

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
HEALTH RESOURCES AND SERVICES ADMINISTRATION**



**Virtual Meeting of the  
CDC/HRSA Advisory Committee on  
HIV, Viral Hepatitis and STD Prevention and Treatment  
November 13-14, 2013**

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**Record of the Proceedings**

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HEALTH RESOURCES AND SERVICES ADMINISTRATION**

**CDC/HRSA ADVISORY COMMITTEE ON HIV,  
VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT  
November 13-14, 2013  
Rockville, Maryland**

**Minutes of the Virtual Meeting**

The U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened the first virtual meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC). The virtual meeting was held on November 13-14, 2013.

CHAC is chartered to advise the Secretary of HHS, Director of CDC, and Administrator of HRSA on objectives, strategies, policies and priorities for HIV, viral hepatitis and STD prevention and treatment efforts for the nation.

**Opening Session: November 13, 2013**

**Laura Cheever, MD, ScM**

Associate Administrator and Chief Medical Officer, HIV/AIDS Bureau  
Health Resources and Services Administration  
CHAC Designated Federal Official, HRSA

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were attending the virtual meeting. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record.

Dr. Cheever informed the CHAC voting members of their individual responsibility to identify real or perceived conflicts of interest and recuse themselves from voting or participating in these

matters. She asked the CHAC voting members to publicly disclose their individual and/or institutional conflicts of interest for the record.

- Virginia Caine, MD: Recipient of federal funding from CDC (Gonorrhea Network Surveillance System) and HRSA (Ryan White)
- Guillermo Chacon: Recipient of federal funding from CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Angelique Croasdale, MA: Recipient of federal funding from CDC and HRSA
- Carlos del Rio, MD: Recipient of federal funding from CDC for gonorrhea laboratory research; care provider in a HRSA-funded Ryan White clinic
- Dawn Fukuda, ScM: Recipient of federal funding from CDC and HRSA (Ryan White Part B and Special Projects of National Significance (SPNS))
- Steven Johnson, MD: Recipient of federal funding from the National Institutes of Health (NIH) and HRSA (Ryan White); consultant to Gilead and Viva Pharmaceutical
- Kali Lindsey: Recipient of federal funding from a CDC Capacity Building Cooperative Agreement (CoAg)

Dr. Cheever announced that the voting members and *ex-officio* members constituted a quorum for CHAC to conduct its business on November 13, 2013. She called the proceedings to order at 10:06 a.m. and welcomed the participants to day 1 of the first virtual CHAC meeting.

The participants joined Dr. Cheever in congratulating Dr. Jonathan Mermin on his new appointment as the NCHHSTP Director and in his new role as the CHAC Designated Federal Official (DFO) for CDC. The participants also welcomed Dr. Elinore McCance-Katz in her role as the new *ex-officio* member for SAMHSA.

**Antigone Dempsey MEd, CHAC co-Chair**

Deputy Director, Knowledge, Transfer and Technical Assistance  
HIV/AIDS Lead, Altarum Institute

**Jeanne Marrazzo, MD, MPH, CHAC co-Chair**

Professor of Medicine, Harborview Medical Center  
University of Washington

Ms. Dempsey and Dr. Marrazzo also welcomed the participants to the first virtual CHAC meeting. They hoped that the availability of 300 open lines would increase public access and participation in CHAC meetings. They emphasized that the CHAC co-Chairs and DFOs would rigorously evaluate the virtual meetings on an ongoing basis to make technical improvements and streamline the overall process. They asked the CHAC members to submit feedback on the first virtual meeting to guide the evaluation.

Ms. Dempsey concluded the opening session by reviewing the agenda for the November 13-14, 2013 CHAC meeting. She pointed out that instructions would be given for the public to make comments to CHAC during the public comment session.

## CDC/NCHHSTP Director's Report

### **Jonathan Mermin, MD, MPH**

Director, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention  
Centers for Disease Control and Prevention  
CHAC Designated Federal Official, CDC

Dr. Mermin covered the following topics in his Director's report to CHAC. At the agency level, the budget is uncertain because CDC is operating under a continuing resolution. In FY2013, CDC operated under a sequester of funds with cuts of 5% to 6% across all NCHHSTP program areas. CDC currently is operating at level funding from FY2013 sequester amounts. An additional sequester is possible in FY2014.

CDC released the *Antibiotic Resistance Threats in the United States-2013 Report* in October 2013. The report noted that >2 million persons in the United States are infected each year with an antibiotic-resistant infection and 23,000 persons die from these infections. The report classified drug-resistant gonorrhea as an "urgent" threat and drug-resistant tuberculosis (TB) as a "serious" threat.

Key findings in the report are highlighted as follows. The reported TB incidence in 2012 of ~3.2 persons/100,000 population was the lowest in U.S. recorded history. Trends in HIV/TB co-infected persons have decreased to 7.5%. CDC recently issued guidelines in two *Morbidity and Mortality Weekly Report* articles: (1) the use of bedaquiline for the treatment of multidrug-resistant TB and (2) the availability of a new nucleic acid assay that can detect rifampin resistance and *Mycobacterium tuberculosis* without the need for culture. The report is available on the CDC.gov website.

The CDC Office of Health Equity celebrated its 10<sup>th</sup> anniversary on November 7, 2013. The keynote presentation, "From Theory to Action: Applying Social Determinants of Health to Public Health Practice," was extremely well received across all parts of CDC. The presentation emphasized the importance of taking actions to increase health equity for all diseases. CDC will release a new *Vitalsigns* Report and other publications in conjunction with World AIDS Day and also will conduct numerous activities in collaboration with its federal and non-governmental partners.

At the National Center level, Dr. Mermin's appointment as the new NCHHSTP Director created a vacancy in the position of the Director of the Division of HIV/AIDS Prevention. Searches are underway to fill this position as well as the Director of the Division of Adolescent and School Health. NCHHSTP leadership is serving as Acting Directors in these positions until the permanent appointments are made.

NCHHSTP released its expanded "Atlas" with local, county-level epidemiological data for HIV and STDs to enhance capacity to identify areas of the United States with the greatest or least disease burden. NCHHSTP published a supplement to *Public Health Reports* on "Applying Social Determinants of Health to Public Health Practice."

At the division level, the Division of HIV/AIDS Prevention (DHAP) released results of a study in July 2013 showing that pre-exposure prophylaxis (PrEP) prevents HIV among injection drug users. DHAP conducted the study in partnership with the Thailand Ministry of Public Health and Bangkok Metropolitan Administration. The study reported that a daily dose of PrEP reduced the risk of HIV acquisition by 49%. DHAP issued interim guidance on the use of PrEP for IDUs, but the official PrEP guidelines are currently undergoing the HHS clearance process.

DHAP released its first Rapid Feedback Report (RFR) for grantees of the "Young Men Who Have Sex with Men (MSM) and Transgender Persons of Color" Funding Opportunity Announcement (FOA). The purpose of the RFR is to compile 6<sup>th</sup> month and annual data from grantees, highlight major indicators, and provide grantees with a report of their progress compared to the FOA goals and the performance of other grantees. The RFR also reduces the overall burden and frequency of data reporting by 25%-30%. The RFR has an added benefit of allowing grantees with less progress to obtain advice, guidance and support from high performing grantees.

DHAP issued a new five-year FOA for capacity building assistance (CBA) for high impact prevention. The funds will support a national CBA Provider Network to serve health departments, community-based organizations (CBOs) and healthcare organizations. The application deadline was October 2, 2013 and awards will be made in the spring of 2014. DHAP launched "Reasons/Razones" as the first national bilingual campaign to encourage HIV testing among Latino gay/bisexual men.

The Division of Viral Hepatitis (DVH) led CDC's investigation that identified the source of a multi-state outbreak of hepatitis A virus (HAV). The U.S. Food and Drug Administration and multiple state health departments collaborated with CDC on the investigation. Pomegranate seeds from Turkey were identified as the source of the outbreak. Of 162 persons who were confirmed with HAV after eating frozen foods containing Turkish pomegranate seeds, 71 were hospitalized. The affected food companies recalled their products and no new infections have been documented since that time.

DVH launched the “Know More Hepatitis B” Campaign in June 2013. The national multimedia campaign is targeted to Asians/Pacific Islanders and was released in English, Chinese, Vietnamese and Korean. DVH partnered with Hep B United in this initiative. The reach of the campaign included total television airplay of 1,590 spots with the public service announcement and >26 million digital impressions. DVH released the “2011 Viral Hepatitis Surveillance Report” on the CDC.gov website.

DVH will host a TwitterChat with Hep B United, the Hepatitis B Foundation, and the Association of Asian Pacific Community Health Organizations on November 19, 2013 at 3:00 p.m. to discuss the “Know Hepatitis B” Campaign.

The Division of STD Prevention (DSTDP) completed a clinical trial with support from NIH to identify new treatment options in the face of growing antibiotic resistance. The clinical trial found that two new antibiotic regimens successfully treated gonorrhea infections: injectable gemtamicin in combination with oral azithromycin and oral gemifloxacin with oral azithromycin. DSTDP will host the 2014 STD Prevention Conference in June 2014 in Atlanta. The deadline for submitting abstracts for the conference is November 15, 2013.

DSTDP published a study in June 2013 that reported a 56% decrease in vaccine-type human papillomavirus (HPV) among female teens 14-19 years of age since the introduction of HPV vaccine in 2006. DSTDP and its partners released an application for the new STD Treatment Guidelines that will be issued in the near future. The application provides clinicians and other healthcare providers with a quick reference on the identification and treatment of STDs. The application is available for Apple and Android electronic devices at no charge and can be downloaded from iTunes, Google Play or at <http://apps.usa.gov/std-treatment-guide.shtml>.

The Division of Adolescent and School Health (DASH) awarded funds for a new five-year school health FOA, “Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.” Funds were awarded to states with the highest HIV burden and also to local school districts based on their HIV/STD burden, poverty level and number of students. The FOA also includes prevention funds for young MSM. School districts were encouraged to provide a safe and supportive environment for lesbian/gay/bisexual/transgender (LGBT) youth.

DASH released the updated “Health Education Curriculum Analysis Tool” to help school districts and schools analyze and ensure that their health education curricula follow federal guidelines. DASH released results of the “2012 School Health Policies and Practices Study.” The national survey assesses school health policies and practices. Key results of the study are highlighted below:

- A decrease in the percentage of school districts that require elementary schools to teach HIV prevention (from 59% in 2000 to 40% in 2012)

- A decrease in the percentage of school districts that require elementary schools to teach STD prevention (from 39% in 2000 to 29% in 2012)
- An increase in the percentage of school districts with policies that allow parents to exclude children from high school HIV or STD prevention education (from 62% in 2000 to 78% in 2012)

DASH will host a TwitterChat with its education and public health partners on November 21, 2013 at 2:00 p.m. The TwitterChat will focus on strengthening HIV/STD prevention strategies for youth.

## HRSA/HAB Associate Administrator's Report

### **Laura Cheever, MD, ScM**

Associate Administrator and Chief Medical Officer, HIV/AIDS Bureau  
Health Resources and Services Administration  
CHAC Designated Federal Official, HRSA

Dr. Cheever covered the following topics in her Associate Administrator's report to CHAC. HRSA is pleased that the Obama Administration strongly supports the Ryan White HIV/AIDS Program (RWHAP) and continuation of its services. Even with full implementation of the Affordable Care Act (ACA), the Administration has stated that RWHAP will continue to play a critical role in improving health outcomes along the continuum of care (*i.e.*, the "Treatment Cascade").

