

**Presidential Advisory Council on HIV/AIDS (PACHA)
62nd Meeting**

**Hubert H. Humphrey Building
8th Floor/Penthouse
200 Independence Avenue, SW
Washington, DC**

August 30, 2017

Council Members—Present

Darrell Wheeler, Ph.D., M.P.H., ACSW, Vice Chair
Ada A. Adimora, M.D., M.P.H.
Oliver Clyde Allen III
Nicholas Carlisle, J.D.
Cecilia C. Chung
Kevin Cranston, M.Div.
Gabriel Maldonado, M.B.A.
Ligia Peralta, M.D., FAAP, FSAHM, AAHIVS
Harlan H. Pruden
Elizabeth Styffe, M.S.N.
Patrick Sullivan, D.V.M., Ph.D.
Mildred Williamson, Ph.D., M.S.W.

Council Members—Absent

None

Staff

Kaye Hayes, M.P.A., PACHA Executive Director
Caroline Talev, Public Health Analyst

Federal Liaisons and Partners

Gina Brown, M.D., Medical Officer, Office of AIDS Research (OAR), National Institutes of Health (NIH), U.S. Department of Health and Human Services (HHS)
Laura Cheever, M.D., Sc.M., Associate Administrator, Chief Medical Officer, HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), HHS
Rick Haverkate, M.P.H., National HIV/AIDS Program Director, Indian Health Service, HHS
Lisa Kaplowitz, M.D., M.S.H.A., Senior Medical Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA), HHS
Peter Kim, M.D., Deputy Director, OAR, NIH, HHS
Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention (CDC), HHS
Richard Wolitski, Ph.D., Director, Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), HHS

Don Wright, M.D., M.P.H., Acting Assistant Secretary for Health (ASH), Office of the Assistant Secretary for Health, HHS

Sara Zeigler, M.P.A., Associate Director for Planning and Policy, National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis (TB) Prevention, CDC, HHS

External Stakeholders

Nancy Campbell, M.S.W., LGSW, Ryan White Program Manager, Johns Hopkins University Pediatric and Adolescent HIV/Program

Dázon Dixon Diallo, D.H.L., M.P.H., Founder and President, SisterLove, Inc.

Robert Greenwald, J.D., Clinical Professor of Law, Harvard Law School; Director, Harvard Law School Center for Health Law and Policy Innovation

Domeniek Harris, M.Ed., Chief Executive Officer (CEO) and President, National Coalition of Pastors' Spouses

John Hassell, National Advocacy Director, AIDS Healthcare Foundation

Debra Hauser, M.P.H., President, Advocates for Youth

Venton C. Jones, Jr., M.S.H.C.Ad., PMP, National Black Justice Coalition

Jennifer Kates, Ph.D., Vice President and Director of Global Health & HIV Policy, Kaiser Family Foundation

Paul Kawata, Executive Director, National Minority AIDS Council

Carolyn McAllaster, J.D., Colin W. Brown Clinical Professor of Law, Duke University School of Law; Founder, Duke AIDS Legal Project and Duke HIV/AIDS Policy Clinic; Director, Southern HIV/AIDS Strategy Initiative

Shanell McGoy, Ph.D., M.P.H., Director, HIV/STD, Tennessee Department of Health

Leandro Mena, M.D., M.P.H., Professor and Founding Chair, Department of Population Health Science, University of Mississippi Medical Center, John D. Bower School of Population Health

Jesse Milan, Jr., J.D., President and CEO, AIDS United

Terrance Moore, Deputy Executive Director, National Alliance of State & Territorial AIDS Directors, Director, Center for Engaging Black MSM Across the Care Continuum

John Peller, M.P.P., Vice President of Policy, AIDS Foundation of Chicago

Daniel Raymond, Policy Director, Harm Reduction Coalition

Justin Rush, J.D., Director of Public Policy, True Colors Fund

Bamby Salcedo, President and CEO, TransLatin@ Coalition

Luis Scaccabarozzi, Director of Health Policy and Advocacy, Latino Commission on AIDS

Carl Schmid, M.B.A., Executive Director, The AIDS Institute

Cathalene Teahan, R.N., B.C., M.S.N., CNS, President, Georgia AIDS Coalition

Stacey Trooskin, M.D., Ph.D., Director of Viral Hepatitis Programs, Philadelphia FIGHT Health Centers; Assistant Clinical Professor of Medicine, Perelman School of Medicine, University of Pennsylvania

Roll Call

At 9:10 a.m., Kaye Hayes, M.P.A., PACHA Executive Director, opened the meeting and called the roll.

Welcome

PACHA Vice Chair Darrell Wheeler, Ph.D., M.P.H., ACSW, welcomed the members of the Council and meeting attendees. He acknowledged the nine members of PACHA who had resigned since the March 2017 meeting: Jeffrey S. Akman, M.D.; Lucy A. Bradley-Springer, Ph.D., R.N., ACRN, FAAN; Gina M. Brown, M.S.W.; Ulysses W. Burley III, M.D., M.P.H.; Vignetta Charles, Ph.D.; William H. Collier; Michelle Collins-Ogle, M.D., FAAP, AAHIVS; Grissel Granados, M.S.W.; and Scott A. Schoettes, J.D. Dr. Wheeler stated that he respected these members' decision to leave the Council and thanked them for their service.

