Minneapolis-St. Paul TGA Application for 2009 Ryan White HIV/AIDS Treatment Modernization Act Part A Funding

PROJECT NARRATIVE

TABLE OF CONTENTS

x. Program Narrative……………………………………………………………. 1

1. Demonstrated Need………………………………………………………… 1

2. Access to HIV/AIDS Care and the Plan for FY 2009……………………. 31

3: Section 3 removed

4. Planning and Resource Allocation…………………………………..…… 38

5. Budget and Maintenance of Effort……………………………………… 44

6. Clinical Quality Management…………………………………………… 44

LIST OF ATTACHMENTS

Attachment 1- Organization Chart

Attachment 2- Letters of Agreement

a. Intergovernmental Agreement Signature Page……………………..…… 1

b. FY 2009 Agreements and Compliance Assurances……....................... 2

c. Planning Council Co-Chairs Letter of Assurance..…………………... 6

Attachment 3- HIV/AIDS Epidemiology Table

Attachment 4- Co-morbidities, Cost and Complexity Table

Attachment 5- Report on the Availability of Other Public Funding

Attachment 6- Unmet Need Framework

Attachment 7- FY 2009 Implementation Plan

Attachment 9- TGA Map of PLWH/A and HIV Care & Services Providers

Program Narrative

1. Demonstrated Need

1.a. HIV/AIDS Epidemiology– AIDS incidence and prevalence and HIV (non-AIDS) prevalence data for the Minneapolis – St. Paul TGA are presented in **Attachment 3**. These data are from the Minnesota Department of Health (MDH) and the State of Wisconsin's HIV/AIDS Reporting Systems (eHARS). Both states have collected names-based AIDS and HIV infection data since 1985 and have highly accurate reporting systems. Data on case reports of HIV infection and AIDS diagnoses are collected through a passive and active HIV/AIDS surveillance system. The MDH data also provide detailed demographic information that includes country of birth, which has proved valuable since 2000 in understanding how the epidemic is emerging among African-born people living with HIV/AIDS (PLWH/A).

HIV/AIDS Cases and Disproportionate Impact – The Minneapolis-St. Paul Transitional Grant Area (TGA) comprises eleven Minnesota counties and two Wisconsin counties with a total population of 3,208,212**.** According to data from the Minnesota Department of Health (MDH) and the Wisconsin Department of Health Services eHARS, 2280 individuals were living in the TGA with an AIDS diagnosis as of December 31, 2007—an increase of over five percent from the previous year; however 287 new AIDS cases were reported from January 1, 2006 to December 31, 2007—a three percent decrease from the previous two-year reporting period. An additional 2,916 individuals were living with HIV (non AIDS) in the TGA, a 5.6% increase. Of 5,950 Minnesotans living with HIV/AIDS, 87% (5,196) live in the TGA. Pierce and St. Croix Counties in Wisconsin accounted for less than one percent (52) of the HIV/AIDS cases in the TGA. The HIV/AIDS epidemic in the TGA continues to be centered in the Twin Cities of Minneapolis-St. Paul, with 55% of Minnesota's PLWH/A. There has been a gradual shift to more cases in the suburban areas, which accounts for 30% of Minnesota's HIV/AIDS prevalence. Of new infections in the TGA in 2007, 37% were among suburban dwellers.

Men who have sex with men (MSM) continue to be the group most affected by the HIV epidemic in the TGA. MSM account for 52% of living HIV/AIDS cases and 41.5% of AIDS cases diagnosed over the two-year period ending December 31, 2007. As the predominant mode of exposure for all living HIV/AIDS cases in the TGA, MSM was identified in 2,956 cases during 2006-2007, which is a five percent increase over the 2005-2006 reporting period. MSM accounted for 46% of new HIV/AIDS infections in 2006-2007. Age is an important factor to determine trends for recent HIV infections. Looking at new HIV infections reported to the MDH among youth (defined by MDH as young men and women ages 13-24), in 2007 this ratio was 15% (50/325). Specifically among young men, while there had previously been a decline in new infections, that number is again increasing steadily from 18 cases in 2002 to 38 cases in 2007 (111% increase). The greatest increases were among young MSM and Latino men (32 new cases in 2007). Additionally race plays a factor in Minnesota among MSM. White MSM make up the largest proportion of HIV infections diagnosed in the past three years (86%); however, MSM of color are disproportionately represented when taking race-specific population size into account. Of the new HIV infections diagnosed in Minnesota among males between 2005 and 2007, MSM or MSM/IDU (intravenous drug users) were estimated to account for 96% of cases among White males, 90% of cases among Hispanic males, 71% of cases among African American males, and 12% of cases among African-born males.

Women and persons of color continue to be a growing proportion of the epidemic. While women comprise 23% of the PLWH/A in the TGA, there was a five percent increase in the

number of women living with HIV/AIDS in 2006. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. In the beginning of the epidemic, white women accounted for a majority of newly diagnosed cases among females.

While men and women of color overall are disproportionately affected by HIV/AIDS, in Minnesota this disparity is most apparent among women. While white women make up approximately 90% of the female population, they accounted for only 26% of new infections among women in 2007, whereas women of color make up approximately 11% of the female population and accounted for 74 percent of the new infections among women. African American women experienced a 39 percent decrease in new cases in 2006-2007 to17 new cases. African-born females, after experiencing a high of 41 new infections in 2002, have decreased in new infections, with 24 cases reported in 2007.

Whites account for 51% of those living with HIV/AIDS in the TGA, compared to 23 for African Americans, 14% for African-born, nine for Hispanics, and two percent and one percent for American Indians and Asians, respectively. Across Minnesota, the distribution by race varies across gender with White males accounting for 62% of males living with HIV/AIDS, compared to 28% for White females.

According to the 2007 MDH Epidemiological Profile, there were 1,205 African Americans (U.S. born) living with HIV/AIDS in the TGA as of December 31, 2007—an increase of almost seven percent over the previous year. Similarly, there were 692 African-born PLWH/A, compared to 630 in 2006 (an almost 10% increase). In the period ending December 31, 2007, of the 103 blacks newly diagnosed with AIDS, 39% are African-born. Hispanics also make up an increasingly larger proportion of the local epidemic. Hispanics account for eight percent (402) of living HIV/AIDS cases in 2007, a 9.6% increase from 2006. Of those living with HIV/AIDS in the TGA, less than two percent (84) are American Indian/Alaska Native, and one percent (67) Asian.

According to the 2000 Census, whites make up about 86% of the state population, and they represent only 42% of all new HIV/AIDS infections in 2007. While populations of color make up 11% of the state's population, they comprise 58% of new HIV/AIDS infections in the TGA. Such a disproportionate impact, particularly on the black community, is consistent with trends seen nationwide, and is especially disconcerting since blacks comprise only about eight percent of the population in the TGA. Hispanics too are disproportionately impacted by HIV compared to their representation in the TGA. Hispanics comprised 16% of new AIDS cases in the TGA between 2006 and 2007, yet make up just five percent of the general population.

The number of African immigrants in Minnesota continues to grow. Census data show a 600% increase in the number of African immigrants in Minnesota between 1990 and 2000. The Minnesota State Demographer estimated that there were 62,612 people living in Minnesota who were born in African countries; however, anecdotal estimates are much higher (up to 100,000). Somalia, Ethiopia, and Liberia are the most common countries of origin although nearly every country in Africa is represented in Minnesota. In 2006, nearly 4,400 primary refugees[1] from African countries were resettled in Minnesota (MDH Refugee Health Program). In 2000, Minnesota became one of six sites in the U.S. to receive HIV-positive refugees. Typically immigrants, including refugees, with HIV/AIDS are not permitted entry into the United States.

[1] Note: A refugee is a specific type of immigrant. A refugee is a foreign-born person who cannot return to his or her country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Primary refugees in Minnesota are those persons who first relocated here; secondary refugees moved to Minnesota after arrival at another site in the United States. The approximated number of 7,000 does not include secondary refugees.

Two Twin Cities agencies coordinated the arrival of 180 HIV-positive African refugees between August 2000 and September 2007, with 116 first settling in Hennepin County.

Increases in the number of HIV infections among African-born men and women have also been documented each year since the late 1990s. For the period ending December 31, 2007, there were 40 newly diagnosed AIDS cases among people born in sub-Saharan Africa who are living in the TGA. African-born individuals now account for a startling 13% of the TGA's HIV/AIDS epidemic but account for less than two percent of the TGA's population. Overall, African-born individuals accounted for 14% of new AIDS cases in 2007.

Data on injection drug use are limited in Minnesota and are based on admissions to treatment programs and emergency room visits. The estimated number of injectable drug users (IDUs) in the TGA is 7,205. The proportion of the local HIV epidemic made up of IDUs continues to be lower than the national average of 21%. IDUs comprise seven percent of the living AIDS cases, six percent of living HIV cases and eight percent of AIDS cases diagnosed in the TGA during the two-year period ending December 31, 2007. Injection drug use was an associated risk factor (either IDU alone or MSM/IDU) for 13% (38 of 287) of new HIV/AIDS infections for 2006–2007 and 12% (599 of 5196) of those living with HIV/AIDS in the TGA at the end of 2007. Among women, IDU is the second most common mode of transmission making up 11% of cases among women in 2007. Intravenous drug use is estimated to account for 10% of HIV cases among African-American women in Minnesota, and 13% among white women.

The epidemic in the TGA continues to change with respect to those who are becoming infected, reflecting the national epidemic. Forty-two percent of new AIDS cases were among whites, 36% among blacks (22% African-American and 14% African born), 16% among Latinos, two percent among American Indians and two percent among Asians.

Consistent with national data, the vast majority (99%) of the TGA's living AIDS cases are adults over age 19. As of December 31, 2007, the TGA had 33 living AIDS cases in children or youth under the age of 19. Four new AIDS cases under age 19 were reported during the two-year period ending December 31, 2007. There are 165 youth under 19 years of age living with HIV (not AIDS) in the TGA as of December 31, 2007. This age group accounts for five percent of all living HIV cases in the TGA. There was one new case of AIDS in 2007 among children younger than 13 years. The higher number of youth living with HIV versus AIDS may reflect not only the national trend of a decrease in HIV transmission from infected mothers at birth, but an increase in unsafe sexual practices among gay male youth and adolescents in general. In 2007, 15% of the 288 new HIV infections were among young men (age 13-24).

The TGA includes several suburban, semi-rural and rural counties surrounding the core cities of Minneapolis and St. Paul, where the epidemic looks quite different. Historically, about 90% of new HIV infections (including AIDS at first diagnosis) in Minnesota have occurred in the TGA. This trend continued in 2007 with 42% of new infections among residents of Minneapolis, 13% in St. Paul, 33% in the surrounding suburbs, and 12% outside the TGA.

Since 2000, the percentage of newly diagnosed persons progressing to AIDS within one year of initial diagnosis of HIV infection has remained relatively stable at around 30%. However, this overall stability masks important differences by race, ethnicity and Country of birth. While the percentage of newly diagnosed cases progressing to AIDS within one year among whites and African Americans is around 29%, this ratio is significantly higher among Hispanics (47%) and African-born (33%). Most of the cases among Hispanics were among the foreign-born, which has significant implications for prevention and care. In its March 2007 *Overview of Homelessness in Minnesota*, Wilder Research Center estimated that 7,713 individuals (of which

206 were unaccompanied youth) were homeless at some time during 2006. Based on interviews with 3,800 homeless adults, the study estimates that two percent are living with HIV, which is 12 times the HIV prevalence rate in the TGA's general population. Data from the Federal Bureau of Prisons and Minnesota Department of Corrections indicate that among individuals discharged in 2007 from detention, 14 from federal facilities and 29 from state facilities were positive for HIV. Information from the correctional facilities of the TGA's two largest counties indicates that a total of 216 HIV-positive people were released during 2005-2007; however, since the majority of them were identified as HIV-positive by self report during brief lengths of incarceration (averaging six to seven days), the actual prevalence among this group is probably much higher. In summary, these data portray an evolving epidemic in the Minneapolis-St. Paul TGA of men who have sex with men continuing to experience the greatest impact. Trends that have emerged nationally also appear in the TGA, specifically:

- Communities of color, specifically African Americans, African-born and Latinos, comprise an increasingly disproportionate share of HIV and AIDS cases;
- African-born persons living with HIV/AIDS account for 14% of all cases in the TGA but less than two percent of the TGA's population;
- The number of women living with HIV/AIDS continues to increase, particularly African American and African-born women of childbearing age;
- The TGA's urban counties (Hennepin and Ramsey) continue to be disproportionately impacted. Fifty-one percent of the TGA's population resides in these counties yet 85 percent of the PLWH/A in the TGA live in them; and
- New HIV infections among young men are increasing in the TGA; the mode of exposure for 98% of new infections among young men is MSM or MSM/IDU.

These trends have a significant impact on the cost and complexity of service delivery in the Minneapolis-St. Paul TGA. The urban area has a strong network of HIV service providers; however, many of these organizations have not traditionally targeted outreach activities to women, communities of color, and now immigrant communities. As the HIV/AIDS epidemic expands to include greater numbers from these communities, the number of individuals with complex issues involving substance use, mental illness, unstable housing, low socioeconomic status, language or cultural barriers and stigma continues to increase. These cofactors make it even more difficult for these populations to access or maintain health insurance and employment, or to adhere to complex medication regimens.

Populations Underrepresented in HIV Primary Medical Care – The 2007 Ryan White services utilization data represent only a partial picture of the HIV/AIDS system of primary medical care. In many states, Ryan White funds are primarily used to pay for medical care for PLWH/A. Minnesota has historically been fortunate to provide extensive access to health insurance through public programs or the purchase of health insurance for PLWH/A. This has reduced the need to use Ryan White Part A and Part B funds to directly support primary medical care and allowed the dollars to be used to create a comprehensive system of services that support access and adherence to medical care. To address disparities in access to care in 2008, the Planning Council allocated 20% of Part A funds for ambulatory medical care to culturally specific primary care. Minority AIDS Initiative (MAI) funds support a culturally specific primary care program that provides bilingual services to Latinos, causing this group to appear considerably overrepresented in the utilization data. Thus for 2007, of those utilizing Ryan White-funded primary care, 21% were Latino, and 19% were white. The largest group utilizing primary care was African American at 33% and one percent identified as "other." The remaining

primary care users were American Indian (1%), Asian (1%), more than one race (12%), and those for whom race was reported "unknown" (12%). Men and women accessed primary care at rates reflective of the epidemic, with 66% men and 33% women seen in primary care. While 38% who utilized Part A-funded primary care services identified "other" as their country of birth (not United States), for 25% this item was listed as "unknown." Early Intervention Services (primary care for newly diagnosed) served 56% whites, 33% African American and African born, seven percent Latino and seven percent Asian individuals.

In July 2003, several changes were made to the Minnesota Health Care Programs that affected the number of uninsured. Undocumented individuals, with the exception of pregnant women, were no longer eligible for publicly-funded Minnesota Health Care Programs. Additionally, in October 2003, the income eligibility guidelines for state-funded insurance for the working poor changed from 175% to 75% of the federal poverty level. These changes in publicly-funded health care programs will likely continue to disproportionately impede the ability of African Americans, new immigrants, Latinos and Native Americans to access primary care.

Estimated Level of Service Gaps – According to 2007 service utilization data, 3,325 unduplicated individuals living with HIV/AIDS, out of a possible 5,248 in the TGA (63%), received some type of service within the Ryan White Part A- and B-funded care system. Of the people in Ryan White services, 41% are white, 37% are African American or African born, five percent are more than one race, nine percent are Hispanic, two percent are American Indian, one percent are Asian , one percent other, and four percent are unknown race. Living HIV/AIDS cases in the TGA are 52% white, 37% African American or African-born, eight percent Hispanic, one percent American Indian, one percent Asian, and one percent multi-race or unknown. Males comprise 77% of all cases living with HIV/AIDS in the TGA and account for 72% of the clients receiving services.

The grantee's Outcomes Evaluation/Client Level Reporting System data on Medical Case Management for 2007 obtained information from 1,231 clients and their case managers about their medical needs in the previous six months. It found that 313 (25%) of clients needed assistance with adhering to medication regimens, 567 (46%) needed help to access or maintain medical care, 252 (21%) needed help to get mental health services, and 185 (15%) identified a need for substance abuse services. In other service needs, 413 (34%) needed Emergency Financial Assistance, 275 (22%) needed Housing Assistance and 316 (26%) needed Psychosocial Support .

1.b. Impact of Comorbidities on the Cost and Complexity of Providing Care

The levels of comorbidities, poverty and lack of insurance for the Minneapolis – St. Paul Transitional Grant Area's (TGA) population are presented in **Attachment 4**.

People who are living with HIV and AIDS (PLWH/A) who are uninsured, homeless, living in poverty, chemically dependent, have severe mental illness, have sexually transmitted diseases (STIs) or other co-infections or were recently incarcerated face additional challenges to access services because systems of care are not well integrated, costs are higher and services may not be adequately reimbursed by third-party payers. In addition, those who were born outside of the United States encounter linguistic and cultural barriers to care. As PLWH/A contend with these issues it may become difficult for them to access or maintain health insurance, attain economic self-sufficiency and stable housing, and adhere to complex medical care and medication regimens. Physicians and case managers spend time trying to assist people with these issues that

must be addressed if treatment is to be successful. Often, there is no compensation for additional services needed to provide quality care for those struggling with multiple diagnoses and stressful socioeconomic circumstances.

The grantee has collected quantitative data on HIV comorbidities, insurance status and poverty in the TGA from: the Minnesota Department of Health; Wisconsin Department of Health Services; the U.S. Census Bureau; local and national reports; needs assessments; and service provider data. Although data are available for several comorbidities, their rates among PLWH/A are difficult to determine because other service systems often do not collect HIV related data. Linkages between systems of care are limited and PLWH/A may remain undiagnosed or untreated for other conditions. In addition to the sources listed above, data from the Minnesota Department of Human Services (DHS), unit costs from HIV primary care clinics and testing sites, and client utilization and service expenditure data are used to provide a more detailed picture of the impact of comorbidities on access to primary medical care and the cost of care for those living with HIV/AIDS in the TGA.

