drugs (MSM/IDU). As of September 17, 2021, an ongoing HIV outbreak among PWID in the TGA's two largest counties accounted for 80 new cases since the outbreak began in December 2018 (seven additional cases diagnosed prior to December 2018 are also considered part of the outbreak). The American Indian subpopulation is overrepresented in this HIV outbreak. In the MSP-TGA, 0.5% of the population is American Indian, yet 25% of the HIV outbreak cases are among individuals who are American Indian.

Housing appears to be the greatest barrier to advancement along the HIV care continuum for the American Indian subpopulation. Among RWHAP clients in the MSP-TGA in 2020, they were the most likely to be unstably housed at 13.5% compared to 5.4% overall. The next highest racial/ethnic group was unstably housed at 7.8%. Data from the NA2020 highlight other needs of this subpopulation. The NA2020 sampled 631 people with HIV in the MSP-TGA; respondents are excluded from the denominator if they skipped the question. American Indian respondents were more likely to have problems paying medical bills in the past 12 months at 37.5% (15/40) compared to 30.3% (190/627) overall. Among American Indian respondents reported often running out of food before they had money to buy more, 27.5% (11/40) compared to 12.5% (79/631) overall, highlighting a high rate of food insecurity. There were also transportation barriers with 40.0% (16/40) of American Indian respondents compared to 23.2% (146/630) overall reporting they put off going to the doctor for HIV medical care because they did not have a way to get there. For the American Indian subpopulation, the ability to pay for HIV medical care and lack of access to services that impact social determinants of health (housing, food, and transportation) are barriers to advancement along the HIV care continuum. Fortunately, these can be addressed by the RWHAP with additional funding and culturally responsive housing opportunities. Finally, culturally responsive mental health services are needed as 37.5% (15/40) of American Indian respondents compared to 24.0% (150/625) overall reported mental health as a reason for missing an HIV medical appointment. In a follow up question, 30.0% (12/40) of American Indian respondents compared to 24.0% (150/626) overall reported mental health as a barrier to remaining adherent to HIV medication.

b) Subpopulation of focus: Black/African American. Individuals who are Black/African American are virally suppressed at a lower rate (63.2%) than the overall population (69.9%). This can be partly attributed to a lower receipt of care rate (74.9% vs 78.8%) and retention in care rate (46.8% vs 49.6%). However, the low viral suppression rate is also found among the Black/African American subpopulation with a viral load where 87.2% are virally suppressed compared to 92.6% overall. This viral suppression gap is also found in the RWHAP system where 91.2% of all RWHAP consumers with a viral load are virally suppressed compared to 88.4% of Black/African American clients.

Despite a decrease in overall HIV incidence in 2020 due to the COVID-19 pandemic, the Black/African American subpopulation saw an increase in HIV incidence (Figure 2, pg. 5) and comprise a growing percentage of new infections overall; from 24.7% in 2016 to 34.3% in 2020. Approximately 12 Black/African American individuals have a late diagnosis in each year from 2016-2020 (low: 9, high: 14). Black/African American individuals are overrepresented in the HIV outbreak comprising 14% of the cases and only make up 8.5% of the MSP-TGA population.

Figure 5. Black/African American HIV incidence 2016-2020



Evaluation of the social determinants of health using RWHAP client-level data and the 2020 HIV community needs assessment (NA2020) reveals housing, transportation, food, and ability to pay medical bills are needs in the Black/African American subpopulation. In 2020, Black/ African American RWHAP clients were more likely to be unstably housed at 7.3% (96/1,323) compared to 5.3% (245/4,594) overall. Black/African American respondents in the NA2020 were more likely to report often running out of food before they had money to buy more at 16.9% (27/160) compared to 12.5% (79/631) overall. Also, 27.7% (44/159) of Black/African American respondents reported putting off HIV medical care because they did not have transportation compared to 23.2% (146/630) overall. According to NA2020 data, 25.2% (40/159) of Black/African American respondents reported having trouble paying medical bills in the past 12 months. While this is lower than the overall (30.3%, 190/626), it is still alarmingly high.

c) Subpopulation of focus: Latinx. In 2019, according to MSP-TGA HIV surveillance data, the Latinx subpopulation has a lower receipt of care compared to the overall population (72.0% vs. 78.8%) and lower retention in care (45.1% vs. 49.6%). This results in a lower viral suppression of 65.3% vs. 69.9%. However, when the Latinx subpopulation's viral suppression rate is examined for those who had a documented viral load, it is 93.0% comparable to the overall at 92.6%. From this data, it appears the barriers to care for the Latinx subpopulation exist at the receipt of care and retention in care stages, not the viral suppression stage. From 2016 to 2019, incidence increased among the Latinx subpopulation from 22 to 34, with a decline in 2020 to 25 cases, likely due to the COVID-19 pandemic and fewer HIV testing opportunities. Among Latinx incident cases in 2019, 26.5% (9/34) had a late diagnosis. This is higher than the overall at 24.1% (55/228).

Data from the 2020 HIV community needs assessment (NA2020) shows the Latinx subpopulation has significant barriers to paying for medical care. Among Latinx respondents, 43.6% (27/62) reported problems paying medical bills in the past 12 months compared to overall was 30.3% (190/627). This is the highest of any racial/ethnic group. Furthermore, 51.6% (32/62) of Latinx respondents reported being "very worried: about their ability to pay future medical bills" compared to 32.9% (205/623) overall. Among Latinx respondents, 7.9% (5/63) compared to 12.5% (79/631) said they often run out of food before they have money to buy more in the past 12 months. While 47.5% (30/63) of Latinx respondents reported sometimes running out of food. This means over half of Latinx respondents experienced some level of food insecurity in the past twelve months. Transportation appears to be a significant barrier as 33.3% (21/63) of Latinx respondents report not attending an HIV medical appointment due to lack of transportation. In 2020, 4.5% (24/535) of Latinx RWHAP consumers in 2020 were unstably

housed compared to 5.3% (245/4,594) overall. However, Latinx RWHAP consumers were more likely to be temporarily housed at 10.5% (56/535) compared to 9.0% (412/4,594) overall. This means nearly 15% of Latinx consumers need a stable/permanent housing solution.

2) Unmet need framework and subpopulations of focus. The key indicator of success for HIV public health programs, including the RWHAP, is movement along the HIV care continuum to viral suppression. The unmet need framework allows the RWHAP to methodologically analyze where the gaps are for subpopulations and where to focus efforts to achieve equitable, high rates of viral suppression. Receipt of care and viral suppression rates were discussed above. The unmet need framework uses similar measures while limiting the denominator to those who had a reported lab to the state health department in the past five years. This cohort is more likely to be reachable to benefit from public health interventions as they had some contact with an HIV medical provider in the MSP-TGA in the past five years. When discussing the unmet need framework, all Black individuals (both African-born and African American) are included together. The Minnesota Department of Health reported that the SAS code provided by the CDC did not allow them to break racial/ethnic groups into subpopulations.

Black and Latinx subpopulations have slightly higher rates of late diagnosis at 26.6%, 26.5%, respectively, compared to the overall at 24.1%. Based on this and incidence trends, these subpopulations will continue to be prioritized for HIV testing and prevention efforts, including RWHAP early intervention services. As there were only eight diagnoses among American Indian individuals in 2019, the 12.5% (1/8) late diagnoses should be interpreted with caution. The RWHAP will continue to monitor late diagnoses in the American Indian subpopulation, given their disproportionate representation in the HIV outbreak among people who inject drugs.

Each subpopulation presented different health and racial disparities when evaluating the percentage with unmet need, percentage in care, and not virally suppressed. The Black subpopulation has a higher unmet need at 14.4% compared to 12.8% overall and a higher percentage in care but not virally suppressed at 15.4% compared to 12.3% overall. The inclusion of the Black subpopulation is substantiated by health and racial disparities in all three components of the unmet need framework using HIV surveillance data. Within the RWHAP system, the percentage of unmet need in the Black subpopulation compared to the overall (3.7% vs 3.4%), and percentage in care but not virally suppressed (17.0% vs 16.9%) were not meaningfully different. This supports including the Black subpopulation as a subpopulation of focus as enrollment in RWHAP appears to improve health outcomes for this subpopulation. Using 2019 HIV surveillance data, the American Indian subpopulation did not have a meaningful difference in percentage of unmet need at 12.9% compared to 12.8% overall. However, there was a gap of 13.1% for the American Indian subpopulation compared to 12.3% overall for the percentage in care but not virally suppressed. These findings are consistent with RWHAP data where 3.6% of American Indian consumers have an unmet need compared to 3.4% overall, but 22.6% of American Indian consumers are in care but not virally suppressed compared to 16.9%. Barriers for the American Indian subpopulation to achieving viral suppression despite obtaining HIV medical care need to be addressed.

