

**Presidential Advisory Council on HIV/AIDS (PACHA)
59th Meeting**

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

May 24–25, 2016

Council Members—Present

Nancy Mahon, J.D., PACHA Chair
David Holtgrave, Ph.D., PACHA Vice
Chair
Jeffrey S. Akman, M.D. (*day one*)
Oliver Clyde Allen III
Lucy A. Bradley-Springer, Ph.D., R.N.,
ACRN, FAAN
Ulysses W. Burley III, M.D., M.P.H.
Vignetta Charles, Ph.D.
Cecilia C. Chung
Michelle Collins-Ogle, M.D., FAAP,
AAHIVS
Yvette Flunder, D.Min. (*day one*)
Grissel Granados, M.S.W.
Gabriel Maldonado, M.B.A.

Ligia Peralta, M.D., FAAP, FSAHM,
AAHIVS
Harlan H. Pruden
Scott A. Schoettes, J.D.
Elizabeth Styffe, M.S.N.
Mildred Williamson, Ph.D., M.S.W.

Council Members—Absent

Ada A. Adimora, M.D., M.P.H.
Gina M. Brown, M.S.W.
William H. Collier
Lawrence A. Stallworth II

Staff

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

Federal Liaisons

Laura Cheever, M.D., Sc.M., Associate Administrator, HIV/AIDS Bureau (HAB), Health
Resources and Services Administration (HRSA)
Teresa Durden, M.P.A., Acting Associate Director for Policy, Division of Global Health
Protection, Centers for Disease Control and Prevention (CDC)
George Fistonich, M.P.H., Policy Assistant, White House Office of National AIDS
Policy (ONAP)
Michael Goldrosen, Deputy Division Director, Division of State HIV/AIDS Programs,
HRSA
Lisa Kaplowitz, M.D., M.S.H.A., Deputy Assistant Secretary for Policy, Office of the
Assistant Secretary for Preparedness and Response, U. S. Department of Health and
Human Services (HHS)
Jennifer Kates, Ph.D., Liaison, CDC/HRSA Advisory Committee on HIV, Viral
Hepatitis, and Sexually Transmitted Disease (STD) Prevention and Treatment
(CHAC)
Amy Lansky, Ph.D., M.P.H., Acting Director, ONAP

Karen A. Scott, M.D., Chief Medical Officer, Office of the Assistant Secretary for Health, HHS
Richard Wolitski, Ph.D., Acting Director, Office of HIV/AIDS and Infectious Disease Policy, Office of the Assistant Secretary for Health, HHS

Presenters

John M. Auerbach, M.B.A., Associate Director for Policy, CDC
Cornelius Baker, Chief Policy Officer, Office of the U.S. Global AIDS Coordinator and Health Diplomacy, U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
Stephanie Brooks Wiggins, Co-Chair, Baltimore City HIV Planning Group and Commission
Patrick Chaulk, M.D., M.P.H., Assistant Commissioner, Bureau of HIV/STD Services, Baltimore City Health Department
Sue Daugherty, R.D., L.D.N., Chief Executive Officer, Metropolitan Area Neighborhood Nutrition Alliance (MANNA)
Sarah Downer, J.D., Clinical Instructor on Law, Center for Health Law and Policy Innovation, Harvard Law School
Jamal Hailey, Director, Special Teens At-Risk, Together Reaching Access, Care and Knowledge (STAR TRACK), School of Medicine, University of Maryland
Ernest Hopkins, Director of Legislative Affairs, San Francisco AIDS Foundation
Felina Laron, Outreach Worker, AIDS Action Baltimore
Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis (TB), CDC
Tracey Packer, M.P.H., Director of Community Health Equity and Promotion, San Francisco Department of Public Health
Dana Van Gorder, Executive Director, Project Inform
Sheri Weiser, M.D., M.A., M.P.H., Associate Professor of Medicine, Division of HIV, Infectious Disease and Global Medicine, Department of Medicine, University of California, San Francisco

Day One—May 24, 2016

Welcome

PACHA Executive Director Kaye Hayes, M.P.A., called the meeting to order at 9:07 a.m. PACHA Chair Nancy Mahon, J.D., was unable to attend in the morning; PACHA Vice Chair David Holtgrave, Ph.D., welcomed the members of the Council and meeting attendees. He noted that the February 2016 PACHA meeting had been cancelled due to bad weather. Dr. Holtgrave thanked the two PACHA members, Robert Greenwald, J.D., and Douglas A. Michels, M.B.A., who had completed their terms of service before this meeting. He also thanked the PACHA staff for their hard work.

Roll Call

Ms. Hayes called the roll.

Introductory Remarks

Amy Lansky, Ph.D., M.P.H., Acting Director, ONAP; and Richard Wolitski, Ph.D., Acting Director, Office of HIV/AIDS and Infectious Disease Policy, HHS

Dr. Holtgrave announced that Douglas Brooks, M.S.W., had resigned as director of ONAP. He welcomed Amy Lansky, Ph.D., and acknowledged her work with ONAP to date. Dr. Lansky expressed her appreciation of the contributions of PACHA, particularly to implementation of the National HIV/AIDS Strategy (NHAS). ONAP has published several important documents recently: the updated NHAS in English and Spanish, a federal action plan identifying commitments through 2020, the first community action plan framework to help stakeholders at all levels align their efforts with the NHAS, and an indicator supplement to allow communities to evaluate data.

Dr. Lansky outlined the four priorities of ONAP:

- Promote widespread HIV testing and linkage to care and services for those at risk.
- Provide resources to communities with the highest burden of HIV.
- Develop indicators to measure uptake of pre-exposure prophylaxis (PrEP), HIV stigma, and HIV among transgender people.
- Address the opioid abuse epidemic to prevent HIV outbreaks and hepatitis transmission.

Addressing opioid abuse is a priority for the current administration. Injection of opioids is a particular concern and this issue opens the door for discussions about prevention measures, including linkage to syringe exchange programs and other care and services for those at risk.

Dr. Lansky asked PACHA members to continue spreading the word about the NHAS to their communities and networks because a combined national effort is needed to achieve the goals of the NHAS. She also suggested that as PACHA and its subcommittees monitor implementation of the NHAS, they “think big” about policy changes and broad actions that could have significant effects.

Dr. Holtgrave announced that Ron Valdiserri, M.D., has left the HHS. He welcomed Richard Wolitski, Ph.D., and praised his work on housing and stigma related to HIV. Dr. Wolitski observed that much has changed since the recognition of HIV/AIDS in the early 1980s. Like Dr. Lansky, he emphasized the importance of a national effort at all levels to fight the epidemic. Dr. Wolitski noted that PACHA represents the diversity of stakeholders needed to respond to the issue, and he expressed appreciation for the Council’s advice and expertise.

In Memoriam: Celebrating the Lives of Reverend Vanessa Sharp and Dr. Beny Primm

Reverend Vanessa Sharp

Oliver Clyde Allen III; Yvette Flunder, D.Min.; and Harlan Pruden

Oliver Clyde Allen III recalled that Reverend Vanessa Sharp knew how to turn lemons into lemonade—she turned everything in her life into something positive and impactful that would motivate and transform the people around her. He hoped her memory would continue to inspire and that PACHA members would follow her example by seeking to change the world around them. He expressed his gratitude for Rev. Sharp’s impact and inspiration.