Sexually Transmitted Infections (STI)– The Minnesota Department of Health (MDH) data indicate that in 2007, the number of reported bacterial STIs reached their highest level ever with 17,057 cases reported. This represents an overall increase of four percent from the previous year and is part of a continued trend observed over the past ten years. Minneapolis-St. Paul and the surrounding seven-county metropolitan area represent 70% of reported cases. From 1997-2007, Minnesota's chlamydia rate doubled while gonorrhea has increased steadily at a slow rate. Minnesota has seen a resurgence in syphilis since 2002, with men who have sex with men (MSM) being especially impacted. Racial disparities in STIs continue to persist in Minnesota with communities of color having the highest rates. Between 2006 and 2007, incidence rates of chlamydia and gonorrhea increased by four percent and five percent respectively. Primary/secondary syphilis increased by 35% among males (95% of whom were MSM), while cases among women remained low. In 2007, incidence rates of chlamydia increased by one percent among males and five percent among females; gonorrhea increased by three percent among males and six percent among females. Adolescents and young adults accounted for 68% of chlamydia and 56% of gonorrhea cases reported in 2007. The prevalence of quinolone-resistant *Neisseria gonorrhoeae* continues to be high (28%) among MSM, but the prevalence is rising in heterosexuals – 4.5% in 2007 compared to 0.8% in 2006.

Sexually transmitted disease infection rates are likely higher among PLWH/A compared to the general population. Of the 242 PLWH/A interviewed for the Comprehensive Needs Assessment of HIV Positive Minnesotans conducted in 2003, 18% reported being diagnosed with an STI other than HIV within the past year. Based on 2007 unit costs for laboratory tests and treatment from the Hennepin County Public Health Clinic, the TGA's largest HIV and STI testing clinic, the cost of screening for chlamydia, gonorrhea and syphilis averages $356 per patient. Antibiotic treatment costs range from $8 – $51. Treatment for co-infections can be as much as $84. Costs are even higher for treatment of sexually transmitted infections in later stages. One latent case of syphilis can cost $679 which includes comprehensive treatment and follow-up. Using the reported diagnosis of sexually transmitted disease infections from the 2003 Needs Assessment to estimate STI prevalence in the TGA's population of PLWH/A (18%), co-infection with an STI may add up to $332,960 to the annual cost of care for PLWH/A in the TGA depending on the STI, how early it is treated, and frequency of infection.

Homelessness – According to *Overview of Homelessness in Minnesota*, a 2007 report by the Wilder Research Center, there were an estimated 7,713 homeless individuals living in the

Minneapolis-St. Paul TGA, including an estimated 206 unaccompanied youth. This study said that two percent of the 3,800 homeless adults interviewed reported that they were HIV positive. Another two percent reported having a STI other than HIV. People of color are vastly overrepresented in the population of homeless persons in Minneapolis and St. Paul. In the general population 65% are Caucasian, 18% are African American, eight percent are Latino, and two percent are American Indian; among the homeless, 57% are African American, and eight percent are American Indian.

In 2007, Ryan White client-level data indicated that eight percent (336 of 4,038) of all Part A and B service recipients whose living situation was known were homeless at some time during the year or in unstable housing. Three percent of clients receiving Medical Case Management services were homeless during both reporting periods in 2007 and another 11-12% were in unstable housing.

According to *Overview of Homelessness*, mental illness and drug abuse are prevalent among homeless adults. The report estimates that 52% have a serious mental illness. Forty-eight percent of homeless men and 28% of homeless women had been in inpatient treatment for chemical dependency. These additional comorbidities are significant barriers to entering and maintaining primary HIV medical care.

Outcomes data collected on 2007 clients receiving Medical Case Management services found that 15% were either homeless or in unstable housing. Homeless patients are more likely to visit the emergency room, are hospitalized more frequently, stay in the hospital for longer periods of time and have poorer health outcomes. According to *Overview of Homelessness,* among those who had received care at an emergency room in the previous six months, 25% said that they were released with instructions they couldn't follow because they were homeless. For those living with HIV, adherence to antiretroviral treatment is likely to be a significant challenge. All of these factors, complicated by inadequate resources to provide stable housing, will significantly increase the cost of care for homeless PLWH/A. Based on the annual average assistance per household of HOPWA rental subsidies of $807 in 2007, providing subsidies to the estimated number of homeless and inadequately housed PLWH/A in the TGA would cost an additional $338,800 annually. Many homeless PLWH/A will require intensive assistance through Medical Case Management to access mental health or chemical dependency treatment, shelter and supportive social services before successful treatment for HIV is likely. Based on the TGA's unmet need estimate of 35% of PLWH/A (N=1800), an estimated 8% rate of homelessness or unstable housing among the TGA's PLWH/A and an average per capita annual MCM cost of $1,300, providing MCM services could add an additional $187,200 to the cost of care for this population.

Uninsured –The *2007 Minnesota Health Access Survey* found that the rate of uninsurance (7.2% of Minnesotans, or 374,000 people) was statistically unchanged since 2004. About 25% had health insurance coverage through a public program (including Medicare). People with the lowest family incomes—at 100% of Federal Poverty Guidelines (FPG)—had uninsurance rates of 18% or below, while those with incomes from 101-300% of FPG were uninsured at a rate of 12.6%. Uninsurance rates in Minnesota also vary by race and ethnicity, with considerable disparities in the rates of insurance experienced by people of color. Latinos are three times as likely as Whites to lack coverage (19% compared to 6.4%), and rates of uninsurance for Black (14.7%) and American Indian 16%) Minnesotans are also disproportionately high. Using population data from the U.S. Census Bureau (2007), we estimate that six percent or 198,909 people living in the TGA are uninsured. Increases in health care costs, recent cuts in Minnesota

Health Care programs and increases in out-of-pocket costs for those on publicly-funded programs may explain the increase.

Results of the Medical Case Management Outcomes Evaluation for 2007 show that 38% needed help to access Part B-funded health insurance programs, while three percent of clients needed assistance to obtain other health insurance. Fifteen percent needed help other than that provided through ADAP to pay for HIV medications and 17% needed other help to pay for medical expenses in the previous six months. Ninety-two percent of those who identified a need for help in obtaining or paying for medical, dental, or behavioral health services in the previous six months also said they would need ongoing case management services to be maintained in care, and 20% said at the time of the survey that one or more of those needs remained unmet.

Minnesota has an array of public programs in which HIV-infected Minnesotans can enroll. In 2007, about 29% of PLWH/A (1,533) were enrolled in the Minnesota Medical Assistance Program (Medicaid), while 983 individuals (19%) were enrolled in the Part B HIV/AIDS Insurance or ADAP Program. Additional publicly-funded program enrollments include 9% in the General Assistance Medical Care Program, 2% in MinnesotaCare (a subsidized insurance program for the working poor), and 7% in the state's supplemental program for qualified Medicare recipients.

Service utilization data for 2007 for the TGA show that of those receiving services who were insured, 34% had private insurance, 29% were enrolled in Medicaid, 17% had Medicare coverage and 16 % were enrolled in another public health care program. Overall 13% were known to be uninsured, and the insurance status of eight percent was unknown.

In the TGA, under-insurance and increasing out-of-pocket health care costs may present more barriers to accessing care than lack of insurance. Among respondents to the 2006 Consumer Needs Assessment Survey (CNAS), of those enrolled in a private health insurance plan or HMO, 46% reported that their premiums had increased compared to 12 months ago. Forty percent reported that their co-payments or deductibles had increased. Significant changes occurred among several Minnesota publicly funded health insurance programs in 2003, raising out-of-pocket costs for many recipients. Among the CNAS respondents who were enrolled in a public health insurance program, 38% reported paying more for co-payments, deductibles, or cost-share premiums. In addition, 13% of respondents reported that at some time in the six months before the survey, they had to go without health care because the money was needed for such basics as food, clothing, or housing. Health care costs included co-payments, deductibles, cost shares, or medication payments. Conversely, 18% of respondents reported that at some time in the last six months they had to go without the money for food, clothing, or housing because the money was needed for health care.

In FY 2007, $650,358 in Part A funds was expended on Primary Care (including culturally appropriate primary care) and Early Intervention Services for 368 of the TGA's uninsured and under-insured PLWH/A. With an average annual expenditure per patient of $1,767 and assuming that the percentage of uninsured PLWH/A is 13% based on client level data, the cost of providing primary care to all of the TGA's uninsured PLWH/A, including those out of care, would approach $1,205,500 annually.

State Medicaid Program and Medicare – Minnesota's Medicaid program, Medical Assistance (MA), covers basic health care services as well as HIV medications. Medical Assistance affords some of the most comprehensive benefits in the country, and includes an expansive drug formulary. Medical Assistance does not limit the number of prescriptions per month, nor limit

prescriptions to any dollar amount. Recipients pay $1-3 per prescription up to a maximum of $12 per month.

In response to a $3.65 million budget deficit in 2003, the Minnesota Legislature reduced income eligibility standards for MA and imposed prescription co-payments. These changes impacted primarily pregnant women and single adults. Some of the funding cuts were restored during the 2005 legislative session, which reduced the maximum monthly prescription co-payment to $12 and eliminated the caps on outpatient and inpatient coverage for a state-funded program that provides coverage for low-income single adults who are not disabled. In 2007, nine percent of the TGA's population was enrolled in Medicaid **(see Attachment 4).** Between 2005 and 2006, MA enrollment in the TGA increased by 3.3 percent from 257,178 to 265,770 recipients. According to the Minnesota Department of Human Services 1,533 or 29% of people living with HIV in the TGA were enrolled in Medicaid in 2007. Client level utilization data show that 29% of PLWH/A (756) in the TGA who accessed a Ryan White funded service in 2007 were enrolled in Medicaid. Forty-seven percent of participants in the 2006 Consumer Needs Assessment Survey were enrolled in MA. Medicaid expenditures for calendar year 2007 accounted for $12,775,351 of the cost of publicly funded HIV outpatient medical care, including pharmacy, in the TGA. The average per-capita annual expenditure on outpatient healthcare for a PLWH/A enrolled in MA in this time period was $8,333.

Although Ryan White funds fill few health care gaps for Medicaid recipients, Ryan White programs help meet access and support service needs. These include Medical Case Management, Benefits Counseling, Outreach, Transportation, Emergency Financial and Housing Assistance, Food and Nutrition, Psychosocial Support, Legal Assistance and other services that allow people to access and remain in care. Medical Case Management is critical for MA recipients and providers are educated about the importance of Ryan White funds as the payer of last resort. In fiscal year 2007, HIV case management outlays accounted for 28% of all Part A expenditures and 32% of Part A funds spent on services. Part A funds supplement a state appropriation and a Medicaid administrative allocation to support case management services for PLWH/A and will account for 51% of Minnesota's annual HIV Medical Case Management budget in FY 2009. This is a high priority service area, ranked second in the Planning Council's 2009-2010 joint Part A and B prioritization process, and allocated 40% of 2009 planned Part A spending. The Planning Council prioritized elimination of waiting lists for Medical Case Management in 2007 and allocated a 65% increase to accomplish this goal. In 2007, 14% of the TGA's population had Medicare coverage. Client level service utilization data show that 17% of clients accessing Part A and Part B funded services in FY 2007 were enrolled in Medicare.

Persons Living at or below 300 percent of Federal Poverty Guidelines – Minnesota has fared somewhat better than the nation as a whole in regard to poverty and income. In 2000, an estimated eight percent of Minnesotans were living at or below the poverty level compared to 13% nationwide, while the per-capita income in the TGA was $26,219. Although these aggregate numbers are favorable, they misrepresent the disproportionate impact poverty has on persons of color in Minnesota. The MDH Health Economics Program (2005) report estimates that nine percent of all Minnesotans were living at or below the poverty level but 29% of African Americans, 25% of American Indians, 19% of Asians and 38% of Hispanics in Minnesota lived in poverty. Access to health insurance is becoming exceedingly difficult for those who are not poor enough to qualify for Medicaid or other state-funded health care programs. The most recent Census figures (2007) report the number of persons living below 300% of poverty in the TGA at 1,000,964 or 31% of the population.

Fifty percent of the participants in the 2006 CNAS were disabled at the time of the survey; another 28% reported being unemployed. Publicly-funded disability and income assistance were the principal source of income for survey respondents. Over one-third of respondents reported that the Social Security Disability Program was their source of income at the time of survey, while Supplemental Security Income was the source for 28%, General Assistance for 12%, and Minnesota Family Investment Program (MFIP) for five percent. Only five percent of respondents received income support from commercial disability insurance. Less than one-quarter (23%) of respondents received their income from full or part-time employment. Financial support or money from parents, friends, or family to pay bills was reported by six percent of respondents. Respondents reported a median income of $684 in the twelve months before the survey. Outcomes Evaluation for 2007 for Medical Case Management shows that 86% of 1,231 case-managed clients received help to obtain Emergency Financial assistance and 11% identified this as a need that was not met. Emergency Housing assistance was a need case managers helped clients to obtain for 30% of all case-managed clients, while 21% who identified this as a need did not receive this assistance. In the same time period, 10% of case-managed clients needed help to access an emergency food shelf and 13% needed help to obtain vouchers for food. In FY 2007, combined Part A and Part B expenditures on Emergency Financial and Housing Assistance reached $425,200 and helped 1,456 PLWH/A avoid eviction, pay utility and/or medical bills.
Tuberculosis (TB) – According to a MDH fact sheet on HIV and Tuberculosis released in August 2007, HIV is the most powerful known factor for risk of developing active TB disease. People without HIV have approximately a 10% lifetime risk of developing active TB disease. For HIV-infected persons this risk increases to seven to 10% annually. The prevalence of HIV infection among TB cases reported in Minnesota from 2002 through 2006 and whose HIV status is known over the past five years is approximately six percent overall. Screening for HIV among patients with active TB disease has improved. In 2006, 92% of TB patients between the ages of 25 and 44 were screened for HIV.

The prevalence of drug resistance among TB cases reported in Minnesota exceeds comparable figures nationally. Multidrug-resistant TB (MDR-TB) is resistant to two of the primary TB drugs so it requires longer and costlier treatment. MDR-TB can cost up to $137,000 per patient to treat. This estimate is for medical care only and does not include the additional expense of providing critical supportive services, such as directly observed therapy, contact investigations, and language interpreter services. The prevalence of MDR-TB (3%) in Minnesota is double the national average. Moreover, about 25 of Minnesota's TB cases per year are resistant to at least one of the common TB drugs, necessitating treatment with costlier drugs for longer periods of time. More than 80% of TB cases in Minnesota occur among persons born outside the United States. This reflects the unique and changing demographics of immigrant populations arriving in the state, particularly persons from regions of the world where TB is common.

In 2007 there were 181 cases of active TB identified within the TGA's thirteen counties. Statewide, four percent of TB cases were identified as being coinfected with HIV. Hennepin County's Public Health Clinic currently provides directly observed therapy for six TB/HIV co-infected individuals.
Hepatitis C (HCV) - Since the test for HCV was put into use in 1989, over 15,000 Minnesotans have been diagnosed and reported. Based upon national estimates and given that many cases go undiagnosed and unreported, approximately 40,000 to 60,000 Minnesotans are estimated to be chronically infected with HCV. The Minnesota Department of Health (MDH) estimates there are 30,048 chronically infected with HCV in the TGA as of December 31, 2007, with 18,0726 living

in the Minnesota TGA counties. There was a total of 27 cases in the two Wisconsin counties of the TGA reported by the Wisconsin Department of Health Services through 2004. In June 2004, MDH released a report on Minnesota Viral Hepatitis: Needs Assessment and Five Year Plan. MDH reports that since 1989 there is evidence of an emerging epidemic of HIV/HCV co-infected individuals. In calendar year 2002, the MDH matched HIV surveillance records with their Hepatitis C database and reported that eight percent of the PLWH/A in Minnesota also had HCV infection. In co-infected persons HCV progresses faster, leading to serious liver disease. HCV is also exacerbated by the continued use of alcohol or drugs and medications used in antiretroviral therapy for PLWH/A. Hepatitis C Virus helps account for the 50% of deaths from liver disease among those with HIV. In addition, persons with a previous diagnosis and history of sexually transmitted infections are also at higher risk for infection from viral hepatitis.

HCV treatment is costly, long in duration and has debilitating side effects including depression. Treatment is contraindicated for persons currently abusing substances or suffering from mental illness. In addition, treatment is only successful for about 40-50% of patients. The Hennepin County Medical Center Infectious Disease Clinic reports that ongoing follow-up clinical care for HCV for a patient co-infected with HIV increases by more than $3,000 per year. This includes the cost of more frequent visits with an Infectious Disease physician and more lab tests. For those patients who are able to adhere to medication treatment and are receiving antiviral treatment for HCV, the cost increases to more than $40,000 for 48 weeks of treatment. Using the HIV/HCV co-infection rate of 8.2 percent reported for 2002 (the last year these data were collected), the estimated additional cost of follow up clinical care including HCV treatment would be $18,504,000 in 2006 for the TGA's estimated 430 co-infected PLWH/A.

Injection Drug Use (IDU) and Other Substance Abuse – Estimates of HIV among alcoholics and non-injecting drug addicts range from three percent to more than 33%. Alcohol-abusing men are six times likelier and alcohol dependent women are 20 times likelier than individuals in the general population to be HIV-positive. Alcohol and other substance use are likely to be significant barriers to accessing care. Outcomes evaluation data (2007) collected from and about clients receiving HIV Medical Case Management services through Ryan White illuminate the problem posed by substance abuse. The combined responses of clients and case managers indicate that 21% of clients have substance abuse issues that impact their ability to adhere to medication regimens, and 14% have substance abuse issues that impact their ability to access HIV medical care.

Injection drug users (IDU) face significant challenges in obtaining treatment for HIV. Until the chemical dependency and HIV systems of care and prevention are linked, IDUs will continue to be challenged to meet their health care needs. Of the HIV positive IDUs interviewed for the 2003 Needs Assessment of HIV Positive Minnesotans, 40% had an AIDS diagnosis; most are more likely to have been homeless or incarcerated for 30 days or longer. Injection drug users were less likely to be taking antiretroviral medications and more likely to report they stopped taking them on their own, not at their doctor's direction. They were also more likely to have spent a week or more in the hospital in the past year. Just over 45% have been in a treatment program in the past five years. Of those IDUs that were interviewed, most reported a greater number of barriers in accessing services. Demographic information from the unmet need estimate indicates that MSM/IDU are much more likely to be out of care. The unmet need estimate for this population is 54%.

The Minnesota Department of Human Services (DHS) reported that in calendar year 2007, 197 PLWH/A in the TGA who were enrolled in a Minnesota Health Care Program received

substance abuse treatment. This represents 13% of the PLWH/A who were enrolled in a MHCP. Expenditure data from the DHS-administered Consolidated Treatment Fund for chemical dependency show that in 2007, $784,841 was expended on chemical dependency treatment for PLWH/A in the TGA who were enrolled in a MHCP with the average cost of treatment at $3,983 per recipient. Costs will vary based on whether an individual is placed in an outpatient or inpatient program and whether or not a recipient completes treatment. If up to 13% of PLWH/A who are out of care are chemically dependent, treatment for those out of care would add an additional $700,700 to the cost of HIV care in the TGA.