Finally, using 2019 HIV surveillance data, the Latinx subpopulation did not appear to have a disparity once in HIV medical care as 10.2% are in care but not virally suppressed compared to 12.3% overall. However, a higher percentage of the Latinx subpopulation had an unmet need at 13.7% compared to 12.8%. These findings are reversed within the RWHAP system where 2.2% of Latinx consumers have an unmet need compared to 3.4% overall and 18.3% are in care but not virally suppressed compared to 16.9% overall. The Latinx subpopulation appears to have

different barriers to achieving viral suppression depending on other factors not examined in the unmet need framework. Their selection as a subpopulation of focus is important, so the Minnesota HIV Council for Care and Prevention can help identify what these factors are and direct resources to eliminate these health and racial disparities.

3) EIIHA activities for the subpopulations of focus.

American Indian Individuals. In the MSP-TGA there have been 80 cases related to an HIV outbreak, many were co-infected with hepatitis C. Of the outbreak cases 20 (25%) are among American Indian/Alaska Native individuals. Additional cases are either from sex or needle sharing between partners. The incident commander of the response to this outbreak for Hennepin County is MSP-TGA Ryan White Program Coordinator. Hennepin County Public Health (HCPH) and the Part A program are coordinating with local partners and the MN Department of Health (MDH) to respond effectively. Many of these activities overlap with EIIHA activities to identify, inform, refer, and link PWH previously unaware of their status to care.

All RWHAP funded and CDC prevention funded providers in the MSP-TGA who are conducting HIV testing are also either linking clients to care or providing the medical care themselves. One of the new Part A funded providers for 2021 is Healthcare for the Homeless, and they have been one of the primary providers to respond to the care and prevention needs of those at risk and diagnosed PWH living in encampments where many of the outbreak cases were identified or linked to. While Healthcare for the Homeless is contracted to provide medical case management, they are also doing HIV testing and informing those tested of their status, providing referrals and harm reduction services, linking newly diagnosed PWH to care, and providing HIV medical care in the field including blood draws for CD4 counts and viral load tests, and ART dispensation. Other RWHAP subrecipients, including: Native American Community Clinic, Hennepin Healthcare, Red Door Clinic, and Allina Health are providing HIV medical care to PWH experiencing homelessness who are part of the HIV outbreak among PWID. Since the HIV outbreak was identified, significant coordination efforts are happening in Hennepin County to ensure effective and culturally responsive EIIHA work is occurring with American Indian people with HIV in the MSP-TGA.

Black/African American Individuals. From 2016 (21%) to 2020 (35%), non-Latinx Black/African American individuals have made up a greater percentage of new infections every year. The data is being closely tracked and the RWHAP is vigilantly trying to address this alarming trend. The Part A recipient's quality management body, MN HIV/AIDS Integrated Quality Management Advisory Committee (QMAC) now oversees the MSP-TGA's EIIHA planning and evaluation processes. Its membership includes the Parts C, D, F recipients, subrecipients, and consumers. QMAC has been working on identifying root causes of health outcome disparities by race and ethnicity experienced by RWHAP consumers and addressing them through guidance for recipient and subrecipient quality improvement plans. Additional efforts include improving cultural responsiveness of subrecipients to service Black/African American PWH, working with a subrecipient to do focus groups with Black/African American MSM, and working with an external consultant to engage African American community faith and civil society organizations to reduce stigma and link Black/African American who are at risk of HIV or HIV positive to connect with testing and services.

Hennepin County Public Health Clinic's Red Door Clinic administers the most HIV tests in the MSP-TGA and finds the most newly diagnosed PWH (20-25%) in Minnesota. As the go-to place for gay men to seek sexual health services, Red Door was the best to host focus groups with Black/African American MSM to identify barriers and facilitators to getting Black/African

American MSM to test for HIV and to access HIV prevention and care services. The results led to a larger conversation on investing in the Black/African American MSM community, addressing stigma, and creating space for them to connect and share information. These recommendations are being made into an actionable plan for 2022 to improve how Black/African American MSM access HIV information and services.

Rev. DeWayne Davis is a Black/African American gay faith leader in the MSP-TGA who is working to engage and facilitate the empowerment of Black/African American same gender loving (AASGL) men to stop new HIV infections. He is building relationships with faith and civil society organizations to identify culturally responsive approaches and opportunities to reduce HIV stigma and support the lives of AASGL men. Rev. Davis is establishing relationships with the greater Black/African American faith and civil society organizations serving Black/African Americans to share HIV information, education, and training. With these approaches the goal is to increase knowledge and utilization of HIV testing, prevention, and treatment services in the MSP-TGA.

Latinx Individuals. The Hennepin County RWHAP has for many years partnered with Minnesota Community Care (MCC), a Federally Qualified Health Center, that is in one of the largest Latinx communities in Minnesota. Their cultural responsiveness, long-term presence, and trust within the Latinx community has led to some of the best health outcomes for Latinx people with HIV in the MSP-TGA. As new contracts were considered for 2021, MCC was selected to provide RWHAP early intervention services. Now, not only does MCC provide HIV care, but they also offer community-based HIV testing, including informing PWH who were unaware of their status, providing referrals to prevention and care services, and linking the newly diagnosed to the culturally responsive HIV medical care that they provide. As infections among Latinx continue to comprise a greater proportion of HIV incidence in the MSP-TGA, it is essential that culturally responsive EIIHA services are available.

▪ *METHODOLOGY*

A. Planning Responsibilities

1) Letter of Assurance from Planning Council Chairs. ***Attachment 6*** is a letter from the Minnesota Council for HIV/AIDS Care and Prevention assuring that the council fulfilled its responsibilities for: a) planning; b) priority setting and resource allocation; c) training of membership; and d) assessing the Part A recipient's administrative mechanism.

2) Resource Inventory

a) Coordination of services and funding streams. ***Attachment 7*** 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 14B** and provides a sense of the geographic accessibility of RWHAP services in the TGA.

▪ *WORK PLAN*

A. HIV Care Continuum Table and Narrative

1) FY 2022 HIV Care Continuum Services Table

a) HIV Care Continuum Services Table. ***Attachment 8*** depicts the goals of Part A funded service categories for improving indicators along the HIV Care Continuum (HCC) in the MSP-TGA and includes baselines from 2019 (the most recent year available) and targets for 2022.

Definitions were adopted from the Centers for Disease Control and Prevention (CDC) in the *HIV Prevention Progress Report, 2019*. The data for the baselines, except the percentage diagnosed and aware of their HIV status, were provided by the HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Program (DMHAP).

2022 baseline and goal development methodology

Diagnosed with HIV: The current estimate (2019) is 91.2% of PWH in Minnesota are aware of their HIV status, meeting the national goal for 2020. The RWHAP applied the most recent percentage (2019) to develop the estimate in Attachment 8 for the baseline (91.2%, 7,430/8,150). Due to the COVID-19 pandemic, the number of HIV incident cases in 2020 decreased. This is best explained by low testing rates and reductions in publicly funded HIV testing programs. In 2021, programs are returning to full capacity. With an ongoing HIV outbreak among people who inject drugs and an anticipated increase in late diagnoses among several other subpopulations in 2021-2022, the RWHAP and HIV epidemiologists are targeting the 2019 estimate (91.2%, 7,430/8,150) for 2022 (91.2%, 8,065/8,843). FY 2023-2025 would align with a new RWHAP request for proposal cycle, and concerted efforts will be made to reduce the number of individuals unaware of their HIV infection to 5.0%, meeting the HIV National Strategic Plan (HNSP) goal of 95.0% of individuals being aware of their HIV status.

