

**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 4-5, 2015**

DRAFT Record of the Proceedings

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**CDC/HRSA ADVISORY COMMITTEE ON
HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT
November 4-5, 2015**

DRAFT 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 a virtual meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) on November 4-5, 2015.

CHAC is a Federal Advisory Committee that 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.

Information for the public to attend the virtual CHAC meeting via webinar or teleconference was published in the *Federal Register* in accordance with Federal Advisory Committee Act regulations. All sessions of the meeting were open to the public (*Attachment 1: Participants' Directory*).

Opening Session: November 4, 2015

Laura Cheever, MD, ScM

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

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were in attendance. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. She reminded the CHAC voting members of their responsibility to disclose any potential individual and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters.

CONFLICT OF INTEREST DISCLOSURES	
CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Bruce Agins, MD, MPH (New York State Department of Health)	Recipient of CDC and HRSA grants
Peter Byrd (Peer Educator and Advocate)	No conflicts disclosed
Virginia Caine, MD (Marion County, Indianapolis Public Health Department)	No conflicts disclosed
Guillermo Chacon (Latino Commission on AIDS)	Recipient of federal funding from CDC; member of HIV advisory committees for Gilead Sciences, Janssen Pharmaceuticals, Merck and ViiV Healthcare; member of the New York State AIDS Advisory Council; member of or advisor to multiple community-based organizations and special programs (e.g., AIDSvU)
Kathleen Clanon, MD (Alameda County, Oakland Medical Center)	No conflicts disclosed
Angelique Croasdale, MA (City of Hartford, Connecticut Department of Health and Human Services)	No conflicts disclosed
Dawn Fukuda, ScM (Massachusetts Department of Public Health)	Recipient of federal funding from CDC and HRSA
Debra Hauser, MPH (Advocates for Youth)	Recipient of federal funding from the HHS Office of Adolescent Health and CDC; member of the Trojan Sexual Health Advisory Council
Marjorie Hill, PhD (Joseph Addabbo Family Health Center)	No conflicts disclosed
Jennifer Kates, PhD (Kaiser Family Foundation)	No conflicts disclosed
Amy Leonard, MPH (Legacy Community Health Services)	No conflicts disclosed

Dr. Cheever confirmed that the 20 voting members and *ex-officio* members (or their alternates) in attendance constituted a quorum for CHAC to conduct its business on November 4, 2015. She called the proceedings to order at 10:07 a.m. and welcomed the participants to the 25th biannual CHAC meeting.

Dr. Cheever highlighted the permanent and temporary changes to CHAC's membership in terms of HRSA appointees.

- Drs. Kathleen Clanon, Steven Johnson and Britt Rios-Ellis are attending their last CHAC meetings due to the expiration of their terms.
- Mr. Peter Byrd is a newly-appointed member who is attending his first CHAC meeting. He is a peer educator and advocate based out of Douglasville, Georgia.
- Dr. Melinda Campopiano is the new CHAC *ex-officio* member for the Substance Abuse and Mental Health Services Administration (SAMHSA). She is Branch Chief of the Division of Pharmacologic Therapies in the SAMHSA Center for Substance Abuse Treatment.
- Dr. Madeleine Shea (Deputy Director of the Centers for Medicare & Medicaid Services (CMS) Office of Minority Health) and Mr. Brandon Wilson (Center for Medicare & Medicaid Innovation) are serving as alternate *ex-officio* members for CMS in the absence of Dr. Stephen Cha.
- Ms. Caroline Talev is serving as the alternate *ex-officio* member for the HHS Office of HIV/AIDS and Infectious Disease Policy in the absence of Ms. Kaye Hayes.

The participants joined Dr. Cheever in welcoming the new CHAC member, *ex-officio* member and alternates to the meeting.

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 Officer, CDC

Dr. Mermin also welcomed the participants to the meeting. He highlighted the changes to CHAC's membership in terms of CDC appointees.

- Dr. Marjorie Hill is attending her last meeting as a CHAC member due to the expiration of her term.
- Dr. Camilla Graham was a newly-appointed member who attended her first meeting in May 2015. However, she recently resigned from CHAC due to changes in her work schedule and potential conflicts of interest.
- NCHHSTP submitted a final nomination package to the CDC Committee Management Office on October 19, 2015 to replace Drs. Hill and Graham.

The participants joined Dr. Mermin in thanking Dr. Graham for the valuable input she provided during the May 2015 meeting to improve the hepatitis C virus (HCV) Care Continuum for patients. The participants also joined Dr. Mermin in commending Dr. Hill for her tremendous contributions and outstanding service to CHAC during her tenure.

Kathleen Clanon, MD, CHAC Co-Chair

Medical Director

Alameda County Health Care Services Agency

Dr. Clanon also extended her welcome to the participants. She reminded CHAC that during the interim teleconference meeting on July 28, 2015, Ms. Antigone Dempsey, Director of the HAB Division of Policy and Data, presented an overview of CHAC's roles and responsibilities. CHAC was informed of two major processes to advise the federal agencies.

First, individual members can provide immediate feedback during meetings in real time in response to the agencies' presentations and requests for input on specific topics. Second, the full CHAC membership can draft and formally vote to approve resolutions/recommendations to be submitted to the HHS Secretary, CDC Director and/or HRSA Administrator for action. Dr. Clanon thanked CHAC for continuing to provide HHS, CDC and HRSA with excellent guidance to improve the health of the nation, particularly in the context of HIV, viral hepatitis and STD prevention, treatment and care.

Dawn Fukuda, ScM, CHAC Co-Chair

Director, Office of HIV/AIDS

Massachusetts Department of Public Health

Ms. Fukuda joined her colleagues in welcoming the participants to the meeting. She was pleased to note that the agenda directly reflected CHAC's requests to CDC and HRSA on specific presentations and updates. She concluded the opening session by reviewing the updates, panel presentation, CHAC workgroup reports and other topics that would be presented during the meeting.

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 Officer, CDC

Dr. Mermin covered the following topics in his Director's report to CHAC. At the agency level, CDC is operating under a short-term continuing resolution through December 11, 2015. Of CDC's total request of \$7 billion in the FY2016 President's budget, the NCHHSTP budget request is ~\$1.2 billion and reflects \$44 million above the FY2015 enacted level.

At the National Center level, NCHHSTP will allocate funds to its programmatic areas in the following amounts if the FY2016 budget request of ~\$1.2 billion is approved: domestic HIV/ AIDS prevention and research for both adult and adolescent populations (\$799 million), STDs (\$157 million), tuberculosis (TB) (\$142 million), and viral hepatitis (\$63 million).

NCHHSTP is continuing its joint investigation with the Indiana State Department of Health in response to the HIV/HCV outbreak that occurred among persons who inject drugs (PWID) in a small, rural community in the southeastern part of the state. Of the total population of 4,200 persons, >180 had HIV. Of the HIV-infected cohort, >90% were co-infected with HCV. The investigation found that the HCV infections were associated with oxymorphone injections and consumption of oral opioids. Phylogenetic analyses and the testing of specimens determined that virtually all of the HIV infections were recently acquired in the past six months. The presence of multiple clusters of HCV infections indicated that the virus had been introduced to the community over the past several years.

Several activities were conducted to address the HIV/HCV outbreak in Indiana. The Adams study was published in the *New England Journal of Medicine* in October 2015 to document the full "diagnosis/epidemic" curve of the HIV outbreak in Indiana from November 16, 2014 to July 16, 2015. NCHHSTP established a temporary emergency operations center (EOC) at National Center, state and community levels to streamline communications, coordinate logistics, and rapidly assign tasks to 90 staff throughout CDC and disease intervention specialists (DISs) in the field.

The temporary EOC infrastructure enabled a rapid and cohesive response to the outbreak and allowed NCHHSTP and its partners to launch a number of important activities: perform contract tracing of persons with exposure to HIV- and/or HCV-infected individuals in the community; develop a data management system to collect and process epidemiologic data; provide technical assistance (TA) on testing and treatment; and conduct research on specific factors that contributed to the outbreak. NCHHSTP closed the EOC in June 2015, but is continuing to provide TA and expertise to Indiana on an ad hoc basis.

NCHHSTP's preliminary research showed that the population of adult PWID in Indiana was extremely high and accounted for 8%-15% of the small community of only 4,200 persons. Moreover, injection drug use (IDU) was reported across multiple generations in a single family. Several factors were found to contribute to the rapid spread of HIV in the community:

- a poor, isolated community with closed networks and limited ability to travel;

- no access to sterile injection equipment;
- oxymorphone injections of up to 10 times per day per individual due to the short half-life of the drug;
- minimal knowledge and understanding of the potential to transmit infectious agents during IDU; and
- one of the lowest levels of economic prosperity and other health indicators compared to other counties in the state.

The state health department implemented several new initiatives in the community as a result of the outbreak, such as ongoing treatment for HIV/HCV, medication-assisted and other drug treatment therapies, and access to sterile injection equipment through syringe service programs.

NCHHSTP updated its Atlas (<http://www.cdc.gov/nchhstp/atlas/index.htm>) with 2013 data for HIV, STD and TB; county-level and origin of birth data for TB; county-level data for all infections except HCV; and an advanced query option to conduct more in-depth searches of the data and perform more complex statistical analyses. The new advanced query will allow users to generate customized tables and produce data for multiple states, counties, years and subpopulations.

NCHHSTP will release the *National HIV Prevention Progress Report, 2015* and the *State HIV Prevention Progress Report, 2010-2013* on December 6, 2015. The reports are based on existing HIV indicators, but will be aligned with the 2020 National HIV/AIDS Strategy (NHAS). The National HIV Progress Report documents both progress and persistent challenges. For example, improved knowledge of serostatus and linkage to care were highlighted as major successes. Condom-less sex with HIV-discordant partners among men who have sex with men (MSM) was noted as an ongoing challenge.

The State HIV Progress Report demonstrates that national HIV prevention goals can be achieved, particularly since one or more states met the 2015 targets. Moreover, five states already have met the 2020 NHAS goal of $\geq 90\%$ of persons living with HIV (PLWH) knowing their status. However, progress in other areas is inequitable across states. While $>50\%$ of states reported improvements in six of the 11 indicators, large disparities persist in various populations. For example, 24 states do not have complete CD4 count and viral load laboratory reporting.

NCHHSTP recognizes that the lack of laboratory data reporting limits the ability in the field to monitor success in the HIV Care Continuum and effectively use surveillance data to reengage individuals in beneficial services. The data also showed that residence in a particular state versus another can increase the likelihood of an individual dying from HIV infection by ≥ 2 -fold. During the May 2016 meeting, briefings and other events with stakeholders, NCHHSTP intends to solicit guidance from CHAC regarding strategies to address challenges described in the National and State HIV Progress Reports.

NCHHSTP will convene the National HIV Prevention Conference on December 6-9, 2015 in Atlanta. The theme of the conference will be “*Accelerating Progress. Prevent Infections. Strengthen Care. Reduce Disparities.*” A VitalSigns™ report on pre-exposure prophylaxis (PrEP) will be published in recognition of World AIDS Day on December 1, 2015. An STD surveillance report will be released in the near future.

At the division level, the Division of HIV/AIDS Prevention (DHAP) awarded a \$216 million cooperative agreement (CoAg) to 90 community-based organizations (CBOs) across the country. Over the five-year project period, the CBOs will deliver high-impact HIV prevention strategies to four key populations: persons of color, MSM, transgender individuals and PWID. The CBOs will design a new generation of medical and behavioral interventions to prevent new cases in the HIV-negative subgroup and reduce the transmission of infection and increase viral load suppression rates in the HIV-positive subgroup.

DHAP published a report, *Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection*, that highlighted key findings of the Medical Monitoring Project (MMP). MMP is a nationally representative survey of clinical and behavioral characters of HIV-positive persons in medical care. The report includes 2012 data collected from 23 project areas and estimated that 94% of HIV patients who are enrolled in care are taking antiretroviral therapy (ART) at this time.

DHAP launched the “Every Dose Every Day” online toolkit and application to improve medication adherence. The toolkit includes training and other resources for nurses, clinical social workers, HIV case managers, health educators, patient navigators and peers to assess, manage and support medication adherence of their patients. The mobile application helps patients to track adherence, monitor their viral load and CD4 counts, remember dosage amounts and appointments, and rapidly access helpful health tips. The toolkit is available on the CDC.gov website:

<https://effectiveinterventions.cdc.gov/HighImpactPrevention/BiomedicalInterventions/MedicationAdherence.aspx>.