HAB created a visual framework to illustrate RWHAP's multiple functions. In addition to its core function of service delivery, RWHAP also plays an important role in four other components of the health sector: policy, assessment, capacity development and quality. HAB provides strict oversight to assure that all five of the RWHAP functions support the National HIV/AIDS Strategy (NHAS) goal of "0 new infections."

For service delivery, HAB provides a seamless system of care for persons living with HIV (PLWH) due to the statutory role of RWHAP as the payer of last resort. HAB funds essential health services and treatment in order for PLWH to remain in care and achieve viral suppression. HAB takes a public health approach to provide a comprehensive system of care for low-income PLWH based on four key objectives: reduce new infections, improve health outcomes, increase the quality of life of PLWH, and decrease health-related disparities.

HAB ensures that RWHAP's basic and important principles are met, particularly the inclusion and engagement of PLWH in the planning of services and the responsibility of providers to ensure that patients are retained in care. HAB awards funding for its grantees and stakeholders

to implement public health interventions that prevent and reduce transmission of HIV and achieve positive health outcomes.

For policy, HAB plays an integral role by providing guidance to other HRSA bureaus on federal, state and local policy initiatives that impact PLWH. HAB funds RWHAP positions in state and local governments to ensure that important input is provided on HIV at state and local levels. HAB engages federal, state, local and community stakeholders to assist in achieving the NHAS goal of 0 new infections. HAB establishes federal HIV care and treatment policy guidelines that are effective for PLWH and are relevant for the national goal of achieving an AIDS-free generation.

For assessment, HAB ensures that its grantees adhere to the Congressionally-mandated statute to identify and fill gaps in RWHAP. HAB collaborates with its state and local partners to examine models of care and service delivery to ensure that RWHAP is maintained as a high-quality and cost-effective program.

HAB collaborates with health professionals to determine the capacity and training needs of an interdisciplinary healthcare workforce and also to provide a comprehensive system of care for PLWH. Most notably, HAB-funded AIDS Education and Training Centers (AETCs), states and cities specifically identify service gaps in their individual regions, states and local jurisdictions. HAB analyzes and monitors the public health impact of the HIV healthcare system that is supported by RWHAP funds.

For capacity development, HAB ensures that HIV care and treatment services funded by RWHAP are aligned with and follow the epidemic. Over the past few years, for example, HAB has targeted more RWHAP resources to build capacity in the South and specific cities because the HIV epidemic has increased in these areas.

HAB's technical assistance (TA) and support have allowed RWHAP service providers to create evidence-based models of care, develop interdisciplinary workforce teams and build patient-centered medical homes (PCMHs). HAB-funded SPNS Initiatives help to integrate health information systems to track health outcomes, monitor investments, and identify gaps in the continuum of care at the jurisdictional level.

For quality, HAB ensures that RWHAP grantees adhere to the Congressionally-mandated statute related to quality management. HAB empowers stakeholders to deliver high-quality HIV care and treatment. HAB played a critical role in establishing and monitoring HIV performance measures and assuring consistency and coordination of these indicators across the federal government. HAB has collected, analyzed and utilized data in various methods to achieve this goal.

In addition to overseeing RWHAP's five primary functions, HAB is continuing to monitor the RWHAP client population in preparation for full implementation of ACA. Based on the 2011 client-level data system, RWHAP served 553,999 clients in 2011. Of general RWHAP clients who received services outside of the AIDS Drug Assistance Program (ADAP), 28% (or ~128,000) were uninsured. The 2012 ADAP data are incomplete and only include 29 states at this time, but preliminary data indicate that 65% of RWHAP clients are uninsured in ADAP.

Based on client-level data for non-ADAP clients, ~69% are at a Federal Poverty Level (FPL) of <100% and 21% are at an FPL of 101%-200%. Preliminary data show that most RWHAP clients who receive non-ADAP services currently have a form of insurance coverage through Medicaid or other sources. HAB is making strong efforts to fill gaps in coverage for the remaining RWHAP clients to ensure continuity and retention in care and adherence to medications. However, most uninsured RWHAP clients will qualify for Medicaid in states that will expand Medicaid coverage under ACA.

States conducted analyses that showed as of October 22, 2013, 25 states elected not to expand Medicaid coverage. The 25 non-Medicaid expansion states were found to serve ~58% of all uninsured RWHAP clients who do not receive ADAP services. In these 25 states, 70.4% of uninsured RWHAP clients had incomes at or below 100% of the FPL. Because many of these clients most likely will remain uninsured under ACA, RWHAP funds might be used for premium assistance and cost sharing for these clients to enroll in Health Insurance Marketplaces as long as coverage is cost-effective and adheres to RWHAP policy. HAB distributed a policy clarification notice to provide states with detailed information in this area.

The state analyses estimated that ~7.5% of RWHAP clients in the 25 non-Medicaid expansion states have incomes between 100%-133% of the FPL. These clients will be eligible to purchase insurance coverage through Health Insurance Marketplaces and also might be eligible for premium tax credits and cost-sharing reductions. Of RWHAP clients who did not receive ADAP services prior to ACA, 27% had Medicaid, 9% had Medicare, 28% were uninsured, and 13% had insurance from other sources.

Healthcare coverage options for RWHAP clients will vary after ACA is fully implemented, including Medicaid/Medicare, other public insurance, expanded Medicaid coverage in some states, and newly opened Health Insurance Marketplaces. However, both insured and uninsured clients will continue to need other RWHAP services that will not be covered by Medicaid/Medicare or Health Insurance Marketplaces.

The RWHAP statute does not allow funds to be used for any item or service to the extent that payment has been made or reasonably could expect to be made by another payment source. The RWHAP statute requires grantees and contractors to vigorously pursue enrollment of their clients in other relevant funding sources or forms of insurance. RWHAP grantees and contractors also are required to make every reasonable effort to ensure that individuals who are

not eligible for public programs and are not exempt from ACA requirements to enroll in health coverage are assessed for eligibility in private Health Insurance Marketplaces. RWHAP will continue to pay for items and services for individuals who remain uninsured or underinsured.

Over the past year, HAB has conducted numerous activities in four major domains (e.g., communication, policy development, training and TA) to assist RWHAP grantees in preparing for ACA implementation. HAB provided grantees with administrative flexibility and guidance to ensure that RWHAP clients make a seamless transition to ACA-funded programs.

HAB funded a new FOA in FY2013 to JSI Research and Training Institute to focus on ACA outreach and enrollment of minorities living with HIV/AIDS. The objectives of this funding is three-fold: (1) provide RWHAP grantees with TA tools to build capacity in ACA outreach and enrollment; (2) collaborate with CDC, SAMHSA, the Centers for Medicare and Medicaid Services (CMS) and other HHS agencies to review best practices in ACA outreach and enrollment across the federal government; and (3) collaborate with other federal partners to develop ACA outreach and enrollment strategies, tools and training for grantees.

HAB has prioritized several new and ongoing initiatives in FY2014. HAB will closely collaborate with CMS to track outcomes and provide grantees with TA related to the RWHAP-ACA Integration Initiative. HAB will conduct several activities to improve health outcomes along the HIV continuum of care, such as launching new SPNS Initiatives and awarding one-time funding to RWHAP Parts C and D grantees. The continuum of care activities will be aligned with the NHAS goals and a new White House Executive Order.

HAB will strengthen both internal and external customer service to staff, grantees and federal partners. HAB will improve grantee oversight through its monthly monitoring calls. HAB will enhance the use of RWHAP data to ensure that data are more efficiently and effectively processed, more usable information is disseminated to grantees, and data are maximized to improve programmatic outcomes.

HAB will continue to fund a special study to better understand and more clearly delineate services that are not covered by primary insurers, but are available to insured clients who present to Ryan White clinics (e.g., case management, medical care and transportation). HAB will revise and update its HIV performance measures portfolio to more strongly emphasize health outcomes, ensure that these indicators are aligned with those of other federal partners, and shift to a smaller set of measures.

HAB's transition to a more efficient and streamlined portfolio is consistent with the National Quality Strategy. Low-priority measures will be deleted and replaced with nationally endorsed measures. Several categories will be combined to develop unified measures. The 42 performance measures include core measures and clinical measures for all age groups, including adults and adolescents. Although some performance measures related to case

management, ADAP, oral health and systems will be archived in the streamlined portfolio, all 7 measures endorsed by the HHS Secretary will be included. HAB and CMS currently are coordinating efforts to include four nationally endorsed measures into CMS Meaningful Use Stage 3 criteria.

Several changes have occurred in HAB's leadership since the June 2013 CHAC meeting. Dr. Cheever was appointed as the Associate Administrator of HAB. Dr. Sylvia Trent-Adams was appointed as the Acting Deputy Associate Administrator of HAB. Dr. Cheever displayed the HAB organizational chart and asked the participants to join her in welcoming the newly appointed Branch Chiefs.

At the agency level, HRSA is continuing to closely collaborate with CDC, other federal partners and key stakeholders. However, efforts are underway to increase coordination and improve relationships across other federal programs. These partnerships will play an important role in HRSA's new activities in FY2014 to reduce the reporting burden on grantees that receive funding from multiple federal agencies. HRSA is collaborating with federal partners to advance evidence-based interventions to improve health outcomes along the continuum of care. HRSA is sharing resources and expertise with federal partners to build capacity at the grantee level.

CHAC discussed the following topics in the question/answer session with Drs. Mermin and Cheever on the CDC/NCHHSTP and HRSA/HAB updates.

- Potential reasons or major drivers for the disappointing decreases in the percentage of school districts that require elementary schools to teach HIV and STD prevention.
- The possibility of CDC conducting a state-by-state study to identify essential public health services related to HIV, viral hepatitis and STD prevention that would not be covered under ACA.
- The possibility of an unintended consequence of ACA in which more RWHAP funds would be awarded to non-Medicaid expansion states and Medicaid expansion states would be "penalized" with less RWHAP funds.
- CDC's plans to link its upcoming Prevention with Positives (PwP) Guidelines to performance measures in order to expand prevention activities for PLWH and support HRSA's HIV care and treatment efforts.
- Feedback, acceptability and implementation in the field of CDC's new algorithm for diagnostic laboratory testing of HIV infection.

The discussion resulted in CHAC advising CDC to collaborate with HRSA and SAMHSA to create a SmartPhone application for the PwP Guidelines that would be similar to the new application for the STD Treatment Guidelines. Ideally, the application should be designed to calculate alcohol risk scores and depression scores in order for clinicians to emphasize prevention in a holistic and comprehensive manner.

For example, SAMHSA could replicate its existing SmartPhone applications with quick screens for clinicians to address mental disorders, anxiety, depression, alcohol use, and prescription/ illicit drug abuse of their HIV patients and make referrals to treatment. Clinicians also should be able to use the new application in conjunction with electronic health records (EHRs).