Yvette Flunder, D.Min., observed that Rev. Sharp turned ashes to joy and sadness to dance. Rev. Sharp fought injustice on multiple fronts; she decried the lack of access to care for people living with HIV (PLHIV), and she also fought unjust incarceration and barriers to women’s rights. Dr. Flunder recalled Rev. Sharp’s efforts to serve those in Africa, calling her an incredible justice warrior and a holy, godly woman.

Harlan Pruden stated that not only could Rev. Sharp turn lemons into lemonade—she also knew when to toss the lemons out altogether in favor of orange juice. That is, Rev. Sharp knew when it was time to create a new path, and she led the way. Mr. Pruden believed Rev. Sharp’s work would continue, as she had planted seeds in PACHA and among all those she affected.

Beny Primm, M.D.

Cornelius Baker, Chief Policy Officer, Office of the U.S. Global AIDS Coordinator and Health Diplomacy, PEPFAR; and David Holtgrave, Ph.D., PACHA Vice Chair

Cornelius Baker described some of the accomplishments of Beny Primm, M.D., noting his strong influence on social policy at the highest levels. He called Dr. Primm an elegant, brilliant man who never forgot his West Virginia roots. Mr. Baker remembered Dr. Primm’s ability to bring groups together, allowing for individual differences while ensuring that everyone pulled forward together. Mr. Baker offered some anecdotes illustrating Dr. Primm’s relentless advocacy on behalf of PLHIV and those facing addiction disorders.

Dr. Holtgrave also remembered Dr. Primm’s commitment and influence, noting that Dr. Primm almost singlehandedly brought about the HHS Secretary’s Minority AIDS Initiative Fund. Dr. Holtgrave hoped PACHA members would have some of Dr. Primm’s wisdom, passion, and commitment to see what needs to be done, to actually do what needs to be done, and to do it with the same selflessness and humility as Dr. Primm.

The Council observed a moment of silence in honor of Rev. Sharp and Dr. Primm.

PACHA Subcommittee Reports

Access to Care Subcommittee

Vignetta Charles, Ph.D., Co-Chair

Vignetta Charles, Ph.D., summarized the Subcommittee's priorities:

- Monitor implementation of the Affordable Care Act (ACA), specifically addressing concerns about transparency, costs (especially drug costs), and coverage of drugs used by PLHIV.
- Monitor integration of the Ryan White HIV/AIDS Program into the ACA to ensure that state workers can navigate the system on behalf of PLHIV.
- Evaluate the response to curative medical treatment for hepatitis C in anticipation of a cure for HIV.
- Delve into the relationship between HIV and social determinants of health (SDH) with informative panel discussions (e.g., housing, trauma-informed care, behavioral health services, food and nutrition services [FNS]).
- Assess the landscape of funding for HIV research and the quality of HIV health information.

Dr. Charles noted that all the subcommittees address both SDH and HIV research. The Access Subcommittee proposed a patient charter that articulates PACHA's beliefs about whole-person health, and Dr. Charles asked all the subcommittees to discuss the concept. She indicated that the Access Subcommittee plans to take the lead on discussions about funding and quality of HIV research and data.

Reducing HIV-Related Disparities Subcommittee

Gabriel Maldonado, M.B.A.; and Scott A. Schoettes, J.D.; Co-Chairs

Gabriel Maldonado, M.B.A., reported that the Subcommittee determined that SDH and the role of faith-based leadership intersect on the issue of stigma. For 2016, the Subcommittee proposes a stigma summit to share various perspectives about the role of stigma, how to measure it, and how to address it. Scott A. Schoettes, J.D., indicated that the stigma summit may happen this summer in conjunction with related work by the White House. The goal is to identify recommendations for reducing stigma that PACHA can consider.

Mr. Schoettes added that the Subcommittee will follow up on its own recommendations to standardize metrics around HIV to better ensure quality across the board. He commented that subcommittees should monitor the progress of the recommendations they propose.

Global Agenda Subcommittee

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

Elizabeth Styffe, M.S.N., made the case that HIV has global public health and economic implications. She presented sobering statistics about the burden of HIV around the world. The Global Subcommittee focuses on two-way learning—that is, not only disseminating best practices but also learning from the rest of the world. It aims to inform PACHA about global trends and bring in new voices in an effort to enhance collaboration and break down silos. Ms. Styffe and Harlan H. Pruden called for more PACHA members to join the Global Subcommittee.

Reducing HIV Incidence Subcommittee

Michelle Collins-Ogle, M.D., FAAP, AAHIVS, Co-Chair

Michelle Collins-Ogle, M.D., stated that the Subcommittee hopes to address two goals before this administration leaves office: to achieve an adequate resolution to the dismantling of the Adolescent Trials Network for HIV/AIDS Interventions (ATN) and to make progress on data collection on Native American populations. The status of the ATN is the subject of a working group and will be addressed later in this meeting.

The Native American Working Group of the Incidence Subcommittee identified three areas of focus around data: lack of collection of accurate data, lack of interagency data sharing, and failure to collect information on gender or sexual identity. The working group is collaborating with tribes and community-based organizations (CBOs) to obtain better data through the Indian Health Service (IHS) on HIV and hepatitis C. A panel discussion is planned for the January 2017 PACHA meeting; the effort likely will culminate in recommendations or a white paper on the topic of data sharing.

Discussion

PACHA members asked whether HIV research could be linked to the intensified effort to address cancer championed by Vice President Joseph Biden; Dr. Lansky agreed to explore the idea. In response to a question about the intersection of hepatitis C, opioid abuse, and injection drug use, Dr. Collins-Ogle indicated that the Incidence Subcommittee is addressing substance abuse primarily in tribal communities and among adolescents.

Cecilia C. Chung recommended that the Access Subcommittee review issues of aging among PLHIV; she considers this issue to be urgent because many long-term survivors are at increased risk of living in poverty. Dr. Charles agreed and added that violence prevention is a key component of all SDH work. Dr. Lansky explained that the President's Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities became part of a broader federal interagency working group that continues to address those issues.

Dr. Lansky expressed her appreciation for the renewed energy of the Global Subcommittee and the reminder that the United States is part of the global HIV

landscape. She also hoped to collaborate on the proposed stigma summit. Dr. Lansky noted that substance abuse is an important issue in the HIV field in general, but she cautioned against confounding HIV prevention efforts with the opioid epidemic. She also hoped that attention to opioids would not detract from attention to HIV.

Dr. Wolitski asked all the subcommittees to consider how to address disparities in care and improve HIV suppression, as no other actions will have a stronger impact on the HIV/AIDS epidemic. Dr. Flunder called for bringing the conversation back to the fundamental questions of which communities are most affected by HIV and how well those communities are represented in the decision-making process. She urged PACHA to consider the cultural divide between people affected by the HIV epidemic and the decision-makers, as the epidemic is “getting browner and browner by the day.”

