LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE
Virtual Meeting

September 13, 2021

1:00PM-3:00PM (PST)

***Meeting Agenda + Packet will be available on our website at: http://hiv.lacounty.gov/Public-Policy-Committee**

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/6uvr3hxp

**Link is for non-Committee members only*

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PUBLIC COMMENTS

Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PUBLIC POLICY COMMITTEE

MONDAY, SEPTEMBER 13, 2021 | 1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/6uvr3hxp
Link is for non-committee members only

To Join by Phone: 1-415-655-0001
Access code: 145 602 3120

Public Policy Committee Members:			
Katja Nelson, MPP Co-Chair	Lee Kochems, MA Co-Chair	Alasdair Burton, (Alternate)	Jerry D. Gates, PhD
Gerald Garth	Eduardo Martinez (Alternate)	Isabella Rodriguez (Alternate)	Ricky Rosales
Martin Sattah, MD	Tony Spears (Alternate)		
QUORUM: 6			

AGENDA POSTED September 9, 2021

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are at 510 S. Vermont Ave. 14th Floor, one block North of Wilshire Blvd on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items

that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests - from members or other stakeholders - within the limitations and requirements of other possible constraints.

Call to Order, Introductions and Check-in, Conflict of Interest Statements 1:00 PM – 1:05 PM

I. ADMINISTRATIVE MATTERS

1:05 PM – 1:08 PM

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT

1:08 PM – 1:10 PM

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

III. COMMITTEE NEW BUSINESS ITEMS

1:10 PM – 1:15 PM

4. Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. Executive Director/Staff Report 1:15 PM – 1:20 PM
   a. Operational Updates
   b. Committee and Caucus Updates

6. Co-Chair Report 1:20 PM – 1:30 PM
   a. Act Now Against Meth (ANAM) Update
   b. Ending the HIV Epidemic COH Leads Update
   c. "So, You Want to Talk about Race" by I. Oluo Reading Activity
      Selected **Excerpts only** from Chapters 12 OR 13

V. DISCUSSION ITEMS

7. Legislative Docket 1:35 PM – 1:50 PM
BREATHE Act
https://breatheact.org/wp-content/uploads/2020/07/The-BREATHE-Act-PDF_FINAL3-1.pdf

8. Policies Priority – Feedback from the Division of HIV and STD Programs (DHSP) on Selecting Priorities 1:50 PM – 2:10PM

9. State Policy & Budget Update 2:10 PM – 2:20 PM

10. Federal Policy Update 2:20 PM – 2:40 PM
a. Blood and Organ Donations

11. County Policy Update 2:40 PM – 2:50 PM

VI. NEXT STEPS 2:50 PM – 2:55 PM

12. Task/Assignments Recap

13. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

14. Opportunity for members of the public and the committee to make announcements

VIII. ADJOURNMENT 3:00 PM

15. Adjournment for the meeting of September 13, 2021

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order as presented or revised.**
MOTION #2	**Approve the Public Policy Committee minutes, as presented or revised.**

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor• Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG • *VIRTUAL WEBEX MEETING*

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PUBLIC POLICY COMMITTEE MEETING MINUTES

Draft

August 2, 2021

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Katja Nelson, MPP, Co-Chair	P	Nestor Kamurigi	A
Lee Kochems, MA, Co-Chair	P	Isabella Rodriguez (Alternate)	P
Alasdair Burton (Alternate)	P	Ricky Rosales	A
Jerry Gates, PhD	P	Martin Sattah, MD	P
Gerald Garth	A	Tony Spears (Alternative)	A
Eduardo Martinez (Alternate)	P		
COMMISSION STAFF AND CONSULTANTS			
Carolyn Echols-Watson, Catherine Lapointe, Academic Intern			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website at
http://hiv.lacounty.gov/Portals/HIV/Commission%20Meetings/2021/Packet/1%20-%20PPC_080221_Final-merged%20Packet.pdf?ver=rKUcYaUDwZSuduftFG5uzQ%3d%3d

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST
Katja Nelson called the meeting to order at approximately 1:07PM. Attendees were asked to introduce themselves and committee members state their conflicts.

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: Approval of the 07/12/2021 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 COMMISSIONJURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMS REQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA:
L. Kochem made a request to adjourn in memory of Vincent Patti. K. Nelson made a request to adjourn in memory of Darren Aiken.

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Commission and Committee Updates

- Members were invited to the Priorities, Planning and Allocations Committee meeting scheduled for August 17, 2021 from 1 to 5PM. The Division on HIV and STD Programs (DHSP) will present program expenditure information for PY 30 and the Committee will begin the process of ranking services and allocation percentages for PY 32, 33 & 34.
- Richard Zaldivar will present on ANAM at the August 12, 2021 Commission meeting.

6. CO-CHAIR REPORT

a. Act Now Against Meth (ANAM) Update

- The Committee will discuss the ANAM information presented at the August 12th Commission meeting at the September 13, 2021 PPC meeting to determine the committee's future actions to support this effort.

b. Ending the HIV Epidemic (EHE) Activities and Feedback

There were no new updates from EHE representatives.

c. "So, You Want to Talk about Race" by I. Oluo Reading Activity
Selected Excerpts from Chapters 10 & 11

- Isabella Rodriguez read an excerpt from Chapter 10.
- K. Nelson invited members to volunteer for future readings. the September reading will be excerpts from Chapters 12 and/or 13.

V. DISCUSSION ITEMS

7. Legislative Docket

Assembly person Garcia's office provided the following regarding AB 453 and AB 1033 (Questions were posed by the Transgender and Consumer Caucuses regarding these bills.)

- **AB 453** was referred to the suspense file. That was done due to costs to the State. The office is working to remove the bill from the suspense file.

DRAFT

  - The Committee agreed to change the "recommended position" for AB 453 from "oppose" to "referred back to committee in discussion". The action was taken to reduce confusion on the Committee/Commission position.

➢ Staff will update the bill position recommendation on the legislative docket.

- **AB 1033** was a previous bill with the same subject matter as AB 453. The bill was not passed because the State legislature had taken a position to not approve new crimes due to prison overcrowding.

➢ The Committee requested staff share the AB 453 and AB1033 updates with the Transgender, Women and Consumer Caucuses.

- Staff noted the Women's Caucus will meet on August 30, 2021 and included AB 453 on their agenda for discussion as requested by the Commission.
- Staff submitted a request to Assembly person Chiu's office requesting a representative to attend the PPC's September 13, 2021 meeting. The request is to provide further information on bills AB 15 COVID-19 Relief: Tenancy: Tenant Stabilization Act of 2021 and AB 16 Tenancies: COVID 19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021. No response has been received to date.
- The Committee reviewed the legislative docket and noted many bills are working their way through various committees. The following bills were signed by the governor.
  - **AB 439 Certificates of Death: Gender Identity** – The law authorizes the deceased gender identity to be recorded as female, male or non-binary.
  - **SB 258 Aging** – The law revises the definition of "greatest social need" to include HIV status as a specified noneconomic factor. It was noted, this expands opportunities for funding and programming for older adults living with HIV. Further New York is the only other state in the country that uses this definition.
  - K. Nelson noted there is interest in working with the California Department of Aging as it relates to the Aging Master Plan and how this change can be incorporated in initiatives included in the plan.

8. Policy Priority - Priorities

- The Committee postponed the discussion on prioritizing policy priorities until a representative from DHSP can provide guidance on how to proceed. The Committee has requested Mario Perez, Director of DHSP to attend a future PPC meeting to discuss this issue with the Committee.

➢ Staff will follow up with M. Perez and request his attendance at the September 13, 2021 PPC meeting.

9. State Policy and Budget Update

- The Committee discussed the signed State budget. The budget is made up of several bills. AB 133 is the bill for the health budget which was signed by the governor. It includes the following budgeted amounts for the current Fiscal Year (FY) 2021-22.
- $13 million for End the Epidemic activities which include:

  - $ 3 million for Syringe Clearing House; $4 million for STD programs; $5 million for HIV and Aging Demonstration Programs and $1 million for hepatitis C testing.
  - In FY 2022 the $6 million for demonstration projects and hepatitis C testing will be re-allocated to the Syringe Clearing House and STD services.
- K. Nelson referred the Committee to the following documents regarding the State budget. (The documents are included in the meeting packet.)
  - 2021-22 Housing and Homeless Budget Summary which included the budget for the Projecthome Key program.
  - Health Access California Health: Consumer Advocacy Coalition Fact Sheet regarding Health Care and Coverage Investments and Improvement in 2021-22 California State Budget. It was noted, the County Department of Public Health's input is needed on how the County will use the allocated funding.
  - An article on the State of California Third District Court of Appeals ruling on a State statute requiring nursing home staff to use the correct pronouns for trans, and nonbinary patients is a freedom of speech violation. This impacts the LGBTQ Long-Term Care Facility Residents' Bill of Rights created by SB 219 in 2017.

10. Federal Policy Updates

a. Blood and Organ Donations

At the July 2021 Executive Committee meeting, a request was made for the PPC to review federal policies on blood and organ donations from PLWH and determine if PPC can make recommendations to improve policies.

- ➢ The Committee will gather information on the subject. K. Nelson will reach out to the Federal government for guidelines on blood and organ donations PLHIV.
- ➢ The Issue will be on the September 13, 2021 PPC agenda.
- The Committee reviewed their commitment to read the BREATHE proposal bill. It was noted, the Movement for Black Lives was contacted prior to the July meeting to provide some insight on the bill and how it varies from the George Floyd Justice and Policing Act of 2021. Staff is awaiting a response.
- ➢ Staff will follow up with the organization and K. Nelson will follow up with Felipe Findley who provide the initial introduction to the Movement for Black Lives.
- The Committee will continue the discussion of the BREATHE Act at the September 13th meeting. If the Movement for Black Lives is unable to present at that meeting the Committee has agreed to discuss and recommend a position to the Commission.
- Portions of the BREATHE bill were reviewed. It was noted the George Floyd Justice and Policing Act of 2021 includes allocating funds to policing. It was noted, the BREATHE Act prioritizes funding supportive services similar to the County of Los Angeles Anti-Racist Diversity and Inclusion Initiative (ARDI). The proposal includes diversion of resources to invest in community safety, housing, health, creating sustainable communities and holding officials accountable.
- ➢ The Committee agree to change the recommended position for the BREATHE Act and George Floyd Justice and Policing Act of 2021 to "referred back to committee, in discussion".

11. County Policy Update

a. Reassessing the County's Response to the STD Epidemic

The Committee discussed the STD Epidemic letter prepared by the Commission for submission to the Board of Supervisors (BOS). It was recommended members make public comments at the BOS meetings or submit written comments. It was noted, the letter will include Black/African American Community (BAAC) Task Force (TF) priorities submitted to Supervisor Holly Mitchell's office. They are as follows.

1) Provide technical assistance to aid Black/AA agencies in obtaining funds for culturally sensitive service

2) Provide on-site cultural sensitivity and education training to include addressing implicit bias and medical mistrust within the Black/AA community for all County-contracted providers and adopt cultural humility into the local HIV provider framework

3) Provide resources to Community-Based Organizations (CBOs) to develop, implement and evaluate primary prevention interventions which are culturally appropriate and relevant

- An educational element was requested for inclusion in the letter. It was noted, the general public is not educated on STD issues.
- The Committee discussed the report back to BOS on establishing an anti-racist, Los Angeles County policy agenda. The County's strategic plan will cross all departments and is targeted for launch in the spring of 2022. County leaders and departments are convening. Trainings are being established.
- ➢ The Committee requested a County representative present on the initiative to PPC to determine the Commission's role.
- The Committee referenced the BOS media release regarding $527 million for Los Angeles County Homeless Initiative. The initiative includes behavioral health infrastructure investments.
- A recommendation was made for the Committee to initiate a conversation with State and County leadership regarding priorities for the public health infrastructure. The Committee may want to provide service recommendations and identify the scope of services State funding can support.

VI. NEXT STEPS

12. **TASK/ASSIGNMENTS RECAP**: Task/Assignments are included in the minutes. Indicated with a red arrow.
13. **AGENDA DEVELOPMENT FOR NEXT MEETING**: Continued agenda items are indicated in the minutes.

VII. ANNOUNCEMENTS

OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS:
No Announcements

VIII. ADJOURNMENT

14. ADJOURNMENT:

The PPC adjourned in memory of Vincent Patti and Darren Aiken with recognition of each individual's activism and contributions specifically those efforts to end HIV. The PPC acknowledged the loss with 30 seconds of silence to memorialize their loss.

The meeting adjourned at approximately 2:05 pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

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CODE OF CONDUCT

We welcome commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. We create a safe environment that celebrates differences while striving for consensus and is characterized by consistent, professional, and respectful behavior. Our common enemies are HIV and STDs. We strive to be introspective and understand and clarify our assumptions, while appreciating the complex intersectionality of the lives we live. We challenge ourselves to be self-reflective and committed to an ongoing understanding. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We strive for consensus and compassion in all our interactions.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen, don't repeat what has already been stated, avoid interrupting others, and allow others to be heard.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **We give and accept respectful and constructive feedback.**
7) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
8) **We have no place in our deliberations for homophobic, racist, sexist, and other discriminatory statements and "-isms" (including transphobia, ableism, and ageism).**
9) **We give ourselves permission to learn from our mistakes.**

Approved (11/12/1998); Revised (2/10/2005; 9/6/2005); **Revised (4/11/19)**

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 8/11/21

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Ambulatory Outpatient Medical (AOM) Benefits Specialty Biomedical HIV Prevention Medical Care Coordination (MCC) HIV and STD Prevention HIV Testing Social & Sexual Networks
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV) STD Screening, Diagnosis, and Treatment Health Education/Risk Reduction (HERR) Mental Health Oral Healthcare Services Transitional Case Management Ambulatory Outpatient Medical (AOM) Benefits Specialty Biomedical HIV Prevention Medical Care Coordination (MCC) Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services Medical Care Coordination (MCC) Ambulatory Outpatient Medical (AOM) Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MILLS	**Anthony**	Southern CA Men’s Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences	No Ryan White or prevention contracts
MORENO	**Carlos**	Children’s Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
THOMAS	**Damone**	No Affiliation	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VEGA	**Rene**	Via Care Community Clinic	Biomedical HIV Prevention
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

2021-2022 Legislative Docket

(Approved by the Commission on HIV as of 07/08/2021) *

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH | County bills noted w/asterisk

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 4 (Arambula)	Medi-Cal: eligibility	The bill would extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB4	Support	*26-AUG-21 In Committee: Held Under Submission.*
AB 15 (Chiu)	COVID-19 relief: tenancy: Tenant Stabilization Act of 2021	This bill would extend the definition of "COVID-19 rental debt" as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and December 31, 2021. The bill would also extend the repeal date of the act to January 1, 2026. The bill would make other conforming changes to align with these extended dates. By extending the repeal date of the act, the bill would expand the crime of perjury and create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB15 *Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.*	Support with questions	11-JAN-21 Referred to Committee on Housing and Community Development
AB 16 (Chiu)	Tenancies: COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021	This bill would establish the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB16 *Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.*	Watch	13-JAN-21 Re-referred to Committee on Housing and Community Development

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 19 (Santiago)	Unemployment insurance compensation: COVID-19 pandemic: temporary benefits	This bill would require the Employment Development Department to provide, until July 1, 2022, following the termination of assistance pursuant to Pandemic Unemployment Assistance (PUA) and Pandemic Emergency Unemployment Compensation (PEUC) or any other federal or state supplemental unemployment compensation payments for unemployment due to the COVID-19 pandemic, in addition to an individual's weekly benefit amount as otherwise provided for by existing unemployment compensation law, unemployment compensation benefits equivalent to the terminated federal or state supplemental unemployment compensation payments for the remainder of the duration of time the individual is unemployed due to the COVID-19 pandemic, notwithstanding the weekly benefit cap. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB19	Watch (with more information)	11-JAN-21 Referred to Committee on Insurance
AB 32 (Aguiar-Curry)	Telehealth	The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB32	Support	*08-JULY-21 In Committee: Set, First Hearing. Hearing Canceled at the Request of Author.*
AB 65 (Low)	California Universal Basic Income Program: Personal Income Tax	This bill would declare the intent of the Legislature to enact legislation to create a California Universal Basic Income Program, with the intention of ensuring economic security for all Californians. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB65	Watch	20-MAY-21 In Committee: Held Under Submission
AB 71 (Luz Rivas)	Homelessness funding: Bring California Home Act	This bill, for taxable years beginning on or after January 1, 2022, would include a taxpayer's global low-taxed income in their gross income for purposes of the Personal Income Tax Law, in modified conformity with the above-described federal provisions. The bill would exempt any standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement its provisions from the rulemaking provisions of the Administrative Procedure Act. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB71	Support	03-JUNE-21 Ordered to Inactive File at the Request of Assembly Member Luz Rivas

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 77 (Petrie-Norris)	Substance use disorder treatment services	This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the State Department of Health Care Services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB77	Support	26-MAR-21 Re-referred to Committee on Health
AB 218 (Ward)	Change of gender and sex identifier	This bill would recast these provisions relating to new birth certificates to provide for a change in gender and sex identifier and to specify that a person who was issued a birth certificate by this state, rather than a person born in this state, may obtain a new birth certificate. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB218	Support	*07-SEP-21 Read Second Time. Ordered to Senate Third reading.*
AB 240 (Rodriguez)	Local health department workforce assessment.	This bill would require the department to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB240	Support with Questions	*26-AUG-21 In Committee: Held under Submission*
AB 245 (Chiu)	Educational equity: student records: name and gender changes	This bill would require a campus of the University of California, California State University, or California Community Colleges to update a former student's records to include the student's updated legal name or gender if the institution receives government-issued documentation, as described, from the student demonstrating that the former student's legal name or gender has been changed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB245	Support	*02-SEP-21 Enrolled and Presented to the Governor*
AB 328 (Chiu)	Reentry Housing and Workforce Development Program	This bill would establish the Reentry Housing Program. The bill would require the Department of Housing and Community Development to, on or before July 1, 2022, take specified actions to, upon appropriation by the Legislature, provide grants to counties and continuums of care, as defined, for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB328	Support	20-May-21 In Committee: Hearing Postponed by Committee