The Division of Adolescent and School Health (DASH) presented a CDC Public Health Grand Rounds on Adolescence, “Preparing for Lifelong Health and Wellness.” The webcast of the grand rounds is available for viewing (<http://www.cdc.gov/cdcgrandrounds>). DASH also launched the mobile-friendly “Healthy Youth” website and released a fact sheet, *Bullying and Absenteeism: Information for State and Local Education Agencies*. The fact sheet emphasized that 16% of bullied students missed one or more days of school in the past 30 days due to safety concerns.

The Division of Viral Hepatitis (DVH) and the Viral Hepatitis Action Coalition co-hosted the “Stopping the Hepatitis C Virus Epidemic Among Young Persons Who Inject Drugs” Summit in Atlanta (www.viralhepatitisaction.org). A panel of experts from DVH, other federal agencies, state/local health departments and academia identified priority surveillance, research and

prevention strategies. The video and presentations of the summit that are available online highlighted potential opportunities to reach young PWID through modeling exercises, described challenges in diagnosing HCV in this population, and proposed approaches to increase access to care and a cure.

DVH participated in an event in October 2015 that launched activities in Oklahoma to eliminate HCV in the Cherokee Nation. The event served as the first initiative to explicitly focus on eliminating HCV in all persons in a U.S. community. DVH provided technical support to the country of Georgia for an external Hepatitis Technical Advisory Group on November 3-4, 2015. The overarching purpose of this effort is to identify key HCV prevention and control strategies and elimination goals due to the disproportionate impact of HCV in the country of Georgia.

DVH and the HHS Office of Minority Health commissioned the Institute of Medicine (IOM) to determine the feasibility of achieving hepatitis B virus (HBV) and HCV elimination goals in the United States. The IOM will examine scientific and policy issues related to the prevention, detection, control and management of HBV and HCV. DVH co-authored publications that presented updated estimates of the number of persons living with viral hepatitis in the United States, maps to illustrate states with Medicaid restrictions for HCV treatment, and data on HCV mortality trends.

The Division of STD Prevention (DSTDP) published the 2015 *Sexually Transmitted Diseases Treatment Guidelines*. The guidelines are the most widely used reference source of the treatment and management of STDs in the United States. The guidelines cover new diagnostic, treatment and prevention recommendations, including alternative treatment regimens for gonorrhea. This resource includes an updated pocket guide, wall chart and Apple version of the guidelines that can be downloaded.

DSTDP, the Public Health Accreditation Board, National Association of County and City Health Officials (NACCHO) and National Coalition of STD Directors (NCSD) co-hosted a webinar on the DIS Certification Project (www.cdc.gov/std/training/webinars.htm). This CDC-funded project supports DIS activities by considering various certification model options and the administration and management of a national DIS certification program.

DSTDP published “Notes from the Field” on October 15, 2015 related to 15 ocular syphilis cases that were reported by California and Washington in 2014-2015. After the publication of the advisory, other states reported their ongoing investigations of >150 ocular syphilis cases. HIV-positive MSM accounted for the vast majority of cases, but other cases have been reported in HIV-negative heterosexual men and women. Some of the cases have resulted in permanent blindness and other serious sequelae.

The Division of Tuberculosis Elimination (DTBE) released *Reported Tuberculosis in the United States, 2014* (www.cdc.gov/tb/statistics/reports/2014/default.htm). Although the 9,421 TB cases

reported to CDC in 2014 represented a 1.5% decrease from 2013, the decline was the smallest in more than 10 years. The 6% of HIV-positive persons with TB in 2014 represented a 7% decrease from 2011 and a 48% decrease since 1993. DTBE released a new online course, *Interactive Core Curriculum on Tuberculosis: What the Clinician Should Know* (www.cdc.gov/tb/webcourses/Course/mainmenu/index.html).

Update by the HRSA Acting Administrator

James Macrae, MA, MPP

Acting Administrator

Health Resources and Services Administration

Mr. Macrae noted that the 25th anniversary of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provided HRSA with an opportunity to reflect on the significant accomplishments and progress of the Ryan White HIV/AIDS Program (RWHAP) and identify new directions for the future. Most notably, other parts of HRSA outside of HAB are being urged to be more extensively engaged in RWHAP activities.

Mr. Macrae announced that HRSA's updated Strategic Plan is available on the HRSA.gov website and highlights five priority goals for the agency.

1. **Increase access to quality health care.** HRSA established goal 1 to enroll more persons in care, ensure the delivery of high-quality care, and improve the health status of all persons who receive care. HRSA has made tremendous progress in goal 1 over time. Recent HAB data show that RWHAP serves ~56% of persons who are diagnosed with HIV, retains ~81% of clients in HIV care, and has contributed to 78% of clients achieving viral load suppression. Other data from the Bureau of Primary Health Care show that 77% of persons who are diagnosed with HIV return to Health Centers to enroll in care within 90 days. HRSA is exploring a number of strategies to make further progress on goal 1. The number of persons who receive HIV testing and screening services in Health Centers will be increased. Surveillance data and reports will be better utilized to proactively target HRSA's resources and efforts to underserved communities prior to an event, such as the recent outbreak of HCV/HIV co-infection among PWID in a rural Indiana community. The latest evidence-based practices will be applied to improve HIV, viral hepatitis and STD prevention, treatment and health outcomes of persons. Interagency efforts with CDC will be enhanced to increase PrEP uptake in Ryan White clinics and other HRSA-funded care programs.
2. **Strengthen the healthcare workforce.** HRSA established goal 2 to strengthen the focus on the delivery of primary care to underserved communities and vulnerable populations

through incentives. HRSA will continue to use its National Health Service Corps to provide training and workforce development, but more emphasis will be placed on team-based and integrated care as well as the dissemination of training information.

3. **Build healthy communities.** HRSA established goal 3 to foster rigorous data collection to demonstrate impact and conduct quality improvement initiatives. HRSA has made significant progress over time in gathering client-level data, but more emphasis will be placed on collecting population-level data for the broader community. HRSA will leverage CDC's expertise to expand client-level clinical data to address population health and effectively apply population health data in its funded clinical settings.
4. **Reduce health disparities.** HRSA established goal 4 to expand the focus on racial/ethnic disparities in HIV, viral hepatitis and STDs to include geographic, income, cultural and language disparities. HRSA will target its disparities efforts to ensure that important subpopulations are not overlooked and gaps in health outcomes are narrowed.
5. **Strengthen internal operations and management.** HRSA established goal 5 to directly address stakeholder feedback that was submitted in response to a recent survey. Based on the survey results, HRSA will build on its existing successes, address areas of improvement, and shift to new or innovative approaches.

Mr. Macrae noted that internal and external partnerships to demonstrate impact are a cross-cutting theme in all five agency-wide priority goals. In addition to implementing its updated Strategic Plan, HRSA also is responding to a request by the HHS Secretary to obtain input on the impact of the Affordable Care Act (ACA) on HIV, hepatitis and STD programs in the field. Most notably, extensive outreach to ensure that eligible persons are enrolled in ACA to meet their healthcare needs continues to be a high priority for the HHS Secretary.

HRSA is interested in obtaining feedback from CHAC in two areas to inform its response to the HHS Secretary. First, ACA will be used as a mechanism to change the healthcare delivery system by shifting from a "volume-based" approach in terms of the number of clinical visits to a "team-based approach" that emphasizes quality, value and population health. Second, health information technology (HIT) will play a key role in broader dissemination of data to providers and patients to have a more significant impact on care.

Mr. Macrae concluded his update by thanking CHAC in advance for providing advice to the HHS Secretary on the impact of ACA. He also thanked the members for continuing to contribute their expertise to improve HRSA's treatment and care programs and strengthen its partnership with CDC in prevention efforts. He confirmed that HRSA will continue to consider and incorporate CHAC's guidance into its programmatic decision-making.

HRSA/HAB Associate Administrator's Report

Laura Cheever, MD, ScM

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

Dr. Cheever covered the following topics in her Associate Administrator's report to CHAC. Several events, initiatives and products were launched in August 2015 to commemorate the 25th anniversary of the Ryan White CARE Act:

- A White House ceremony and letter from President Obama
- New webpage (<http://hab.hrsa.gov/ryanwhite25>)
- New branding: "Moving Forward with CARE: Building on 25 Years of Passion, Purpose and Excellence"
- Infographic
- HHS press release
- Twitter chat and social media promotional events
- Videos featuring RWHAP grantees
- 4 blog posts from the White House and AIDS.gov
- Special 25th anniversary track during the U.S. Conference on AIDS

HAB recently released 2010-2014 Ryan White Services Report (RSR) data. The retention in care rate slightly decreased from 82.1% in 2010 to 80.4% in 2014. The viral load suppression rate dramatically increased from 69.5% in 2010 to 81.6% in 2014, but significant regional disparities need to be addressed. However, HAB acknowledges that the largest gains in RWHAP will be to increase the number of persons outside of HRSA clinical settings who are diagnosed, linked to care, and re-enrolled/newly enrolled in care.

The HAB website (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>) is continually being updated with policy clarification notices to grantees on various topics:

- RWHAP and reconciliation of advance premium tax credits under ACA
- Treatment of costs under the 10% administrative cap for RWHAP Parts A, B, C and D
- Clinical quality management
- RWHAP and program income
- Utilization and reporting of pharmaceutical rebates
- Update on the provision of services for Armed Forces veterans
- Updated service definitions

HAB is addressing its FY2016 priorities at this time. HRSA and other federal agencies will operate under a continuing resolution until December 11, 2015. RWHAP will continue to be integrated into the new healthcare landscape. The 2020 NHAS will be implemented with a focus on the greatest health disparities and the HIV Care Continuum. The White House will release the NHAS Action Plan on World AIDS Day.

New partnerships will be established (e.g., U.S. Social Security Administration) and existing collaborations will be enhanced (e.g., CDC, CMS and SAMHSA) to expand the reach of RWHAP. Advancements will be made in data utilization to improve health outcomes. HRSA's national and international leadership will be strengthened to promote RWHAP's important public health role in care and treatment to improve population health. HAB's internal operations will be improved with a stronger focus on customer service, including its routine interactions with CDC grantees to ensure a seamless transition across HIV prevention and care. For example, HAB and CDC recently released integrated planning documents for its grantees.

HAB is proud to announce that its former Deputy Associate Administrator, Dr. Sylvia Trent Adams, was sworn in as the Deputy Surgeon General of the U.S. Public Health Service (USPHS) in October 2015. Dr. Letitia Robinson is serving as HAB's Acting Deputy Associate Administrator and Ms. Ruth Roman is serving as HAB's Senior Advisor. Other changes in HAB's leadership include new division and branch appointments: Midwestern and Northeastern Branch Chiefs (Ms. Mindy Golatt and LCDR Shaun Chapman); Senior Advisor of the Division of Policy and Data (Ms. Tanchica Terry); Data Management Branch Chief (Mr. Vimal Rao); and HIV Education Branch Chief (Ms. Sherrillyn Crooks).

The HAB Division of HIV/AIDS Training and Capacity Development was reorganized as a new office with two divisions and four branches to enhance programmatic capacity and expand global activities. The Division of Global Programs houses the Data, Quality and Evaluation Branch and the Health Systems Strengthening Branch. The Division of Domestic Program houses the HIV Education Branch and Demonstrations Branch. HRSA staff will relocate to new offices at 5600 Fishers Lane in Rockville, Maryland at the end of November 2015.

HAB convened a staff retreat to specifically discuss the 11 steps and 37 actions in the 2020 NHAS that focus on key populations, priority areas and practices. HAB staff devoted a considerable amount of time during the retreat on the 2020 NHAS goal that emphasizes the availability of PrEP. To achieve this goal, HRSA will lead an agency-wide effort to explore strategies for its programs to build capacity in increasing PrEP utilization in the United States. HRSA also will collaborate with CDC on broadcasting informational PrEP webcasts to its providers.

HAB acknowledges that RWHAP funds are mandated for the care and treatment of HIV-positive persons and cannot be used to directly pay for PrEP prevention services for HIV-negative persons. However, RWHAP's existing expertise and systems can be leveraged to support PrEP uptake, including the AIDS Drug Assistance Program (ADAP) infrastructure, a "Clinician's PrEP

Line” for clinical training, AIDS Education and Training Centers (AETCs) for TA, and provider expertise in HIV antiviral treatment.

The 15th Ryan White HIV/AIDS AETC Program Clinical Care Conference will be held in New Orleans, Louisiana on December 15-17, 2015. The conference will include presentations on the latest state-of-the-art research, care and treatment and also will serve as a unique opportunity for RWHAP providers to interact with their peers. The AETC Program will convene the next clinical conference in December 2016.