Linked to care: In 2022, the RWHAP and HIV partners aim to increase linkage from the 2019 baseline of 92.9% (209/225) to the NHSP goal of 95.0% (214/225). As noted above, the assumption is the number of diagnoses will be the same in 2021 and 2022 as 2019. Continuous progress has occurred for years on increasing linkage to care, and the RWHAP plans further improvement in 2022 to meet the HNSP goal ahead of the 2025 deadline.

Denominator for Receipt of Care, Retention in Care, and Viral Suppression: HCC 2020 data is not yet available, and 2021 is still in progress. Hence, the goals for 2022 were based on extrapolation of 2017-2019 data assuming the same number of new diagnoses in 2021-2022 as 2019 to develop the denominator.

Receipt of care: Based on preliminary data, rates for receipt of care decreased in 2020 which is best explained by an overall decrease in service utilization as a direct result of the COVID-19 pandemic. The RWHAP anticipates 2021 will be a stabilizing year (return to 2019 numbers) for receipt of care. In 2022, the goal is to increase receipt of care by 1.5% from the 2019 baseline of 78.8% (5,672/7,195) to 80.3% (6,287/7,830) in 2022.

Retention in care: Preliminary data shows a significant decline in the 2020 retention in care number due to many people with HIV deferring in-person HIV medical care and laboratory tests. While HIV healthcare providers began seeing people with HIV in late 2020 and conducting lab tests again, many will not have had labs drawn twice in 2020. As safety and health measures increase, 2021 is showing an increase in access and utilization, which should result in a return to the highest percentage in the most recent three years available (2017-2019). This was 51.7% (3,483/6,741) in 2017. In 2022, the goal is to increase the retention in care measure by 1.5% to 53.2% (4,166/7,830).

Viral suppression: Like receipt of care and retention in care, preliminary data shows 2021 as a stabilizing year, where the population viral suppression rate can return to the highest viral suppression achieved in 2017-2019, 70.2% (4,734/6,741) in 2017. Assuming 2021 is 70.2%, the RWHAP aims to increase this by 1.5% to 71.7% (5,614/7,830) in 2022.

2) HIV Care Continuum Narrative

a) HIV care continuum changes, program impact, and response

Changes in the MSP-TGA HIV care continuum from CY 2017 to CY 2019. Figure 6 and Table 6 present the most recent three years (2017-2019) of jurisdictional HIV care continuum (HCC) data by stages along the continuum for the population of people in the MSP-TGA diagnosed with HIV infection. The definitions are the same as those used by the Centers for Disease Control and Prevention (CDC) in the *HIV Prevention Progress Report, 2019*. This data was provided by the HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Program (DMHAP) and uses 2017-2019 CDC surveillance data for each stage of the HIV care continuum.

Figure 6: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019

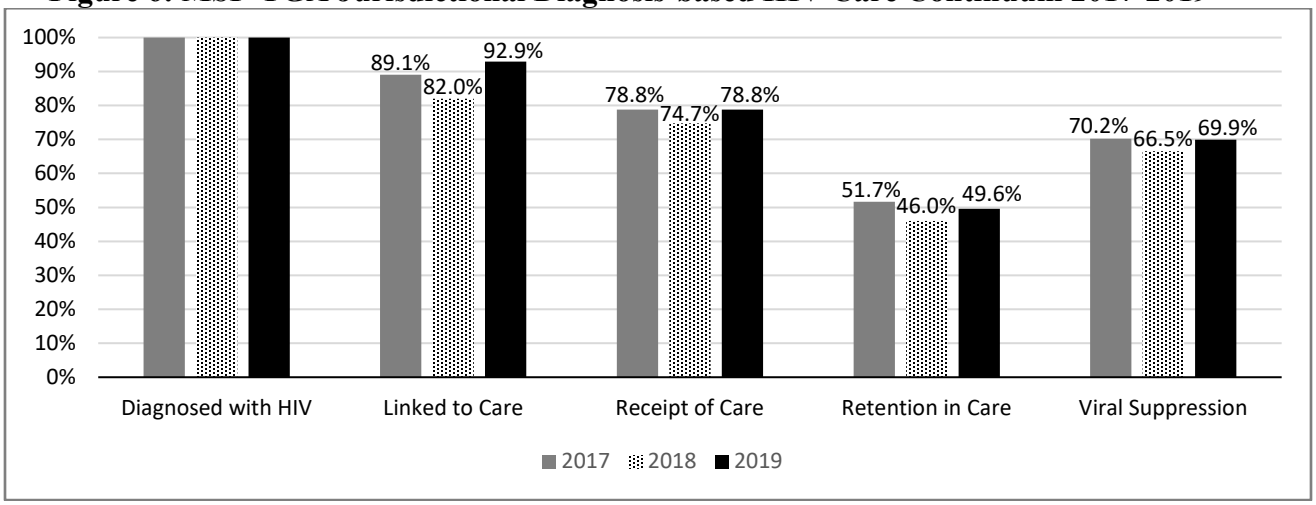


Table 6: MSP-TGA Jurisdictional Diagnosis-based HIV Care Continuum 2017-2019

Stage	2017	2018	2019
Diagnosed with HIV	6,978	7,199	7,430
Linked to Care	89.1% (204/229)	82.0% (187/228)	92.9% (209/225)
Receipt of Care	78.8% (5,312/6,741)	74.7% (5,200/6,963)	78.8% (5,672/7,195)
Retention in Care	51.7% (3,483/6,741)	46.0% (3,202/6,963)	49.6% (3,569/7,195)
Viral Suppression	70.2% (4,734/6,741)	66.5% (4,632/6,963)	69.9% (5,029/7,195)

The number of people diagnosed with HIV has steadily increased in the MSP-TGA with an increase of 221 from 2017 to 2018, and 231 from 2018 to 2019. Linkage to care fluctuated between 89.1% in 2017, 82.0% in 2018, and 92.9% in 2019. The MSP-TGA linkage to care percent in 2017 and 2019 surpassed the 2020 national goal of 85% of newly diagnosed PWH being linked to care in 30 days. The 2019 percentage is close to the 2025 national goal of 95%. Receipt of care fluctuated from 78.8% in 2017, down to 74.7% in 2018, and back up to 78.8% in 2019. Retention in care was highest in 2017 at 51.7%, falling to 46.0% in 2018, then increasing to 49.6% in 2019. In consultation with HIV medical providers, there are three groups of individuals who are not retained in care by the definition. The first group includes people with only one viral load in the calendar year but are virally suppressed. HIV medical providers only draw labs once a year for these patients who are durably virally suppressed and adherent to their HIV medication. These individuals will likely continue to be virally suppressed and not retained in care by the definition. The second group are PWH who would be at the receipt of care stage (at least one viral load or CD4 count in a year) but are not retained in care and are not virally suppressed. They should be attending an HIV medical appointment more than once a year, but due to multitude of reasons, they only attended one HIV medical appointment. The RWHAP is

focusing in on this group who need additional public health interventions to increase their attendance at HIV medical appointments, increase enrollment in medical case management, and supportive services to address the social determinants of health. Understanding this subset of individuals presents opportunities to advance more people along the HIV care continuum. Public health interventions should be less effort and more cost-effective for this group than those who never attended an HIV medical appointment. A cost evaluation of potential public health interventions is being conducted by the RWHAP through a collaboration with University of Minnesota epidemiological researchers. The third group attended no HIV medical appointment and will be targeted with data-to-care efforts to advance them to the receipt of care stage and preferably the retained in care stage, as they re-engage in HIV medical care.

Viral suppression was highest in 2017 at 70.2%, falling to 66.5% in 2018, before rising to 69.9% in 2019. Advancing PWH from receipt of care to retention in care, coupled with support services and medical case management, should advance some to viral suppression.

Impact of the care continuum on the Part A program and response to changes.

The MSP-TGA HIV care continuum data for 2017-2019 shows promise that the 2025 HNSP goal of 95% of newly diagnosed individuals are linked to care in 30 days is achievable. However, there is a large gap to meet the HNSP goals for receipt of care, retention in care, and viral suppression.

The RWHAP and Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) are using the MSP-TGA and Minnesota HIV care continua to evaluate how to drive improvement in the next iteration of *Positively Hennepin* (Hennepin County's strategy to end the HIV epidemic), END HIV MN (the state strategy to end the HIV epidemic), and the council's integrated plan. There continue to be health and racial disparities among American Indian, Black/African American, and Latinx subpopulations, hence their selection as the subpopulations of focus.