PACHA remains committed to eradicating HIV and AIDS and, until that is accomplished, serving those affected, Dr. Wheeler stated. He thanked Ms. Hayes and Public Health Analyst Caroline Talev for their leadership and support of PACHA. Dr. Wheeler also thanked Richard Wolitski, Ph.D., for his leadership of OHAIDP. He looked forward to a robust discussion among PACHA members and invitees about the potential for collective impact, which is not a solution in itself, he noted, but rather an important part of the process of addressing HIV/AIDS in the United States and globally.

PACHA Subcommittee Reports

Increasing Access to Care Subcommittee

Kevin Cranston, M.Div.

Mr. Cranston stated that the Subcommittee remains committed to addressing implementation of the Affordable Care Act (ACA) as it relates to HIV and seeks to articulate the importance of the ACA in reaching the goals established by the National HIV/AIDS Strategy (NHAS). The Subcommittee will continue to advocate for ACA improvements, particularly regarding coverage, transparency, and costs.

In recent meetings, the Subcommittee has focused on successful models using state and Federal dollars for improving the ACA. The March 2017 full PACHA meeting included several presentations and discussions on health care financing, and the Subcommittee is working on recommendations in response to those presentations.

The Subcommittee continues to address the intersection of HIV, hepatitis (particularly hepatitis C virus [HCV]), and the opioid epidemic. Mr. Cranston commented that the Subcommittee appreciates the current Administration's focus on the opioid epidemic. Now is an important time to ensure that evidence-based programs (e.g., syringe exchange) and evidence-based education play a central role in efforts to combat opioid abuse, he concluded.

Reducing HIV-Related Disparities Subcommittee

Gabriel Maldonado, M.B.A., and Mildred Williamson, Ph.D., M.S.W., Co-Chairs

Dr. Williamson reported that the Subcommittee has been focusing on issues that people living with HIV (PLHIV) and those at risk face in rural communities and how to address stigma and other social determinants of health (SDH). The Subcommittee plans to propose a comprehensive review of HIV programs that acknowledges the effect of stigma

and SDH on PLHIV in rural areas. This review should include Federally Qualified Health Centers, Indian Health Service centers, and migrant health services. It should identify strong programs and best practices, whether they occur in Federal, state, local, community, or private organizations. Exemplary programs and practices should be acknowledged in future HHS funding efforts. The review should look not only at health care, but also at housing, transportation, and other areas in which stigma and SDH play a role.

Global Agenda Subcommittee

Harlan H. Pruden and Elizabeth Styffe, M.S.N., Co-Chairs

Mr. Pruden pointed out that the people of the United States also are global citizens, and the Subcommittee represents the voice of those around the world. About 37 million people worldwide live with HIV. Of those, about 1.8 million are younger than age 15. About 60 percent know their status; the remaining 40 percent (18 million people) need access to testing. Mr. Pruden noted that the Subcommittee seeks to influence or broaden the conversation to build on global and domestic efforts to address HIV. The Subcommittee is teaming with the Disparities Subcommittee to further the discussions that came out of the Stigma Summit in September 2016. It also is seeking best practices and models outside the United States that could inform domestic efforts.

Reducing HIV Incidence Subcommittee

Ada Adimora, M.D., M.P.H., and Patrick Sullivan, D.V.M., Ph.D., Co-Chairs

Dr. Adimora reported that the Subcommittee had been updating its long-term work plan to include promotion of preexposure prophylaxis (PrEP) and use of treatment as prevention, with attention to assistance with cost-sharing and access to PrEP by minors. The Subcommittee seeks to ensure that support services and case management are available for those at high risk for HIV, such as those who use drugs; young, gay men of color; and transgender people. The Subcommittee would like CDC to update the data for the cascade (i.e., data indicating the number of PLHIV who get tested, know their status, have sought treatment, and remain in care). The Subcommittee continues to focus on access to antiretroviral medications and drug pricing schemes that affect access. The PACHA had invited HHS Secretary Thomas Price, M.D., to discuss the Administration's position on these issues, but he declined.

Since January 2017, the Administration has proposed a budget that would dismantle Medicaid, which would affect 40 percent of PLHIV, and Congress proposed repealing the ACA and replacing it with a program that cuts benefits to millions of people. Although Congressional efforts to repeal and replace the ACA have failed so far, it is not clear that the attack on health care has ceased, commented Dr. Adimora. Therefore, the Incidence Subcommittee drafted a letter to Secretary Price outlining the impact of proposed changes on PLHIV.

Also in response to the efforts to cut health care, Dr. Adimora and former PACHA member and co-chair of the Incidence Subcommittee Dr. Collins-Ogle published an [op-ed](#) on the dire ramifications of Congress' proposed legislation. As U.S. Senate Republicans pursued further efforts to roll back Medicaid expansion and eliminate the

consumer protections of the ACA, Dr. Collins-Ogle and several other PACHA members resigned from the Council. Dr. Adimora published further concerns about how President Donald Trump's Administration is [reversing progress on HIV treatment](#).

