

Presidential Advisory Council on HIV/AIDS (PACHA)
55th Meeting
Renaissance Washington DC Hotel
Washington, DC
February 12–13, 2015

Council Members—Present

Nancy Mahon, J.D., PACHA Chair
(by telephone)
David Holtgrave, Ph.D., Vice Chair
Dawn Averitt (day 2 only)
Lucy A. Bradley-Springer, Ph.D., R.N.,
ACRN, FAAN
Gina M. Brown, M.S.W.
Vignetta Charles, Ph.D.
William Collier
Michelle Collins-Ogle, M.D.
Robert Greenwald, J.D.
Douglas A. Michels, M.B.A.
(by telephone)
Ligia Peralta, M.D., FAAP, FSAHM,
AAHIVMS
Harlan H. Pruden
Scott A. Schoettes, J.D.
Rev. Vanessa D. Sharp, M.Div.,
M.A.C.M., M.A.T.M.

Lawrence A. Stallworth II
Elizabeth Styffe, M.S.N.
Mildred Williamson, Ph.D., M.S.W.

Council Members—Absent

Ada A. Adimora, M.D., M.P.H.
Cecilia C. Chung
Humberto Cruz, M.S.
Patricia Garcia, M.D., M.P.H.
Grissel Granados, M.S.W.
Mario Pérez, M.P.H.

Staff

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

Federal Liaisons

Eva Margolies, M.P.A., Associate Director for Planning and Policy Coordination, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC)
Ronald O. Valdiserri, M.D., M.P.H., Deputy Assistant Secretary for Health, Infectious Diseases; Office of HIV/AIDS and Infectious Disease Policy, Office of the Assistant Secretary for Health, U. S. Department of Health and Human Services (HHS)

Presenters

Rusty Bennett, L.G.S.W., Ph.D., Executive Director, Collaborative Solutions
Deborah Birx, M.D., Ambassador at Large, U.S. Global AIDS Coordinator, and U.S. Special Representative for Global Health Diplomacy, U.S. Department of State
Mary Blake, C.R.E., I.T.E., Public Health Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA)

Douglas Brooks, M.S.W., Director, White House Office of National AIDS Policy (ONAP)
Karen B. DeSalvo, M.D., M.P.H., M.Sc., Acting Assistant Secretary for Health, HHS
Melissa Harris, Acting Deputy Director, Disabled and Elderly Health Programs Group,
Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services
(CMS)
Heather Hauck, M.S.W., L.I.C.S.W., Director, Division of State HIV/AIDS Programs,
HIV/AIDS Bureau, Health Resources and Services Administration (HRSA)
Amy Killelea, J.D., Associate Director, Health Care Access, National Alliance of State and
Territorial AIDS Directors (NASTAD)
Randy Mayer, M.S., M.P.H., Chief, Bureau of HIV, STD, and Hepatitis, Iowa Department
of Public Health
Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, CDC
Carmel Shachar, J.D., M.P.H., Staff Attorney, Harvard Law School
Patrick Sullivan, Ph.D., D.V.M., Center for AIDS Research, Rollins School of Public Health,
Emory University
Alice C. Thornton, M.D., Chief, Infectious Diseases, Bluegrass Care Clinic, University of
Kentucky Medical Center
Mohini Venkatesh, M.P.H., Vice President, Practice Improvement, National Council of
Behavioral Health (NCBH)
Brian Webb, M.P.A., Manager of Health Policy, National Association for Insurance
Commissioners (NAIC)
Tiffany West, M.P.H., M.S.P.H., CEO and Chief Strategist, DARE Global Innovations
Doug Wirth, M.S.W., President and CEO, Amida Care

DAY 1

Welcome and Introduction

PACHA Vice Chair David Holtgrave, Ph.D., called the meeting to order at 9:05 a.m. and welcomed the members of the Council and meeting attendees. (PACHA Chair Nancy Mahon, J.D., was unable to attend in person.) Dr. Holtgrave outlined the agenda and said that HHS and the White House are evaluating a number of highly qualified candidates nominated for PACHA.

Remarks by Karen B. DeSalvo, M.D., M.P.H., M.Sc., Acting Assistant Secretary for Health, HHS

Dr. DeSalvo expressed gratitude for the work and advice of PACHA, which has been critical in advising HHS and the rest of the Federal Government. She described how her personal and professional experiences shaped her understanding of people living with HIV/AIDS (PLWHA) and contributed to her perspective as a public servant.

The Patient Protection and Affordable Care Act, or ACA, offers a new opportunity to serve PLWHA by offering greater access to care. Dr. DeSalvo looks forward to PACHA's input on the health care marketplace, essential health benefits (EHBs), and the integration of the Ryan White HIV/AIDS program with the ACA. The HHS Secretary, Sylvia Matthews Burwell, identified health disparities among men who have sex with men (MSM), especially men of color, as a priority. To that end, on National Black HIV/AIDS Awareness Day, she announced a 4-year cross-agency demonstration project that will support community-based models for preventing and treating HIV among MSM, including MSM of color. The project weaves together care and services, including stable housing. Dr. DeSalvo concluded that PACHA's insights matter, because the Department wants to be thoughtful in serving people as it develops policy.

Roll Call

Ms. Hayes called the roll.

Updating the National HIV/AIDS Strategy (NHAS)

Douglas Brooks, M.S.W., ONAP Director

Mr. Brooks offered updates on ONAP high-priority activities:

- **Further implement the HIV Care Continuum Initiative.** HRSA now requires community health centers (CHCs) to report two new indicators: the HIV infection prevalence and the percentage of patients linked to care within 90 days of HIV diagnosis.
- **Update the 2015 NHAS targets.** To assist with updating the NHAS, ONAP convened a Federal interagency working group. Mr. Brooks said most Federal agencies indicate that they have found the NHAS to be a helpful tool.

- **Monitor the status of the Ryan White program and its coordination with the ACA.** Mr. Brooks plans to meet with CMS' Center for Consumer Information and Insurance Oversight (CCIIO) on current activities related to coordination of the Ryan White program and the ACA. He hopes to learn more from CCIIO about the Federal response to charges that insurance providers are using drug costs as a tool for discriminating against PLWHA in the health care marketplace.
- **Align resources according to the epidemiological data and reduce HIV-related health disparities among gay and bisexual men, particularly men of color.** The demonstration project described by Dr. DeSalvo addresses health disparities among black MSM. Mr. Brooks noted that Sec. Burwell's announcement incorporated language from a PACHA resolution passed a year ago. He thanked Ronald O. Valdiserri, M.D., M.P.H., for his efforts to get the demonstration underway.
- **Develop public-private partnerships to augment Federal efforts.** PACHA member William Collier, head of ViiV Healthcare North America, announced a \$10 million investment in HIV/AIDS health care for black gay men and MSM. Mr. Brooks responded that he appreciated the investment of resources in alignment with the goals of the NHAS.

The budget proposed by President Barack Obama would increase domestic spending for HIV/AIDS. Among other strategic investments, it would provide more funds to CDC for viral hepatitis prevention and to the HHS Office of Adolescent Health, both requested by PACHA. Mr. Brooks emphasized that ONAP needs advice from PACHA about shifting funds and resources to areas most in need, which will not be an easy discussion.

The Federal interagency working group addressing the NHAS created a data subgroup to recommend how to measure progress toward goals and how to establish targets. Amy Lansky, M.D., M.P.H., Deputy Director for Surveillance, Epidemiology, and Laboratory Science in the Division of HIV/AIDS Prevention at CDC, detailed to the Office of National Drug Control Policy and ONAP, and Andrew Forsyth, Ph.D., senior science advisor in HHS' Office of HIV/AIDS and Infectious Disease Policy, are Co-Chairs of the subgroup. Dr. Lansky said the subgroup is meeting weekly; it will address a limited set of indicators and will consider the best ways to measure progress toward NHAS goals. Mr. Brooks said the subgroup will provide draft recommendations, and the working group will then seek input from external data experts.

Mr. Brooks suggested that the NHAS incorporate the recommendations and goals of the HIV Care Continuum Initiative and the White House *Update on Efforts to Address the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities*.