Changes in the MSP-TGA's HIV care continuum impact service prioritization, resource allocation, population prioritization, and capacity development to address the most persistent gaps along the continuum where improvement in health outcomes is slower, including receipt of care, retention in care, and viral suppression. Based on analysis of receipt of 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 beginning in FY2019. 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 for Black and Latinx subpopulations (with the American Indian subpopulation being added in 2022) to support care retention and viral suppression by providing medical case management, which includes treatment adherence support, and outpatient ambulatory health services to close the persistent wider gap in these stages of the care continuum that these populations experience.

Beginning in 2016, the Part A recipient began a collaborative project with the Minnesota Department of Health 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 complete Minnesota and MSP-TGA HIV care continua for all diagnosed PWH who receive RWHAP services. The first complete match of eHARS with MN CAREWare data was completed in October 2017. Now, Hennepin County Part A 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, 91.3% of Part A clients had a viral load in MN CAREWare, and in 2020 (impacted by the COVID-19 pandemic), 87.9% of Part A clients had a viral load in MN CAREWare. The integration of surveillance with client-level services data in MN CAREWare is positively impacting programs and RWHAP clients. In 2019, Part A recipient staff along with staff administering MN CAREWare developed mechanisms, protocols, and training for subrecipients 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 FY19, Part A medical case management programs are reporting on viral suppression rates on a quarterly basis as a contractual performance measure. Subrecipients can more effectively monitor consumer health outcomes and identify where along the HIV care continuum performance is lacking and where disparities exist. In 2021, the RWHAP is working on a more focused approach with this data by having subrecipients run reports on individuals who have met the receipt of care definition but are not retained in care and not virally suppressed. These individuals can then be prioritized to receive the additional core medical and support services needed to advance them along the HIV care continuum to viral suppression.

To increase receipt of care and retention in care, the RWHAP and Hennepin County Public Health (HCPH) colleagues are using innovative data to care (D2C) models to ensure people with HIV who are out of HIV medical care are re-linked to an initial appointment and followed for six months or until a medical case management relationship is established, whichever is longer. The Minnesota Department of Health (MDH) assigns PWH who are not-in-care for follow up to the HCPH D2C team. The MDH defines not-in-care as no reported lab value to MDH in the past 15 months based on HIV surveillance data. HCPH matches RWHAP Part A clients against this MDH client list. If the individual matches, their RWHAP service data is used to generate a list of HCPH and Minnesota Department of Human Services (DHS) funded RWHAP services received. Additionally, HCPH D2C staff will review electronic health records and the Minnesota Homeless Management Information System (HMIS) system for client encounters. These data on where and which services PWH are receiving enable public health staff to successfully contact individuals. These PWH have then been re-engaged in HIV medical care and are now working towards durable viral suppression. These partner organizations broker a relationship between their clients and public health professionals. Summary-level data is also informing collaborative partnerships. If a number of PWH meeting the MDH definition of not-in-care are engaging with a program at a RWHAP service provider, the RWHAP will work with them on a systems level approach to improve care retention.

B. Funding for Core and Support Services

1) Service Category Plan

a) Service Category Plan Table. ***Attachment 9*** presents the Part A and MAI core medical and support service allocated funds for FY 2021 and planned allocations for FY 2022 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 2022. The service category plan matches the intended waiver request. Additional priorities set by the Minnesota Council for HIV/AIDS Care and Prevention not reflected in ***Attachment 9*** are funded by Part B and 340B ADAP rebate funding, core medical services: AIDS drug assistance program (ADAP), health insurance premium and cost sharing assistance, oral health care;

support service areas: emergency financial assistance, medical transportation, case management (non-medical), and referral for health care/supportive services. A core medical services expenditure waiver request for the MSP-TGA for FY 2022 will be submitted separately from this grant application by March 1, 2022.

b) MAI Service Category Plan Narrative

i. MAI services to meet the unique needs of populations of focus. All anticipated FY22 MAI service funds ($344,825) are allocated to core medical services. The goals and objectives of the FY22 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, American Indian, and Latinx PWH through culturally responsive (CR) medical case management (MCM) and CR outpatient/ambulatory health services (OAHS). The goals for the MAI-funded services are based on the HIV prevalence data through 2020 and HIV surveillance data used to develop the current TGA HIV Care Continuum (HCC) through 2019. The HCC identifies the populations experiencing the greatest HIV-related health inequities. The TGA's CR standards are multi-faceted strategies that use evidence-based approaches to remove barriers that perpetuate the inequities evident in the HCC. The CR standards include participatory engagement and advisory from members of the population of focus along with planning, implementation, evaluation, and system improvements with the objective of meeting the CR needs of the populations of focus and eliminate health inequities. Culturally responsive MAI MCM and OAHS are designed to assure that the subpopulations of focus are connected to and receive the core medical and supportive services that impact the social determinants health in ways that lead to improved care retention and viral suppression.

Disparities in engagement along the HCC as it pertains to the MAI goals are as follows. Comparative measures along the HCC were examined for racial/ethnic groups using 2019 HIV surveillance data (the most recent year available). Linkage to care within 30 days was 92.9% without meaningful differences between race/ethnicities. Overall, receipt of care (defined as at least one viral load or CD4 count reported to the HIV surveillance system) was 78.8%. Black/ African American and Black/African-born individuals have a lower receipt of care, 74.9% and 73.3%, respectively. Latinx PWH also have a lower receipt of care at 72.0%.

American Indians have a comparable receipt of care rate (78.1%) as the overall population. However, among American Indians with a documented viral load, only 87.7% were virally suppressed compared to 92.6% in the overall population. This means despite accessing HIV medical care, the American Indian population is less likely to be virally suppressed. The focus of MAI medical case management for American Indians will be addressing the barriers to medication adherence with the goal of achieving and maintaining viral suppression.

The Black/African-born and Latinx subpopulations are virally suppressed at a lower rate of 64.1%, and 65.3%, respectively, compared to the overall population (69.9%). However, the Latinx subpopulation has a comparable viral suppression rate (93.0%) to the overall percentage (92.6%) when only those with a documented viral load are included. The same is true of the Black/African-born subpopulation at 91.8%. Medical case management for these subpopulations will advance them along the HIV care continuum by ensuring they receive HIV medical care at a comparable rate.

The Black/African American subpopulation is virally suppressed at a rate of 63.2%. Some of this lower rate can be explained by a lower receipt of care. However, 87.2% are virally suppressed when only those with a documented viral load are included in the denominator. The Black/African American subpopulation is experiencing barriers to accessing HIV medical care

and achieving viral suppression once retained in care. MAI outpatient ambulatory health services and MCM treatment adherence interventions are designed to improve viral suppression among this subpopulation.

ii. MAI services to prevent new HIV infections, improve health outcomes, and advance health equity for populations of focus. Advancements of racial/ethnic-related health equity are best measured by the MSP-TGA's HCC. Empirical data has proven that early HIV diagnosis, treatment adherence, and retention in care result in viral suppression. Advancement along the HCC not only improves individual health, but it also improves community health and prevents new HIV infections. The goal of MAI funded OAHS is to increase the number of Black/African American and African-born, American Indian, and Latinx PWH who are continuously engaged in quality HIV medical care, as many 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*. OAHS standards now require the adoption of a rapid ART model of expedited access and engagement through formal referral and coordination agreements with EIS and other HIV testing programs. Additionally, the Cultural Responsiveness (CR) standards are integrated into the programs to address culturally specific needs. The MAI OAHS 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 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 40% of the MAI funds in FY 2022 ($137,899). Part A funds will also support OAHS services in FY22.

