LOS ANGELES COUNTY
COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

PUBLIC POLICY COMMITTEE MEETING MINUTES

October 15, 2018

The Public Policy Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support Public Policy Committee activities.

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	COMM STAFF/ CONSULTANTS
Aaron Fox, MPM, *Co-Chair*	Eduardo Martinez *(Alt.)*	Jason Brown	Cheryl Barrit, MPIA
Terry Goddard, MA, *Co-Chair*	Katja Nelson	Danielle Campbell	Jane Nachazel
Kyle Baker	Martin Sattah, MD	Craig Pulsipher	Julie Tolentino, MPH
Alasdair Burton *(Alt.)*		Craig Scott	
Jerry D. Gates, PhD	**MEMBERS ABSENT**		**DHSP STAFF**
Lee Kochems, MA	Eric Paul Leue		None additional
Andrew Lopez *(Alt.)*	Greg Wilson		

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Public Policy Committee Agenda, *10/15/2018*
2) **Minutes**: Public Policy Committee Meeting Minutes, *9/10/2018*
3) **Template**: 2019 Work Plan (WP) Template, Draft/For Review, *10/15/2018*
4) **Priorities**: 2018 Policy Priorities, *1/8/2018*
5) **Policy**: Federal AIDS Policy Partnership, Ryan White Work Group, HIV/AIDS Community Consensus on the Future of the Ryan White HIV/AIDS Treatment Modernization Act, *9/10/2009*
6) **Fact Sheet**: Health Reform Fact Sheet, Improving Access to HIV Prevention, Care, and Treatment for Women, *March 2013*
7) **Fact Sheet**: HRSA's Ryan White HIV/AIDS Program, Program Fact Sheet, *January 2018*
8) **Table**: Quick Reference for Planning Council Support (PCS) Staff: Legislative Requirements for Planning Councils/Bodies, with HRSA/HAB Definitions, Clarifications, and Expectations, *March 2017*
9) **Fact Sheet**: Los Angeles County Commission on HIV, Fact Sheet, *9/26/2018*
10) **Statement**: Los Angeles County Commission on HIV, Vision, Mission
11) **Description**: Los Angeles County Commission on HIV, Standing Committee Description, *10/4/2018*
12) **PowerPoint**: Los Angeles County Comprehensive HIV Plan (CHP), 2017-2021
13) **Graphic**: Los Angeles County Commission on HIV, Comprehensive HIV Continuum Framework, *12/8/2016*
14) **Table**: Division of HIV and STD Programs (DHSP) and Commission on HIV (COH), Roles and Responsibilities
15) **Graphic**: California State Legislation: How a Bill becomes a Law
16) **Graphic**: Federal Legislation: How a Bill becomes a Law
17) **Article**: Washington- House Passes $854 billion Spending Bill to Avert Shutdown, *9/26/2018*
18) **Table**: 2018-2019 Legislative Docket, *10/4/2018*
19) **Graphic**: Medi-Cal Facts and Figures, *December 2017*
20) **Fact Sheet**: U.S. Federal Funding for HV/AIDS: Trends Over Time, *November 2017*

CALL TO ORDER: Mr. Fox called the meeting to order at 1:05 pm.

I. ADMINISTRATIVE MATTERS

1. **APPROVAL OF AGENDA**:
MOTION #1: Approve the Agenda Order, as presented (***Passed by Consensus***).

2. **APPROVAL OF MEETING MINUTES**:
MOTION #2: Approve the 9/10/2018 Public Policy Committee Meeting Minutes, as presented (***Passed by Consensus***).

II. PUBLIC COMMENT

3. **OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION**: There were no comments.

III. COMMITTEE COMMENT

4. **NON-AGENDIZED OR FOLLOW-UP**: Dr. Gates reported the AIDS Education and Training Center (AETC) Program has been funded for five years at a higher level than previously. Individual grants have not been determined, but fears of cuts are now allayed.

IV. REPORTS

5. **EXECUTIVE DIRECTOR/STAFF REPORT**:
   a. **Committee Work Plan 2019**:
      - Ms. Barrit noted the template in the packet. All Committees are prioritizing their work for 2019. She included proposed Prioritization Criteria of: 1. Represent core functions of the Commission and Committee/subgroup; 2. Advance goals of the Comprehensive HIV Plan (CHP) and Los Angeles County HIV/AIDS Strategy (LACHAS); 3. Align with Commission staff and member capacities and time commitment. Other criteria specific to Public Policy can be added, if desired.
      - ➲ Ms. Barrit will email a Word copy of the document to Public Policy members to input priority suggestions and return.