Mr. Brooks said ONAP is working with the White House counsel and the Office of Management and Budget (OMB) to understand what authority may be needed to integrate the documents into one strategy. He hopes to pass on to the next

administration a single document that sets HIV goals and targets for the country, and he called for PACHA input.

Discussion

Mr. Brooks hopes to have a draft of the updated NHAS available for PACHA to review at its meeting in May. He does not think a completely new strategy is necessary, but the NHAS should be updated to include scientific advances since 2010 and other new information. He asked PACHA to consider whether there are populations or areas that should be integrated into the NHAS (that are not already clearly identified) or for which measures are not clear. Harlan H. Pruden said Native Americans are referenced in the NHAS but not fully included in it or any of the other documents identified. Mr. Brooks said the updated NHAS should include some new task-based action steps but should not be greatly expanded. He said the NHAS should be broad enough to provide flexibility but targeted enough to give guidance, and the current format has been useful to agencies.

Global Update

Deborah Birx, M.D., Ambassador at Large, U.S. Global AIDS Coordinator, and U.S. Special Representative for Global Health Diplomacy, U.S. Department of State

Amb. Birx said that PACHA has been pivotal in the way the Federal Government regards the HIV/AIDS epidemic. She thanked Mr. Brooks for working closely with her to communicate the urgency of a fundamental crisis in the United States and globally in addressing HIV/AIDS. As demonstrated by the alarming rates of HIV among young men of color in this country and young women in sub-Saharan Africa, there is a pressing need to shift resources to help young people identify their risk and take action. In this country, the Federal Government and groups like PACHA must be willing to move precious resources so they will have more impact, which involves difficult decisions.

Amb. Birx described the effect of HIV on women in sub-Saharan Africa in particular and some of the successes realized with investments through the President's Emergency Plan for AIDS Relief (PEPFAR), for example. However, even countries that made great strides against the spread of HIV, such as Uganda, can reverse. Young people in sub-Saharan Africa—a bulging demographic—are at high risk. In response, resources must be deployed in different ways at this critical moment, Amb. Birx explained.

To focus resources on the areas with the most potential impact, it may be necessary to shift funds now available in high-income countries to low-income countries, which will require difficult decisions at the State and city level. Low-income countries are particularly challenged with balancing budget constraints against the expanding need for services. Amb. Birx said PEPFAR has evolved from providing emergency aid to building sustainable programs, monitoring their success, and redeploying resources as needed.

New research has revealed tools that work, said Amb. Birx. Advancements in data collection and mapping help identify needs, which could lead to a revolution in the use of epidemiological data for decisionmaking. A partnership among PEPFAR, the Bill & Melinda Gates Foundation, and the Nike Foundation is helping women and girls live “Determined, Resilient, Empowered, AIDS-free, Mentored and Safe” lives (the DREAMS project).

Ultimately, said Amb. Birx, stopping the HIV epidemic requires a focus on transparency, accountability, and impact. Where funding had been used to support health care broadly, it must now go to those with the greatest need. Given the data, there is no other choice, said Amb. Birx, and people understand that. She concluded, “We are all going to have to make some hard choices if we are going to change the course of the pandemic globally, including in the United States.”

Discussion

In a response to Dr. Valdiserri, Amb. Birx explained that the global strategy homes in on areas with growing numbers of new infections, a problem that is not financially sustainable for anyone. The Global Fund and the World Health Organization have taken lead roles, focusing where the epidemic is hottest. The solution includes identifying and treating young men and women with HIV and educating them about prevention.

Rev. Vanessa D. Sharp, M.Div., M.A.C.M., M.A.T.M., asked whether efforts have included the use of complementary medicine in areas where conventional medications are not available and to cut costs. Amb. Birx responded that such options are readily available in all countries, but those who do not know their status will not use any kind of treatment. The system must meet people where they are and engage them. Rev. Sharp added that when the elders in a community speak, younger people respond; younger people will not discuss HIV/AIDS without support from elders.

Amb. Birx said efforts are underway to craft economic arguments that will help higher-income countries recognize the return on investment of shifting more resources to lower-income countries. More innovative funding is needed to mobilize resources in countries that have them. In higher-income countries, said Amb. Birx, the cost of delivering services is higher than in lower-income countries.

Mr. Collier suggested that the updated NHAS could force the issue of resource reallocation at the city and State levels; he asked what other vehicles might be available. Amb. Birx said the HIV/AIDS community has a history of great leadership, which will help in this effort. She praised the leadership of the Peace Corps for being willing to sacrifice some of its resources in countries where the burden of disease is low. Amb. Birx called on leaders to explain the crisis, saying people are willing to sacrifice when there is transparency and accountability. People around the world demonstrate a strong desire to be fair and to give to those in need, she said.

Mr. Brooks noted that PACHA can take a lead role in the discussion at the Federal, State, and local levels. Amb. Birx agreed that PACHA can make significant contributions by focusing on domestic funding and changing the course of the epidemic.

PACHA Subcommittee Reports

Access to Care Subcommittee

Vignetta Charles, Ph.D., and Robert Greenwald, J.D., Co-Chairs

As part of its focus on ACA implementation, Dr. Charles said, the Access to Care Subcommittee is building on previous PACHA discussions about the need for consumer protections or Federal regulations related to transparency, costs, and coverage of HIV/AIDS medications. PACHA sent a memo detailing concerns to Mr. Brooks.

The Access to Care Subcommittee is collaborating with the Incidence Subcommittee on the integration of the Ryan White program and the ACA. Taking into account an earlier PACHA discussion of hepatitis C virus (HCV), the Access to Care Subcommittee thinks PACHA should discuss in more detail the ethical considerations involved in paying for very expensive but curative medical treatment.

The Access to Care Subcommittee is turning its attention to the ways social determinants of health (SDH) affect access to care, and the Subcommittee coordinated the panel discussion on SDH for this PACHA meeting. The Access to Care Subcommittee and the Incidence Subcommittee continue to push for comprehensive sex education that provides young people with medically accurate and unbiased information.

Mr. Greenwald described the barrier posed by the 6-month recertification requirement for the AIDS drug assistance program (ADAP). The requirement is not statutory but rather comes from HRSA guidelines, and OMB sees recertification as an important mechanism for ensuring that the Ryan White program is the payer of last resort. Others say that recertification facilitates access to State Medicaid and other programs. Mr. Greenwald said HRSA has reformed its guidelines in some areas, allowing for self-attestation, but some States still require complete recertification every 6 months. It was noted that the Office of the Inspector General audited ADAP on the payer-of-last-resort issue, which was the impetus for the recertification requirement.

Disparities Subcommittee

Scott A. Schoettes, J.D., Co-Chair

Mr. Schoettes said the Disparities Subcommittee established its agenda for the next 4 years. It set up three subgroups to address near-, long-, and far-term goals. The Health Equity and Justice Subgroup will address SDH that cause disparities across the board and not just among specific populations. This subgroup will seek ways to provide input on the process of updating the NHAS. It also aims to ensure that subpopulations with a high

prevalence of HIV/AIDS but small total numbers are recognized and included (e.g., American Indian/Alaska Native people and transgender people).

The Performance Measures Subgroup will focus on the potential need for Healthcare Effectiveness Data and Information Set (HEDIS) measures (used to assess insurance plans) specific to NHAS goals. Mr. Schoettes said requiring health plans to report a measure of viral load could motivate them to better address the issue and improve disparities. The subgroup will look at a variety of performance measures, but there is consensus on advocating for a single measure that would be used by Medicaid programs. Another measure under consideration would require plans to report the percentage of the population who are candidates for HIV screening that get tested.

The Stigma Subgroup will look at methods for measuring stigma. Data are needed, said Mr. Schoettes, because evidence moves policy and funds.

Global Subcommittee

Harlan H. Pruden and Rev. Vanessa D. Sharp, M.Div., M.A.C.M., M.A.T.M., Co-Chairs

Rev. Sharp said the Subcommittee has focused on how to support PEPFAR. Today's remarks from Amb. Birx provide some food for thought. Mr. Pruden added that the Subcommittee will propose a PACHA panel discussion on international HIV/AIDS issues, which will yield possible actions for the Global Subcommittee.