The goal of MAI-funded CR MCM is to increase access to core medical and support services for Black/African American and African-born, American Indian, as well as Latinx PWH. CR MCM prioritizes access, retention if care, that staff and provision of services are responsive to the culturally specific needs of PWH, with an emphasis on the subpopulations of focus. MCM targeting Black/African American PWH is also funded by Part A. Sixty percent ($206,926) of Part A MAI funds are allocated to MCM in FY22. The Federally Qualified Health Center located in the heart of St. Paul that receives MAI funding for OAHS also provides CR MCM services by bilingual (Spanish and English) and culturally responsive staff. The second CR MCM organization to receive Part A MAI funds focuses on Black/African-born individuals. This subrecipient has well-established relationships with clinical providers of HIV medical care and early intervention services in Minneapolis and St. Paul. The third CR MCM program provides services for Black/African American and African-born, American Indian, and Latinx PWH in the east metro area of the MSP-TGA. This program is housed within an infectious disease clinic with a large specialty care group. This subrecipient has an extensive history of demonstrated success, through improved health outcomes, in working with individuals from diverse PWH populations. All three subrecipients have established and maintained effective referral and care coordination formal agreements and processes with other subrecipients within the RWHAP system of care. The objectives of MCM for these populations are to link clients to health care, psychosocial support, medical transportation, mental health, and substance abuse outpatient services that address clients' barriers to consistently access HIV medical care.

Black/African Americans (U.S. born) comprise 22% of the people 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 TGA population. Latinx individuals 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 RWHAP system, uses the HRSA definition that only includes those with a documented viral load in the denominator.

With 75% of men 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 American 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%).

Data are collected by MAI funded agencies as they provide services and are reported through MN CAREWare to determine the impact of MAI funded services on the priority populations. Viral load values and CD4 counts are uploaded into MN CAREWare for all RWHAP in the MSP-TGA and Minnesota from the state's HIV surveillance system which allows for monitoring of receipt of care, care retention, and viral suppression among all RWHAP clients that receive MAI funded services. This allows both the Part A recipient and subrecipients to evaluate the progress toward 2022 MAI goals and to meet the HRSA requirement to report on client level health outcomes for all FY 2022 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) Unmet Need

i. Interventions to improve outcomes for individuals with unmet need. The Part A Program prioritizes Black/African American and African-born, American Indian, and Latinx populations with focused systemwide and service specific efforts to eliminate the HIV-related unmet need as presented in ***Attachment 4*****.** These three populations account for more than half of new HIV diagnoses (59.6%, 136/228) with a quarter of these individuals being late diagnoses (25.7%, 35/136), according to 2019 HIV surveillance data. These three populations of focus also accounted for 55.2% (485/879) of the unmet need within the RWHAP. Even in care, Black/African American and African-born and American Indian populations have higher percentages of not being virally suppressed, at 15.4% (348/2,260) and 13.1% (8/61), respectively, compared to 12.3% (737/5,970) overall. This indicates that these two populations of focus require more intentional and culturally responsive approaches to treatment adherence and to overcome related systemic barriers to food resources and housing services. Latinx PWH in care have the lowest rate of not being virally suppressed at 10.2% (61/600). This suggests that current efforts to reduce unmet need for Latinx PWH is working and will continue. The Part A Program implements systemwide and programmatic specific interventions to advance the goal of improved health outcomes for Black/African American and African-born, American Indian, and Latinx living with HIV in the TGA who are experiencing disparities along the care continuum as result of late diagnosis and other critical components of unmet need.

Systemwide. The Part A Program implements system-wide interventions, including Culturally Responsive (CR) standards, evidence-based community engagement activities, along with evaluation and improvement of administrative policies and practices. The primary goal is to improve health outcomes for Black/African American and African-born, American Indian, and Latinx people with HIV in the TGA who are experiencing disparities along the care continuum as result of late diagnosis and unmet need for HIV health care. Part A recipient staff developed in FY17, implemented in FY18, and continue to evaluate and improve the MSP-TGA's CR standards to ensure the accurate identification of system barriers that contribute to unmet need of prioritized subpopulations. The standards were developed utilizing a community-based participatory research (CBPR) approach. Community leaders and civil society groups from populations disproportionately affected by HIV in Minnesota were collaborators. In addition to integrating the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, the CR standards contain the following requirements: 1) collect and analyze client demographic data to identify disparities and develop strategies to eliminate disparities; 2) have job descriptions and staff development plans that include competencies with cultural responsiveness; 3) complete subrecipient CR program assessments to identify areas for improvement; 4) establish and maintain a consumer advisory board that is reflective of the community needing services; and 5) have ongoing quality improvement goals around CR. Due to diversity and complexities inherent in cultural needs, including differences in subpopulations within populations, the MSP-TGA's CR standards allow for a level of autonomy in engaging and responding to the diversity within prioritized populations experiencing unmet need. The CR standards also guide the Part A recipient's administrative functions including program planning, procurement of services, technical assistance, and capacity building, and systemwide evaluation and improvement. In addition to the CR standards, the Part A program response to reducing unmet need includes plausibility analysis that prioritizes health and racial equity along with technical feasibility and economic and political viability for all administrative, policy, and program planning processes.

In practicing and modeling one of the CR standards, the Part A program adopted community based participatory and service-learning models to engage communities with the highest unmet need. Through engagement and support of community leaders as equal partners and experts, the Part A program successfully implemented several community engagement (CE) efforts to inform the MSP-TGA's RWHAP system of care. The modes of CE were informed and led by community members. An African American Same Gender Loving Men workgroup resulted in a complete shift in council participation and leadership by Black/African American, and specifically same-gender-loving men. Success was also measured by participants providing advisory functions that informed pilot projects and service specific focus in response to Black/African American community needs. Similarly, engagement with African Faith Leaders through capacity building and technical assistance support of the West African HIV Task Force increased awareness of the importance of early diagnosis, treatment, and viral suppression and is reducing HIV-related stigma in the TGA's West African communities. Latino Gay/Bi Men social media campaigns along with interviews continue to inform and improve service delivery, specifically for early intervention services (EIS) and outpatient ambulatory health services (OAHS). An American Indian/Native American HIV workgroup resulted in engagement of community members that informed a CR approach to a recent HIV outbreak and response to the COVID-19 pandemic. Through these community engagement efforts, the perspectives of individuals experiencing the greatest unmet need are centered and inform efforts to eliminate barriers that produce the HIV-related health disparities along the care continuum.

Service-Specific Interventions**.** In addition, the following table and narrative outline specific Part A programmatic interventions that focus on improving outcomes for individuals with unmet need that are late diagnosed, have unmet need, or are in care and not virally suppressed.

Programmatic Interventions	**Unmet need components**		
	Late diagnosis	Have unmet need	In care but not virally suppressed
Early Intervention Services (EIS)	✓		
Food Bank/Home Delivered Meals		✓	
Health Education/Risk Reduction		✓	✓
Housing		✓	✓
Medical Care Management incl. treatment adherence*		✓	✓
Mental Health		✓	✓
Outpatient Ambulatory Health Services*	✓	✓	✓
Psychosocial Support		✓	✓
Substance Abuse-Outpatient		✓	✓

*MAI funded

(1) Late diagnosis. Using the unmet need framework based on 2019 HIV surveillance data, there were 228 new HIV diagnoses in the MSP-TGA with 24.1% (55/228) having a late diagnosis, with percentages of late diagnoses among Black/African American and African-born, and Latinx cases higher than overall. Specific interventions for populations with higher rates of late diagnosis include culturally responsive early intervention services provided by two community-based organizations that prioritize Black/African American and African born, and Latinx subpopulations for their HIV testing and care linkage activities. In addition, Hennepin County Healthcare for the Homeless outreach staff collaborate with community partners to deliver pop-up HIV testing at encampments where people experiencing homeless reside.
Health Education/Risk Reduction services continue to require education on the importance of partner notification along with early diagnosis and treatment. These service specific interventions are also required to integrate the CR programmatic standards to ensure population specific system barriers are dismantled.
(2) Unmet Need. The 2020 Comprehensive HIV Needs Assessment data highlight that American Indian, Black/African American and African-born, and Latinx respondents were more likely to have problems paying medical bills in the past 12 months. Additionally, survey respondents from the three populations of focus often ran out of food before they had money to buy more, indicating higher rates of food insecurity. Transportation barriers were also impactful for all three populations. High percentages of respondents from the three populations of focus reported putting off going to the doctor for HIV medical care because they did not have a way to get there. In response, Part A funds CR food bank/home delivered meals with emphasis on CR programmatic standards and oversight to ensure CR services are available and provided. The Part A program also coordinates with Minnesota's Part B program to ensure that health insurance premium assistance, emergency financial assistance, and medical transportation are prioritized with emphasis on access for the three subpopulations of focus. Housing is the greatest barrier to advancement along the HIV care continuum to sustained viral suppression, particularly for the American Indian and Black/African American and African-born. In 2020, Latinx PWH reported a lower rate of unstable housing compared to overall average. In response, the Part A program invested more in housing services, with specific interventions for American Indians and Black/African American and African-born.