Mental Illness – The DHS estimates that there are 212,431 persons with serious mental illness or serious and persistent mental illness (SMI/SPMI) living in the state. According to the DHS, in calendar year 2007, 478 of the people living with HIV who were enrolled in a Minnesota Health Care Program accessed some form of mental health therapy. The total expenditure for mental health services for PLWH/A in the TGA on a publicly funded health care program in 2007 was $459,560, costing $961 per recipient. A 2001 study utilizing data from the HIV Cost and Services Utilization Study screened PLWH/A for mental health disorders during the previous twelve months. Nearly half screened positive for a mental health disorder. Untreated mental health disorders may lead to missed medical appointments and poor medication adherence resulting in the development of drug-resistant strains of HIV.

Coordination of care for people with SMI/SPMI can be difficult because the systems of Medical Case Management for HIV and for people with SMI/SPMI are separate and poorly connected. In 2007, 252 (20%) of 1,231 case managed clients participating in outcomes evaluation surveys identified obtaining mental health services as a need in the previous six months; 65% said this need had been met with the assistance of their case manager; 92% of those with mental health needs and 14% of all case-managed clients said ongoing case management would be needed to help address this need. Based on the MCM outcomes evaluation in 2007, 89 clients reported that their mental health needs remained unmet. Based on the per client cost of mental health services for PLWH/A enrolled in a Minnesota Health Care Plan, meeting this need would add an additional $85,500 to the cost of care just for those PLWH/A receiving MCM.

Formerly Incarcerated PLWH/A – According to the Federal Bureau of Prisons, there was a total of 37 individuals living with HIV or AIDS released in 2005-2007 from federal facilities in Minnesota. All of the 37 individuals released were male. The majority (95%) of PLWH/A released in 2005-2007 were from the Federal Medical Center located in Rochester, Minnesota.

According to the Minnesota Department of Corrections, there was a total of 84 people living with HIV or AIDS released in 2005-2007 from state correctional facilities in Minnesota. The Minnesota Department of Corrections began routine screening for HIV at the St. Cloud facility in October, 2007 and at the Shakopee facility in January, 2008. The Shakopee facility houses all female correctional residents and the St. Cloud facility serves as the central prison where all males entering the correctional system begin their sentences.

Routine HIV testing is not conducted within the penal system at the local level. All TGA county correctional facilities have an initial medical screening form completed by medical personnel during an individual's intake process. Individuals are asked whether they have a communicable disease including HIV infection. If a person discloses their positive status, their care and medication are continued through the institution's medical clinic. .However, TGA counties do not compile self-disclosed HIV status in aggregate form. According to the Hennepin County Corrections nursing supervisor, it is estimated that approximately 180 individuals living with HIV have been incarcerated at the workhouse facility and released in 2005-2007.

According to the Ramsey County Corrections section manager, there have been approximately 36 individuals living with HIV incarcerated at the workhouse facility who have been released in 2005-2007. Estimating HIV-positive individuals detained in the county jails is made difficult by an average length of stay of six to seven days. While it is believed that the actual number of HIV-positive individuals in local facilities is much higher, there is little incentive for an individual to request testing or identify themselves as HIV positive primarily due to potential HIV related stigma and the transitory nature of their detainment periods. Medical Case Management services would likely assist PLWH/A being released from incarceration in staying in or reconnecting to care. Estimating that a minimum of 82 PLWH/A are released from the TGA's largest two county's (Hennepin and Ramsey) facilities annually, providing MCM services to the formerly incarcerated may add $106,600 to the cost of care.

1.c. Impact of Part A Funding: Funding Mechanisms and the Impact of the Decline in Ryan White Formula Funding

i) Report on the Availability of Other Public Funding

See **Attachment 5** for a summary of other public funding anticipated to be available for HIV services during the FY 2008 budget period.

ii) Coordination of Services and Funding Streams

In planning the continuum of prevention and care and prioritizing and allocating Part A funds, services funded by other sources are considered in the following ways:

Medicaid – To ensure that priority setting and resource allocation consider Medicaid as well as other state-funded health care programs, the grantee and the Planning Council have taken the following steps: 1) The Minnesota Department of Human Services (DHS), the state Part B grantee and agency responsible for Medicaid and all other state-funded health care programs, is a party to the Intergovernmental Agreement (IGA) (**Attachment 2a**) and has two seats on the Council including staff representing the state Medicaid office and from the Part B grantee office; 2) Staff from the DHS sit on Planning and Priorities and Needs Assessment Committees, which are responsible for priority setting, long-range planning, resource allocation and standards development; 3) The Part A and Part B grantees monitor program usage and identify emerging issues related to the coverage of health care services and medications; 4) DHS staff determine eligibility for all persons living with HIV who may qualify for state sponsored insurance programs as well as Ryan White funded programs such as ADAP in an effort to ensure the Ryan White program is the payer of last resort; and 5) The grantee and Planning Council receive an annual report from the DHS on the number of people living with HIV/AIDS enrolled in all Minnesota Health Care Programs (MHCP) and all MHCP expenditures on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services and home and community-based support.

Medicare – As of December 31, 2007, 440 PLWH/A in the TGA who received Ryan White Part A and B funded services (16.7%) were enrolled in Medicare. Prior to the implementation of Medicare Part D on January 1, 2006, Planning Council members participated in a Medicare workgroup, convened by the DHS, to develop strategies to address the impact of Medicare Part D on access to medications and primary care. Minnesota's Part B grantee currently provides additional assistance to PLWH/A with incomes between 150 and 300% of federal poverty guidelines (FPG) who are enrolled in Medicare Part D through ADAP and the HIV Insurance Program. In addition to ADAP funds, a state appropriation provides additional support for the HIV Insurance Program. For FY 2008, the Planning Council allocated $178,600 in Part B funds

to provide benefits counseling (non-Medical Case Management) to assist PLWH/A in identifying the most comprehensive and cost-effective private and public health care programs to ensure continued access to affordable treatment. This helps PLWH/A who are Medicare eligible to enroll in Medicare Part D prescription drug plans and "extra-help" programs. The DHS periodically provides the Planning Council with information on the number of PLWH/A on Medicare who are also enrolled in ADAP and the HIV Insurance Program. As of December 31, 2007, 75 PLWHA on Medicare were receiving assistance from the DHS HIV/AIDS Program to alleviate the prohibitive out-of-pocket cost burden of the Medicare Part D "doughnut hole."
State Children's Health Insurance Program – Fortunately, the number of children aged 19 or younger living with HIV/AIDS in the TGA as of December 31, 2007 remains relatively small at 155 (3% of HIV/AIDS prevalence). The State has a small health insurance program for children with disabilities. Most low-income children with disabilities can get coverage under Medicaid or MinnesotaCare. Because of this coverage, few children access Ryan White funded insurance or drug programs. A representative from DHS, which administers the children's health insurance program, sits on the Planning Council and provides information about this and other DHS programs in order to reduce duplication of services.
Veterans Affairs Programs – The TGA is home to a Veterans Administration Medical Center with an HIV specialty clinic that provided care to 127 patients in calendar year 2007. Veterans are offered the same comprehensive drug formulary as Medicaid offers and most veterans with HIV receive comprehensive services through the veterans' system. Veterans may use other Ryan White funded services that are not part of the veterans' benefits, including medical case management, psychosocial support, health education, meals and nutritional services.
HOPWA (Housing Opportunities for Persons with HIV/AIDS) – The Minnesota Housing Finance Agency (MHFA) and the City of Minneapolis receive HOPWA formula funding. The Minneapolis program provides rental subsidies and the MHFA program provides both rental and mortgage assistance. A member of the Planning Council and the Planning Council Coordinator participate in the Minnesota HIV Housing Coalition's long range planning workgroup. The Council's Planning and Priorities Committee consider HOPWA funded programs in the planning process. A leading member of the Minnesota HIV Housing Coalition presented an update on HOPWA funded services in Minnesota at the Planning Council's May 2008 meeting as part of the informational sessions for Council members leading up to the 2008 biennial prioritization. The TGA's largest AIDS service organization is a sub-recipient of state formula HOPWA funds and also has a Part A contract to provide emergency housing assistance. Their Transitional Housing Program coordinator chairs the Minnesota HIV Housing Coalition. The grantee works closely with this agency to coordinate Part A and Part B funds allocated for housing assistance with their HOPWA funds.
CDC Prevention Program – The grantee and Planning Council have a long history of coordination with the Minnesota Department of Health (MDH), the CDC grantee. In FY 2002, the Planning Council and the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) developed a plan that identified where care and prevention intersect, formulated strategies to maximize resources and improved coordination between care and prevention. The Planning Council also worked with CCCHAP in 2003 and 2004 to expand the HIV continuum of care to include prevention. As a result, improved awareness of the full spectrum of HIV service needs has assisted in effective planning for both prevention and care. Planning Council and the CCCHAP co-chairs meet biannually to update each other on planning activities and discuss ways to improve linkages between care and prevention programs. Finally, the grantee implemented

collaborative funding with MDH in FY 2005 to maximize resources, ensure efficient use of outreach dollars and bridge the gap between prevention, counseling, testing referral and care services. Joint funding of these outreach programs will continue at least through the end of FY 2008.

Services for Women & Children – Services such as Women, Infants and Children and substance abuse treatment programs for pregnant women are considered in the planning process in several ways. First, a Women and Families service provider network, which is convened by the Part D grantee–West Side Community Health Services (WSCHS) in St. Paul–meets regularly to coordinate the HIV service needs of women and children. The Part A grantee's capacity development consultants, Community Consulting Group, have provided technical assistance to help sustain the Women and Families Network since 2003. West Side Community Health Services also receives Part A funding to deliver Medical Case Management, culturally appropriate Primary Care, Psychosocial Support and Health Education and Risk Reduction services. Second, WSCHS' Part D grantee coordinator is a member of the Planning Council and its Planning and Priorities Committee. Staff from state and local agencies administering programs such as WIC and substance use treatment programs also sit on the Planning Council or participate on its committees. Finally, providers of services for women and children also contributed to the 2006 Statewide Coordinated Statement of Need.

Other State & Local Social Service Programs – Other social service programs are considered during the planning and priority setting process in ways similar to those described above. The Minnesota DHS HIV/AIDS program is situated in the department's Disabilities Services Division. The DHS HIV/AIDS director apprises the Council of other state funded programs for persons with disabilities such as Minnesota's "Pathways to Employment" program and the state's Medicaid waiver community support programs. Administrators of other state and local support programs, such as Economic Assistance, participate in the Planning Council and its committees as well as in formulating the Statewide Coordinated Statement of Need.

Federal, State and Local Funds for Substance Abuse and Mental Health Treatment Services – The DHS also administers substance use services and provides key information for the Council about how substance use treatment services are funded and utilization of mental health services by PLWH/A who are enrolled in Medicaid and other publicly funded health care programs. In keeping with the goals of the 2006–2008 Comprehensive Plan, the Planning Council and grantee conducted a mental health and substance use treatment systems assessment in FY2007. In general, treatment on demand is available for persons living with HIV, especially those who are low-income. Treatment services are paid for either through the State's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant or through a client's health insurance. Thus, the Council chose to not allocate funds to directly support substance use treatment services in 2007 and 2008. The Council's FY 2009 allocations plan includes Part B funding to develop the capacity of chemical dependency treatment programs that receive public funding to deliver HIV competent services.

Several steps have been taken to avoid duplication of services and ensure that a continuum of care exists for PLWH/A who are substance users. First, as mentioned above, DHS oversees all substance use treatment services and staff participates in the planning, priority setting and allocations processes. Secondly, the DHS regularly conducts training for case managers that focuses on how to help clients access Minnesota's Rule 25 chemical assessment and treatment placement process and available substance use treatment options for PLWH/A. Beginning in

FY2007, Part A funds supported a medical case manager, certified to conduct Rule 25 assessments, at the TGA's largest HIV specialty clinic.

Other Ryan White Funding – Representatives from all Parts of the Ryan White HIV/AIDS Treatment Modernization Act participate in HIV services planning, as well as share information to ensure coordination of federal dollars. The Government HIV Administration Team (GHAT) – Hennepin County Human Services and Public Health Department (Part A grantee), Minnesota Department of Human Services (Part B grantee) and Minnesota Department of Health (CDC Prevention grantee) – meets bimonthly to coordinate budgets and spending and to plan for the most efficient disbursement of federal and state dollars. A periodic All-Parts meeting is hosted by the Department of Human Services (DHS) and attended by representatives from all parts of the Ryan White Act, including Part F. Minnesota has two Part C programs, Hennepin County Medical Center (HCMC) and the Rural AIDS Action Network, and one Part D program, West Side Community Health Services. Part F is represented by the Minnesota AIDS Education and Training Center at the University of Minnesota, and a dental reimbursement program at HCMC.

The Part A and B grantees work together with the Minnesota HIV Services Planning Council to support a joint Part A and Part B prioritization and allocation process. The Part A Intergovernmental Agreement established the Planning Council as joint Part A and Part B planning body in 1995. This close relationship ensures that Part A and B base funds are allocated efficiently and effectively, and those resources are maximized for Primary Care, Medical Case Management, drug assistance, insurance continuation and other health care and supportive services. This joint planning process has worked well since the Minneapolis-St. Paul TGA has always been the epicenter of Minnesota's HIV/AIDS epidemic with 87% of the state's PLWH/A residing in the TGA. Furthermore, many PLWH/A in greater Minnesota travel to the major HIV specialty clinics in the TGA for their primary medical care. Some services prioritized by the Planning Council are not allocated either Part A or Part B base dollars because funding for those services is available through other programs, such as State HIV insurance reimbursement and drug reimbursement. For example, ADAP and rebate funds support drug coverage and cost effective HIV insurance continuation.

The Part B grantee also administers $1.2 million in state HIV case management funds. In August 2008, the Part A and B grantee managers formalized a set of principals to ensure coordinated administration of Part A, B and state appropriations for HIV services. The "Principles of Coordinated Government Administration of HIV Service Delivery" serve as a framework for administrative decision-making to ensure that service procurement and contract administration are well coordinated and efficient and reimbursement methods for service delivery are uniform across providers regardless of which government agency manages contracts. The "Principles" are also designed to prevent duplication of state and local funding of HIV services and promote the development of uniform standards and sub-recipient monitoring procedures.

Both the Part A Minority AIDS Initiative (MAI) and the Part B ADAP MAI are incorporated into the Planning Council's prioritization and allocations process and were prioritized by the Council just prior to passage of the new Ryan White HIV/AIDS Treatment Modernization Act. The portion of Part A MAI funds allocated to outreach services and ADAP MAI funds are used to connect African American and African-born PLWHA who know their status to care. To assure coordination of MAI outreach funding, the Part B grantee passes its ADAP MAI funds through the Part A grantee which are then disbursed through a contract with a single provider, the African American AIDS Task Force (AAATF). The AAATF also receives Part A MAI

funding for Medical Case Management as well as Part B funds for Medical Transportation, which are also passed through the Part A grantee to ensure efficient administration of funds. The remainder of Part A MAI funds support a Culturally Appropriate Primary Care program that targets Latinos.

Further coordination with other Ryan White programs is demonstrated by the involvement of the Part C and D grantees with planning and quality management activities. Part C supports a collaborative effort between Hennepin County Medical Center in Minneapolis and Health Partners Specialty Clinics in St. Paul. Representatives from the Part C program sit on both the Planning Council and the grantee's Quality Management Advisory Committee (QMAC). In addition, West Side Community Health Services receives Part D funding. Also a current Part A contractor, West Side has been a voice for the needs of Latinos living with HIV. A representative from West Side also sits on the Council and QMAC. Finally, a representative from the Rural AIDS Action Network, a Part C grantee that serves non-urban counties of the TGA and Greater Minnesota, sits on the QMAC. The Planning Council regularly considers the TGA's Part C and D resources in allocating funds to prioritized services as the Council's Part C and D representatives share information about their program activities and funding levels.

The coordinator of the Midwest AIDS Training and Education Center (MATEC) is a member of the QMAC and participates in the All-Parts meetings. The MATEC coordinator has also been working with the Part A and Part B grantees on a consumer health literacy project that was piloted with funds carried forward in 2005. Both Part A and Part B grantees send representatives to the regional AIDS Training and Education Center Policy Training and Advisory Council held annually in Chicago.

1.d. Assessment of Emerging Populations with Special Needs – The epidemic in Minnesota is driven by sexual exposure, primarily among men who have sex with men (MSM), who represented the largest percent of those living with HIV/AIDS (57%) and new cases (42%) in 2007. Among females, heterosexual contact is estimated to account for 55% of new HIV infections diagnosed in 2007. New cases among Latino males increased from 12 in 1990 to 112 for 2004-2007, with 33 new infections in 2007 alone.

The HIV epidemic in Minnesota affects racial and ethnic minorities disproportionately, especially African Americans, who are over-represented in every risk group. Additionally, the emerging epidemic among African-born persons continues to increase at a rapid rate. The changing epidemic, in combination with the significant presence of comorbidities and reductions in public funding for health care services, exacerbates the needs of the following six populations: men who have sex with men (MSM [including MSM/IDU]), men of color who have sex with men (MCSM), women of color, African Americans, Latinos and African-born immigrants. Service delivery challenges exist for all of these populations. The following table provides estimates of these six populations in the TGA along with HIV and AIDS prevalence:

2007 EMERGING POPULATIONS WITH SPECIAL NEEDS ESTIMATES FOR MPLS-ST.PAUL TGA Source: Minnesota Dept. of Health				
Population with special needs.	Estimated # of persons in TGA	Estimated # of persons living with AIDS	Estimated # of persons living with HIV (not AIDS)	Estimated # of persons living with HIV (including AIDS)
*Men who have sex with men (includes MSM/IDU) by age:	51,477[#]			
13 – 24 years		3	70	73
25 – 49 years		910	1,202	2,112
50 years and older		396	375	771
*Men of color who have sex with men (includes MSM/IDU)	7,379	373	396	769
Women of color (≥ 13 years)	738,261	353	524	877
*Latinos/Latinas	117,730	210	189	399
*African Americans	209,989	529	676	1,205
*African-born Immigrants	35,000 – 50,000	308	384	692
*These groups are not unduplicated in this table.				
3,208,212 MN/WI State Demographer Estimates of TGA Population (2007).				
#Estimates for population size not available				

This narrative addresses unique challenges that each population presents to the service delivery system, service gaps, and estimated costs associated with delivering services to each of these populations. Data sources used to estimate the costs of services for emerging populations with special needs include: 2007 client level service utilization data; 2007 HIV/AIDS prevalence data (Minnesota Department of Health HIV/AIDS Reporting System, Wisconsin Department of Health Services); and fiscal year 2007 Part A and Part B base (not ADAP) expenditures on medical and support services.