Incidence Subcommittee

David Holtgrave, Ph.D., Co-Chair

Dr. Holtgrave said the effort with the Access to Care Subcommittee on recertification offers a good example of timely, collaborative efforts and HRSA partnership. The panel discussion at this PACHA meeting on using surveillance data to inform programming grew out of the Incidence Subcommittee's and PACHA's attention to creating a dashboard of progress measures. The Incidence Subcommittee worked with the Disparities Subcommittee on the use of data to better reveal issues of concern for Native Americans. The Incidence Subcommittee will review new CDC guidelines on HIV prevention that include nonclinical recommendations for health departments and community settings to determine the uptake of the guidelines.

Discussion

Dr. Charles noted that the Access to Care Subcommittee also is interested in the HEDIS measure on viral load, and Mr. Collier is on both the Access to Care and Disparities Subcommittees. Mr. Schoettes added that the Disparities Subcommittee wants to follow up on PACHA recommendations on HIV status disclosure and on American Indian/Alaska Native people. The Subcommittee also hopes to have a discussion with the new U.S. Surgeon General about new education efforts. Dr. Charles requested confirmation that there is still a PACHA liaison to the Federal interagency working group on the

intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities.

Lucy A. Bradley-Springer, Ph.D., R.N., ACRN, FAAN, said many of the issues under discussion are reminders of the problems that arise in the absence of timely, accurate data. Without the numbers—for example, the prevalence of HIV among American Indian/Alaska Native people—efforts always lag behind. When funds are removed because the need appears to have diminished, she continued, the requirement for a rapid response system remains to ensure that the problem does not resurge. When resources are shifted, there may be a rebound in disease. Dr. Holtgrave agreed that there should be an evaluation strategy whenever funding is shifted.

Mr. Schoettes asked how PACHA could provide input into the process of updating the NHAS, such as through a liaison to the Federal interagency working group. Mr. Brooks said he plans to meet first with the Federal agencies responsible for implementing the NHAS. There will be public forums around the country to gather input on various topics related to the NHAS goals. Mr. Brooks said PACHA will have an opportunity to review the updated NHAS and make recommendations for changes. Mr. Greenwald noted that he and Ms. Mahon were invited to observe a related Federal group's deliberations about the original NHAS, which informed PACHA's discussions. Mr. Brooks said the process should remain federally focused, but he is open to PACHA input.

Mr. Schoettes said the Disparities Subcommittee discussed whether the updated NHAS should set goals for 2020 or perhaps consider benchmarks (or short-term goals) that build toward long-term goals. Dr. Valdiserri noted there has been high-level discussion about the fact that the current NHAS set goals for 2015, so the next steps are not clear.

Dr. Valdiserri suggested that ONAP gather input from the Federal agencies and then propose specific questions for consideration by PACHA subcommittees. Mr. Brooks agreed enthusiastically and reiterated that he wants PACHA input on the draft. He pointed out that PACHA's role is to advise on NHAS implementation, not content.

Surveillance Data: Collection, Processing, and Dissemination

Moderator: David Holtgrave, Ph.D., PACHA Vice Chair

HIV Surveillance: Talkin' 'Bout an Evolution

Patrick Sullivan, Ph.D., D.V.M., Center for AIDS Research, Rollins School of Public Health, Emory University

Dr. Sullivan noted that the value of data varies depending on how they are used. For resource allocation, for example, precise findings are needed, while monitoring progress depends on timeliness. He reminded the participants that when considering a surveillance system, it is possible to have two of the following qualities—cheap, fast,

good—but not all three. Therefore, data users should determine which two qualities are most important and select the surveillance attributes that best fit their purposes.

Dr. Sullivan described some ways that users have put the AIDSvu interactive online data map to work to answer public health and policy questions. They reveal a persistent tension between the need for timeliness and the need for authoritative data. Consumers always want data sooner and in more detail, but for public health purposes, the timeliness and granularity of available data often are sufficient. Dr. Sullivan appreciates CDC's role as a good steward of data and its responsiveness to data requests. He praised State and local health departments' commitment to transparency and service to their constituents.

Dr. Sullivan offered several recommendations to improve surveillance data:

- Modernize data systems to electronically report laboratory data and deaths, which would improve timeliness.
- Distinguish what attributes of data are needed and select those that fit the purpose.
- Support CDC and local health departments in improving collection of up-to-date addresses, which aids with targeting resources and programs.
- Advocate for legislative and administrative rule changes to support efficient laboratory reporting in all States. Communicate the benefits of timely, complete data to support changes.

HIV Surveillance From a State Perspective

Randy Mayer, M.S., M.P.H., Chief, Bureau of HIV, STD, and Hepatitis, Iowa Department of Public Health

Mr. Mayer explained that redistribution of national funds has left Iowa with less funding for HIV prevention. In response, the State employed resource allocation modeling to revise its funding approach. The new approach focuses on HIV prevention through health care access, minimizing the spread of disease, and expanded testing.

By looking more closely at surveillance data on the number of PLWHA in care in Iowa and following up with CDC and other States to confirm current addresses, Iowa learned that more than half had moved (and some had died). These findings translated into a reduced HIV prevalence and a higher percentage of PLWHA in care. Mr. Mayer emphasized that the care continuum for PLWHA in Iowa looks better when the data reflect individuals' current residences, not their residences at the time of diagnosis.

Mr. Mayer outlined the key issues that affect the quality of surveillance data:

- Obtaining and maintaining information about current residence is problematic. Routine interstate review of duplicate records is helpful but laborious and does

not provide timely results. Laboratories must be urged to provide current address information. Surveillance systems must recognize the most recent addresses. States may need mechanisms to access other databases for current information, such as the Housing Opportunities for Persons with AIDS (HOPWA) database.

- Electronic reporting is needed. Laboratory reporting differs by State. Iowa has proposed a network to link States, but Mr. Mayer suspects that many States will resist exchanging data. The integration of electronic medical records and public health surveillance remains a struggle.
- Estimating the number of undiagnosed PLWHA is difficult but necessary to map the continuum of care.
- Staff lack the time and expertise to analyze data and map continuums of care. Funding for staff is limited.
- National measures are not meeting local needs, especially measures of retention in care and viral suppression.

National HIV Surveillance System

Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, CDC

Dr. McCray summarized the data collected for the National HIV Surveillance System, which aims to provide accurate epidemiological data to guide Federal, State, and local public health actions. Information comes from multiple sources and then must be processed to ensure accuracy. Once the data are analyzed, CDC releases them through quarterly reports and other means.

Dr. McCray said CDC encourages electronic laboratory reporting because it has the capacity to improve the timeliness of surveillance data; he thinks that such reporting is necessary to assess progress toward NHAS goals. However, eight States do not require laboratories to report CD4 counts or viral load values.

Tracking deaths is a key part of surveillance and is critical for measuring some NHAS indicators. CDC established the National Death Index, among other efforts, to improve death ascertainment, and plans to release more information from the Index in a timely fashion, which should assist in reporting accurate HIV-related indicators and other measures.

Dr. McCray said CDC provides considerable technical assistance to State and local entities, but some face challenges of insufficient staff, even with CDC help.

Dr. McCray outlined CDC's methods of disseminating data and its timelines for collecting, analyzing, and releasing key HIV surveillance data. He anticipated that CDC will be releasing some data more quickly in the near future. However, many of the NHAS indicators measure outcomes or impacts, which require time to assess and so will not be

available until 1 to 2 years after the NHAS ends. Dr. McCray noted that CDC is always seeking ways to improve the quality and timeliness of data.

Improving Capabilities of Public Health Systems: Observations, Insights, and Opportunities for Leveraging Data and Technology To Improve Surveillance Systems

Tiffany West, M.P.H., M.S.P.H., CEO and Chief Strategist, DARE Global Innovations

Ms. West pointed out that public health epidemiologists are required to understand a complex system for which they have not been trained, while the private sector employs numerous tools and specialized expertise to simplify processes and navigate systems. Existing public health data systems are redundant, inefficient, and ineffective. Ms. West urged better communication between the public and private sectors. Modernizing HIV surveillance practices requires a better understanding of the business processes involved and technological solutions to address redundant, process-driven business rules, she said.

Public health should be positioned as customer service, and experts such as epidemiologists should play a prominent role in communicating how surveillance data can be used to improve care, said Ms. West. With more investment in technology and workforce development, epidemiologists can spend more time discussing important, relevant data with the community and less time cleaning data.