HAB launched several initiatives for all RWHAP stakeholders to achieve specific goals and priorities. HAB requested feedback on two questions to ensure success in these areas: (1) What strategies can HAB better implement to support RWHAP recipients in their efforts to achieve viral load suppression of PLWH? (2) What actions can HAB take to better align finite resources with these goals? HAB is aware that increasing the role of community health workers in the field and promoting the leadership of PLWH in terms of planning RWHAP activities will be critical for stakeholders to accomplish these goals.

HAB recently convened technical expert panels to address trauma and HIV care, improved care for youth living with HIV, and improved care for women living with HIV. Reports by the panels currently are undergoing the HRSA clearance process and should be released in the near future. HAB’s recent publication of a report on HIV in youth is available on its website. HAB funded two new Special Projects of National Significance (SPNS) in 2015: (1) *Use of Social Media to Improve Engagement, Retention and Health Outcomes Along the HIV Care Continuum* and (2) *Dissemination of Evidence-Informed Interventions to Improve Health Outcomes Along the HIV Care Continuum*.

HAB funded two new studies to determine the impact of ACA on RWHAP. *Emerging Issues Related to Affordable Care Act Implementation-The Future of Ryan White Services: A Snapshot of Outpatient Ambulatory Care* was completed in September 2015 and will be presented to CHAC during the meeting. *Ryan White HIV/AIDS Program Outcomes Within the Context of the Affordable Care Act* will be completed in September 2017.

HAB contracted Leonard Resource Group to convene the 2016 RWHAP All-Grantee meeting to continue to provide TA and peer-to-peer training. Planning efforts were initiated in October 2015. Up-to-date information will be available at <http://ryanwhite2016.org>.

CHAC DISCUSSION: CDC AND HRSA UPDATES

CHAC requested additional details on the following topics during the question/answer session with Dr. Cheever, Mr. Macrae and Dr. Mermin.

- CDC’s plans to address states that do not report chronic and/or acute HCV cases.

- HRSA's new initiatives, studies and other strategies to reach and engage persons who are at high risk for HIV, but are outside of the healthcare delivery system (e.g., youth, young IDUs and black MSM (BMSM)).
- HRSA's stronger focus on customer service, utilization of a team-based approach, and tailored strategies in HIV clinical settings to increase the retention rate of clients from 80% to 90%, particularly in youth populations.
- HRSA's efforts to collect follow-up data to determine whether the 20% of RWHAP clients who are not retained in care receive ART from other sources (e.g., comprehensive HIV care from other jurisdictions, private providers or correctional institutions).
- Plans by CDC and HRSA to target additional funding to epidemiologists, surveillance staff and other data collection experts to achieve engagement and retention in HIV care goals.

Ms. Fukuda announced that she and Dr. Clanon received a response to CHAC's letter to CDC and HRSA leadership regarding the need for enhanced data collection processes for young persons who are vulnerable to infectious diseases. The letter was distributed to CHAC for review.

Ms. Fukuda highlighted key points from the CDC and HRSA updates for CHAC to consider formalizing as additional recommendations to the agencies.

- HRSA's priority goal to shift from a narrow clinical client-level approach to a broader population health approach that will allow states and local jurisdictions to better utilize federal data to improve prevention, treatment and care.
- HRSA's stronger emphasis on ACA to improve clinical interactions with both insured and uninsured clients.
- The critical need for CDC and HRSA to promote PrEP as a treatment as prevention strategy.
- HRSA's approaches to improve health outcomes along the HIV Care Continuum, including engagement and retention in care and viral load suppression of vulnerable populations.
- New opportunities to further maximize synergies between CDC and HRSA in terms of prevention, care and treatment of HIV, viral hepatitis and STDs.

CHAC commended CDC and HRSA for the extraordinary number of activities and studies that have been conducted in a short period of time to further advance the prevention and treatment of HIV, viral hepatitis and STDs. Several members noted that epidemiology and surveillance staff in HRSA-funded health departments typically are viewed as administrative staff rather than personnel with a direct role in public health interventions and services. CHAC advised HRSA to reclassify funded personnel that directly interact with DIS, epidemiology and surveillance staff to acknowledge their key role in advancing service models in jurisdictions.

Overview of the HRSA HIV Clinical Workforce Study

CAPT Letitia Robinson, PhD, RN

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

Advice Requested from CHAC by HAB:

1. What is CHAC's feedback in three key areas: (1) overall input on findings of the HIV Clinical Workforce Study; (2) recommendations for further research; and (3) guidance to develop policy and program responses to ensure that PLWH continue to access quality care?

Dr. Robinson presented an overview of the HRSA HIV Clinical Workforce Study. HRSA contracted Mathematica Policy Research to conduct the study from 2010-2013. The objectives of the study were two-fold: (1) estimate the number of clinicians who provide HIV-related medical services in the United States and (2) forecast the magnitude of the expected HIV clinician shortage. The study was designed to answer five key research questions.

1. What is the number of clinicians who provided HIV care in RWHAP and non-RWHAP settings?
2. What is the demographic and professional characteristics of these clinicians?
3. What is the market demand and need for HIV-related medical services?
4. Does the supply of and demand for HIV clinicians vary by region?
5. What factors influence the supply of HIV clinicians as well as the demand and need for HIV-related medical services?

A workforce survey was developed to assess and project the supply of HIV clinicians at sites based on specific parameters, such as the number of hours worked per week, the proportion of time spent on HIV care, and the number of HIV visits conducted within one hour. The findings of the study were based on an estimate of the number of services demanded, treatment patterns, and HIV prevalence as reported by CDC, state and local surveillance data.

HRSA acknowledged several limitations of the study. The supply projections were based on high-volume HIV providers, defined as those who treated ≥ 10 HIV patients, who were identified in medical claims in 2010. Claims data were based on electronic transmissions of pharmacy and medical claims and did not necessarily capture HIV clinicians who treated uninsured or indigent patients and undocumented immigrants.

Clinicians who treated < 10 patients and providers who did not bill for their services (e.g., physician assistants/nurse practitioners (PAs/NPs)) were excluded from the dataset. The market-based

demand projections did not account for changes in market conditions, such as ACA, changes in treatment patterns or unmet needs (e.g., persons with no HIV diagnosis and HIV-diagnosed persons who were not in care or did not receive optimal care).

The study was designed to determine the number of clinician visits based on the observed total number of medical visits that were provided under prevailing market conditions. The analysis only captured HIV-related medical visits with an HIV-related diagnosis code, including HIV as a secondary diagnosis; HIV testing and counseling visits were excluded. The number of visits included the overall number of persons diagnosed with HIV and the number of HIV-related visits per each diagnosed individual. The analysis captured both ambulatory and in-patient hospital visits. Ambulatory surveys included uninsured patients who were excluded from the medical claims dataset.

Of all ambulatory visits, 82% were identified based on a primary HIV diagnosis. A primary HIV diagnosis for in-patient visits was assumed to have been made during at least one daily visit from an HIV specialist. A secondary HIV diagnosis was assumed to have been made during at least one visit per hospitalization or discharge. Of ~56,000 primary care physicians/providers (PCPs), 5,000 were identified as infectious disease (ID) specialists who submitted at least one HIV-related claim in 2010. Of these providers, ~12% submitted HIV-related claims for ≥ 10 patients. Of patients with HIV-related claims that were submitted by PCPs, ~75% were treated by providers with ≥ 10 HIV-positive patients.

ID specialists were more likely to fall into a high-volume HIV category than PCPs. Of 5,000 ID specialists with at least one HIV-related claim, 53% submitted a claim for ≥ 10 patients. Of ~5,000 high-volume HIV clinicians who treated ≥ 10 patients and were included in the study, 55% were PCPs, 37% were ID specialists, and 8% were PAs/NPs. Although the management of HIV care in the United States is shared by multiple medical specialties and allied health professionals in the clinical workforce, a significant number of providers identified in the claims analysis who treated ≥ 10 HIV patients did not consider themselves as "HIV clinicians." These providers, particularly PCPs, reported spending <50% of direct patient care time on treating HIV.

Data were collected on the demographics of ~5,000 high-volume HIV clinicians who were included in the study: male (66%), ≥ 65 years of age (16%), white non-Hispanic (68%), and service provision in the South (~40%). The total number of HIV-related visits provided in 2010 by high-volume HIV clinicians was estimated at 5.1 million. Of these visits, PCPs accounted for ~45%, ID specialists accounted for ~40%, and PAs/NPs accounted for ~15%. PCPs and ID specialists had more HIV patient visits than PAs/NPs, but PAs/NPs reported spending more time on providing clinical care and treating HIV patients than their physician counterparts.

By age, the proportion of all HIV-related visits demanded in 2008 was persons 35-54 years of age (63%) and persons ≥ 55 years of age (15%). By gender, the proportion of all HIV-related visits demanded was males (67%) and females (33%). By race/ethnicity, the proportion of all HIV-

related visits demanded was black non-Hispanics (45%), white non-Hispanics (34%), and Hispanics (~18%). By geographic region, the proportion of all HIV-related visits demanded was the South (42%) and Northeast (28%).

Several assumptions and factors influenced projections of the number of HIV clinicians. Supply site factors included entry and attrition among clinicians and the demographic distribution of the HIV workforce due to entry, attrition and aging. Demand site factors included changing demographics, utilization patterns and medical services among PLWH. The incidence and mortality rates of PLWH as well as HIV service utilization rates per age group and gender were assumed to remain constant. However, the influencing factor of age might change the projections over time. For example, the rate of HIV visits might increase as the HIV patient population ages or might decrease as more young persons are diagnosed.

The study reported that ~150 new high-volume HIV clinicians entered the HIV workforce each year from 2005-2010. By specialty, ~38% were PCPs, 37% were ID specialists, and 25% were PAs/NPs. By gender, 57.3% were women. By age, 76% were <45 years of age. By race/ethnicity, >54.7% were white non-Hispanics, 11.3% were black non-Hispanics, and 9.3% were Hispanics.

Projections of the supply and demand of HIV visits are summarized as follows. The number of clinicians who manage HIV care was projected to decline by ~400 PCPs and ~200 ID specialists by 2015. The number of PAs/NPs who provide HIV care was projected to increase from 408 in 2010 to 511 in 2015. The total number of HIV visits supplied was projected to decrease from 5.1 million in 2010 to 4.8 million in 2015 (or a 6% reduction). PAs/NPs were projected to provide an increasing share of services for HIV care.

By attrition, the decrease in HIV visits primarily was attributed to the gap between a smaller number of new clinicians who are entering the workforce and a larger number of experienced clinicians who are leaving the workforce due to retirement, death or other factors. By gender, the shift to a larger population of women in the HIV clinical workforce was identified as a contributing factor to the decrease in HIV visits. The workforce survey showed that female clinicians in HIV medicine work 11% fewer hours than their male counterparts on average. By age, ID specialists were found to enter the field of HIV care at an older age than PCPs.

From 2010-2015, the number of new HIV cases was projected to increase by 140,000 and the total number of visits demanded was projected to increase by 14%. The growth in the number of visits demanded primarily was due to the steady increase in the number of newly diagnosed HIV infections and the low mortality rate among the current population of PLWH. The increase in the demand for visits largely was attributed to aging of the current HIV diagnosed population. Persons 45-54 years of age accounted for the vast majority of HIV-related visits.

The study projected that the total number of HIV clinicians supplied in the United States would decrease from ~1,800 in 2010 to ~1,700 in 2015 (or a reduction of ~5.5%). The total number of HIV clinicians demanded in the United States was projected to increase from 1,945 in 2010 to ~2,200 in 2015 (or an increase of ~14%). The shortage of ~133 HIV clinicians in the base year was projected to increase to a shortage of 500 clinicians in 2015. Low-volume PCPs should be considered as a source to expand the supply of HIV clinicians, particularly to reach patients who are new to or disengaged from care.

CHAC DISCUSSION: HIV CLINICAL WORKFORCE STUDY

CHAC commended HRSA for conducting a rich and robust study that will be extremely useful to national, state and local training programs in planning for and addressing important issues in the HIV clinical workforce. The members urged HRSA to contribute to the scientific literature by publishing the study in a peer-reviewed journal.

CHAC made several comments and suggestions in response to Dr. Robinson's request for input on the study findings and recommendations for further research.