ATN: PACHA Working Group Update

Michelle Collins-Ogle, M.D., FAAP, AAHIVS; and Ligia Peralta, M.D., FAAP, FSAHM, AAHIVS

At its September 2015 meeting, PACHA discussed the decision by the National Institutes of Health (NIH) to restructure and effectively dismantle the ATN and the impact that this decision will have on youth. The Working Group was formed to seek more transparency on the plans for restructuring; the group asked the NIH to develop a framework for community involvement that would keep youth engaged, but it was unable to get sufficiently detailed information from the NIH. In the meantime, the NIH published its request for applications to restructure the program; awards are scheduled to be announced in June. The Working Group now seeks to focus on accountability of the new program—specifically, how adolescents are engaged in research.

Ligia Peralta, M.D., emphasized that funding a minimal or partial network may waste critical time and resources needed to find solutions for youth with HIV, especially for transgender youth and youth of racial and ethnic minorities. The ATN revealed that the epidemic looks different among youth; any future program should have the breadth and depth to end HIV infection among youth. Dr. Peralta raised concerns about insufficient infrastructure to complete needed trials that are already licensed and underway for promising biomedical interventions.

Dr. Collins-Ogle explained that some studies underway through the ATN were halted abruptly, and no plan seems to exist to link studies that are underway with future efforts. The restructuring plan appears to dismiss the substantial experience of those who have spent many years developing the unique skills required to engage adolescents in research.

Dr. Collins-Ogle added that PACHA plays a role in ensuring that federal agencies are working together to implement the NHAS; the lack of transparency around the NIH restructuring is concerning. The NIH indicated it would convene an external advisory group around the issue but has not yet stated who would serve on that group, and it is not clear that young people and community representatives will have a voice in that process.

The Working Group drafted a letter to the HHS secretary for review by PACHA members outlining its concerns and offering recommendations to address them.

Discussion

Grissel Granados, M.S.W., emphasized that the interruption of services already has had an impact, leaving research staff with years of experience out of work and projects addressing unique populations suddenly without funding. She decried the lack of transparency and the exclusion of important stakeholders from decision-making.

Mildred Williamson, Ph.D., suggested that the racial and ethnic composition of the staff involved in ATN projects be compared with that of the new mechanism, and a commitment should be made not to go backward. She noted that HIV is concentrated among people of color and the disenfranchised and suggested seeking support from NIH's National Institute on Minority Health and Health Disparities.

Mr. Schoettes suggested that the letter should be updated to focus only on those issues on which PACHA can still have an impact. Drs. Collins-Ogle and Peralta responded that those issues are the following: creation of an external advisory group with sufficient youth and community representation, communication of the transition plan from the ATN to the new structure, and commitment of sufficient funding for the infrastructure.

Lucy A. Bradley-Springer, Ph.D., pointed out that current ATN grantees were ignored by the NIH in this restructuring. These grantees created the network and developed expertise but now are left without funding to continue their work. She added that the abrupt transition will result in losses that cannot be regained.

Council members agreed to review and vote on a revised draft of the letter on the second day of this meeting.

HIV Trends in Key Populations

Eugene McCray, M.D., Director, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC

Eugene McCray, M.D., pointed out that though new tools are available to prevent HIV transmission and some success has been realized, progress has been uneven. For example, whereas HIV diagnoses are decreasing among most U.S. populations, they are increasing dramatically among Asian Americans. Heterosexual transmission has decreased, but male-to-male transmission has increased. Diagnoses among women are decreasing across all races and ethnicities, but a significant gap in diagnosis rates persists between African American women and other women. Among men who have sex with men (MSM), diagnoses are increasing among Latino and African American men and among young MSM of all races and ethnicities.

More analysis and better data are needed. For example, limited data indicate many new HIV infections occur among transgender women, but more data are needed. Existing data show that individuals' awareness of their HIV status is lowest among those in the Deep

South, where PLHIV also have the highest death rates in the country. Linkage to and retention in care remain problematic and are far short of national targets.

Recent CDC data on the lifetime risk of HIV suggests vast disparities across populations and alarmingly high projections among MSM of color. Notably, most MSM with HIV live in urban or periurban areas, mostly in smaller cities in the South. Efforts are underway to better define the denominators at local, state, and national levels.

Dr. McCray commented that the heavy burden of HIV, especially in the South, is neither inevitable nor acceptable. Progress depends on developing new ways of thinking, identifying what works, and capitalizing on what already exists. Tools are available now to stop HIV, but the need to improve access so that people do not die because of where they live is urgent. Dr. McCray concluded that to tackle these problems, stakeholders at all levels must be engaged and address stigma, including internalized stigma.

Discussion

Dr. McCray acknowledged that health disparities in the South are not limited to HIV but occur around many conditions, such as diabetes and hypertension, and the disparities are not entirely related to money. CDC increased funding to health departments to address some of the problems, but questions remain about the fairness of diverting resources from good programs and sending them to programs that will not use them.

Dr. McCray explained that data can identify what is happening but not why. For example, efforts to improve data collection are still hampered by stigma, such as the stigma among transgender people and the undocumented. CDC is considering how to release incomplete data. It is also considering working more closely with providers who care for transgender people to gather better data. Dr. McCray noted that CDC is modeling the continuum of care (or cascade) for Native Americans.

Follow-Up Item

- PACHA staff will follow up with Dr. McCray on the status of the Native American continuum of care and CDC proposals to better address HIV among Native Americans. The information will be presented to PACHA for input.

Efforts are underway to review data by county to reveal differences between urban and rural areas, especially in the South. More funding is needed to ensure accountability.

Dr. McCray called for more discussion on measuring innovation. The lack of capacity to analyze data poses a big challenge, especially in southern states. CDC faces some restrictions in measuring innovation but is moving in the right direction.

Remarks

The Honorable Ron Dellums

The Honorable Ron Dellums, a former U.S. representative and former mayor of Oakland, California, explained that he served on PACHA twice, under two presidents of different parties. His advocacy for PLHIV began in the late 1990s when he saw nothing being done to help people dying in Africa. He proposed a global trust fund for low-income countries that formed the foundation of the World Bank AIDS Marshall Plan Trust Fund Act and advised HHS Secretary Tommy Thompson, J.D., on what would later become PEPFAR. As a mayor, he championed the Get Screened Oakland initiative to promote HIV screening through a public-private partnership that remains active today.

The Hon. Mr. Dellums observed that he came from a generation that had a sense of urgency, conviction, compassion, and commitment—a generation that raised hell, brought people together, and forced the issues because they could not let people die while doing nothing. He reminded the audience that the statistics presented by Dr. McCray are not numbers but humans; the current situation is unacceptable. For too many years and on too many issues, African Americans, followed by Latinos, have carried the greatest burden and risked the most harm. He lamented that when he chaired PACHA 15 years ago, the Council was having the same conversations, yet people are still dying and in pain.