Men Who Have Sex with Men (MSM) – The number of people living with HIV in this group has increased to now represent fully 52% of all PLWH/A in the TGA. Access, cost, and attitude barriers were the top reasons identified by MSM for not accessing services in a 2003 Needs Assessment study performed for the TGA by Calabash: Learning, Evaluation and Research. These barriers range from not knowing where to go for help, to transportation problems, to not having insurance. Those who are not open about their same-sex activities or do not identify as gay or bisexual are difficult to reach. Young MSM, particularly those who are homeless, engage in sex work or heavy drug use, are often difficult to bring into the service delivery system. Reflecting the national trend, new infections among young men in Minnesota are increasing. Over the past four years the annual number of new infections among young men increased steadily from 18 cases in 2002 to 38 cases in 2007, a more than 111% increase. Further, the

recent increase in syphilis cases in Minnesota among HIV-infected MSM indicates a need for continued health education and risk reduction interventions.

In the 2006 Consumer Needs Assessment Survey (CNAS), MSM reported that they needed but did not receive an average of 1.6 services in the six months prior to the survey. The 2003 Needs Assessment also highlights service delivery challenges unique to MSM. They were less likely to have used case management services; more likely to have multiple sex partners in the past year, and more likely to have exchanged money or drugs for sex. Client level data from 2007 show that only 43% of those receiving Medical Case Management services were MSM, significantly below their representation in the epidemic. Thirty-seven percent report having been homeless at one time and 63% identified barriers to affordable housing with 48% identifying paying for housing as a problem. Twenty-nine percent report difficulty obtaining food by the end of each month. Seventy-seven percent indicate that their HIV has affected their ability to work. Poverty has had a dramatic impact on MSM living with HIV/AIDS, who reported living on an average monthly income of $940. In addition, 20% were uninsured and 46% experienced access to care barriers due to the cost of health care. This population most often cited transportation as a barrier to medical care. Service gaps exist for this population in affordable housing, transportation, substance abuse treatment, health insurance, employment, and transmission prevention services.

Ryan White utilization data show a total of 1,374 MSM and MSM/IDU of all races in the TGA that used funded services in 2007 (41% of MSM living with HIV/AIDS in the TGA). While 57% of the PLWH/A in the TGA are MSM, only 41% of those who utilized Part A and B funded services were MSM. Although the TGA has a smaller ratio of MSM who are Intravenous Drug Users than the national average, it is of concern that the number of MSM/IDU who are out of care continued to be unacceptably high in 2007 at 54% of those in the eHARS dataset. Unmet need demographic data indicate that up to 42% of MSM (including MSM/IDU) of all races may be out of care.

Using service utilization data from the TGA's Client Level Reporting System and Part A and Part B end of year expenditure reports, the estimated cost of providing Part A and B base (not including ADAP) funded services to all MSM living with HIV/AIDS (White men and men of color) in 2007 was $2,453,500. The estimated cost for Part A funded services alone was $1,681,000.

Men of Color Who Have Sex With Men (MCSM) – MCSM make up a growing proportion of new HIV infections among MSM in the TGA. From 2006 through 2007, 27% of PLWH/A were non-white MSM. MSM of color are disproportionately represented when taking race-specific population size into account. African American males only comprised four percent of the State's male population in 2000. In 2007, 22% of the 325 new male cases were African American; of these 69% were identified as MSM. Similarly Hispanic males make up three percent of the male population yet 13% of the 325 new male cases; of these 88% were identified as MSM. This disproportional impact is even greater among young (13–24 years of age) MSM. Men of color account for 59% of cases among young MSM compared to 21% among adult MSM. Especially impacted are African American and Hispanic males, with young men accounting for 17% and 32% of MSM cases, respectively.

As noted in the MDH 2007 Epidemiological profile, race is not considered a biological reason for disparities in the occurrence of HIV experienced by persons of color. Race, however, can be considered a marker for other personal and social characteristics that put a person at greater risk for HIV exposure. These characteristics may include lower socioeconomic status,

less education, stigma of same-gender sexual behavior, less access to culturally and linguistically appropriate services and greater prevalence of drug use. There are great disparities in income between Whites and communities of color. While the per-capita income for Whites in Minnesota is $34,353, it is about half that ($17,126) for people of color. The disparity is even greater in the TGA.

In the Consumer Needs Assessment Survey (2006), non-White MSM were more likely than White MSM to report needing but not getting case management in the six months before the survey. The average number of services needed, but not received, among non-White MSM came to 2.3 compared to 1.5 for survey respondents overall who identified one or more services needed but not received. In the 2003 Needs Assessment, MCSM identified housing as a major issue with 79% acknowledging they faced barriers to affordable housing. Only 25% had a housing subsidy, 65% had been homeless at some time, and 44% constantly faced difficulty in paying for housing. This study reported that the average income for this group is lower than MSM in general at $785 per month. Forty-five percent had an AIDS diagnosis. Fifty percent of MCSM interviewed described knowledge and attitude barriers that discouraged them from entering services. Instability of health insurance can also affect ability for MCSM to access and remain in care. Ninety percent indicated they currently had insurance, however, 32% indicated problems with eligibility, and one-third of them had lost their insurance since their diagnosis. MCSM comprised 28% of the 242 PLWH/A in the study who identified provider issues as a barrier to services, citing not feeling like the provider understood what they needed.

There are national data to support concern about increasing rates of HIV infection among gay and bisexual African Americans. Nine out of ten HIV-positive African Americans in a study released by the CDC in June 2005 were unaware of their HIV status. Four culturally specific community-based organizations in the TGA that provide HIV services reported serving a combined total of only 135 MSM, including IDU, in 2007. Given their representation in the epidemic, these low numbers may be indicative of the strong stigma toward same-gender sexual behavior that persists in communities of color, which may be a significant barrier to care. Service gaps that exist for MCSM include: affordable housing; maintaining access to health insurance, health education and risk reduction; culturally appropriate substance abuse services; and mental health services.

As mentioned above, the estimated cost of providing Part A and B services to all MSM living with HIV/AIDS (White men and men of color) in 2007 was $2,453,500. Since 26% of the TGA's MSM living with HIV are men of color, a rough estimate of the cost of Part A and Part B base funded services for this population in 2007 was $961,900. The estimated cost for Part A funded services alone was $730,200.

Women of Color – The number and proportion of cases of HIV/AIDS among females in Minnesota continues to increase. In 2007 there were 1,181 women living with HIV/AIDS, with 98% aged 13 or older. Seventy-five percent (75%) were women of color. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. In the beginning of the epidemic, white women accounted for a majority of newly diagnosed cases among females. Since 1991, the number of new infections among women of color has exceeded the number among white women. In 2007, women of color accounted for 74 % of new infections among females, with African American and African born women accounting for over 50 % of those infections. The number of new infections among White women had decreased to a low of eight in 2003, however since that date the number of cases has increased steadily to 20 cases in 2007. Since 2000, the annual number of new infections diagnosed among African American

females had been stable at around 20 cases per year and 17 new cases were diagnosed in 2007. Cases among African-born females have risen sharply, from three cases in 1996 to a high of 41 cases in 2002. However since 2002, the number of new HIV infections began to steadily decline, with 24 cases reported in 2007. The annual number of new infections diagnosed among Hispanic, American Indian, and Asian females continues to be quite small. Between 2003 and 2007 the number of births to HIV-positive women in Minnesota increased from 47 to 61, a 30% increase. During that same time period the rate of perinatal transmission was 1.2 percent, the expected rate of transmission when both mother and child receive preventive antiretroviral treatment. Only six cases of pediatric HIV infection have been diagnosed between 2003 and 2007. While it is fortunate that the rate of perinatal transmission has remained low in the state, the growth in births to HIV positive women suggests a need for health education and risk reduction in this population.

One of the most significant changes in Minnesota is the rapid increase in the number and proportion of women born in Africa now living in and diagnosed with HIV in Minnesota. In 2007, 30% (404) of women living with HIV/AIDS in Minnesota were African born, and of those, 94% identified heterosexual contact as the mode of exposure. Another 30% (416) of female PLWH/A were African American, while 28% were white. Women of color continue to be disproportionately affected by HIV/AIDS in Minnesota. For persons for whom English is a second language and who are dealing with cultural differences, it can be complicated to access most social services, including those specific to HIV/AIDS, without a case manager. Especially for African-born women, there exists a great deal of shame and stigma associated with an HIV diagnosis. African-born women face cultural expectations about having children and may be looked down upon if they do not. This type of stigma may be higher among African-born than other ethnic groups in the community. Because of inadequate knowledge, and the fear that they may not have children if they are known to be HIV-infected, African-born women may be reluctant to get tested for HIV until after they become pregnant. Although interventions to prevent transmission of HIV from the mother to the infant are highly accepted and highly effective, learning of one's HIV status during pregnancy is often particularly difficult. Many women struggle with disclosure to sexual partners for fear of abandonment or violence. Without community support, these women are especially vulnerable and have significant needs for culturally, linguistically and gender appropriate services.

The special needs of women reflect the issues that make their access to HIV care difficult. For example, because women are likely to be primary caregivers of children and other family members also infected with HIV, services that provide care for children or family members while these women access HIV/AIDS care are essential. Additionally, foreign-born women may avoid accessing HIV services due to fears that immigration authorities may remove their children from them because of their HIV status. Legal services that help women with immigration and plan for guardianship of children are also important.

While the 2006 Consumer Needs Assessment Survey (CNAS) found that compared to men, women were significantly more likely to be enrolled in one of Minnesota's publicly funded health insurance programs, 38% of those program recipients were paying more for co-payments, deductibles, and cost shares. An analysis of needs specific to childbearing women was compiled from the 2003 Needs Assessment. Out of the 57 women who were 18-44 years of age, 71% were women of color; 44% being African American and African-born. The average monthly income for this group was $786, substantially below the median of all those surveyed. Significantly, of

the women interviewed with an AIDS diagnosis, 40% said that they received their AIDS diagnosis at the time of or within one year of testing positive for HIV.

These women were more likely to have tested for HIV because of illness, pregnancy or a sex partner that was ill; to report that there were two or more days in the past 30 days where they had nothing to eat; and more likely to report that people were no longer supportive once they learned of their HIV status. They were less likely to report that they have an HIV physician and to be currently taking antiretroviral medication. In addition, 61% reported having been homeless in the past and 32% indicated that their HIV has made it more difficult to find housing. Also in the 2003 Needs Assessment, 72% of women interviewed believed sex abuse played a role in their becoming HIV positive and 46% believed substance use played a role in becoming HIV positive.

Affordable housing and lack of child care ranked the highest as service gaps for women. In addition, there is a lack of domestic violence programs for HIV positive women. Women identified system barriers such as waiting lists for services, being told to call another place or someone else for help, and finding their way through a complex system. Other major barriers were not knowing where the services were located, confidentiality concerns, uncertainty about how they would be treated, lacking transportation or too great a distance to travel.

Based on an unduplicated total of 913 women utilizing Ryan White services in the TGA, 75% of which are projected to be women of color, the estimated cost of providing Part A and B base funded services to women of color in 2007 was $815,700 The estimated cost for Part A funded services alone was $619,200.

Latinos– The Latino population in the 11 Minnesota counties in the TGA grew from 99,740 in 2000 to 139,539 in 2006—a 40% increase. It is also a young population with 47% between 20 and 44 years of age, compared to 36% of the general population being in this age bracket. Among all the racial and ethnic groups in the U.S., Latinos experience a very high poverty rate (20.6%), and low education levels, with 43% of adults lacking high school diplomas. Thirty-eight percent of adults are not able to speak English well. Accompanying these socioeconomic issues is persistent, often increasingly poor access to health services, poorer health status and poorer health outcomes as compared to other groups. An estimated 32% of Latino adults currently do not have health insurance in Hennepin County, according to the *Survey of the Health of Adults, the Population and the Environment* (SHAPE) conducted in 2006. Beginning in 2003, undocumented immigrants, many of whom were born in Latin American countries, were no longer eligible for publicly funded health programs in Minnesota. Only 62% of Latino adults report they usually go to a doctor's office or clinic when they are sick, as compared to 85% for all Hennepin County adults. Almost one-fourth of Latino adults who needed medical care delayed or did not receive the medical care they needed in the previous 12 month period because of lack of insurance, cost, or dislike or distrust of medical providers. Not seeking help for mental health issues was reported by more than one fourth of Latino adults as compared to 19% for all adults in the county. Almost half (48%) of those in need of mental health care delayed or did not seek care, primarily due to lack of insurance or cost, being unaware of where to get services, or dislike or distrust of service providers.

Surveillance data from 2007 indicate 402 Latinos were living with HIV/AIDS in the TGA. This represents eight percent of the total prevalence, and a 9.6% increase over the previous reporting period. Forty-seven new AIDS cases were diagnosed among Latinos in 2006-2007 in the TGA. In the 2006 CNAS, 35 of 379 HIV-infected respondents identified themselves as Latino. Of these 26% were homeless, 31% were unemployed, and 51% had been diagnosed with AIDS. As this community is disproportionately affected by poverty, lack of community

resources, and cultural and language barriers, the HIV continuum of care must be responsive to the complex set of needs faced by Latinos. Health insurance, understanding where health care and support services are located, affordable housing, accessible transportation, and language-appropriate services are essential HIV/AIDS services for Latinos.

The estimated cost of providing Part A and Part B base funded services for Latinos living with HIV in 2007 was $472,800. The estimated cost for Part A funded services alone was $358,900.

African Americans—United States health disparities for African Americans living with HIV continue to be out of proportion with their numbers in the overall population. The CDC shows HIV-related disease as the leading cause of death among African American women ages 25-44. There is a direct relationship between higher AIDS rates and lower income levels, as almost one in four African-Americans lives in poverty. The 2005 U.S.Census Estimate shows that African Americans are the second largest racial or ethnic group (behind whites) in Minnesota, comprising four percent of the total population. U.S.-born African Americans account for 19% of men and 30% of women living with HIV/AIDS in Minnesota, a disturbing disparity when compared to their representation in the general population.

The MDH reports that in 2007, 22% of new HIV infections were among US-born African Americans. African American PLWH/A are younger than the general population of PLWH/A. MSM accounted for 67% of new infections among African American males from 2004 to 2006. African American women represent 31% of women living with HIV/AIDS in Minnesota.

The 2003 Needs Assessment interviewed 92 U.S.-born African Americans. Seventy-six percent had experienced being homeless and 77% indicated barriers to affordable housing. Eighty-five percent had talked with a doctor about antiretroviral medications, 70% were recommended to be on medications and only 49% were on antiretroviral medications. Forty percent had transportation barriers and 19% indicated financial issues as barriers to getting or maintaining HIV medical care. Transportation and mental health rated high as needs that were not met.

In 2007, 76% of the TGA's US-born African Americans living with HIV utilized Ryan White services. Some service gaps identified for African Americans include information about HIV services, health education and risk reduction services, and transportation. The ever-widening poverty gap for African Americans cannot be ignored in the TGA.

Based on service utilization and expenditure data, the estimated cost of providing Part A and B base funded services to African Americans in 2007 was $1,129,100. The estimated cost for Part A funded services alone was $857,200.

African born Refugees/Immigrants –The 2005 American Community Survey estimates that there are 50,000 African-born persons living in Minnesota. However, many believe this to be an underestimate of the true African population in Minnesota, with some community members estimating that number at close to 100,000. The state demographer estimates that there were 63,612 African-born residents of Minnesota in 2006. Minnesota's African immigrants come from more than 25 countries, primarily Somalia and Ethiopia. The SHAPE 2006 study reported about one in five African born immigrants speak English "less than well," compared to 3.2% of all adults in Hennepin county. Nearly 20% of African born people who are 25 years of age and older have not completed high school, compared to 9.4% of their counterparts. Nearly 10% were uninsured for the entire year preceding the study compared to 3.4% of all adults in the county. Of African born individuals needing medical care, 20% reported that there was a time in the previous 12 months when they needed medical care but delayed or did not get the care they

needed. Cost or not having health insurance were the most common reasons. Other reasons noted were: family responsibilities; transportation issues; couldn't get an appointment; don't like, trust, or believe in doctors; had bad experiences; being afraid, scared, worried or embarrassed about accessing medical care. Sixty percent of African born reported that they had worried "often" that food would run out before they have enough money to buy more. This compares to 2.4% of all adults in the county. In addition, African born were approximately three times more likely than all adults to report they missed a mortgage or rent payment because they did not have enough money.

The total cases of HIV/AIDS among African born in the TGA for 2007 is 692. Of new HIV infections diagnosed in 2007, African born persons accounted for 14% of cases, but represented less than one percent of the state's population. African born women had the third highest new infection rate among other female groups, 18 out of 90 cases in 2005-2007. African born men and women share an almost equal distribution of cases.

Compared to the general population of PLWH/A in the TGA, African born persons are underrepresented in Ryan White Part A and B funded services. Ryan White services were provided to 344 of 751 (46%) of African born persons in MDH surveillance data in 2007. By comparison 63% of the TGA's PLWH/A who know their status utilized Ryan White funded services in 2007.

The Twin Cities TGA was one of three sites selected by HRSA under Special Projects of National Significance (SPNS) to study why Africans are not in care or services. The study's final report in 2006 said that African PLWH/A who were in care knew about medical services, case management, housing, and food services but needed more information on other services available. African PLWH/A who were out of care or newly diagnosed were not aware of services other than medical care and said they had "too many issues to deal with" to get into services. All service providers identified the lack of coordinated entry into the HIV continuum of care from refugee resettlement agencies as a barrier. Understanding eligibility requirements for services is also a barrier. African PLWH/A identified lack of transportation and employment as their most critical needs. Accessibility, defined as transportation, flexible clinic hours and appointments were identified as needs by all Africans interviewed. Cultural competency issues identified by Africans in care were lack of interpreters, lack of employment assistance and need for more patience from service providers. Africans out of care were concerned about privacy, life after diagnosis, discrimination, provider communication styles and gender and ethnicity of service providers. Many did not understand the purpose of support groups. Africans in care wanted more information on medications, HIV and services. Those out of care or newly diagnosed wanted more information on HIV and life after diagnosis and understanding of the qualifications of service providers.