- HRSA should expand the workforce study to analyze the role and efficacy of emerging co-management models, supportive structures and other innovative strategies that have been designed to fill gaps in clinical expertise. For example, Project Extension for Community Healthcare Outcomes (ECHO), warm-lines and tele-medicine initiatives are increasingly being used to address clinical challenges when experts are not immediately available.
- HRSA should conduct a follow-up study to model other factors that also play a critical role in the HIV clinical workforce, such as the health outcomes of patients and the impact of ACA.
- HRSA should broadly promote the pairing of experienced ID specialists with PCPs who are new to the field to narrow the gap in the HIV clinical workforce.
- HRSA should review the study data to determine the extent to which HIV care delivered by ID specialists, PCPs or ancillary members of a care team can be reimbursed in the context of both quality and volume of visits.
- HRSA should expand the study to determine the implications of gaps in the HIV clinical workforce on the broader public health workforce, particularly in ID specialties. For example, traditional HIV clinicians increasingly are expanding the provision of care and treatment to include HCV patients. Moreover, HIV clinicians typically are considered as experts in STD.

**PANEL PRESENTATION: HRSA ASSESSMENTS OF THE
RYAN WHITE HIV/AIDS PROGRAM AND AFFORDABLE CARE ACT**

A panel of guest speakers and HAB staff presented key findings from a HRSA-funded study to identify emerging issues related to ACA implementation; summarized a preliminary analysis of 2014 RSR data to determine the impact of ACA on RWHAP clients, services and clinical outcomes; and described the implications of ACA on STD clinics. The overviews are presented below.

Overview of the Affordable Care Act Implementation Study

Michael Costa, MPH

Senior Associate
Abt Associates

Advice Requested from CHAC by HAB:

1. What is CHAC's feedback in two key areas: (1) overall input on findings of the ACA Implementation Study and (2) recommendations to assist RWHAP providers in adapting to ACA implementation?

Mr. Costa presented an overview of the HRSA-funded special study, *Emerging Issues Related to Affordable Care Act Implementation-The Future of Ryan White Services: A Snapshot of Outpatient Ambulatory Medical Care (OAMC)*. HRSA charged Abt Associates with designing the study to assess three key areas.

- The current status of RWHAP services during the early stage (January-June 2014) and the later stage (July-December 2014) of ACA implementation.
- The extent to which RWHAP is positioned to improve clinical outcomes throughout the HIV Care Continuum, including viral suppression, retention in care and linkage to care services.
- Efforts of RWHAP providers to adapt to ACA implementation.

The study design included data collection on service provision, quality of care, barriers, gaps and challenges related to ACA implementation in 2014. The mixed-method study design included both qualitative and quantitative analyses. The qualitative analyses were based on in-person interviews with 30 RWHAP sites in June-July 2014 and follow-up telephone interviews with the same sites in February-March 2015. Grant application narratives also were reviewed and information on qualified health plan (QHP) benchmarks and Medicaid alternative benefit plans

were collected from state insurance departments, peer-reviewed publications and GRADE literature sources. The quantitative analyses were based on interview data as well as 2013 and preliminary 2014 RSR client-level data that accounted for ~44,000 HIV cases per year.

The sample was stratified to ensure the distribution of diverse types of RWHAP providers in the study.

Site Criteria	Site Selection
Medicaid expansion	<ul style="list-style-type: none"> • 18 sites in 10 Medicaid expansion states: Arizona, Arkansas, Colorado, Illinois, Maryland, Michigan, New Jersey, New Mexico, Oregon, Washington • 12 sites in 5 non-Medicaid expansion states: Alabama, Florida, Louisiana, New Hampshire, Texas
Prevalence	High-, mid- and low-prevalence sites (33%) Includes 4 sites in the CDC-funded Enhanced Comprehensive HIV Prevention Project (<i>i.e.</i> , the “12 Cities Project”)
Population density	Metropolitan, micropolitan and rural sites
Service provision by site	Number of RWHAP services (1 - 21) Types of RWHAP services: <ul style="list-style-type: none"> • Sites serving >50% of OAMC clients (23) • Sites serving <50% of OAMC clients (7)
Numbers of clients served by site	116 - 4,286
RWHAP funding source	Parts A and/or B funding (92%) Parts C and/or D funding (33%) Funding from both of the above categories (26%)

Key findings of the study are highlighted as follows. Some sites that successfully established billing agreements with managed care organizations (MCOs) and private insurers offering QHPs reported increased revenues. The increased revenues allowed these sites to expand staff and offer additional services by reprogramming the additional funds. Of all 30 study sites, three in Medicaid expansion (ME) states and one in the non-Medicaid expansion (NME) state of Texas noted that clients who gained insurance through MCOs and QHPs experienced increased access to both providers and services.

All sites noted that sustained RWHAP funding would be essential to maintaining the level and quality of care needed by RWHAP clients. RWHAP funding was credited at one site for being able to provide all services necessary to function as a patient-centered medical home for its HIV-positive clients. Sites with QHP-insured clients used RWHAP cost-sharing support services (e.g., ADAP and health insurance assistance) to support client premiums and deductibles. Clients at these sites would have been unable to maintain coverage without this support.

Nearly all 30 study sites reported an ability to continue to provide all RWHAP services as needed to newly-insured clients regardless of their insurance status or ability to meet cost-sharing requirements. However, one site reported its inability to provide non-urgent care to insured RWHAP-eligible clients without co-pays. The majority of sites reported increasing staff with the following positions to assist with client enrollment and new insurer requirements: case managers, benefits counselors, resource specialists, certified application counselors and billing specialists. New staff also was hired to assist with early intervention services, patient navigation services and mental health services.

Sites in six states noted that some clients experienced a disruption in care due to the difficulty of providers in obtaining contracts with insurers. These challenges included no contracts with insurers or contracts that designated HIV providers as specialty care providers rather than PCPs. Some sites, but not all, were able to ameliorate the impact. The study sites listed the top eight services that should be packaged as an essential set of RWHAP services: primary medical care, mental health services, substance abuse services, medication, case management, medical case management, oral health and transportation. Of all 30 study sites in both ME and NME states, six core services were reported as always being offered to newly-insured clients through an RWHAP-funded approach: medical case management, oral health, mental health, case management, nutritional assistance and transportation.

The 8.0% decrease in OAMC services at sites in ME states was statistically significant. However, this finding was determined to be obscure due to HRSA's broad definition of "OAMC," various interpretations of OAMC across sites, and services in the OAMC category that extend beyond those provided in a routine primary care office visit. Minimal changes were observed in other core medical services and support services. By site, the length of clinic visits for a full range of services varied from 15 minutes to 4 hours. By client profile, the median times of client visits ranged from 41-145 minutes: 45-240 minutes for new clients; 15-160 minutes for stable, virally suppressed clients; 30-180 minutes for unsuppressed, non-adherent clients; and 30-240 minutes for clients with multiple co-morbidities.

The average length of time greatly varied between a typically funded primary care visit (15 minutes) and an OAMC visit (47 minutes) with a range of 20-30 minutes to 45-90 minutes across sites. Variability in the length of time was due to the number and type of activities reported by different sites as part of an OAMC visit. The activities most often associated with longer OAMC visits were primary care treatment and screening/patient education. Denials of certain drugs for HIV, HCV and other conditions as well as high cost-sharing challenges continued to be reported throughout the first year of ACA implementation.

Despite fluctuations within sites, no statistically significant changes in the number of RWHAP clients were reported from 2013-2014 in either ME or NME states. Of all 30 study sites in both ME and NME states, 22 (or 73%) reported a reduction in the proportion of uninsured RWHAP clients and 17 (or 57%) reported an increase in Medicaid recipients. The 7% increase in the viral

suppression rate at sites in ME states was statistically significant (from 67% in 2013 to 71% in 2014). The 4% increase in the viral suppression rate at sites in NME states was not statistically significant (from 62% in 2013 to 64% in 2014).

Abt Associates reached several conclusions based on the study findings. RWHAP funding continues to be critical to ensure the care necessary to fill gaps in essential services for clients. The divergence of experience between ME and NME states likely will continue in the immediate future. RWHAP sites are successfully adapting to ACA, but a number of challenges persist.

RWHAP clients at some sites experienced fragmentation of care due to the lack of provider contracts with new insurers. Several sites have added additional insurance enrollment and billing staff. Fewer clients received OAMC services in ME states than in NME states after ACA implementation, but the reduction cannot be statistically distinguished from an overall downward trend in all states.

Abt Associates applied the study findings to provide HRSA with three key recommendations to further assist RWHAP providers in adapting to ACA implementation.

- The broad OAMC visit should be broken down into more specific categories.
 - Category 1: Include services that HRSA expects to be covered by insurers (e.g., diagnostic testing, preventive care and screening, examinations by practitioners, medical history intake, diagnosis and treatment).
 - Category 2: Include intensive OAMC activities, such as prescribing and managing of ART, education and counseling on health issues, care management of chronic HIV-related conditions, and referral/provision of specialty care (e.g., behavioral health and support needs).
 - Category 3: Include support for cost-sharing.
- Strategies should be implemented to provide training and TA to RWHAP grantees and providers to help maximize RWHAP services.
 - Flexible health insurance assistance and ADAP across services and medications
 - Appropriate reallocation of funds for services that currently are covered by insurance
 - Improved health insurance literacy for both providers and clients
 - Establishment of contracts with MCOs and Health Marketplace insurers, including billing by different levels of severity to account for longer site visits; contracting with MCOs and Health Marketplace insurers; designating RWHAP providers as PCPs; and obtaining authorizations for medications, services and testing
- Recording and reporting of RWHAP services should be better categorized.

Preliminary Analysis of HAB's 2014 Ryan White Services Report Data

Antigone Dempsey, MEd

Director, HAB Division of Policy and Data
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Advice Requested from CHAC by HAB:

1. What are CHAC's recommended next steps or additional analytic issues that HAB should consider?
2. What additional questions need to be answered to address the main goal of the analysis?
3. What is the impact of the analysis on the landscape of HIV care provision?

Ms. Dempsey, Dr. Klein and Mr. Milberg presented HAB's preliminary analysis of 2014 RSR data. The overarching goal of the analysis was to determine the impact of ACA on RWHAP and identify variations across the country, particularly those between ME and NME states. The analysis compared 2012-2013 RSR data pre-ACA implementation (*i.e.*, the baseline) and 2014 RSR data post-ACA implementation.

The key outcomes of interest of the analysis were demographic characteristics of RWHAP clients, service utilization and clinical outcomes, including retention in care and viral load suppression. The population of interest included in the analysis was HIV-positive RWHAP clients only. Data on family members, non-HIV-positive clients, ADAP, and clients who received services in multiple states (clients who received services in multiple states comprised <2% of the RWHAP population) were excluded from the analysis.

Several case definitions were established for purposes of the analysis. "ME" states were defined as those that expanded Medicaid coverage by December 31, 2014. "NME" states were defined as those that did not expand Medicaid coverage by December 31, 2014. The Kaiser Family Foundation served as the data source for these definitions. "Healthcare coverage" was defined as Medicare; Medicaid or other public health sources; Medicare and Medicaid or other public health sources; private healthcare coverage; and no insurance or uninsured. Other public health

sources included Veteran's Administration, Indian Health Service, Tricare, CHIP, or other military coverage.

The results of HAB's preliminary analysis of 2014 RSR data are highlighted as follows. RHWAP served 492,240 HIV-positive clients in 2014. This population accounted for 96% of all 512,214 clients living with or affected by HIV who were served by RHWAP in 2014. ME states accounted for 55% of clients and NME states accounted for 45% of clients who received RHWAP services in 2014. No differences in gender and age distributions of RHWAP clients were observed between ME and NME states, but variations by race/ethnicity were reported. African Americans accounted for 39% of RHWAP clients in ME states and 56% of RHWAP clients in NME states. Hispanics accounted for 29% of RHWAP clients in ME states and 15% of RHWAP clients in NME states.

Healthcare coverage among HIV-positive RHWAP clients did not significantly change over time: from 27.9% in 2012 to 25.4% in 2014 among uninsured clients and from 33.3% in 2012 to 33% in 2014 among clients covered by Medicaid/other public health sources. However, greater differences were observed by expansion status. In ME states, healthcare coverage decreased from 22.2% in 2012 to 16.7% in 2014 among uninsured RHWAP clients and increased from 39.3% in 2012 to 42.7% in 2014 among RHWAP clients covered by Medicaid/other public health sources. In NME states, healthcare coverage increased from 35.2% in 2012 to 36.6% in 2014 among uninsured RHWAP clients and decreased from 25.6% in 2012 to 21.1% in 2014 among RHWAP clients covered by Medicaid/other public health sources.