Additionally, CR medical case management, including treatment adherence, outpatient ambulatory health services, mental health services, psychosocial support, and substance abuse

outpatient services are prioritized with the requirement of addressing the CR specific needs of the three subpopulations of focus.

(3) In care but not virally suppressed. The MSP-TGA's unmet need estimate indicates 12.3% (737/5,970) of people with HIV in the MSP-TGA are in care but not virally suppressed with American Indian and Black/African American and African-born having the highest rates of in care but not virally suppressed at 13.1% (8/61) and 15.4% (348/2,260), respectively. The specific interventions designed to meet the healthcare needs of PWH in care and not virally suppressed, especially populations with lower rates of viral suppression include culturally responsive early intervention services and Part A and MAI funded outpatient ambulatory health services and medical case management services that prioritize Black/African American and African-born, American Indian, and Latinx PWH. Other interventions identified through the Part A program's community engagement activities to reduce unmet need include CR food, housing, mental health, psychosocial support, and health education/risk reduction services which support treatment adherence and sustained viral suppression. The Part A program is also revising its OAHS and EIS standards to facilitate rapid ART access through improved coordination between these two service areas. The aim is to expedite initial HIV appointments, ART initiation, and engagement in services that support lifelong retention in care and sustained viral suppression.

ii. Ending the HIV Epidemic efforts. Although, unfortunately, Hennepin County is not among the jurisdictions funded under "Ending the Epidemic in the U.S.," the MSP-TGA Part A program activities designed to engage PWH with unmet need closely align with *Positively Hennepin*, Hennepin County's strategy to end the HIV epidemic. In 2016, inspired by National HIV/AIDS Strategy goals and lack of a statewide HIV strategy for Minnesota, Hennepin County, the MSP-TGA Part A recipient, embarked on a process to develop a strategy to end the HIV epidemic. Hennepin County is the largest county in the MSP-TGA, where 61% of PWH in the 13-county MSP-TGA live (4,850/7,969) and 52% (4,850/9,408) of Minnesotans with HIV reside. The strategy was updated in 2021 to respond to emerging needs of PWH and those at highest risk of acquiring HIV infection in the county.

Positively Hennepin's updated plan for 2021 through 2023 is implemented using a framework of goals, actions, tactics, and principles all aimed at creating the structure necessary to integrate HIV services throughout Hennepin County's health and social service system to advance HIV health and racial equity. *Positively Hennepin's* three goals are: to decrease new infections; ensure access to and retention in care; and engage and facilitate the empowerment of communities disproportionately affected by HIV to stop new infections and eliminate disparities. Each goal has two to three actions and each action has two to three tactics to employ to work towards achieving the goal. The following describes *Positively Hennepin* actions and corresponding Part A service activities to improve outcomes for individuals with unmet need.

(1) Late diagnosis. *Positively Hennepin* actions: 1) increase opportunities for routine HIV testing so people unaware of their HIV status are diagnosed and connected to care; 2) eliminate barriers to testing for high-risk populations (as determined by epidemiologic data) so people are willing and able to access HIV testing; and 3) increase HIV services in community-based, non-clinical settings so more isolated, marginalized people are tested and stay in care. Part A activities: 1) early intervention services prioritizing Black/African American and African-born, Latinx, people who inject drugs, and MSM subpopulations; and 2) HRSA/HAB funded "Building Capacity for HIV Elimination in Ryan White HIV/AIDS Program Part A Jurisdictions" community engagement and targeted HIV awareness campaign activities with West and East African immigrant communities and with African American same-gender-loving men.

(2) Unmet need. *Positively Hennepin* actions: First, ensuring all newly diagnosed PWH are connected to HIV health care and supportive services to support lifelong retention in care no matter where they are diagnosed or access services in the county. To accomplish this, all newly diagnosed PWH will be offered a medical appointment within 24 hours of diagnosis. Second, improve access to services that meet basic needs of PWH by eliminating barriers to adherence to their HIV medical plan. This would happen by ensuring access to low barrier safe housing options, particularly for people who inject drugs and are experiencing unsheltered homelessness. Third, engaging PWH who left care or were never connected to care to get them retained in care and achieve viral suppression by utilizing and coordinating surveillance and public and private clinical data to locate them. Fourth, increase access to care in community settings so more isolated and marginalized PWH stay in care. Part A activities: 1) early intervention care linkage services that prioritize Black/African American and African-born, and Latinx; 2) medical case management including MAI funded services that prioritize Black/African American and African-born, Latinx, and American Indians; 3) outpatient ambulatory health services including MAI funded services that prioritize Black/African American and African-born, Latinx, and American Indians; 4) housing coordination and rental assistance; 5) food bank home delivered meals; and 6) health education risk reduction services that teach PWH about the benefits of antiretroviral treatment and core medical and support services that are available.
(3) In care but not virally suppressed. *Positively Hennepin* actions: Eliminate barriers to care by improving access to services that meet basic needs for people with HIV so that any barriers to adhering to their HIV medical care plan are eliminated. Eliminating barriers to care includes offering up to 6 months of no cost HIV medical care to individuals who are unable to afford care. Part A activities: 1) Medical case management including medication adherence support and MAI funded services that prioritize Black African American and African born, and Latinx; 2) Outpatient ambulatory health services, including MAI funded services, that prioritize Black African American and African born, Latinx, and American Indians; and 3) Health education risk reduction services that teach PWH about the benefits of antiretroviral treatment and core medical and support services that are available.

d) Core Medical Services Expenditure Waiver. A core medical services expenditure waiver request for the MSP-TGA for FY 2022 is not included in this grant application and will be submitted separately by March 1, 2022.

- *RESOLUTION OF CHALLENGES.*

A. Resolution of Challenges Table. The following table describes the MSP-TGA's 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. As of August 31, 2021, 80 cases have been identified in these two counties. Of the cases identified thus far 43% are experiencing unsheltered homelessness. Blacks and American Indians are disproportionately represented among outbreak cases, with 25% of cases among American Indians and 11% among Blacks. 40% have CD4 counts <500, and 34% are not virally suppressed.	a) Scale up HIV testing among PWID, who are homeless. b) Provide contact tracing and partner services by 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, core medical, and supportive services. d) Provide medical case management services through Healthcare for the Homeless. e) Provide harm reduction services to PWID including access to syringe services, referrals to substance use disorder programs, and medication assisted therapy. f) Develop and provide low-barrier culturally responsive pathways to long-term safe, stable, desirable housing for homeless PWH who inject drugs. g) Provide low-barrier PrEP services for people who are experiencing homelessness, as well as needle sharing and sex partners of outbreak cases. h) Provide low-barrier antiretroviral treatment for unsheltered PWH who are living in encampments or on the street. i) Leverage cross-sector data (HIV surveillance, Ryan White client-level, and social services data) to engage PWH, who inject drugs and are unsheltered, in HIV medical care.	• People who became infected in the outbreak and are experiencing homelessness are sheltered and linked to the MSP-TGA's HIV housing programs or other programs that provide desirable 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 are unstably housed receive care coordination from an EIS navigator, medical case manager, non-medical case manager, and/or housing navigator to help meet their immediate housing, 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 to HIV testing and harm reduction services including syringe services, medication for opioid use disorder, and PrEP.	• Hennepin County Public Health (HCPH) has an incident command structure to respond to the dual outbreaks of HIV and Hepatitis A. The ICS is in its 22nd operational period. • HCPH disease investigators follow all HIV outbreak cases, contact trace, offer partner services and linkage to HIV medical care. • HC Healthcare for the Homeless public health nurses provide outreach, including HIV, syphilis, and Hepatitis C tests, Hepatitis A vaccinations, and syringe services at homeless encampments and on the street. • Part A funded EIS navigators partner with public health nurses 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 MDH funded SSPs are providing sterile syringes and HIV testing in homeless encampments and on the street in Hennepin and Ramsey Counties. • Outbreak case line lists are matched with Ryan White client-level data, public insurance, and social service data to provide information to assist disease investigators, outreach nurses, and service navigators to engage outbreak cases in HIV medical care.
2. Ensuring people with HIV receive the COVID-19 vaccine: While people with	a) Evaluate the number of people with HIV who are fully vaccinated	• Vaccination rates for PWH are comparable to the general	• The RWHAP partnered with the Minnesota EHR Consortium COVID-19 Project at Hennepin Healthcare Research Institute to