Based on expenditure and service utilization data, the estimated cost of providing Part A and Part B funded services for Africans living with HIV in 2007 was $119,400. The estimated cost for Part A funded services alone was $99,400.

Costs of Addressing Unmet Need Among Emerging Populations -Demographic information from the unmet need estimate along with service utilization and Part A and Part B base expenditures in FY 2007 can provide an estimate of the costs of providing care to those out of care from populations with emerging needs: The following table provides these cost estimates:

Population with Special Needs	Unmet Need Estimate (# out of care)	Percentage of Population Utilizing Services in 2007	Expected to Utilize Part A & B base Funded Services	Estimated Annual Cost of Providing Services for those Out of Care
MSM/MSM IDU - All	1,235	54%	669	$984,028
Women of Color	246	75%	184	$270,631
Latinos	144	95%	138	$202,176
Black/African American (U.S. born)	444	76%	335	$493,007
Black/African-born	179	45%	81	$119,424

The average per client cost of Ryan White Part A and B base funded services in fiscal year 2007 was $1,470. The number expected to utilize services is the unmet need estimate multiplied by the proportion of the population with special needs living with HIV in the TGA that utilized Part A and Part B base funded services in FY 2007.

1.e. Unique Service Delivery Challenges

The demographics of the epidemic in the TGA present a significant challenge in successfully engaging people living with HIV in care earlier. People living with HIV born outside the U.S. are more likely to test late. By December 31, 2007, 19% of those living with HIV in the TGA were born outside the U.S. In 2007, 38% of foreign-born cases progressed to AIDS within a year of diagnosis compared to 29% of U.S. born cases. Some consumers from within these groups who do access care lack the knowledge and confidence to navigate the system of HIV care and support services effectively. As a starting point to address these needs, in 2007 the Part A grantee co-produced, with Twin Cities Public Television (TPT), a program that was broadcast in Spanish with English subtitles. Members of the local Latino consumer and healthcare communities interacted with each other, two members of the Minnesota Legislature, and two national leaders in HIV care for Latinos, with an emphasis on addressing stigma and empowering Spanish-speaking consumers to advocate for their own HIV health care needs. The program was broadcast on two occasions, and copied to DVD, with more than 800 copies to date distributed as educational resources to consumers and providers in the TGA.

The success of this approach to health education for underserved communities underscores the need to continue and expand this partnership in order to address stigma and promote health literacy in reaching African-American and African-born PLWH/A, two groups within the TGA who face considerable cultural and linguistic barriers to accessing HIV medical care. In late FY2007 and early FY2008, the grantee used $66,000 in carryover funds to again partner with TPT to produce two additional programs and related DVDs to address stigma, access to care needs and health literacy deficits in the two targeted populations.

Increasing costs of care along with increasing socio-economic stress on low income PLWH/A creates a significant challenge in maintaining the TGA's comprehensive continuum of care. While Ryan White funds in many states are primarily used to pay for primary medical care for people living with HIV/AIDS, Minnesota has historically been fortunate to provide extensive access to health care through state and federally funded programs such as Medicaid, Minnesota Care and a high risk insurance pool. Additionally, several clinics and hospitals throughout

Minnesota have had a tradition of providing extensive charitable care for HIV/AIDS. This has reduced the need to use Ryan White Part A and B funds to support primary medical care, and allowed the dollars to be used to create a comprehensive system of support services. Because of the high rate of clients in the service system who are able to access health care-related services through their health insurance, the number of clients served through these types of Ryan White Act funded programs has historically been rather low. However, Minnesota's system of health care access is changing. Rising health care costs and reductions in public spending on health care for the poor add significantly to the challenge of providing a continuum of services for people living with HIV and decreasing unmet need. Cuts in funding for Minnesota Health Care Programs beginning in 2003 along with tighter eligibility restrictions and higher out-of-pocket costs continue to increase the burden on Ryan White funded services. When it became apparent, in 2004, that Minnesota's ADAP award, along with a $1.15 million state appropriation for the HIV Insurance Program, would no longer provide sufficient revenue to purchase medications and insurance premiums for all eligible ADAP and insurance program recipients in the state, the Minnesota Department of Human Services (DHS), the Part B grantee, implemented cost-sharing measures for ADAP recipients whose incomes fell between 100% and 300% of federal poverty level. Although the cost-sharing requirement was suspended in December 2007 due to an increase in Minnesota's ADAP award, the Part B grantee's latest ADAP forecast indicates that another shortfall may occur in FY 2010 or 2011. In addition, the State cut the $2.4 million in state appropriations for the HIV Insurance Program and Medical Case Management in FY 2009 due to a budget deficit and will use rebate funds to fill the funding gap.

In the past two years the number of clients seen by the Part A funded Primary Care programs increased by over 200%, from 144 clients in 2004 to 418 clients in 2006, and leveled off at 363 in 2007. Due to the rise in health care costs, including the imposition of cost-sharing for ADAP and the Medicare Part D "doughnut hole" for recipients whose incomes are too high to qualify for extra help, PLWH/A in the TGA more frequently face prohibitive out-of-pocket costs and hospitals and clinics are cutting back on the amount of charitable care provided. In response to the increasing cost barriers to care, the Minnesota HIV Services Planning Council increased Part A allocations to core medical services by 89% from 2004 to 2007. Compounding the challenge created by increasing costs of medical care, many of the services funded by Part A in the TGA that help bring people into or maintain primary health care, such as Outreach and Medical Case Management, are not reimbursable through private or public insurance programs. To eliminate waiting lists at two Medical Case Management (MCM) providers, the Part A allocation for MCM increased from $1,039,500 in 2006 to $1,421,900 in 2008.

These economic phenomena along with a harder-to-serve population of PLWH/A are increasing the cost of HIV service provision. Part A funds are increasingly needed to provide quality care for those struggling with multiple diagnoses and difficult socioeconomic circumstances. Recent consumer needs assessments conducted in 2005 and 2006 together with increased utilization of Part A funded support services indicate that more PLWH/A are faced with the choice between paying for medical care or meeting basic needs. Part A allocations to support services such as Food Shelf, Home Delivered Meals, Emergency Financial and Housing Assistance and Medical Transportation are essential to maintaining access to medical care by mitigating economic barriers. In 2007, among Ryan White funded supportive service categories, Transportation was the most utilized, with 1,306 clients (39% of total Ryan White clients) accessing transportation services. Food & Nutrition was the next most utilized service with 1,047

clients (31% of total clients). The next most used support services were Emergency Financial Assistance and Health Insurance Assistance, with 757 and 581 clients, respectively.

1.f. Impact of a Decline in Ryan White Formula Funding

The Minneapolis-St. Paul TGA did not experience a decline in Ryan White formula funding in Fiscal Year 2008. Formula funding increased from $2,963,378 in FY 2007 to $3,073,368 in FY 2008. Between fiscal years 2006 and 2007, the TGA's total Part A award increased by 48%.

1.g. Unmet Need

Unmet Need Estimate: The unmet need estimate for Minnesota, using the Framework developed by HRSA and the University of California, San Francisco, and revised in September 2008 is presented in **Attachment 6**.

Estimation Methods - Population estimates for PLWH/A were computed using MDH eHARS data for the Minneapolis-St. Paul TGA. HIV infection (non-AIDS) is a reportable condition in Minnesota and the estimates reflect those living with HIV (non-AIDS) and those living with AIDS who know their status. Two counties in the TGA are in Wisconsin (Pierce and St.Croix); while they are not calculated with the Minnesota data in the Unmet Need Framework, their data are reported in this narrative. Epidemiological data from Wisconsin show 27 individuals living with AIDS and 25 living with HIV(non-AIDS). These 52 individuals represent just one percent of the total estimated population for PLWH/A in the TGA. The 2007 Wisconsin Part B Unmet Need Estimate showed a total unmet need of 44.2%, which when applied to the 52 individuals in the Wisconsin counties of the TGA adds 23 individuals to the total of 1,800 HIV+/aware not receiving primary medical care services. Utilization data show that five individuals from the two Wisconsin counties of the TGA (just under 10% of the epidemic reported in those counties) accessed Ryan White funded services in 2007, but no Primary Medical Care services were accessed by them. It is not known how many of the residents living with HIV within the TGA's two Wisconsin counties meet eligibility requirements for Ryan White services.

Reporting rules in Minnesota do not explicitly require labs to report viral loads and CD4 counts to MDH every time these tests are performed. Despite this barrier, MDH receives regular updates of viral loads and CD4 counts from most clinical systems. However, one major medical center – Hennepin County Medical Center (HCMC), which provided medical care to 1,230 patients in 2007, representing 24% of Minnesotans living with HIV - does not report these values on a regular basis. HCMC does provide MDH with an aggregate number of patients receiving CD4 and/or viral load tests in the calendar year along with some demographic information. While this doesn't provide as accurate an estimate as it would if HCMC patient CD4 and viral load tests were reported to eHARS, it does allow for a good estimate of the number of PLWH/A "in-care," or those with "met" need who were patients at HCMC. Limitations to data obtained by this method are that they are aggregate numbers, not a list of individual names, so are not "de-duplicated" from eHARS records. It is possible that some individuals are listed in eHARS for a different primary care clinic. No residence information is provided, so it is unknown how many individuals reside in the Minneapolis-St. Paul TGA vs. greater Minnesota. However, utilization data for HCMC show that 663 individuals accessing care identified living in a TGA county (81%). We cannot determine how many are living with AIDS vs. HIV/non-AIDS, which is a requirement for the unmet need calculation.

The above limitations are addressed by using aggregate clinic data to supplement eHARS data. These cases are not counted where a non-reporting clinic is listed as the primary care clinic,

even when a CD4 or viral load was reported in 2007. Because they are included in the aggregate numbers provided by the clinics, they are thus not counted twice. However, eHARS data that are provided by these clinics are used to estimate the percentage of individuals who reside in the TGA and those who have AIDS vs. HIV/non-AIDS. Thus by applying the above percentages to the aggregate numbers provided by HCMC, unmet need is calculated for both reporting and non-reporting clinics. See the Unmet Need Framework **in Attachment 6.**

Minnesota's Part A, B, C, and D grantees rely on the MDH for Minnesota's unmet need estimates. The Part A and B grantees work closely with MDH to improve this methodology. The Part C-funded clinics in the TGA, HCMC in Minneapolis and HealthPartners in St. Paul, report CD4 counts and viral loads to MDH either through eHARS or through aggregate clinic data for the specified recent time period. The TGA's Part D funded clinic, West Side Community Health Services, reports CD4 counts and viral loads through eHARS.

Assessment of unmet need - Demographic information on those in care is available, although incomplete. The eHARS data and aggregate patient data from HCMC include information on gender. The available demographic information on those in care during the specified time period are summarized below:

Demographic Characteristics of PLWH/A In-care, Mpls-St.Paul TGA January 1 – December 31, 2007 (Source: Minnesota Dept. of Health)			
Race/Ethnicity and Gender *	**In-care (AIDS & HIV not AIDS)**	**Surveillance Total (AIDS & HIV not AIDS)**	**% Out of Care**
White	1,687	2,719	38
Black – U.S. Born	761	1,205	37
Black - African Born	513	692	26
Hispanic/Latino	255	399	36
American Indian	45	83	46
Asian	45	67	23
Multiple/Unknown	--	--	
TOTAL	**3,396**	**5,196**	**35**
Male	2,547	4,022	37
Female	846	1,174	28
TOTAL	**3,396**	**5,196**	**35**

* Does not include individuals of multiple races or unknown race.

The demographic data indicate the following:

- American Indians, as a group, were the least likely to be in care (46% out of care), having greater unmet need compared to the population of those in the TGA who know their status.
- The proportions of Whites, African Americans, and Latinos out of care in 2007, were similar ; 38%, 37% and 36% respectively.
- African-born blacks and Asians may be more likely to be in care compared to the overall population of those who know their status, but still had 26% and 23% respectively out of care in 2007.

- For new HIV cases in 2007, 38% of foreign-born individuals who tested positive were diagnosed with AIDS within one year of testing.
- Women, compared to men, may be more likely to be in care.
- Limited information on exposure category among those who know their status and are not in care indicate that men who have sex with men (MSM) and MSM who report injection drug use may be less likely to be in care (54%) compared to the overall population of those who know their status (65%).

Clients of Minnesota agencies receiving Ryan White funds were recruited to participate in a Part A-funded survey during April and May, 2006 with a focus on utilization and financing of HIV services. Surveys were completed by 379 respondents spread across 13 agencies (42% clinical and 58% non-clinical). The instrument focused on indicators of access and unmet need, including public or commercial insurance coverage, sources and frequency of HIV medical care, sources of dental care, patterns of use of HIV medications, whether medical care or essentials of living were foregone due to inability to pay both, and what specific service types were needed but not received. The data from this needs assessment indicate the following regarding unmet need: 1.) Thirteen percent of respondents reported that they had to go without health care because money was needed for food, clothing, or housing. Conversely, 18% of respondents reported that they had to go without essentials of daily living because the money was needed for health care or medication. 2.) Expansion of cost-share arrangements for programs like Medicaid or ADAP and the HIV Insurance Program or discontinuation of publicly insured programs were seen as likely to negatively impact HIV-positive Minnesota residents.

In addition to the consumer survey discussed above, the Planning Council's Needs Assessment and Evaluation Committee completed a two-phase systems assessment to identify gaps and barriers to care. The goal of the first phase of the systems assessment worked to identify service sectors of the TGA's care system that are the most difficult to access or are not meeting the needs PLWH/A. In 2006, the needs assessment consultant, Community Consulting Group, conducted focus groups and an on-line survey with case managers, client advocates, outreach providers and key informants in the mental health field to gather qualitative data on system gaps and barriers. The provider focus group and survey questions were informed by the results of the client survey conducted in April and May 2006.

Results from the first phase of the systems assessment indicated that gaps or capacity limitations of the HIV case management, chemical dependency and mental health sectors may pose barriers to accessing care, particularly for those PLWH/A experiencing co-morbidities. The second phase of the systems assessment was completed in late FY2007 by Bob Tracy Consulting and focused on those services identified in the first phase that are the most difficult to access and seem to have the least capacity to meet the needs of PLWH/A—mental health, substance abuse, and dental services, as well as prevention services for people who are HIV positive and aware of their status. Its findings included the following: while most PLWH/A in the TGA are able to get the dental care they need, this is less true for people of color; consumer knowledge about oral health implications of HIV needs improvement; and low rates of reimbursement by Medicaid for dental services creates a barrier to care by significantly decreasing the number of appointments providers make available to patients with Medicaid coverage. While coverage for mental health services is available to low-income Minnesotans, there is a pressure on the overall mental health system due to large patient-to-provider ratios, making it difficult to get timely services. In addition, it is challenging to find mental health providers who are knowledgeable about HIV, and

providers of HIV care and services are seeing an increase in the numbers of their clients who display signs of more serious mental distress and disorders. HIV case managers surveyed as part of the 2006 Minnesotans Living with HIV Survey reported that 13% of their clients demonstrated problems adhering to care plans because of alcohol or drug use. While funding is accessible through public health care programs, they are accessed exclusively through Rule 25 assessors, who may not always be available at the time a client exhibits readiness to enter the substance abuse services system. Finally, prevention services aimed at people living with HIV need to be better coordinated, especially around barriers imposed by the separate funding structures for CDC-funded HIV prevention and Ryan White care services. The Minnesota epidemiological profile points to subgroups that would especially benefit from greater prevention with positives efforts, notably men who have sex with men (MSM) who are members of social groups that stigmatize them and women in heterosexual relationships with MSM.

The grantee and Planning Council, in collaboration with Minnesota's Parts A, B, C, and D grantees and the MDH (CDC prevention grantee), are employing a multi-pronged approach to finding PLWH/A who are not in care and getting them into primary care. Components of the 2006—2008 comprehensive plan designed to reduce unmet need include:

1.) Medical Care Retention ($65,300 in FY 2008) - Designed to identify patients of HIV primary care clinics who are not current with their care and facilitate a return to HIV primary care. Two TGA primary care providers that also provide Medical Case Management (MCM) identify clinic patients who have missed appointments and work with them to help return to care. Case managers assess factors that keep patients from attending appointments and help them connect to other services, such as transportation, that can mitigate barriers to care. In FY 2009 Medical Care Retention interventions will be incorporated into MCM and MCM funding will increase accordingly.

2.) Outreach ($139,900 Part A and $50,000 MAI in FY 2008) - Three community-based organizations are funded to identify people who know their status and are not in care and coordinate their entry into primary medical care. The grantee is collaborating with MDH to coordinate prevention and care outreach activities. MDH provides additional funds for counseling and testing that is passed through the contract the grantee has with one Part A Outreach provider. This collaboration allows the Outreach program to conduct counseling, testing and referral and prevention outreach activities for high-risk individuals. Many of the high-risk individuals are partners of those who already know their status. Outreach targets injection drug users, other substance abusers, African Americans, African immigrants, and men who have sex with men. The Planning Council allocation for Outreach will be sustained in FY 2009.

3.) Culturally Appropriate Psychosocial Support and Health Education/Risk Reduction - Sub-Saharan African Youth and Family Services of Minnesota (SAYFSM) conducts an emotional support and health education group targeting the needs of African immigrants who are HIV-positive. This service is culturally appropriate for both East and West African PLWH/A in the TGA. With stigma a significant barrier for this population, this emotional support group offers African immigrants an entry point into care. This program also provides health education and risk reduction activities that teach participants about their infection, build health literacy and provide information on what services are available and how to access them. In FY 2007, SAYFSM provided psychosocial support and health education/risk reduction services to 38 Africans living with HIV/AIDS. $136,700 in combined funding for these services in FY 2008 also supports three other programs targeting Latinos, MSM and African Americans.

4.) Quality Improvement Programs - A key component of the grantee's quality management program requires that all Part A and Part B funded providers assess whether or not their clients have received primary medical services in the past six months. If they have not, providers are required to make referrals to medical care or other services that will facilitate entry into care. For those clients who have been out of care, providers are also expected to follow up on the referral either with the client or provider to see if they entered care and if they need additional assistance. In 2008, all provider quality improvement goals focus on improving interventions that assess client utilization of care, referrals to care and follow up on referrals to care.