By state, the absolute percent change in RHWAP clients covered by Medicaid/other public health sources greatly varied from 2013-2014 and ranged from a decrease of ~20% in Nebraska to a 25% increase in Oregon. ME states accounted for 15 of all 16 states with at least a 5% increase in Medicaid coverage of RHWAP clients. In terms of the absolute percent change in uninsured RHWAP clients from 2013-2014, most states reported a decrease. ME states accounted for 6 of all 7 states with at least a 15% decrease in uninsured RHWAP clients.

By demographic subgroup in ME states, the absolute percent changes in RHWAP clients covered by Medicaid/other public health sources from 2012-2014 were higher or slightly higher than average increases in clients who were 19-34 years of age, male, white and African American. No significant change was observed in Hispanic RHWAP clients in ME states. By demographic subgroup in NME states, the absolute percent decrease of 10% in Hispanic RHWAP clients covered by Medicaid/other public health sources from 2012-2014 was statistically significant. No significant changes were observed in other demographic subgroups in NME states.

By insurance status in ME states, the absolute percent change in uninsured RHWAP clients decreased in all demographic subgroups from 2012-2014. The largest decline in uninsured clients 19-34 years of age was particularly notable. HAB has specifically targeted this population due to its extremely low healthcare coverage rate. By insurance status in NME states, the

absolute percent change in uninsured RWHAP clients was minimal across all demographic subgroups from 2012-2014. However, the absolute percent increase of 5% in uninsured Hispanic RWHAP clients was the exception to this finding.

No significant differences were observed in the percent of RWHAP clients (~60%) with ≥ 1 OAMC visits in both ME and NME states from 2012-2014. NME states had a higher percent of RWHAP clients with ≥ 1 case management, substance abuse or mental health visits than ME states from 2012-2014, but these differences were not significant. Retention in HIV care rates were relatively stable: 82.1% in 2012, 81% in 2013, and 80.4% in 2014. No differences in retention in HIV care rates of RWHAP clients were observed between ME and NME states. "Retention in HIV care" was defined as RWHAP clients who had at least 2 medical visit dates at least 90 days apart in the measurement year with at least one visit prior to September 1.

Viral load suppression rates in RWHAP clients increased by 3% each year: 75% in 2012, 78.6% in 2013, and 81.4% in 2014. The increases were slightly higher in ME states (from 76.5% in 2012 to 82.5% in 2014) than in NME states (from 73.2% in 2012 to 80.2% in 2014). Higher levels of uninsured clients were associated with lower viral suppression rates in ME states. RWHAP clients who were uninsured or covered by Medicaid/other public health sources accounted for the lowest viral suppression rates. "Viral suppression" was defined as the most recent HIV RNA level of < 200 copies/mL in the calendar year. The rate was calculated among clients with available visit dates and viral load values who received RWHAP-funded HIV medical care.

HAB reached several conclusions based on the results of its preliminary analysis of the 2014 RSR data. In ME states, the percentage of RWHAP clients covered by Medicaid/other public health sources decreased by 4% and the percentage of uninsured clients decreased by 5%. Variations in healthcare coverage were observed across states could be due to a number of factors: the timing of Medicaid expansion, public and political support for ACA, marketing and promotion of QHPs and Medicaid, the availability of assistance to enroll in healthcare coverage, and the capacity of ADAP programs to purchase insurance.

In ME states, RWHAP clients 19-34 years of age accounted for the largest increase in coverage by Medicaid/other public health sources and the largest decrease in uninsured clients. Hispanic RWHAP clients accounted for minimal or no changes in Medicaid/other public health coverage or uninsured status. Minimal changes were observed in the percent of clients who received OAMC, case management, substance abuse treatment and mental health services as well as the volume of these services received over time. No changes were observed in retention in HIV care rates by expansion status or over time. Viral load suppression rates increased by 3% each year in both ME and NME states. Higher viral load suppression rates were observed in ME states than in NME states, but these data were not adjusted for confounders.

HAB's next steps will be to build on its preliminary analysis of the 2014 RSR data by adjusting for client-level and state-level confounders, examining trends in specific states, and including

additional years of data to perform robust time trend analyses. HAB's advanced analyses of the RSR data will produce more valid estimates, strengthen the confidence of the findings, and generate a better description of the impact of ACA on RWHAP clients in 2014, including healthcare coverage, service utilization and clinical outcomes. If sample sizes of the RSR data are sufficient, HAB also intends to conduct state-level analyses to identify specific state-level trends in the impact of ACA on RWHAP.

Implications of the Affordable Care Act on STD Programs

William Smith

Executive Director

National Coalition of STD Directors

Mr. Smith described the implications of ACA on STD programs. The traditional role of STD programs has been to provide testing of and treatment for syphilis, gonorrhea and chlamydia. However, the role of STD clinics has greatly expanded over time to include reproductive health issues (PAP smears and emergency contraception) and other infectious diseases (hepatitis screening and vaccination as well as HIV counseling and testing). In terms of their critical role in HIV prevention, STD programs account for ~20% of new HIV diagnoses and provide leadership in the implementation of PrEP and post-exposure prophylaxis.

STD programs are encountering significant barriers to delivering services in an evolving healthcare system. Because data collected from STD programs over the past few years primarily focused on budget cuts and other programmatic issues, a rigorous systematic review should be conducted to determine the impact of ACA on STD programs. The major challenges to STD programs post-ACA implementation are outlined below.

NCSD and NACCHO have collaborated in conducting several studies to document the most significant challenges to STD programs. First, appropriations of federal dollars have been severely cut due to inflation and sequestration. The purchasing power of federal dollars has decreased by ~33% from the STD budget. State and local contributions to STD programs have declined or are entirely non-existent. States that do not allocate any funding to their STD programs are particularly problematic because clinics receive 100% of their funding from state/local sources. The severe budget cuts have caused numerous clinics to close or restrict their hours and services. Recent data show that 43% of clinics have reduced their hours, 40% of clinics have decreased screening, and 7% of clinics continue to experience closures.

Second, STD programs consistently need to clarify the myth that ACA has made safety net services obsolete, including those delivered in STD clinics. Third, disease burdens are continuing to increase. Fourth, "STD clinics" have not been clearly or consistently defined to date, but efforts

are underway to fill this data gap. For example, CDC will convene an expert consultation on quality STD clinical services to better understand the different levels of service delivered by clinics. Moreover, Dr. Beth Meyerson is leading a study at Indiana University regarding the taxonomy of STD clinics.

STD programs have institutionalized several key principles at state, local and clinic service delivery levels as ACA has evolved over time. Engagement with and adaptation to evolving healthcare delivery and payer systems are essential. A more diverse group of payers and revenue streams is critical to supporting STD services at the clinic level. An assessment of the percentage of uninsured/under-insured patients who access services in STD clinics is an important effort. For example, recent modeling studies estimate that 4.7 million patients will still be eligible for safety net services in STD programs in 2023.

STD services are not “free” and should only be provided to patients at “no cost” when absolutely necessary to meet the public health goal of preventing the transmission of infectious diseases. On January 1, 2014, for example, the Denver Metro Health Clinic announced its new reduced fee schedule for clinic visits based on the services provided, income, family size and other factors. Medicaid, other insurance sources and ACA insurance options are listed as acceptable forms of payment. However, the announcement emphasized that uninsured patients or those with an inability to pay would still receive necessary STD services.

High-quality and comprehensive sexual health care is a key focus area due to the shift from a fee-for-service to a value-based model for reimbursement of STD services. Efforts are underway to develop and implement a master billing system for STD clinical services to train providers in delivering comprehensive care. Public health departments across the country and their local partners must ensure the availability of sexual health service delivery. The focus on substantive differences between sexual health services and other primary care/public health services, particularly in the context of confidentiality, must be maintained. For example, a recent study reported that 50% of patients who access STD clinics demand confidentiality.

NCSD/NACCHO studies also have described important impacts on STD programs. Trends in the closure of STD clinics have been relatively stable, but the number of service delivery sites across the country has decreased. Significant funding challenges still exist, but several innovative models have been implemented to adopt new business practices to operate STD clinics.

The Florida Department of Health in Broward County provides STD clinical services through a contract with the Ft. Lauderdale AIDS Healthcare Foundation. The Denver Metro Health Clinic has created and sustained Sexual Health Centers of Excellence that provide full STD screening, HIV testing, family planning services and sexual health services. The clinic leveraged the existing infrastructure and expertise of Denver Health to provide billing and reimbursement, patient care monitoring and information technology systems.

STD clinics in the New York City Department of Health and Mental Hygiene are making long-term reinvestments in the sexual health safety net. New York City STD clinics have redesigned their programs with the following features:

- Self-pay honor system with a sliding fee scale of \$0-\$50 based on income and family size for patients ≥ 19 years of age.
- Billing of services to Medicaid and private insurers for patients ≥ 19 years of age.
- Provision of services to uninsured patients or those without an ability to pay.
- Renovation of the Chelsea STD Clinic and other facilities.
- Policy development through a March 2013 Executive Order signed by the governor that allows for billing.

Other models that have been implemented to promote the adoption of new business practices include the consolidation of services in a single public health delivery site, including STD, family planning and immunization services. STD/sexual health services have been integrated into primary care to improve service delivery and strengthen the role of health departments and training centers in empowering a new array of providers.

NCSD is interested in obtaining feedback from CHAC on the future needs of STD programs in an evolving healthcare system.

- Additional discretionary program funding is needed from federal, state and local jurisdictions. Most notably, approval of the Senate proposal of a \$30 million cut to the CDC/DSTDP budget would devastate the delivery of STD clinical services across the country.
- Greater coordination of and an overall increase in federal investments are needed in two key areas: (1) billing and reimbursement for public health and STD clinics beyond fee-for-service models and (2) HIT and other information systems that have the ability to benefit public health.
- Continued access to the HRSA-funded 340B Drug Pricing Program, including payment for expedited or patient-delivered partner therapy for STDs, is needed for public health and STD programs.
- Ongoing partnerships with public health laboratories are needed, including support for continued laboratory capacity to develop and perform tests.
- Close collaboration with industry partners is needed to support better STD diagnostics and treatment. Improved diagnostics should address the collection and types of specimens and include rapid syphilis and HCV point-of-care tests that are waived by the Clinical Laboratory Improvement Amendments.
- Strong support for workforce development is needed in STD programs and clinics, including training of clinicians to provide treatment and care in accordance with CDC's *STD Treatment Guidelines*, training of DIS staff, and training of front office staff to bill insurers for reimbursement of STD services.

Overall, the sexual health safety net must be preserved to continue to provide STD services to uninsured persons and address unique sexual health issues that are substantively different than primary care or other public health issues. Moreover, the critical role of STD clinics in conducting research to advance the field must be retained. In some cases, the healthcare delivery system is unable or unwilling to conduct STD prevention activities.

CHAC DISCUSSION: HRSA'S ACA ASSESSMENTS

CHAC made several comments and suggestions for HRSA to consider in refining the ACA assessments.

- HAB should continue its close collaboration with the CHAC Data Workgroup to conduct additional analyses of the RSR data. Several potential outcomes should be incorporated into the design of future analyses.
 - Include ADAP data.
 - Include additional years of post-ACA implementation data to determine changes in the overall number of RWHAP clients and identify differences between ME and NME states over a longer period of time. In the NME state of Texas, for example, eligible RWHAP clients increasingly are enrolling in Health Marketplaces.
 - Better understand the role of QHPs in RWHAP.
 - Strengthen the focus on substance abuse issues. For example, substance abuse disorders might impact the length of time or frequency of clinical visits or influence a client's incomplete response to HIV therapy.
 - Identify specific criteria to help NME states achieve a similar level of performance and progress as ME states in providing OAMC services to RWHAP clients.
 - Produce additional findings on engaging and retaining demographic subgroups, particularly Hispanics, in HIV care.
 - Compile and broadly disseminate data from ME states that have successfully increased their retention in care and viral load suppression rates.
- HAB should conduct a series of TA calls to assist RWHAP grantees in more extensively engaging MCOs in a comprehensive system of care, particularly in the context of sharing data across multiple systems to better serve the needs of clients.
- HAB should encourage its RWHAP grantees in other states and local jurisdictions to review and replicate the California model. Effective health insurance assistance strategies will soon be implemented in the state to reach and enroll undocumented immigrants, particularly Hispanics, in healthcare systems. Moreover, a key topic of discussion during the 2015 National Immigrant Integration Conference that will be held in New York City on December 13-15, 2015 will be potential approaches to provide healthcare coverage to all New Yorkers, including persons without permanent U.S. citizenship and undocumented immigrants. Federally Qualified Health Centers are expected to play a critical role in this effort.