### Update by the Presidential Advisory Council on HIV/AIDS (PACHA)

#### **Douglas Brooks, MSW**

Senior Vice President for Health Services  
Justice Resource Institute  
CHAC Liaison Representative, PACHA

Mr. Brooks covered the following topics in his update to CHAC on PACHA's recent activities. PACHA structured its September 2013 meeting as an open forum with two expert panels. Panel 1 was charged with exploring the relationship between ACA and RWHAP. The panel highlighted the major ACA provisions that will benefit PLWH, particularly access to insurance regardless of preexisting conditions. In non-Medicaid expansion states, some PLWH with incomes above the FPL will be eligible for subsidies to purchase insurance. However, other PLWH will continue to rely on RWHAP for coverage.

The panel described multiple services RWHAP provides to PLWH that will not be covered under ACA (e.g., medical and nutrition counseling, home meal delivery, home-based care, visual/dental care and housing support). The panel agreed that coverage completion is the hallmark of RWHAP and demonstrably improves health outcomes along the continuum of care for PLWH.

The panel noted that although many Southern states have elected not to expand Medicaid coverage, access to HIV care is particularly problematic in these jurisdictions. Low-income PLWH in these states who would not be eligible for subsidies as well as undocumented immigrants who would not be eligible for ACA coverage will be the most severely impacted populations. ACA will offer tremendous opportunities to reduce the number of uninsured persons in the United States, but existing challenges for PLWH still need to be addressed.

The panel discussed the successful Massachusetts model in which 95% of the population has health insurance coverage, while RWHAP funds are used to ensure coverage completion and offset some costs of purchasing insurance. The panel highlighted the most impressive outcomes of the Massachusetts model: a 45% decrease in new HIV/AIDS diagnoses, a 20% reduction in AIDS-related deaths, and improved health outcomes across diverse populations. Most notably, two studies reported that >70% of PLWH in Massachusetts have achieved viral suppression higher than the national goal.

The panel hoped that the seven-year timeline for Massachusetts to expand the sole RWHAP system of care to a broader system of universal access to care would be shorter for other states. However, the panel was aware of the specific amount of time that would be required for certain states and local jurisdictions to modify their existing infrastructures to meaningfully serve PLWH in a responsive manner. The panel described changes that would need to be made in several areas to achieve this goal: engagement and retention in care, medical services, laboratory treatment, and public health interventions.

Panel 2 was charged with considering the implications if RWHAP is not reauthorized in the future; proposing strategies to reach PLWH in localities with limited services; exploring approaches to manage co-morbidities; and making recommendations to successfully reach the prevention and treatment goals. The panel was pleased that the Obama Administration recognized the need to continue RWHAP in order to improve health outcomes for PLWH and proposed a \$20 million increase with discretionary dollars in the FY2014 President's budget.

The panel pointed out that 70% of RWHAP beneficiaries currently have a form of insurance coverage, but some clients will still need RWHAP services after ACA is fully implemented. The panel emphasized the need to efficiently use resources to better meet the needs of marginalized populations and maximize workforce capacity to improve care for PLWH. However, the panel raised questions regarding specific legislation to enact or existing policies to modify to effectively and equitably allocate resources.

The panel extensively discussed RWHAP's statutory role as the payer of last resort. Even after full ACA implementation, RWHAP will still be needed to engage and retain insured PLWH in care, reach and meet the needs of uninsured PLWH, and provide crucial non-medical services (e.g., intensive case management and housing assistance).

The panel described several of HRSA's actions that are particularly relevant for ACA. HRSA issues waivers to some grantees regarding their requirement to allocate RWHAP funds for core services. HRSA has encouraged grantees to align their screening and eligibility determinations with Health Insurance Marketplaces in order to take advantage of the open enrollment period. HRSA has informed grantees of their responsibility to ensure that RWHAP funds for services are more cost effective than private insurance.

The panel characterized RWHAP as a hallmark of a public/private partnership and was in favor of using the delay in RWHAP reauthorization as an opportunity to consider the future needs and structure of the program. Most notably, specific components of the current healthcare system and barriers to PLWH fully utilizing these services should be better understood as more persons will be encouraged to seek care under ACA.

The panel agreed on the importance of reframing HIV as a chronic disease and a public health imperative to reduce stigma and prevent the spread of disease, but individual panelists were

divided on the structure of RWHAP in the future. Some panelists noted that RWHAP serves as a “life line” to PLWH and should not be disrupted until a better replacement has been identified. Some panelists believed that RWHAP, in its current structure, should not be perpetuated or reauthorized. Some panelists were in favor of expanding RWHAP to a broader “Coverage Completion Program” for persons with a range of chronic diseases.

The panel was aware that some providers currently are delaying the treatment of HIV/hepatitis co-infection because a new regimen is anticipated. HRSA will develop a specific treatment protocol after the new regimen is more widely available. The panel also noted that despite a growing body of evidence, many hepatologists still view RWHAP beneficiaries as poor candidates for hepatitis treatment. The panel agreed that any program with a separate “HIV silo” would not be effective for providers or patients because multiple chronic conditions and other needs related to increased age would be overlooked.

The panel discussed the limited success of RWHAP grantees and Community Health Centers (CHCs) collaborating to develop a multidisciplinary medical home model for patients. The panel raised the possibility of CHAC placing this topic on a future agenda to propose strategies in this area.

The panel discussed the potential for flexibility in HRSA’s HIV Continuum of Care Initiative to address the NHAS goals and improve health outcomes along the continuum of care even if RWHAP reauthorization continues to be delayed. The initiative is designed to provide guidance on applying the best evidence-based interventions and using data to inform local community efforts. HRSA has encouraged grantees to implement continuum of care interventions with a demonstrated track record of success in the field and collect additional data on health impacts. These data should be widely disseminated to assist Planning Councils, CBOs and providers in improving care.

PACHA engaged the panels in extensive discussions on several topics. HRSA described its focus on integrating routine HIV testing and linkage to care in CHCs that currently provide care to PLWH, but are not recipients of RWHAP funding. HRSA informed PACHA of supplemental funding that is available for areas of severe need to address disparities, but only a small portion of these resources could be targeted to localities with the greatest need.

CHAC proposed several areas of collaboration with PACHA for the two advisory committees to provide additional expertise and guidance to HRSA and HHS on the future of RWHAP.

- CHAC and PACHA should frame effective messaging to educate Congressional staffers on RWHAP’s critical role in advancing public health and improving the individual health of PLWH over time. Congressional staffers should be informed that with the evolution of RWHAP under ACA, legislative decisions will need to be made on prioritizing specific interventions, ensuring the efficient use of resources, strengthening efforts to meet the

needs of marginalized populations, and maximizing workforce capacity to care for PLWH. RWHAP's tremendous infrastructure of a highly skilled workforce of HIV providers should be widely publicized.

- CHAC and PACHA should compile lessons learned and experiences from the Massachusetts model to provide federal agencies with clear guidance on implementing universal access to care at the national level. For example, Massachusetts successfully achieved the goal of universal health care across the state, but minimal attention has been given to paying for these services under ACA.
- CHAC and PACHA should explore strategies to resolve problems with the panel's recommendation to expand RWHAP to a broader Coverage Completion Program. The "coverage completion" concept greatly underestimates the extent to which medical care is provided to patients during their normal visits to Ryan White clinics. Outside of ACA, patients typically receive care in three areas during their routine clinic visits: (1) primary care to address personal health issues; (2) specialty care to assist in managing antiretroviral (ARV) therapy and other HIV complications; and (3) public health care to promote prevention and ensure treatment adherence to reduce the spread of HIV and other risks. Clinicians will need clear guidance to continue to comply with RWHAP's statutory role as the payer of last resort, while still providing all three types of care without increasing the burden on patients with additional clinic visits. Messaging also should be formulated to highlight RWHAP as an excellent program even with full ACA implementation.
- CHAC and PACHA should issue a position statement to emphasize the link between care provided by RWHAP and the persistent incidence of >50,000 new HIV infections per year. To shift from crisis management and make further progress on achieving the goal of an AIDS-free generation, RWHAP must be structured as a PwP framework, a health disparities framework and a comprehensive system of care for PLWH.

### **Panel Presentation: Federal Updates on Affordable Care Act Implementation**

A panel of federal agency representatives presented a series of updates describing the ongoing activities of their respective agencies to prepare for implementation of ACA. The updates are summarized below.

#### **Rebecca Slifkin, PhD**

Director, Office of Planning, Analysis and Evaluation  
Health Resources and Services Administration

Dr. Slifkin presented an update on HRSA's ongoing ACA implementation activities. HRSA is continuing to gather ACA outreach and enrollment data from grantees in the field and distribute this information to appropriate HHS entities. HRSA maintains a robust feedback loop with

various HHS entities that are responsible for specific components of ACA implementation. HRSA is making strong efforts to address and resolve as many issues in real time as possible.

HRSA prioritizes each ACA issue during biweekly calls with CMS. The most common ACA questions grantees have raised include designation as a Certified Application Counselor Organization (CACO), training for individuals, Medicaid issues, and state barriers to consumer assistance and enrollment in ACA.

Several websites and e-mail addresses have been created for grantees to pose questions and receive timely information on ACA. Organizations can submit questions on CACO designation to [cacquestions@cms.hhs.gov](mailto:cacquestions@cms.hhs.gov). Experiences and success stories related to CACO designation can be shared at [getcovered@hrsa.gov](mailto:getcovered@hrsa.gov).

The “In the Loop” online learning community is open to any organization or individual to share experiences and lessons learned related to ACA enrollment ([www.enrollmentloop.org](http://www.enrollmentloop.org)). The website includes a mechanism that forwards feedback and questions to the White House and HHS agencies. This mechanism is used to generate reports that broadly address general issues and problems, but recommendations also are formulated for HHS to address specific concerns.

**Kristen Mangold**

Policy Development Branch Chief, HIV/AIDS Bureau  
Health Resources and Services Administration

Ms. Mangold presented an update on HAB’s ongoing ACA implementation activities in the context of RWHAP. HAB is continuing to strengthen communications with RWHAP grantees on ACA through policy development, training and TA tools. In terms of communication, HAB created a new electronic mailbox for grantees to submit their ACA-related questions; launched an ACA-specific webpage that is regularly updated with guidance documents, policy documents and other useful tools; and routinely addresses ACA-related issues during its quarterly meetings with national partners. Aggregated responses to ACA-related questions are available to all grantees on the webpage, while individual questions are addressed by the grantee’s Project Officer.

In terms of policy development, HAB partnered with CMS to issue an ACA outreach and enrollment letter to grantees and a notice of ACA’s key provisions to providers. The primary purpose of these notices was to explain various policy components that will provide grantees with as much flexibility as possible while continuing to adhere to RWHAP’s statutory role as the payer of last resort. The policy clarification notices have played an integral role in aligning RWHAP and ACA requirements and ensuring that grantees understand the available coverage options for PLWH.

In terms of training, HAB is continuing to provide training and education to staff and grantees. Most notably, HAB and CMS jointly hosted webcasts in conjunction with the release of each policy notification. The webcasts have been well attended with 300-600 participants on average. The next webcast will focus on RWHAP and modified adjusted gross incomes. Grantees can access HAB's ACA-specific webpage to view and download each archived webcast, specific updates and frequently asked questions.