Dr. Adimora outlined other detrimental Administration policies, such as the U.S. Department of Justice's determination that Federal law does not protect against discrimination based on HIV; Justice Department requirements for applying the harshest possible sentence to all offenders, which will likely increase the number of young, black men who are incarcerated; and the normalization of racism demonstrated by President Donald Trump's equating white supremacists with those who protest against them. Dr. Adimora concluded by observing that although these and other policies directly threaten PLHIV, what harms some of us ultimately threatens all of us. Her words were met with strong applause.

Discussion

Dr. Wheeler stated that although PACHA focuses on HIV/AIDS, it continues to stand up to the assaults on people disproportionately affected by poor economic status, education, health, and health services, as well as myriad other social and political factors in the United States and around the world. He hoped the meeting attendees would provide clear thinking on a path forward.

Impact of ACA Repeal on HIV Prevention: Incidence Subcommittee Draft Statement for Review

Ada Adimora, M.D., M.P.H., and Patrick Sullivan, D.V.M., Ph.D., Incidence Subcommittee Co-Chairs

Dr. Adimora read aloud the draft letter to HHS Secretary Price on the consequences of repealing or diminishing the ACA. The Incidence Subcommittee requested that PACHA endorse the letter and send it to Secretary Price on behalf of the full Council. Dr. Sullivan added that Subcommittee members felt strongly that PACHA should identify the tools that are working to make gains against HIV infection.

Motion: PACHA members voted unanimously to endorse the letter submitted by the Incidence Subcommittee to the HHS Secretary recommending consistent access to comprehensive health care coverage for all Americans, including PLHIV, through the state marketplaces and the Medicaid program, by supporting actions to (1) stabilize the non-group insurance market; (2) maintain and enforce Essential Health Benefits and nondiscrimination protections, including for individuals who are lesbian, gay, bisexual, or transgender; and (3) ensure that as States seek more flexibility in their Medicaid programs, their proposals do not create barriers to coverage, services, and treatment, including antiretroviral medications, which are essential for people at risk for HIV infection and PLHIV. (See Appendix A.)

Continued Support for the NHAS: Incidence Subcommittee Draft Statement for Review

Ada Adimora, M.D., M.P.H., and Patrick Sullivan, D.V.M., Ph.D., Incidence Subcommittee Co-Chairs

Dr. Sullivan read aloud a letter to Secretary Price drafted by the Incidence Subcommittee calling on the Administration to endorse the NHAS publicly and restore it to the White House website. The Incidence Subcommittee requested that PACHA endorse the letter and send it to Secretary Price on behalf of the full Council.

Discussion

Dr. Wheeler suggested changing the term “people of color” to “non-White people,” noting that racism and violence are at the forefront of all the current challenges. The U.S. economic structure was built on unpaid labor, he added. Mr. Pruden observed that the U.S. economic structure was built on land stolen from indigenous people; he agreed that “people of color” does not adequately address such issues.

Dr. Williamson suggested the letter mention that PLHIV contributed to the NHAS, and removing it from the website sends a message that their work is not appreciated. Ligia Peralta, M.D., FAAP, FSAHM, AAHIVS, pointed out that young people also contributed to the NHAS. She added that the community sought a comprehensive strategy for years.

Dr. Wolitski noted that the work of previous administrations always is archived. The Federal intra-agency working group on HIV/AIDS continues to meet, and it remains focused on indicators of progress toward the goals of the NHAS, especially indicators for black men in the South. Data on NHAS indicators are reported on the website HIV.gov and updated frequently. Dr. Wolitski hopes to publish a report on NHAS indicators in December. He also noted that the current strategy expires in 2020; if a new iteration beyond 2020 is to be produced, efforts should begin soon, because the process can take up to 2 years.

Mr. Maldonado observed the need to ensure that the NHAS includes specific outcomes that are applicable to the current climate. Much of the current NHAS is tied to ACA policies, so an update would have to take any new policies into account. Dr. Adimora suggested adding language about the importance of health care access for all. Council members debated whether asking the White House to reinstate the Office of National AIDS Policy would be helpful. After lunch, Dr. Sullivan presented a revised draft in which the comments of PACHA members and guests were considered.

Motion: PACHA members voted unanimously to endorse the letter submitted by the Incidence Subcommittee (as revised) to the HHS Secretary calling for renewed support of the NHAS. (See Appendix B.)

Welcome from the Acting ASH

Don Wright, M.D., M.P.H., Acting ASH, Office of the Assistant Secretary for Health, HHS

On behalf of HHS and Secretary Price, Dr. Wright expressed gratitude for the leadership, expertise, and guidance provided during their tenure by those PACHA members who had resigned. He noted that important progress has been made against HIV but more remains to be done. Getting input from outside the Federal “family” helps HHS do its job better, Dr. Wright observed. To improve transparency and accountability to the public, HHS plans to webcast future PACHA meetings. In addition, HHS continues to monitor NHAS indicators, particularly for populations of concern (e.g., gay and bisexual men, African Americans, Latinos, homeless people, and people living in the South), and posts results on the website HIV.gov.