Although he is 80 years old, the Hon. Mr. Dellums stated that he was not ready to quit fighting and so started the Dellums Institute for Justice. He would be honored to partner with PACHA, the White House, and community organizations to eradicate HIV domestically and abroad. He recalled going to the Pentagon to make the case that HIV/AIDS is a national security issue and that in the name of enlightened self-interest, the United States should invest all its resources to end the epidemic. He asked why no domestic Marshall Plan, trust fund, or concerted effort exists to save young people's lives. The Hon. Mr. Dellums' comments received a standing ovation.

Making the Updated NHAS a Reality: Case Studies of Baltimore and San Francisco

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

Baltimore

*Patrick Chaulk, M.D., M.P.H., Assistant Commissioner, Bureau of HIV/STD Services,
Baltimore City Health Department*

Baltimore is focused on NHAS Goal 3: reducing HIV-related health disparities and health inequities. Patrick Chaulk, M.D., observed that HIV infections among injection drug users (IDUs) have been declining since 2000, largely thanks to syringe exchange programs, and recent legislation will allow for more such programs.

Regional and demographic patterns have a strong impact on Baltimore's efforts to tackle HIV. Baltimore; Washington, DC; and Philadelphia are among the 15 cities with the

greatest numbers of PLHIV. These three cities also rank in the top 10 cities with the greatest amount of municipal debt, so they face resource challenges. Dr. Chaulk called for a national model similar to PEPFAR to address the funding gap.

Other challenges that Baltimore faces are stigma and the narrow focus of HIV prevention messages, which often exclude some groups, such as heterosexuals, women, and Native Americans. Efforts to reduce new infections include a targeted campaign focused on the Baltimore ballroom community and a broader campaign aimed at making HIV testing routine. The latter project includes an HIV action kit for providers and a process for identifying people at risk and linking them to care. Baltimore received CDC funding to scale up use of PrEP and has launched campaigns to fight stigma and mistrust of the medical system. These efforts are part of a new kind of public health approach that engages the community in addressing its challenges.

Jamal Hailey, Director, STAR TRACK, School of Medicine, University of Maryland

Jamal Hailey explained that his organization focuses on health and social justice issues with attention to sex-positive cultural sensitivity. It provides clinical services, particularly to hard-to-reach populations. Mr. Hailey described some of the current and historic events that feed into mistrust of the medical system, which is strong among African Americans in Baltimore. He urged providers not to dismiss concerns as unfounded but rather to work with clients to build their health literacy and advocate for their own health.

STAR TRACK trains providers to develop trusting relationships with clients, retain clients, and avoid retraumatizing them. Training may address specific issues, such as intimate partner violence among African American male couples. Mr. Hailey noted that a state-led program is focusing on the interaction between internalized homophobia and racism.

Felina Laron, Outreach Worker, AIDS Action Baltimore

Felina Laron described some of the programs her organization supports, such as T Time, which provides one-on-one counseling as well as support groups and education for transgender people to help them navigate various health, emotional, housing, and financial issues. AIDS Action is a trusted name in Baltimore with a long history of building on successful, established programs to reach the transgender community.

Stephanie Brooks Wiggins, Co-Chair, Baltimore City HIV Planning Group and Commission

Stephanie Brooks Wiggins described her experience being diagnosed with HIV 30 years ago, when there were no treatment options. She urged PACHA members and other attendees to ensure that efforts address all populations because everyone needs the same information and access to providers.

Ms. Wiggins developed Older Women Embracing Life and is currently creating a pilot program about health and HIV for senior centers and senior residences. She emphasized

the value of support groups to spread awareness and resources. She pointed out that it does not always take money to make a difference.

Ms. Wiggins noted that HIV/AIDS is linked to poverty, and women and children in poor communities are at high risk. The problem should be tackled from all fronts.

Ms. Wiggins described the stigma and racism she continues to face, even from health care workers, who need increased education about how HIV is spread. She noted that seniors may not be aware of the risk of HIV from sexual activity with new partners.

Ms. Wiggins emphasized that talking about HIV will help raise awareness and reduce stigma, but more resources are needed in all settings.

Discussion

Mr. Pruden pointed out that medical mistrust is significant among Native Americans, with good reason. Jeffrey S. Akman, M.D., suggested that organizations in Baltimore and Washington, DC, could partner with academic entities like Howard University around the issue of medical mistrust. Dr. Chaulk agreed that more discussion is needed.

San Francisco

Tracey Packer, M.P.H., Director of Community Health Equity and Promotion, San Francisco Department of Public Health

Tracey Packer, M.P.H., stated that the San Francisco Department of Public Health promotes “active HIV intervention,” an approach that combines biomedical strategies with behavioral change and leadership around social justice and human rights. In 2010, it shifted its goals to focus less on education for HIV-negative populations and more on HIV intervention as an effective mechanism for prevention. When the new plan was rolled out, however, the community pushed back, maintaining that the new plan relied too much on biomedical strategies and not enough on the emotional support provided by CBOs through partnerships.

Eventually, the city reached a compromise and reallocated funding to ensure health education and risk reduction resources were not dramatically reduced. Ms. Packer explained that this process revealed that HIV prevention dollars had funded a social safety net around HIV for many years. City officials also learned the importance of getting community input early. The new approach has increased testing and treatment with promising results across the continuum of care.

Dana Van Gorder, Executive Director, Project Inform

Dana Van Gorder acknowledged that San Francisco is well-resourced and has tremendous political will to address HIV. The city has also benefitted from a relentless focus on HIV testing and a commitment by the city health department and area clinics to offer treatment as early as possible.

The San Francisco Getting to Zero campaign seeks to eliminate deaths from HIV, new HIV infections, and HIV-related stigma and discrimination by 2025. By 2020, it aims to

reduce deaths and new infections by 90 percent. The campaign is organized around committing to diversity of all kinds, building on 30 years of experience, and ensuring support for existing programs before asking for funding for new efforts, among other principles.

Mr. Van Gorder gave examples of strategic initiatives to address PrEP, rapid treatment initiation, linkage to and retention in care, and stigma reduction. These efforts have been successful, but San Francisco still lacks resources to address a number of key SDH for PLHIV.

Ernest Hopkins, Director of Legislative Affairs, San Francisco AIDS Foundation

Ernest Hopkins observed that although “getting to zero” is a bold goal, it motivates and mobilizes communities and advocates. Advocates are discussing actions that can and should be done at the national level in support of this goal, such as addressing homelessness. Mr. Hopkins proposed that cities pair up to leverage their resources, and he added that community participation is essential to ensure that programs work.

Mr. Hopkins called for more attention to using data to create systems that people want to use. He believes that PLHIV who are not getting treatment are different from those who are in treatment, and it is time to look closer at systems to understand why some do not get treatment. Mr. Hopkins applauded those who are trying to change the face of the infection in their community but noted that much remains to be done for PLHIV who are outside those communities. He hoped PACHA and others would grapple with the issue, because “getting to zero” is for everyone.

Discussion

Dr. Peralta expressed concern about the sustainability of programs, and Dr. Chaulk responded that he seeks to build an infrastructure that will persist beyond current funding. Dr. Chaulk emphasized that sustaining adolescent engagement is particularly important because that population is politically marginalized and poorly managed in the health care system. Ms. Packer was concerned about balancing adolescents’ privacy with the need to bill private payers, often via a parent’s insurance policy, for care. She also drew attention to the need to integrate services and programs funded by various partners.