In terms of TA tools, HAB serves on the HRSA-wide ACA Outreach and Education Workgroup. HAB has posted answers to ACA frequently asked questions on its website. HRSA-funded Technical Assistance Resource Centers also are helping HAB grantees with ACA outreach and enrollment activities. HAB is aware that grantees in some states have been challenged in locating information on specific ACA-related issues (e.g., formularies and the overlap between RWHAP core medical services and potential health benefits). HAB is making strong efforts to address these complex questions.

**Stuart Berman, MD, ScM**

Senior Advisor, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention  
Centers for Disease Control and Prevention

Dr. Berman presented an update on CDC's ongoing ACA implementation activities. ACA outlines additional requirements for charitable hospitals to maintain their tax-exempt status. At this time, 3,000 U.S. hospitals account for ~\$13 billion in tax exemptions. Hospitals previously were granted tax exemptions for conducting charitable community activities only, but the new ACA mandate will require hospitals to also conduct Community Health Needs Assessments (CHNAs) and adopt an implementation strategy to meet community health needs identified by CHNAs.

Hospitals will be required to obtain input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health, and make the CHNA findings widely available to the public. CDC advised the Internal Revenue Service (IRS) on specific requirements for hospitals to collaborate with health departments in order to comply with the ACA mandate.

In response to CDC's guidance, the IRS issued a Notice of Proposed Rulemaking on April 5, 2013. The language states that a hospital must take into account input from at least one state, local, tribal or regional governmental public health department (or an equivalent department or agency) with knowledge, information or expertise relevant to the health needs of the community.

CDC partnered with external stakeholders to develop CHNA web resources and training for health departments and also supported the development of "Principles to Consider for the Implementation of a Community Health Needs Assessment Process." The key CHNA principles are highlighted below.

- Maximum transparency to improve community engagement
- Multi-sector collaboration that supports shared ownership of the approach
- Proactive, broad and diverse community engagement
- A broad definition of “community” that also addresses disparities
- Use of high-quality data compiled from diverse sources
- Use of evidence-based interventions and innovative practices

CDC reviewed various models and tools that have been applied to conduct a CHNA. HIV/AIDS, STDs and TB were among the most frequently recommended health outcome metrics to improve population health in terms of morbidity. In 2014, CDC’s “Community Health Status Indicators” website is expected to have county-level data available for the most commonly cited indicators.

The Center for Medicare and Medicaid Innovation (CMMI) announced round 2 of its Health Care Innovation Awards in May 2013. The \$1 billion initiative will fund testing of new payment and service delivery models. CMMI will award funding to ~100 projects, but proposals were specifically solicited for four major activities: (1) rapidly reduce Medicare, Medicaid and/or Children’s Health Insurance Program (CHIP) costs in outpatient and/or post-acute settings; (2) improve care for populations with specialized needs; (3) transform financial and clinical models of specific types of providers and suppliers; and (4) improve the health of populations through better prevention efforts.

For innovation projects in categories 2 and 4, CMMI prioritized HIV/AIDS as a high value target of change and emphasized the need for organizations to submit proposals in this area. CMMI defined the “health of populations” by geographic location (the health of a community), clinical status (the health of persons with specific diseases), and socioeconomic class. CMMI further noted that population health activities should focus on engagement of beneficiaries, prevention, wellness, and comprehensive care extending beyond the clinical service delivery setting. CDC will closely collaborate with CMMI to review and evaluate the HIV/AIDS innovation proposals.

An important decision was documented in a final Medicaid ruling, published July 15, 2013. State Medicaid programs can now reimburse for preventive services when recommended by a physician or other licensed practitioner. Under the new rule, state Medicaid programs potentially could reimburse for HIV and STD testing, counseling and other services provided by community health workers, other non-clinicians that are state-qualified providers. CDC will compile and provide CMS with models, case studies and best practice approaches to facilitate implementation of the new rule.

In June 2013, the U.S. Preventive Services Task Force (USPSTF) recommended hepatitis C virus (HCV) screening of persons at high risk for infection and one-time HCV screening of the 1945-1965 birth cohort (Grade B). In September 2013, CMS initiated a national coverage

analysis for HCV screening of adults that will be completed on June 3, 2014. CMS closed the public comment period on October 5, 2013 and expects to release its final decision memorandum on March 5, 2014. If CMS approves coverage, HCV screening would be available to Medicare recipients without cost sharing.

**Melissa Harris**

Director, Division of Benefits and Coverage  
Disabled and Elderly Health Programs Group  
Centers for Medicare and Medicaid Services

Ms. Harris presented an update on CMS's ongoing ACA implementation activities. CMS is continuing to conduct TA activities and provide guidance to both Medicaid expansion states and non-Medicaid expansion states regarding coverage of populations via an Alternative Benefit Plan. CMS's in-depth TA on changes to Medicaid as a result of ACA includes participation in daily conference calls with 6-7 states and weekly meetings with other states. To date, 32 states have informed CMS of their intention to use authority under Section 1937 of the Social Security Act to provide services to existing and new Medicaid beneficiaries.

CMS's TA activities are designed to ensure that states understand the benefit requirements outlined in the ACA Essential Health Benefits (EHBs) and Section 1937 of the Social Security Act. The Alternative Benefit Plan (formerly the Medicaid Benchmark Program) provides an opportunity for states to craft and offer benefit packages to the new adult populations and other Medicaid-eligible persons. These benefit packages can be similar to or different from services states traditionally provide under their plans. However, ACA has added a floor of coverage to Section 1937 that will serve as 10 EHBs in commercial plans selected by states.

Commercial plans for states to define EHBs for Medicaid will be the same as those used in Health Insurance Marketplaces to define EHBs. The commercial plans include federal and state employee plans, the largest commercial non-Medicaid health maintenance organizations, and the three largest small-group plans. The commercial plans represent a variety of options for states to select and define EHBs and also to achieve the goals of their respective benefit packages.

CMS is continuing to collaborate with states to ensure that their state plan amendments for their new adult populations include all benefits required by ACA and in keeping with state goals for service provision. States must demonstrate to CMS that benefits provided in their plans meet or exceed the floor of coverage mandated by ACA.

CMS is pleased that some EHBs have led to unexpected positive outcomes, particularly the inclusion of more robust mental health, substance use and preventive services. Prior to ACA, for example, some state Medicaid plans offered relatively weak substance use benefit packages or provided no benefits at all in this area. Because substance use is listed as an EHB under

ACA, all Medicaid expansion states and all states using Section 1937 to authorize benefits for traditional Medicaid-eligible groups must include substance use services in their Section 1937 programs. A few states have informed CMS of their intention to include substance use services in their traditional plans for the remainder of Medicaid-eligible beneficiaries.

Regardless of services covered in commercial plans, states must meet the federal definition of “preventive services” included in the EHB category: all services with a USPSTF Grade A or B recommendation, all vaccines recommended by the Advisory Committee on Immunization Practices, all of HRSA’s Bright Future preventive services recommendations, and all Institute of Medicine (IOM) women’s preventive services recommendations. This requirement has led several states to add the same menu of preventive services to their existing plans by aligning benefits between their new adult populations and the remainder of their Medicaid-eligible beneficiaries.

To date, CMS has not approved any proposed actions on state plans to establish benefit packages under the Alternative Benefit Plan for the new Medicaid-expanded population. After the approval process is complete, however, CMS will post the state plans on the Medicaid.gov website. The public will be able to review the following information:

- specific plans selected by states to define EHBs for Medicaid;
- specific services provided by states as defined in their selected plans;
- specific services states have added to their Alternative Benefit Plans to exceed the floor of EHB coverage;
- the amount, duration or limitations in scope of services provided in Alternative Benefit Plans; and
- other services outside of commercial plans that states have added in an Alternative Benefit Plan (e.g., targeted case management, personal care, long-term nursing facility care and freestanding birthing center services).

CHAC discussed the following topics in the question/answer session with the federal agency representatives on the ongoing ACA implementation activities of their respective agencies.

- The possibility of HRSA compiling information from the “In the Loop” website into simple fact sheets or key bullet points for dissemination to grantees, CBOs and other groups.
- The ability of HRSA to provide state ADAPs with insurance premium rates directly from insurers that will offer plans on state Exchanges to ensure PLWH are informed of plans with the best value.
- HRSA’s plans to address the potential for decreased availability of ARVs and diminished care for PLWH due to the placement of these drugs in the Tier 4 (highest cost share) formulary by private insurance plans.

- HRSA's plans to evaluate successes, challenges and limitations in the overall HIV care armamentarium based on collaboration between Ryan White clinics and Medicaid health homes that currently serve HIV/AIDS patients.
- Plans of the federal agencies, states and jurisdictions to qualitatively and quantitatively monitor changes in prevention, care and treatment of PLWH as ACA is implemented.
- Plans of the federal agencies to use federal funding to count toward the Medicaid spend down, particularly to increase medication adherence among minority PLWH.
- Efforts by the federal agencies, states and stakeholder organizations to develop and distribute consumer education materials and other resources for PLWH, particularly to address the complexities of ACA enrollment in a simplified manner and increase health insurance literacy.
- CMS's plans to widely distribute lessons learned, experiences and best practices by states that intend to amend their state plans and adopt preventive services for new and traditional Medicaid populations without cost sharing.

### Public Comment Session

Ms. Dempsey opened the floor for public comments; no participants responded.

### Preparation for the CHAC Business Session

#### **Antigone Dempsey MEd, CHAC co-Chair**

Deputy Director, Knowledge, Transfer and Technical Assistance  
HIV/AIDS Lead, Altarum Institute

Ms. Dempsey reviewed key topics from the presentations and discussions on day 1 of the meeting that would be drafted as recommendations or resolutions and presented for CHAC's formal vote during the business session on the following day.

#### *Topic 1: CDC's PwP Guidelines*

- Champions: Tommy Chesbro; Antigone Dempsey, MEd; Kali Lindsey
- Focus: Development of provider-specific questions and integration of SAMHSA's existing assessment tools. Several CHAC members expressed an interest in rebranding "Prevention with Positives" as "Prevention with Persons Living with HIV."

#### *Topic 2: Drug Formularies and Health Insurance Plans*

- Champions: Kathleen Clanon, MD; Carlos del Rio, MD; Jennifer Kates, PhD

- Focus: Changes to Medicaid coverage for PLWH as a result of ACA, including drug formularies and health insurance plans

*Topic 3: The future structure and evolution of RWHAP*

- Champions: Kathleen Clanon, MD; Angelique Croasdale, MA; Dawn Fukuda, ScM; Jeanne Marrazzo, MD, MPH
- Focus: HRSA guidance to RWHAP grantees to further improve short-term continuity of care for PLWH; development of specific messaging for RWHAP; and flexibility to allow local RWHAP providers to define a set of acceptable Medicaid measures under ACA in one visit

With no further discussion or business brought before CHAC, Ms. Dempsey recessed the virtual meeting at 4:02 p.m. on November 13, 2013.

### Opening Session: November 14, 2013

**Laura Cheever, MD, ScM**

Associate Administrator and Chief Medical Officer, HIV/AIDS Bureau  
Health Resources and Services Administration  
CHAC Designated Federal Official, HRSA

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were attending the virtual meeting. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record.