To move toward a more data-driven culture, the public health sector should assess the functional and technical requirements and engage the private sector to solve problems and produce information more quickly. Bringing in outside perspectives can lead to innovation. Ms. West recommended that public health departments consider how to break down silos and better collaborate internally across divisions. Public health departments also must consider how to incorporate the tools and techniques used by the private sector to optimize health data surveillance. Ms. West stressed that a cultural shift is needed to begin transforming surveillance data into actionable intelligence. As the discussion turns to reallocating resources to be more efficient and effective, the public health sector must examine how existing funds are spent and determine how it will respond to the questions of the 21st century.

Ms. West concluded the following:

- Accurately measuring progress toward NHAS goals requires a shift in culture and functional and technical requirements.
- Leveraging changing data and technology advancements offer a critical opportunity to optimize the public health response.
- Engaging nontraditional stakeholders in the public and private sector can add extraordinary value to public health surveillance.
- Investment in the public health workforce—specifically data, analytics, and technology—should be prioritized.

Discussion

Dr. Charles asked the panelists whether efforts to improve the interface across databases included collaborating with the corrections community. All of the panelists agreed on the need to gather such data, but collaborating with correctional institutions is complex and differs by State. Identifying common capacity takes considerable energy, Dr. Sullivan noted, and coding of diagnoses in the correctional setting varies by State, which complicates standardization of data.

Ligia Peralta, M.D., FAAP, FSAHM, AAHIVMS, asked the panelists to describe the barriers to and incentives for adopting electronic laboratory reporting. Dr. McCray said most States lack the infrastructure for electronic reporting; adoption depends on the number of laboratories, State laws, and the adequacy of staff to facilitate reporting, for example. Mr. Mayer said most of the Federal incentives for meaningful use of electronic health data went to hospitals. Ms. West noted that the Washington, DC, Department of Health was not equipped to receive electronic data from laboratories but eventually negotiated a low-cost solution. She stressed the need to identify innovative approaches and best practices to meet goals.

Mildred Williamson, Ph.D., M.S.W., asked about the role of fourth-generation tests in improving the speed of HIV surveillance data and the use of laboratory data in real time to support linkages to care and partner services and to prevent new infections. Dr. McCray said efforts are underway at the national level to evaluate uptake of fourth-generation testing. Ideally, he noted, having more timely data available will inform care.

2015 Health Care Marketplace: A Review of EHBs and Provider Networks

Moderator: Michelle Collins-Ogle, M.D., PACHA Member

Amida Care

Doug Wirth, M.S.W., President and CEO, Amida Care

Amida Care, a Medicaid HIV special-needs health plan for New York City, serves as a model for innovative approaches to caring for PLWHA. While most health plans are concerned with overutilization, said Mr. Wirth, the dropoffs at each stage across the continuum of care (from diagnosis to viral suppression) are a function of underutilization.

Modeled on CMS' chronic condition special-needs plans, which offer comprehensive services, Amida Care is designed to increase access to care and retention, ultimately improving clinical outcomes. It established a network of qualified HIV providers and services so that clients can choose their care. The plan currently has 6,000 members.

Several factors contribute to Amida’s success so far:

- Local HIV providers of medical, behavioral health, and social services participate. The plan’s primary care providers are HIV specialists.
- The board includes Amida clients as voting members. A member panel provides input on daily operations, and executives seek out its recommendations.
- Staff reflect the population served.
- Private interests have partnered with Amida.
- Each client is served by a team of providers using a member-centered approach.
- The plan has strong outreach mechanisms to ensure retention in care and successfully reengaged 80 percent of members who had dropped out of care.
- Amida takes a holistic approach to wellness—for example, hosting health and wellness activities that counter isolation and stigma.

Mr. Wirth said 94 percent of Amida’s members get regular outpatient care, and most get regular screening for substance use and mental health issues. He added that 70 percent of members have a suppressed viral load, but 90 percent receive medications, so the rate of suppression could be better.

Trends in Medicaid Expansion

Melissa Harris, Acting Deputy Director, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, CMS

Ms. Harris said that as States modify or expand their Medicaid programs, some are using managed care approaches for populations traditionally excluded or for services traditionally provided by fee-for-service plans. CMS ensures that plans understand the requirements of Medicaid programs and monitors the implementation and integration of managed care plans in those programs.

Programs are moving toward more comprehensive services and care coordination models. CMS has approved several State amendments to include HIV/AIDS as one of the chronic conditions for which health homes should be considered. Ms. Harris said States are countering the fee-for-service model, which rewards quantity over quality of care, with incentives to provide comprehensive, coordinated care that noticeably improves outcomes. She said the ACA’s focus on preventive services is now coming to the forefront, and CMS’ regulations have been modified, giving States the flexibility to decide which nonmedical practitioners can provide preventive services. Section 1115 of the Social Security Act paves the way for demonstration projects or waivers that allow States to test novel premium structures or incentives.

Medicaid takes its cues from CCIIO, said Ms. Harris. That office recently sought public comment on proposed changes to prescription drug access, such as category limits, formulary transparency, and mail-order requirements. CCIIO has some rules against discrimination by age or condition; Ms. Harris said that not covering a group of drugs

used to treat a specific condition or offering them only at prohibitively expensive rates clearly constitutes a discriminatory benefit practice. Some other policies are less clear, and Ms. Harris invited PACHA to provide examples of discrimination to her office.

Other topics under consideration are whether to issue a Federal statement on the provision of services for transgender individuals, especially for Medicaid programs, or on States' responsibility to pay for HCV medication, Ms. Harris concluded.

Perspective of the NAIC

Brian Webb, M.P.A., Manager of Health Policy, NAIC

Mr. Webb said the ACA removed the two mechanisms that insurance companies used to limit their costs: excluding coverage for high-risk individuals or underwriting and pricing plans to accommodate high-cost conditions. Now, they must manage risk and design benefits to promote good choices by members. Insurance commissioners address abuses by insurance plans. The NAIC is seeking comments on a model plan that addresses network adequacy, Mr. Webb noted.

The NAIC thinks consumers need more education and tools they can use to shop for health insurance. Such tools would help consumers better understand their provider networks and drug coverage. Consumers also need to know what to do if their plans' networks or formularies change midyear.

Insurance commissioners also address discriminatory benefit design. From 2014 to 2015, some insurers moved certain categories of drugs into tiers with high copays. It is important to ask whether insurers are making such changes to promote better decisionmaking by consumers, as they may claim, or whether the changes just limit consumer access. Mr. Webb said everyone's rights should be protected. Another issue of concern is ensuring care for people who find themselves moving back and forth between Medicaid and private plans, a scenario that is likely to happen more often.

Mr. Webb said that in the new marketplace, it behooves insurers to make sure all of their members participate in wellness programs. Now that all the payers are essentially linked together, every plan will find itself paying more for members who did not get the care they should have. Regulators, advocates, consumers, and carriers all have much work to do to ensure that the new marketplace works for everyone, Mr. Webb observed.

2015 Health Care Marketplace and the HIV Community: A Review of EHBs and Provider Networks

Carmel Shachar, J.D., M.P.H., Staff Attorney, Harvard Law School

Ms. Shachar described how PLWHA continue to face barriers to care. For example, the ACA set thresholds using actuarial values that were intended to ensure that plans spent most of the funds collected from members on care. However, because actuarial value

considers only the average cost of care across all members, insurers can stay within Federal guidelines while pushing more of the cost of treatment onto PLWHA through adverse tiering (i.e., placing HIV/AIDS medications in the highest-cost tiers).

A recent study demonstrated that insurers use adverse tiering to discourage PLWHA from enrolling, and that it results in higher costs for covered PLWHA. A review of qualified health plans in five southern States found that in most plans, the cost of a single-dose regimen for HIV amounted to at least 30 percent of median yearly household discretionary income. Ms. Shachar gave examples of alarming trends in cost shifting by plans in Georgia, Illinois, and Louisiana.

The President's proposed budget for FY 2016 would provide more funding for HIV prevention and treatment, and HHS regulations would address discrimination in drug coverage and access. However, Ms. Shachar called for the following immediate actions:

- Amend the EHB rule to require coverage of all widely accepted specialty drugs.
- Create regulations that clarify the antidiscrimination provisions of the ACA.
- Amend the EHB rule to prohibit excessive coinsurance for specialty drugs.
- Improve transparency by requiring plans to provide complete, accurate, and accessible formulary information in a standard format.
- Limit the ability of plans to change benefits after the end of open enrollment.