Public Comment Session

Emily McCloskey

Senior Manager, Policy and Legislative Affairs
National Alliance of State and Territorial AIDS Directors (NASTAD)

Ms. McCloskey provided the following comments for CHAC's consideration. NASTAD represents public health officials who administer state and territorial HIV and viral hepatitis prevention and care programs nationwide. An FY2016 Senate appropriations bill proposes to eliminate or decrease several important funding streams: the Secretary's Minority AIDS Initiative Fund (SMAIF), RWHAP SPNS funding, SAMHSA Minority AIDS Initiative (MAI) funding and DSTDP funding. These cuts would hinder activities by state health departments and community partners to create culturally competent care and fill healthcare gaps for populations that are most disproportionately impacted by the HIV epidemic.

These federal funding sources provide and enhance direct health services to PLWH and other vulnerable populations. Because recent data estimate that 1 in 16 African American men and 1 in 32 African American women will be diagnosed with HIV during their lifetime, CHAC's efforts to urge the President to support these funding sources would be vital.

State health departments administer programs funded by both SMAIF and SPNS. For example, the Care and Prevention in the United States Demonstration Project funded eight jurisdictions that aimed to reduce HIV-related morbidity and mortality by building the capacity of non-governmental organizations and health departments.

HRSA awarded a CoAg to NASTAD to identify, collect and disseminate best practices and effective models of HIV clinical care and treatment across the HIV Care Continuum. The key outcome of the CoAg is to increase the capacity, quality and effectiveness of healthcare providers to screen, diagnose, link and retain BMSM in HIV clinical care. The HRSA CoAg and partial resources by SMAIF supported the establishment of the Center for Engaging Black MSM Across the Care Continuum.

Of all SPNS grantees, 28% are state or local health departments. These grantees create innovative models of HIV care to rapidly respond to new and evolving medical needs of RWHAP clients. For example, the Systems Linkages and Access to Care Initiative is a multi-state demonstration project and evaluation of innovative models of linkage to and retention in HIV care. The initiative funds seven states to design, implement and evaluate new strategies to intervene at different components of the public health system. These projects are targeted to high-risk populations and HIV-positive persons who are unaware of their status. The projects also are designed to improve health outcomes along the HIV Care Continuum.

The proposed cuts to the DSTDP budget will have a significant impact on the HIV epidemic. Gay men and other MSM continue to comprise a disproportionate share of persons with STDs. MSM account for 75% of syphilis cases in the United States. Men also accounted for the 10% increase in syphilis cases. Cases of HIV/syphilis co-infection are continuing to increase as well. State and local health departments need resources to integrate HIV/STD prevention programs that particularly target populations at the highest risk for syphilis and other STDs.

NASTAD is aware of current budget constraints and the need to streamline funding, but the importance of devoting funds to address structural inequities among persons of color should not be overlooked. NASTAD is now asking CHAC to inform the Administration of its support of the continued need for these federal funding sources. NASTAD looks forward to its ongoing collaboration with CHAC to implement effective HIV care and prevention programs, including those supported by SMAIF, SAMHSA MAI funding, SPNS funding and DSTDP funding, to prevent disease and deliver lifesaving care to all Americans.

Tracy Matthews

Deputy Director, HAB Division of Policy and Data
Health Resources and Services Administration

Ms. Matthews informed CHAC of two unidentified questions from the public that were placed in the chat box regarding the inadequate number of HIV specialists to care for PLWH. To build the next generation of the HIV care workforce, what steps can be taken to encourage medical students or new professionals entering the medical care field to pursue a specialty in HIV care? What strategies can be implemented to motivate existing care providers to pursue a specialty in HIV care?

Dr. Virginia Caine, a CHAC member, noted the significant decline in the number of African American men who are entering medical school. By gender, women now account for a larger percentage of medical school graduates than men. Her position was that disparities by race/ethnicity and gender in the overall medical care field must be addressed before efforts can be made to build the next generation of HIV care specialists.

Dr. Cheever added that HAB re-competed the CoAg for regional AETCs in 2015 and placed strong emphasis on the development of a pipeline of HIV care providers. HAB traditionally discouraged AETCs from outreaching to medical students and residents, but the current CoAg encourages these types of collaborations to strengthen the HIV clinical workforce.

Preparation for the CHAC Business Session

Dawn Fukuda, ScM, CHAC Co-Chair

Director, Office of HIV/AIDS

Massachusetts Department of Public Health

Ms. Fukuda summarized CHAC's comments and suggestions in response to the overviews, updates and panel presentation on day 1 that might warrant formal action during the Business Session on the following day.

Topic	Outcome/Next Steps
HRSA youth studies (including young MSM and young BMSM)	Agenda item: HRSA/HAB will present findings from these studies during the May 2016 meeting. CHAC will determine whether a formal resolution is needed on this topic after the presentation
HBV/HCV elimination	Agenda item: CDC/DVH will present findings from the IOM feasibility study on achieving HBV and HCV elimination goals in the United States during the May 2016 meeting. CHAC will determine whether a formal resolution is needed on this topic after the presentation.
Development of an acuity framework	Discussion topic: CHAC will discuss approaches to develop an acuity framework to improve RWHAP service delivery to clients. Issues that will be covered in the discussion include the length of service encounters, health insurance in ME and NME states, and the need for tailored strategies for RWHAP clients. CHAC will determine whether a formal resolution is needed on this topic after the discussion.
Replication of successful models	Discussion topic: CHAC will discuss existing models that have successfully responded to HIV, viral hepatitis and STDs in rural areas and medically underserved communities. The discussion will highlight emerging co-management models, Project ECHO and tele-medicine initiatives as potential models for replication. CHAC will determine whether a formal resolution is needed on this topic after the discussion.

Topic	Outcome/Next Steps
Additional analyses of RSR data	Recurring agenda item: The Data Workgroup will provide CHAC with regular updates on its collaborative efforts with HAB staff to conduct additional analysis of RSR data. The workgroup and HAB will consider CHAC’s suggestions on the design of future analyses, such as including ADAP data. CHAC will determine whether a formal resolution is needed on this topic after the workgroup completes this task.
Sexual health safety net	Discussion topic: CHAC will discuss the need to preserve the sexual health safety net to continue providing key public health services in an ACA environment. CHAC will determine whether a formal resolution is needed on this topic after the discussion.
Workforce capacity	Discussion topic: CHAC will discuss the need to encourage PCPs to develop expertise to treat HCV patients. The discussion will focus on CMS restrictions that prohibit PCPs from obtaining reimbursement for treatment of HCV patients. Opportunities to diagnose HCV cases are being missed due to the requirement for PCPs to have specialized HCV training and expertise. CHAC will determine whether a formal resolution is needed on this topic after the discussion.
Sustainability of public health funding	Draft resolution: Peter Byrd and Dawn Fukuda will serve as champions of a draft resolution regarding the importance of sustaining public health funding for HIV, viral hepatitis and STD programs in an ACA environment. The draft resolution will highlight essential public health initiatives that are vulnerable in FY2016 due to a Senate proposal for the elimination of or severe cuts to their federal funding streams: SMAIF, SAMHSA MAI funding, SPNS funding and DSTDP funding. The impact of the loss of public health funding on high-risk and underserved populations will be emphasized. The draft resolution will be presented to CHAC on the following day for review, discussion and a formal vote.

With no further discussion or business brought before CHAC, Ms. Fukuda recessed the meeting at 4:02 p.m. EST on November 4, 2015.

Opening Session: November 5, 2015

Laura Cheever, MD, ScM

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

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were in attendance. 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 responsibility to disclose any potential individual and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters. None of the CHAC 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 confirmed that the 20 voting members and *ex-officio* members (or their alternates) in attendance constituted a quorum for CHAC to conduct its business on November 5, 2015. She reconvened the proceedings at 10:00 a.m. EST and welcomed the participants to day 2 of the meeting.

Dr. Cheever reminded the participants of the outgoing HRSA-appointed CHAC members who are attending their last meeting due to the expiration of their terms. Dr. Kathleen Clanon brought to bear a wealth of experience, innovative perspectives, and excellent leadership in the field of HIV care and treatment in her previous role as a CHAC member and her current position as the Co-Chair. Dr. Steven Johnson provided a valuable public health perspective on HIV care in the field. Dr. Britt Rios-Ellis contributed outstanding expertise and insights on the unique cultural aspects of HIV care for Hispanic populations. The participants joined Dr. Cheever in thanking the three outgoing members for their service to CHAC.

Dawn Fukuda, ScM, CHAC Co-Chair

Director, Office of HIV/AIDS
Massachusetts Department of Public Health

Ms. Fukuda also welcomed the participants to day 2 of the CHAC meeting. She summarized the updates, overviews and panel presentation that were made on day 1. She announced that the majority of day 2 would be devoted to CHAC workgroup reports and the Business Session.

Several members were pleased that the presentations have allowed CHAC to strengthen its advisory role to HHS, CDC and HRSA, particularly in the areas of the 2020 NHAS, HIV care in an ACA environment and data utilization. The members noted that these important and high-quality presentations would assist CHAC in developing relevant policy statements.

Overview of RWHAP's Critical Role in Improving Outcomes

Heather Bradley, PhD

Behavioral and Clinical Surveillance Branch, Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention

John Weiser, MD, MPH

Behavioral and Clinical Surveillance Branch, Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention

Heather Hauck, MSW, LICSW

Director, Division of State HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration

Advice Requested from CHAC by CDC/HRSA:

1. What is CHAC's input regarding the findings of the two RWHAP impact studies?
2. What are CHAC's recommendations on policy decisions to inform RWHAP's role under ACA?

Dr. Bradley, Dr. Weiser and Ms. Hauck reported findings of two new studies that CDC and HRSA jointly conducted and published to document the critical role of RWHAP in improving outcomes. Both studies were based on MMP data. MMP is a surveillance system that utilizes a cross-sectional, complex sample survey.

MMP produces nationally representative estimates of behavioral and clinical characteristics of HIV-infected adults in clinical care in the United States and characteristics of healthcare facilities that provide HIV care. CDC changed the MMP sampling method in 2015 to include all HIV-infected persons in the United States. The study design included data collection from facility and patient interviews, medical record abstraction, surveys and other sources.

Study 1 by Weiser, *et al.*, "Service Delivery and Patient Outcomes in Ryan White HIV/AIDS Program-Funded and Non-Funded Healthcare Facilities in the United States," was published in 2015 in *JAMA Internal Medicine*. Data were collected from probability samples of 8,038 patients and 934 facilities. The 2009-2011 MMP datasets showed that 34% of facilities received RWHAP funding and 73% of patients received care at RWHAP-funded facilities.

Patient characteristics associated with poor health outcomes were more prevalent in RWHAP-funded facilities than in non-RWHA-funded facilities. The higher percentages of these patient characteristics in RWHAP-funded facilities were all statistically significant.

Patient Characteristic	RWHAP-Funded Facility	Non-RWHAP-Funded Facility
18-29 years of age	9%	5%
Female	30%	20%
African American	48%	26%
Hispanic	23%	13%
Less than a high school education	26%	11%
No health insurance	25%	6%
Homelessness during the past year	10%	5%
Incarceration during the past year	7%	3%

RWHAP-funded facilities were much more likely to provide each RWHAP-funded service assessed for the study. The higher percentages of these services provided by RWHAP-funded facilities were all statistically significant.

Service	RWHAP-Funded Facility	Non-RWHAP-Funded Facility
Mental health services	64%	18%
Substance abuse treatment	34%	12%
Dental care	49%	9%
Case management	76%	15%
Adherence counseling	82%	30%
Interpreter services	59%	29%
Transportation assistance	53%	11%
Nutritionist/dietician	60%	22%
Risk reduction counseling	71%	22%

The medical record review found no statistically significant differences between the percentage of patients who were prescribed ART in RWHAP-funded facilities versus non-RWHAP-funded facilities (90% vs 91%). Patients at RWHAP-non-funded facilities were significantly more likely to be virally suppressed (viral load undetectable or <200 copies/mL, 79% vs 74%). However, patients living at or below the Federal Poverty Level who received care in RWHAP-funded facilities were 9% more likely to be virally suppressed than those at non-RWHAP-funded facilities. The primary conclusion of Study 1 was that low-income patients who received care at RWHAP-funded facilities were more likely to be virally suppressed.