Dr. Wright expressed excitement about recent scientific advancements of the past few years in HIV prevention and treatment that could make it possible to end new HIV cases. He thanked Dr. Wheeler for a productive meeting in which the two discussed PACHA’s work. Dr. Wright noted the need to coordinate efforts across all sectors of society, so today’s meeting with leaders and advocates from a wide range of organizations is important. With the funding and budget challenges that public health faces, the importance of collaboration cannot be overemphasized, stated Dr. Wright. He thanked PACHA for its commitment and for the work that PACHA members do in their communities, noting that HHS appreciates their perspectives and efforts.

Public Comment Period

No members of the general public requested time to comment. Therefore, some of the invited guests expressed their thoughts.

Dázon Dixon Diallo, D.H.L., M.P.H., suggested that PACHA’s work and the two letters proposed earlier explicitly highlight the intersections of HIV with other conditions and policies. For example, HIV research has led to improved treatments for cancer patients. Also, populations affected by HIV also are heavily impacted by HCV, TB, human papillomavirus, and other infections.

Dr. Diallo added that, since the NHAS was drafted, the field has shifted focus from reducing infections to ending the HIV epidemic. She suggested that the NHAS and the proposed letters from the Incidence Subcommittee reflect the new emphasis on ending HIV. Dr. Diallo’s proposal to revise and rename the NHAS as the National Strategy to End the HIV Epidemic in the United States was met with applause.

Jesse Milan, Jr., J.D., recommended that PACHA make a clear request that the President and HHS Secretary publicly affirm in writing that the NHAS continues to be the federally endorsed strategy for addressing HIV in the United States. Robert Greenwald, J.D., countered that the NHAS remains in place unless it is actively rescinded, so no such request is needed.

Several other comments about the NHAS arose:

- Shanell McGoy, Ph.D., M.P.H., suggested adding hepatitis and addictions to the discussion of routine care for sexually transmitted infections (STIs).
- Bamby Salcedo commented that if the NHAS is revised, its discussions of SDH should better address concerns for transgender people, people who are incarcerated, and people in immigration detention centers.
- Carolyn McAllaster, J.D., concurred that the next NHAS should center on ending HIV/AIDS. A continued focus on reduction could lead to continued geographic disparities. Even when resources flow to the South, not enough go to the rural areas in need. Marginalized groups, like transgender people, often are left out.
- Dr. Wheeler added that focusing on reduction and not eradication results in glossing over certain populations, such as indigenous people, who lack political and economic clout.
- Debra Hauser, M.P.H., noted that the current Administration has endorsed abstinence-only education and risk avoidance as primary prevention for STIs. She urged PACHA to be aware of efforts under way across the Administration that affect HIV/AIDS. Ms. Hauser added that effective, evidence-based sex education is an important part of the NHAS.

PACHA's Role in Serving People Living with, or at Risk of, HIV and AIDS: A Collective Impact Roundtable Discussion in a Changing Environment

Introduction and Overview

PACHA members, external stakeholders, and Federal partners introduced themselves briefly. Dr. Wheeler opened the floor for discussion around the potential for collective impact. He hoped the day would offer an opportunity to find commonalities, debate differences, and find a way forward, regardless of who resides in the White House. Dr. Wheeler further hoped that this meeting would help build bridges across organizations and unify the participants around the cause of serving PLHIV and those at risk.

Key Points of Discussion

Current Status and Way Forward

- The science, understanding, and capacity to end the HIV epidemic exist, but it is not clear that there is sufficient political will and money to do so. (Continued scientific research is needed, however.)
- It is not clear where the current Administration stands on HIV.
- Within the Federal government, many people continue their work to combat HIV. Rather than force the issue and risk that work being shut down, advocates outside the government should continue to work with PACHA, OHAIDP, the HHS Office of Civil Rights, and others to develop relationships.
- A focus on addressing HIV in the South may be a way to engage the President and Republicans.

- Advocates involved in HIV/AIDS should continue to hold social justice—that is, including the excluded—as a central premise even if PACHA disbands.
- Some small groups (e.g., those representing transgender people or Asians/Pacific Islanders with HIV) may begin to focus their limited resources on fighting for human rights broadly, rather than tackling issues specific to HIV.

Federal Funding and Policies

- PACHA should comment on the effect of the proposed dramatic budget cuts on PLHIV.
- The NHAS is not sufficient to address the related issues of opioid and heroin use, particularly the lack of drug treatment options for people in rural areas, and deep Federal funding cuts threaten efforts to address the crisis.
- How can PACHA leverage the Administration’s response to the opioid crisis?
- The proposed elimination of the Secretary’s Minority AIDS Initiative Fund (SMAIF) is concerning and would have a disproportionate impact on the South.
- As the number of PLHIV older than age 50 increases, more attention is needed to the health care and service infrastructure for older PLHIV.
- PACHA should address the Administration’s efforts to destabilize the ACA, which include fostering uncertainty about cost-reduction payments for insurance companies and demonstrating unwillingness to enforce the individual mandate and antidiscrimination statutes.