Challenges and Barriers	Proposed Resolutions	Intended Outcomes	Current Status
HIV (PWH) who are ART adherent appear to have the same risks for COVID-19 as people without HIV, a significant percentage of PWH are not currently accessing HIV medical care and adherent to treatment. This places them at higher risk for COVID-19. Vaccination data, when adjusted for age, indicate PWH in the MSP-TGA are vaccinated at a lower rate than the general population. Vaccination gaps among PWH range from 8% to 26% depending on age group.	b) Analyze results and identify opportunities to increase COVID-19 vaccination rates c) Work with subrecipients and public health communications to develop strategies to promote COVID-19 vaccinations among people with HIV d) Increase vaccination rates among RWHAP clients to improve population rates among all people with HIV	population and age adjusted gaps are eliminated • Fewer PWH experience COVID-19 complications, including hospitalization and death.	measure COVID-19 vaccination rates among people with HIV. This project combines summary data from Minnesota healthcare systems and can estimate the number of people with HIV who have received a COVID-19 vaccine. As of 9/27/2021, data show lower vaccination rates for people with HIV across all age groups. • The RWHAP partnered with the Hennepin County Public Health immunization team to measure RWHAP Part A consumers' vaccination rates. • The RWHAP allocated $12,500 in CARES Act funding for COVID-19 vaccine incentives. • The RWHAP has produced a COVID-19 vaccine toolkit that supports subrecipients to promote COVID-19 vaccinations among their clients.
3. Operationalizing RWHAP Culturally Responsive (CR) Standards: 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 PWH, particularly PWH from subpopulations of focus. Preliminary evaluation and monitoring found various subrecipients required training and technical assistance to meet CR standards.	a) Assess subrecipient barriers to meeting CR standards. b) Conduct CR standards training. c) Conduct training on accessing and analyzing data to identify HIV health outcome improvement opportunities. d) Convene a subrecipient CR community of practice to regularly share successes and challenges. e) Provide evidence-based community engagement technical and capacity building assistance including on participatory engagement and board development. f) Provide regular population-specific CR training, prioritizing populations of focus. g) Monitor and evaluate subrecipient CR initiatives and population advancement along the HIV Care Continuum.	• Subrecipients understand the critical role of CR Standards in advancing health equity and eliminating unmet need. • Subrecipients understand the conceptual frameworks of health equity and participatory approaches to community engagement. • 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.	• Assessed progress in meeting CR Standards during site visits and quarterly report reviews in FY21. • Assessed subrecipient planned CR activities and training needs in FY21. • Conducted CR Standards and data access trainings in FY20. • Coordinating CR trainings scheduled for winter FY22 focusing on Black/African born and African American MSM communities. • Coordinating CR training on mental health focusing on Black/African-born communities. • Ongoing: monitor, evaluate, and improve subrecipient and systemwide CR efforts. • Continue to assess subrecipient CR standards readiness to operationalize CR standards and provide technical assistance and training tailored to the identified need of each subrecipient.

Challenges and Barriers	Proposed Resolutions	Intended Outcomes	Current Status
4. Developing capacity of small community-based organizations to reach subpopulations of focus and reduce HIV-related health disparities: MSP-TGA Black/African Americans and African-born, American Indians, and Latinx RWHAP consumers have higher rates of late diagnosis, and lower rates care retention and viral suppression compared to Whites, indicating health inequities. Community-based organizations and civil society groups, that have CR expertise in serving subpopulations of focus are critical to reduce these inequities. However, some of these organizations have less capacity and experience with RWHAP grant requirements.	a) Assess provider capacity to meet RWHAP grant requirements. b) Provide technical assistance to organizations to develop programmatic, organizational, and financial capacity so that they can satisfy RWHAP grant requirements. c) Reduce institutional disruptions by developing succession planning. d) Increase community input through the development of consumer advisory boards. e) Reduce provider staff turnover and burnout via self-care and trauma informed care trainings.	• Small community-based organizations that are culturally responsive to disproportionately impacted communities have the capacity to meet RWHAP grant requirements. • Small organizations have increased capacity to reach more individuals from populations of focus and provide additional services. • Disparities in viral suppression rates for Black/African Americans and African-born, American Indians, and Latinx are eliminated.	• Hennepin County has contracted with an organizational development consultant to provide technical assistant and improve capacity of small community-based organizations. • Five Ryan White subrecipients with consumer subpopulations experiencing disparities are currently receiving technical assistance. • Hennepin County provided training for subrecipients on self-care and trauma informed care in FY 2021 to help reduce staff burnout.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY*

A. Clinical Quality Management (CQM)

1) Changes made to the MSP-TGA CQM based on prior years' experience. The Part A CQM program and the MN Council for HIV/AIDS Care and Prevention (MCHACP) utilize diagnosis-based HIV Care Continuum (HCC) data provided by the MN Department of Health (MDH) for the MSP-TGA's population of diagnosed PWH to determine differences in linkage to care within 30 days, receipt of care, retention in care, and viral suppression. Within the HCC disparities along demographic categories including gender, race/ethnicity, country of birth, HIV exposure category, and age are analyzed. Additionally, current client-level data in MN CAREWare provides the following for Part A clients: linkage to care for newly diagnosed and reconnected to care clients; receipt of care and retention in care for all clients; prescribed antiretroviral therapy for outpatient ambulatory health services (OAHS) clients; 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 2019 MN and MSP-TGA HCC as well as demographic data informed the development of the 2021 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. In 2021, this calculator was used on the provider level to assist providers in data analysis and disparity reduction action planning. Through much analysis and community input, the most glaring disparities identified are:

Viral Suppression Rates Among Ryan White Populations in the MSP-TGA						
Year	Data	**All Populations**	**Black/African American MSM**	**Black/African American Women**	**Multi-Racial Individuals**	**Non-Hispanic, American Indian**
2016	% VLS	88%	81%	85%	81%	82%
	% Missing	11%	10%	9%	8%	12%
2017	% VLS	89%	80%	87%	83%	80%
	% Missing	*10%*	*11%*	*11%*	*10%*	*9%*
2018	% VLS	90%	83%	87%	84%	85%
	% Missing	*13%*	*11%*	*14%*	*13%*	*16%*
2019	% VLS	91%	89%	86%	84%	79%
	% Missing	*11 %*	*10%*	*11%*	*8%*	*6%*
2020	% VLS	91%	86%	92%	90%	72%
	% Missing	*16%*	*16%*	*16%*	*13%*	*17%*
5-year avg	% VLS	90%	84%	87%	84%	80%
	% Missing	12%	12%	12%	10%	12%

Three of the five 2021 CQM Goals were informed by these findings, specifically: increasing the viral suppression rates of RWHAP consumers who are Black/African American or Multi-racial, as well as providing more culturally responsive services to both of those populations. This was a change from the previous year where the focus was on Black/African American men who have sex with men (MSM) and Black/African American women. The data showed that Multi-racial RWHAP consumers were experiencing a health disparity, so a goal was established to focus on their health outcomes. As Multi-Racial RWHAP consumers are greatly heterogenous, challenges remain in determining the effective ways to address this disparity. As of the drafting of the CQM plan data on Non-Hispanic American Indian Ryan White consumers was suppressed due to small numbers and data suppression rules. During 2021, this data began to be shared with the

Quality Management Advisory Committee and will be used in the review of the 2021 CQM and drafting of the 2022 CQM plans. This work is 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. The viral load data completeness reduced in 2020 to 84% due to less clients going to medical providers, less availability of lab appointments, and other effects of the ongoing COVID-19 pandemic. The recipient and subrecipients are aware of this decrease and are attempting to improve this performance measure.