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 369 (Kamlager)	Medi-Cal Services: Persons Experiencing Homelessness	This bill would require the department to implement a program of presumptive eligibility for individuals experiencing homelessness, under which an individual would receive full-scope Medi-Cal benefits without a share of cost. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB369	Support	*02-SEP-21 Senate Amendments Concurred in. To Engrossing and Enrolling*
AB 439 (Bauer-Kahan)	Certificates of death: gender identity	This bill would authorize the decedent's gender identity to be recorded as female, male, or nonbinary. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB439	Support	09-JULY-21 Chaptered by Secretary of State – Chap 53 Statues of 2021
*AB 453** (Garcia)*	*Sexual battery: nonconsensual condom removal*	*This bill would additionally provide that a person commits a sexual battery who causes contact between a penis, from which a condom has been removed, and the intimate part of another who did not verbally consent to the condom being removed.* *The bill has been referred to the Suspense File due to costs to the state. However, the Assembly person's office is hopeful it will get off Suspense because the bill ensures the public has access to justice. Assembly person Garcia is continuing to work on AB 453 and remains hopeful that the bill will be signed by Governor Newsom in the fall.* *Return to Committee per the Executive Committee (E.C.) motion. E.C. requested Transgender, Consumer and Women Caucuses review and provide comment on the bill. E.C. is concerned that a bill that criminalizes "non-consensual condom removal" would be opposed.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB453*	*Referred Back to Committee in Discussion*	*07-SEP-21 Senate Amendments Concurred in. To Engrossing and Enrolling.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 789 (Low)	Health care facilities	This bill would require a primary care services in an outpatient department of a health facility or a primary care clinic, as specified, to offer a patient receiving health services a hepatitis B screening test and a hepatitis C screening test, as specified. The bill would also require the practitioner to offer the patient follow up health care or refer the patient to a health care provider who can provide follow up health care if the screening test is positive or reactive, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB789	Support	*01-SEP-21 Senate Amendments Concurred in. To Engrossing and Enrolling*
AB 835 (Nazarian)	Hospital emergency departments: HIV testing	This bill would require every patient who has blood drawn at a hospital emergency department to be offered an HIV test, as specified. The bill would specify the manner in which the results of that test are provided. The bill would state that a hospital emergency department is not required to offer an HIV test to a patient if the department determines that the patient is being treated for a life-threatening emergency or if they determine the person lacks the capacity to consent to an HIV test. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB835	Support	*26-AUG-21 In Committee: Held Under Submission*
AB 1038 (Gipson)	California Health Equity Program	This bill would establish the California Health Equity Program, a competitive grant program administered by the Office of Health Equity to community-based nonprofit organizations, community clinics, local health departments, and tribal organizations to take actions related to health equity. The bill would establish the California Health Equity Fund. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1038	Support	*26-AUG-21 In Committee: Held Under Submission*
AB 1344 (Arambula)	State Department of Public Health: needle and syringe exchange services	This bill would expressly exempt needle and syringe exchange services application submissions, authorizations, and operations from review under the California Environmental Quality Act. Further, the bill would provide that the services provided by an entity authorized to provide those needle and syringe exchange services, and any foreseeable and reasonable consequences of providing those services, do not constitute a public nuisance under specified existing law. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB1344	Support	*01-SEP-21 Senate Amendments Concurred In. To Engrossing and Enrolling*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 1400 (Kalra)	Guaranteed Health Care for All	This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1400	Support	22-FEB-21 Read First Time.
AB 1407 (Burke)	Nurses: implicit bias courses.	This bill would state the intent of the Legislature to enact legislation that would address discrimination in health care. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1407	Support	*01-SEP-21 Senate Amendments Concurred in. To Engrossing and Enrolling*
AB 2218 (Santiago) (Formerly)	Transgender Wellness and Equity Fund	This law establishes the Transgender Wellness and Equity Fund to organizations serving people that identify as transgender, gender nonconforming, or intersex (TGI), to create or fund TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care, as defined, and related education programs for health care providers.	In Support of Transgender Wellness Fund	26-SEP-20 Approved by the Governor
SB 17 (Pan)	*Office of Racial Equity*	This bill would state the intent of the Legislature to enact legislation to require the department to address racism as a public health crisis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB17	Support	*26-AUG-21 Set for First Hearing Canceled at the Request of Author.*
SB 56 (Durazo)	Medi-Cal: eligibility	This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB56	Support	23-June-21 From Committee: Do Pass and Re-refer to Committee on Appropriation

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 57 (Wiener)	Controlled Substances: Overdose Prevention Program	This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile consumption supplies, and providing access or referrals to substance use disorder treatment. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB57 *The City of Los Angeles approved a pilot site for this program and requested a bill amendment to include the City of Los Angeles. The sponsor held the bill for this legislative session and will continue the legislative process in January 2022 (Legislative Session 2022-23).*	Support	05-July-21 From Committee with Author's Amendments. Read Second Time and Amended. Re-referred to Committee on Health
SB 110 (Weiner)	Substance use disorder services: contingency management services	This bill will expand substance use disorder services to include contingency management services, as specified, subject to utilization controls. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB110	Support	*03-SEP-21 Assembly Amendments Concurred in. Ordered to Engrossing and Enrolling*
SB 217 (Dahle)	Comprehensive sexual health education and human immuno-deficiency virus (HIV) prevention education.	This bill would require the governing board of a school district to adopt a policy at a publicly noticed meeting specifying how parents and guardians of pupils may inspect the written and audiovisual educational materials used in comprehensive sexual health education. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB217	Opposed Unless Amended	20-MAY-21 May 20 Hearing: Held in Committee and Under Submission

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 221 (Wiener)	Health care coverage: timely access to care	The bill would require both a health care service plan and a health insurer to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan or a health insurer to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a follow up appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB221	Support	*03-SEP-21 Ordered Third Reading.*
SB 225 (Wiener)	Medical procedures: individuals born with variations in their physical sex characteristics	This bill would prohibit a physician and surgeon from performing certain sex organ modification procedures on an individual born with variations in their physical sex characteristics who is under 12 years of age unless the procedure is a surgery required to address an immediate risk of physical harm, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB225	Support	05-APR-21 April 5 Set for First Hearing Canceled at the Request of the Author.
SB 258 (Laird)	Aging	The bill would revise this definition "greatest social need" to include human immunodeficiency virus (HIV) status as a specified noneconomic factor. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB258	Support	23-JULY-21 Chaptered by Secretary of State. Chapter 132, Statues of 2021.
SB 306 (Pan)	Sexually transmitted disease: testing	This bill would require a health care provider to include "expedited partner therapy" on a prescription if the practitioner is unable to obtain the name of a patient's sexual partner. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306	Support	*07-SEP-21 Read Third Time and Amended.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 316 (Eggman)	Medi-Cal: federally qualified health centers and rural health clinics	This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB316	Support	*30-AUG-21 Read Second Time. Ordered to Third Hearing.*
SB 357 (Wiener)	Crimes: loitering for the purpose of engaging in a prostitution offense	Existing law prohibits soliciting or engaging in an act of prostitution. This bill would repeal those provisions related to loitering with the intent to commit prostitution and would make other conforming changes. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB357	Support	*01-SEP-21 Ordered to Third Reading.*
SB 464 (Hurtado)	California Food Assistance Program: eligibility *and benefits*	This bill, commencing January 1, 2023, would instead make a noncitizen applicant eligible for the California Food Assistance Program if the noncitizen satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB464	Support	01-July-21 From Committee: Do Pass and Re-refer to Committee on Appropriation. Re-referred to Committee Appropriation
SB 523 (Leyva)	Health care coverage: contraceptives	This bill would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issues, amended, renewed, or delivered on and after January 1, 2022. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB523	Support	*26-AUG-21 August 26 Hearing Postponed by Committee.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 803 (Beall) (Formerly)	Mental health services: peer support specialist certification	This law requires the department, by July 1, 2022, to establish statewide requirements for counties to use in developing certification programs for the certification of peer support specialists. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB803	Requires funding to implement. The State has proposed $4.7 million for 22-23 fiscal year. LAC is in support of the proposal.	25-SEP-20 Approved by the Governor
FEDERAL BILLS				
H.R.5 (Cicilline)	Equality Act	This bill prohibits discrimination based on sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. https://www.congress.gov/bill/117th-congress/house-bill/5	Support	17-March-2021 Senate Committee on the Judiciary Hearings Held
H.R. 1201 (Lowenthal-Markey)	International Human 5 Rights Defense Act of 2021	The bill is to establish in the Bureau of Democracy, Human Rights, and Labor of the Department of State a Special Envoy for the Human Rights of LGBTQI Peoples. The Special Envoy shall serve as the principal advisor to the Secretary of State regarding human rights for LGBTQI people internationally. https://www.congress.gov/bill/117th-congress/house-bill/1201/text	Support	02-APRIL-21 Referred to the Subcommittee on Africa, Global Health and Global Human Rights

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
*H.R. 1280** (Bass)*	*George Floyd Justice and Policing Act of 2021*	*This bill addresses a wide range of policies and issues regarding policing practices and law enforcement accountability. It increases accountability for law enforcement misconduct, restricts the use of certain policing practices, enhances transparency and data collection, and establishes best practices and training requirements.* *The Commission on HIV refer this bill back to the Committee because funding for the police is included in the bill. This is at odds with the movement for Black Lives which opposes the bill.* *https://www.congress.gov/bill/117th-congress/house-bill/1280?q=%7B%22search%22%3A%5B%22George+Floyd+Justice+and+Policing+Act+of+2021%22%5D%7D&s=2&r=1*	*Referred Back to Committee in Discussion*	09-March-21 Received in the Senate
*Federal Bill*** Proposal (Sponsored Movement for Black Lives)*	*The BREATHE Act*	*Divesting Federal Resources from Policing and Incarceration & Ending Federal Criminal-Legal System Harms* *Investing in New Approaches to Community Safety Utilizing Funding Incentives* *Allocating New Money to Build Healthy, Sustainable & Equitable Communities for All People* *Holding Officials Accountable & Enhancing Self-Determination of Black Communities* *file:///S:/2021%20Calendar%20Year%20-%20Meetings/Committees/Public%20Policy/07%20-%20July/Packet/The-BREATHE-Act-V.16_.pdf*	*Referred Back to Committee in Discussion*	
S.1 (Merkley)	For the People Act	This bill addresses voter access, election integrity and security, campaign finance, and ethics for the three branches of government. https://www.congress.gov/bill/117th-congress/senate-bill/1?q=%7B%22search%22%3A%5B%22S+1%22%5D%7D&s=1&r=1	Support	*11-AUG-21 Placed on Senate Legislative Calendar Under General Orders.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
S.4263/ H.R.4 (Leahy)	John Lewis Voting Rights Advancement Act 2021	To amend the Voting Rights Act of 1965 to revise the criteria for determining which States and political subdivisions are subject to section 4 of the Act, and for other purposes. https://www.congress.gov/bill/116th-congress/senate-bill/4263?q=%7B%22search%22%3A%5B%22S+4263%22%5D%7D&s=6&r=1	Support	*24-AUG-20 Motion to Reconsider Laid on the Table Agreed to Without Objection. Action by: House of Representatives*

* Includes bills not approved by the Commission on HIV on July 8
** The bill was not approved by the Commission on HIV on July 8
*** Commission on HIV recommended bill for the Legislative docket

Footnotes:
(1) Senate Rule 28.8 means if the Chair determines that any state costs of a bill are not significant, the measure will be sent directly to the Senate Floor for Second Reading without a hearing in the committee.

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PUBLIC POLICY COMMITTEE (PPC)
2021 POLICY PRIORITIES

(Approved 04/08/2021)

HIV has been raging in communities across the world for almost 40 years and with advancements in biomedical interventions, research and vaccines, the time for the HIV cure is now. With a renewed sense of optimism and urgency, the PPC remains steadfast in its commitment to universal health care, eradication of racism in all forms, and unfettered access to care and supportive services to ensure that all people living with HIV and communities most impacted by HIV and STDs, live, full, productive lives.

The COVID-19 global pandemic has demonstrated that with political will, funding, and most important of all, urgency, rapid and safe vaccine development is possible. The COVID-19 global pandemic is severely impacting the delivery of HIV prevention and care services. The PPC is compelled to encourage and support innovative efforts to reduce bureaucracy, increase funding and enhance HIV prevention and care service. This effort is to address negative impacts pre-COVID service levels, as well exceed the quantity and quality of HIV and prevention services.

The PPC recommends the Commission on HIV endorse the prioritization of the following issues. PPC will identify support legislation, local policies, procedures, and regulations that address Commission priorities in calendar year 2021: (Issues are in no particular order.)

Racism

a. Health equity, the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e. homophobia, transphobia and misogyny); housing; mental health; substance abuse; and income/wealth gaps.
b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out of systemic and systematic racism as it affects Black/African American communities.

Housing

a. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS.

b. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
c. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.

Sexual Health

a. Access to prevention, care and treatment and bio-medical intervention (such as PrEP and PEP) services. Promote the distribution of services to people at risk for acquiring HIV and people living with HIV/AIDS.
b. Comprehensive HIV/STD counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.
c. Maximize HIV prevention to reduce and eliminate syphilis and gonorrhea cases, among young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color.
d. Advance and enhance routine HIV testing and expanded linkage to care.
e. Maintain and expand funding for access and availability of HIV, STD, and viral hepatitis services.
f. Promote women centered prevention services to include domestic violence and family planning services for women living with and at high risk of acquiring HIV/AIDS.
g. Preserve full funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Abuse

a. Advocate for substance abuse services to PLWHA.
b. Advocate for services and programs associated with methamphetamine use and HIV transmission.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWHA) and those at risk of acquiring HIV. This includes young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color, transgender and the aging.

Aging

a. Create and expand medical and supportive services for PLWHA ages 50 and over.

Women

a. Create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare and substance abuse.

Transgender

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund created by the passage of AB2218.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.
c. Increase and enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to **not** disincentives contractors from referring clients to other contractors.
d. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.

Service Delivery

a. Enhance the accountability of healthcare service deliverables. This would include a coordinated effort between federal, state, and local governments.
b. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine mirroring the COVID 19 vaccine process.

Criminalization

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.
b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

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.

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FESIA A. DAVENPORT
Chief Executive Officer

Board of Supervisors
HILDA L. SOLIS
First District
HOLLY J. MITCHELL
Second District
SHEILA KUEHL
Third District
JANICE HAHN
Fourth District
KATHRYN BARGER
Fifth District

September 3, 2021

To: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Fesia A. Davenport
Chief Executive Officer

SACRAMENTO UPDATE - ENACTMENT OF THE FISCAL YEAR 2021-22 STATE BUDGET ACT AND FINAL OUTCOME OF ADVOCACY ITEMS

OVERVIEW

This memorandum provides an update on the Fiscal Year (FY) 2021-22 State Budget Act, including the "Main Budget Bill" (AB 128) which Governor Gavin Newsom signed on June 28, 2021. The Governor also signed three "Budget Bill Jr.'s", AB 161 on July 9, 2021, SB 129 on July 12, 2021, and AB 164 on July 16, 2021, which amend the Main Budget Bill and make statutory changes to implement the State budget. These four measures, along with several budget trailer bills, enact most of the FY 2021-22 State Budget Act (2021 State Budget Act). The Legislature is expected to work on spending packages related to climate, wildfire, energy, and transportation, as well as introduce additional budget trailer bills to address other policy issues, in the remaining weeks of the first year of the 2021-22 legislative session.

As of the signing of the 2021 State Budget Act, the State was projecting a $75.7 billion surplus, which combined with over $25 billion in federal relief, will fund the State budget's economic recovery package (California Comeback Plan) that includes the following items of importance to the County:

- $12 billion over two years to tackle the homelessness crisis;
- $12 billion to expand the Golden State Stimulus program;
- $6 billion to expand broadband access coverage;
- $5.2 billion for back-rent and future rent payments;
- $5.1 billion for drought support, water supply, and natural habitat restoration projects;
- $1.5 billion in additional funding, for a total of $4 million in direct grants to small businesses;
- $3.9 billion to accomplish the State's zero-emissions vehicle goals;
- $3 billion into building more affordable housing for low-income families;
- $2 billion for wildfire and emergency preparedness;
- $2 billion for past-due water and utility bills and tenant legal assistance; and
- $1.1 billion to clean up streets by partnering with local governments.

Major County-Advocacy Items Included in the 2021 State Budget Act

The 2021 State Budget Act includes many items the County advocated for including:

Broadband – $6 billion over three years for broadband infrastructure and improved access to broadband services;

Homelessness – $4.8 billion over two years, including $1 billion for flexible local aid in both FY 2021-22 and FY 2022-23, with up to 80 percent of the funding each year allocated to cities, counties, and continuums of care;

Affordable Housing – $500 million to create a Foreclosure Intervention Housing Preservation program;

Behavioral Health Continuum Infrastructure – $2.2 billion for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources;

Public Health Infrastructure – $300 million annually beginning in FY 2022-23 for Local Health Jurisdictions to build a 21st century public health system;

Recall Election – $243.6 million in SGF for counties for the recall election;

CalWORKs Grant Increases – $142.9 million to provide a 5.3 percent increase to CalWORKs Maximum Aid Payment levels effective October 1, 2021;

Exide Facility Cleanup – $332.4 million over three years to cleanup an additional 3,000 residential properties, $132 million to complete closure activities and to conduct additional needed cleanup at the former Exide facility, and $16.5 million in SGF to support the State's Exide cost recovery efforts;

Rapid Response Fund – $105.2 million in one-time SGF to provide support for migrant family arrivals at the Southern California border;

High Road Training Program (HRTP) – $75 million for the expansion of the HRTP to be available until June 30, 2026; and

Homelessness Hiring Tax Credit – $30 million to implement the tax credit for taxable years 2022 through 2026.

The 2021 State Budget Act does not include two budget proposals the County successfully opposed:

Discontinuance of the Lanterman-Petris-Short (LPS) Beds Patients Contracts with Counties – Rejects the proposal to discontinue the State hospitals as a treatment option for LPS patients. Instead, requires the California Department of State Hospitals to convene an Incompetent to Stand Trial (IST) Solutions Workgroup to identify short-term, medium-term, and long-term solutions for alternatives to placement of defendants determined to be IST in a State Hospital.

The California Secretary of Health and Human Services would be authorized to discontinue admission of patients civilly committed under the LPS Act to a State Hospital and make other changes to reduce the existing LPS population if the Secretary determines that either: the IST Solutions Workgroup recommendations cannot be completed or the recommendations are not able to be implemented in a timely manner.

CalWORKs Single Allocation – $68.3 million in FY 2021-22 and $40.8 million in FY 2022-23 and ongoing, to reject and restore the Governor's May Revision proposal to reduce funding for the eligibility component of the Single Allocation.

The 2021 State Budget Act contains the following County-opposed proposal:

Non-Restorable Felony Incompetent to Stand Trial (IST) Trailer Bill Language – Requires felony IST patients deemed not restorable to mental competency to be returned to the county within 10 days and remain in the county, otherwise the State will charge the county a daily bed rate for continued treatment. This Office will continue to monitor this issue and seek opportunities for fiscal relief.

The attachment provides a detailed summary of the final outcome of the 2021 State Budget Act items the County took an advocacy position on, as previously reported and consistent with existing policy. Updates on specific County funding allocations will be provided as additional funding allocation information becomes available.

Should you have any questions concerning this matter, please contact me or Samara Ashley, Assistant Chief Executive Officer, at (213) 974-1464 or sashley@ceo.lacounty.gov.

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Attachment

c: All Department Heads

OUTCOMES OF THE FY 2021-22 COUNTY-ADVOCACY STATE BUDGET ITEMS

HOMELESSNESS

Homelessness – $7.3 billion for homelessness in Fiscal Year (FY) 2021-22, plus an additional $4.47 billion in FY 2022-23 for a total homelessness package of $12 billion. This includes $1.45 billion ($1.2 billion in federal American Rescue Plan Act [ARPA] funds and $250 million in State General Funds [SGF]) for Project Homekey in FY 2021-22 and $ 1.3 billion ($1 billion federal ARPA funds and $300 million in SGF) for Project Homekey in FY 2022-23.

County-supported Bring California Home (BCH) Act – $12 billion for homelessness, including $2 billion in one-time SGF to assist counties, Continuums of Care, and large cities address homelessness in their communities. $1 billion is provided in FY 2021-22 and $1 billion in FY 2022-23, with future years subject to appropriation. These funds, which will run through the Homeless Housing, Assistance, and Prevention program (HHAP), build upon over $1.5 billion in flexible aid provided to local jurisdictions over the past three years.

HOUSING

Emergency Rental Assistance – The County supported $1.4 billion federal Emergency Rental Assistance allocation, via SB 91 (Chapter 2, Statutes of 2021), to assist low-income tenants to stay housed and help stabilize small property owners.

Eviction Moratorium Extension – Includes the County-supported extension of the State's eviction moratorium that was enacted on January 29, 2021, via SB 91 (Chapter 2, Statutes of 2021).

Foreclosure Intervention Housing Preservation Program – $500 million, available for encumbrance or expenditure and for liquidation until June 30, 2027, for the creation of a Foreclosure Intervention Housing Preservation program.