Role of PACHA

- PACHA was effective in communicating to the Federal government some lessons learned from the field, most notably that a health care system that works for PLHIV and those at risk works for most people. PACHA can continue to highlight successes of the ACA and the Ryan White HIV/AIDS Program (RWHAP).
- PACHA can play a critical role in informing people new to the Administration about the broader benefits of offering services to PLHIV and those at risk.
- PACHA can advise on efforts to support market development and access to care, e.g., through flexibility in state Medicaid programs.

Underrepresented Populations

- There is continued need for a leadership pipeline among populations most affected by HIV (e.g., youth, blacks, Latinos).
- More young people should have “a voice at the table,” so that recommendations reflect their perspectives. However, many young people, even those in the leadership pipeline, feel disenfranchised.
- Transgender people, those who are incarcerated, and indigenous people are underrepresented in HIV policymaking. However, these communities are small, and it is difficult for their representatives to attend every meeting.

Education, Awareness, and Cross-Sector Collaboration

- The role of the faith-based community should be clarified.

- Young people need education and a sense of empowerment so that they will seek out testing and treatment. PACHA should demand that the Administration put resources toward education for young people that links to HIV services.
- It is important to name and increase awareness about issues that make it harder to address HIV/AIDS, such as stigma, homophobia, and transphobia.
- More science, such as implementation science, is needed to inform how advocates can work under adverse conditions.
- More input and expertise is needed from those in the fields of housing and homelessness, science, political science, and economics, among others.

Perspectives of Federal Partners

Dr. Wheeler thought the afternoon discussion should seek to uncover areas in which PACHA and others can act. He asked the Federal partners in the room to comment.

Regarding PACHA membership and reauthorization, Ms. Hayes noted that PACHA's charter allows as many as 25 members, and it currently has 12. The PACHA charter sunsets on September 30, 2017—a date intended to allow the incoming Administration time to understand the work of existing advisory bodies and determine future needs. Ms. Hayes and others are awaiting word about reauthorization of PACHA before seeking to fill empty seats on the Council.

CDC representatives noted that the proposed fiscal year 2018 budget for domestic HIV prevention states that CDC should continue working toward national targets despite budget cuts. CDC continues to focus on the targets described by the NHAS. It also seeks to prevent new infections, as evidenced by a new funding opportunity announcement. It was suggested that a comprehensive program that addresses the many effects of health disparities in the South (e.g., rates of HIV, diabetes, and hepatitis) may be worth pursuing.

HRSA is focused on outcomes, which aligns with directives from the new Administration. It also has taken steps to reduce the administrative burden on grantees. HRSA is seeking ways to address three priorities of the President: children's health, the opioid epidemic, and mental illness.

SAMHSA's new leadership has a focus on HIV and substance use disorders, a reason for some optimism that SAMHSA could focus on the intersection between HIV and the opioid epidemic.

One example of NIH's work is the partnership between OAR and the Washington, DC, Partnership for AIDS Progress. The effort began as a research agenda and evolved into a mechanism for linking people with HCV to HIV testing and care.

Key Points of Discussion

Capacity of Community-Based Organizations (CBOs) That Serve PLHIV

- It would be helpful to send more funding directly to CBOs.

- Service providers sometimes are burdened with local regulations that go beyond HRSA requirements; more guidance at the state level would be helpful to counter such overreach.
- At the local level, the amount of administrative burden required to secure RWHAP funding is excessive.
- HRSA should evaluate data on disparities, as well as on disease burden and prevalence, as part of its criteria for RWHAP Part B supplemental and other funds.

Collaboration Across Organizations and Sectors

- The NHAS has been effective in galvanizing stakeholders around common principles and new ways of working, creating synergy among Federal, state, and local entities. Broadly, entities should work together to strengthen ties and find areas of overlap. At the state and local levels, more collaboration to remove obstacles and share best practices would have a positive impact on HIV.
- PACHA could help by making recommendations about using surveillance and other data to drive performance measurement.
- At the local level, health departments should build relationships with university campuses to increase testing and awareness of services available and to increase knowledge among providers about access to PrEP and the prevalence of HIV.
- Organizations should work together to translate complex scientific outcomes into tools and ideas that clinics and providers can use on the ground, such as the concept that “undetectable equals untransmissible.”

Effect of State and Federal Programs on PLHIV

- Medicaid is the largest provider of care to PLHIV in the United States, but Medicaid programs pay little attention to the quality of HIV care. If Medicaid focused efforts to identify and treat PLHIV, new infections could be reduced by one-third.
- The SMAIF is important for vulnerable communities.
- The ACA is likely to remain the law for the near future. In the short term, the next battle will be waged around state waivers, which are subject to the authority of the HHS Secretary. PACHA should advise the Secretary on specific proposals and ensure that states do not cut essential health benefits, change out-of-pocket limits, or make health care unaffordable.