Study 2 by Bradley, *et al.*, “Impact of Ryan White HIV/AIDS Program Assistance on HIV Treatment Outcomes,” was published in 2015 in *Clinical Infectious Diseases*. The 2009-2012 MMP datasets showed that 41% of patients received RWHAP assistance; 25% received RWHAP assistance as a supplement to another healthcare payer type; and 15% solely relied on RWHAP assistance for HIV care.

Patient medical records were abstracted to analyze two patient outcomes by healthcare payer type. In terms of the logistic regression model for outcome 1, ART prescription in the past year, patients who received RWHAP assistance only were used as a reference group and were adjusted for the following confounders: age, race, time since HIV diagnosis and HIV disease stage. In terms of the logistic regression model for outcome 2, an undetectable viral load/viral load suppression of <200 copies/mL, patients who received RWHAP assistance only also were used as a reference group and were adjusted for the following confounders: age, race, place of birth, poverty, education, homelessness and HIV disease stage.

ART PRESCRIPTION	
Healthcare Payer Type	Prescribed ART
RWHAP assistance only	94%
Private insurance	89%
Medicaid	89%
Medicare	93%
Medicaid plus Medicare	94%
VIRAL SUPPRESSION	
Healthcare Payer Type	Virally Suppressed
RWHAP assistance only	77%
Private insurance	79%
Medicaid	66%
Medicare	78%
Medicaid plus Medicare	76%

Percentages of the two patient outcomes by healthcare payer type changed after adjusting for specific patient characteristics (e.g., poverty and education level). Patients who received RWHAP assistance only were more likely to be virally suppressed than those with other healthcare payer

types: 5% more likely than patients with private insurance, 4% more likely than dual-eligible patients, and 12% more likely than patients with Medicaid coverage.

Patients with RWHAP assistance plus private insurance (81%) or Medicaid (75%) were significantly more likely to be virally suppressed than those with only private insurance (76%) or Medicaid (71%). The primary conclusion of Study 2 was that uninsured and under-insured patients who received RWHAP assistance only were 4%-7% more likely to be prescribed ART and virally suppressed than those with all other healthcare payer types.

Dr. Weiser informed CHAC that CDC collects extensive data on the prevalence of risk behaviors, co-morbidities and program performance based on quality indicators. In future analyses of MMP data, he confirmed that CDC intends to evaluate these and other factors to determine their relationship to receipt of patient care and clinical outcomes at RWHAP-funded and non-RWHAP-funded facilities.

CHAC DISCUSSION: FINDINGS OF THE RWHAP IMPACT STUDIES

CHAC requested additional details on the following topics during the question/answer session with the CDC and HRSA panel of speakers.

- The ability of the studies to determine potential differences in HIV patient treatment and care without RWHAP-funded facilities.
- The rationale for statistically significant differences in the percentage of patients who were virally suppressed by healthcare payer type after adjusting for patient characteristics.
- Additional analyses of patients both in and out of HIV care that potentially could be performed with CDC's revised MMP sampling methodology (e.g., the impact of RWHAP assistance on better continuity of care or provision of clinical care in accordance with guidelines).
- The potential value of identifying specific RWHAP services have a more appreciable impact on HIV patients than others.
- The timeline for CDC and HRSA to expand the studies in the future (potentially as early as June 2016) with updated MMP data and additional years of post-ACA implementation data.
- Key behavioral and sociodemographic factors (e.g., young persons, racial/ethnic minorities, low education level, low-income level, homelessness and incarceration) that warrant stronger emphasis to further improve clinical care outcomes of HIV patients.
- The rationale for differences in viral load suppression rates of RWHAP patients by data source: 80.4% based on HRSA's RSR data versus 74% based on CDC's MMP data.

CHAC made comments and suggestions in two key areas for CDC and HRSA to consider in refining the RWHAP impact studies. In terms of future research, the MMP data should be used to compare RWHAP-specific and national viral load suppression rates. The new study should

include an economic analysis to demonstrate to Congress and the American public the tremendous cost-savings that RWHAP services have generated over time.

In terms of dissemination, the findings of the two RWHAP impact studies should be repackaged for a lay audience and widely distributed beyond peer-reviewed journals. Dissemination of these results to a much larger audience will be particularly important in an ACA environment to quantitatively document the essential role of RWHAP in improving HIV treatment and clinical outcomes of patients and preventing further transmission of infection.

Update by the CHAC Pre-Exposure Prophylaxis Workgroup

Kathleen Clanon, MD, CHAC Co-Chair

Medical Director

Alameda County Health Care Services Agency

Dr. Clanon covered the following topics in her update to CHAC on the workgroup's recent activities. The workgroup was charged with drafting CHAC's recommendations to CDC and HRSA on supporting wider use and availability of PrEP. The workgroup fulfilled its charge by drafting a letter to Dr. Thomas Frieden, Director of CDC, and Mr. James Macrae, Acting Administrator of HRSA.

The content of the draft letter includes a background on the population of PLWH in the United States; the recommendation in the 2020 NHAS to ensure full access to comprehensive PrEP services over the next five years; and CHAC's guidance to CDC and HRSA to overcome barriers to making PrEP services more accessible. The four recommendations in the draft letter address the following areas:

1. Provision of PrEP education by state/local STD programs and STD clinics in accordance with CDC guidelines.
2. CDC's amendment of the *2015 STD Treatment Guidelines* to include information on PrEP.
3. Resources to HRSA to modify electronic health record systems to routinely collect data on sexual orientation, sexual behavior and gender identity as part of the standard demographic record.
4. CDC's collaborations with state partners to leverage funding for PrEP from multiple sources and eliminate cost barriers to accessing PrEP.

Dr. Clanon noted that the draft letter was distributed in advance of the meeting for CHAC's review, comment and formal vote. CHAC proposed three revisions for the workgroup to consider in finalizing the draft letter.

- Recommendation 1: Clarify “explore readiness” to offer PrEP.
- Recommendation 1b: Change the language to “Larger STD clinics.”
- New recommendation: Address the need for the availability of PrEP for young persons <18 years of age who are at high risk for HIV.

Update by the CHAC Data Workgroup

Jennifer Kates, PhD

Vice President & Director, Global Health and HIV Policy
 Kaiser Family Foundation
 CHAC Member & Workgroup Chair

Dr. Kates covered the following topics in her update to CHAC on the workgroup’s recent activities. For the benefit of new members, she explained that CHAC unanimously approved the formation of the workgroup during the December 2012 meeting. The workgroup’s formal charge is to “collaborate with CDC and HRSA on assessing emerging data that should directly inform the implementation of ACA, particularly its relationship to prevention interventions and the delivery of care in clinics receiving RWHAP funds and in Community Health Centers.”

The workgroup convened its most recent teleconference meeting on September 3, 2015 with participation by a number of CDC/HRSA leadership and staff. Since that time, CDC and HRSA have made tremendous efforts to conduct studies and perform data analyses in response to the workgroup’s requests. The workgroup is pleased to report that CDC and HRSA utilized their nationally representative data to produce high-quality, rigorous and groundbreaking quantitative research to better determine the impact of ACA on PLWH and RWHAP. The current meeting and future agenda items reflect the responsiveness of CDC and HRSA to the workgroup.

Request by the Data Workgroup	Agency Response
Overview of findings from two newly published studies that CDC and HRSA jointly conducted on the relationship between HIV treatment outcomes and RWHAP support.	Completed; November 2015 presentation
Overview of findings from HRSA’s analyses of 2014 RSR client-level data that specifically focused on the impact of ACA on RWHAP clients and services, including variations between ME and NME states.	Completed; November 2015 presentation

Request by the Data Workgroup	Agency Response
Interagency agreement between CDC and HRSA on the development of a set of grantee indicators that directly track with the 2020 NHAS indicators.	Ongoing
Preview of CDC's upcoming release of the <i>National HIV Prevention Progress Report, 2015</i> and the <i>State HIV Prevention Progress Report, 2010-2013</i> on December 6, 2015 and the alignment of these data with the 2020 NHAS.	Completed; November 2015 preview. Pending; full update in the May 2016 CDC/NCHHSTP Director's Report
Overview of HRSA's World AIDS Day reports and activities.	Completed; November 2015 HRSA/HAB Associate Administrator's Report
Overview of findings from CDC's pilot project to incorporate HIV-positive persons who are not in care into the MMP dataset.	Pending; May 2016 presentation

Dr. Kates concluded her update by asking CHAC to provide input on additional data-related topics that should be placed on the May 2016 agenda.

Update by the CHAC Hepatitis C Virus Workgroup

Kathleen Clanon, MD, CHAC Co-Chair
 Medical Director
 Alameda County Health Care Services Agency

Dr. Clanon presented the report in the absence of Dr. Sanjeev Arora, the HCV Workgroup Chair. The workgroup drafted, finalized and sent CHAC's May 21, 2015 letter to the CDC Director and Acting HRSA Administrator recommending the development of HCV treatment and care guidelines endorsed by the federal government. The letter emphasized the critical need for federally-endorsed guidelines to ensure that all patients, regardless of their geographic location or insurance type, receive the necessary treatment and care to manage and cure their HCV infections. CDC and HRSA leadership responded to the letter in November 2015 and informed the CHAC Co-Chairs that resources are not available at this time to develop federally-endorsed HCV treatment and care guidelines.

The workgroup is now soliciting advice from CHAC on appropriate next steps to address the incomplete response by CDC and HRSA leadership. For example, CHAC could send a follow-up letter to CDC and HRSA leadership or issue a formal position statement to describe problems in the field related to the lack of federally-endorsed HCV treatment and care guidelines.

CHAC made two suggestions for the workgroup to consider. First, the workgroup should consult with Dr. Mildred Williamson, the liaison representative to the Presidential Advisory Council on HIV/AIDS (PACHA), to explore CHAC's potential next steps in submitting guidance at a higher level than CDC and HRSA leadership. Second, the workgroup should conduct an economic analysis of the national burden of HCV-infected persons who do not receive care, treatment and a cure due to payers that deny treatment or do not comply with existing guidelines.

Dr. Mermin informed CHAC that CDC recently initiated communications with the National Institutes of Health (NIH) regarding experience with HIV treatment guidelines in collaboration with other USPHS agencies. NIH advised CDC that a considerable level of staff and financial resources would be needed to appropriately develop, implement and manage HCV treatment guidelines at the federal level.

Dr. Clanon confirmed that she would inform the workgroup of the comments and suggestions by CHAC and Dr. Mermin. The workgroup will report its next steps to CHAC during the May 2016 meeting. Dr. Williamson confirmed that she would attend the workgroup's teleconference meetings to provide PACHA's perspective as needed.

CHAC Business Session

Dawn Fukuda, ScM, CHAC Co-Chair

Director, Office of HIV/AIDS

Massachusetts Department of Public Health

Ms. Fukuda opened the business session and called for CHAC's review, discussion and/or formal action on several topics.

TOPIC 1: DRAFT CHAC MEETING MINUTES

CHAC voting members properly placed motions on the floor for CHAC to approve two sets of meeting minutes.

- Mr. Guillermo Chacon moved and Dr. Jennifer Kates seconded CHAC's approval of the May 2015 meeting minutes.
- Dr. Jennifer Kates moved and Ms. Debra Hauser seconded CHAC's approval of the July 2015 meeting minutes.

CHAC unanimously adopted the Draft May 20-21, 2015 and the Draft July 28, 2015 Meeting Minutes with no changes or further discussion.

TOPIC 2: PREP RECOMMENDATIONS

Ms. Hauser proposed a new recommendation for the PrEP Workgroup to consider including in the draft letter to CDC and HRSA leadership: “CHAC recommends that CDC and HRSA provide guidance to help STD clinics assess risks for HIV among clients <18 years of age and offer assistance as appropriate or as indicated to obtain PrEP.”

Dr. Agins noted that the new recommendation to address the availability of PrEP for young persons <18 years of age should include general guidance for states to review their existing policies on whether PrEP is defined as “treatment” or a “preventive intervention.” State policy on the role of PrEP will determine whether young persons <18 years of age will need written parental consent to obtain ART.

Dr. Clanon entertained a motion for CHAC to formally approve the PrEP Workgroup’s draft letter to CDC and HRSA leadership.

Co-Chair’s Call for a vote	Motion properly made by Mr. Peter Byrd for the PrEP Workgroup to finalize the letter with the revisions proposed by CHAC Motion seconded by Ms. Debra Hauser
Outcome of vote	Motion unanimously passed by 12 CHAC voting members
Next steps	Dr. Clanon will include CHAC’s revisions to finalize and send the letter to the CDC Director and Acting HRSA Administrator. HRSA staff will provide Dr. Clanon with minor editorial corrections.