Asked how to address medical mistrust at the national level, Mr. Hailey responded that talking about it without trying to skirt the issue of racism is an important first step. The national HIV agenda has space for social justice issues, he noted.

Discussion turned to the idea that provider teams should promote cultural understanding and empathy by including people from the communities or populations they serve. Other comments centered on the need to ensure that maintaining access to treatment does not force PLHIV to live in poverty.

Health Systems Transformation Presentation and Discussion

John M. Auerbach, M.B.A., Associate Director for Policy, CDC

John M. Auerbach, M.B.A., outlined some of the health care reforms that have paved the way for novel approaches to care. The ACA increased access to insurance, leading to coverage for 20 million more people since 2010, and provided more flexibility and incentives to promote value over quantity of care. Currently, 50 million Americans are covered under a patient-centered medical home or an accountable care organization.

Mr. Auerbach noted that many public health systems have not adapted to the changing demographics of this country and that public health funding has been cut at all levels. Therefore, public health must focus on core functions, paying for vital services that no other entity will cover. Because more people have insurance, public health should provide fewer direct services and turn attention “upstream” to policies and SDH that affect overall health. New partnerships must be developed to link people not only to health care but also to other services such as housing, transportation, and education.

To push systemic change, Mr. Auerbach challenged PACHA members to “get a seat at the table” where policies and decisions are made. CDC has created toolkits to help advocates make a business case for health promotion policies. CDC has identified six high-volume, high-cost health conditions and outlined 18 interventions that insurers should pay for that are likely to demonstrate cost benefits within 5 years. All the interventions are either preventive steps that can be taken during a traditional clinical visit (e.g., screening, immunization) or new, effective steps that fall under the umbrella of value-based approaches (e.g., diabetes counseling programs, home visits to pinpoint and reduce asthma triggers).

Mr. Auerbach described great successes using this approach, especially among Medicaid programs and large insurers. CDC’s tools identify the evidence, demonstrate the relevance of the condition to the payer, provide evidence-based solutions, and translate the data into language that is meaningful to insurers. CDC is developing tools to make the case for HIV and hepatitis interventions and has created a website to provide uniform data about SDH. Finally, CDC is taking a similar approach to population health policy, seeking definitive evidence on interventions that have a positive impact on health and costs within 5 years.

Discussion

Mr. Schoettes suggested making a case to insurers that providing uniform coverage without copays benefits all the payers, even if beneficiaries move across plans.

Mr. Auerbach suggested targeting areas with relatively few payers; in such cases, ensuring that addressing public health issues is part of decision-making should be helpful. He also recommended being prepared with data that speak to the concerns of payers.

Mr. Auerbach clarified that the CDC approach he described aims to help public health representatives make the business case for a limited number of interventions that will improve health and save money within 5 years, thus justifying insurance coverage

without increased premiums or copays. The safety net is still needed, but it should be different now that more people have insurance and can get care.

Jennifer Kates, Ph.D., observed that CDC's approach could free up some public health resources, allowing more dollars to go to services for PLHIV. It also could stimulate the political will, community engagement, and advance planning needed to ensure sustainability.

Public Comment Period

Natalie Kean of The AIDS Institute presented an analysis of 2015 Ryan White HIV/AIDS Program awards by state and case counts to determine whether funding is being distributed to the areas of highest need. Examining Part A and Part B funding together demonstrates that some states receive funding well above the median per case count, whereas others' funding is below the median^[SP1]. Ms. Kean emphasized the importance of considering all Part A, B, C, and D funding that is not related to the AIDS Drug Assistance Program together because some states receive less funding in one category but a greater amount of funding in another. In addition to the amount of funding greater than or less than the median per case, total funding should be assessed to realize the magnitude of funding differentials. The AIDS Institute encouraged HRSA to examine their supplemental award process and recommended that Part C and D awards better distribute funding based on need within the parameters of current law. Ms. Kean suggested that the group's data can help inform the conversation about distribution of current Ryan White HIV/AIDS Program funding. In the long term, different ways to distribute funding may be considered, such as using measurable factors other than or in addition to case counts to better reflect need.

Carol Treston, R.N., of the Association of Nurses in AIDS Care expressed her appreciation that PACHA had discussed the issue of medical mistrust. Most providers acknowledge the history but dismiss it as a concern that is no longer relevant. Ms. Treston emphasized the need to recognize microaggressions that support mistrust and often go unseen by providers but are acutely felt by the people served. She commented that providers think of themselves as sensitive people, but that is not always true. It is important to recognize the role of providers, including nurses, in stigma and acknowledge that stigma is real. People with the best intentions often are busy, stressed, or jaded, and they need continuous learning. Ms. Treston commented that medical and nursing education should make discussion of the facts that drive HIV and health disparities a higher priority, and there is a shared responsibility to provide that education. She added that HIV education is difficult to obtain and PACHA members would be surprised how little HIV education occurs in nursing. She urged PACHA to think about innovative solutions to educate providers, who are critical to addressing medical mistrust and to "getting to zero."

Follow-Up Item

- At an upcoming PACHA meeting, the Council will consider convening a panel on medical mistrust that includes concrete examples of effective programs to overcome mistrust.

Marsha Martin pointed to the statistics projecting that one-half of all African American MSM and one-quarter of Latino MSM will be diagnosed with HIV. She suggested that PACHA should clearly state that these projections are unacceptable and should challenge federal agencies to quadruple their efforts to prevent these projections from being realized. In some states, HIV rates among Latinos have doubled in the past few years. Ms. Martin asked that PACHA challenge the government to respond to these data with action.

Closing Remarks

Ms. Mahon indicated that PACHA's role is to speak truth to power and to do so in a way that is pointed and gives specific directions. She also noted that health care is an issue that has been raised in presidential election debates, but candidates are not focused on the people who need to be served. Ms. Mahon pointed out that although the current administration is coming to an end and individuals are leaving, PACHA is still here and should consider what it wants to do, such as issue a call to action to tackle HIV among men and women of color.

The meeting adjourned for the day at 4:48 p.m.

Day Two—May 25, 2016

Welcome

Ms. Mahon called the meeting order at 9:05 a.m. She presented to Mr. Greenwald a plaque in honor of his service to PACHA; Mr. Michels was not in attendance. Ms. Mahon also presented a certificate of appreciation to Dr. Holtgrave, whose term on PACHA is coming to an end.

Swearing-In of New PACHA Members

*Jewel Mullen, M.D., M.P.H., M.P.A., Principal Deputy Assistant Secretary for Health,
HHS*

Jewel Mullen, M.D., swore in four new PACHA members: Nicholas Carlisle, J.D.; Kevin Cranston, M.Div.; Patrick Sullivan, Ph.D., D.V.M.; and Darryl Wheeler, Ph.D., M.P.H., ACSW.