BEHAVIORAL HEALTH

Behavioral Health Continuum Infrastructure Program – $755.7 million ($445.7 million in SGF and $310 million in federal Coronavirus Fiscal Recovery Fund) in FY 2021-22, $1.4 billion ($1.2 billion SGF and $220 million Coronavirus Fiscal Recover Fund) in FY 2022-23 and $2.1 million SGF in FY 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure.

Discontinuance of the Lanterman-Petris-Short (LPS) Bed Patients Contracts with Counties – The Legislature rejected the County-opposed proposal to discontinue State hospitals as a treatment option for LPS patients over three years, provide treatment for these patients at the county level only, and utilize State hospital beds for Incompetent to Stand Trail (IST) treatment.

However, AB 133 (Chapter 143, Statutes of 2021) requires that the California Health and Human Services Agency (CHHS) and the California Department of State Hospitals (DSH), convene an IST Solutions Workgroup to identify solutions to advance alternatives to placing defendants at a DSH facility who are deemed IST. The workgroup must submit recommendations to CHHS and the California Department of Finance on or before November 30, 2021, for short-term, medium-term, and long-term solutions that can be accomplished on or before specified dates.

If the recommendations cannot be completed by December 31, 2024, or if other described conditions are not met, DSH would be authorized to discontinue admissions for specified patients, impose patient reduction targets, and charge 150 percent of the daily bed rate to counties for specified patients that are above the patient reduction targets.

Non-Restorable Felony IST Patients – AB 133 (Chapter 143, Statutes of 2021), contains the County-opposed trailer bill language (TBL) to require felony IST patients deemed not restorable to mental competency to be returned to the county within 10 days and remain in the county, otherwise DSH will charge the county a daily bed rate.

Expansion of HOME Program – The County-supported $100 million in one-time SGF for a five-year expansion of the program, was not included in the 2021 State Budget Act.

Medi-Cal Peer Support – The County-supported $4.7 million in State funding to begin the Peer Support Specialist Certification program, was not included in the 2021 State Budget Act.

HEALTH

Expansion of Medi-Cal Coverage and Benefits – Includes the following funding:

- $16.3 million ($6.2 million in SGF), increasing to $201 million ($76 million in SGF) by FY 2026-27, to allow community health workers to provide benefits and services to Medi-Cal beneficiaries, effective January 1, 2022;

- $90.5 million ($45.3 million in SGF) in FY 2021-22 and $362.2 million ($181.1 million SGF) in FY 2022-23, growing to approximately $400 million ($200 million SGF) until April 1, 2021, to extend Medi-Cal eligibility from 60 days to 12 months for postpartum individuals, effective April 1, 2022, for up to five years; and

- $403,000 ($152,000 in SGF) in FY 2021-22 and approximately $4.4 million ($1.7 million in SGF) annually at full implementation to add doula services as a covered benefit in the Medi-Cal program effective January 1, 2022.

LAC + USC Restorative Care Village and General Hospital – The County-supported $500 million over multiple fiscal years for the reuse initiatives at the LAC + USC Medical Center Campus was not included in the 2021 State Budget Act. However, as previously indicated in this report, AB 133 (Chapter 143, Statutes of 2021) provides County-supported funding of $755.7 million to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure.

PUBLIC HEALTH

Public Health Infrastructure – $300 million in ongoing SGF beginning in FY 2022-23 to address the State's public health infrastructure, health equity, and racial justice.

Public Health Care Systems – County-supported $300 million in one-time SGF to help public health care systems cover costs associated with critical care delivery needs provided during and beyond the pandemic.

California Health Equity Program (AB 1038 - Gipson) – A minimum of $300 million ongoing, beginning in FY 2022-23 to address the State's public health infrastructure, health equity, and racial justice needs.

License and Certification – Continues the County-supported $19.1 million proposal for the third year of the County's contract with the State to conduct licensing, certification, and inspection of approximately 3,200 health care facilities in the County, and $4.5 million to support increased medical breach and caregiver investigation workload.

Local Health Department Workforce Assessment – $3 million to support a public health infrastructure study.

JUSTICE

Coroner Training and Equipment – County-supported $1 million for rapid DNA training technology and mass fatality training.

Division of Juvenile Justice (DJJ) – Dispositional Track TBL – SB 92 (Chapter 18, Statutes of 2021), includes County-supported provisions clarifying which county agencies are eligible for SB 823 (Chapter 337, Statutes of 2020) programmatic funding that accompanies the shift of responsibility and directs funding to county board of supervisors to determine its use.

Human Trafficking Victims Assistance – County-supported $10 million each year for three years, starting in FY 2021-22, for a total of $30 million in one-time SGF to expand human trafficking survivor support programs including, but not limited to, advocates, victim assistance to help human trafficking victims recover from the trauma they experienced and assist with reintegration into society, and programs to improve outcomes for human trafficking victims.

Repurposing of the Challenger Facility – The County-supported $25 million during FY 2020-21 and FY 2021-22 was not included in the 2021 State Budget Act. However, as previously indicated in this report, AB 133 (Chapter 143, Statutes of 2021) provides County-supported funding of $755.7 million to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure.

INFRASTRUCTURE

Broadband Infrastructure – $6 billion over a three-year period for broadband infrastructure and improved access to broadband services throughout the State, including $3.25 billion for middle-mile infrastructure in unserved communities and $2 billion for last mile, $1 million of which will be allocated to urban counties.

ECONOMIC RECOVERY

Golden State Stimulus – $2.4 billion proposal to provide a $600 tax refund to qualified taxpayers was enacted on February 23, 2021, via SB 88 (Chapter 8, Statutes of 2021). Technical amendments (clean-up language) was enacted on March 17, 2021, via AB 88 (Chapter 12, Statutes of 2021).

Small Business and Cultural Institutions Grant Program – An additional $1.5 billion to the $2.5 billion investment the State made in the Small Business COVID-19 Relief Grant program for a total of $4 billion to help businesses stay open and keep Californians employed.

California Dream Fund – County-supported $35 million in one-time SGF for micro-grants of up to $10,000 to seed entrepreneurship and small business creation in underserved small business groups that are facing opportunity gaps, including immigrant Californians and Californians who speak limited English.

SOCIAL SERVICES

CalWORKs

- **Employment Services Intensive Case Management and Work Participation Rate Indemnification** – $37.5 million in FY 2021-22, $75 million in FY 2022-23, and, subject to appropriation in the 2023 State Budget Act, $128.5 million in FY 2023-24, and $257 million in FY 2024-25 and on-going to incrementally increase CalWORKs intensive case management services over a four-year period.

- **Applicant Earned Income Disregard (EDI)** – $1 million in FY 2021-22, $94.8 million in FY 2022-23, increasing to $135.1 million in 2023-24 and on-going to raise the applicant earned income disregard from $90 to $450.

- **Federal Pandemic Emergency Assistance** – Requires the California Department of Social Services (CDSS) to make a flat rate one-time payment to each CalWORKs assistance unit that is an active assistance unit on the date of eligibility. It also requires the amount of the one-time payment to be based on the funds available and the most recent caseload data, and that CDSS submit a written report to the Legislature, by November 1, 2021, that includes information relating to the one-time payments.

- **Housing Support Program (HSP)** – $190 million in SGF in both FY 2021-22 and FY 2022-23, available until June 30, 2024, to combat homelessness, including providing housing support to CalWORKs recipients at risk of becoming homeless prior to the start of an eviction and for whom housing instability would be a barrier to self-sufficiency or child well-being.

- **Grant Increases** – County-supported $142.9 million in FY 2021-22 to provide a 5.3 percent increase to the CalWORKs Maximum Aid Payment effective October 1, 2021.

- **Single Allocation** – County-supported $68.3 million in FY 2021-22 and $40.8 million in FY 2022-23 and ongoing to restore the proposed program cut and maintain the CalWORKs eligibility funding in the Single Allocation at the FY 2020-21 level.

- **Assistance for Family Reunification** – County-supported $8.7 million in SGF in FY 2021-22 and ongoing for counites to continue providing CalWORKs services for no more than 180 days when a child has been removed from the home and is receiving out-of-home care. CDSS must issue comprehensive policy, fiscal, and claiming instructions to counties before July 1, 2022, and notify the Legislature when the Statewide Automated Welfare System has automated this change.

- **Time-On-Aid Exemption and Time Clock** – Requires CDSS to automate a one-time process that allows former CalWORKs recipients excluded from an existing assistance unit due to the formerly applicable 48-month time limit, but who have fewer than 60 countable months of time on aid in CalWORKs, to be added to the existing assistance unit if all information needed to

complete an eligibility determination is in the case record and all other eligibility requirements have been met.

- **Overpayments** – Includes the County-supported authorization for counties to reduce the collection of all non-fraudulent related CalWORKs overpayments that are considered administrative errors from 10 percent to five percent of a family's aid payments beginning April 2020 through the end of the pandemic or June 30, 2022, whichever is sooner, and to reduce the CalWORKs overpayment collection timeframe from five to two years.

In-Home Supportive Services (IHSS)

- **Seven Percent Fiscal Penalty** – Authorizes a County-opposed one-time 1991 Realignment revenue withholding equivalent to seven percent of a county's FY 2021-21 IHSS Maintenance of Effort beginning October 1, 2021, for counties that after, July 1, 2021, do not reach a collective bargaining agreement for their IHSS providers after several mediation and factfinding steps.

- **County Administration** – County-supported caseload increase of approximately $17 million.

CalFresh

- **State County Administration** – $33.6 million in SGF for CalFresh County administration simplifications and $16 million in one-time federal funds for county administration related to the CalFresh temporary eligibility expansion for college students. Also includes $5.6 million in SGF in FY 2021-22, $11 million in SGF in FY 2022-23, and $10 million in SGF in FY 2023-24 and on-going to protect the expansion of CalFresh to the Supplemental Security Income caseload for cases that are losing benefits when they exit the Transitional Nutrition Benefit Program.

- **Simplified CalFresh Application for Elderly and Disabled (SB 107)** – $33.6 million in SGF for CalFresh County administration simplifications.

Medi-Cal County Administration – $73 million ($36.5 million SGF) in one-time funding in FY 2021-22 and FY 2022-23 to resume annual Medi-Cal redeterminations upon conclusion of the federal public health emergency and continuous coverage requirement.

CHILD WELFARE

Family First Prevention Services Act (FFPSA) – $222.5 million in SGF in FY 2021-22 to be expended over three years to assist counties with new prevention services implementation efforts allowable under the new federal FFPSA. These one-time resources will assist counties to build locally driven prevention services and supports for children, youth, and families at risk of entering foster care.

Child Welfare Services Resource Family Approval (RFA) Process – $85 million in one-time SGF in FY 2021-22 to reflect actual expenditures and true-up costs for counties to conduct the RFA process, an integral part of the Continuum of Care Reform effort.

Child Welfare Services – $85 million in one-time SGF to support child welfare service activities.

Short-Term Residential Therapeutic Program COVID-19 Support – County-supported $42 million in one-time SGF for Foster Care Short-Term Residential Therapeutic Program COVID-19 Relief.

Emergency Caregiver Funding – $24.5 million in SGF and federal Temporary Assistance for Needy Families block grant funds in FY 2021-22 to provide caregivers with up to four months of emergency assistance payments pending resource family approval and up to twelve months for cases that meet good cause criteria.

Emergency Child Care Bridge Program for Foster Children – $10 million for program augmentation.

Child Welfare Services Training System – County-supported $7 million in SGF in both FY 2021-22 and FY 2022-23 for the training system.

CHILD SUPPORT

Increased Child Support Funding – Restores the funding that was reduced in 2020 including $19.1 million in ongoing SGF to support Local Child Support Agency staffing and services.

EARLY CARE AND EDUCATION

Early Care and Education Investments – The 2021 State Budget Act makes several investments including, but not limited to:

- $579 million for a pandemic relief package of federal funds to subsidized childcare, State preschool, and all licensed early care and education facilities;
- $250 million for facility development with a focus on communities with significant gaps through September 30, 2024;
- $40 million in one-time funds to expand and strengthen training opportunities for family child care providers and address the workforce needs of California, as well as career, knowledge, and skill aspirations of all family childcare providers; and
- $4.8 million for the design of a childcare data system.

GENERAL GOVERNMENT

California Creative Corps Pilot Program – $60 million one-time SGF, to be spent over three years to implement the California Creative Corps Pilot program. This program will support artists and local arts organizations with a focus on art campaigns including: public health awareness messages to stop the spread of COVID-19; public awareness related to water and energy conservation, and emergency preparedness, relief, and recovery; civic engagement, including election participation; and social justice and community engagement. The California Arts Council will provide grants in every county and prioritize grants in zip codes in the lowest quartile of the California Healthy Places Index.

Creative Youth Development Grant Program – County-supported $40 million one-time SGF in FY 2021-22, to be spent over three years, to support the California Arts Council's existing Creative

Youth Development programs and will target programs in underserved communities. The Arts Council will use partnerships between community-based organizations, educators, and local artists to expand participation in these programs statewide.

Public Libraries – Includes the following County-supported funding: $5 million in one-time SGF for local library jurisdictions with the lowest per capita spending to implement early-learning and after-school programs to provide services for school-aged children; $3 million in one-time SGF for local library jurisdictions to purchase bookmobiles and community outreach vehicles to expand access to books and other library materials; and $800,000 in ongoing SGF to support the Lunch at the Library program.

Racial Equity and Inclusion – $588,000 in ongoing SGF to establish and support the State's first ever Chief Equity Officer within the California Government Operations Agency (GovOps), which will build upon and implement the work of the California Leads Taskforce. The Chief Equity Officer will develop a uniform framework for creating equitable policies, practices, and metrics for hiring and procurement.

Also includes $200,000 in SGF in FY 2021-22 through FY 2025-26 to establish the Racial Equity Advisory Council, which will advise GovOps in developing statewide policies that promote diversity, equity, and inclusion in the State workforce. The Administration will continue to work with the Legislature to finalize the creation of the Council.

WORKFORCE DEVELOPMENT

High Roads Training Program (HRTP) – $100 million one-time SGF for the California Workforce Development Board to fund additional HRTP in current and new sectors, such as property services, agriculture, forestry, and manufacturing.

Homeless Hiring Tax Credit – Creates the County-supported Homeless Hiring Tax credit for eligible employers that hire employees including those experiencing homelessness.

UCLA Labor Center – $15 million on a one-time basis to support the UCLA Labor Center facility. The amount allocated will remain available for encumbrance or expenditure until June 30, 2024.

ENVIRONMENTAL PROTECTION

Exide Cleanup – $322.4 million in SGF over three years to clean an additional approximately 3,000 residential properties with lead contamination from the former Exide battery facility in Vernon. Also includes $132 million to complete closure activities and to conduct additional needed cleanup at the former Exide facility, and $16.5 million in SGF to support the State's Exide cost recovery efforts.

California Geologic Energy Management Division (CalGEM) – A County-supported baseline increase of $4.8 million from the Oil, Gas, and Geothermal Administrative Fund, phased over three fiscal years to strengthen enforcement at CalGEM.

Department of Toxic Substance Control (DTSC) Reform – Through SB 158 (Chapter 73, Statutes of 2021) establishes the Board of Environmental Safety within the DTSC, restructures and increases charges that support the Hazardous Waste Management Account, restructures and increases the tax that supports the Toxic Substances Control Account, and provides funding to support brownfield cleanups and investigations across the state and Exide residential cleanup.

CLIMATE CHANGE

Zero-Emission Vehicles (ZEV) and ZEV Infrastructure – $2.7 billion in FY 2021-22 and $3.9 billion ($2.98 billion in SGF, $565 million in Cap and Trade, and $394 million in other funds) over three years for ZEV and infrastructure investments. These investments include: $2 billion for heavy-duty zero emission vehicles; $1.2 billion to invest in consumer adoption of ZEVs and in clean mobility for disadvantaged and low-income communities; $407 million to demonstrate and purchase or lease state-of-the-art, clean bus and rail equipment and infrastructure that eliminate fossil fuel emissions and increase intercity rail and intercity bus frequencies; and $250 million for manufacturing and supply chain grants to expand California's ZEV manufacturing footprint.

Recycling and Waste Reduction Proposal & Senate Cap-and-Trade Spending Plan – County-supported $130 million one-time SGF over two years that will spur new circular economy growth. The Administration will work with the Legislature over the summer to determine allocation of these funds.

Community Power Resiliency Grants to Mitigate Efforts of Public Safety Power Shutoffs (PSPS) Events – $1.5 million from the 2020 Community Power Resiliency appropriation, until June 30, 2023, to support the continued administration of the local assistance grants and the development of the required report. The County supports the proposal to provide $100 million to restore the Community Resiliency Grant program.

Fire Crew Funding for Contract Counties – The County-supported $14.3 million State budget request sponsored by the Association of Contract Counties to fund six crews for Contract Counties to an existing State Budget Change proposal is not included in the 2021 State Budget Act. However, this proposal is pending as the Legislature is continuing discussions on wildfire prevention and response funding.

Elimination of Transformative Climate Communities – The Transformative Climate Communities, if reinstated, would be funded by the State Budget's Cap-and-Trade Spending Plan, which is to be finalized later this summer.

IMMIGRATION

Immigration Services – $105.2 million in one-time SGF for the Rapid Response Fund to provide support for migrant family arrivals at the Southern California border; $15.3 million to provide legal services to undocumented unaccompanied minors; and $4.7 million for mental health assessments in support of undocumented minors arriving unaccompanied to the United States, and for navigation services to connect with existing services that support reunification and post-placement needs of undocumented minors arriving unaccompanied.

Also includes $25.0 million one-time SGF in FY 2021-22 to fund filing fees for Deferred Action for Childhood Arrivals (DACA) and Naturalization Filing Fees.

VETERAN AFFAIRS

County Veteran Services Offices (CVSO) – Includes the County-supported proposal for an increase of $5.4 mil ongoing basis.

CHCF Fact Sheet

CalAIM Explained: A Five-Year Plan to Transform Medi-Cal

What Is CalAIM?

California Advancing and Innovating Medi-Cal — known as CalAIM — is a far-reaching, multiyear plan to transform California's Medi-Cal program and to make it integrate more seamlessly with other social services. Led by California's Department of Health Care Services, the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs.

What Are the Goals of CalAIM?

- Make services more standardized and more equitable across the state, bringing consistency to the current patchwork of programs that vary by county.
- Ensure that the Californians who need the most help and support actually get it — by emphasizing proactive outreach to bring people with complex needs into care and offering a "no wrong door" approach to people seeking help.
- Enable Medi-Cal managed care plans to couple clinical care with a range of new nonmedical services. Those services, which will be reimbursed by Medi-Cal, include housing supports, medical respite, personal care, medically tailored meals, and peer supports.
- Require plans and incentivize public health systems to be more responsive, equitable, and outcome-focused by:
  - **Focusing on population health**, which involves matching the right patients to the right services at the right time — in a way that increases equity.
  - **Implementing payment reform** to lay the foundation for paying physical and behavioral health providers based on outcomes rather than services.
  - **Ensuring greater accountability** for Medi-Cal managed care plans by requiring them to coordinate access to services provided by counties and community-based organizations.

Who Will CalAIM Help?

While CalAIM's broad reach is intended to help all Medi-Cal enrollees, many of the reforms focus on improving care for people with the most complex needs. This group includes:

- People experiencing homelessness
- Frequently hospitalized patients, including those who regularly use emergency rooms as a source of care
- People with significant behavioral health needs, including people with serious mental illness, serious emotional disturbance, or substance use disorder
- People with complex physical or behavioral health needs who are transitioning from jail or prison
- Seniors and people living with disabilities, including those at risk for institutionalization and eligible for long-term care, as well as those living in nursing facilities and wishing to transition to the community
- Children with complex medical conditions, such as cancer, epilepsy, or congenital heart disease
- Children and youth in foster care

Timeline for Implementation

The first reforms will start to be implemented in January 2022, and additional reforms will be phased in through 2027. Many of the activities that CalAIM will cover require a waiver approval from the Centers for Medicare & Medicaid Services, and that is expected to be finalized in December 2021. In the meantime, work is actively underway to ensure a smooth transition from existing programs to CalAIM once those first reforms are approved.