Potential Initiatives

- Support for a southern health initiative may be politically viable and address those with the heaviest burden of the HIV epidemic.
- Efforts to address HIV in the South should take into account the diminished workforce and lack of transportation. Expanding telehealth/telemedicine capacity could counteract those barriers.
- A decisive effort is needed to ensure tools to treat and prevent HIV reach those who need them.

- SAMHSA and HRSA can highlight the role of opioids and HCV coinfection in the HIV epidemic. Syringe exchange programs, naloxone, and people trained to administer naloxone all are needed.
- CDC should publish interim findings more rapidly. The ability to characterize and localize the epidemic using data is important. Close monitoring of HIV incidence data is more important than ever. CDC plans to provide tools to help states evaluate their own incidence data in a more timely way.
- PACHA, the Federal partners, and the external stakeholders should map the intersections between HIV and opiate use disorders and treatment to identify opportunities for intervention and models of care.
- PACHA and others should examine how the U.S. Department of Education is addressing sex education.

Action Item

PACHA staff will coordinate with CDC to ensure that PACHA receives interim reports on HIV-related federally funded projects.

Future Topics for PACHA Subcommittees

Dr. Wheeler asked PACHA members to identify topics raised throughout the day for consideration by the Subcommittees. He directed Subcommittees to update their work plans accordingly and post them on the PACHA website for input from constituents and colleagues.

Reducing HIV Incidence Subcommittee

- Data surveillance, particularly getting data to states more rapidly
- Potential effect of state Medicaid waivers on HIV incidence rates
- Ensuring health care market stability (e.g., addressing uncertainty)

Increasing Access to Care Subcommittee

- Economic barriers and innovative financing for health care
- Specific, up-to-date targets for increasing use of PrEP that incorporate current cost data, include connections with other medical conditions, and acknowledge the need for ongoing testing and maintenance
- Drug pricing
- Potential impact of state Medicaid waivers on access to care
- Continued analysis of the impact of policies on access to care

Reducing HIV-Related Disparities Subcommittee

- Impact of SMAIF and the Care and Prevention in the United States demonstration projects
- Potential effect of state Medicaid waivers on disparities
- Effect of Federal budget cuts on health care disparities, resulting in potential new HIV infections

- Capacity of AIDS service organizations, CBOs, and other direct providers to implement recommendations (e.g., for PrEP and postexposure prophylaxis)
- Direct funding to CBOs
- Reclassification of psychosocial services provided by CBOs as clinical, billable services

Global Agenda Subcommittee

- Cuts to U.S. funding for global HIV efforts
- Attention to global HIV issues on the PACHA agenda and website, such as continued collaboration with global stakeholders, including faith-based organizations, and strong support for funding for the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and The Global Fund
- Successful strategies and mechanisms used in other countries

Additional PACHA Motions and Other Items

Dr. Wheeler entertained the following motions, which were supported unanimously by the Council.

Motion: Given the ongoing racial and ethnic disparities in HIV/AIDS incidence in the United States, PACHA calls on the Administration to sustain and adequately fund the SMAIF. (PACHA members voted unanimously to incorporate this motion into the letter supporting endorsement of the NHAS.)

Motion: As the Administration moves forward in considering Section 1115 waivers, PACHA calls on HHS to consider the implications of specific provisions for PLHIV and reject provisions that undermine effective access to care and treatment, including proposals that would allow the following:

- Premiums and copayments greater than statutory limits
- Work requirements
- Time limits on coverage
- Limiting expansion eligibility to 100 percent (partial expansion)
- Monthly income verification and eligibility renewals
- Lock-outs for failure to renew eligibility on time
- Tobacco surcharge
- Drug screening

(PACHA members voted unanimously to incorporate this motion into the letter supporting endorsement of the NHAS.)

Discussion

External stakeholders offered other suggestions for PACHA:

- PACHA should state its support for PEPFAR’s Key Populations Investment Fund, which has been stalled for bureaucratic reasons since January.

- PACHA should acknowledge the success of PEPFAR Ambassador-at-Large, Deborah L. Birx, M.D., in transforming PEPFAR and pushing for accountability and incorporation of data into care.
- PACHA should ask the Administration to fulfill President Trump's campaign promise to allow the U.S. government to negotiate drug prices with manufacturers.
- PACHA should advise Secretary Price that the framework applied to address the opioid crisis be mindful of the downstream effects of the crisis, such as increasing rates of HIV infection.

The following motions were passed unanimously by the Council.

Motion: PACHA appreciates the recognition from Acting ASH Don Wright, M.D., M.P.H., commending the work and commitment of PACHA and urging that the Council continue its efforts. Current PACHA members are eager to continue working with the HHS Secretary and the Administration to address the national HIV epidemic.

Motion: PACHA reaffirms its continued and unwavering support for The Global Fund and PEPFAR.