Dr. Cheever reminded the CHAC voting members of their individual responsibility to identify real or perceived conflicts of interest and recuse themselves from voting or participating in these matters. None of the voting members publicly disclosed any individual or institutional conflicts of interest for the record that were new or different than those declared on day 1 of the meeting.

Dr. Cheever verified that the voting members and *ex-officio* members constituted a quorum for CHAC to conduct its business on November 14, 2013. She reconvened the proceedings at 10:01 a.m. and welcomed the participants to day 2 of the virtual CHAC meeting.

**Antigone Dempsey MEd, CHAC co-Chair**

Deputy Director, Knowledge, Transfer and Technical Assistance  
HIV/AIDS Lead, Altarum Institute

Ms. Dempsey also extended her welcome and thanked the participants for ensuring that day 1 of the first virtual CHAC meeting was productive. She reviewed the overviews and workgroup reports that would be presented on day 2 of the meeting. Ms. Dempsey concluded her opening remarks by summarizing the topics that would be presented for CHAC's formal vote during the business session.

### **Panel Presentation: Clinical Workforce Issues and the Affordable Care Act**

A panel of HRSA leadership presented a series of overviews describing the ongoing activities of various bureaus to meet the primary care workforce needs in the United States, such as the implementation of specific strategies and development of interdisciplinary teams. The purpose of the overviews was to describe the landscape and increase understanding of the current HIV care and treatment workforce; highlight potential workforce gaps in the future; and discuss the possibility of expanding the roles of mid-level providers. The overviews are outlined below.

#### **Jennifer Fiedelholtz, MPP**

Director, Office of Policy Coordination  
Bureau of Health Professions  
Health Resources and Services Administration

Ms. Fiedelholtz described HRSA's activities to meet the primary care workforce needs in the United States. The key goals for the future workforce are to provide high quality care at a reasonable cost; assure access to care; increase diversity to improve health equity; make effective use of the current workforce through innovation, training and continuous education; and help health workers to fully practice consistent with their education, training, competencies and credentials.

Several major developments and trends impact the health workforce. Most notably, the demand for healthcare services has increased as the U.S. population has grown and aged. Healthcare reform has added insurance coverage for millions of new individuals and also has improved coverage for millions of other persons. Increased costs of healthcare services and healthcare technology are unsustainable. The needs of the healthcare workforce are uncertain. Issues related to inefficiencies and the potential for overuse are problematic. These developments and trends have led to increased interest in identifying strategies to improve efficiency and improve health outcomes.

HRSA currently is focusing on areas that are particularly challenging for the workforce. Potential shortages in primary care, chronic/long-term care, behavioral health and oral health are specific areas of concern. The existing workforce is not equitably distributed. Increased workforce diversity is a critical need to assure health equity. Health workers are not used to the

maximum of their education and skills. The impact of the changing healthcare system on individual health occupations needs to be rigorously assessed and analyzed. The development of a comprehensive data system to inform healthcare workforce decisions is a critical need across all HRSA bureaus, HHS agencies and states.

The national healthcare labor supply has dramatically grown from 1950 to 2010 based on data showing health employment per 100,000 population. Most notably, HRSA has allocated a great deal of funding to support the rapid growth in three components of the workforce: physician assistants, nurse practitioners and graduate medical education. However, HRSA is continuing to analyze demand versus supply, retirements, distribution and other factors that affect the workforce supply.

The mission of the HRSA Bureau of Health Professions (BHP) is to increase the nation's access to quality health care, particularly for underserved persons, by developing, distributing and retaining a diverse and culturally competent health workforce. BHP strongly focuses on the primary care workforce to help build the broader healthcare workforce. The BHP budget decreased from \$678 million in FY2012 to \$600 million in FY2013. The FY2014 President's budget request includes a further decrease for BHP to \$461 million. However, a revolving fund supports a loan repayment program for several BHP grantees.

BHP is focusing on healthcare workforce planning through its National Center for Healthcare Workforce Analysis. The core activities of this initiative are highlighted as follows. Healthcare workforce data collection and analysis are being expanded and improved. BHP's datasets, including Area Health Resource files, are available on its website.

BHP collaborates with states and professional organizations to build a minimum dataset on several health professions. Projections of the workforce supply, demand and need are being improved. BHP posts reports of its projections on its website, but findings, data and other information also are widely disseminated to key stakeholders. Health workforce planning capacity is being strengthened at the state level.

BHP primarily funds academic institutions that support training and education across a wide array of health professions, including medicine, nursing, public health, geriatrics, physician assistants and behavioral health. The BHP initiatives that focus on building the workforce supply include the ACA-funded Teaching Health Centers (THC) Program to support primary care, medical and dentistry residencies in community-based settings.

Federally Qualified Health Centers (FQHCs) in underserved areas account for the large number of THC Program participants. Research shows that students who train in underserved areas are more likely to remain and practice in these communities. BHP has more than doubled the number of resident full-time equivalents (FTEs) since the inception of the THC Program in

FY2010. BHPr will support >300 primary care resident FTEs in academic year 2013-2014 and will graduate the first class of the THC Program in the spring of 2014.

BHPr has a strong focus on supporting innovations in health professions education and training, particularly interprofessional and team-based care. BHPr and four private foundations began supporting the new National Center for Interprofessional Education and Collaborative Practice in FY2013 with five-year funding of \$16 million. The primary goals of this initiative are to identify best practices and effective models, evaluate outcomes and disseminate information on training practitioners in interprofessional education. To support this effort, BHPr is developing metrics to assess the quality of team-based care, such as the impact of interprofessional education on reducing healthcare costs and improving health outcomes. BHPr also supports Title VII and VIII programs to promote primary care and community-based training.

**Rene Sterling, PhD, MHA**

Senior Advisor, Office of Quality and Data  
Bureau of Primary Health Care  
Health Resources and Services Administration

Dr. Sterling described key themes regarding HIV in the primary care workforce. The HRSA Bureau of Primary Health Care (BPHC) has tremendously grown from 2008 to 2012: a 23.2% increase in the number of patients, a 19.4% increase in the number of sites, and a 31.1% increase in the number of jobs. The top three revenue sources of BPHC grantees are Medicaid (38%), the BPHC 330 Grant (18%), and state, local or other funding sources (17%).

Of 21.2 million patients served by FQHCs in 2012, 93% were below 200% of the FPL, 62% were racial/ethnic minorities, 36% were uninsured, ~1 million were homeless, 903,089 were migrants or seasonal farmworkers, and 219,220 were residents of public housing. These patients made ~94 million visits to FQHCs in 2012. FQHCs represent 1,198 grantees at >8,900 service sites. The FQHC workforce of >148,000 staff includes >10,400 physicians and >7,500 nurse practitioners, physician assistants and certified nurse-midwives.

BPHC maintains close collaborations across other HRSA bureaus and HHS agencies to focus on three major themes related to HIV in the primary care workforce. To “build the HIV workforce,” BPHC avoids shifting the existing workforce from Ryan White clinics to FQHCs. Instead, BPHC is training primary care physicians and other providers in basic health care through peer-based learning, clinical consultation and tele-health modalities. BPHC also trains FQHC leadership, boards and staff on the HIV epidemic in their local service areas and other relevant issues.

To “integrate HIV into the current scope of FQHC projects,” BPHC defines and delineates HIV primary healthcare services that reasonably could be provided by a primary care physician with a source for clinical consultation. This definition establishes a minimum threshold for FQHCs to

reach and eventually expand; informs the development of AETC curricula and other training or TA resources for use by FQHCs; and allows for awarding of supplemental funding to FQHCs to support HIV activities. However, supplemental funding cannot be used to expand the current scope of FQHC projects. BPHC also uses HIV integration models for FQHCs to facilitate and strengthen new and existing community-based partnerships.

The primary characteristics and requirements of FQHCs are highlighted as follows. FQHCs must be located in or serve medically underserved areas or populations. FQHCs must be governed by a community-based board with a majority of patients who represent the populations served. FQHCs must provide comprehensive, culturally competent and quality primary healthcare and supportive services. Section 330 of the Public Health Service Act delineates the required and additional primary health services of FQHCs and defines the scope of FQHC projects.

To develop an HIV infrastructure, BPHC places strong emphasis on reengineering and revamping FQHCs at a systems level. The key activities and resources to achieve this goal include training of FQHC clinicians, leadership and staff; integration of HIV into existing FQHC policies, procedures and protocols; EHRs, clinical decision support for HIV care, and system enhancements; PCMH recognition; and care coordination across the healthcare system.

BPHC's next steps to advance its focus on HIV in the primary care workforce are to collaborate with CDC to build on lessons learned and expand HIV measures in the HRSA Uniform Data System (UDS). BPHC also has identified several new venues and partnerships to develop materials and disseminate information: a listserv to facilitate ongoing communications with all FQHC Clinical Medical Officers; circulation of risk alerts and practice alerts through the Federal Tort Claims Act Program; and collaboration with national CoAGs that focus on special population health.

**Philip Budashewitz, RPh, MA, CAPT USPHS**

Director, Policy and Shortage Designation

Bureau of Clinician Recruitment and Service, National Health Service Corps

Health Resources and Services Administration

Capt. Budashewitz described the role of the National Health Service Corps (NHSC) in addressing primary care workforce needs. NHSC was established in 1972 to expand access to health care, address inequitable distributions in providers across the country, and improve the health of persons who live in three types of health professional shortage areas (HPSAs): clinical/medical care HPSAs, oral/dental health care HPSAs, and behavioral/mental health care HPSAs.

By program, the total NHSC "field strength" includes >40,000 clinicians who have worked in underserved communities in the field since the establishment of NHSC in 1972. By year, the

NHSC field strength has grown from 3,601 clinicians in FY2008 to 8,899 clinicians in FY2013. Due to three separate funding sources in FY2011 (e.g., base appropriations, the Recovery Act and ACA), the 10,279 funded clinicians accounted for the highest field strength in the history of NHSC. By category, the FY2013 NHSC field strength breaks down as follows: multiple types of mental health providers (27%), physicians (27%), nurse practitioners (16%), dentists (13%), physician assistants (13%), dental hygienists (2%), and nurse midwives (2%).

Of \$1.5 billion that ACA will provide to NHSC over the next five years, the HRSA Bureau of Clinician Recruitment and Service (BCRS) will award \$305 million in contracts for individuals to provide direct clinical care in FY2014. BCRS expects to make 4,513 Student to Service (S2S) Loan Repayment Program awards, 211 Scholarship Program awards, and 100 Loan Repayment Program (LRP) awards. The number of funding awards that will be made under the State Loan Repayment Program has not been determined at this time.

Of >5,700 LRP applications that were submitted in FY2013, BCRS made 2,106 new awards. Individual awards were up to \$60,000 to clinicians placed in HPSAs with scores of  $\geq 14$  and up to \$40,000 to clinicians placed in HPSAs with scores of  $\leq 13$ . BCRS determines HPSA scores based on the shortage of clinicians in the area. The key features for LRP applicants include an electronic employment verification system and credits for the provision of telemedicine services. BCRS will conduct the FY2014 LRP application cycle in January-March 2014.

