HIV Health Improvement Affinity Group

Expression of Interest Form

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State: _____

The HIV Health Improvement Affinity Group aims to improve health outcomes—including rates of sustained virologic suppression--among Medicaid and CHIP beneficiaries living with HIV. To accomplish these goals, the group supports state collaborations between public health and Medicaid programs to improve the availability, accessibility, and quality of HIV prevention and care services delivered to HIV-infected Medicaid and CHIP enrollees.

A. Your Project and Goals

1. **The HIV Health Improvement Affinity Group will focus on improving health outcomes among Medicaid and CHIP enrollees who are living with HIV in order to improve health and prevent transmission of HIV. Has your state Medicaid program previously undertaken activities in this area or are you currently engaged in related activities?**

   ◯ No, our state Medicaid program has not yet undertaken work to improve health outcomes among Medicaid and CHIP enrollees living with HIV. **(Note: Previous work in this area is not required to participate.)**

   ◯ Yes, our state Medicaid program has previously undertaken work to improve health outcomes among Medicaid and CHIP enrollees living with HIV.

   If yes, please describe your efforts in this area and indicate the extent to which state public health partners (including HIV prevention and care programs) were involved as partners in this work

2. **Briefly describe the project that will be the focus of your participation in this Affinity Group.**

3. **What results does your state hope to achieve by November 2017?**

4. **Has your state already started work on this project?** ◯ Yes ◯ No
   If yes, what is the current status of the project?

5. **Is there any specific technical assistance your state will need or barriers to your success that you anticipate? If so, please describe.**

B. Your Team

6. Please identify the state Medicaid staff person who will serve as the point of contact for the team.

Name _____ Title _____

Medicaid Agency _____ State _____

Phone Number _____ Email Address _____

7. Please identify team members and their roles within the state.

Name	Title	Agency

(Attach an additional list if necessary)

C. Leadership Expression of Support

8. Affinity Group state teams are expected to have the support of the Medicaid senior leadership AND the state AIDS Director to demonstrate the state's interest in achieving the project's goals. Please indicate below the names of the supporting officials.

Senior Medicaid Official

Name _____

Signature _____

Title _____

Agency _____

AIDS Director

Name _____

Signature _____

Title _____

Agency _____

Send completed Expression of Interest forms to MedicaidCHIPPrevention@cms.hhs.gov.