About the California Health Care Foundation
For more information, visit us at www.chcf.org/about.

How Can CalAIM Improve the Lives of People Enrolled in Medi-Cal?

The following scenarios illustrate the types of people who have the potential to benefit from CalAIM and the kinds of meaningful improvements the program is striving to make.

Alma lives alone and prioritizes healthy eating and daily exercise to manage her diabetes and heart failure. One day she has a paralyzing stroke and needs intensive rehabilitation, as well as help with cooking, bathing, and managing her medications. She is discharged to a nursing home, but wants to return home.

In the current Medi-Cal program, her options for returning home are limited. Her recovery is slow, and she stays in the nursing home for several months. The social security income she relies on goes to paying the nursing home, resulting in the loss of her apartment. Ultimately, with daily physical and occupational therapy, she gets to the point where she could live independently with the right supports, but she does not have the resources to find and furnish an apartment that can accommodate her needs or locate and hire a caregiver. As a result, the nursing home becomes her home even though she doesn't need that level of care. Alma develops a bedsore and is in and out of the hospital because the wound keeps getting reinfected. Her Medi-Cal managed care plan is concerned about her frequent hospitalizations, but the plan can't do much about it because her medical care is covered by Medicare fee-for-service. The staff in the nursing home are worried about her, but the administrator can't ignore that every time she is discharged from the hospital, the care she gets in the nursing home is reimbursed by Medicare at three to four times the payment they get from Medi-Cal for the first 60 days. A year after her stroke, she's still living in the nursing home and has spent more than three weeks in the hospital in the last six months.

If CalAIM is successful, Alma will receive a visit from a care manager shortly after her stroke. The care manager will elicit her goals, and working across the Medicare and Medi-Cal benefits (offered by a managed care plan responsible for both), help her get physical and occupational therapy at home, make modifications to her apartment to meet her physical needs, and provide personal care services through an agency until she can find a caregiver through the In-Home Supportive Services (IHSS) program. The care manager will support her changing needs, organizing transportation to appointments, arranging back-up care when her usual IHSS worker is unavailable, and working with her primary care physician to help simplify her medication regimen. A year after her stroke, she will be living at home with the care she needs to keep her out of a nursing home or hospital.

Brian lived in his car before the pandemic, parking it in the lot of the restaurant where he washed dishes. After losing his job and his parents during the COVID-19 pandemic, he sinks into a deep depression. To manage his sadness, he drinks heavily. One night his car is towed, and unable to pay to retrieve it, he starts living on the streets. As his alcohol use worsens, he sometimes loses consciousness in public places.

In the current Medi-Cal program, it is unlikely that Brian will get the treatment he needs for his depression and substance use. When picked up for being publicly intoxicated, he is taken first to the emergency department and then to the county jail, where he can access treatment only if he is willing to be formally diagnosed with depression and alcohol use disorder. He resists those diagnoses and continues to suffer, cycling through short-term jail stays or trips to the emergency room. His managed care plan notices his frequent visits to the emergency department for intoxication but only learns about them when they get a claim from the facility, limiting their ability to act. In addition, the managed care plan finds that he had been disenrolled when his Medi-Cal is suspended because of a jail stay. His criminal justice involvement makes employment and housing further out of reach, driving him deeper into a pattern of depression, alcohol use, and trips to the emergency room and jail.

If CalAIM is successful, Brian will be taken to a sobering center instead of jail or the emergency room. From the center, he will be connected to a care manager to help him find short-term housing. With a safe place to stay and support from the care manager, contracted through his Medi-Cal managed care plan, he's willing to engage in treatment, which includes peer support. When he experiences a relapse, and winds up in the emergency department, his care manager gets a real-time notification and is able to meet him there and support him through the crisis. Eventually, he's able to get his car back, find work, and transition to subsidized housing. His care manager will introduce him to a social worker at his primary care clinic, providing someone to turn to if he needs help.

Linda and John and their daughter Sophia live slightly above the poverty line. Sophia, who lives with asthma, has Medi-Cal coverage, while John and Linda get coverage elsewhere. Linda becomes pregnant and enrolls in Medi-Cal because she is eligible by virtue of her pregnancy. She goes to all of her appointments at a community clinic, and at one of them is diagnosed with high blood pressure.

In the current Medi-Cal program, Linda isn't enrolled in managed care. She is given a referral to a specialist, and after calling several, is given an appointment in three months, too late to avoid harm to the baby. Born early and small, the baby needs lots of extra care, putting added stress on the family. Sophia's asthma flare-ups due to wildfire smoke add to the family's stress, and Linda's blood pressure remains high.

If CalAIM is successful, Linda would be enrolled in Medi-Cal managed care. Her diagnosis would trigger her managed care plan to find her a specialist appointment within a few days. As a result, Linda's blood pressure would be treated and the baby would be born almost full term and have fewer needs. The managed care plan would contract with a county case manager to provide high-touch support during and after the baby's stay in the neonatal intensive care unit, helping connect the family to specialty county and regional center providers. Even after Linda's Medi-Cal coverage ends, her family would stay on the radar of the Medi-Cal managed care plan. For example, after refilling Sophia's asthma rescue medication twice in a month, Linda would receive a call from the plan, making sure that the family has access to what they need to stay healthy. If their home needed an air filtration system to reduce exposure to particles from nearby fires, the plan could pay to have that installed.

Health4All Older Adults FAQ

This document seeks to provide partner organizations with information regarding the implementation of Health4All 50+ as of August 26th 2021. Please use this as a guide for creating materials for your community.

What is Health4All 50+?

On July 28, Governor Newsom signed into law the removal of immigration status as a barrier to Full-Scope Medi-Cal eligibility for Californians ages 50 and over. This means that ***low-income adults ages 50+, regardless of immigration status, will be eligible for comprehensive Medi-Cal health insurance coverage****, making California's health system more equitable and universal for all.*

When will undocumented immigrants ages 50+ be able to access Full-Scope Medi-Cal?

Implementation of Health4All 50+ is ***expected to happen in May 2022****. The Department of Health Care Services (DHCS) is preparing for implementation and their goal remains May 2022.*

How will eligible patients enroll into Full-Scope Medi-Cal?

Patients who enroll now in Restricted-Scope/Emergency Medi-Cal will automatically be transitioned to full Medi-Cal without further action*. Thus, enrolling in Restricted-Scope Medi-Cal as soon as possible will allow for a timely transition and is a good way for people to ensure they have access to Full-Scope care immediately in May 2022. DHCS is expected to mail notices to this population, and the DHCS website will also be updated with information about implementation in multiple languages.*

For folks not currently enrolled in Medi-Cal*, DHCS has a step-by-step guide on how to apply for Medi-Cal benefits, including links to the paper and online application.*

Find a local health center that can help you enroll in Medi-Cal: bit.ly/390NSYc

What services are included in Full-Scope Medi-Cal?

Full-Scope Medi-Cal has comprehensive health benefits including preventative care, dental, vision, and prescription drug coverage, among many others. A full list of services can be found here.

Will accessing Full-Scope Medi-Cal affect the "Public Charge" test?

Accessing Full-Scope Medi-Cal will not count toward the "Public Charge" test. *Using Medi-Cal will not negatively affect applications for green cards because the Medi-Cal expansion for older adults is state-funded, not federally funded, AND because the 2019 Public Charge Rule is no longer in effect.*

How does Health4All 50+ relate to the repeal of the Medi-Cal Assets test?

California will eliminate the Medi-Cal assets test, which limits seniors and people with disabilities to assets of no more than $2,000 for individuals and $3,000 for couples in order to access Medi-Cal, in July 2022. If an undocumented Californian over the age of 65 falls over this asset limit, they may not be able to benefit from Full-Scope Medi-Cal until July 2022.

Will the Full-Scope Medi-Cal coverage retroactively cover previous medical services and/or bills?

Applicants can request retroactive Medi-Cal coverage for up to three months prior to the month of application. For example: A newly-eligible individual who applies for Full-Scope coverage in the month of May 2022 can request coverage up to February 2022.

Why is Health4All implementation taking place in May 2022 and not the beginning of the year?

DHCS is undergoing system upgrades, and that date is the soonest DHCS would be ready to implement older adult expansion.

What is the eligibility criteria for this Medi-Cal expansion?

- *Age 50 or older (ages 25 and younger are already eligible)*
- *Household income under 138% of the Federal Poverty Level (FPL). For example, for a household of 4 people, this would be an annual household income of $36,570 (find information about income requirements here).*
- *Live in California*
- *Immigration status is NOT a criterion for eligibility. Undocumented individuals are eligible.*

California Health Care Foundation

Medi-Cal Facts and Figures

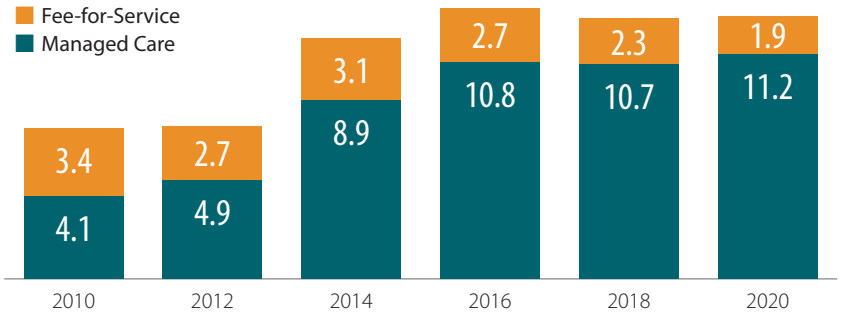
For more on California's Medicaid program and how it has evolved over the years, see www.chcf.org.

CALIFORNIA HEALTH CARE ALMANAC QUICK REFERENCE GUIDE

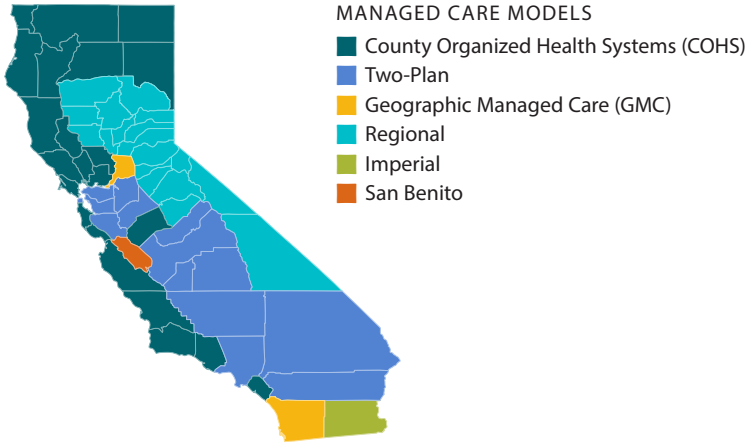
AUGUST 2021

Enrollment, 2010 TO 2020, SELECTED YEARS

IN MILLIONS

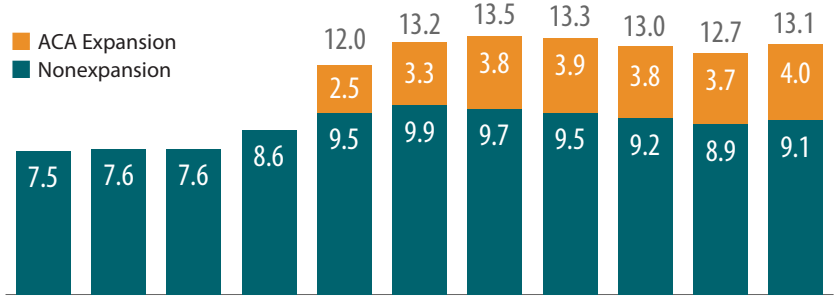


Note: Enrollment is from November of each year.



Enrollment, 2010 TO 2020

IN MILLIONS



Note: Enrollment is from November of each year.

Eligibility Levels, SELECTED PROGRAMS, 2020

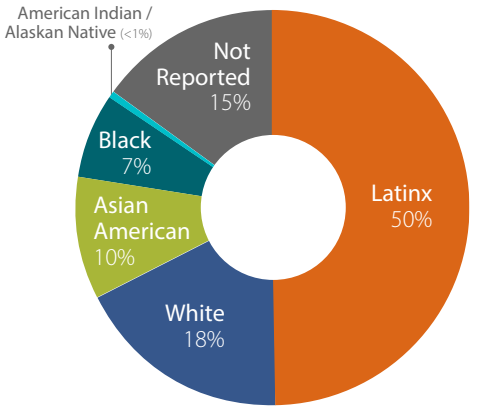
Adults: 138% FPL (ACA expansion) Pregnant Women: 213% FPL Children: 266% FPL

Note: The federal poverty level (*FPL*) in 2021 was $12,760 for an individual.

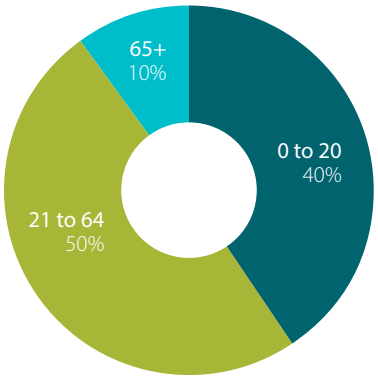
Enrollment, January 2021

TOTAL ENROLLEES
13.6 million

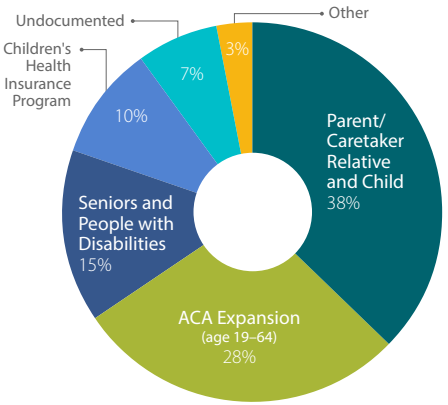
BY RACE/ETHNICITY



BY AGE



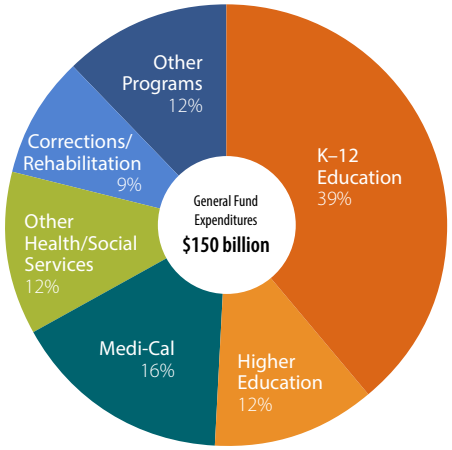
BY AID CATEGORY



Notes: *Undocumented* includes aid categories restricted to only pregnancy-related, long-term care, and emergency services for adults who do not have satisfactory immigration status, also known as restricted-scope benefits. *Other* includes long-term care and aid categories including Adoption/Foster Care, Refugee Medical Assistance / Entrant Medical Assistance, Breast and Cervical Cancer Treatment Program, Abandoned Baby Program, Minor Consent Program, Accelerated Enrollment in the Children Health and Disability Prevention Program (CHDP), Trafficking and Crime Victims Assistance Program, and state and county inmates. Source uses *African American, Asian / Pacific Islander,* and *Hispanic*. Segments may not total 100% due to rounding.

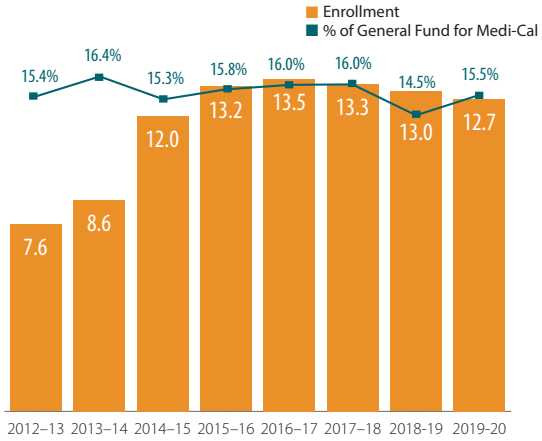
Source: *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, August 2021, California Health Care Foundation, August 2021.

GENERAL FUND EXPENDITURES
FY 2019–20

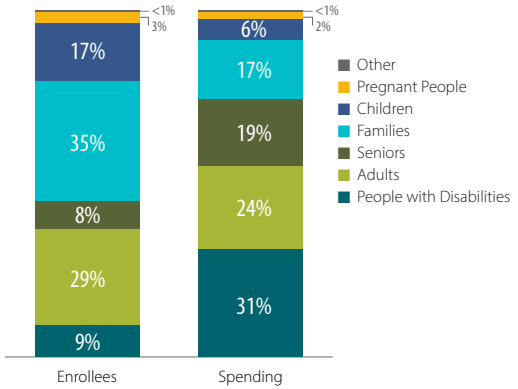


Notes: 2019–20 general fund expenditures as reported in the 2020–21 budget. Includes expenditures for medical care services, eligibility (county administration), fiscal intermediary management, and benefits (medical care and services).

MEDI-CAL ENROLLMENT AND SHARE OF GENERAL FUND
FY 2013 TO FY 2020

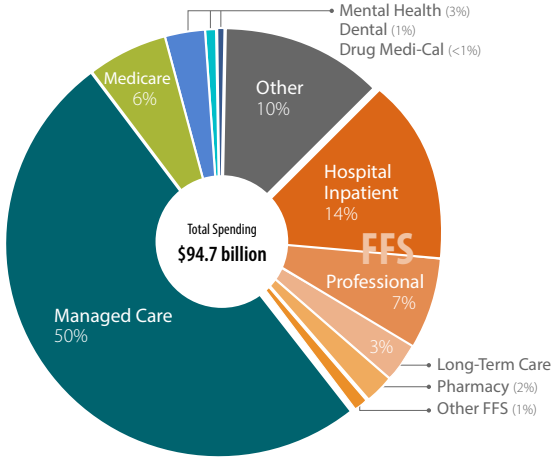


ENROLLEES AND SPENDING*
BY ELIGIBILITY CATEGORY, FY 2019–20



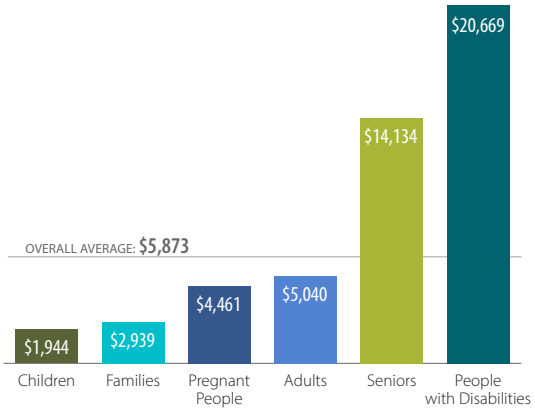
Notes: *Other* includes Hospital Presumptive Eligibility and other aid codes.

MEDI-CAL EXPENDITURES*
BY SERVICE CATEGORY, FY 2019-20



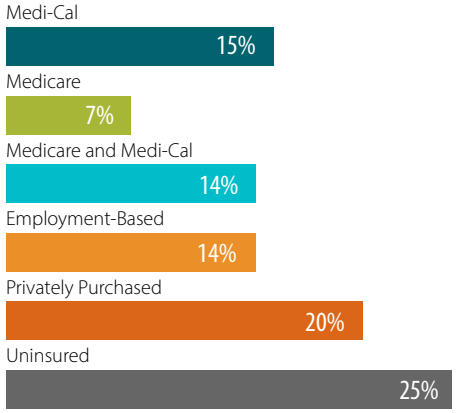
Notes: *FFS* is fee-for-service. *Other FFS services* includes medical transportation, home health, and other services. *Other* includes audits/ lawsuits, state hospitals / developmental centers, recoveries, and miscellaneous services.