Of >1,700 Scholarship Program applications that were submitted in FY2013, BCRS made 180 new awards. Upon completion of training, scholars are required to provide one year of service in NHSC for each year of support provided (or a minimum of 2 years of service). Scholarship Program awards include tax-free payments for tuition and required fees, tax-free payments for books and other educational needs, and a taxable monthly living stipend. The key features for Scholarship Program applicants include resources under the "Getting Prepared for NHSC Service Program" (e.g., webinars, social media communications, a mentor program and virtual job fairs). BCRS will conduct the FY2014 Scholarship Program application cycle in February-April 2014.

Of 100 S2S Program applications that were submitted in FY2013, BCRS made 78 awards. The average debt per application was >\$200,000. The pilot S2S Program is targeted to medical students in their fourth year of training who must match their primary care residency to an NHSC-designated discipline. The key features for S2S Program applicants include placement assistance and loan repayment of \$120,000 for a three-year commitment. BCRS plans to make 100 awards after the FY2014 S2S Program application cycle closes on November 14, 2013.

For all NHSC programs, applicants must be a U.S. citizen or national. For specific NHSC programs, LRP applicants must be licensed in an NHSC-designated discipline. Scholarship Program applicants must be a full-time student at an accredited school or pursuing a degree in

an NHSC-designated discipline. S2S Program applicants must plan on completing an accredited primary medical care residency in an NHSC-designated discipline.

The types of sites that are eligible for NHSC greatly vary: FQHCs and “Look-Alike” Health Centers, American Indian Health Facilities (e.g., Indian Health Service Facilities, Urban Indian Health Programs and Tribally-Operated 638 Health Programs), Certified Rural Health Clinics, Community Mental Health Centers, state/county health departments, critical access hospitals, community outpatient facilities, private practices, free clinics, correctional/detention facilities, school-based clinics, and mobile units/clinics. However, all sites must meet the same set of criteria for inclusion in NHSC:

- Location in a federally-designated HPSA
- Provision of primary medical, dental or mental/behavioral healthcare services
- Assurance of access to ancillary, inpatient and specialty referrals
- Provision of services regardless of the patient’s ability to pay
- Acceptance of patients covered by Medicare, Medicaid or CHIP
- No discrimination in the provision of services
- Provision of a supportive environment and agreement not to reduce a provider’s salary due to NHSC support
- Provision of sound fiscal management
- Provision of free or reduced-cost services to persons at or below 200% of the FPL

BCRS launched the redesigned NHSC Jobs Center website in May 2012. The updated website includes Google Maps technology, a “site profile” webpage for sites to describe their success stories, and enhanced search features to locate specific sites, vacancies and HPSA scores by state or city. The NHSC Jobs Center website averages >40,400 visits per month. BCRS also has ensured that updated information on NHSC is regularly available through multiple platforms: social media (e.g., Facebook, Twitter and YouTube), a HRSA e-mail address and website, and a toll-free telephone number.

**Sylvia Trent Adams, PhD, RADM USPHS**

Deputy Associate Administrator, HIV/AIDS Bureau  
Health Resources and Services Administration

Dr. Trent Adams informed CHAC that HAB funding of the “HIV Clinical Workforce Study” was initiated in 2010 and ended in the summer of 2013. Because the final report is undergoing HRSA’s internal review process at this time, specific details on the study have not been cleared for public discussion. She expected that the clearance process would be completed over the next few months in time for HRSA to present key findings from the study during the next CHAC meeting.

CHAC discussed the following topics in the question/answer session with leadership of the HRSA bureaus on their current activities to meet the primary care workforce needs in the United States.

- The possibility of HRSA repeating its previous HIV workforce consultation with diverse groups, particularly to address new issues related to ACA and discuss new findings from the upcoming report of the HIV Clinical Workforce Study.
- The ability of the “Treatment as Prevention” framework to emphasize the importance of including HIV treatment in the integrated public health/primary care model.
- Development of a surveillance system to formally track and monitor specific activities by the HIV workforce and the provision of HIV services in each jurisdiction on an ongoing basis.
- The role of HRSA-funded Primary Care Associations in HIV workforce activities at state and regional levels.
- BPHC’s CoAg funds, partnerships and other activities to more fully integrate viral hepatitis and sexual health in FQHCs.
- BPHC’s ongoing efforts to make HIV expansion capacity dollars available to FQHCs that do not have PCMH recognition.
- Establishment of a set of cross-cutting themes or criteria (e.g., data, education or creative tele-health experience) as the standard to define a high level of capacity for a skilled, qualified and credible primary care workforce.
- The need to include psychiatrists and behavioral health specialists in interdisciplinary teams.
- Improved training to HIV clinicians on pain management to minimize prescription drug abuse of their patients.

CHAC advised HRSA to apply the “HIV Treatment and Care Cascade” or the “HIV Continuum of Care” as a framework to utilize various provider skills, activities and systems to facilitate integration across agencies and diseases in a holistic manner. For example, providers who care for persons at risk for HIV (*i.e.*, the pre-infection phase) also could use the same opportunity to assess their sexual health risks, drug use and other risk behaviors. These providers could then engage clinicians or specialists to provide expertise on ARVs and other specialty issues related to HIV.

## Overview of the HIV Testing Measure for Federally Qualified Health Centers

### **Rene Sterling, PhD, MHA**

Senior Advisor, Office of Quality and Data

Bureau of Primary Health Care

Health Resources and Services Administration

Dr. Sterling presented an overview of the HIV testing performance measure that BPHC is proposing to establish for FQHCs and incorporate into UDS. UDS is a core set of information that is appropriate for reviewing the operation and performance of FQHCs. UDS also serves as a reporting system for FQHCs and “Look-Alike” Health Centers (*i.e.*, Health Centers that meet all 330 Program requirements, but do not receive 330 Program funding).

UDS maintains data on both FQHC grantees and Look-Alike Health Centers, including the age, race/ethnicity and other characteristics of patients as well as the services, clinical and cost data, use of EHRs and PCMH recognition of an individual FQHC. UDS maps allow users to pinpoint the location of FQHCs and identify primary care and sociodemographic-related data. UDS data are publicly available on the BPHC website.

BPHC added several FQHC-specific performance measures to UDS in 2008, including clinical, fiscal, quality of care and disparities measures. UDS performance measures have shown continued growth in HIV testing at FQHCs. For example, the number of patients FQHCs have tested for HIV has increased from 691,208 in 2009 to 999,484 in 2012. The number of patients FQHCs have served with a primary or secondary diagnosis of HIV has increased from 94,972 in 2009 to 114,881 in 2012.

BPHC received approval from the Office of Management and Budget (OMB) to adopt 2 of the 7 HHS core measures. “Linkage to care” will be reported as an outreach/quality of care measure for patients whose first ever HIV diagnosis was made by FQHC staff between October 1 and September 30 and who were seen for follow-up within 90 days of the first ever diagnosis. “HIV positivity rate” will be reported as a patient count for persons diagnosed with HIV for the first time ever in their lifetime. FQHCs will begin collecting these data in 2014 and BPHC will report its first full year of data from the two HHS core measures in 2015.

BPHC has participated in numerous calls with stakeholders over the past year to obtain external input on clearly defining and establishing an HIV testing performance measure for FQHCs. Based on this feedback, BPHC is proposing the following HIV testing measure. The measure would be targeted to patients 15-65 years of age who have ever been tested for HIV in their lifetime. The measure would be aligned with USPSTF recommendations and ongoing activities of its federal partners.

The HHS Office of the National Coordinator for Health Information Technology is funding a one-year contract to implement an e-Specify HIV screening measure and develop clinical decision support. CDC is making efforts to add an HIV screening measure to Meaningful Use Stage 3 criteria and the Medicaid Adult Core Measure Set. After these activities are completed, BPHC anticipates submitting its proposed HIV testing measure for FQHCs for OMB approval by 2015.

CHAC advised BPHC to require FQHCs to track CD4 counts and the time at which persons access care. This measure would be important to improve early diagnosis of HIV, particularly for minority populations that typically enter care late with an AIDS diagnosis.

### Update by the CHAC Data Workgroup

**Jennifer Kates, PhD, CHAC Member**

Vice President & Director, Global Health and HIV Policy  
Kaiser Family Foundation

Dr. Kates covered the following topics in her update on the workgroup's recent activities. CHAC unanimously approved the formation of the workgroup with a charge of gathering and analyzing CDC and HRSA data to track the impact of ACA on PLWH at implementation and over time.

The workgroup is utilizing several key sources to fulfill its charge: CDC Medical Monitoring Project data; CDC's first national estimates of PLWH who are in care and uninsured, but will gain new coverage under ACA; and HRSA data on RWHAP clients by insurance and income status.

### Update by the CHAC Ryan White Reauthorization Workgroup

**Kathleen Clanon, MD, CHAC Member**

Director, Division of HIV Services  
Alameda County Medical Center

Dr. Clanon covered the following topics in her update on the workgroup's recent activities. The RWHAP legislation has expired and has not been rewritten or reauthorized at this time. The workgroup will propose a resolution during the business session for CHAC to extend its charge to formulate guidance on the future of RWHAP, particularly its intersection with ACA. If CHAC approves the extension, the workgroup intends to propose recommendations to CDC and HRSA in the following areas.

- Advice to HRSA-funded grantees to comply with RWHAP's statutory role as the payer of last resort
- Advice to HRSA-funded grantees to help PLWH navigate the enrollment process for ACA Exchanges
- Advice to CDC and HRSA on including HCV screening and treatment in a more robust manner

- Advice to HRSA on compiling pharmacy data on single-tablet HIV regimens to make a strong argument about state plan formularies
- Advice to CDC and HRSA on long-term action steps or specific information the agencies should provide over the next 4-5 years

### Update by the CHAC Integration Workgroup

**Bruce Agins, MD, MPH, CHAC Member**

Medical Director, AIDS Institute  
New York State Department of Health

**William Garrett**

Program Associate, AIDS Institute  
New York State Department of Health

**Kali Lindsey, CHAC Member**

Director, Government Affairs and Communications  
National Minority AIDS Council

The workgroup covered the following topics in the update on its recent activities. Since its formal establishment during June 2013 CHAC meeting, the workgroup has reviewed existing integration models, analyses and taxonomy to refine its charge and better understand the complexities related to integration. The workgroup focused on answering four key questions in this effort.

One, what services should be included in integration? Different infectious diseases (e.g., hepatitis, STDs and TB) should be integrated into HIV care. These infectious diseases also should be integrated into primary care and the public health/primary care model, particularly the integration of HIV/HCV/STD prevention and care into CHCs; the integration of HIV/HCV/STD care into general medical care; and the integration of hospital HIV clinics into the larger healthcare system.

In terms of subpopulations, HIV/HCV/STD should be integrated into a population-specific framework, such as expanded LGBT, mental health and substance abuse programs and the integration of behavioral health into HIV care. Experiences and lessons learned from other models should be considered, such as the provision of family-centered care through the integration of maternal and child HIV care and Chronic Disease Centers or models that integrate care for chronic disease patients (e.g., the integration of HIV into diabetes or heart disease). To assist in answering question 1, the workgroup reviewed a briefing document that the National

Alliance of State and Territorial AIDS Directors (NASTAD) recently released on the status of collaboration between CHCs and health departments.

Two, is full integration needed for integrated service delivery models? To assist in answering question 2, the workgroup reviewed the 2010 Shigayeva, *et al.* paper, “Health Systems, Communicable Diseases and Integration.” The study reported that the levels of integration include no formal interaction between programs, partial integration through linkage or coordination, and full integration. The workgroup presented the Shigayeva paper with detailed definitions on each type of integration model for CHAC’s review.