Roll Call

Ms. Hayes called the roll. Ms. Mahon announced that Dr. Wheeler would assume the role of PACHA Vice Chair.

Food Is Medicine: The Case for Integrating FNS Into Health Reforms

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

Robert Greenwald, J.D., explained that food programs were pioneers in convincing lawmakers that support services should be part of HIV/AIDS programs. This panel was convened to give concrete examples of the importance of sustaining the integrated Ryan White HIV/AIDS Program model for PLHIV as they transition into the general Medicaid population or private insurance systems. The long-term support for FNS under the Ryan White HIV/AIDS Program has created a large body of evidence demonstrating that food as medicine satisfies the three aims of health care reform: it improves individual health outcomes, addresses public health concerns, and reduces costs.

Although it is unlikely that Medicaid programs will take on the task of addressing malnutrition and food insecurity broadly, it is reasonable to propose that insurance cover food as medicine (i.e., prescribed, medically tailored meals) for people who have or are at risk for acute or chronic illness or disability. For example, hospitals now face penalties for readmissions, and people with acute HIV are often readmitted because of malnutrition and dehydration. Mr. Greenwald noted that providing three medically tailored meals per day for 6 months costs less than 1 day of hospitalization.

Mr. Greenwald indicated that his organization can provide data to support PACHA recommendations on integrating food as medicine into public and private insurance. He noted that millions of dollars are going to food providers now, but there is a need to integrate programs more effectively.

Sheri Weiser, M.D., M.A., M.P.H., Associate Professor of Medicine, Division of HIV, Infectious Disease and Global Medicine, Department of Medicine, University of California, San Francisco

Sheri Weiser, M.D., defined food insecurity, distinguishing it from malnutrition, and reported that one-half of PLHIV who are in care are food insecure. Food insecurity kicks off a vicious cycle: it contributes to poor nutrition, poor mental health, and less adherence to recommended health behaviors, which increases the risk for HIV and worsens HIV outcomes. These factors drive hospital, emergency department (ED), and health clinic visits, which further entrench people in poverty and unemployment, worsening food insecurity.

Data demonstrate these effects of food insecurity. For example, poor nutrition doubles the risk of obesity. It is associated with depression, anxiety, and drug and alcohol use disorders, and these effects are worse for PLHIV. Most data show a link between food insecurity and nonadherence to treatment. Those facing food insecurity have higher rates

of HIV and other STDs. Those PLHIV with food insecurity have higher mortality rates than those who are food secure. Food insecurity increases the likelihood of ED visits and hospitalization, and annual health care costs are higher for those who are food insecure. Food insecurity is also linked to other chronic diseases, such as diabetes, hypertension, osteoporosis, and kidney disease. Dr. Weiser observed that these effects are distinct from related issues of poverty, such as lack of stable housing.

Robust research on medically tailored meals demonstrates that they improve outcomes for PLHIV, improve quality of life, and reduce health care costs. Dr. Weiser offered data from domestic and international studies showing that such interventions address the effects of food insecurity and lower health care costs. These interventions can achieve the goals of health care reform, she concluded.

Sue Daugherty, R.D., L.D.N., Chief Executive Officer, MANNA

Sue Daugherty, R.D., pointed out that the evolution of her organization mirrored the evolution of HIV/AIDS treatment. In the late 1990s, MANNA shifted from providing comfort care at the end of life to offering nutritional maintenance—that is, from helping people die to helping people live. As health care reform came about, MANNA conducted research to demonstrate the impact of food as medicine, showing, for example, a 62 percent decrease in health care costs after just 3 months of daily meal service.

Unlike a food bank or meal delivery service, MANNA designs meal plans for specific clients, typically people who are very sick with multiple chronic diseases and have particular dietary needs. Because it tailors meals to clients, MANNA usually cannot accept food donations. It also relies heavily on volunteer labor.

Ms. Daugherty reported that MANNA used its data to convince one insurer to treat dietary prescriptions the same as pharmaceutical prescriptions for its beneficiaries. Within 1 year, 850 people in the plan received dietary prescriptions, and many were able to discontinue medications as a result, saving the health plan money. As a result, the state is considering mandating such coverage. Ms. Daugherty expressed hope that the model would scale up to a national level.

Sarah Downer, J.D., Clinical Instructor on Law, Center for Health Law and Policy Innovation, Harvard Law School

Sarah Downer, J.D., indicated that her organization has long made the case for using health care dollars to address SDH. With food interventions, the impact is significant and immediate, so the time is right to make the case for Medicaid coverage. Food as medicine meets all three aims of health care reform and fits well with models that prioritize value.

Some critical gaps must be addressed. Most medically tailored meals programs are located on the East or West Coast, and few exist in the South or central United States, where HIV burden is highest. Many providers are not aware of available resources—although when they see the data and learn about resources, they refer patients to services. Ms. Downer emphasized that funding should follow demand so that services can scale

up. Scaling up means moving food services away from reliance on discretionary, annual appropriations and philanthropic donations and into health care systems.

Ms. Downer described several mechanisms that states can use to cover FNS in Medicaid programs under existing regulations, including some new paths created by the ACA. Hospitals have new incentives to reduce readmissions, and nonprofit hospitals are now required to assess community needs. Ms. Downer predicted that there will be significant uptake of food-as-medicine programs among private insurers in the short term because they recognize the potential for reducing health care costs. Aggressive efforts are needed to push for Medicaid coverage of FNS. Ms. Downer advocated for including food interventions in all demonstration projects proposed by the Centers for Medicare & Medicaid (CMS) Innovation Center.

Discussion

Dr. Peralta pointed out the opportunity to show the cost-effectiveness of food as medicine when compared with rehabilitation. Mr. Greenwald emphasized that focusing first on the sickest patients shows immediate effects and attracts much attention.

Mr. Greenwald indicated that his organization is seeking recommendations from PACHA to the HHS secretary to (1) expand coverage of medically tailored meals for Medicare beneficiaries with chronic illnesses; (2) provide guidance to states on Medicaid coverage of medically tailored meals; and (3) allow funding for demonstrations to pay for community-based services such as meals. Ms. Downer added that the Food Is Medicine Coalition aims to create best practices and some standards for service providers to ensure quality.

Dr. Collins-Ogle noted that people in rural areas not only face food insecurity but also live in food deserts and lack access to dietitians and nutritionists. She sought broader recommendations that would provide options in places where there is no infrastructure on which to build. Ms. Bradley-Springer pointed out that the shortage of health care providers underscores the need for more interdisciplinary care. In Ryan White HIV/AIDS Program and Medicaid initiatives, experts in nutrition and social services should be available to relieve some burden from physicians. More programs need dietitians; even dietitians who are only available periodically could be useful to clients whose medical needs have been met but who require dietary information and education.

Dr. Sullivan pointed out that getting government to support FNS may require standard, reliable, ongoing indicators around food insecurity. Such indicators should be part of data collection and integrated into prospective studies to make the long-term case for food interventions.

Discussion turned to the nuances of what HRSA can pay for in various programs and whether those policies are guidelines that can be modified by HRSA or regulations determined by statute, which require congressional action to change.