MEDI-CAL ANNUAL SPENDING PER ENROLLEE*
BY ELIGIBILITY CATEGORY, FY 2019–20



Notes: Reported values exclude Hospital Presumptive Eligibility and other aid codes totaling 0.3% of enrollees.

DELAYED CARE FOR ANY REASON
BY SOURCE OF COVERAGE, 2019



Note: Based on self-reported insurance status. When asked by survey researchers about health coverage, some immigrants who are undocumented and who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage.

* Figures presented are estimates for FY 2019–20 calculated as of May 2020 and reflect annual spending.

Note: Segments may not total 100% due to rounding.

Source: *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, August 2021, California Health Care Foundation, August 2021.

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From:	Sandra Young
Subject:	Washington – Pursuit of County Advocacy Position on Federal Legislation Related to Public Health Infrastructure - 8/06/21
Date:	Friday, August 6, 2021 2:25:10 PM

Washington – Pursuit of County Advocacy Position on Federal Legislation Related to Public Health Infrastructure

Executive Summary

This report contains the following pursuit of County position:

- **Support S. 674 (Murray, D-WA).** This measure would establish a Core Public Health Infrastructure Program at the Centers for Disease Control and Prevention (CDC), awarding grants to state, local, tribal and territorial health departments to ensure they have the tools, workforce and systems in place to address existing and emerging health threats and reduce health disparities. Therefore, unless otherwise directed by the Board, consistent with existing policy, **the Washington, D.C. Advocates will support S. 674 and similar measures**

Pursuit of County Position on Federal Legislation

PUBLIC HEALTH INFRASTRUCTURE SAVES LIVES ACT

Background

- S.674 (Murray, D-WA), as introduced on March 10, 2021, would appropriate $750 million in Federal Fiscal Year (FFY) 2022, $1 billion in FFY 2023, $2 billion in FFY 2024, $3 billion in FFY 2025, and $4.5 billion in FFY 2026 and each subsequent year, to direct the U.S. Secretary of Health and Human Services through the Director of the Centers for Disease Control and Prevention to establish a core public heath infrastructure program to strengthen the public health system of the United States, including the nation's ability to respond to the COVID-19 pandemic.
- Core public health infrastructure would include the ability or capacity track the health of a community and respond to emergencies of all kind.
- No less than 50 percent of the funds would be awarded as grants to each State or territorial health department, and to local health departments that serve 500,000 people or more.
- No less than 30 percent of the funds would be awarded as competitive grants to State, territorial, or local health departments. Priority would be given to applicants demonstrating core public health infrastructure needs.
- Entities receiving these grants must expend the funds to supplement and not supplant non-Federal and Federal funds otherwise available to them for the purpose of addressing core public health infrastructure needs and must maintain expenditures of non-Federal amounts at a level not less than that of the fiscal year preceding the fiscal year for which the entity receives the grant.

County Impact

- The Department of Public Health (DPH) supports federal funding and related legislation, including S.674, to strengthen the nation's public health capabilities by filling long-standing gaps in public health, enabling modernization of outdated technologies and systems, and building a foundation for a more effective, efficient public health response to future pandemics.
- DPH reports that due to the prolonged underinvestment by the federal government in state and local public health infrastructure, there has been a steady decline in public health workforce, scientific expertise, clinical capacity, and the ability to respond to diverse and dynamic community needs. The shortage of the resources was exacerbated by the COVID-19 pandemic response.
- DPH reports that it was forced to divert substantial resources from critical public health services for COVID-19 response activities such as emergency operation coordination, public information and warning, epidemiology and surveillance, infection control and prevention, laboratory services, vaccine dispensation, pharmaceutical and non-pharmaceutical interventions, patient care and management, environmental services and community outreach.
- DPH reports that federal investment in public health infrastructure could be immediately put to use for critical issue areas, distinct and separate from the COVID-19 response, including sexually transmitted diseases (STD) screening and treatment services, tuberculosis control and prevention efforts, communicable disease control, public health laboratory enhancements, digital infrastructure, chronic disease control and prevention efforts, and to enhance programs focused on elders, domestic violence and violence prevention.

Support and Opposition

- S.674 has 20 co-sponsors and is supported by over 315 organizations including: Southern California Public Health Association, American Public Health Association, Delaware Public Health Association, Illinois Public Health Association, Johnson County Public Health, Louisiana Public Health Institute, Nevada Public Health Association, New Jersey Public Health Association, New York State Public Health Association, Washington State Department of Health, Washington State Public Health Association, and Wisconsin Public Health Association, among many others.
- S.674 was referred to the Senate Health, Education, Labor and Pensions Committee on March 10, 2021.

Recommendation

- This Office and DPH support S.674 and similar measures that provide increased funding for state, local, tribal and territorial core public health infrastructure as they would help ensure that local public health departments have the tools, workforce and system in place to address existing and emerging health threats and reduce health disparities .
- Therefore, unless otherwise directed by the Board, consistent with existing policies to support proposals that increase funding for public health, **the Washington, D.C. Advocates will support S.674 and similar measures.**

Thank you,

Sandra Young
Chief Executive Office
Legislative Affairs and Intergovernmental Relations
Phone: (213) 974 -1724
Email: *Syoung@ceo.lacounty.gov*

Ending The HIV Epidemic

Ending the HIV Epidemic in the US (EHE) – Quarterly Stakeholder Webinar
Federal Agency Updates
July 14, 2021

The following includes high-level updates from federal agencies on improving outcomes of Syringe Service Programs (SSPs) and advancing the EHE initiative.

U.S. Department of Housing and Urban Development	EHE HOPWA Resource Tool ● HUD has developed an EHE HOPWA Resource Tool, currently available on the AHEAD Dashboard. HUD will continue to work collaboratively with EHE leadership and commit to furthering work on federal partnerships toward this effort.
CDC Centers for Disease Control and Prevention	FY21 Funding ● CDC funding in FY21 will support testing expansion, more locations, extended hours of operation, and additional services in existing SSPs to ensure meeting the needs of the community. SSP Activity Expansion ● 23 of 32 EHE plans described activities to expand SSPs—and 25 jurisdictions have proposed evidence-based strategies to address substance use, including increasing the number of venues and prescribers that offer medication-assisted treatment for opioid use disorder and syringe services. Community Engagement Priority Populations Identified in EHE Plans ● 19 EHE plans included PWID among their community engagement priority populations. ● 18 EHE plans included persons experiencing homelessness among their community engagement priority populations.

Ending The HIV Epidemic

	Technical Assistance & Additional Resources ● National Harm Reduction Technical Assistance Center: https://www.cdc.gov/harmreductionta/index.html . ● Technical package on SSP implementation: https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf . ● Suite of materials is available: www.cdc.gov/ssp .
HRSA Ryan White HIV/AIDS Program	HRSA HAB Quarterly EHE Recipient Webinars The second quarterly EHE recipient webinar took place on Wednesday, June 16th. Upcoming webinars: ● September 15, 2021 ● December 8, 2021 Community Engagement Session ● Since the last quarterly webinar, HRSA HAB has hosted 4 Regional EHE Virtual Community Engagement Sessions Upcoming Sessions ● Mountain West (Regions 8 & 10) – August 10 & 12, 2021 ● South Central (Region 6) – August 17 & 19, 2021 ● Southeast (Region 4) – September 7 & 9, 2021
HRSA Health Center Program	HRSA BPHC Primary Care HIV Prevention (PCHP) ● FY 2022 President's Budget Request: $50 million to support up to 140 additional PCHP health centers.

Ending The HIV Epidemic

	• FY 2021 PCHP funding: $48 million to provide expanded support for the Phase 1 health centers and add approximately 108 new PCHP health centers - applications are currently under review for an anticipated August 1 award date. • FY 2020: $54 million to support 195 health centers - Primary Care HIV Prevention (PCHP) funding to expand prevention and treatment services to people at high risk for HIV transmission, including Pre Exposure Prophylaxis (PrEP)-related services, outreach, and care coordination at the nation's health centers - additional implementation data will be available in early August. Preliminary SSP Implementation Data • Health centers are reporting engagement with some form of SSPs nationwide, including in CA, IN, NY, and OH
	Indian Health Service HIV Testing & Incidence • HIV screening coverage of all persons ages 13-64 as per national guidelines increased from 30.6% in 2012 to 57.2% in 2020. These are unique patients. In 2020, IHS's overall HIV testing volume was 33,962 persons, representing 8% of the user population tested. • HIV incidence stable, HIV mortality declining. A stable transmission rate and a lower mortality rate are positive indicators – a 21% increase in HIV patients in 2014-2018 and a 31% drop in mortality in the same period means HIV patient cohorts are growing. The key to successful viral suppression is case management using remote and in-person case management support specific to the context. National Surveillance Data • MHAF funds assisted IHS in establishing a collaboration with the CDC Division of HIV/AIDS Prevention to analyze national surveillance data on HIV diagnosis, deaths, and continuum of care metrics for American Indian/Alaska Natives. IHS and CDC staff stratified the national data by IHS Service Area to evaluate geographic variations in Indian Country.

Ending The HIV Epidemic

NIH EHE Awards & Funding

- At least 30 NIH EHE Awards to be funded Summer 2021. Information on EHE awards made in 2019 and 2020 can be accessed on the CFAR website.

- New NIH EHE research funding opportunities were announced this quarter. Selected examples:
  - NOT-MD-21-023 involves a funding collaboration between the National Institute of Minority Health and Health Disparities and the Minority HIV/AIDS Fund for Research Centers in Minority Institutions
  - NOT-MD-21-020 supplements to support research on populations that experience health disparities, socioeconomically disadvantaged populations, underserved rural populations, and sexual and gender minorities
  - RFA-AI-21-023 Respond pillar epidemiology research to better understand HIV susceptibility and ongoing transmission
  - RFA-AI-21-024 Implementation science regarding multidisciplinary approaches in HIV care and treatment
  - RFA-AI-21-025 Diagnose and Prevent pillar research to reduce HIV incidence
  - RFA-AI-20-069 Innovative Models for Delivering PrEP and STI Services *(on HIV.gov)*
  - PAR-20-274 New Models of Integrated HIV/AIDS, Addiction, and Primary Care Services
  - PAR-20-036 Understanding HIV Viral Suppression and Transmission
  - Other NIH EHE-related funding opportunities are available here

Ongoing NIH EHE Projects on SSP

- Implementation of Telemedicine Test and Treat for On-site Initiation of Antiretroviral Therapy at Miami's IDEA Exchange SSP
  Jurisdiction: Miami-Dade County, FL
  Pillars: Diagnose, Treat, Respond
- Mobile Delivery of PrEP and Medication Assisted Treatment at an SSP – A Pilot Study
  Jurisdiction: Miami Dade County, FL
  Pillars: Treat, Prevent

Ending The HIV Epidemic

SAMHSA Substance Abuse and Mental Health Services Administration	Ongoing SAMHSA SSP Funding and Support • Substance Abuse Prevention and Treatment Block Grants (SABG) • State Opioid Response Grants (SOR) • Minority AIDS Initiative (MAI) Programs

Federal Unemployment Benefits End

Apply for Vital Food, Housing, Utility, and Health Care Assistance

After September 4, 2021, federal unemployment benefits will expire. If you are receiving these benefits you will get a notice regarding the impact to your claim. We know this pandemic has been tough on many workers and their families and you are certainly not alone. That's why we want to make sure you are aware that you may qualify for several vital programs to help cover your food, housing, utility, and health care expenses.

If your federal unemployment benefits are ending, you are encouraged to apply for these vital programs which have been expanded by the American Rescue Plan:

- Over $234 per person per month in food assistance via CalFresh (GetCalFresh.org) whether you are working or not.
- Rental and utility assistance via Housing is Key (HousingIsKey.com). Get 100 percent of rent and utilities paid. Contact the Rent Relief call center: 1-833-430-2122
- Californians can apply directly to the county human services agency for cash aid and services for families with children (CalWORKs), food assistance (CalFresh), and free health insurance (Medi-Cal) through BenefitsCal.org.
- Health insurance—for as low as $1 per month for workers who received unemployment benefits, through Covered California (CoveredCA.com).

Which federal unemployment benefits are ending September 4, 2021?

- Pandemic Unemployment Assistance (PUA) created for self-employed workers and others who don't qualify for regular state Unemployment Insurance (UI).
- Pandemic Emergency Unemployment Compensation (PEUC) that provides additional weeks of unemployment benefits beyond the basic 26 weeks of regular state UI.
- Pandemic Additional Compensation (PAC), also known as Federal Pandemic Unemployment Compensation (FPUC), that provides an extra $300 per week of benefits for workers collecting PUA, PEUC, FED-ED, and regular state UI.
- Mixed Earner Unemployment Compensation (MEUC) supplement that provides an extra $100 per week in benefits for regular state UI recipients who earned at least $5,000 in self-employed earnings.

NOTE: A separate extension of regular UI benefits known as the FED-ED will no longer be payable after September 11, 2021.

For help finding gainful work, job training, and other employment services, you are also encouraged to access the following Employment Development Department (EDD) resources:

- CalJOBS℠ (CalJOBS.ca.gov) is the state's online, no-cost virtual job center that includes over a million job listings from private job boards and recruitment sites.
- Job search assistance, resume writing, interview preparation, and access to job training is available through America's Job Center of California (edd.ca.gov/office_locator) locations throughout the state.
- For more information about services available, see EDD's Returning to Work (edd.ca.gov/return-to-work.htm) webpage.

COVERED CALIFORNIA

CalFresh

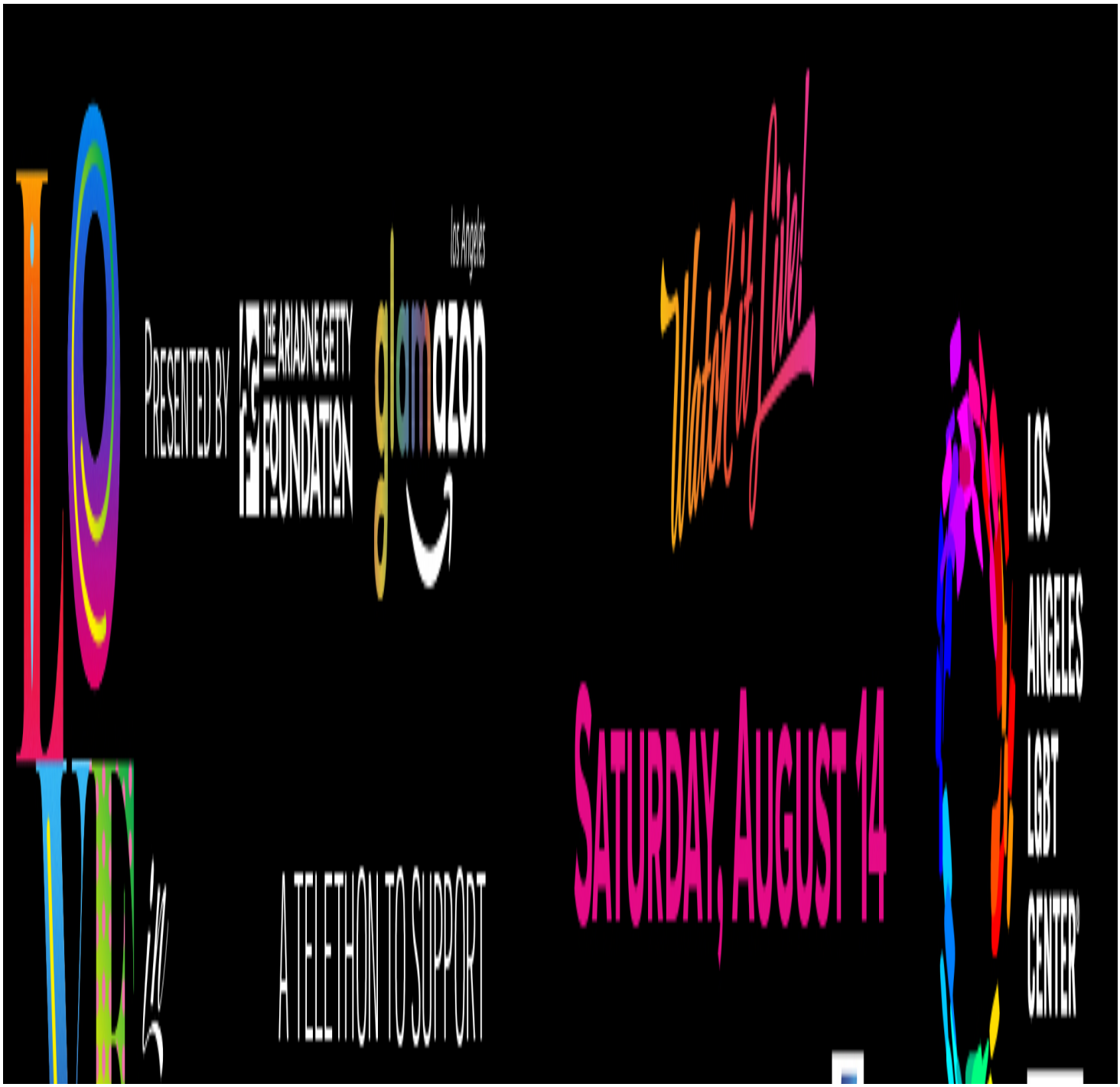
CA COVID-19 RENT RELIEF

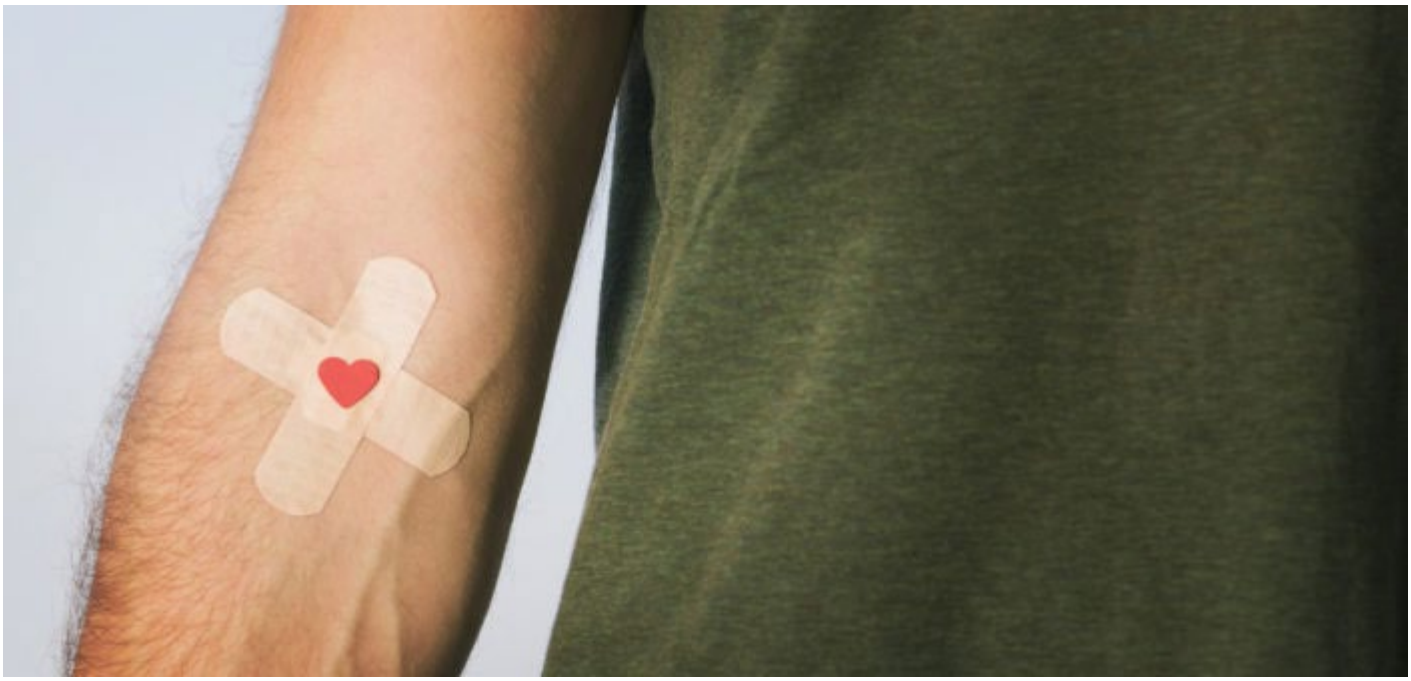
CDSS

EDD Employment Development Department State of California

TRENDING
LA Pro Sports Teams Cheer the Center's Work

LOS ANGELES LGBT CENTER
LGBT NEWS NOW





How the Center Is Doing Its Part to End Blood Donation Discrimination Against Gay and Bi Men

JULY 30, 2021 HEALTH

By Greg Hernandez

If a gay or bisexual man wants to donate blood in the United States today, he is not supposed to have had sex with another man for at least three months prior.