Ms. Shachar explained the case before the U.S. Supreme Court, *King v. Burwell*, in which States contend that Federal subsidies for individuals to purchase private insurance are only valid in federally operated health exchanges. If the challenge succeeds, it will be important to distinguish Federal from State marketplaces and define where State–Federal partnerships stand. Such a decision also would likely convince some States not to expand their Medicaid programs, and providers and advocates would have to prepare for a return of PLWHA to Ryan White and other programs. A victory for the Administration could encourage States to proceed with Medicaid expansion.

Finally, Ms. Shachar said the SPEAK UP! project continues to call for real-world examples of discrimination. Some qualified health plans are effective at enrolling PLWHA, but considerable effort is necessary to ensure they get meaningful coverage.

Discussion

Asked how some plans have succeeded in restricting access to drugs approved by the U.S. Food and Drug Administration (FDA), despite Medicaid requirements that govern both fee-for-service and managed care plans, Ms. Harris maintained that there should be no barriers to access to FDA-approved drugs. She said CMS is working to ensure that its pharmacy and managed care divisions are aware of each other's efforts. It may be necessary to amplify guidance for the managed care plans. Ms. Harris asked for specific examples of drugs or services not available.

In response to Michelle Collins-Ogle, M.D., Ms. Shachar explained that the basis of the *King v. Burwell* case is a question about the interpretation of the ACA. Mr. Greenwald clarified that if the States prevail, those that run their own health care exchanges would not be eligible for Federal subsidies, effectively eliminating the individual mandate to buy health insurance. The result would be a country divided by States with and without Medicaid expansion and subsidized insurance.

Dr. Collins-Ogle asked how rural hospitals have been affected in States that have not expanded Medicaid, especially with declining Medicaid reimbursement. Ms. Harris said such hospitals are suffering financially. They are their communities' safety net providers. In States that have not expanded Medicaid, hospitals are treating many uninsured people and rapidly acquiring uncompensated care costs. Mr. Webb said Wyoming is using State funds to prop up its hospitals, and he anticipated that other States would do the same.

Mr. Schoettes raised the concern that Section 1115 waivers reinforce existing disparities if the waivers result in less care for PLWHA. He asked whether CMS has a strategy on waivers that aims for parity. Ms. Harris explained that the goal of demonstrations is to gather evidence about proposed models. Ultimately, the pros and cons of every request are weighed against the goal of expansion, she said.

Lawrence A. Stallworth II asked whether consideration has been given to the human rights implications of denying coverage of sexual reassignment surgery for transgender people. Ms. Harris said the question of whether gender dysphoria is a real medical condition has been settled; what remains under discussion is what plans may offer to treat it. Such discussions involve complex issues, such as what must be covered for those under age 21.

Mr. Greenwald called for better alignment of the EHBs across CCIIO and Medicaid to address discrimination in prescription drug coverage. Ms. Harris said Medicaid has an advantage over private plans because of rebates allowed under Section 927 and the required coverage floor. Medicaid has formulary and cost-sharing protections that do not apply in the commercial world, she added. Proposals to modify the prescription drug floor will be considered as regulations are finalized. Ms. Harris agreed that the recent study shedding light on adverse tiering practices will make it difficult for companies to continue such practices without HHS scrutiny. She encouraged PACHA members to contact her, and she agreed to connect them with CCIIO representatives who work on EHBs.

Responding to Rev. Sharp, Ms. Shachar said some of the President's proposed funding would be used to educate consumers about how insurance works. However, she stressed the need for regulations and guidance to prevent the marketplace from embracing negative trends like adverse tiering and other cost-shifting efforts.

Dr. Valdiserri reminded the group that the barriers to access to high-cost drugs are not limited to HIV or HCV. He called for ideas on legislative or regulatory approaches to ensure that poor and vulnerable populations can get the best available recommended treatments. Ms. Shachar noted the importance of aligning incentives correctly to ensure appropriate coverage for all chronic diseases.

Dr. Bradley-Springer praised the Amida model and said the ACA promotes holistic and preventive care for everyone. Mr. Wirth responded that advocates won the battle to get health insurance for PLWHA and now are fighting with insurers to provide that care. HIV-specific quality measures are needed to engage insurers in performance improvement efforts related to HIV. Mr. Wirth added that Amida's outreach efforts not only bring members back into care but also provide living-wage jobs, a key SDH.

Public Comment

Lisa Stand of The AIDS Institute said her organization is awaiting a response from the HHS Office of Civil Rights about its complaint that four private plans in Florida place all HIV drugs, including generics, in the highest drug tier with the highest coinsurance costs. The AIDS Institute was pleased that in releasing its proposed rule on EHBs, HHS took the occasion to share its view that it is discrimination for an insurer to refuse to cover a single-tablet regimen that is customarily prescribed or to place most or all drugs for a specific condition in the highest-cost tier.

Florida's insurance commission opened an investigation into the four plans identified by The AIDS Institute on the basis of long-standing State law against HIV/AIDS discrimination. The four insurers have since agreed to cost-sharing limits for some HIV drugs in 2015. However, these positive steps do not go far enough to address national problems, said Ms. Stand. The AIDS Institute wants to see regulations and vigorous Federal enforcement against discrimination. Ms. Stand asked PACHA to communicate to Sec. Burwell the importance of enforcing ACA nondiscrimination provisions.

David J. Martin, Ph.D., of the American Psychological Association (APA), called attention to the importance of research on structural factors that continue to drive the HIV epidemic. Recent advances in understanding structural factors and their roles in health outcomes form the basis for interventions to further reduce HIV transmission through behavioral risk reduction and to improve uptake of and adherence to biomedical interventions. Structural factors are economic, social, policy, organizational, or other environmental aspects that affect an individual's HIV prevention behaviors, said Dr. Martin. They vary from community to community. Factors contributing to HIV risk reduction in one community may actually increase risk in another.

The APA urges continued support for vital research on structural interventions to reduce HIV transmission, and makes the following recommendations:

- Social science research to identify structural factors and their social contexts is crucial to the design of effective structural interventions.
- Research on theoretically grounded structural interventions is needed, followed by translation and implementation research to ensure maximal impact in the communities at risk.
- There is a great need to invest in young investigators who have the educational and training backgrounds to engage in research on structural factors contributing to the HIV epidemic.

Last week, Dr. Martin said, the final results of a randomized clinical trial of different combinations and administration routes of HIV prophylaxis among women living in sub-Saharan Africa had to be terminated because of futility. None of the treatments worked—not because the treatments were biologically ineffective, but because the women did not take them. In planning the study, the investigators appear to have overlooked the structural factors (e.g., social stigma) that prevented adherence. The APA sincerely hopes that PACHA will encourage additional research on structural factors and interventions in ongoing efforts to stem the epidemic, Dr. Martin stated.

Martha Sichone-Cameron of The Women’s Collective spoke on behalf of a client, Angela, who could not attend the meeting but wanted to share her story. After she was released from incarceration, Angela came to The Women’s Collective for treatment. She had been homeless for about 3 months since her release. Angela talked about the lack of HIV services in prison and the spread of HIV in prison. At first, The Women’s Collective could not find a shelter for Angela, and when it did, Angela felt she was in danger of becoming sick if she stayed there because she was already immunocompromised. Ms. Sichone-Cameron urged PACHA and others to take into account grim stories like Angela’s when they think about HIV in jails and HIV services following incarceration.

Vanessa Johnson, speaking on behalf of the 30 for 30 Campaign, said that women with HIV, Part D providers, and advocates are disappointed with the proposed consolidation of Ryan White program Part C and Part D described in the President’s FY 2016 budget. With ACA implementation underway, systems of care are in transition. Before changes are made, it is imperative to assess the impact of the ACA and to see how the Ryan White program can effectively complement the ACA to meet the care, treatment, and support needs of PLWHA.