The TGA's entire continuum of prevention and care is focused on the goal of easing entry into and maintaining people in care. The Planning Council, together with its Needs Assessment & Evaluation and Planning & Priorities committees, receive an annual presentation on the unmet need estimate by a MDH epidemiologist. In 2008, the Planning & Priorities committee has begun reviewing Unmet Need data as it begins work on the 2009—2011 Comprehensive Plan. The Unmet Need estimate based on eHARS and clinic data from 2007 is being made available to the work group, which will continue to support the goal to: "Increase the percentage of HIV positive Minnesotans who receive HIV medical care." The Planning Council received an update on unmet need using data from 2006 in preparation for its allocations retreat in August 2008.

2. Access to HIV/AIDS Care and the Plan for FY2008

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

The Minneapolis-St. Paul TGA's 2008 HIV care system has multiple points of entry for those who are newly diagnosed or have been living with HIV but need to become connected to care. One of the most prominent is a statewide toll-free telephone referral service that provides confidential information about HIV and connects callers to resources to assist them to access, return to, or remain in care. The Minnesota Department of Health (MDH) funds HIV testing sites in clinical and community settings that refer newly-diagnosed individuals into the HIV care system. The TGA contracts with two clinical providers of Early Intervention Services based in the public-health clinics of the state's two most populous counties to provide newly diagnosed individuals with medical care, laboratory testing, and assistance to connect to ongoing primary care, case management and support services. Three Outreach providers (one that is MAI funded to focus on providing services to African American and African-born PLWH/A) plan activities to identify individuals who are HIV positive and know their status but are not in care, assisting them to overcome barriers to become connected to HIV medical care.

The TGA's Part A funded core medical service system comprises three Primary Care providers (one MAI funded to provide culturally appropriate care to Spanish-speaking PLWH/A); Treatment Adherence through two Medication Adherence providers; one Home and Community-Based Health Care provider; and four clinic-based providers of Medical Case Management services. One community-based provider receives Part A MAI funds to provide Medical Case Management services to African American PLWH/A. Mental Health and Oral Health Care for the TGA's uninsured and underinsured PLWH/A are funded through Ryan White Part B base funds. Substance Abuse Treatment services can be accessed through Minnesota's publicly funded health care programs, including Medicaid, as well as through the State's Consolidated Treatment Fund. The Consolidated Treatment Fund provides substance abuse services at no cost to individuals with incomes of up to 215 percent of the Federal Poverty Guidelines (FPG) with no third-party coverage with a buy-in option for those with incomes above 215 of FPG.

Support services designed to address barriers to care are most often, though not required to be, accessed through Medical Case Management. These include Emergency Financial and Housing Assistance, Medical Transportation, Benefits Counseling and Legal Services, and HIV Insurance. Food and Nutrition Services, including Home Delivered Meals, On-Site Meals, Food Shelf, Food Vouchers, and Nutritional Supplements, help meet basic needs that, when unmet, are major barriers to accessing regular HIV medical care.

Additional services in the continuum of care that address barriers to HIV primary care are Psychosocial Support (including Emotional Support and Culturally Appropriate Emotional Support programs that focus on African American, African-born, Latino populations and MSM) and Health Education/Risk Reduction. These services both work to address issues of stigma, health literacy, and challenges to coping with living with HIV, with a focus on assisting clients to generate solutions and self advocate to obtain optimal medical services.

2.b. Table: FY2008 Implementation Plan (see the Table in **Attachment 7**) presents the following four core medical service categories included in the TGA's FY2009 Implementation Plan in order of Planning Council priority: Medical Case Management (#1, preceded by Part B-funded ADAP Treatments in the Council's combined Parts A and B priority rankings); Outpatient/Ambulatory Medical Care (Priority #2); Oral Health Care (Priority #6); and Mental Health Services (#8). Two supportive service categories presented in the plan are Food Bank/Home Delivered Meals (#5) and Outreach Services (#12). The Planning Council assigned allocations to these areas according to data from Needs Assessments completed in 2003, 2004, 2006, and 2008 and expenditure data from 2006 and 2007. The amount for the six service areas combined comprises 87 % of the Part A budget for services.

2.c. Implementation Plan Narrative

Connections Among the Latest Needs Assessments, Comprehensive Plan, Service Priorities and the FY 2009 Implementation Plan – The Planning Council relied on the results of the following needs assessments to formulate the goals for the 2006—2008 Comprehensive Plan, prioritize services for fiscal years 2009 and 2010 and allocate funds to services for FY2009:

- Oral Health and Behavioral Health Services Assessment (2008)
- 2006 Consumer Needs Assessment Survey (CNAS).
- Care System Assessment Demonstration Project (2006)
- Brief Survey (2004)
- Needs Assessment of HIV Positive Minnesotans (2003)

In addition, the Planning Council reviewed the results of the two most recent Unmet Need estimates.

The barriers to care and gaps in medical and support services identified by the needs assessments informed the goals of the 2006—2008 Comprehensive Plan and the Implementation Plan for 2009. The results of the needs assessments, along with the most recent Unmet Need estimate **(see Attachment 6)**, identified the following strategies to meet the health care and social service needs of PLWH/A in the TGA:

- Continue to ensure access to publicly funded health care coverage;
- Increase access to the primary health care system;
- Ensure that PLWH/A have their basic needs met including housing, nutrition and medical transportation;

- Improve access to behavioral health services (mental health and substance abuse treatment;
- Enhance awareness of existing HIV services; and
- Mitigate cultural and linguistic barriers to care.

Overall, the Planning Council's priorities closely match the top needs identified by consumers interviewed for the Needs Assessment of HIV Positive Minnesotans. Outpatient/Ambulatory Medical care, Medical Case Management, Emergency Financial Assistance, ADAP, Transportation and housing assistance are included in the top six needs of those interviewed for the study. The top six funded service areas outlined in the 2009 Implementation Plan, which include Outpatient/Ambulatory Medical Care and Medical Case Management, reflect these consumer identified needs. Other objectives in the plan, including Oral Health and Mental Health services, Food Bank/Home Delivered Meals and Outreach services focus on facilitating access to complete health care and mitigating consequences of poverty.

The service goals of the Implementation Plan are also consistent with the findings from the Brief Survey (2004) and the recent (2006) Consumer Needs Assessment Survey (CNAS). In the Brief Survey, 33 percent of respondents reported having to pay more for health care to meet their basic needs in the previous six months. Thirty-eight percent reported having to pay more for medications and 21 percent reported having to pay more for housing. When asked to predict the impact of changes (such as prescription co-payments for Medicaid and cost-sharing for ADAP) in public health care programs, 29 percent of respondents predicted a negative effect on their ability to get prescription medications and 23 percent predicted a negative effect on maintaining health insurance. Twenty-five percent of CNAS respondents reported needing but not being able to get housing or rental assistance in the six months prior to their interview and 11 percent of respondents reported needing and not getting case management services.

Access services such as Medical Case Management and Outreach will enhance knowledge of existing services for PLWH/A who need to connect to care but do not know what services are available, where they are offered or how to successfully navigate the complex system of health care reimbursement. Fifty-two percent of participants in the Needs Assessment of HIV Positive Minnesotans said that lack of knowledge about services was a barrier to care. The Care System Assessment Demonstration Project (CSAD) concluded that a lack of knowledge about the system and services available to assist in paying for medications was a significant barrier for Minnesota's population of Africans living with HIV/AIDS, who may not know how to access or navigate the system of HIV care.

Unmet need estimates using eHARS and clinic patient data from calendar years 2006 and 2007 indicate that African Americans, American Indians, men who have sex with men (MSM) and MSM/injection drug users may be less likely to be in care. Fifteen percent of PLWH/A interviewed for the Needs Assessment of HIV Positive Minnesotans reported that cultural barriers impede access to needed services. The CSAD Project recommended increased funding for intensive case management services that are able to address cultural barriers to care encountered by African-born PLWH/A. The CSAD Project also identified a need for competent language interpretation services that are sensitive to HIV stigma among African communities and the intense fear of unwanted disclosure of HIV status to community members. Although not listed as one of the top-funded support services in the Implementation Plan, linguistic services are a component of the complete plan for 2009.

The plan for 2009 is congruent with the two overarching goals and more specific objectives of the 2006 - 2008 Comprehensive Plan, which is under revision by the Planning Council for 2009 - 2011. The Comprehensive Plan goals, objectives and activities were derived from the key findings of the needs assessments and unmet need estimates. For each of the service goals under the six service priority areas included in **Attachment 7,** corresponding goals and objectives from the Comprehensive Plan are specified. Five of the six service areas included rank within the top ten (out of 24) service categories prioritized for 2009 – 2010 by the Planning Council. Many of the Plan's objectives, including the provision of mental health and outreach services, are designed to address the complex issues and additional costs associated with delivering care to the TGA's PLWH/A affected by the co-morbidities of poverty, homelessness, mental illness, and chemical dependency.

Core Services Not Prioritized in the Part A Plan – Since the Minnesota HIV Services Planning Council also serves as the planning body for Part B, ADAP medications, health insurance premium/cost sharing assistance and substance abuse services (outpatient) are included as core medical service priorities funded solely by Part B in the statewide plan for HIV services.

Although ranked sixth in priority in the statewide plan, the Planning Council did not allocate Part A or B base funds for local AIDS Pharmaceutical Assistance since the anticipated ADAP award, the state appropriation for HIV insurance continuation, the Department of Human Services' forecast of approximately $4,008,200 in drug rebate revenue along with Medicaid, Medicare and other Minnesota Health Care Programs are deemed adequate to meet the needs of Minnesota's PLWH/A in 2009. Also, home health care and hospice services are covered through Minnesota Health Care programs and private insurance, and thus are not allocated Ryan White funding.

Increased Access to the HIV Continuum of Care for Minority Communities – The access services: AIDSLine (Referral for Healthcare/Supportive services--Part B funded); Outreach (case finding and coordination of entry into care); and Medical Case Management (medically focused comprehensive care coordination) are important keys to entry into the HIV Continuum of Care in the TGA. Case Management ensures initiation and continuation of primary medical care, health insurance coverage and maintenance, treatment adherence counseling, comprehensive behavioral health assessments, and HIV risk reduction interventions, as well as addressing the myriad of individual needs of PLWH/A. Service plans must include continual assessment and reassessment of all cultural and socioeconomic factors that can interrupt HIV primary medical care. The Medical Case Management system includes five culturally specific agencies located in communities disproportionately impacted by HIV. Among three providers of Medical Case Management there are three multi-lingual African-born case managers serving the growing population of Africans living with HIV/AIDS.

The Part A allocation for Medical Case Management was increased by eight percent from $1,632,200 in FY2008 to $1,775,500 for FY2009 to ensure that this critical service is available to all eligible PLWH/A in the TGA. Benefits Counseling–prioritized as non-Medical Case Management and supported with Part B base and drug rebate funds–provides PLWH/A with advocacy and technical assistance to access and maintain benefits including insurance, ADAP, and disability benefits. Consumers also may utilize Legal Services which is funded to assist them as needed to maintain continued access to the continuum of care for PLWH/A.

The objective of Culturally Appropriate Primary Care, which is considerate of language, culture, country of origin and immigration status, is to provide multidisciplinary health care services for 120 unduplicated Spanish-speaking PLWH/A and is supported with MAI funding.

Obtaining and paying for health insurance remains a critical strategy for PLWH/A to access health care. To ensure people continue their coverage is a top priority for the HIV Insurance Program (Part B funded) which provides financial assistance to help pay premiums.

The Ryan White Part A program provides the wrap-around support services that bring people who know their status into medical care and are crucial for maintaining the continuity of care necessary for effective long-term treatment of HIV. The FY 2009 plan provides for Outreach activities that target communities where HIV is increasing, including African Americans and the African-born, as well as men of color who have sex with men and injection drug users. The objective of Outreach services is to successfully engage, refer, provide information to, and support PLWH/A in order to increase access to primary care for individuals not currently in care. Needs assessment data have documented knowledge of services as a major barrier to accessing medical care. Outreach activities establish the relationship for trust building, which is often the first step in connecting to care. These activities are supported with both Part A and MAI funds and include a program that is culturally specific. Food and nutritional services are critical to maximizing the benefits of primary medical care. Fiscal year 2009 objectives consist of: home-delivered meals; emergency food shelf services; congregate meals; and emergency food vouchers for low income PLWH/A. Home-Delivered Meals are often the key in supporting patients to maintain good health and nutrition, enabling them to remain independent in their homes. The complexity of pharmaceutical regimens requires extensive coordination with each client's eating patterns and the Part A-funded food and nutritional services remain an important priority. The On-Site Meals provider also provides a Food Shelf and is often a referral point of entry into primary care. Part A will begin funding Medical Nutritional Therapy in 2009, providing registered dietician services housed at a community based organization to assist clients enrolled in the Minnesota Department of Human Services HIV/AIDS enteral nutritional supplement program.

Stable housing is a fundamental need for PLWH/A and can be critical in maintaining treatment adherence. The objective of Emergency Housing Assistance is to provide direct financial assistance for PLWH/A to mitigate homelessness. This assistance subsidizes rent or moving expenses and is coordinated through the centralized Emergency Financial Assistance program. Applicants for emergency housing assistance grants are referred to housing programs, including HOPWA funded subsidies and transitional programs, that can help identify resources that can provide long term solutions to maintaining stable housing. Additional supportive services included in the complete plan to promote access and maintenance of primary care include: Health Education/Risk Reduction activities and Linguistic services which provide a critical link to care for the TGA's ever-increasing immigrant populations.

Objectives that Address the Needs of Emerging Populations of Special Need –The continuum of access services, especially Medical Case Management, addresses the needs of special populations by placing an emphasis on services that are culturally appropriate and diminish barriers to care. Culturally Appropriate Primary Care provides support for health care services for 120 Spanish-speaking PLWH/A in the TGA. Oral Health Services will help to address the disparity in access to optimal oral health care experienced by low income people of color who were found in the 2008 Service Assessment to be less likely to have a usual source of dental care and more likely to experience barriers presented by low Medicaid reimbursement rates that cause dental practitioners to limit the number of publicly funded patients they see. The combination of stress related to living with HIV, particularly for people also affected by poverty, and the shortage in Minnesota of adequate numbers of mental health practitioners, contributed to

the Outcomes Evaluation finding in 2007 that 27% of case managed clients were assessed in need of case management services because of mental illness, and 35% of those with a need for Mental Health services reported that need was unmet. Confidential mental health support is a key entry point for African individuals for whom the stigma of HIV is a major barrier to care. Through an African specific agency, mental health groups address isolation and fear of HIV for African-born men and women as well as provide information and referrals to needed services through health education and risk reduction programming available to group members. The Implementation Plan objective to provide individual and group mental health services will help address that need, especially for those among the emerging populations who are living in poverty. The Food Bank and Home Delivered Meals programs will help to address needs for adequate nutrition of the identified populations and reduce the need to choose between accessing medical care and paying for food. Outreach services target MSM and women of color of childbearing age who are clients of Hennepin County's public health clinic and a large community-based multi-service organization dedicated to providing information, referral, and resources to PLWH/A. An additional Outreach provider, funded with MAI dollars, targets African Americans living with HIV. Data from interviews conducted for the 2004 Brief Survey and 2006 Consumer Needs Assessment Survey demonstrates a high level of poverty among the TGA's populations of color, particularly African-born and Spanish-speaking immigrants. Services that address basic needs such as Emergency Financial and Housing Assistance and Insurance are crucial to support continued access to HIV primary medical care and remain a top priority for the TGA.

Objectives to Ensure Engagement in Primary Medical Care and Treatment Adherence – Early Intervention services will provide 45 newly tested individuals with primary health care exams, preliminary lab work and the necessary referrals to support entry or re-entry into care. Several objectives are aimed at assisting PLWH/A with maintaining access to care. Primary care will be provided for a total of 292 PLWH/A in the TGA. An additional 120 individuals will receive Culturally Appropriate Primary Care funded through the TGA's Minority AIDS Initiative. Since these funds must be used as a last resort, they provide a critical safety net for persons with no source of health care coverage to enter the primary care system and receive quality medical care. Medical Case Management will be provided to 1,358 PLWH/A to assess needs for and facilitate access to HIV primary medical care. Service plans address barriers that may impact maintaining medical care and treatment. Medication adherence counseling will be provided to 948 PLWH/A with medication adherence assessment, counseling, education, tools and follow-up services.

Promoting Parity of Services – Because the vast majority of PLWH/A in the TGA reside in Hennepin and Ramsey counties (84%), most of the services that are funded in the TGA are located in Minneapolis and St. Paul (see Map of HIV Service Providers in **Attachment 9**). Medical Transportation services are provided with Part B funds and include a cooperative process for PLWH/A to obtain rides or bus cards for available public transportation to medical appointments. While all Ryan White Part A-funded vendors are required to provide services for the entire TGA, the contracted transportation providers plan together to make sure services are available in all sectors of the TGA (and state) and to avoid duplication. A Culturally Appropriate Primary Care program is currently funded and located on the West Side of St. Paul in one of the largest Latino neighborhoods in the TGA. Medical Case Management programs are also located throughout the community and several serve specific populations, including African Americans and Latinos.

Healthy People 2010 Initiative and the 2009 Implementation Plan - The TGA's 2009 Implementation Plan will work toward achieving Healthy People 2010 Goal 13 by preventing HIV infection and its related illness and death. Although the goals and objectives of the 2009 plan address the majority of the objectives under Healthy People 2010 Goal 13, the activities planned for 2009 will focus primarily on the following goals:

13-13. Increase the proportion of HIV-infected adolescents and adults who receive treatment and prophylaxis consistent with Department of Health and Human Services treatment guidelines

13-14. Reduce deaths from HIV infection

13-15. Increase years of life of an HIV-infected individual by extending the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis

13-16. Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death.

The 2008 Implementation Plan secondarily addresses additional Healthy People 2010 goals by bringing PLWH/A who know their status into care, thus reducing transmission and disease progression. These additional goals addressed by the Plan include:

13-1. Reduce AIDS among adolescents and adults

13-2. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men

13-3. Reduce the number of new AIDS cases among females and males who inject drugs

13-4. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men and inject drugs.