TOPIC 3: SUSTAINABILITY OF FEDERAL FUNDING

Ms. Fukuda presented the draft resolution that she and Mr. Byrd developed to address CHAC’s concerns related to sustaining federal funding streams to support innovative HIV, STD and viral hepatitis prevention and care programs in the context of continued ACA implementation.

CHAC recommends that the HHS Secretary preserve dedicated federal funding streams from CDC and HRSA to support critical public health programs for vulnerable populations impacted by HIV, STDs and viral hepatitis. The Patient Protection and Affordable Care Act (ACA) has vastly increased access to public and private health insurance coverage, including for persons living with and at risk for HIV, STDs and viral hepatitis. Despite increased access to healthcare services following the passage of ACA, the full impact of these massive changes in the healthcare landscape are still not understood. Health professional shortage areas, medically underserved area designations, and wide variations of the integration of HIV, STD and viral hepatitis services into primary care create gaps for marginalized populations.

Data from the HRSA Ryan White HIV/AIDS Program (RWHAP) continues to demonstrate high rates of engagement and retention in care and viral suppression for HIV-positive program participants. An added value of RWHAP services on health outcomes also is documented in HIV-positive individuals with public or private health insurance coverage. CDC-supported STD clinics and other models to deliver publicly funded sexual health services in clinical settings continue to diagnose the majority of STDs in the United States. These programs are uniquely qualified to provide accessible and responsive services to vulnerable populations, promptly and effectively treat new infections, and link individuals to prevention and partner services.

Healthcare reforms that are a component of ACA have been unevenly implemented across the country and are still evolving, notably the universal expansion of Medicaid for persons under 100% of the FPL. HIV, STDs and viral hepatitis continue to disproportionately impact racial/ethnic minority populations, gay/bisexual men and other men who have sex with men, LGBTQ youth, inmates and reentry populations, and persons who use injection drugs. Federally-supported initiatives through the Secretary's Minority HIV/AIDS Program, HRSA Special Projects of National Significance, and the CDC Division of STD Prevention support the design and development of innovative approaches to prevent these communicable infections, reduce health disparities, and improve health outcomes at both individual and population levels.

Lessons from these initiatives have informed and continue to shape HIV, STD and viral hepatitis prevention programs. If these dedicated investments are prematurely abandoned, substantial ground in past achievements to advance health promotion and disease prevention relative to these communicable infections is at risk of being lost and might never be fully or sufficiently reimbursed through health insurance.

CHAC has determined that substantive data exist to establish the importance of sustained federal support for HIV, STD and viral hepatitis prevention programs in the context of continued implementation of ACA. CHAC strongly recommends that these funding streams receive continued support and rigorous evaluation.

CHAC proposed several revisions that should be considered in finalizing the draft resolution.

- Include stronger language regarding the need to “increase” rather than “sustain” the federal funding streams.
- Include new language to strengthen the impact of the resolution and present a more powerful case for continued support of the federal funding streams: “Opportunities are available at this time to stop the progress of HIV and HCV epidemics over the next 20 years.”
- Include new language to clearly describe existing gaps in ACA coverage, define the added value of RWHP, and provide a strong rationale for the critical need to increase or sustain the federal funding streams.
- Include new language to acknowledge the importance of building synergies between health insurance coverage and the delivery of public health services at the local level: “ACA coverage is insufficient because populations affected by HIV, viral hepatitis and STDs that are served by the federal funding streams require a different level of investment.”
- Include new language to recommend applying cost-savings from ACA implementation to the federal funding streams to help reverse the HIV and HCV epidemics, but acknowledge the challenges in integrating the funding sources to advance models of care.
- Include new language to recommend strategies to retain case management or other support services as a critical component of the healthcare system and identify specific services with the most significant impact as PLWH shift to other healthcare coverage types.

Ms. Fukuda noted that the CHAC members proposed extensive revisions to the draft resolution to sustain federal funding streams to support innovative HIV, STD and viral hepatitis prevention and care programs. Instead of calling for a formal vote, she described the next steps in this effort.

Ms. Fukuda and Mr. Byrd will include CHAC’s suggestions and any additional comments that are submitted to them after the meeting (Dawn.Fukuda@state.ma.us; Peterbyrd51@gmail.com) to refine the draft resolution. The revised draft resolution will be circulated to CHAC for further review and comment. An interim teleconference meeting will be held before the May 2016 in-person meeting for CHAC to discuss and take a formal vote on the revised draft resolution and resolve any other outstanding business items.

TOPIC 4: AGENDA ITEMS

Ms. Fukuda moderated CHAC’s discussion, review and summary of new agenda items that were raised over the course of the meeting.

NEW AGENDA ITEMS

Presenter(s)	Topic
CDC/DVH	Overview of the IOM feasibility study on achieving HBV and HCV elimination goals in the United States
HRSA/HAB	Overview of HRSA's new studies on youth, including young MSM and young BSM
CDC/DHAP	Overview of CDC's pilot project of the newly revised MMP sampling method to capture all HIV-infected persons in the United States, including those not in care
SAMHSA	Overview of substance use/mental health issues; access to and availability of SAMHSA's substance use disorder/mental health services and treatment; and integration of SAMHSA's services into CDC/HRSA prevention and treatment programs
CHAC Membership	Discussions to determine whether specific topics warrant formal resolutions by CHAC: <ul style="list-style-type: none"> • Approaches to develop an acuity framework to improve RWHAP service delivery to clients • Existing models that have successfully addressed HIV, viral hepatitis and STDs in rural areas and medically underserved communities • Collaborative efforts by HAB and the CHAC Data Workgroup on additional analysis of RSR data and post-ACA implementation data • Preservation of the sexual health safety net to continue providing key public health services in an ACA environment • Improvement of workforce capacity by encouraging PCPs to develop expertise to treat HCV patients to obtain reimbursement for these services

Closing Session

The next CHAC meeting will be CDC-focused and convened as an in-person meeting in Atlanta on May 11-12 or May 18-19, 2015. CDC and HRSA will circulate a Doodle poll to the CHAC members to identify the best date.

Ms. Fukuda thanked the CHAC members, federal agency officials and other staff who continue to contribute their time and expertise to ensure the success and productivity of meetings. She

also thanked the members of the public for taking time from their busy schedules to provide CHAC with important feedback from the field.

With no further discussion or business brought before CHAC, Ms. Fukuda adjourned the meeting at 11:44 a.m. EST on November 5, 2015.

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

Date

Kathleen Clanon, MD, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment

Date

Dawn Fukuda, ScM, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment



Attachment 1: Participants' Directory

CHAC Members Present

Dr. Kathleen Clanon, Co-Chair
Ms. Dawn Fukuda, Co-Chair
Dr. Bruce Agins
Mr. Peter Byrd
Dr. Virginia Caine
Mr. Guillermo Chacon
Ms. Angelique Croasdale
Ms. Debra Hauser
Dr. Marjorie Hill
Dr. Steven Johnson
Dr. Jennifer Kates
Ms. Amy Leonard

CHAC Members Absent

Dr. Sanjeev Arora
Dr. Carlos del Rio
Mr. Michael Kaplan
Dr. Britt Rios-Ellis

CHAC Ex-Officio Members Present

Dr. Pradip Akolkar
U.S. Food and Drug Administration

Ms. Sonya Bowen
(Alternate for Dr. Stephen Cha)
Centers for Medicare and Medicaid
Services

Dr. Melinda Campopiano
Substance Abuse and Mental Health
Services Administration

Dr. Paul Gaist
Office of AIDS Research
National Institutes of Health

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

Ms. Lisa Neel
Indian Health Service

Ms. Caroline Talev
(Alternate for Ms. Kaye Hayes)
Office of HIV/AIDS and Infectious Disease
Policy, U.S. Department of Health and
Human Services

Mr. Brandon Wilson
(Alternate for Dr. Stephen Cha)
Center for Medicare & Medicaid Innovation,
Centers for Medicare and Medicaid
Services

CHAC Ex-Officio Members Absent

Dr. Stephen Cha
Centers for Medicare and Medicaid
Services

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

CHAC Liaison Representative

Dr. Mildred Williamson
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

Ms. Chrissy Abrams-Woodland
Ms. Holly Berilla
Dr. Stuart Berman
Ms. Stephanie Bogan
Dr. Gail Bolan
Dr. Heather Bradley
Dr. Tarsha Cavanaugh
Ms. Stacy Cohen
Ms. Gary Cook
Ms. Antigone Dempsey
Dr. Patricia Dietz
Dr. Rupali Doshi
Ms. Teresa Durden
Mr. John Eaton
Mr. Michael Evanson
Ms. Shelley Gordon
Ms. Amy Griffin
Ms. Heather Hauck
Ms. Kerry Hill
Ms. Andrea Jackson

Ms. Carrie Jeffries
Ms. Jan Joyce
Ms. Theresa Jumento
Ms. Niki Keiser
Ms. Amelia Khalil
Dr. Pamela Klein
Ms. Michelle Li
Mr. James Macrae
Ms. Marlene Matosky
Mr. John Milberg
Mr. Robert Mills
Mr. Paul Monsoger
Ms. Sera Morgan
Ms. Tia Morton
Ms. Susan Robilotto
Dr. Letitia Robinson
Ms. Ruth Roman
Ms. Gold Rosen
Ms. Helen Rovito
Ms. Mae Rupert
Ms. Amy Schachner
Ms. Margie Scott-Cseh
Ms. Nicole Smith
Ms. Tanchica Terry
Mr. Jesse Ungard
Ms. Abigail Viall
Ms. Candace Webb
Dr. John Weiser
Ms. Kelley Weld
Dr. Stephanie Zaza

Members of the Public

Ms. Stephanie Arnold Pang
National Coalition of STD Directors

Mr. Aaron Austin
American Academy of HIV Medicine

Ms. Ilana Cohen
The AIDS Institute

Mr. Michael Costa
Abt Associates

Mr. Nathan Danskey
HIV Medicine Association

Ms. Lindsey Dawson
Kaiser Family Foundation

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

Ms. Cheri Levenson
Washington State Department of Health

Mr. Joseph Lunievicz
Acria

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

Ms. Amber McCracken
American Academy of HIV Medicine

Ms. Kimberly Miller
HIV Medicine Association

Ms. Judy Nielsen
Montana Department of Public Health and
Human Services

Mr. Carl Schmidt
The AIDS Institute

Mr. William Smith
National Coalition of STD Directors

Ms. Lisa Stand
The AIDS Institute

Ms. Cathalene Teahan
Georgia AIDS Coalition

Dr. Ivy Turnbull
AIDS Alliance

Ms. Ana Maria Visoui
Urban Coalition for HIV/AIDS Prevention

Ms. Andrea Weddle
HIV Medicine Association

Ms. Calicia White
Ebony House, Inc.



**Attachment 2:
Glossary of Acronyms**

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETCs	AIDS Education and Training Centers
ART	Antiretroviral Therapy
BMSM	Black Men Who Have Sex With Men
CARE Act	Comprehensive AIDS Resources Emergency Act
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CMS	Centers for Medicare & Medicaid Services
CMS	Centers for Medicare and Medicaid Services
CoAg	Cooperative Agreement
DASH	Division of Adolescent and School Health
DHAP	Division of HIV/AIDS Prevention
DISs	Disease Intervention Specialists
DSTDP	Division of STD Prevention
DTBE	Division of Tuberculosis Elimination
DVH	Division of Viral Hepatitis
EOC	Emergency Operations Center
FOAs	Funding Opportunity Announcements
FPL	Federal Poverty Level
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
ID	Infectious Disease
IDU	Injection Drug Use

IOM	Institute of Medicine
MAI	Minority AIDS Initiative
MCOs	Managed Care Organizations
ME	Medicaid Expansion
MMP	Medical Monitoring Project
MSM	Men Who Have Sex With Men
NACCHO	National Association of County and City Health Officials
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCSO	National Coalition of STD Directors
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
NME	Non-Medicaid Expansion
NPs	Nurse Practitioners
OAMC	Outpatient Ambulatory Medical Care
OAMC	Outpatient Ambulatory Medical Care
PACHA	Presidential Advisory Council on HIV/AIDS
PAs	Physician Assistants
PCPs	Primary Care Physicians/Providers
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
Project ECHO	Project Extension for Community Healthcare Outcomes
PWID	Persons Who Inject Drugs
QHP	Qualified Health Plan
RSR	Ryan White Services Report
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SMAIF	Secretary's Minority AIDS Initiative Fund
SPNS	Special Projects of National Significance
TA	Technical Assistance
TB	Tuberculosis
USPHS	U.S. Public Health Service