Part D programs are uniquely situated to achieve the NHAS goals, Ms. Johnson said. They provide lifesaving primary and specialty medical care and support to children and youth with HIV/AIDS. They are instrumental in preventing mother-to-child transmission, ensuring that women and youth have access to quality HIV care, and improving health outcomes. The potential loss of expertise in subspecialty medical care could lead to the destabilization of comprehensive care models, resulting in a resurgence of perinatal

infections. The only components of the Ryan White program that target women and youth should not be dismantled but rather bolstered, she concluded.

Tom Bonderenکو of the Food Is Medicine Coalition, which serves PLWHA through prescribed diets, said food and nutritional services are critical to accomplishing the aims of health care reform for PLWHA. Such services promote positive health outcomes, save health care funds by facilitating access and adherence to care, and keep people in their homes and out of more expensive institutions. Access to food and nutrition services makes medicines more effective and reduces viral loads. These services can play an important role in improving health, achieving NHAS goals, and leading to a disease-free generation. Food and nutrition services make up a low-cost, high-impact intervention.

The Ryan White program takes a holistic approach to PLWHA, recognizing that housing, transportation, and access to nutritious food are all key determinants of health. Despite strong research and evidence, the ACA did not include comprehensive coverage for medically tailored diets for any serious medical conditions. To achieve a more coordinated national response to the HIV epidemic and to reduce health care spending nationwide, food and nutrition services must be included in all health care reform efforts, including the Ryan White program and the ACA. Mr. Bonderenکو suggested CMS partner with Congress to cover such services for people with severe, chronic disease by modifying the Medicaid statute. Such a step would be good for many people for whom food is medicine, Mr. Bonderenکو concluded.

Martha Sichone-Cameron of The Women’s Collective seconded the comments of Ms. Johnson, saying The Women’s Collective is deeply concerned about the proposal to consolidate Part C and Part D of the Ryan White program. The redirection of limited resources for women, children, and youth appears misguided. However, should the proposed budget move forward, The Women’s Collective recommends the following:

- Deliberate and specific language that protects Part D funds transferred to Part C, so that these funds continue to be dedicated solely to women, children, and youth
- Description of procedures and quality measures to ensure that women will have access to and make use of services allocated for them
- Immediate consultation with all those affected by the proposed consolidation to paint a more thorough picture of the barriers and disparities they would face as a result of the change.

Ms. Johnson, speaking this time for the Positive Women’s Network, said the Ryan White program has been successful at retaining PLWHA in care. It should be maintained intact, not eliminated, as the ACA changes the landscape of care. Only 41 percent of women with HIV nationally are retained in care, according to CDC. However, the Ryan White program effectively retains 77 percent of its female clients in care, according to HRSA. Ryan White Part D has helped drastically reduce rates of vertical HIV transmission

through outreach and coordinated care for pregnant women with HIV and their families. Eliminating Part D could negatively affect outcomes at a time when real progress has been made. Part D is vital for women and families, said Ms. Johnson. The Positive Women's Network asks that PACHA state that all parts of the Ryan White program should remain intact as ACA implementation takes place and specifically oppose the consolidation of Parts C and D. Administrative concerns should not be resolved by cutting benefits to women with HIV.

Holly Kilness Packet of the American Academy of HIV Medicine said HIV providers are struggling with several issues. Specifically, some plans restrict prescription of certain medicines to certain types of providers as a utilization management technique. When plans limit who can prescribe certain drugs, such as a single-drug regimen for HIV, they rule out many qualified providers who have built rapport and trust with their patients over a long period. Restricting providers amounts to restricting patient access, said Ms. Packet.

All over the United States, many HIV providers are finding it impossible to gain entry into plan networks, Ms. Packet continued. Despite the EHB requirement to include community providers, there are many gaps. For example, geographic area is not defined, which means plans can make many of their patients travel far to see a provider. Provider networks are insufficient. The low threshold for essential providers should be expanded. The online databases available to help consumers review plans should have up-to-date provider lists and should be more user-friendly. Insurers should update the provider lists more than once a year. Ms. Packet noted.

PACHA Discussion

Dr. Holtgrave invited PACHA members to identify some of their priorities on the basis of the day's presentations. He reminded the group that Mr. Brooks is seeking PACHA's input on reallocating funds. Also, PACHA should consider how to evaluate the impact of reallocation and how to establish a meaningful floor.

Promoting Health and Wellness

Mr. Pruden commented on the amazing work and outcomes of Amida Care, which underscore how increasing cultural pride and self-esteem contribute to better decisionmaking. He thinks that health care must begin embracing efforts to heal the spirit. He added that indigenous populations define "health" in a way that is more like "wellness."

Consequences of Reallocating Resources

Dr. Bradley-Springer said she has experienced resource reallocation and cautioned that staff and clients should be prepared for feelings of grief when jobs and services are eliminated. It is important to ensure that staff expertise does not get lost in the process; ideally, staff should be integrated into new programs, she said.

Losing Ground on HIV Care

Gina M. Brown, M.S.W., expressed pessimism about the future of care in Louisiana, where opposition to the ACA and Medicaid expansion has led to the closure of emergency rooms and a decrease in services. Dr. Collins-Ogle expressed frustration that States have the right not to provide adequate or appropriate care. She called on PACHA to pressure States to do the right thing or risk making no progress toward NHAS goals and losing the ground gained in testing, linking, and retention in care. Dr. Collins-Ogle does not believe States should have the right to deny access to care.

Dr. Williamson also feared losing ground because of the uneven implementation of the ACA. One great success has been the reduction of mother-to-child HIV transmission, yet the proposal to consolidate Ryan White Parts C and D could jeopardize those achievements. She does not understand the rationale for consolidation, and she is concerned about the potential impact on women and youth, especially in areas without Medicaid expansion.

Need for Metrics

Mr. Collier reiterated PACHA's role of advising on the implementation of the NHAS, and he called for metrics, not only of viral suppression but also of the percentage of patients tested according to CDC guidelines. He asked for more discussion on measuring time from diagnosis to viral suppression, which represents access to care and retention in care. Mr. Greenwald said PACHA already has done some foundational work on metrics. He recommended distributing to insurers the metrics already created (such as those by Mr. Forsyth at HHS). Mr. Schoettes pointed out the effort involved in adding to the HEDIS set of measures; the Disparities Subcommittee agreed to advocate for adding a single measure, viral suppression.

Consumer Protection

Dr. Charles noted that PACHA can make clear its commitment to consumers by advocating for consumer protections in the marketplace, especially in States that have not expanded Medicaid. It is unconscionable that low-income people must pay 30 percent of their discretionary income for medications. PACHA can advise HHS on improving transparency, coverage, and costs.

Dr. Peralta echoed concerns about the need for transparency and the costs of coverage. She agreed with the public commenters about the consolidation of Ryan White Parts C and D, noting that now is a critical time to incorporate specific language to protect young people if the consolidation occurs. Elizabeth Styffe, M.S.N., noted that children are often forgotten, and HIV among youth is an area that still has not been effectively addressed.

Adjournment

Dr. Holtgrave thanked the members and participants for a productive day. Ms. Hayes thanked the commenters, and the meeting adjourned for the day at 4:30 p.m.

DAY 2

Call to Order and Roll Call

Dr. Holtgrave called the meeting to order at 9:35 a.m., and Ms. Hayes called the roll.

ACA Qualified Health Plans and Ryan White Program Integration

Moderator: Robert Greenwald, J.D., PACHA Member

Ryan White HIV/AIDS Program: Moving Forward and ACA Implementation

Heather Hauck, M.S.W., L.I.C.S.W., Director, Division of State HIV/AIDS Programs, HIV/AIDS Bureau, HRSA

Ms. Hauck described the role of the Ryan White program within the context of the ACA:

- Provide a safety net for PLWHA who have little or no income.
- Provide services for those not eligible for other assistance (with or without access to expanded Medicaid programs).
- Cover needed services not provided by other insurance.
- Facilitate entry into medical care and assist with enrollment in more comprehensive plans.

HRSA provides guidance and technical assistance to service providers, evaluates gaps in services, and considers new ways to distribute Ryan White funding. This year, said Ms. Hauck, HRSA has projects aimed at improving resource allocation in Part A supplemental funding and in Part C. She emphasized that community input is vital to HRSA's understanding of issues in the Ryan White program. She summarized collaborative efforts with CCIIO and described workforce resources available from HRSA.