Paul Osborne had something to say about the policy.

“It’s entirely discriminatory—people need blood,” said the 51-year-old before walking into the Los Angeles LGBT Center’s McDonald/Wright Building for an appointment. “They should open it up to everyone so that everyone can give blood. Then, they can have a bigger supply for those who need it, particularly those with a less common blood type.”

In an effort to change the policy, the Center is one of eight LGBT centers nationwide that are each responsible for recruiting 250–300 gay and bi men between 18 to 39 years old for the ADVANCE (Assessing Donor Variability and New Concepts in Eligibility) study funded through a contract with the U.S. Food and Drug Administration (FDA).

The pilot study is being launched by three of the nation’s largest blood centers: Vitalant, OneBlood, and the American Red Cross.

“Even though it’s taken the FDA and blood organizations this long, this is a really important moment,” pointed out the Center’s Director of Research Risa Flynn. “It’s important that everybody who is eligible step up and participate to give us the data we need.”

The study will evaluate alternatives to the FDA’s current blood donor policy which is less stringent than the 1985 complete ban on gay and bi men donating blood. At that time, nearly four decades ago, there was little science on the mechanisms of HIV transmission, and the AIDS epidemic was concentrated in the gay community.

“When the epidemic started, we knew so little about transmission,” said Flynn. “There was this very intense fear—health professionals were afraid to interact with patients who were infected—which carried over into the blood supply. People became infected with HIV through donated blood.”

The complete ban was lifted in December 2015. But, in April 2020, the policy was revised to require gay and bi men to abstain from sex for one year in order to donate blood although, according to the Centers for Disease Control and Prevention, all donated blood products are now tested for HIV and other pathogens such as hepatitis C virus.

“From the perspective of the Center and our community, it communicated such intense stigma and discrimination,” said Flynn. “People want to donate their blood and do an act of public good—but still being told it’s not safe. They’re made to feel judged for who they are.”

The ADVANCE study is looking at eliminating the three-month time period deferral in favor of having an extended questionnaire for potential donors to assess any risk behavior.

“There already is a pretty substantive questionnaire that anybody donating blood has to complete,” explained Flynn. “The study’s

idea is that there would just be some additional questions asked. We know a lot now about what kinds of behavior leads to the likeliness of HIV infection: sex without condoms, substance use, number of partners."

Participants in the study will have a blood sample drawn for HIV testing and will answer different questions designed to determine individual HIV risk factors. The study will assess if the questions related to behavior are effective in distinguishing gay and bi men who have recently tested positive for HIV from those who have not. Its findings will help determine the next steps needed to modify the donor history questionnaire.

Data collected from the ADVANCE study will then be submitted to the FDA who will review and decide next steps.

For Center client Michael Campo, 62, it is incredulous to him that a loosened FDA policy still exists today.

"Discrimination is bad no matter what," said Campo, who identifies as bisexual and lived through the AIDS pandemic. "Putting stipulations on one group is bad. I didn't even know something like this was still possible in this day and age. It should be equal all the way around."

To learn more about the ADVANCE study and to enroll, visit ADVANCEstudy.org

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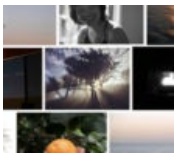

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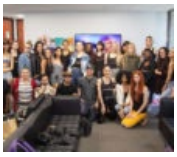

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LGBT News Now is a publication of the Los Angeles LGBT Center. Celebrating its 50th anniversary in 2019, the Center is the largest LGBT organization in the world, dedicated to building a world where LGBT thrive as healthy, equal, and complete members of society. Learn more at lalgbtcenter.org.

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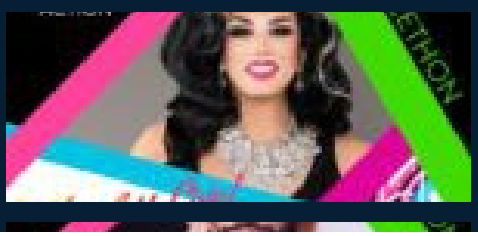
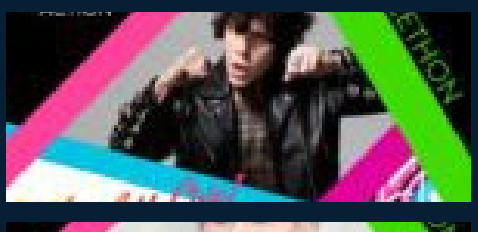
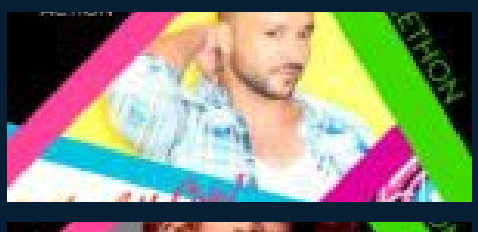

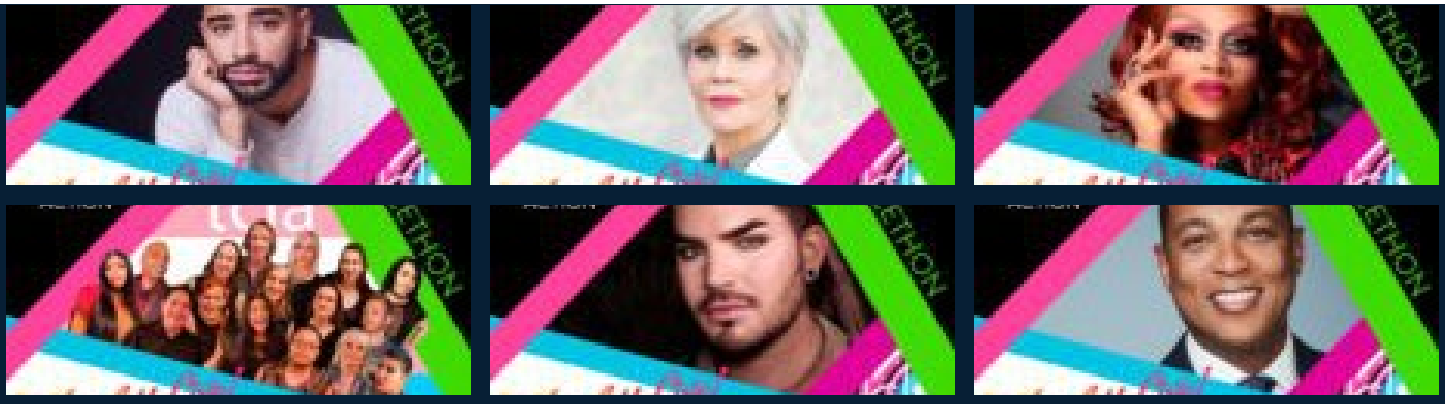

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DEMANDING BETTER:

An HIV Federal Policy Agenda by People Living with HIV

ACKNOWLEDGMENTS

This document was a collaborative effort informed by our relationships with thousands of people living with HIV throughout the United States, as well as our lived experience.

Authors contributed thought leadership as well as writing, research, reflection, and editing time. We are grateful to Martha Cameron, Barb Cardell, Marco Castro-Bojorquez, Cecilia Chung, Tami Haught, Vanessa Johnson, Ronald Johnson, Naina Khanna, Kamaria Laffrey, Lorenzo Lewis, Mark Misrok, Heather O'Connor, Venita Ray, Malcolm Reid, Bamby Salcedo, Linda Scruggs, Waheedah Shabazz-El, Andrew Spieldenner, Kiara St. James, Sean Strub, and Evany Turk for their contributions.

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We dedicate this agenda to the many people living with HIV who paved the way for our understanding of HIV as an issue of justice, and on whose shoulders we stand. Some are still with us and too many have been lost along the way.

May this collective set of priorities, created jointly by U.S. based networks of people living with HIV for the first time ever, assure a better world for all of us.

For Mary. For Marco. For Deloris. For Loren. For Juanita.

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EXECUTIVE SUMMARY

Networks of people living with HIV in the United States have come together as the U.S. People Living with HIV Caucus (HIV Caucus) to outline our policy agenda for the federal response to the HIV epidemic. People living with HIV networks are organized formations created, led by, and accountable to the estimated 1.1 million people living with HIV in the United States. They are vehicles through which we, as people living with HIV, can define our own agenda, choose our own leaders, and speak with collective voices.

For stakeholders in the federal government, the HIV Caucus brings a unique lens, informed by lived experience, to the development of policies to ensure better care, treatment, and quality of life for people living with HIV. The networks which make up the HIV Caucus have been involved as service providers, have run programs that serve people living with HIV, and have built community-based organizations and advocacy initiatives from the ground up. We are in direct contact with tens of thousands of people living with HIV throughout the United States.

These unique abilities and access inform our work and led us to create this living policy agenda to collect our expertise into a road map for lawmakers and other key stakeholders to use in addressing the HIV epidemic at the federal level.

This policy agenda contains recommendations in 5 issues areas which must be centered in every aspect of the federal HIV response:

1. **Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response;**
2. **Proactively creating an affirming human rights environment for people living with HIV by addressing stigma, eliminating HIV criminalization, and halting molecular HIV surveillance;**
3. **Addressing inequities in the federal response by attending to racial and gender disparities;**
4. **Adding sex workers and immigrants living with HIV as priority populations throughout the federal response; and**
5. **Affirmatively committing to improving quality of life for people living with HIV.**

To address each of these issue areas, we have suggested concrete recommendations for the associated executive agencies, the HIV National Strategic Plan, and the Ending the HIV Epidemic Plan, which are broadly delineated on the pages that follow.

Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response
Staff federal bodies addressing the epidemic, such as the Office of National AIDS Policy, with people living with HIV from the communities most impacted by the epidemic and recharter the HIV advisory boards of the federal agencies to include a minimum of two seats for representatives of the HIV Caucus.
Develop a process to solicit input from, engage and consult with the HIV Caucus, and include meaningful involvement of people living with HIV indicators in the final version of the HIV National Strategic Plan and in updates to the Ending the HIV Epidemic Plan.
Proactively creating an affirming human rights environment for people living with HIV
Identify stigma-reduction activities that partners in the HIV response can engage in, require Ending the Epidemics jurisdictions to create plans that incorporate these activities, and resource people living with HIV networks to develop and implement stigma-reduction initiatives.
Utilize data collection tools and interventions that examine structural change.
Promote advocacy efforts to remove punitive laws and policies, like HIV criminalization, by acknowledging the federal government's role in creating them and making clear commitments in federal plans to end HIV criminalization.
Declare a moratorium on molecular HIV surveillance and partner with people living with HIV networks to develop standards for obtaining informed consent; privacy protections; and security, sharing, and storage protocols.
Implement community generated standards in all aspects of the federal HIV response and ensure funding is in place for training and compliance.
Addressing inequities in the federal response: attend to racial and gender disparities
Explicitly include racial and gender disparities as elements of the HIV epidemic to be addressed in all funding opportunities and create grant opportunities for and led by these populations.
Require Ending the Epidemic jurisdictions to target resources to Black, Indigenous, and other people of color, especially those who are also gay and bisexual men, people of trans experience, people who use drugs, sex workers, and immigrants.
Require jurisdictions and grantees to provide care services to dependents while people living with HIV receive services and to screen for intimate partner violence.
Adding sex workers and immigrants living with HIV as priority populations throughout the federal response
Push to prohibit the practice of using condom possession as evidence of sex work and eliminate federal policies conflating sex work and human trafficking.
Prioritize and require commitments to the decriminalization of sex work, including restrictions of individuals with sex work-related or drug-related convictions from accessing federal programs and services.
Ensure health care is accessible regardless of immigration status.
Add sex workers and immigrants as priority populations in the federal HIV response and fund programs led by and serving them accordingly.
Fund language services, particularly those that are in-person, and require certain grantees to staff certified medical interpreters or train staff on interpretation utilization.
Affirmatively commit to improve quality of life for people living with HIV
Create a minimum standard of care and quality of life for people living with HIV, promulgate regulations requiring those providing health care to people living with HIV to conform to those standards, and monitor and report how these standards are being upheld.

Establish access to online and in-person benefits counseling/advisement for people living with HIV; design system to improve portability of benefits between jurisdictions; and create programs to train, recruit, and hire people living with HIV into the HIV workforce and other employment opportunities.
Fully fund Housing Opportunities for People with AIDS and other federal housing programs and enforce the Fair Housing Act to address housing discrimination.
Require the federal HIV programs to track and address housing for people living with HIV.
Improve the Supplemental Nutrition Assistance Program to account for regional differences, increase overall benefits, continue extensions of work requirements, and reduce administrative burdens for people living with HIV.
Improve, expand, and fund access to sexual and reproductive health care for people living with HIV, including transition-related care, and monitor this progress with metrics in the federal HIV response.
Fund research and create accessible guidelines for birthing people living with HIV to breast/chest-feed their children that do not include criminalization.

DEMANDING BETTER:
An HIV Federal Policy Agenda by People Living with HIV

BACKGROUND

About Us

We are networks of people living with HIV (PLHIV networks) in the United States. PLHIV networks are organized formations created, led by, and accountable to the estimated 1.1 million people living with HIV (PLHIV) in the United States. PLHIV networks are vehicles through which we, as PLHIV, can define our own agenda, choose our own leaders, and speak with a collective voice.

Our networks represent communities most impacted by the epidemic in the United States: Black gay and bisexual men living with HIV in the U.S. South, Black cisgender and transgender women living with HIV, transgender women of color living with HIV, Latinx people living with HIV, survivors of HIV criminalization, and people aging with HIV. Our constituencies are diverse – including groups organized around race, gender, age, gender identity, sexual orientation, and immigration status – and we work across coalitions and communities on issues that impact us.

PLHIV networks bring a unique lens, informed by lived experience, to the development of policies to ensure better care, access to treatment, and quality of life for PLHIV. As PLHIV, we understand HIV-related stigma, discrimination, and structural conditions -- including racism, homophobia, sexism, transphobia, xenophobia, ableism, and poverty -- in direct, embodied ways. Many of us have been involved as service providers, have developed and led programs that serve PLHIV, and have built community-based organizations (CBOs) and advocacy initiatives from the ground up. We are in direct contact with tens of thousands of PLHIV throughout the United States and are consequently able to identify and, where resources allow, respond to emerging trends quickly.

There is a marked difference between collaborating with or taking input from individual PLHIV and engaging with organized formations of PLHIV. Processes to take input from or consult with individuals living with HIV generally have no available mechanisms for, nor resources to support, community accountability. Nor do they provide real avenues to support engagement by PLHIV representing the communities most affected by HIV, who may be facing various barriers that circumscribe their ability to effectively participate in decision-making or advisory processes. Thus, working with individual PLHIV is frequently tokenizing and disempowering to PLHIV and reinforces the inequities in race, gender, and class that have framed dominant discourse and policymaking on the HIV epidemic to date.

The United States People Living with HIV Caucus (HIV Caucus) emerged in 2010 from the need for a national voice for PLHIV. The HIV Caucus is composed of members Global Network of People Living with AIDS -- North America, International Community of Women with HIV/AIDS -- North America, National Working Positive Coalition, Positively Trans, Positive Women's Network-USA (PWN), Reunion Project, SERO Project, and THRIVE SS. As a national "network of networks," the HIV Caucus has taken the lead on several issues that PLHIV face, including addressing national HIV plans and policies that affect us.[1] The HIV Caucus has been a coordinating partner with AIDS United and Treatment Access Expansion Project at AIDSWatch, the national HIV advocacy day, bringing together hundreds of PLHIV and allies from around the country each year in Washington, D.C., to engage legislators and federal agencies.

It is long past time for national leadership on HIV

to make this shift towards formally recognizing PLHIV networks as necessary partners to help organize, inform, and implement the federal domestic response. Put simply, you cannot end the HIV epidemic without us. This is no longer a demand – it is an absolute imperative. It is in this spirit of partnership that we bring the below analysis of the current federal response and our recommendations forward.

Contextualizing the Federal Response to the United States HIV Epidemic

The federal response to the domestic HIV epidemic is situated within a larger context of politics and culture, including sex negativity, HIV-related stigma, racism, homophobia, transphobia, sexism, classism, and the criminalization of poverty. As a result, since the first cases of AIDS were reported 40 years ago, and while health care providers, clinicians, and community advocates organized to develop compassionate approaches, the political response itself has been plagued by an overall lack of will to actively value, invest in, and affirm the lives of those communities most impacted by the domestic HIV epidemic -- the same communities our networks represent.

For nearly 30 years, the U.S. did not have a comprehensive, national plan to address the HIV/AIDS epidemic. Critical programs and policies to provide health care and treatment to PLHIV, especially the Ryan White HIV/AIDS Program, and various initiatives to prevent HIV funded by the Centers for Disease Control and Prevention (CDC), collectively formed a patchwork response to the domestic epidemic. This fragmented approach to HIV was ironic given that the U.S. engaged with other countries to develop their annual national plans (known as Country Operational Plans, or COPs) as a required component of the funding process under the President's Emergency Plan for AIDS Relief (PEPFAR), established in 2003[2]. However, it was also inevitable – prior to the adoption and enactment of the Patient Protection and Affordable Care Act (ACA), health insurers were legally permitted to discriminate against people with pre-existing conditions[3], such that PLHIV in the U.S. were not generally eligible for private or employer-sponsored health insurance coverage[4], and relied on a medley of social and health related services to fill in the gaps.

In the mid-2000s, as early data began to show that viral suppression in PLHIV would reduce the likelihood of onward HIV transmission, epidemiologists began making the case that any successful plan to "end the HIV epidemic" would have to rest on a foundation of two primary bedrocks:

1. Aggressive HIV testing to identify new diagnoses and
2. Medical treatment to suppress the viral loads of those living with HIV.

This became known as the "test and treat" model. Some advocates pushed to expand the model's frame first to "testing, linkage, and care" (TLC), then to TLC+, in a discursive recognition that successfully implementing widespread and early HIV treatment for those who receive a positive diagnosis requires first that people living with HIV are in medical care and that they were likely to need other services and support in order to facilitate access to that medical care.[5]

The United States National HIV/AIDS Strategy: 2010-2020

The Obama administration's release of a 2010-2015 National HIV/AIDS Strategy for the United States (NHAS, or the NHAS)[6] in July 2010 represented a significant milestone. The NHAS was a White House-level document, complete with the Presidential seal. It was designed as the first cross-government response to HIV, explicitly requiring leadership and action by multiple federal agencies, along with involvement from other stakeholders including the private sector and faith sector, to achieve four major goals:

1. reducing new HIV transmissions;
2. increasing access to care and improving health outcomes for people living with HIV;
3. reducing HIV-related health disparities; and
4. achieving coordination in the national HIV response.[7]

Operational components of NHAS, such as the CDC's Enhanced Comprehensive Prevention Plans (ECHPP) and the "Twelve Cities" approach[8], represented early stages in a geographical approach to test-and-treat type strategies.