Follow-Up Items

- The Center for Health Law and Policy Innovation will develop a fact sheet describing the kinds of food interventions currently covered by HRSA under the Ryan White HIV/AIDS Program and explaining how states can use existing policies to support FNS.
- The Center for Health Law and Policy Innovation will propose policy fixes that HRSA can enact to enhance support for FNS. Mr. Greenwald will work with PACHA's Access Subcommittee to bring recommendations to PACHA.

Numerous approaches were suggested for possible recommendations to the secretary:

- Implement a food insecurity screening protocol into regular provider visits (e.g., the two-question screen known as the Hunger Vital Sign).
- Explore the role of telehealth to provide access to dietitians and nutritionists.
- Allow long-term funding for food purchase in Part A and Part B of the Ryan White HIV/AIDS Program.
- Promote coordination among CMS, HRSA's HAB, and HRSA's Bureau of Primary Health Care and advocate for best practices across federally qualified health centers.
- Engage with the faith community and faith-based organizations, especially those already involved in food programs.

The Council agreed that all these issues could be explored further. In the meantime, it supported the recommendations proposed in the draft letter prepared by the Center for Health Law and Policy Innovation, with the addition of language asking for clarification of existing regulations about FNS coverage under the Ryan White HIV/AIDS Program and attention to the needs of rural or hard-to-reach communities that lack access to resources.

Recommendation

PACHA voted unanimously to recommend to the Honorable Sylvia Burwell, Secretary, HHS, that HHS expand coverage of medically tailored meals in Medicare, Medicaid, and demonstration projects with the following language added: "We urge HRSA to clarify the scope and context in which FNS can be provided by Ryan White Program providers in urban and rural or hard-to-reach communities (see Attachment A)."

Viral Hepatitis Action Plan Update

Richard Wolitski, Ph.D., Acting Director, Office of HIV/AIDS and Infectious Disease Policy, HHS

Dr. Wolitski explained that HHS is seeking input from PACHA on the update to the National Viral Hepatitis Action Plan for 2017–2020. About 20 to 25 percent of PLHIV have hepatitis B or C, and hepatitis C is a leading cause of death for PLHIV.

A federal interagency working group was chartered to update the National Viral Hepatitis Action Plan, which expires in 2016. It will convene listening sessions for stakeholder input. Dr. Wolitski indicated that the group hopes to complete the update by October 2016. Discussions are underway about restructuring the plan to better align with the NHAS goals.

Dr. Wolitski proposed three questions for discussion:

- What are the most important actions needed to reduce infections, improve access to care, improve outcomes, and improve surveillance?
- What should federal agencies start doing differently in response to hepatitis?
- How can federal stakeholders best be engaged in the effort?

Discussion

Dr. Collins-Ogle commented that insurers are denying coverage for hepatitis C treatment on the basis of irrelevant guidelines they have created. She expressed hope that CMS could convince insurers that treatment is cost-effective. Council members offered initial suggestions in response to Dr. Wolitski's questions:

- Engage federal stakeholders and explicitly identify what community advocates can do that federal stakeholders cannot by supporting a technical summit to review the action plan (similar to AIDS United's summit on the NHAS).
- Fund more research analyzing the cost-effectiveness of treatment.
- Advocate effective prevention techniques, such as syringe exchange programs and safe injection facilities.
- Promote and support testing. For example, cover hepatitis C testing in addition to HIV testing under the Ryan White HIV/AIDS Program's early intervention services.
- Conduct screening in correctional facilities.
- Address stigma.
- Provide more support for surveillance and data coordinators in state health departments.
- Set the tone for an ethical approach that allows access to curative treatment early rather than withholding treatment until the disease becomes severe.
- Expand screening recommendations to cover a broader population.
- Facilitate better coordination among states that receive federal funding for behavioral health services and incorporate into those services screening for HIV and hepatitis and better linkages to community harm reduction programs.
- Engage the IHS and ensure that the impact of hepatitis on Native Americans is meaningfully addressed.
- Support research on treatment for native and indigenous populations.

Mr. Cranston pointed out that there is a good public health infrastructure in place for PLHIV, and PACHA should consider how to minimize the inevitable reintroduction of HIV among IDUs. Recent increased attention to the opioid epidemic may spur changes in

the law that would allow for exploration of new models, such as safe injection facilities (currently in use in Canada).

Dr. Kates stated that hepatitis is on the agenda for the upcoming CHAC meeting; she will report back to PACHA about the discussion. She also suggested that PACHA include hepatitis among its recommendations for the next administration.

Letter to the Secretary on Restructuring the ATN

Dr. Collins-Ogle and Dr. Peralta briefed the new PACHA members on the concerns about the NIH's restructuring of the ATN. Mr. Schoettes explained that the letter presented to the Council yesterday was revised and takes into account the possibility that future grantees may include some of the experienced investigators from currently funded sites. The revised letter also uses the term "adolescents living with HIV" instead of "HIV-infected adolescents" to avoid stigmatization.

Dr. Collins-Ogle stated that the letter encourages transparency as the NIH establishes its external advisory group, recommends that the community and youth are represented on the advisory group, and seeks to ensure that the goals of the NHAS are addressed by the funded research.

Recommendation

PACHA voted unanimously (with one abstention) to recommend to Sec. Burwell that HHS review the NIH's restructuring of the ATN (see Attachment B).

Closing Remarks

Dr. Holtgrave recalled the momentous occasion of the 2010 release of the NHAS and how impressed he was with President Obama's heartfelt commitment to ending AIDS. At the time, President Obama indicated that achieving the goals of the NHAS would be a matter of political will. Dr. Holtgrave reminded the Council that if issues need to be addressed—such as high HIV drug prices, disparities in care, and resource gaps—it is important for PACHA to speak up. He added that it is up to others to determine how to address the problems. He concluded that it had been an honor to serve on the Council.

Adjournment

Ms. Mahon again thanked Dr. Holtgrave for his incredible service and welcomed the new PACHA members. She especially thanked PACHA staff, Ms. Hayes and Caroline Talev, for their hard work in support of the Council. Ms. Mahon adjourned the meeting at 11:58 a.m.

Attachment A



May 25, 2016

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

Dear Madame Secretary:

Thank you for your continued support and leadership in the fight against HIV. In this letter, the President's Advisory Council on HIV/AIDS (PACHA) advocates for adoption of policies that will help our country meet the goals of the National HIV/AIDS Strategy, including reducing HIV incidence and HIV-related health disparities, and increasing access to care and optimizing health outcomes.

Researchers, medical providers, policymakers, and advocates increasingly recognize the importance of social determinants of health (SDH) such as food security, housing status, education, and income, in determining health outcomes.¹ Recently, PACHA heard from experts in research, policy, and provision of services about the impact of food and nutrition services (FNS) on health outcomes and healthcare costs for people living with HIV. There is compelling evidence that provision of medically-tailored meals and food (that are designed by a registered dietitian to meet the health needs of an individual with HIV and other comorbidities) reduces the number and length of hospitalizations, increases the likelihood that someone can be discharged from the hospital to their home instead of to an acute care facility, and significantly reduces health care costs.² Effective use of FNS has been shown to improve retention in care, treatment adherence, and overall health outcomes.³ We urge the Department of Health & Human Services to take the following steps:

¹ *Social Determinants of Health: Healthy People 2020*, OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, available at <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> (last visited Jan. 22, 2016).