In preparation for subrecipients developing their quality improvement plans for FY21, subrecipients were trained on the quality management Model for Improvement using the Plan-Do-Study-Act cycle. The guidance subrecipients were given to create their quality improvement plans included prioritizing any corrective action from the previous contract year, any issues of compliance with service and universal standards, any contract concerns communicated by recipient staff, improvement of cultural responsiveness, reduction of enrollment and health outcome disparities especially for Black/African American and Multi-racial RWHAP consumers, increasing consumer engagement, and/or improving the parts of the care continuum their services affect.

In the summer of 2021, the Part A recipient office analyzed health outcomes data using the disparities calculator on the provider level. This analysis had been done before only system wide. Providers were given their data, analysis of disparities if any existed, and resources on how to better serve their client populations who are experiencing disparities. A CDC Public Health Associate begin work in the fall of 2021 to continue to support providers and consumers in this disparity reduction effort. The quality management coordinator (QMC) reviews every subrecipient QI Plan, reviews quarterly updates on their QI plan, and provides support and feedback to ensure optimized outcomes in their efforts to improve their HIV Care Continuum performance measures.

An essential part of the Part A recipient's efforts to eliminate racial and ethnic disparities is its Minority AIDS Initiative (MAI) program. HIV care retention and viral load performance measures inform the MSP-TGA Part A MAI programming. The MSP-TGA's MAI funds were allocated to OAHS ($129,293), and MCM ($206,926), focusing on Latinx, Black/African-Born, Black/African American, and non-Hispanic Indian American PWH in FY21. 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 receipt of care, 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 100% retained in care and 93% virally suppressed.

While most of the efforts focused on eliminating disparities are on increasing viral suppression as the retention in care data across all populations is above 90%, disparities do exist earlier on in the care continuum as well. The Part A Recipient is concerned with incidence and prevalence rates, late diagnoses, unaware estimate, and linkage to care disparities experienced by specific racial, ethnic, gender, and risk factor subpopulations. To be more coordinated, more efficient, take a more data driven approach, and be better at reducing disparities in the MSP-TGA early identification of individuals with HIV/AIDS (EIIHA) efforts are being integrated into the existing quality management infrastructure. In the spring of 2021, The Part A MSP-TGA Recipient and the MN Part B Recipient, The MN Department of Human Services met to discuss how to improve and institutionalize EIIHA work. The decision was made to add EIIHA oversight and coordination in their respective quality management advisory bodies for Hennepin County, The MN HIV/AIDS Care and Prevention Quality Management Advisory Committee (QMAC) and for DHS Clinical Quality Management Committee (QMN). With this change, EIIHA activities and data will be reviewed quarterly by these quality bodies leading to more timely improvements and accountability.

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 within 30 days for both new case findings and out of care case findings; 2) receipt of care and 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, the data, and the discussion around them help Part A and other RWHAP Parts understand the impact of funding, specific service efficacy, and where disparities exist to better serve the MSP-TGA. With this information the council and QMAC make informed allocations decisions and recommends areas of focus for quality improvement at both the recipient and subrecipient level for better outcomes for PWH in the MSP-TGA.

The NAE Committee 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 and committee members so that they are equipped to make data informed decisions to improve services and health outcomes for RWHAP clients. The NAE Committee 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 Public Health's epidemiological staff to develop internal dashboards in Power BI to assess data completeness, HIV incidence and prevalence, 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 for more in-depth analysis, more 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. With more nuanced cuts of data, the Part A recipient staff can identify disparities by subpopulations and take action to address those disparities.

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, 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. Prior to the beginning of FY21, the Qualtrics based reporting system was further simplified based on feedback from recipient and subrecipient staff. It is anticipated that there will be improvements made annually. While some stumbling blocks occurred, as is common in standing up a new technology, the benefits have led to increased efficiency and faster turnaround in feedback to subrecipients.

- *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 11***. 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 (1.0 FTE funded by Part A) 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 (0.5 FTE) and Administrative Specialist (0.5 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 sit on the interview panel and provide input in selection of 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 organization.

2) Grant Recipient Accountability

a) Monitoring

i. Subrecipient monitoring for FY 2021**.** Subrecipient fiscal and programmatic compliance monitoring activities integrated COVID-19 pandemic safety measures. This included limiting in-person contacts and following public health guidelines. Annual site visits were conducted remotely and were abridged, reducing the sample size of client files reviewed to accommodate the limitations of the remote platform to receive files. In addition to client file reviews and interviews with subrecipient staff, contract managers conduct an invoice audit for a randomly selected month of expenditures. Additionally, Hennepin County internal audit conducts a comprehensive fiscal audit of a minimum of two subrecipients annually. There were very few findings in 2021; however, 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. Contract managers also monitor spending through invoice review and entry into the RWHAP financial MS Excel invoice 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. Subrecipient quarterly reports are reviewed by recipient staff including contract managers, planners, and the quality management coordinator for performance assessment and to identify technical assistance needs. Finally, program staff meet monthly to review programmatic and fiscal compliance

concerns along with spending and performance in order to identify spending and utilization trends and respond to emergent issues.
ii. Ensuring subrecipient compliance with the single audit requirement. Prior to the annual subrecipient program and fiscal site visits, subrecipients submitted 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 contain 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 FY20, all eleven Part A subrecipients receiving $750,000 or more in federal funds complied with the federal single audit requirement.
iii. Audit findings and corrective actions. The internal comprehensive fiscal audit resulted in one subrecipient receiving two deficiencies. This subrecipient provides outpatient/ambulatory health, mental health, and medical case management services and is in the process of completing their corrective action plan based on the two findings. The first was a financial state deficiency where a detailed aging report was not available for pharmacy accounts receivable. The second was incorrect sliding fee calculations or filing of the related forms. Internal audit recommended the subrecipient "address the findings and improve internal audit controls, as well as implement a corrective action plan submitted to the external auditor."

There were very few findings from the FY21 site visits. Four out of the one hundred and twenty-nine (3%) charts reviewed were not current on eligibility documentation to receive RWHAP services. These four files were at two subrecipients. Both reported challenges with income, insurance, and residency documentation. Subrecipients reported that RWHAP consumers are experiencing heightened income and housing insecurities along with HIV-related health safety concerns due to the COVID-19 pandemic. The main challenges for numerous RWHAP consumers continue to be homelessness, unstable housing, or being at-risk for homelessness. 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 internally 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 also implemented a site visit policy that includes selecting all files for active clients that had missing eligibility documentation the previous year.

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 before RWHAP contracts are executed. 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 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. Income eligibility for the Part A RWHAP is 400% of the federal poverty level (FPL). Upon intake and every six months, subrecipient staff ask all clients for documentation proving their income, residency, 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. 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 2022, 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, residency in the MSP-TGA, and health insurance coverage. In 2021, 129 client records were reviewed for eligibility determination documentation. Of the 129 records reviewed, 100% had documentation of HIV infection, 98% had documentation of income, 98% had documentation of health insurance, and 98% 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. The statements must include all revenue sources. 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 recipient staff lead the fiscal oversight of the grant with assistance from analysts in Hennepin County's Health and Human Services Financial Analysis and Accounting Area (*see **Attachment 11B***). Contract managers monitor spending through invoice review and entry into the RWHAP financial MS Excel invoice 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. Once approved by the contract manager, invoices are scanned into a document database, assigned a receipt number, and then payment is issued via electronic transfer to subrecipients' financial institutions. Part A staff reconcile payments to subrecipients with invoice amounts monthly and enter administrative and clinical quality management (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 contract managers and 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. Expenditures on administration, CQM, and services are each divided based on the proportion of the grant award that is formula and supplemental because of the penalties for unobligated formula funds established by the RWHAP legislation. 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 used to track expenditures include a MS Excel invoice ledger where contract managers enter subrecipient invoice amounts by budget line item and a master Power BI report that pulls data on service expenditures 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 Part A and MAI 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 three 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 (month or quarter) 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 contract manager. Once approved and submitted for payment, payment is made by electronic transfer within five days. Subrecipient contracts stipulate that payment will be made within 35 days of invoice receipt unless the invoice is incorrect.

B. Maintenance of Effort (MOE). ***Attachment 12*** presents a table that identifies the Minneapolis-St. Paul Part A TGA's MOE budget elements and the amount of actual expenditures for FY 2020 and budgeted amounts for FY 2021.

iii. Budget. *See form SF424.*

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