In 2015, the NHAS was updated and re-released with new language, new metrics, and a 2020 timeframe for achievements.[9] The four-goal structure remained, with added emphasis on increasing HIV testing and linking people who tested positive to care; providing support to retain PLHIV in care; achieving viral suppression; and focusing HIV efforts on populations most impacted by HIV, including people in the southern states.[10]

The Ending the HIV Epidemic Plan: 2019-present

In January 2019, the U.S. Department of Health and Human Services (HHS) released a ten-year operational plan setting targets of reducing the number of new HIV acquisitions in the United States by 75 percent by 2025, then by at least 90 percent by 2030, through a geographic focus on the 48 hardest-hit counties and the seven states with a "substantial number of HIV diagnoses in rural areas."[11]

This plan is known as the Ending the HIV Epidemic Plan (EHE) and rests on four pillars:

1. diagnose;
2. treat;
3. prevent (through "proven interventions, including pre-exposure prophylaxis and syringe services programs;" and
4. respond to "potential HIV outbreaks to get needed prevention and treatment services to those who need them." [12]

The fourth and final pillar relies on invasive, nonconsensual HIV surveillance activities known broadly as molecular HIV surveillance (MHS) or cluster tracing.[13] Funding has been appropriated from Congress in fiscal years 2020 and 2021 to support the launch of the EHE.[14]

The EHE in its current iteration is viewed by PLHIV networks as deeply flawed in its equation of PLHIV and our viruses to problems that must be surveilled without our consent and managed and controlled via treatment, rather than attending to us as equal citizens with claims to human rights and dignity. We also believe the EHE is necessarily limited in its effectiveness due to its overly biomedical focus, lack of attention to structural and social issues, and failure to partner with PLHIV networks on developing a robust plan and corresponding budget for meaningful community engagement at the federal and jurisdictional level.

The HIV National Strategic Plan: 2021-present

In early December 2020, as the second NHAS was coming to a close, HHS released a draft of a third iteration of a national HIV strategy for public comment, renaming it the HIV National Strategic Plan for 2021-2025 (HIV Plan). A major intent of the draft updated plan was to align the HIV national strategy with the EHE federal initiative. After a brief comment period, the outgoing Trump administration released the 2021-2025 update in mid-January 2021.[15]

PLHIV networks submitted comments on the draft plan, including the HIV Caucus and PWN. The HIV Caucus's and PWN's comments highlighted shortcomings and gaps in the draft plan, notably:

1. the importance of involving organized PLHIV networks;
2. serious concerns with the draft plan's inclusion of the use of HIV genomic sequencing data, cluster detection, and data derived from MHS;
3. lack of inclusion of immigrants and sex workers in the draft plan;
4. inadequate attention to structural determinants of health, most notably racism and racial inequities; and
5. inadequate attention to improving the quality of life of people living with HIV.[16]

We are disappointed to note that PLHIV networks' recommendations were largely not addressed in the final version of the HIV Plan released in January 2021.

The below set of policy recommendations seeks to offer a path forward that will strengthen the overall domestic federal response through a specific focus on improving the structures themselves via which the HIV response is organized and led, along with

concrete improvements to major policies guiding that response in the U.S. as of July 2021– the HIV Plan and the EHE. Again, because the HIV epidemic and response are situated within and rest on broader systems, this document also identifies some policy areas of broader focus that must be considered as foundational to creating a safe, dignified, and rights-based environment for people living with and most vulnerable to acquiring HIV.

ISSUE AREAS AND RECOMMENDATIONS

Issue Area 1. Concretely Elevate Meaningful Involvement of People Living with HIV and Disproportionately Impacted Communities in the HIV Response

Meaningful Involvement of People Living with HIV: Defining the Issue

CDC's Notice of Funding Opportunity PS20-2010 acknowledges that "[r]eaching and maintaining viral suppression among people with HIV is the most effective way to reduce new infections."[17] Biomedical tools needed to meet this already exist, such as antiretrovirals, pre-exposure prophylaxis, and post-exposure prophylaxis. The primary impediments to "ending the HIV epidemic" are structural and social; thus, visible, organized, and effective leadership by PLHIV in all aspects of the HIV response is more important than ever.

PLHIV are, by necessity, intimately familiar with factors that place individuals and communities at risk for acquiring HIV in the first place, such as barriers to accessing care and treatment and challenges to living a full and healthy life with dignity. When PLHIV are effectively involved in program and policy development, implementation, and monitoring, the relevance and effectiveness of strategies improve. Moreover, raising visibility of PLHIV and elevating their voices and experiences can help decrease HIV-related stigma and discrimination.

Meaningful involvement of people with HIV/ AIDS (MIPA) is a globally recognized principle first articulated in the Denver Principles in 1983 and endorsed by the United Nations Programme on HIV/AIDS (UNAIDS), the body that coordinates global action on the HIV/ AIDS epidemic.[18] As UNAIDS explains, at its most basic level, MIPA does two important things:

1. Recognizes the important contribution that people living with and affected by HIV/AIDS can have in the response to the epidemic as equal partners; and
2. Creates a space within society for involvement and active participation of PLHIV in all aspects of that response.[19]

The HIV Caucus has put forth a body of work that further articulates MIPA within a modern U.S. context to acknowledge that MIPA must fully integrate a lens around racial, gender, class, and other axes of power and privilege to be truly "meaningful." The HIV Caucus definition of MIPA goes beyond merely accounting for HIV-positive status to include representation and expertise from constituencies that are disproportionately affected by the epidemic. Within the U.S. and territories, this means that true MIPA must account for regional differences as well as intentionally developing and supporting leaders living with HIV from marginalized communities, especially Black and Latinx people, youth, people who use drugs, immigrants, the LGBTQ community, cisgender and transgender women, people with incarceration experience, sex workers, people aging with HIV, and so many others.

There is no "one-size-fits-all" model to assure meaningful engagement of community, and it takes time for government and public health partners to build trust with communities that have been harmed by multiple systems. Through real and ongoing partnership with organized, constituency-led formations that reflect most impacted communities, like PLHIV networks, these nuances can be addressed over time.

Involving PLHIV networks in decision-making and implementation translates into concrete benefits for public health leadership, including: pre-existing community trust and cultural humility that facilitates development and implementation of strong programs; a real-time sense of challenges and opportunities on the ground;

informed analysis of the myriad and complex effects of interlocking stigma and discrimination; increased effectiveness of policies and programs; and improved sustainability of projects and organizations.

This space within society can be formalized through various mechanisms. For example, in the Ryan White Part A program, jurisdictional planning councils composed of individuals who make decisions about the allocation of resources are legislatively mandated to meet requirements including "reflectiveness" of the local epidemic and "representation" in filling various types of membership categories.[20] The legislation also mandates that 33 percent of planning council members are people who receive Ryan White Part A services and who do not have a conflict of interest as staff, paid consultants, or board members of Part A funded entities.[21] In addition, guidance followed by the Global Fund reflects clear commitments to this type of structured civil society participation by requiring its Country Coordinating Mechanisms to "show evidence of membership of people that are both living with and representing people living with HIV" and of people from and representing "key populations."[22]

MIPA: Opportunities to Strengthen Meaningful Involvement of People Living with HIV in the Federal Domestic HIV Response

The federal domestic HIV response can be strengthened through true partnership with PLHIV networks. The collective voices and organized leadership of PLHIV, as represented in national and local PLHIV networks, must be viewed as essential to crafting or changing HIV policy; prevention, care, and treatment guidelines; data collection and surveillance practices; the HIV research agenda; in the design of HIV service delivery; and in all aspects of monitoring and evaluation. The best way to achieve this is by consulting and involving PLHIV networks as critical stakeholders and partners at every level of the policy and program decision-making that so profoundly affect our lives.

True MIPA requires resources, planning and accountability, and these must be included in the plan with commensurate metrics, indicators, strategies, and funding.

Currently, neither the HIV Plan nor the EHE have real mechanisms that incorporate the core tenants of MIPA: organized, ongoing, and meaningful engagement with PLHIV. The HIV Plan does not explicitly require federal agencies, efforts, or initiatives to partner with PLHIV networks and lacks any specific accountability to the community of PLHIV. While PS20-2010, an implementation component of the EHE, acknowledges the importance of community engagement as part of its' "respond" pillar and requires that 25 percent of funds be designated towards "community engagement," the CDC's definition of engagement[23] is limited and poorly defined.

Similarly, the three national advisory bodies providing guidance to federal agencies on HIV policy – the President's Advisory Council on HIV/AIDS (PACHA), the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (also known as CHACHSPT or CHAC), and the Office of AIDS Research Advisory Council (OARAC) -- currently have no formal guidance mandating organized involvement from PLHIV networks, although some of them require representation of PLHIV.[24]

Established in 1993 during the Clinton administration, the Office of National AIDS Policy (ONAP) is tasked with coordinating an integrated response to the domestic and global HIV epidemic, specifically on matters of prevention, treatment and care. ONAP also oversaw community engagement efforts, utilizing both virtual and in-person mechanisms to hear from, connect with, and be accountable to PLHIV.[25]

Unfortunately, the Trump administration shut down ONAP, leaving a significant gap in coordination and dismantling an avenue for community engagement and feedback on federal HIV policy and initiatives like the HIV Plan and EHE.[26]

The Biden administration recently reconstituted ONAP as part of the Domestic Policy Council and appointed Harold Phillips, a Black, gay man openly living with HIV, as director to lead that office.[27] This is a positive step forward in embodying meaningful involvement of people living with HIV. To support that, it is more important than ever that this newly

constituted ONAP be equipped to meet the needs of PLHIV. Doing so requires ONAP to be robustly staffed, resourced, and supported to lead the federal response, and to directly engage PLHIV networks as part of its mandate.

Recommendations for Issue Area 1 - Meaningful Involvement of People Living with HIV

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
White House/Office of the President of the United States	1. Require ONAP staffing structure to include diverse PLHIV from the communities most impacted by the epidemic, including Black gay and bisexual men, Black cisgender women, and transgender women of color. 2. Recharter PACHA, CHAC and OARAC to each include at least two standing seats for designated representatives of the HIV Caucus, to be filled by the HIV Caucus utilizing representatives of our own choosing.
Department of Health and Human Services	1. The Office of HIV/AIDS and Infectious Disease Policy should develop a formal and regular process to solicit input from, engage and consult with the HIV Caucus, as the representative collective of all U.S.-based national PLHIV networks. 2. Amend the HIV Plan to include measurable metrics for formal engagement of PLHIV networks. 3. Amend the EHE and future funding related to it to: 4. Redefine community engagement beyond resourcing already developed plans, including paid consultation and decision-making on all aspects of the EHE by PLHIV networks; 5. Apply such a commitment to community engagement across the EHE plans – beyond but including the "cluster detection and response" pillar. 6. Amend the EHE, the HIV Plan, and require future HIV initiatives to require MIPA indicators for federal, state, and local advisory and decision-making bodies with purview over HIV, including local EHE jurisdictional planning processes. The required MIPA indicators should include meaningful PLHIV engagement and leadership from the communities most impacted by the domestic epidemic.

PLHIV have been responsible for mass shifts in the ways that HIV is understood, prevented, treated, and addressed: our activism, choices, and actions have built organizations, fought stigma, and advanced science. We are a powerful and underutilized resource that, when supported and engaged appropriately, can dramatically improve efficacy of public health interventions and programs, reduce HIV transmission, and improve quality of life and health outcomes for PLHIV. The federal response can structurally achieve this by making a formal commitment to measurable MIPA.

Issue Area 2. Proactively Create an Affirming Human Rights Environment for People Living with HIV: Address Stigma; Eliminate HIV Criminalization and Halt Molecular HIV Surveillance

2A. Addressing HIV-Related Stigma.

HIV-Related Stigma: Defining the Issue

HIV-related stigma and other intersectional stigmas persist among and against PLHIV. Intersectional stigma refers to the ways that multiple kinds of stigmas - around gender identity, sexual orientation, socioeconomic class, mental health, history of drug use, incarceration, and/or sex work - are compounded for some PLHIV.[28] These have deleterious impacts on people's lives, as they experience further marginalization from communities and institutions. Intersectional stigma also can result in being targeted by multiple punitive laws and policies, as well as bias and discrimination in health care, law enforcement, employment and education.

Where most of the literature places HIV-related stigma either as a psychodynamic model (how people feel) or related to a public health outcome (clinical usage), PLHIV experience stigma throughout every part of their lives. Legal frameworks such as HIV criminalization provide powerful proof of institutionalized stigma. Stigma affects how PLHIV find support,[29] whether PLHIV are successful in pursuing education and employment,[30] and overall quality of life[31].

The result of these stigmas is often seen in the lack of social protections provided to the diverse communities of PLHIV. Criminalization based on HIV-status is one clear aspect of this, yet PLHIV face multiple vulnerabilities. Punitive laws around sex work and drug use affect PLHIV, as well as how intensive policing disproportionately affects the Black community, people of transgender experience, people with disabilities, and immigrants in the U.S. The EHE notes that HIV-related stigma, homophobia, and transphobia are contributing barriers to a successful HIV response, yet there is no clear initiative in the $670 million plan to address and dismantle these barriers.[32]

In order to address these issues, the Global Network of People with HIV/AIDS (GNP+) developed the People Living with HIV Stigma Index (Stigma Index).[33] The Stigma Index is a community-led way to document stigma in a country and develop action plans to address it. The Stigma Index has been conducted in over 100 countries with over 100,000 people living with HIV involved.[34] In the U.S., the attempt to conduct the Stigma Index was cut short due to funding.[35]

HIV-Related Stigma: Opportunities to Strengthen the Federal Response

The HIV Plan envisions "every person with HIV ha[ving] high-quality care and treatment and liv[ing] free from stigma and discrimination," and HIV-related stigmas in the form of interpersonal, community, health system, and structural stigma and discrimination are acknowledged as a barrier to achieving public health goals throughout it.[36] HIV-related stigma is framed as a problem, a challenge to overcome, and a barrier throughout the HIV Plan, which proposes some concrete and useful strategies to address this: developing and implementing campaigns and resources to reduce HIV-related stigma;[37] training health care staff on stigma and discrimination;[38] increasing health literacy among patients; supporting communities to address HIV-related stigma;[39] reframing public health and HIV messaging campaigns that may perpetuate stigma;[40] and developing and implementing evidence-based interventions designed to reduce HIV-related stigma and discrimination in public health and health care systems[41]. Indeed, HIV-related stigma and discrimination may be the problem and barrier to achieving HIV prevention, care, and treatment goals most consistently identified throughout the HIV Plan.

Despite this overwhelming acknowledgment that HIV-related stigma represents a tremendous barrier, there is only one indicator within the HIV Plan that holds the federal response accountable to address this. It holds measurable success solely at the individual level, suggesting the use of a 10-item questionnaire to assess whether individuals diagnosed with HIV are experiencing reduced stigma.[42] The HIV Plan and broader federal HIV response would benefit from ensuring

that its metrics to assess success in reducing or eliminating HIV-related stigma are grounded in what PLHIV are asking for and that they seek to address individual, community, and structural HIV-related stigma and discrimination.

Recommendations for Issue Area 2A - Addressing HIV-Related Stigma

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
Department of Health and Human Services	1. In partnership with PLHIV networks, identify specific stigma-reduction activities that health departments, AIDS Service Organizations (ASOs) and Community-Based Organizations (CBOs), health clinics and other partners in the HIV response can engage in. 2. Require grantees to address employment barriers at all levels for PLHIV as an important way to combat stigma. 3. Resource PLHIV networks to develop and implement stigma-reduction initiatives that reflect the intersectional kinds of stigma that impact the local community of PLHIV.
HIV National Strategic Plan	1. Center the lived experience of intersectional stigma amongst PLHIV, inclusive of Black, Indigenous, and other people of color; people of transgender experience; gay and bisexual men; sex workers; people who use drugs; immigrants; and people who are incarcerated and in other institutional settings. 2. Utilize data collection tools and interventions that go beyond individual feelings and examine structural change, such as, the GNP+ Stigma Index 2.0. This could include building and resourcing PLHIV networks.
Ending the HIV Epidemic Plan	1. Require jurisdictions to have clear, actionable, resourced community-led initiatives to reduce HIV-related stigma and other intersectional stigmas. 2. Identify resources that work towards community-led stigma reduction and community resilience building in its portfolio. 3. Promote advocacy efforts to remove punitive laws and policies and acknowledge how they contribute to HIV-related stigma.

2B. Eliminating HIV Criminalization

HIV Criminalization: Defining the Issue

HIV criminalization is the unjust use of criminal laws, policies, and practices to police, regulate, control, and punish PLHIV based on their HIV-positive status. HIV criminalization laws exist at the state level and vary in scope from state to state.[43] HIV-specific laws may criminalize a range of activities including alleged HIV non-disclosure prior to sex, potential or perceived HIV exposure through many different means, or unintentional transmission of the virus.[44] Although these laws do not exist in every state or territory in the U.S., PLHIV have been convicted or received sentence enhancements based upon their HIV status even when no HIV-specific statute exists,[45] and even when no risk of HIV transmission was scientifically possible.[46]

By contributing to an environment where PLHIV can be targeted and punished, HIV criminalization laws present a deterrent to achieving federal HIV prevention and care goals, while institutionalizing HIV stigma as part of the legal system. Furthermore, data from several states with HIV criminalization laws provide evidence of racial and gender bias in their application, disproportionately enforced against Black and Latinx gay and bisexual men and cisgender and transgender women.[47]

HIV criminalization inflicts long-lasting harm on PLHIV, their families, and their communities. A prosecution or investigation related to HIV status itself and negative media attention may lead to violations of confidentiality, job loss, housing insecurity, complications with custody arrangements, and more. A conviction under an HIV criminalization law may lead to a person being placed on a sex offender registry, which has implications for stigma, childcare, housing, employment, food security, and mental and emotional well-being.[48] Thus, the practice of criminalization is in direct opposition to strategies that seek to improve access to and sustained connection to prevention and treatment methods for the most vulnerable populations.[49]

HIV Criminalization: Opportunities to Strengthen Federal Leadership

Both the HIV Plan and EHE advise state governments to reform or repeal HIV criminalization laws and practices,[50] but do not provide resources or requirements in their respective plans.

EHE does not require its priority jurisdictions to address criminalization in their plans,[51] leaving it up to each jurisdiction to decide for themselves whether to address their respective HIV criminalization laws.[52]

The HIV Plan recognizes the detrimental impact HIV criminalization has on PLHIV, noting how it fuels HIV-related stigma and discrimination.[53] To achieve the goal of ending HIV-related stigma and discrimination, the HIV Plan provides one strategy that calls for reforming state HIV criminalization laws to be rooted in science and public health strategies.[54] It also identifies the need to educate legislators, prosecutors and law enforcement on HIV transmission risks.[55]

Federal leadership on the HIV response has an important role to play in creating an affirming legal, social, and political climate for people living with and vulnerable to HIV to engage in health care and have all their human rights protected.

Recommendations for Issue Area 2B - Eliminating HIV Criminalization

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
HIV National Strategic Plan	1. Draw clear connections between criminalization and the disparate health outcomes of various groups such as Black, Indigenous, and other people of color, sex workers, and those who use drugs. 2. Strengthen the focus on negative consequences of criminalization on access to and retention in HIV care and treatment.
Ending the HIV Epidemic Plan	1. Acknowledge the federal government's role in creating HIV criminalization laws and make equal commitments to repeal these laws. 2. Require EHE jurisdiction plans to include clear commitments to support state efforts to reform or repeal HIV criminalization laws as a condition for funding. 3. Call for EHE jurisdictions that are being funded to engage with PLHIV who have experienced incarceration to address the residual impacts of criminalization, including access to adequate treatment and care.
Congress	1. Pass a Repeal Existing Policies that Encourages and Allow Legal (REPEAL) HIV Criminalization Act that is consistent with current HIV decriminalization advocates' understanding and strategy and that incentivizes states to reform or repeal their respective laws.