Three, what are the specific components of a full integration model? The workgroup’s literature review showed that several areas of a program would need to be integrated in order to achieve full integration: service delivery, governance, financing/funding systems, strategic planning, leadership support and endorsement, and quality measures to demonstrate impact.

Four, what experiences and lessons learned can be applied from existing integration models? The workgroup identified several examples of integration in its literature review: Department of Veterans Affairs healthcare facilities, Project ECHO® (Extension for Community Healthcare Outcomes), CDC’s Program Collaboration and Service Integration demonstration projects, and services for subpopulations (e.g., LGBT, mental health and substance abuse programs).

CHAC made several suggestions in response to the workgroup’s request for input on its next steps, areas of focus and future directions.

- Integrate viral hepatitis into behavioral health care and maternal/child health care.
- Integrate family planning or women’s health care into HIV care.
- Address the tension between service integration and policies and the integration of different infectious disease programs along the point of service.
- Specifically name “Opioid Treatment Centers” in programs that integrate substance abuse and HIV/HCV/STD care.
- Focus on specific policies, federal agencies, barriers and national strategies/measures (e.g., NHAS) that will impact services included in integration.
- Identify opportunities for integration in ACA (e.g., the shift to EHRs and best practices from the CMMI-funded Health Care Innovation Awards).
- Use the new White House Executive Order on continuum of care as an opportunity to emphasize the importance of integration in reaching persons across the spectrum of their needs and improving all health outcomes.
- Formulate guidance on integration from an individual patient/client perspective rather than from a broad systems level. An ideal integration model would provide linkages to care, treatment and other services for persons with a new positive HIV test and also would provide referrals to relevant services for persons with a new negative HIV test to maintain their status. For example, a Ryan White medical home provides patients with

medical and psychiatric care, various testing, and linkages to treatment for abuse of opioids or other substances.

Dr. Agins thanked CHAC for its concrete suggestions on the workgroup's next steps, areas of focus and future directions. However, he emphasized that the workgroup would need outside expertise on ACA and other issues to respond to some of CHAC's suggestions.

## CHAC Business Session

### **Antigone Dempsey MEd, CHAC co-Chair**

Deputy Director, Knowledge, Transfer and Technical Assistance  
HIV/AIDS Lead, Altarum Institute

### **Jeanne Marrazzo, MD, MPH, CHAC co-Chair**

Professor of Medicine, Harborview Medical Center  
University of Washington

Ms. Dempsey and Dr. Marrazzo opened the business session and called for CHAC's review, discussion and/or formal action on the following topics.

#### **Topic 1: Adoption of the Draft CHAC Meeting Minutes**

Ms. Dempsey entertained a motion for CHAC to approve the previous meeting minutes. A motion was properly placed on the floor and seconded by Mr. Kali Lindsey and Mr. Guillermo Chacon, respectively, for CHAC to approve the previous meeting minutes.

**CHAC unanimously adopted the Draft June 18-19, 2013 Meeting Minutes with no changes or further discussion.**

#### **Topic 2: Prevention with Persons Living with HIV (formerly "Prevention with Positives") Champions: Tommy Chesbro; Antigone Dempsey, MEd; Kali Lindsey**

The following motion was properly placed on the floor and seconded by Mr. Guillermo Chacon and Dr. Virginia Caine, respectively.

Given the important impact that both early engagement with a healthcare provider and initiation of treatment above 500 establish optimal health and prevention outcomes for persons living with HIV (PLWH), strategies and interventions to support sustained viral suppression have primacy in addition to primary prevention efforts for opportunistic infections and other STDs, such as hepatitis and syphilis.

- CHAC recommends that CDC collaborate with HRSA to bring its Prevention with Persons Living with HIV (PwPLWH) Guidelines to completion and online. CHAC expects that the completed guidelines will be presented at the next meeting in May 2014.
- CHAC recommends that the PwPLWH Guidelines include input from providers and PLWH. Modules addressing brief screenings for addictions and mental health issues, intimate partner violence, and strategies to mitigate behaviors that may be adopted to manage certain life circumstances should be included as well.
- CHAC recommends that CDC and HRSA assess the viability of a user tool for providers either through electronic medical records or a downloadable application.

CHAC proposed the following amendment to the motion:

- Include new language describing strategies to reduce stigma among PLWH.

**CHAC unanimously approved the resolution with the proposed amendment.**

**Topic 3: Drug Formularies and the Healthcare Exchange**  
**Champions: Kathleen Clanon, MD; Carlos del Rio, MD; Jennifer Kates, PhD**

The following motion was properly placed on the floor and seconded by Drs. Bruce Agins and Jeanne Marrazzo, respectively.

CHAC notes that as more persons living with HIV gain access to private insurance coverage through new Healthcare Marketplaces being established in each state, access to recommended antiretroviral (ARV) therapy also should be available as specified in HHS guidelines. The final HHS rule for coverage of prescription drugs in the marketplace states that plans must cover “at least the greater of 1 drug from every U.S. Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB benchmark.” However, the final HHS rule does require plans to have procedures in place to “allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.”

Because of this, concerns have been raised and early data support the following. (1) Not all recommended combination antiretroviral therapeutic regimens are covered by all plans in each Marketplace. (2) Several state qualified health plans are placing all HIV antiretrovirals on the highest cost-sharing tier and requiring prior authorization for these medications. (3) Obtaining data on plan coverage of ARVs by state is difficult and poses considerable challenges to Ryan White grantees, particularly AIDS Drug Assistance Programs that need this information to assess their ability to help clients purchase plan coverage in the Marketplace. (5) No clear guidance has been given to plans about the

HHS HIV Treatment Guidelines. (6) Plan processes for allowing enrollees to request access to clinically appropriate drugs not covered by a plan are not yet available or easy to obtain.

Therefore, CHAC requests that HRSA work with its federal partners, particularly the HHS Center for Consumer Information and Insurance Oversight, to:

1. Assess the extent of ARV coverage by plan in each Marketplace and ensure that formulary and cost information are readily available;
2. Provide guidance to plans regarding discriminatory formulary designs that include, as an example, placing all HIV medications in the highest cost-sharing tier;
3. Conduct specific outreach to state Marketplaces where plans do not cover recommended combination therapies; and
4. Ensure that policies allowing enrollees to request access to clinically appropriate drugs not covered by plans be accessible and readily available.

CHAC proposed the following amendments to the motion:

- Include new language to ensure that problems with formularies and the Healthcare Exchange do not interfere with the ability to achieve optimal patient outcomes and impact the quality of care.
- Specifically name the single-tablet regimens in item 3.
- Acknowledge the ongoing efforts by HIV Medicine Association, NASTAD and other organizations in this recommendation.

**CHAC unanimously approved the resolution with the proposed amendments.**

**Topic 4: Changes to the Ryan White HIV/AIDS Program (RWHAP)**

**Champions:** Kathleen Clanon, MD; Angeliq Croasdale, MA; Dawn Fukuda, ScM; Jeanne Marrazzo, MD, MPH

It appears that the RWHAP authorizing law will not be rewritten in the near future. CHAC notes the complex interactions between ACA provisions and the current RWHAP language. In particular, the Payer of Last Resort provision and 75/25 rule in RWHAP may have unintended consequences in the era of health reform, serve to reduce the comprehensiveness of HIV care provided by RWHAP, and have consequences for both individual and public health outcomes. CHAC strongly [advises? directs?] HRSA and its partners to review program guidance, particularly for RWHAP Parts A, B, C, and D, to explore updating the definitions of care to recognize the following:

- Allowable services under the medical services program may include primary care of PLWH, specialty HIV care, or adherence/risk reduction visits. Each of these services can be provided by a medical team under the direction of a physician and a given

care episode may include one or more of these visit types. However, there may be widely varying levels of reimbursement for these services and requirements for licensure or certification for providers who deliver them. Given the uncertainty of coverage scopes under both expanded public and private insurance options available through ACA, CHAC recommends that HRSA develop a staged analysis during implementation of healthcare reform at the jurisdictional level and perform a corresponding assessment of policies related to payer of last resort requirements.

- All PLWH do not need the same interventions to be successful with treatment, yet RWHAP assumes that. CHAC recommends that HRSA review RWHAP guidance to allow for a service package that is based on presenting health status, acuity level, and other psychosocial and environmental considerations and is measured by goals jointly established by the consumer and medical care team, including sustained viral suppression, optimal visits and laboratory frequency. This approach would allow for RWHAP clients to be triaged by patient level of need and at varying levels of intensity.
- HRSA should explore strategies to use RWHAP funds to leverage ACA to strengthen the Continuum of Care, both in the short- and long-term.

**CHAC endorsed the “general spirit” of the resolution with no formal vote.**

The Ryan White Reauthorization Workgroup would revise the resolution with clearer language and more specific recommendations for CHAC’s formal vote by the next meeting.

**Topic 5: Future Agenda Items**

CHAC proposed several topics to include on future meeting agendas.

- **CDC, HRSA Bureaus and CHAC:** Continuation of the workforce agenda item.
  - Overviews by CDC and HRSA grantees on their current activities to strengthen workforce capacity by providing more integrated care related to HIV, sexual health, viral hepatitis and TB, particularly to ensure concurrence across all of these disease categories for vulnerable populations and also to take advantage of tremendous advancements in viral hepatitis care. The overviews should describe integration efforts by the CDC and HRSA grantees to overcome problems related to silos and resolve barriers to categorical funding that focuses on specific diseases. The following grantees should be invited to present overviews: CDC-funded Prevention Training Centers, HRSA-funded AETCs, HRSA-funded THC Program grantees, and HRSA-funded Nurse Education, Practice, Quality and Retention Program grantees.
  - CHAC’s development of formal workforce recommendations to CDC and HRSA in the following areas: maintaining a skilled workforce, addressing LGBT health, and

- increasing training to HIV providers on pain management to minimize opioid abuse among their patients.
- CHAC's targeted discussion to identify and fill gaps in three specific areas of workforce capacity: (1) clinicians providing medical care for PLWH; (2) CHCs, safety net hospitals and other providers serving vulnerable populations at risk for HIV and viral hepatitis; and (3) CHCs serving as true HIV health homes for PLWH based on the traditional RWHAP model.
  - **HRSA:** Update on the integration of HIV health homes and HIV groups that are expanding to include primary care.
  - **HRSA:** Regular updates on the number of patients FQHCs test for HIV each year (numerator) relative to their annual patient populations (denominator).
  - **HRSA/AETCs:** Presentation with geomapping data that target locations of HIV providers who would be willing to mentor primary care providers in rural and underserved areas.
  - **CDC:** Update on the DASH portfolio, including targeted programming for young gay/bisexual men and expanded access to Early Intervention Services in school health.
  - **CDC:** Update on the PwPLWH Guidelines in an ACA environment. The update should cover the national emphasis on universal treatment regardless of CD4 count or viral load.
  - **CDC/HRSA:** Potential strategies to blend prevention and treatment funding streams to improve the continuum of care for HIV and HCV. The presentation should include an overview of the IOM analysis regarding the integration of CDC, HRSA, CMS and SAMHSA funding streams.
  - **Guest Speaker:** Overview by the HRSA-funded National LGBT Health Education Center at Fenway Institute on its efforts to evaluate health issues and clinical concerns among the LGBT community beyond HIV, STDs and other traditional program areas at the federal level. The overview should describe skill sets that are needed to adequately assess LGBT sexual behavior, sexual identity and sexual orientation in the context of poor health outcomes (e.g., disclosure and increased risk taking). The overview should serve as CHAC's initial discussion on early diagnoses, biomedical/behavioral prevention and interventions for transgender health, particularly to address underlying factors for the tremendous disparity in HIV and STD rates among female-to-male transgenders.
  - **Guest Speakers:** Panel presentation by RWHAP grantees and other groups that have successfully expanded to primary care. An invitation should be extended to Mike Gifford, President and Chief Executive Officer of AIDS Resource Center of Wisconsin, to describe experiences and lessons learned in successfully certifying this organization as an HIV medical home through the state Medicaid program.