Ms. Hauck said HRSA seeks input from the field to inform the development and clarification of policies. Through cooperative agreements, three projects are underway to address barriers and facilitate effective services: one focuses on enrolling eligible clients in ACA plans; another with NASTAD and others will help Ryan White providers join the networks of private and Medicaid plans; and a third will determine how nonclinical AIDS service organizations fit in to the new landscape.

HRSA is encouraging Ryan White grantees to continue educating their clients about enrolling in health care plans and how to use those plans effectively. It also is providing resources on how Ryan White providers can become part of health plan networks. Ms. Hauck again urged those in the field to let HRSA know what is working and what needs attention.

ACA Updates and Priorities

Amy Killelea, J.D., Associate Director, Health Care Access, NASTAD

Ms. Killelea said NASTAD's strategies for addressing ongoing challenges to the integration of the Ryan White program and ACA plans include ongoing monitoring of plan coverage and costs and developing relationships with partners and plans to work around or avoid gaps. Restrictive formularies and high out-of-pocket costs persist, although Federal regulations will address some of these issues beginning in 2016.

Funds from ADAP and Ryan White programs have been essential in helping people buy private coverage or pay for out-of-pocket costs. Even in States that do not plan to use ADAP funds to purchase insurance, NASTAD is working with providers to mitigate cost barriers.

Ms. Killelea called for more education and resources related to the Federal income tax filing requirements related to the ACA. Case managers need a better understanding of the premium tax credits so they can help clients, especially those who do not usually file taxes. Some ADAP and Ryan White programs are adopting new policies to ensure that coverage is vigorously pursued, screening clients for coverage eligibility and ensuring that tax requirements are met.

Experience from Ryan White programs demonstrates that keeping PLWHA in care requires case management and linkage to services. However, there is no reporting code that would facilitate payment for the effort involved in linking clients to services. As Ryan White programs integrate into the ACA, providers must be held accountable for high-quality care for PLWHA, said Ms. Killelea. It is important to assess what kind of services health plans can and cannot provide and how to pay for services that PLWHA need. Ms. Killelea urged PACHA and others to think about where insurance ends and the safety net begins. She cautioned that dismantling the Ryan White program could result in the loss of expertise and infrastructure that have successfully served PLWHA.

ACA and Ryan White Program Integration: Bluegrass Care Clinic's Experience

Alice C. Thornton, M.D., Chief, Infectious Diseases, Bluegrass Care Clinic, University of Kentucky Medical Center

Kentucky made a smooth transition to the ACA, initiating a successful State-run exchange and expanding Medicaid, and the average number of uninsured people dropped from 20 percent to 11 percent. The Bluegrass Care Clinic led the way in enrollment by identifying potentially eligible clients and hiring a team of social workers and certified health connectors to work with them. Dr. Thornton stressed that enrollment involved a great deal of human effort for which no one was paid. Access to insurance is not enough to get patients enrolled, she said, and the newly insured need help navigating the system and understanding cost sharing.

The transition to the ACA has resulted in higher demand for case managers and administrative staff. Claim denials, mostly from Medicaid, spiked after the transition. Preauthorization requirements became such a burden that the hospital hired two new staff members to manage the process. The clinic now has a large Medicaid population, but very few providers outside of the University of Kentucky hospital system accept Medicaid patients, especially mental health service providers, and that poses serious problems.

The clinic historically loses money, but charges have gone up 50 percent since the transition (although the number of faculty doubled at the same time). Overall, enrollment for 2015 went smoothly. Many clients handled their own re-enrollment, which Dr. Thornton attributed to the quality of information provided by the clinic's social workers and health connectors. She concluded that the integration of the Ryan White program with the ACA should ensure the following:

- Support for PLWHA who do not qualify for health care coverage
- Premium and cost-sharing assistance
- Provision of key services, including complex case management
- Investment in staff and systems to support enrollment and administrative tasks
- Education of Medicaid managed care organizations on HIV clinical guidelines.

Discussion

Dr. Charles noted that ADAP and Ryan White grantees now must learn how to navigate insurance plans and tax credits; she asked whether HRSA's cooperative agreements include workforce training to address the new skills needed. Ms. Hauck said one such agreement is developing practical training tools, such as scripts and worksheets (in English and Spanish) about enrollment, as well as training on tax issues. These training tools will be rolled out through webinars and other efforts.

In response to Dr. Charles, Ms. Killelea said many States recognize that using ADAP funds to purchase insurance for PLWHA is more cost-effective than buying medications only. She said NASTAD and HRSA are working with States and their ADAP and Ryan White programs to build capacity and infrastructure to manage insurance issues and tax credits. Meanwhile, Ms. Killelea noted, it is necessary to consider filling gaps, using creative collaborative efforts as needed.

Dr. Peralta expressed concern that preauthorization requirements could lead to delays in care or treatment that could put HIV patients at risk for complications. They also could cause people to drop out of care or stop taking medications, which would result in major costs in the long run. Ms. Hauck said HRSA does not have quantifiable data but has heard from grantees and national partners about the problem. She said CCIIO is considering how to address the question. Dr. Peralta suggested working closely with the

private sector, especially insurers, to educate them about the unique barrier preauthorization poses for PLWHA.

Dr. Williamson asked whether CMS will recognize peer supporters and community health workers (CHWs) in the framework of health homes, pay-for-performance initiatives, and other programs. Ms. Killelea said CMS has many demonstration projects underway to test models of care delivery and payment that include such staff. Advocates have contacted State Medicaid directors to let them know what they can do under current State law. Many States and CDC recognize the potential benefits of employing CHWs.

Mr. Brooks asked the panelists for their input on immediate steps needed to support integration, including changes to the NHAS. Ms. Killelea responded that more collaboration with CMS is needed to support demonstrations that answer whether the Ryan White care model can be replicated within Medicaid. She added that using CHWs can be effective, but finance and payment mechanisms have not been tested.

Dr. Thornton said the lack of mental health services is a significant problem for all patients that must be addressed. She added that effective HIV care is intensive and complicated and therefore not easily translated into other settings. Mr. Brooks said HIV care is less complex now, and he questioned how much specialized expertise is needed. Dr. Thornton expressed concern about the potential for mistakes in prescribing by providers who lack such expertise. Dr. Collins-Ogle noted that the complexity of treating PLWHA has changed from a focus on treating opportunistic infections to addressing comorbidities, including diseases of aging, and considering the effects of long-term therapy. Dr. Valdiserri said the HHS Office of HIV/AIDS and Infectious Disease Policy and HRSA are working with CHCs outside of the Ryan White program to define basic HIV care and distinguish it from complex care.

Dr. Thornton suggested that HRSA gather input from Ryan White programs on how they could expand their services. She found, for example, that a local CHC was willing to treat PLWHA if her clinic would provide some Ryan White funding to support it. There may be new opportunities to engage providers outside of clinics, she said.

Mr. Greenwald said everyone in the field should be considering what a new, different Ryan White program would entail, especially in light of budget constraints and the need to target funding. Dr. Valdiserri observed that Federal agencies have been striving for 20 years to determine how to better allocate resources. He noted the need for more complex analyses that look at delivery systems.

SDH and Health Care Integration

Moderator: William Collier, PACHA Member

SAMHSA's Framework for a Trauma-Informed Approach Through Health, Behavioral Health, and Related Systems

Mary Blake, C.R.E., I.T.E., Public Health Advisor, SAMHSA

Ms. Blake discussed *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, published in July 2014. The agency sought to create a shared understanding of trauma-informed care that would be acceptable to a wide variety of providers. The paper presents a framework and guidance; it integrates trauma-focused research, knowledge generated from practice, and lessons from those affected by trauma. Ideally, it will help providers and institutions become more responsive to the trauma-related needs of their clients.

SAMHSA's definition of trauma incorporates not only the event(s) and the effects but also the experience of the individual. That is, how an individual interprets and processes traumatic events contributes to the long-term impact of those events, Ms. Blake explained. A trauma-informed approach to care fulfills the following objectives:

- Realizes the impact of trauma and potential paths for recovery
- Recognizes signs and symptoms of trauma in clients, families, staff, and others
- Responds by fully integrating knowledge into policies, procedures, and practices
- Resists reactivating the traumatic experience.