Ensuring Resource Allocations for WICY – Meeting the service needs of Women, Infants, Children and Youth (WICY) who are living with HIV/AIDS continues to be a priority for the TGA. Infants, children and youth, however, make up a relatively small proportion of the TGA's epidemic. Women account for 25 percent of all living HIV/AIDS cases, while Youth (age 13-19) make up 5 percent, and Infants and Children (age <13) make up 1.5 percent. Given these small numbers, the TGA and Planning Council have requested data to assure that spending by the state's Medicaid and Children's Health Insurance Programs, as well as other federal and state spending, occurs in proportion to how these populations appear in the local epidemic. As such, the TGA along with the Part B grantee applied for and were granted joint WICY waivers for 2003 through 2008. Despite the waivers, the grantee and Planning Council make every effort to ensure that Part A and B resources for WICY with HIV/AIDS are proportionate to their representation in the overall epidemic. Women are generally overrepresented in Ryan White funded services in the TGA; for example, in 2007, 31% of those accessing Case Management services were women. Women face additional barriers to care in meeting basic needs for themselves and their children, and services which address these barriers include Benefits Counseling, Emergency Financial and Housing Assistance, Food Shelf, Food Vouchers, On-Site and Home-Delivered Meals.

Minority AIDS Initiative (MAI) – The Minneapolis-St. Paul TGA's MAI plan for 2008 includes allocations for Culturally Appropriate Primary Care ($149,094), Medical Case Management ($51,000) and Outreach ($50,000). The objective of Culturally Appropriate Primary Care, which is considerate of language, culture, country of origin and immigration status, is to provide multidisciplinary health care services for 120 Spanish speaking PLWH/A. This program will serve 30 percent of PLWH/A identified as Hispanic in the TGA. The MAI-supported Medical Case Management services target African Americans and provide assistance

in applying for publicly funded health care programs, accessing primary medical care, treatment adherence services and support services that meet psychosocial and basic needs. The FY 2008 MAI plan provides for Outreach activities that target communities where HIV is increasing, including the African American and African-born communities. The objective of Outreach services is to successfully provide information, support and referrals to PLWH/A in order to increase access to HIV care services for individuals not currently in care. Needs assessment data document knowledge of services as the major barrier to care for all special needs populations. Outreach activities establish the relationship for trust building, which begins the communication that is often the first step in connecting to care.

4. Planning and Resource Allocation

4. a.1. Letter of Assurance from Planning Council Chairs. *See Attachment 2C.*

4.a.2. Description of Priority Setting and Resource Allocation Processes

The Minnesota HIV Services Planning Council (Council) completed its biennial prioritization process for fiscal years 2009-2010 in August 2008. The Council prioritizes services and allocates funds for both the Minneapolis-St. Paul TGA's Part A award and Minnesota's Part B base award. In 2007, the Council refined the prioritization process based on feedback from the previous process completed in 2006. The Planning and Priorities Committee reviewed the list of allowable services and activities eligible for funding. MAI services, prioritized in 2006 just prior to the current MAI three-year funding cycle, were therefore not prioritized again in this process. To ensure that the needs of those not in care and those from historically underserved and emerging populations were considered, the Planning and Priorities Committee carefully compared demographic patterns of client utilization of services with epidemiological data, expenditures on culturally appropriate service activities, and demographic breakout reports from the needs assessments conducted in 2003, 2004 and 2006 for African Americans, Latinos and African-born PLWH/A and the Care System Assessment Demonstration (CSAD) Project in determining categories to be funded by the TGA's Part A award. Once the Council approved the list of services to be prioritized, Council staff revised a grid of service categories on which members conducted a paired comparison analysis of one service against another as they worked their way through the list of eligible services. A second paired comparison analysis process was used to rank service activities within service categories, providing a clearer and more compelling picture of the Council's priorities. Members were given the option to attend one of two open house sessions, where Council staff was available to answer questions about the service areas or the process. The paired comparison analysis mechanism results in each service area and activity receiving a score from each Council member. Scores from all Council members are then totaled to determine priority order for service areas and activities within those areas.

With priorities established, Council members attended a daylong retreat to determine allocations. An independent consultant facilitated this process. The Planning and Priorities Committee developed a set of values to guide the Council in its allocations decision making including: majority rules, individuals vote; transparency; data-based decisions; culturally competent services; based on consumer and system needs; efficient use of resources; and flexible and responsive to system changes. The agreed-upon values demonstrate the premium placed on data-based decision making, as well as consideration of the needs and input of consumers of

services and people affected by HIV/AIDS. At the retreat, allocations for FY 2009 were approved with the assumption of flat funding. The Council will approve a final allocations proposal once all awards are determined.

Involvement of People Living with HIV – The Council strives to ensure representation by all communities impacted by HIV/AIDS. Currently, all of the populations identified as having severe need are represented on the Council, including three African immigrants. The Council's Community Voice Committee (CVC) meets monthly and includes HIV-positive community members and HIV-positive Council members. The CVC provides perspective on emerging service needs and problems associated with the current service delivery network. Most importantly, the group provides the Council with key insights into issues associated with living with HIV/AIDS. While planning the 2008 prioritization process, the lists of service areas and activities developed by the Planning and Priorities Committee were reviewed with the CVC committee for input before forwarding them for consideration by the full Council. People living with HIV/AIDS populate all Council committees, where they provide input on services and allocations as well as data collection and analysis. In addition, as co-chairs of the various standing committees, six members of the ten-member Executive Committee are PLWH/A.

In addition to serving on the Council and its respective committees, PLWH/A are consistently involved in the priority setting and allocations processes. First, PLWH/A participate in both needs assessments and consumer surveys. Three hundred seventy-nine consumers participated in the Consumer Needs Assessment completed in 2006. The assessment included one-to-one surveys conducted by case managers, care advocates and outreach workers from 13 agencies. The surveys provide an avenue by which the Planning Council gets direct feedback information about barriers to care and gaps in services from affected communities. An Oral Health and Behavioral Health Services Assessment conducted in 2007 and 2008 included individual as well as five group interviews of PLWH/A. Second, time is allotted at the beginning of each Council meeting for community members to come and discuss service needs in an open forum setting. Finally, the Council is currently composed of 24 members; nine (38%) identify as living with HIV disease. Both Planning Council Co-chairs are PLWH/A.

During FY2008, the Council held a consumer workshop to solicit additional consumer input for service prioritization. Participants were given an opportunity to complete the paired comparison analysis mechanism to be used by the Council to set priorities. In addition, consumers were asked to identify gaps in services and barriers to receiving services. This feedback was presented to the Council for consideration during the prioritization process. In addition, the Council conducted an open meeting in October 2007 to seek public input on the availability of core medical services in the TGA.

To ensure consideration of the needs of consumers residing in the two Wisconsin counties (Pierce and St. Croix) included in the TGA, the Council has sought to further develop relations with the Wisconsin Department of Health and Family Services. Individuals from state government and a local service provider have been identified to assist in the dissemination and gathering of information and data from consumers and providers within the two Wisconsin counties. In addition, these individuals have been notified of opportunities for consumer participation in the community planning process.

Use of Data in the Prioritization and Allocation Processes to Increase Access to Core Medical Services and Reduce Disparities - Preparation for priority setting spanned an entire year. During that time, several data resources were presented to the Council for review and consideration. For the FY 2009-2010 priority setting and allocations process, the Council

considered epidemiological data, the unmet need estimate, outcomes evaluation results, service utilization data, needs assessments and other qualitative data including a consumer survey conducted in 2006, a systems assessment conducted in 2007-08, the Care System Assessment Demonstration Project, and quarterly and annual grantee expenditure reports.

In May 2008, epidemiology staff from the Minnesota Department of Health (MDH) presented the Minnesota HIV Epidemiological Profile to the Council. The Council examined epidemiological changes and trends over the previous two year period, changes in demographics of HIV/AIDS cases, information regarding populations with emerging and special needs, and estimates of unmet need. Epidemiological data are used in the allocation process in two key ways. First, consideration is given to service area allocations based upon increased prevalence over the previous year. Second, the data are used to determine if new service areas or activities should be considered to fill any gaps.

Outcomes data were also considered in the FY 2009-2010 priority setting process. Outcomes evaluation results are presented in a report format called Service Area Reviews (SARs), which integrate information about epidemiology, service utilization, outcomes, needs assessment and consumer satisfaction data for a particular service area. Outcomes data provide the Council with a sense of the impact of a service and the ability to meet its intended goals. For example, outcomes data for Primary Care services continue to document that CD4 and viral load results improved for persons accessing the service. This outcomes data supported the Council's decisions to increase Primary Care allocations by $225,600 in 2007, $351,700 in FY2008 and by $96,000 in 2009.

Service utilization data include an analysis of under- or over-utilization of each funded service area by population. This analysis is also used in conjunction with the grantee's year-end expenditure report to calculate per-client costs for each of the funded services. Because the Council initially allocates based on an assumption of flat funding, utilization data had a direct impact on the allocations process. Due to increased prevalence in the TGA, the Council agreed to increase by two percent allocations to services funded in the previous fiscal year. This meant lower prioritized services which had been previously funded might suffer because of the increased allocations for higher ranked services, although this was not the case in FY2007 due to a significant increase in the TGA's Part A formula award nor in 2008 due to another increase in the award. Attention to under utilization in 2007 for some service areas allowed the Council to allocate funding to lower prioritized service areas such as Legal Services, Linguistics, Outreach and Child Care services which may have lost funding otherwise.

Qualitative data play a key role in integrating the perspectives of PLWH/A into the priority setting and allocation process. The Council collects these data in many ways, including: focus groups, public forums, needs assessments, consumer satisfaction surveys, and community participation on Council committees. Other qualitative data considered by the Council were represented by the Care System Assessment Demonstration (CSAD) Project. The CSAD data included an assessment of system and individual barriers experienced by African born PLWH/A. The TGA was one of three in the nation that participated in this Special Project of National Significance.

Needs Assessment data were used extensively during the most recent priority setting and allocations processes. Face-to-face surveys conducted in 2006 with 379 PLWH/A revealed a mean monthly income of $911 during the previous twelve months (a decline from the Brief Survey conducted in 2004); twenty-one percent of respondents reported enrollment in private health insurance or a health maintenance organization while six percent were uninsured; five

percent reported not accessing HIV medications in the past six months while 13 percent reported not seeking healthcare in the past 12 months because of concerns about how to pay.

Needs assessment data document that for PLWH/A, Primary Care, Emergency Financial Assistance and Medical Case Management are among the top five services they need to manage their HIV disease. The Council had ranked Outpatient/Ambulatory Medical Care and Medical Case Management among the top five priorities.

A brief survey of 466 HIV case-managed clients conducted in 2004 also informed the Council's decisions on priorities and allocations for FY2009. The survey was designed to assess the impact of legislative changes to state-funded health care programs such as scaling back of eligibility and cost-containment measures. The survey indicated that PLWH/A were having greater difficulty meeting their basic needs because they had less income on which to live and out-of-pocket health care costs had increased. This study supported the Council's decision to fund Insurance Premium and Cost Sharing Assistance for FY2009.

Needs Assessment data were also gleaned from a Systems Assessment conducted in 2007-2008. This assessment was particularly useful in examining need in four service areas: substance abuse, mental health, oral health and prevention with positives. Based on the findings of the Systems Assessment, the Council increased its allocation for mental health services to fund psychiatric services at the TGA's largest HIV specialty care provider and allocated service specific capacity development funds to increase the HIV competency of chemical dependency treatment providers that receive public funding.

The Council used data in multiple ways to establish priorities and allocations for core medical and support services. First, a Service Area Review summary of data presented to the Council demonstrated that persons who routinely access medical care show improvements in CD4 and viral load clinical indicators. The Council increased the allocation for Primary Care by $225,600 in 2007, $351,700 in 2008, and $96,000 for 2009. Second, outcomes data demonstrated that persons participating in an adherence program experienced fewer missed doses and showed improved clinical outcomes. The Council increased funding for this activity by $142,000 for 2009.

To increase access and reduce disparities, the Council increased allocations to two core medical services – Outpatient/Ambulatory Medical Care and Medical Case Management for the sixth consecutive year. The Council also allocated Part A resources to the four remaining prioritized core medical services. The Council's plan for FY 2009 has 79 percent of the Part A budget for services allocated to core medical services.

In addition, allocations for Culturally Appropriate Outpatient/Ambulatory Medical Care to assist under-represented communities with accessing and adhering to HIV primary medical care have increased the past three years and increased again to $149,100 for FY 2009. The program currently funded through the TGA's Minority AIDS Initiative to provide this service has helped increase the numbers of Latinos living with HIV/AIDS who access as well as maintain their health care and has helped to reduce disparities in access to care. Past studies have shown high rates of uninsured individuals among this population, which is a barrier to care. Latinos in Minnesota are also more likely to have AIDS at first diagnosis or progress to AIDS within the first year of diagnosis. Providing accessible, affordable, culturally appropriate primary health care that is considerate of culture and language has helped address this disparity. The additional allocation of MAI funds will help to increase access and reduce disparities for communities of color.

Part A funds were not allocated for the purchase of medications, substance abuse services, health insurance premium/cost sharing assistance, or home health care. Forty-one percent of the TGA's PLWH/A access medications through state-funded health care programs (Medicaid, Minnesota Care and General Assistance Medical Care). Minnesota's ADAP award is supplemented by rebate dollars and provides medications for 16 percent of PLWH/A in the TGA. The State of Minnesota also provides an annual appropriation of $1.2 million for the HIV Insurance Program, which will purchase high-risk insurance pool policies for a projected 40 percent of its enrollees in 2009. As with medications and primary care, most PLWH/A in the TGA can access dental care through publicly funded health care programs or private insurance, some of which is purchased through the HIV Insurance Program. To provide access for PLWH/A without dental coverage, the Planning Council allocated $142,200 in Part A funds and $21,200 in Part B base funds for oral health care. Substance abuse services are funded through the State's Consolidated Treatment Fund supported through a SAMHSA Block Grant, Medicaid, state funded insurance programs, and private insurance.

Mental health services are also typically covered by other sources of funding, such as Minnesota Health Care Programs and private insurance. Low-income PLWH/A who do not have a source of third-party payment for mental health services can access Part A and Part B funded mental health services through any Medicaid provider, which helps to ensure that the need for culturally appropriate mental health services is met.

Use of Changes and Trends In Epidemiological Data on Priority Setting and Allocations – As the epidemic in the TGA has shifted, greater emphasis has been placed on services to communities of color and women, especially African-born immigrants. As part of the biennial prioritization process conducted in 2008, the Planning and Priorities Committee revised the list of culturally appropriate services to be supported with Part A formula/supplemental, Part B and MAI funds to include Culturally Appropriate Outpatient/Ambulatory Medical Care, Medical Case Management, Mental Health Services, Health Education/Risk Reduction, and Outreach. The Council allocated funds to continue funding Culturally Appropriate Primary Care that targets Latinos. Allocating MAI funds for Medical Case Management, targeted for African Americans, has increased resources for this activity every year since 2005. MAI funding for Outreach supports case finding and coordination of entry into care for African American and African-born PLWH/A who are aware of their status and not in care. Recent trends in new infections among African-born immigrants and the associated increase in prevalence in this population resulted in the Council allocating carryover funds in 2004 for an Emotional Support/Health Education program for African-born PLWH/A. This program will continue through the end of FY2008 and will receive funding for Culturally Appropriate Mental Health Services in 2009 and 2010 which will provide mental health therapy in the form of psychosocial support groups. These programs have been instrumental in addressing the intense HIV stigma many African PLWH/A experience, which is a significant barrier to care.

Use of Cost Data in Making Funding Allocation Decisions – Council members were provided with client capacity data based on provider contractual goals, along with client utilization data, units of service provided and expenditures for each service activity. These three sources are used to estimate unit and per-client costs. Expenditure data were provided quarterly by the grantee. Provider capacity and client service utilization data are provided annually. Prior to the all-day allocations meeting for FY 2009 funding, the Council received data on these three elements for all of the services funded in 2007 through service area reviews and summaries. Because of allocation adjustments made in previous years based on this data, particularly reductions for

Health Education activities because some members believed that the cost per client was too high, further adjustments were minimal for FY 2009 allocations. In 2005, Council members allocated funds to create an emergency assistance program to help ADAP and HIV Insurance Program recipients meet their new monthly cost-share payment. This decision was partly based on projected ADAP and HIV Insurance Program costs and cost-share premium information provided by the Part B grantee. This service activity received an 11 percent increase for the FY2007 allocation and an additional increase to an all-time high allocation of $114,500 for FY2008. Because the cost sharing program was recently suspended by the State, this allocation was no longer necessary, allowing the Council to allocate these resources to other service areas. Comparing unit costs and costs per client for some service areas has been difficult since the types of services and how they are delivered can vary dramatically from one provider to another. As the Part A grantee continues to procure more services through unit rate contracting, the Planning Council will receive more accurate unit cost information. Medical Case Management services are now procured on a unit rate basis as are Food Bank and Home Delivered Meal services.

How Unmet Need Data were used in making funding allocation decisions - In setting priorities and determining allocations for FY 2009-2010, the Needs Assessment and Evaluation and the Planning and Priorities Committees reviewed the estimate of unmet need. In response to the first unmet need estimate conducted in 2003, the Council allocated carryover funds in FY 2004 to pilot an "inreach" project. The Inreach pilot was conducted by the TGA's largest HIV primary care clinic to find and follow up with PLWH/A who had missed appointments or were missing from care. After successful implementation of the pilot, in which 33 patients were brought back into care, the Council included Inreach on the service activity list for prioritization in 2004 and again in 2006 and allocated funds for Inreach for FY 2005 through 2008. In FY2008, the Council felt strongly about continuation of this service activity and allocated resources through Medical Case Management to continue the service activity as clinical retention. In FY 2006, the Council allocated MAI funds for Outreach to find cases of PLWH/A who know their status and are not in care. The MAI funded an Outreach program targeting African Americans. The most recent unmet need estimate demographic data (see **Attachment 6**) indicates that efforts such as Clinical Retention services and Outreach have had some success in connecting PLWH/A who know their status to care. Compared to the unmet need estimate in 2005, the year after the pilot program was first funded, the 2007 estimate indicates that the proportion of Hispanic PLWH/A who were in care increased from 53 percent in 2005 to 64 percent in 2007. In addition, MAI funds were also earmarked for culturally appropriate primary care in 2005, 2006, and 2007 and increased to $136,700 in 2008. In 2007 the MAI funded clinic provided care for 32 percent of all Latinos living with HIV in the TGA. The unmet need estimate from 2006 data indicated that Latinos were more likely to be out of care (47%) than PLWH/A in the general population (36%), while the unmet need estimate from 2007 data indicates that Latinos are no longer more likely (36%) to be out of care compared to the general population (36%), indicating some improvement in connecting Latinos to care.