6. **CO-CHAIR REPORT**: There was no report.

V. DISCUSSION ITEMS

7. **POLICY OVERVIEW**:
   - Mr. Fox provided a foundational overview of legislation and programs pertinent to the Commission's work in order to prepare for 2019. He also included various documents in the packet for reference.
   - He called this presentation "Follow the Money" since it examined how programs do, or do not, fit together. Advocacy has successfully closed gaps between systems in some cases, but not in others. Key funding sources include: Ryan White Program (RWP), Medicaid (Medi-Cal in California), Medicare, Centers for Disease Control and Prevention (CDC), Housing Opportunities for People With AIDS (HOPWA), Substance Abuse and Mental Health Services Administration (SAMHSA).
   - The Obama administration made an effort to coordinate these programs by initiating an interagency working group on HIV, but they remain largely siloed. It also launched the first National HIV/AIDS Strategy, though the United States President's Emergency Plan for AIDS Relief (PEPfAR) had required an HIV/AIDS strategy for grantees since its 2003 inception.
   - Initiation of the Patient Protection and Affordable Care Act (ACA) created expected and unexpected changes impacting all the programs noted above, those who benefit from them, their government employees, policy activists, and community planners in what may be a rapidly changing environment depending on whether or not a state expanded Medicaid. There is little change in states like Mississippi that did not expand Medicaid because the federal government manages its exchange and the state does not contribute. Change is massive and complex in states like California that did expand Medicaid.
   - Prior to ACA, PLWH were ineligible for Medi-Cal until they reached a threshold of symptoms so RWP was their primary resource for medical care, medications, and other services. Ryan White is unique among federal laws in establishing a community planning mechanism to determine how funds are spent. The Commission represents that in Los Angeles County

(LAC). Funding is also disbursed among: Part A, for the most heavily impacted areas (Eligible Metropolitan Areas [EMAs] and Transitional Grant Areas [TGAs]); Part B, for the state; and Part C, for clinics serving specific needs, e.g., rural areas.

- Enacted on 8/18/1990, the law has been re-authorized four times with 2009 the last and the one which governs current work. It instituted the 75%/25% rule which requires spending a minimum of 75% of the Part A award on core medical services with no more than 25% on support services. That has become a major problem in many areas following enactment of the ACA because many PLWH moved from the RWP to another payer. The RWP is the payer of last resort, and has never covered hospitalization or specialist care not directly related to HIV. The RWP is not an entitlement which must be funded.
- Historically, the RWP began with and maintained bipartisan support, but there are now divisive issues, e.g., funding services for the undocumented, so most advocates prefer not to open the legislation for reauthorization at this time. Mr. Baker added advocates now routinely hear congresspersons question the continued need for the RWP since enactment of the ACA. Mr. Fox also noted the extensive list of those who signed on from every state to 2009 community recommendations in the packet. With health care landscapes differing across states, the potential for such broad agreement today was poor.
- Overall, Medicaid and Medicare are the largest HIV care funders in the United States, especially in light of the ACA. Funding for Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs), i.e., 330 grants, is a related key funding stream as FQHCs make up the backbone of the health system in many states, especially California. All but one RW-funded medical provider in LAC are FQHCs. Funding is due for renewal in 2020, but the last renewal was delayed until after funding expired creating provider uncertainty and uncertainty for their clients. It is not known if that will occur again.