Closing Remarks

Dr. Wheeler stated that he was remarkably pleased with the discussion. Dr. Wolitski added that he was energized by the constructive comments and forward-looking vision of all the participants. Ms. Hayes thanked the external stakeholders for their time and feedback, the Federal partners for their ongoing work with PACHA, and the contractors who support the meeting. Finally, she thanked Dr. Wheeler for his vision and leadership.

Adjournment

Dr. Wheeler adjourned the meeting at 4:20 p.m.

Appendix A

Presidential Advisory Council on **HIV/AIDS**



August 30, 2017

The Honorable Thomas Price, MD
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Price:

For the past five months, there has been considerable debate about repealing or revising the Affordable Care Act and on other legislation and policies that would affect access to healthcare. The ACA, through its market protections, support for states to expand their Medicaid programs, and subsidies that enable lower income people to buy insurance, has significantly expanded insurance coverage for people with HIV, and there has rightly been discussion about the impact that ACA revision would have on their health and wellbeing. But the impact of such legislation on the number of new HIV infections has received less attention.

Changes to the ACA, either through legislation or policy, that decrease healthcare access would cause catastrophic damage to HIV prevention – an area in which the nation has achieved substantial progress in the past 7 years -- by (1) decreasing access to primary care, screening, and prevention services among people at risk for HIV and (2) reducing access to care and thus the ability to achieve viral suppression among Americans living with HIV. Such actions would increase the number of new HIV infections in the United States and exacerbate racial/ethnic disparities in the domestic epidemic.

Access to healthcare coverage, including a minimum package of prevention services, allows Americans to receive routine clinical screenings and, for people who receive an HIV diagnosis, effective HIV treatment. For example, HIV screening is recommended by the US Preventive Services Task Force (USPSTF) and is currently included without additional costs to patients as part of routine healthcare. Since the ACA was passed the proportion of Americans living with HIV who are unaware of their HIV infection status has decreased from about 1 in 5 to 1 in 7 Americans. Routine healthcare also provides access to screening for sexually transmitted infections (STIs) and required treatments; having an untreated STI increases one's risk of acquiring HIV. Health insurance also facilitates screening tests and provision of pre-exposure prophylaxis (PrEP), which can reduce the risk of acquiring HIV infection by 90% or more. Healthcare visits are also important opportunities for education about health risks, including sexual health risks. Removing access to these screening, treatment, educational and prevention services will increase the risks of HIV infection among Americans who lose coverage and will lead to new, preventable HIV infections.

Of equal importance, legislation that decreases healthcare coverage would undermine access to medical care for people living with HIV. Medical care provides antiretroviral therapy for people with HIV, which suppresses their HIV viral load to below detectable levels, and makes their risk of transmitting HIV to

others negligible. Therefore, effective antiretroviral therapy is a powerful prevention tool. Currently, 4 in 10 people with HIV receive Medicaid. Over 90% of new HIV infections come from people from living with HIV who are not in effective medical care. Reducing access to medical care for HIV infection will compromise viral suppression among Americans living with HIV, and will result in increased new HIV infections. In addition, loss of Medicaid and other ACA-supported coverage will shift costs of care for these patients to Ryan White, community health centers, and other federally funded programs.

The costs of new HIV infections are not borne only by the individuals who acquire HIV. The current estimated lifetime cost of caring for a person with HIV is about \$367,134. Changes that reduce access to healthcare would likely increase new HIV infections, and even modest increases in HIV transmissions will have substantial future costs in medical care and lost productivity. For example, if reduced access to prevention and treatment increased HIV transmission by 25% --comparable to the decreases in HIV transmission we have achieved in recent years -- it is estimated that an additional 10,000 new HIV infections would occur each year.

Finally, differential access to health insurance by race explains, to a significant extent, why Black Americans are so disproportionately impacted by HIV in the United States. An NIH-funded Emory University study evaluated 803 Atlanta men who have sex with men to determine what factors caused higher rates of new HIV infections among Black men. They determined that men without health insurance were more than twice as likely to acquire new HIV infections, and that lower access to health insurance by Black men could account for why Black men in the study were nearly 4 times more likely to acquire HIV. Thus, changes to current public or private insurance programs that reduce access to healthcare would promote the disparate impacts of HIV on communities of color in the United States.

There is no question that broad access to healthcare, including antiretroviral medications and preventive services, is required to reduce HIV incidence in the United States. Cutting back on that access will move us in the wrong direction and threaten the progress we have already made.

Therefore, in order to continue progress in reducing new HIV infections in this country, we recommend that you ensure consistent access to comprehensive healthcare coverage for all Americans, including people with HIV, through the Marketplaces and the Medicaid Program, by supporting actions to: 1) stabilize the non-group insurance market; 2) maintain and enforce Essential Health Benefits and non-discrimination protections, including for individuals who are lesbian, gay, bisexual or transgender; and (3) as states seek more flexibility in their Medicaid programs, ensure that their proposals do not create barriers to coverage, services and treatment, including antiretroviral medications, which are essential for people at risk for HIV infection and people with HIV.