Ms. Blake emphasized that the trauma-informed approach goes beyond raising awareness and improving practice; it calls for commitment to change at the organizational level that is reflected in all aspects of operations.

The principles of a trauma-informed approach are safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and understanding the impact of cultural, historic, and gender issues.

The SAMHSA paper provides guidance for implementing a trauma-informed approach across all domains, including, for example, the importance of identifying a leader who will oversee implementation. Ms. Blake pointed out that the effectiveness of trauma-informed care in one setting is diminished when another setting retriggers the trauma for the client. The impact of trauma cannot be addressed in one setting alone, she noted.

Housing as a Structural Intervention

Rusty Bennett, L.G.S.W., Ph.D., Executive Director, Collaborative Solutions

Dr. Bennett made the case for housing as a form of prevention of and treatment for HIV. Homelessness is a major risk factor for HIV, and PLWHA are at high risk of homelessness. Homeless or unstably housed PLWHA who receive housing assistance are more likely to get medical care and adhere to HIV treatment regimens and less likely to engage in risky behaviors, ultimately leading to better health. Lack of stable housing among PLWHA equates to less treatment adherence, delayed care, and poorer health outcomes.

Among PLWHA at risk of homelessness, safe housing doubles the likelihood of viral suppression and reduces AIDS-related mortality by 80 percent over 3 years, said Dr. Bennett. Those with stable housing are more likely to avoid acute or emergency settings.

To demonstrate the effects of housing, Dr. Bennett compared the care continuum for PLWHA across the United States, within New York City (regardless of housing), and among New York City HOPWA recipients. The New York City HOPWA recipients demonstrated the best rates across the board, with 99 percent linked to care, 95 percent retained in care, 87 percent prescribed antiretroviral therapy, and 63 percent achieving viral suppression. The results support the strong effect that housing has on the health of PLWHA. Dr. Bennett recommended bridging the gap between the housing and medical care systems, because stable housing clearly reduces overall health care costs.

Observations of the NCBH

Mohini Venkatesh, M.P.H., Vice President, Practice Improvement, NCBH

Ms. Venkatesh said NCBH represents community-based mental health and addiction provider organizations that serve as a safety net for those who lack access to care. Such organizations are considering more broadly how to serve the needs of their clients, in particular those with HIV/AIDS, cancer, or other chronic conditions. Recently, NCBH began a collaboration with AIDS United related to behavioral health services to support HIV prevention and treatment. The initiative will consider how specialty behavioral health systems can incorporate HIV screening and education and make referrals for HIV treatment and services. It also will help organizations that serve PLWHA link their clients to mental health service providers.

Ms. Venakatesh said NCBH provides technical assistance to grantees of two HHS-funded programs that recognize the importance of integrating behavioral and medical care. The Primary and Behavioral Healthcare Integration (PBHCI) program, funded by SAMHSA, supports communities in coordinating and integrating primary care services into publicly funded, community-based behavioral health settings. The Minority AIDS Initiative also is working with the PBHCI program to integrate behavioral and medical care, especially for

minorities. Ms. Venkatesh said NCBH hopes to build more partnerships and better understand the challenges of HIV prevention and care.

Finally, Ms. Venkatesh noted that on the basis of the Excellence in Mental Health Act, Congress approved an eight-State demonstration project to improve community behavioral health services. The funding will open up opportunities for collaboration.

Discussion

Dr. Bradley-Springer pointed out that the Ryan White program has led to the creation of HIV specialty care settings that include connections to services, but overall, the connections to mental health services, housing, and trauma-informed care are not well defined in most health care settings. Paying attention to SDH is key to the progress made against HIV, she noted.

Dr. Holtgrave pointed out that the NHAS set a goal of moving up to 86 percent of Ryan White clients into stable housing; he asked Dr. Bennett for input on a goal for the updated NHAS. Dr. Bennett responded that it is difficult to capture the unmet need for housing among PLWHA. The U.S. Department of Housing and Urban Development is working on a standard, methodologically sound way for grantees to report housing need. Dr. Bennett suggested that Ryan White programs look more deeply at the conditions related to clients' housing, such as the amount a client spends on housing or a history of homelessness. He added that medical and service providers must share information and think holistically. Moreover, housing programs should integrate measures of medical outcomes, and medical providers should measure housing indicators.

In response to Dr. Charles, Ms. Blake described the development of a general adult trauma screening tool and brief response intervention to help providers screen for trauma in contexts other than intimate partner violence and to respond appropriately. Also, SAMHSA is working with public and private partners to develop a toolkit for primary care providers and settings to begin screening for trauma and making referrals. The agency also is training Federal HIV/AIDS project officers about trauma and the supports needed to implement and sustain trauma-informed care. Ms. Blake said SAMHSA continues to coordinate with HRSA and others to ensure that behavioral health is part of the discussion about care.

Regarding resource allocation, Dr. Bennett said programs must pay close attention to where the greatest needs are. Addressing those needs requires rational formulas, such as revising the HOPWA funding formula to incorporate the number of PLWHA rather than the cumulative number of AIDS cases. While there has been disagreement on how to factor in poverty, there is agreement that it should be included in the formula. Finally, reallocation requires a responsible approach; it cannot occur overnight.

Dr. Charles asked Ms. Venkatesh for lessons learned about the burden of stigma related to mental health care that would apply to PLWHA. Ms. Venkatesh replied that there are parallels, but not nearly enough effort has been made to identify lessons and share them across fields. However, as with HIV, the use of peers as paid staff in behavioral health facilities is very effective.

Mr. Stallworth pointed out that many services are available to HIV-positive youth but almost nothing for lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youth who do not have HIV, so they are ignored until they become HIV-positive. Dr. Bennett said the first step is raising awareness and identifying barriers in the community; he agreed that much more must be done for LGBTQ youth.

Ms. Brown asked whether post-traumatic stress disorder looks different in women than in men, and Ms. Blake said it does. There is much more research on women than on men about trauma impact, prevention, and response. One major difference is that in women, the effects of trauma are more likely to manifest inwardly and affect interpersonal relationships, while men are more likely to act out or turn to violence.

Ms. Brown asked Dr. Bennett whether housing programs include case management and peer advocates. Dr. Bennett said research shows that a whole range of supportive services are needed to keep people stably housed, including childcare and mental health services, to name a few. Many providers struggle to pay for wraparound services; discussions are needed at the policymaking level to ensure that services are connected across agencies.

Mr. Pruden asked about research on historical trauma, such as that experienced by Native Americans, African Americans, and others—specifically, systematic trauma supported and enforced by deliberate policies. Ms. Blake said SAMHSA plans to address community trauma and recognizes the legacies of historical trauma. Much significant research has addressed historical trauma, she added. Ms. Venkatesh said much research has been done on community resilience and building a trauma-informed community. Such efforts aim to lay the foundation for a resilient community, recognize and validate emotional and historical trauma, and prevent recurrence. The focus is on preventing future trauma, particularly where the infrastructure failed the community at key moments, said Ms. Venkatesh.

Closing Remarks and Adjournment

Dr. Valdiserri suggested that PACHA explore lessons learned and outcomes of accountable care organizations and accountable community care organizations created under Medicare, which seek to coordinate care and control costs. Some are taking a broad approach to serving vulnerable populations that may be informative.

Mr. Brooks said all of the issues that PACHA and its Subcommittees are working on now are of interest to ONAP, and PACHA is welcome to submit ideas and recommendations

for the NHAS before the updated draft is ready for review. He noted that the proposed FY 2016 budget would allot billions for areas that affect HIV, such as housing, education, and criminal justice reform, and he asked for suggestions on how to tap into those existing systems rather than focusing only on HIV funding.

Within the HIV community, Mr. Brooks said, it is important to consider preserving capacity and services and ensuring culturally competent, HIV-focused care. Programs are at risk when they depend on only one or two sources of funding, he cautioned. Mr. Brooks invited PACHA members to coordinate with ONAP on conceiving a new, reformed system to serve PLWHA. He also asked PACHA to propose bold yet achievable indicators of progress for the updated NHAS.

Dr. Holtgrave thanked the PACHA staff—Ms. Hayes and Caroline Talev, as well as the members and participants. He adjourned the meeting at 12:35 p.m.