- The ACA took full effect on 1/1/2012 driving massive change, in particular to the RWP which remains unchanged since 2009. The largest change was Medicaid, or in California Medi-Cal, expansion. Eligibility was no longer based on disability and an asset test. Instead, ACA uses a citizenship requirement and Modified Adjusted Gross Income (MAGI) below 138% of the Federal Poverty Level (FPL). FPL is $12,000 for a single person so 138% of FPL is approximately $14,000 or $15,000.
- In many ways, HIV advocates should take significant credit for this expansion. The Early Treatment for HIV Act (ETHA) would have extended Medicaid to uninsured PLWH. It was introduced multiple times beginning in 2000, but never passed.
- The ACA impacts health insurance generally, such as plans under Covered California, by prohibiting discrimination based on pre-existing conditions, e.g., denial or excessive premiums, and removing annual or lifetime benefit caps.
- The ACA also changed access to HIV medications. Previously, medications were mainly accessed directly through RWP Part B funds supporting the AIDS Drug Assistance Program (ADAP). It also paid for a small Health Insurance Premium Payment (HIPP) program, but most insurers did not cover PLWH or premiums were too high. After ACA, it was less expensive to help a PLWH purchase comprehensive health insurance than to just pay medications so HIPP expanded. This year, California expanded HIPP again to help with premium payments and out of pocket costs for employer-based insurance as well.
- All ADAP programs now serve PLWH up to 500% of FPL excluding any co-payments. Approximately 30,000 PLWH in California now access ADAP with half on ADAP alone and the rest split between Medicare and private insurance.
- The ACA impacted other funding streams, too. For example, the Bush administration added Part D, a pharmacy benefit, to Medicare, but did not fund it. Medicare paid for drugs to a set amount, the "donut hole." Patients then paid until reaching a second set amount at which point Medicare resumed payment. For PLWH, expensive HIV drugs meant patients reached the "donut hole" quickly, but ADAP was not counted toward out of pocket costs so they never left. The ACA redefined ADAP as True Out Of Pocket (TROOP) cost so PLWH could traverse the "donut hole." There is also a Medicare Part D premium payment program. While program names differ, advocates worked to fill gaps by funding these items through ADAP.
- At the same time, the RWP remains a payer of last resort so roughly 70% of the RWP population receiving medical care shifted to Medi-Cal. California executed an 1115 Waiver, piloting ACA, in 2010. At that time, some 19,900 PLWH received Ambulatory Outpatient Medical (AOM). Now, despite new patients over time, approximately 6,300 PLWH receive AOM. Some of those individuals may be eligible for other RWP services such as Medical Care Coordination (MCC), Nutrition Support, Food Banks, or Child Care if not provided by other payers, but AOM remains the most expensive service category.
- Mental Health and Substance Abuse are other key RWP services that have seen a significant drop due to patient migration.
- The 2009 RWP reauthorization changed the basis for RWP formula funding to PLWH since, by that time, all HIV jurisdictions had name-based HIV surveillance providing a better, recent indicator of their disease burden. Previously, indicators such as AIDS cases did not accurately account for those who may have changed insurers, left a jurisdiction, or died.
- Advocates also worked to successfully change allocations from 50%/50% to 75% of funds for RWP formula funding and 25% for supplemental funding with the 2009 reauthorization. Historically, formula funding is more stable which helps planning.
- In 2008-2009, the national economy was in deep trouble and the California budget was $20 billion in the red. California is required by law to balance its budget every year so was pulling funds from multiple programs including $80 million of HIV services with some $27 million of that in HIV prevention state General Fund dollars. At one point, the state was contributing