² Jill Gurvey et al. *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, 4 JOURNAL OF PRIMARY CARE & COMMUNITY HEALTH 311 (2013).

³ *Food and Nutrition Services, HIV Medical Care, and Health Outcomes*, C.H.A.I.N. (COMMUNITY HEALTH ADVISORY & INFORMATION NETWORK) FACT SHEET #3, available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/c_hain_factsheet3.pdf (last visited Jan. 22, 2016).

- (1) **Expand coverage of medically-tailored meals and food in Medicare for people with chronic illness.** The provision of medically-tailored meals or medically-tailored food has enormous potential to help improve health outcomes and reduce costs in an elderly population with chronic illness, including HIV/AIDS. We assert that such meals or food items should be a covered Medicare benefit upon diagnosis of a chronic illness such as HIV and prescription by a medical provider. While some Medicare programs currently cover meals, access to this benefit is extremely limited. In general, Medicare does not cover medically-tailored meals or food under Parts A and B. Under Part C (Medicare Advantage), plan carriers can choose to offer meals as a benefit to individuals for a short period of time under limited circumstances. Some Medicare Special Needs Plans (SNPs) cover meals, but these plans are not available in all areas to individuals who would meet the eligibility criteria. Action by CMS is necessary to expand these benefits so that all Medicare enrollees who meet the qualifying medical profile can receive them.
- (2) **Provide guidance to states on coverage of medically-tailored meals and medically-tailored food in Medicaid.** We urge the Secretary to direct the Centers for Medicare & Medicaid Services (CMS) to clarify that meals or food can be covered as part of a Home and Community Based Services (HCBS) and Section 1115 Waiver. The populations served by these waivers generally have high health needs and may have one or more chronic conditions. Inclusion of nutritional counseling along with meals and other food items as a covered benefit is both cost-saving and effective in improving outcomes for serious and chronic health conditions. It also addresses food security as a critical SDH in these groups.
- (3) **Urge all CMMI demonstration model funding to include FNS as a component of the model and allow funding to pay for community-based services such as medically-tailored meals and medically-tailored food.** We assert that future demonstration models should test the efficacy of food as medicine by allowing payment for services such as medically-tailored meals and food. While alternative healthcare delivery and funding models developed and administered by the Center for Medicare & Medicaid Innovation (CMMI) increasingly emphasize collaboration between healthcare providers and community-based services that address SDH, very few of these models allow funding to be used to pay for provision of the actual service. In practice, this means that although medical providers may attempt to establish referral relationships with community-based organizations (CBOs) that address SDH, such as food and nutrition service providers, CBOs are often not able to meet the increased demand for services from the provider's patients without a corresponding increase in support.
- (4) **Call on the Health Resources and Services Administration to carefully evaluate the current regulatory regime regarding FNS and to issue a Policy Clarification**

that supports the maximum utilization of Ryan White HIV/AIDS Program (RW) resources to support FNS, including nutritional counseling and the provision of medically-tailored meals and other food items for all RW recipients, including rural and urban hard-to-reach populations.

We sincerely appreciate your thoughtful consideration of these requests. We believe that addressing SDH and, in particular, access to nutritious and appropriate food, is critical to achieving the objectives of the National HIV/AIDS Strategy. Expanding coverage of FNS in public insurance is an important part of a responsible strategy for improving short- and long-term health outcomes for people living with HIV in the United States. PACHA stands ready to assist in ensuring that these requested changes are fully realized.

Best regards,

Nancy Mahon
Chair
PACHA

Enclosure

CC: Amy Lansky, PhD, MPH, Acting Director, Office of National AIDS Policy
Anne Reid, MPH, Counselor, Science and Public Health
Karen DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health

Attachment B



May 25, 2016

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

Dear Madame Secretary:

On behalf of the Presidential Advisory Council on HIV/AIDS (PACHA), we write to advise you of the Council's concerns regarding the National Institutes of Health (NIH) transition from the Adolescent Trials Network III (ATN III) to a network formed using the U19 mechanism. As you may know, the ATN III infrastructure has been dismantled, resulting in an abrupt interruption of clinical studies and potential research gaps. The U19 proposals were recently reviewed within the National Institute of Child Health and Human Development and the funding decisions will take place June 8th. We are concerned that the National Institutes of Health (NIH) will fund a much more limited network, one that lacks the capacity to address the individual and structural drivers of the epidemic among adolescents and young adults.

The primary mission of the ATN is to conduct research, both independently and in collaboration with existing research networks and individual investigators, in youth living with HIV and HIV-at-risk pre-adolescents, adolescents, and young adults up to 25 years of age. The ATN has extensive experience in recruiting and retaining understudied youth populations in the United States. Much of the research activity of the ATN has focused on collaboration with Clinical Trials Networks supported by other institutes of the NIH including but not limited to the Division of AIDS, National Institute of Allergy and Infectious Diseases (NIAID) and the National Cancer Institute (NCI) through research coordination. The ATN infrastructure consists of developmentally-appropriate adolescent clinical sites with expert clinicians who understand the intricacies of youth development, HIV care, prevention, and research.

We must stem the tide of HIV in our youth. Replacing established and effective research programs with a completely untested new research mechanism seems to us a high-risk strategy at this point in the epidemic. To mitigate this risk, we believe it is important to fund a significant number of adolescent research programs with established expertise in the stages of adolescent development as a prerequisite for a U19 success. PACHA has two specific recommendations to ensure continued and improved success of the U19:

1. Funding a clinical, community and research infrastructure capable of completing the ongoing and needed behavioral, community and biomedical trials. Examples include licensing trials for promising upcoming biomedical prevention interventions and research on adolescent substance abuse, mental health, stigma and other social determinants of health.
2. Establishing an independent and interdisciplinary external advisory group (EAG) with stakeholder representation to monitor and assess the U19 progress. It is imperative that the EAG will involve key community members with expertise in pediatric and adolescent research. Similarly, it is crucial to include youth as they are essential stakeholders and have the greatest increase in new cases of HIV for all age groups.

These recommendations derive from the National HIV/AIDS Strategy action item 1.A.s *which explicitly states that we include stakeholder expertise by inserting specific RFA language and review criteria related to the meaningful involvement of communities and clinical sites with expertise in adolescent development in order to avoid marginalization that may negatively impact the research agenda.*

We respectfully ask for the Administration's support to obtain a commitment from NIH for adequate infrastructure funding and independent monitoring of the new U19 mechanism to ensure results from these important research efforts are maximized.

Best regards,

Nancy Mahon, JD
Chair
PACHA

Enclosure

CC: Robert W. Eisinger, PhD, NIH Acting Associate Director for AIDS Research and Acting Director
for the Office of AIDS Research
Anne Reid, MPH, Counselor, Science and Public Health
Karen DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health