## Topic 6: Action Items

CHAC reviewed the action items and other tasks that were raised over the course of the meeting.

- Ms. Kaye Hayes, CHAC *ex-officio* member for HHS, will provide CHAC with the website link to the minutes of the September 2013 PACHA meeting after the document has been cleared for release.
- Ms. Melissa Harris, of CMS, will provide CHAC with lessons learned, experiences and best practices by states that intend to amend their state plans and adopt preventive services for new and traditional Medicaid populations without cost sharing.
- The CDC and HRSA Committee Management Specialists will distribute the IOM analysis to CHAC in preparation of the presentation on integrating CDC, HRSA, CMS and SAMHSA funding streams.
- Dr. Hazel Dean, Deputy Director of NCHHSTP, will share lessons that the CDC Advisory Council on Tuberculosis Elimination has learned over the past year in convening virtual meetings.
- Dr. Rene Sterling, Senior Advisor to the BPHC Office of Quality and Data, will identify a staff member to serve on the CHAC Integration Workgroup on an ongoing basis.
- The Co-Chairs will draft a letter to provide feedback to the CDC Director, HRSA Administrator and HHS Secretary on outcomes of CHAC's first virtual meeting. The CHAC members should e-mail any points or issues that should be emphasized in the letter. An e-mail will be distributed to assist CHAC in providing qualitative input in response to specific questions. Several CHAC members made comments in the interim:
  - Notification of CHAC's virtual meeting through a *Federal Register* notice and the HRSA/HAB listserv was not sufficient for public outreach.
  - The virtual meeting was far too compact for three 2.5-hour sessions over two days. The number of presentations should be reduced or an additional 2.5-hour session should be included on day 2. Most notably, the numerous presentations on ACA were difficult to digest and did not allow for extensive discussion by CHAC.
  - Efforts should be made to reinstate CHAC's two in-person meetings per year. The virtual meeting was helpful, but was not the ideal format for CHAC's discussions on complex issues. To support this request, CDC agreed to perform a cost analysis to compare the differences in labor and other costs between an in-person and virtual CHAC meeting.

## Closing Session

The co-Chairs, DFOs and CDC/HRSA leadership thanked the CHAC members and all of the attendees for their ongoing participation and extensive engagement over the course of the first virtual meeting. The participants applauded Ms. Shelley Gordon, the CHAC Committee Management Specialist for HRSA, for her outstanding efforts in preparing for and overseeing the logistical arrangements for the meeting.

Ms. Dempsey reiterated that the CHAC members would receive e-mail messages soliciting their comments and feedback on successes, flaws and areas of improvement related to the first CHAC virtual meeting. She emphasized that this input would serve as the basis in refining CHAC's virtual meetings in the future.

The next in-person CHAC meeting would be held on May 21-22, 2014 in Atlanta, Georgia. With no further discussion or business brought before CHAC, Ms. Dempsey adjourned the virtual meeting at 12:33 p.m. on November 14, 2013.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Antigone Dempsey, MEd, Co-Chair  
CDC/HRSA Advisory Committee on HIV,  
Viral Hepatitis and STD Prevention and  
Treatment

\_\_\_\_\_  
Date

\_\_\_\_\_  
Jeanne Marrazzo, MD, MPH, Co-Chair  
CDC/HRSA Advisory Committee on HIV,  
Viral Hepatitis and STD Prevention and  
Treatment



## Participants' Directory

### CHAC Members Present

Ms. Antigone Dempsey, co-Chair  
Dr. Jeanne Marrasso, co-Chair  
Dr. Bruce Agins  
Dr. Virginia Caine  
Mr. Guillermo Chacon  
Mr. Tommy Chesbro  
Dr. Kathleen Clanon  
Ms. Angelique Croasdale  
Dr. Carlos del Rio  
Ms. Dawn Fukuda  
Dr. Perry Halkitis  
Ms. Regan Hofmann  
Dr. Steven Johnson  
Dr. Jennifer Kates  
Mr. Kali Lindsey

### CHAC Members Absent

Dr. Sanjeev Arora  
Dr. Marjorie Hill  
Dr. Britt Rios-Ellis

### CHAC Ex-Officio Members Present

Dr. Pradip Akolkar  
Food and Drug Administration

Dr. William Grace  
National Institutes of Health

Ms. Kaye Hayes  
Office of HIV/AIDS and Infectious Disease  
Policy, U.S. Department of Health and  
Human Services

Dr. Iris Mabry-Hernandez  
Agency for Healthcare Research and  
Quality

Dr. Elinore McCance-Katz  
Substance Abuse and Mental Health  
Services Administration

Ms. Lisa Neel  
Indian Health Service

Dr. Richard Wild (Alternate)  
Centers for Medicare and Medicaid  
Services

### CHAC Ex-Officio Member Absent

Dr. Steve Cha  
Centers for Medicare and Medicaid  
Services

### CHAC Liaison Representative Present

Mr. Douglas Brooks  
Presidential Advisory Council on HIV/AIDS

## **CHAC Designated Federal Officials**

Dr. Laura Cheever  
HRSA/HAB Associate Administrator

Dr. Jonathan Mermin  
CDC/NCHHSTP Director

## **Federal Agency Representatives**

Dr. Sylvia Trent Adams  
Dr. Barbara Aranda-Naranjo  
Dr. Jose Aulay  
Ms. Cristina Batt  
Ms. Jewel Bazilio  
Mr. Geoff Beckett  
Dr. Stuart Berman  
Ms. Kim Brown  
CAPT Philip Budashewitz  
Dr. Kenneth Castro  
Ms. Janet Cleveland  
Mr. Gary Cook  
Ms. Erin Corriveau  
Mr. Jason Crow  
Dr. Hazel Dean  
Dr. Rupali Doshi  
Ms. Cherrie Dowdell  
Dr. Wayne Duffus  
Ms. Teresa Durden  
Ms. Gala Edwards  
Ms. Lori Elmore  
Dr. Jennifer Fiedeholtz  
Mr. Andrew Forsyth  
Ms. Demetria Gardner  
Ms. Shelley Gordon  
Ms. Yvonne Green  
Dr. Cynde Grubbs  
Ms. Melissa Harris  
Ms. Heather Hauck  
Dr. Deborah Parham Hopson  
Ms. Karen Ingvoldstad  
Ms. Andrea Jackson  
Ms. Amanda Jones  
Dr. Amy Lansky

Ms. Alice Litwinowicz  
Mr. Everett Lott  
Ms. Faye Malitz  
Ms. Kristen Mangold  
Ms. Tracy Matthews  
Dr. John Moore  
Dr. Jose (Rafi) Morales  
Dr. Robert Nolte  
Mr. Harold Phillips  
Ms. Amy Pulver  
Ms. Brittany Rizek  
Dr. Polly Ross  
Ms. Amy Schachner  
Ms. Margie Scott-Cseh  
Dr. Rebecca Slifkin  
Dr. Rene Sterling  
Ms. Caroline Talev  
Ms. Jewel Vavilio  
Ms. Abigail Viall  
Ms. Candace Webb  
Ms. Lynn Wegman  
Mr. David Whittier  
Dr. Pascale Wortley  
Mr. Steve Young

## **Members of the Public**

Mr. Nathan Danskey  
HIV Medicine Association

Ms. Lindsey Dawson  
The AIDS Institute

Mr. William Garrett  
AIDS Institute, New York State Department  
of Health

Ms. Kate Heyer  
National Association of County and City  
Health Officials

Mr. Jeremiah Johnson  
Treatment Action Group

Ms. Meghan Lawson  
Cepheid

Ms. Ann Lefert  
National Alliance of State and Territorial  
AIDS Directors

Mr. Oscar Mairena  
National Alliance of State and Territorial  
AIDS Directors

Ms. Emily McCloskey  
National Alliance of State and Territorial  
AIDS Directors

Ms. Kimberly Miller  
HIV Medicine Association  
Ms. Sonji Miller  
Lawndale Christian Health Center

Ms. Pellavi Sharma  
Planned Parenthood Federation of America

Ms. Dea Varsovczky  
Urban Coalition for HIV/AIDS Prevention  
Services

Ms. Bridget Verrette  
The AIDS Institute

Ms. Vera Wakovchenko  
VA New England Healthcare System

Ms. Andrea Weddle  
HIV Medicine Association

Ms. Isha Weerasinghe  
Association of Asian Pacific Community  
Health Organizations



## Glossary of Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETCs	AIDS Education and Training Centers
ARV	Antiretroviral
BCRS	Bureau of Clinician Recruitment and Service
BHPr	Bureau of Health Professions
BPHC	Bureau of Primary Health Care
CACO	Certified Application Counselor Organization
CBA	Capacity Building Assistance
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CHCs	Community Health Centers
CHIP	Children's Health Insurance Program
CHNAs	Community Health Needs Assessments
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CoAg	Cooperative Agreement
DASH	Division of Adolescent and School Health
DFO	Designated Federal Official
DHAP	Division of HIV/AIDS Prevention
DSTDp	Division of STD Prevention
DVH	Division of Viral Hepatitis
EHBs	Essential Health Benefits
EHRs	Electronic Health Records
FOA	Funding Opportunity Announcement
FPL	Federal Poverty Level
FQHCs	Federally Qualified Health Centers
FTEs	Full-Time Equivalent

HAB	HIV/AIDS Bureau
HAV	Hepatitis A Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HPSAs	Health Professional Shortage Areas
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
IRS	Internal Revenue Service
LGBT	Lesbian/Gay/Bisexual/Transgender
LRP	Loan Repayment Program
MSM	Men Who Have Sex With Men
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NHAS	National HIV/AIDS Strategy
NHSC	National Health Service Corps
NIH	National Institutes of Health
OMB	Office of Management and Budget
PACHA	Presidential Advisory Council on HIV/AIDS
PCMHs	Patient-Centered Medical Homes
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
PwP; PwPLWH	Prevention with Positives; Prevention with Persons Living with HIV
RFR	Rapid Feedback Report
RWHAP	Ryan White HIV/AIDS Program
S2S	Student to Service
SAMHSA	Substance Abuse and Mental Health Service Administration
SPNS	Special Projects of National Significance
TA	Technical Assistance
TB	Tuberculosis
THC	Teaching Health Centers
UDS	Uniform Data System
USPSTF	U.S. Preventive Services Task Force