Respectfully,



Darrell P. Wheeler, PhD, MPH, ACSW
Vice Chair, Presidential Advisory Council on HIV/AIDS

cc: Don Wright, MD, MPH, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services

Appendix B

Presidential Advisory Council on HIV/AIDS



August 30, 2017

The Honorable Thomas Price, MD
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Price:

The National HIV/AIDS Strategy (NHAS) for the United States was launched in July 2010 to provide diverse stakeholders and responsible federal agencies with a shared set of priorities, indicators and 5-year targets to guide the national response to the HIV epidemic, and to provide benchmarks against which to measure progress. The plan was updated in July 2015 to include new advances in HIV prevention and treatment science and to update indicators and targets to the year 2020. These documents laid out a bold vision: “The United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.” The NHAS provided shared vision and promoted mutual efforts across responsible governmental agencies, state and local health departments, community-based and faith-based organizations, and academic institutions to make progress in reducing new HIV infections and providing life-saving medical care and services to those living with HIV. The NHAS incorporated the input of diverse partners, and reflects the collective work of governmental experts, people living with HIV, young people, providers, scientists, and members of heavily impacted communities.

In January 2017, the NHAS was removed from the White House website. Although the document continues to be available through numerous places on the internet, the removal of the document and the lack of subsequent direction from the White House about the NHAS has created a lack of clarity about the administration’s commitment to NHAS priorities. Further, staff in different HHS agencies have received different messages about whether the NHAS is still our national strategy. Many stakeholders have continued to plan their efforts with the assumption that the NHAS still reflects the coordinated plan of the United States to respond to the HIV epidemic. However, the lack of a clearly articulated or endorsed national strategy has decreased the efficiency and sense of common purpose among stakeholders and responsible federal agencies; most federal reports and materials no longer reference the NHAS, although they are reporting monitoring and process data using the NHAS indicators and using data systems optimized to monitor these indicators. In short, the collective efforts of HIV prevention and treatment researchers, program scientists, prevention experts, and community organizations are working without a shared plan.

The impacts of this lack of clarity and leadership from the administration are profound. During the period of the preparation and implementation of the NHAS, new HIV infections in the United States fell by 18%. The NHAS called for coordination of federal efforts to increase the impact of federal dollars spent on HIV prevention and treatment, and federal agencies developed and implemented coordinated data systems to measure key NHAS targets and increase accountability. Scientists convened to build consensus on approaches to measuring new scientific targets, following the science and laying out systems to support continued progress in HIV prevention and in reaching all those living with HIV with effective treatments. Importantly, government at all levels could be evaluated against pre-specified goals for prevention. The NHAS created accountability for the use of federal programmatic and research funds, and shaped the development of priorities in funding that will increase the impact of research dollars in controlling HIV transmissions in the United States.

As importantly, the silence of the administration about our national strategy to control the spread of HIV and to care for those living with the virus represents a void of leadership at a critical time in our response to the epidemic. The NHAS made a compelling scientific and public health case for the roles of stigma and discrimination in perpetuating inequalities in health, and called for policy and legal changes to ensure that HIV prevention and treatment efforts had the best environment in which to succeed. That the current administration removed the existing NHAS and has not either re-endorsed it has made issues of pressing national interest invisible. HIV disproportionately impacts those Americans with more limited socio-economic resources – those living in poverty, those with less income, and people of color – and the absence of an explicit commitment to endorsing the NHAS turns a blind eye to profound disparities in health equity.

We call on the administration to:

1. Publicly affirm NHAS as the national strategy for addressing HIV in the United States, and that it will remain in place until an updated strategy for 2020-2030 has been adopted and made available to the public;
2. Provide clear direction to HHS operating units and other responsible federal agencies to engage in coordinated efforts to adopt the priorities, apply the strategies, and pursue the targets of the NHAS, especially where performance targets have not been met;
3. Continue to produce annual monitoring reports to make agency actions and progress towards indicators transparent;
4. In support of key elements of the President's Management Agenda, as described in the Budget Blueprint, PACHA wishes to support the President's goals of improved government performance and accountability. We therefore request that the administration:
 - a. Prepare, in coordination with PACHA representatives, and present at each future PACHA meeting, a report and a briefing on the status of the Strategy's implementation, including up to date information from HHS agencies on their progress towards meeting the strategy's goals, priorities and indicators.
 - b. Request each HHS agency prepare and submit to PACHA a summary of how 2018 budget allocations will impact their ability to meet their previous commitments to address NHAS priorities and monitor NHAS indicators; and

5. Initiate a process to develop a plan for development of the next NHAS that will cover the interval from 2020-2030. This project should incorporate the input of subject matter experts recognized by the established scientific community and should incorporate new scientific advances and embrace increasingly realistic goals for elimination of HIV.

Respectfully,

A handwritten signature in blue ink, appearing to read "Darrell Wheeler", with a large loop at the top and a long horizontal stroke extending to the right.

Darrell P. Wheeler, PhD, MPH, ACSW
Vice Chair, Presidential Advisory Council on HIV/AIDS

cc: Don Wright, MD, MPH, Acting Assistant Secretary for Health, U.S. Department of Health and Human Services