How the Planning Council's process will prospectively address any funding increases or decreases in the Part A award – From FY 2003 to 2005, the Minneapolis – St. Paul EMA's Title I award declined. The award decreased by five percent between 2003 and 2004 and by 2.7 percent between 2004 and 2005. The award increased slightly by 1.1 percent between FY 2005 and 2006. After reauthorization of the legislation and the recognition of Minneapolis-St. Paul as a TGA rather than an EMA, the FY2007 Part A award increased by 47 percent. The FY2008 award returned to a more modest increase of 4.6 percent. Based on the last few years, the

Council anticipated the possibility of a decrease in Part A funding or, at best, flat funding when it designed the prioritization and allocations process used for FY 2009 and 2010. However, the Council has had experience over the past few years in planning for fluctuations in award amounts. Much like the uncertainty of funding levels in FY2007 due to reauthorization and late notices of grant awards, the Planning & Priorities Committee recommended planning for FY 2009 allocations based on flat funding with contingencies for increased or decreased funding amounts. If funding is decreased, allocations will be first decreased in lower prioritized support service areas proportionately and then the lower prioritized core medical services if necessary. If funding is increased, allocations will be increased proportionately for core medical services and then support services if appropriate. Any revisions will be done with an emphasis on continuing to ensure that all core medical services are available to eligible PLWH/A residing in the TGA and that the 75% core medical service expenditure requirement be maintained.

5. Budget and Maintenance of Effort (MOE)

5.a. ***Budget*** *– See Budget Information for Non-Construction Programs (Form 5161-1, SF 424A) and Budget Narrative Attachment.*

5.b. ***Maintenance of Effort***

The following Part A Maintenance of Effort (MOE) Summary Report details FY 2006 and 2007 HIV-related expenditures by local governments within the Minneapolis-St. Paul Transitional Grant Area (TGA):

Item No.	Agency/Department/Other Unit of Government	FY2006 Amount	FY2007 Amount
1	Minneapolis Department of Health and Family Support	$49,312	$74,948
2	Hennepin County Human Services and Public Health Department	$294,199	$298,661
3	St. Paul – Ramsey County Public Health Department	$156,345	$157,930
	TOTAL:	**$499,856**	**$531,539**

There was a small increase (6.3%) in the overall level of HIV-related expenditures from fiscal year 2006 to 2007, primarily due to increased support by the City of Minneapolis for HIV testing and counseling services through the Neighborhood Health Care Network. These data, using the MOE methodology approved by HRSA in 2004, show that HIV-related expenditures are maintained from year to year.

6. Clinical Quality Management

6.a. Description of Clinical Quality Management Program

Clinical Quality Management Structure, Vision, Mission and Goals –

Vision: The TGA's contracted care providers will deliver high quality care and services and be supported in their mission of providing care for people living with HIV/AIDS (PLWH/A).

Mission: To assure that PLWH/A in the Minneapolis-St. Paul TGA have access to, understand, and receive care that meets Department of Health and Human Services (DHHS) standards.
Overall Goal– Each contracted provider agency will develop expertise in maintaining a quality improvement program that meets the unique needs of the agency, its staff and its clients for timely, efficient, and effective services that ultimately facilitate PLWH/A to initiate and continue in HIV primary care.

Annual Quality Goals (AQGs) for FY 2009–

AQG 1: Increase the proportion of people living with HIV/AIDS in the TGA who know their status and are in care.

AQG 2: Support the Minnesota HIV Planning Council's priority setting process through needs assessment analysis and reporting, service area reviews, and Quality Improvement project results.

AQG 3: Support contracted providers' quality improvement efforts and adherence to the TGA's "Universal Standards for Funded Programs" through training, technical assistance, and site visit activities.

AQG 4: Engage consumers of Ryan White services in learning about standards for HIV care and self advocacy for obtaining highest quality care and services.

Roles of Clinical Quality Management Staff Members and Committee—The TGA has a full-time CQM coordinator responsible for obtaining and evaluating annual quality work plans from each contracted service provider as well as semi-annual quality improvement progress reports. The coordinator communicates with providers about their progress toward their goals and how it integrates with the Part A system-wide quality goals and efforts. In collaboration with the grantee's program contract managers and contract analyst, the coordinator performs annual site visits and client record reviews for compliance with Universal Standards and contract goals. The coordinator works with contracted service providers to promote the implementation of best practice standards, and provides training and technical assistance for providers toward that end. CQM activities are coordinated as a collaborative effort across Ryan White Parts to develop strategies that ensure HIV care is provided in accordance with DHHS Public Health Service guidelines. The CQM Coordinator acts as a liaison among the grantee; Planning Council; contracted provider agencies; consultants contracted to perform outcomes measurement, evaluation, needs assessment and capacity development for the TGA; quality coordinators from other Ryan White Parts; Minnesota Department of Health (MDH) epidemiology and prevention program representatives; and the Quality Management Advisory Committee (QMAC).

The TGA's CQM plan and work are guided by the Quality Management Advisory Committee (QMAC), which is made up of representatives from Parts A, B, C, D and F of the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA), the MN HIV Services Planning Council, HIV service providers, the MDH, community consumers, and Calabash: Learning, Evaluation and Research (CLEAR), the grantee's outcomes evaluation consultant. The QMAC, which meets bimonthly, has developed and revises the TGA's "Universal Standards for Funded Programs." Activities and progress in quality improvement are reported at each meeting. Aggregate information about site visit findings (including client chart audits for compliance with Universal Standards) and contracted providers' progress toward meeting quality improvement goals are reviewed by the QMAC annually. The CQM coordinator seeks individual consultation from committee members throughout the year as needed to ensure timely completion of work plan objectives.

The Ryan White Program Coordinator provides oversight and approval of the Part A annual quality workplan and its integration into the overall Part A program; serves as a member of the QMAC and provides expertise on the RWTMA; and supervises the CQM Coordinator. The Part A grantee budgets up to five percent of its overall annual budget to Quality Management activities.

Internal CQM Program Assessments and Activities to Assess Quality of Services–The QMAC reviews and approves the Part A grantee's annual CQM Work Plan and conducts an annual quality program assessment using the "Checklist for the Review of an HIV-Specific Quality Management Plan" developed by the National Quality Center. This tool enables the annual evaluation of the Part A program, covering 11 domains from overall quality goals to program structure to performance measurement planning, capacity building, and evaluation.

Specific Indicators Monitored for Outpatient and Ambulatory Health Services and Medical Case Management–Each Part A contracted service provider in all service categories collects and submits data semi-annually through a Client Level Reporting System on the following indicators:

- Number and percent of program participants who are current in care (have received HIV medical care in the previous six months)
- Number and percent of participants who are not current with care and are successfully referred to receive care
- Number and percent of program participants who initiate and/or maintain health insurance coverage
- Race, ethnicity, and country of origin of HIV services participants

Medical Case Management providers also measure and report on the:

- Number of program participants classified in target groups including those who are homeless or in unstable housing, and those with chemical dependency or current chemical abuse issues
- Frequency with which case managed clients keep HIV medical appointments
- Need for medication adherence support for case managed clients
- Need for dental, mental health, and substance abuse treatment services for case managed clients
- Number and types of barriers to remaining current in care addressed by case management services

Clinical measures for the funded Outpatient/Ambulatory Medical Care sites are as follows:

- CD4 counts and viral load test results reported over time for patients of two Medication Adherence programs and one Culturally Appropriate Primary Care Clinic
- Initial CD4 counts (health status indicator) at one Short Term Intervention clinic
- Annual number of pelvic exams and Pap screening tests completed for women patients of three Primary Medical Care providers (two Part A funded providers and one funded through the MAI for Culturally Appropriate Primary Care).
- Annual number of pregnant women receiving HIV medical care, and number of those who were prescribed antiretroviral medications, at three Primary Medical Care providers.

Data Collection Strategy–The above data are collected by contracted providers during the course of providing care and reported either on the semi-annual Client Level Reporting System (CLRS) or on Outcomes Evaluation data forms that are collected, analyzed, and reported by the TGA's contracted Outcomes Evaluation consultant. Information about pelvic exams, Pap tests,

pregnancy counts and ARV for pregnant clients is reported to the grantee through the funded providers' Ryan White Data Reports (RDR), because they are each also Part C or D grantees.
Activities and Plans Using Data to Demonstrate Clinical Health Outcomes–Outcomes Evaluation reports are completed on a periodicity schedule specific to each service area. Each provider agency receives its own individual results in full detail; aggregated results showing outcomes for entire service areas are made available to the providers within that service area and to the Planning Council; the Part A grantee is copied on all reports. These data are used to inform individual providers' annual quality work plans, the QMAC's annual evaluation of the TGA's quality program, and the Service Area Reviews (SARs) utilized by the Planning Council in its bi-annual prioritization process.

6. b. Description of Data Collection and Results
Preparation for Client Level Data Reporting—Improvement of the system-wide provider data collection and reporting system is an ongoing quality improvement project of the grantee. To analyze its current data collection process and plan for the new client level data (CLD) reporting requirements, the Part A grantee has formed, together with the Minnesota Department of Human Services (the Part B grantee) and the Minnesota Department of Health, a Data Improvement Project Work Group. The work group's charge is to create a data management solution that will utilize a centralized database system for accurate, efficient, and effective data collection and reporting. In September 2008, the Part A grantee was awarded a Special Projects of National Significance (SPNS) grant for CLD capacity building. As part of the application process for that grant, the grantee assessed each contracted provider's readiness to begin electronically submitting the required CLD elements starting in 2009, and developed a plan to assist providers to address readiness gaps in hardware, software, and staff training for data collection and reporting.

Centralization of the Ryan White Parts A and B data management will allow all stakeholders, including providers and grantees, access to their own information in a unified and accurate manner. Additionally, federal reporting responsibilities will be maintained at each partner agency and each will be able to independently utilize their own data for planning, policy and grant development. Ongoing communications with contracted providers have been initiated about CLD requirements and specific ways that they will be able to use the collected data to monitor their performance on the first two groups of HAB HIV core clinical measures, and how to incorporate these measures into their annual clinical quality improvement work plans. The grantee will use the collected data to assess its progress on meeting its annual quality goals, in collaboration with the QMAC as it completes its annual evaluation of the Part A QI Plan. Likewise, each contracted provider's annual QI Work Plan will be evaluated by the CQM Coordinator for how it incorporates its individual data sets into identifying areas for improvement and measuring the outcomes of planned quality interventions.
Process for Collecting and Reporting Client Level Data—To ensure all service providers incorporate new CLD requirements, the grantee's Data Improvement Project work group has identified a subcommittee dedicated to planning and delivering communications to inform all contracted providers about the new HRSA CLD expectations. This subcommittee is in the process of implementing a plan to develop written materials and trainings that will outline the changes between the previous and new CLD requirements, update the current data requirements to describe CLD fields, and update the reporting schedule as determined by HRSA. As

appropriate, the communications work group will meet with service providers to further explain the data requirements either in groups or individually, depending on provider needs.

In order to understand service providers' current electronic reporting capabilities and to identify any barriers, an assessment work group has been formed to utilize an assessment tool with providers to develop an understanding of their current hardware, software, and connectivity capacities, and to understand any IT policies and procedures that may present barriers. Funds from the SPNS grant will be distributed to the contracted providers, based on the outcomes of their electronic reporting assessments, to allow purchase or upgrades of hardware and software, cover programming costs, and provide staff training.

At a minimum, all contracted providers will receive necessary training and technical assistance to enable them to manage the new CLD requirements. Those who choose to use CAREWare will receive custom data screens and fields designed to adapt CAREWare to continue collecting the additional utilization and outcomes data currently required by the Part A and B grantees. These providers will also receive a standard query-and-report template that will generate the data set required by the grantees and HRSA. This will allow the service providers to manage data and to create their own CLD reports for internal management and operating purposes.

All hardware and software installation as well as software and encryption training are planned for completion by November 30, 2008. By December 31, 2008, all service providers will be asked to complete testing of their electronic CLD storage and reporting systems. Service providers will be expected to use these new systems to collect CLD electronically beginning January 1, 2009.

Data Collected–Data related to the TGA's established performance measures are collected as follows:

- All contracted providers submit data for the previous six months on all Ryan White program service recipients in July and January to the Client Level Reporting System (CLRS) including HIV/AIDS status; exposure category; age, race, ethnicity, country of birth, and county of residence; health insurance status and coverage type; HIV care status and number and percent of referrals and follow-ups for those out of care; type and number of services provided; and financial eligibility for Ryan White services.

This data collection will transition to the new CLD reporting system, which will incorporate the above data elements.

- Medical Case Management Outcomes forms are completed together by case managers and clients and have been submitted in March and September since 2000. In July 2007 these were redesigned as Form II of the CLRS and are submitted with it in July and January. Custom screens for electronic CLD data collection and reporting are being designed to include Outcomes data with the HRSA-required CLD fields. Data collected on these forms include acuity scale (episodic, maintenance, or intensive case management required); issues that contribute to eligibility and need for case management services; status of client needs related to medical care, including assistance to obtain HIV medications and health insurance, treatment adherence issues, access to coverage for co-occurring conditions, access to HIV medical care, dental care, mental health or substance use services, issues related to participation in clinical trials; other client needs that impact participation in HIV medical care, including need for culturally appropriate services, food and nutrition, medical transportation, health education, home health services, and emergency financial and housing assistance.

- Clinical data are collected through the Outcomes Evaluation program at funded Outpatient/Ambulatory Medical Care sites as follows: CD4 levels and viral loads are continuously collected at two clinics providing Medication Adherence services, and reported annually in aggregate. In addition, these providers collect data on length of time clients have been on antiretroviral therapy, number of regimes, presenting issue, and medication adherence services provided. CD4 levels and viral loads are also collected at one clinic providing Culturally Appropriate Primary Care services, and reported annually in aggregate. This report shows changes over ten collection times since 2002. Two Primary Medical Care providers that are funded by both Part A and Part C or D collect and submit data on CD4 levels, TB testing and treatment, gynecological care, and hepatitis and STI screenings.

Data Collection Results–Comparative CLRS results for calendar years 2005-2007 are shown below:

Client Level Reporting System Quality Indicators 2005-2007 Findings									
Program	Number of CLRS Cases			Accessed Care			Out of Care and Referred		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Medical Case Management (all tiers)	1706	1856	1556	62%	65%	89%	30%	19%	19%
Outreach	92	165	107	79%	70%	84%	50%	25%	67%
Education/Self Advocacy	257	508	369	56%	58%	83%	55%	6%	15%

Please note that while the findings appear to show a decline in the percentage of clients who were referred to care in 2006, this table does not reflect a quality improvement initiative undertaken by the TGA just prior to the July, 2006 report. To address the unacceptably large number of clients whose care status was reported as "unknown" on the 2005 CLRS reports, training and technical assistance were provided to all reporting agencies. The resulting decrease in "unknown" reports coincided with an increase in "no" responses to the question "Has the client received HIV medical care in the past six months?" This created a larger denominator for the pool of clients to be referred to care. Since these results were shared with case management providers, they have increased their efforts to assess and assist clients to keep medical appointments, resulting in an increase in the percent of clients who had accessed care in the 2007 reporting periods.

Medical Case Management outcomes for the second half of 2007 showed 92% of participating clients were reported to have current health insurance, and 94% had seen their physician in the prior six months. However, 67% of clients were reported to have one or more barriers to accessing medical care and 94% were assessed as needing ongoing case management services to continue to access care.

Culturally Appropriate Primary Care outcomes for patients at the clinic contracted to provide this service show a change in mean CD4 count from 312 at baseline to 392 among patients with eight reported CD4 counts. In 2007, 85% of clients had a CD4 count greater than 200 cells/ml., remaining comparable to 87% of patients in 2006.

How Data Are Used to Improve or Change Service Delivery–The Minnesota HIV Services Planning Council uses reported results of the TGA's CQM program in its biannual priority

setting process. The CQM coordinator regularly reports on quality improvement progress to the Council's Needs Assessment and Evaluation subcommittee. This committee is responsible for compiling all data into understandable formats for Planning Council members to use in prioritizing services and allocating both Part A and Part B base award funds. Outcomes Evaluation results are summarized as 31 service area reviews and made available to the Planning Council in advance of its prioritization and allocation process. The CQM program's system-wide effort to measure progress in getting PLWH/A who are aware of their status into care helps the Planning Council to focus its priorities and allocations on addressing unmet need. This is reflected in the two overarching goals in the 2006–2008 Comprehensive Plan (see FY 2009 Implementation Plan, **Attachment 7**).

Quality Improvement Projects– The Part A Clinical Quality Program's overarching goal is to increase the number of people living with HIV/AIDS in the TGA who access and maintain HIV medical care that meets DHHS guidelines for the treatment of HIV. All agencies providing Ryan White-funded services are required to document how they assessed their clients' current care status, defined as whether they have had an HIV medical visit in the previous six months, and provided referrals and follow-up to those who are not current. Providers are also required by contract to develop and submit an annual quality improvement work plan. Providers whose CLRS findings show less than optimal participation in care are strongly encouraged to focus their QI work plans on improving this measure. Expectations are that Primary Care and Medical Case Management providers will have higher rates of clients who are current in care than those who provide brief transactional services such as Emergency Financial Assistance or Food services, so there is no single benchmark for the spectrum of service providers. The CQM coordinator continues to work with contracted providers to achieve their initial goals and develop and implement quality improvement interventions based upon CLRS data and service-specific outcome measures.

The CQM coordinator is the project leader on the Data Improvement Project, a cooperative effort with the Part B grantee and the Minnesota Department of Health STI and HIV Section with the goal to improve client level data collection, analysis and reporting. One community-based provider of multiple services (Benefits Counseling, Care Outreach, Medical Case Management, Emergency Financial Assistance, Health Education, Legal Services, Resource & Referral, Transportation) wanted to improve the number of client medical care status assessments done by its non-Medical Case Management programs (case management was doing well, with 94% of clients current in care, but its other programs, most of which are brief and transactional in nature, was pulling the agency-wide rate down to 60% for FY2006). Using training on its new data collection system as the measurement tool, the agency set a goal of 75% current in care for FY2007, and worked with each program area to adapt its client contact procedures to include this assessment. The overall care status rate for the agency exceeded the goal and came in at 80% for 2007 through this QI plan.

A Culturally Appropriate Primary Care Clinic, the majority of whose patients have cultural and linguistic challenges to accessing health care as well as poverty barriers, learned in discussions with frontline staff that a lack of current contact information for patients made it difficult to provide appointment reminders and transportation assistance. By implementing a plan to verify contact information at each clinic visit for primary care, health education and case management visits, and tracking the number of corrections to encounter form data and emotional support activity mailings, the clinic was able to increase its overall rate of clients who were current in HIV medical care from 82% to 93% from FY2006 to FY2007.