$150 million to the ADAP program but, under economic duress, not only wanted to reduce ADAP funding but also institute co-payments for all beneficiaries. Advocates pushed back to limit those subject to co-payments but, in the end, the state zeroed out its HIV General Funds except to maintain the Office of AIDS (OA) and a small amount of surveillance funding.

- The Commission, the then Prevention Planning Committee (PPC, now integrated into the Commission), and the then Office of AIDS Programs and Policy (now DHSP) worked together to explore creative ways to fund necessary programs, e.g., using manufacturer rebate dollars from the ADAP program to fund services such as linkage to care and retention, and PrEP.
- Advocates also worked to improve efficiencies and staffing at OA to better manage coordination of all systems. Since 2009, the California HIV Alliance has also presented general fund asks. Initially, asks were for small, pilot projects, e.g., $3 million. This year, HIV received $15 million, $8 in prevention and $7 in surveillance, in one-time General Fund resources.
- California now has a rainy day fund in the billions and is passing budgets on time by July 1st. Since ACA, it has passed legislation that builds on it, e.g., to further cut out of pocket costs, ensure nondiscriminatory drug formularies, prohibit junk insurance that does not protect pre-existing conditions, submitted Medicaid Waiver to protect against barriers to access.
- Health 4 All is working to cover all eligible undocumented persons on Medi-Cal. Although the federal government will not cover the undocumented, California is using General Funds to do so, e.g., children are now covered. Two bills this year proposed adding young adults and adults over 65. Not signed, they will likely be picked up by the next administration. Care 4 All California wants to increase quality, affordability, and access across Medi-Cal and Covered California systems.
- A richer budget has funded improved Drug Medi-Cal and brought back the previously defunded Denti-Cal resulting in patients previously eligible for RWP Oral Health migrating to Denti-Cal. These are further examples of building on the ACA.
- The Commission and Board of Supervisors (BOS) have supported these policies. Yet, they have unintended consequences for RWP planning and funding while payer of last resort remains in place and reauthorization is not now politic. Budgets are policy documents and funding choices are policy choices. It is not feasible to operate in the same way as in the past.
- Mr. Baker added RWP Part A must be fully maximized or the next year's grant will be reduced by the amount not spent. Minority AIDS Initiative (MAI) funds may be rolled over for one year. Due to underspending, LAC has rolled forward MAI funding for several years and spent it in the following year. Contracts may be underspent because of a lack of service demand or because of provider staffing issues, e.g., inability to hire a clinician for six months equals $288,000 not billed.
- Mr. Fox continued there are also LAC contracting challenges noted in the Assessment of the Administrative Mechanism (AAM). If addressed, they could somewhat mitigate funding challenges. Mr. Baker noted DHSP previously wrote contracts for 110% of funding which allowed flexibility in maximizing possible expenditures when other services are underspent. The BOS disallowed the practice some years ago which may impact RWP more than other programs due to today's situation.
- Mr. Martinez urged understanding community concerns when consumers find a provider closed due to lack of funds and then hear about unused funds at the Commission. Mr. Fox replied he was attempting to describe the much larger construct that is influencing all of the resources in a trend that was inevitable and is only going to become more critical.
- Mr. Kochems said from 2008 to now there have been closures, but services were also consolidated in ways that allowed people to get to them. The whole landscape of HIV from the number of agencies to how they provide services has shifted. Mr. Baker added many agencies that did not offer medical services were affected when RWP funding shifted to 75% core medical. Mr. Fox continued that shift took into account scientific advancements that worked, but are very expensive.
- Dr. Gates empathized with patients jerked from one payer source to another who do not understand the complexities of why funds might remain on the table. He felt the Committees and the Commission as a whole has to anticipate how the landscape is changing from the science and the politics to everything else. He urged being proactive in preparing an initial reauthorization draft before someone else does and then review it periodically to keep it fresh.
- Mr. Kochems uplifted the consumer voice. It is stunning when you walk around a corner and find an agency has evaporated, a service has changed, or you have to go an extra ten miles to get to it. In this time, we may need to think about what kind of legislation we need and find authors to write it. This Committee is unique as it is separately funded from RWP so can engage in advocacy. He traveled from Georgia to Ohio and other places where concerns such as the coal industry fell second to health care concerns. That is changing the political conversation and California is seen as the leader.

➲ Ms. Barrit will email the Commission's Reauthorization Principles to the Public Policy Committee and include them in the November packet. The Principles were developed for the 2006 reauthorization and revised for the 2009 reauthorization.

➲ Add to Work Plan: Consideration of legislation to sponsor and recruitment of authors to write it.

8. **STD RESOLUTION FOLLOW UP**:
   - Mr. Fox reported several organizations met on 10/18/2018 after the Commission passed its resolution. They also want action and asked to be agendized on the 10/31/2018 Health Deputies meeting, but have not yet received a response. Usually the Health Deputies only review items with a Board Letter already scheduled for a BOS meeting.
   - Nevertheless, he felt the group would come to the Health Deputies meeting whether agendized or not. They appear to be using the previously successful PrEP example of the Health Deputies hearing the topic raised from the community and the Commission in order to enlist their support before the BOS.
   - Ms. Barrit added the Executive Committee Policy Work Group reviewed a draft of a comprehensive Board Letter designed to take advantage of the one-year anniversary mark of the Los Angeles County HIV/AIDS Strategy (LACHAS). It is also being reviewed by key people at the Department of Public Health. The goal is to present it for approval at the 11/8/2018 Annual Commission Meeting and have it signed by all the Commissioners to underline the full representation of the body.
   - The Board Letter addresses the STD Resolution, AAM recommendations, larger policy issues impacting the Commission's ability to do an effective Priorities- and Allocations-Setting process, and the housing carve-out conversation.
   - ➲ Mr. Kochems will inform Consumer Caucus members at their 10/16/2018 meeting about the 10/31/2018 Health Deputies meeting STD presentation, the importance of raising the consumer voice there, and available help with speaker training.

9. **COUNTY POLICY ISSUES**: This item was tabled.

10. **STATE LEGISLATION AND BUDGET**: This item was tabled.

11. **FEDERAL POLICY UPDATE**: This item was tabled.

VI. NEXT STEPS

12. **TASK/ASSIGNMENTS RECAP**: There were no additional items.

13. **AGENDA DEVELOPMENT FOR NEXT MEETING**: There were no additional items.

VII. ANNOUNCEMENTS

14. **OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS**: There were no announcements.

VIII. ADJOURNMENT

15. **ADJOURNMENT**: The meeting adjourned at 3:05 pm.