2C. Declare a Moratorium on Molecular HIV Surveillance Until Adequate Safeguards Protecting the Privacy and Autonomy of People Living with HIV Are Implemented

Molecular HIV Surveillance: Defining the Issue

Molecular HIV surveillance (MHS) refers to the practice of using HIV genetic material to compare with other HIV genomic sequences to determine whether acquisitions are similar enough to be related to each other and therefore linked. For PLHIV, MHS begins in the clinical setting by which during a medical visit, often early in an individual's diagnosis, blood is drawn and from it HIV genetic material is sequenced, stored in a database, and shared with other databases. For public health purposes, MHS is primarily used for "cluster detection," or the practice of identifying instances when it appears there may be multiple linked HIV acquisitions appearing within a short amount of time, thereby triggering a public health investigation and response. Of notable concern, the processes of HIV genomic sequencing, data storage, and data sharing -- essential to MHS -- are conducted without an individual's consent and knowledge.

As PLHIV networks, we strongly oppose these practices for several reasons that generally fall into the following categories, some of which are interlinked:

1. Lack of informed consent from PLHIV;
2. Lack of consultation or meaningful engagement with PLHIV in development and implementation of MHS;
3. Wide variation in state-level data sharing environments and legal protections for MHS data;
4. Risk of potential data misuse in civil, immigration, and/or criminal proceedings;
5. Concerns about breaches of privacy and confidentiality; and
6. Lack of consistent standards for competency in the HIV disease investigation intervention workforce to attend to sensitivities around stigma, culture, and violence.

Lack of consent from and consultation with people living with HIV.

PLHIV generally do not know, nor have consented, to having our HIV genomic sequence data collected, shared, stored, and utilized in this way by public health authorities. This is a fundamental breach of trust. Due to the lack of informed consent, MHS may undermine trust in the health system, deterring people from seeking HIV screening and testing in the first place and from engaging in health care once diagnosed. This presents a serious problem for "ending the HIV epidemic" efforts. PLHIV tend to be from communities that already have justifiable distrust of medical and research institutions, as well as public health authorities, and may have made significant efforts to overcome that distrust to participate in their health care.[56]

HIV clinicians and health care providers frequently go to great lengths to ensure safety and confidentiality for their patients – and cannot opt out of the use of this medical information for surveillance purposes.[57]

While PS20-2010, which is an implementation component of the EHE, acknowledges the importance of community engagement as part of its "respond" pillar and requires that 25 percent of funds be designated toward "community engagement,"[58] this is too little, too late, considering that several years ago, the CDC's PS18-1802 mandated funded health departments to tackle MHS as a core component of their prevention efforts[59].

Wide variation in state-level data sharing environments and legal protections for MHS data.

Laws protecting the privacy of health data and permitting sharing and use of molecular HIV data vary widely from state to state, and there is no current national standard that would uniformly protect misuse of this data for people living with HIV.[60] The National Association of State and Territorial AIDS Directors (NASTAD) produced an analysis of the legal and regulatory HIV data privacy environment in ten states and found wide variation in how well HIV data is protected and under what conditions personally identifiable data may be shared without the person's consent, including sharing HIV data with law enforcement.[61] In particular, NASTAD's report found that:

> "In general, statutes provided health departments with authority to disclose personally identifiable HIV data without consent (emphasis added) for the following general purposes: surveillance, investigation, or control of communicable disease; treatment, payment, research, or health care operations; justifiable public health need. Within this broad statutory authority, a few states enumerated specific allowable and unallowable health department HIV data-sharing activities (particularly for data-sharing related to law enforcement and research). However, the vast majority of statutory schemes used more general language giving discretion to health departments and their legal counsel to act under fairly broad authority as long as the statute's purposes were met. This lack of specificity in state laws places great importance on health department internal data-sharing policies and gatekeeping functions."[62]

While every state had protections for reducing data shared with law enforcement, states vary on the strength of the legal protections in place to compel a health department to produce HIV data, and which data may be shared, for law enforcement purposes. Ultimately, much is left up to the discretion of the health department's legal counsel. Further, there is substantial variation in legal authority to share personally identifiable information of PLHIV for research purposes.[63]

Risk of potential data misuse in civil, immigration, and/or criminal proceedings.

As acknowledged in the HIV Plan, over 30 states still have laws criminalizing PLHIV, and even more prosecute PLHIV under other general criminal laws, including assault.[64] Among PLHIV, Black and Latinx people, sex workers, queer and trans people,[65] immigrants, those who are unhoused or marginally housed,[66] people who use drugs, and people who live with mental illness are already frequently targeted by law enforcement.[67] In criminal prosecutions for alleged HIV exposure,

prosecutors may seek to introduce evidence that the defendant or plaintiff is part of a transmission cluster.[68] Judges, prosecutors and juries may be biased due to stigma and may also not understand the science enough to know its limitations (for example, MHS cannot currently demonstrate direct transmission, only whether viruses are closely related). For immigrants of any legal status, it is unclear what protections exist if MHS data were presented in immigration proceedings. This creates further vulnerability for communities already vulnerable to surveillance and policing.

Concerns about breaches of privacy and confidentiality.

Attention from public health departments and from media linked to "cluster detection" investigations can disclose private health information of PLHIV, even inadvertently. One newspaper in Seattle went so far as to publicly identify a street on which an "HIV outbreak" was happening and to name that the people involved were unhoused, sex workers, and/or drug users.[69] This type of disclosure presents a risk of further targeting from police for PLHIV. Worse, it is well documented that PLHIV have lost jobs,[70] housing, and even their lives[71] as a consequence of disclosure of HIV status. These types of irresponsible actions by public health officials can literally put our lives at risk.

Health department workforces do not have consistent standards for training and implementation that protect people living with HIV from possible harm.

While the CDC recognizes the need for the public health workforce to receive training in culture and diversity,[72] it is unclear to what extent contact tracers, disease investigators, or cluster detection responders are receiving specific training in the nuances of HIV stigma, disclosure and privacy sensitivities, and risks for community violence and criminalization. Cultural competence is a necessary skill for members of the public health workforce engaged in such sensitive activities, and recommendations from experts support ensuring that under-represented populations, such as PLHIV, are involved in developing effective health solutions.[73]

Dr. George Ayala and other PLHIV have called for not offering partner notification services where PLHIV and other socially marginalized groups are criminalized[74] if the risks of doing so outweigh the benefits.[75] Anecdotally, there are many examples of public health HIV contact tracing activities paving the way for inadvertent disclosure of HIV-positive status in employment settings, housing, and with family members. Significant and ongoing workforce training is necessary to ensure safety for people living with and vulnerable to HIV who may be involved in cluster detection investigations.

In summary, the practice of MHS, cluster detection, and corresponding public health investigations create vulnerabilities for inadvertent disclosure; stigma; risks to physical safety, employment, and housing; and even criminal liability for PLHIV. MHS and cluster detection practices must be stopped immediately and have no place in any national HIV plan until significant steps are taken to address these concerns. Sharing of HIV data is a sensitive issue and must be thoughtfully considered in real, meaningful partnership with PLHIV networks before it is further implemented.

Opportunities to strengthen HIV data privacy and sharing protections

Currently, MHS comprises one of four pillars of the EHE.[76] Recent federal budgets have prioritized CDC funding for cluster detection and response[77], and the CDC is essentially requiring health departments funded under EHE efforts systematically implement and/or scale MHS activities.[78] The HIV Plan also highlights MHS and cluster detection and response among "activities that exemplify improved integration and coordination of efforts" -- which is one of the four primary goals of the HIV Plan.[79] Further, the HIV Plan explicitly names the need to improve coordination "across partners to quickly detect and respond to HIV outbreaks" as a strategy.[80]

The HIV Plan explicitly calls for "enhanc[ing] the quality, accessibility, sharing, and use of data, including HIV prevention and care continuum data and social determinants of health data," and goes on to describe data sharing across disparate systems as a top priority.[81] Such an expansion of

MHS without strong and consistent data privacy and confidentiality laws, coupled with boundaries on the sharing of HIV genomic sequence data and identifiable information about PLHIV, is dangerous and irresponsible.

Health departments describe the CDC's 2011 guidance on HIV data privacy and security as a crucial resource in informing their own internal data privacy policies.[82] That guidance explicitly states that "data collection and use policies should reflect respect for the rights of individuals and community groups and minimize undue burden."[83] It calls for training of individuals who have access to identifiable health information in policies and procedures for data sharing, laws governing data sharing, procedures for storing data – but does not require any training in, for example, specific sensitivities around HIV stigma, criminalization, and other dangers of HIV-positive status disclosure.[84]

PLHIV networks are not alone in their call for adequate legal safeguards and community education on MHS. AIDS United's Public Policy Committee has issued a strong set of principles and recommendations to guide the use of MHS.[85] We support many of these recommendations and have provided additional recommendations below:

Recommendations for Issue Area 2C - Molecular HIV Surveillance

Agency, Federal Body, or Policy	Recommended Action(s)
Department of Health and Human Services	1. Work in collaboration with PLHIV networks to develop and implement a process to obtain informed consent from PLHIV before HIV genomic sequence data is collected, analyzed, stored, and/or shared. 2. Issue a public statement that affirmatively clarifies that HIV genomic sequence data cannot be used in criminal, civil, or immigration proceedings. 3. Work in collaboration with the HIV Caucus to develop consistent national standards on HIV data security, sharing, and storage that explicitly prohibit sharing HIV genomic sequence data with law enforcement, immigration enforcement, employers, and other relevant entities and which limit the amount of time HIV data can be stored and how it may be shared.
Ending the HIV Epidemic Plan	1. Remove the requirement that EHE-funded jurisdictions conduct MHS activities. 2. Prohibit EHE-funded jurisdictions from conducting MHS activities if they cannot meet the security, storage, and data-sharing standards described above.
HIV National Strategic Plan	1. Remove MHS and all cluster detection and response activities from the HIV Plan until the above issues have been addressed.
White House Office of National AIDS Policy	1. Declare an immediate moratorium on the further collection, use, and sharing of MHS data in public health efforts until the above standards are achieved. 2. Develop community engagement standards that require active involvement from PLHIV networks in any future development of HIV-related data collection, use, sharing, and storage.

Centers for Disease Control and Prevention	1. Require that any jurisdictions funded to conduct MHS prove they can meet the standards created above. 2. Require certification from state and local jurisdictions that public health officials will comply with CDC data security guidance and only share data with law enforcement pursuant to a valid, enforceable court order issued following notice to the subject(s). Effective notice should both inform subjects that their data has been sought and provide them an opportunity to oppose disclosure in court. 3. Fund initiatives to educate public health department staff and legal counsel on the legal safeguards and required processes and protections for disclosing public health information to law enforcement. 4. Make funding for MHS and research based on MHS contingent upon such certification. 5. Partner with the HIV Caucus to develop and implement a curriculum for relevant public health workforce staff inclusive of content on HIV stigma, HIV criminalization, cultural sensitivities on HIV, and risks of HIV status disclosure. 6. Require that all staff involved in disease investigation, contact tracing, partner notification, MHS, and cluster detection response receive this training. 7. Require that HIV genomic sequence data be stored in an anonymized form that cannot be re-identified. This should include the use of advanced anonymization techniques that make molecular surveillance data resistant to re-identification by algorithms or humans. 8. Develop standardized, publicly available disclosures to ensure that PLHIV are informed of routine and potential use of their identifiable health information, including any contemplated use of individual, identifiable treatment information and resistance testing results, and including their right to object to having their data used in this this way.

Issue Area 3: Addressing Inequities in the Federal Response: Attend to Racial and Gender Disparities

Addressing Racial and Gender Inequities in the Federal Response: Defining the Issue

Racial Inequities. HIV has a disproportionate impact on Black, Latinx, and Indigenous communities which is inadequately addressed by every domestic HIV plan. The CDC has consistently found that Black and Latinx communities are disproportionately affected by HIV compared to other racial/ethnic groups. For example, while Black individuals represented 13 percent of the U.S. population, they represented 41 percent of PLHIV in 2018 CDC data.[86] While Latinx individuals represented 18 percent of the population, 23 percent of PLHIV were Latinx in the same year.[87] In the U.S., gay and bisexual men - particularly Black, Latinx and Indigenous - constitute the majority of new HIV diagnoses, yet this is not reflected in funding and resources for community-led programs.[88]

Among cisgender and transgender women, Black women are disproportionately affected by HIV as compared to women of other races/ethnicities.[89] From 2014-2018, the rate of new HIV acquisitions among cisgender Black women was 13 times that of white women and four times that of Latinx women.[90] Further, in 2017, Black Americans had an age-adjusted HIV-related death rate of 6.6 per 100,000, compared to 0.9 per 100,000 for white Americans.[91]

The impacts of structural racism[92] are not limited to relative rates of HIV acquisition. They impact all areas of life, including economic opportunity and justice, well-being, and mental health care. Until structural racism and racism within the HIV epidemic is explicitly recognized and addressed, the HIV epidemic will not end. Expanding biomedical responses without attention to the racism that prevents Black, Latinx, and Indigenous people from accessing HIV prevention, care, and treatment in the first place will only further the racial disparities in the HIV epidemic. Instead, the focus must be on structural and social drivers of health; dismantling oppressive, discriminatory systems; and understanding and ameliorating the effects of understandable medical mistrust.

Gender Inequities. Women, including women of trans experience, account for about a quarter of the domestic HIV epidemic.[93] In 2018 alone, an estimated 7,189 cisgender women and 554 transgender women were newly diagnosed with HIV in the United States.[94] The single largest percentage increase in the number of persons living with HIV from 2014 through 2018 by gender was among transgender women.[95] Gender disparities are also racialized and geographic: Black, Latinx, and other women of color represent a majority of women living with HIV in the United States and a majority of new HIV acquisitions.[96]

Black cisgender women, who live at the intersection of anti-Black racism and gender-based oppression, are disproportionately impacted by HIV.[97] Cisgender women with HIV are concentrated in the South, which in 2018 had more reported HIV acquisitions (3,988) among adult women and adolescents than any other region.[98]

In health care settings, stigma and bias against transgender people may compromise access to quality services, as well as policies restricting what can be covered by payer sources. Transgender people face discrimination in all aspects of life, from housing to health care, from public accommodations to policing, from employment to education. Again, race and gender intersect in complex ways: Black, Indigenous, and other transgender people of color face even higher rates of discrimination and violence in these settings. In health care settings, stigma and bias against transgender people itself may compromise access to quality services, as well as policies in the form of structural stigma that restrict what can be covered by payer sources. While important moves have been made to restore non-discrimination protections, for transgender people living with HIV, it can still be nearly impossible to find culturally relevant and non-stigmatizing health services and providers.

Transgender and cisgender women living with and at risk for HIV face severe challenges to accessing services, health care, and information they need, including socioeconomic and

structural barriers such as poverty, cultural inequities, and intimate partner violence (IPV).[99] Women living with HIV are more likely to receive some care, but less likely to be retained in care, as compared to the statistical average person living with HIV.[100]

The rates of death among PLHIV reflect this disparity, as cisgender women, transgender women, Black people, people of more than one race, and people in the South saw smaller gains in their rates of deaths from HIV from 2010 until 2018 than other PLHIV, and women are more likely to die of HIV related complications than men.[101] Higher percentages of cisgender women and transgender women who are clients of the Ryan White HIV/AIDS Program are living below the federal poverty line than men.[102] Fifty-five percent of women living with HIV report experiences of intimate partner violence, and the associated trauma can also lead to poor treatment outcomes and higher transmission risks.[103] Without focused attention to racial and gender inequities, these interrelated disparities will continue to persist.

Racial and Gender Disparities: Opportunities to Strengthen Federal Leadership

As noted above, both the EHE and the HIV Plan do not provide enough focus and concrete steps to address gender or racial disparities as they pertain to PLHIV. The racial inequalities of the federal response can be more firmly grasped by reviewing the way funding is provided to grantees as part of the EHE plan.[104] The first three Notice of Funding Opportunities[105] make no mention of racial disparities as it pertains to HIV, except to give an example of a program focused upon Black men who have sex with men.[106] However, addressing the needs of Black, Latinx, and Indigenous people who are disproportionately affected by the epidemic is not mentioned in any of these three funding opportunities.[107] Even when Black, Latinx, Indigenous, and people of color do begin to be noted as under-served populations, there is no focus outside of viral suppression[108] or access to PrEP.[109] HIV-related stigma as it intersects with racial disparities is only mentioned in one funding opportunity, and there it is not substantively addressed.[110]

As with racial disparities, cisgender women[111] and transgender people are generally not prioritized in funding decisions. When women are mentioned, it is generally in the context of PrEP access or testing,[112] not sexual and reproductive health care needs, care-taking responsibilities, or the other unique needs of women. Even when women are addressed in funding opportunities, these opportunities are grossly underfunded when compared to the scale of the issues.[113]

While racial disparities have been more fully addressed in the HIV Plan, which includes concrete commitments to strengthen civil rights laws,[114] its discussion of other social and structural drivers of health which result in racial disparities is lacking.[115] While these issues[116] are addressed more broadly as they relate to all under-served populations, there are no commitments to address these issues directly as to how they impact Black, Latinx, and Indigenous communities.[117]

Similarly, gender disparities also receive a more complete, yet still inadequate treatment in the HIV Plan. We are pleased to see that transgender and Black women are noted as priority populations.[118] Further, the need to scale up trauma-informed services is included as a goal.[119] The need for comprehensive, supportive services for transgender individuals as well as a discussion of the challenges that exist is present; however, the indicators of success are biomedical indicators of viral suppression.[120] Still, the HIV Plan makes no mention of sexual and reproductive health,[121] of gender specific disparities in employment and housing, and other challenges to care and well-being that exist, such as care-taking responsibilities, discrimination based upon gender, and mistrust of medical professionals.

Recommendations for Issue Area 3 - Inequities in the Federal Response

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
White House/Office of National AIDS Policy	1. Explicitly center racial equity throughout the federal HIV response by including Black, Latinx, Indigenous, and other people of color as priority populations in funding opportunities. 2. Explicitly include racial and gender disparities as elements to be addressed in all grant funded opportunities.
Department of Health and Human Services	1. Fund via grants Black-led organizations addressing the epidemic through a racial equity lens. 2. Fund programs led by women and people of trans experience to address the HIV epidemic through a gender equity lens.
End the HIV Epidemic Plan	1. Require that jurisdictional resources be targeted for Black, Indigenous, and other people of color, especially those who are also gay and bisexual men, people of trans experience, people who use drugs, sex workers, and immigrants. 2. Create funding opportunities that specifically address social and structural drivers of health as they relate to Black, Indigenous, and other people of color. 3. Prioritize funding for organizations run by members of the communities to be served. 4. Require grantees to include intimate partner violence screenings in health care and supportive service settings. 5. Require jurisdictions to create and fund programs that provide care-taking services for the dependents of PLHIV while they are receiving services.
HIV National Strategic Plan	1. Include a racial and gender equity lens that is informed by the direct inclusion of community by hiring them as staff in federal agencies and paying them for their work. 2. Utilize multiple factors to gauge the success of the HIV Plan outside of viral suppression.

Issue Area 4. Add Sex Workers and Immigrants Living with HIV as Priority Populations Throughout the Federal Response.

Sex Workers Living with HIV: Defining the Issue

Sex workers are at a greater vulnerability for acquiring HIV and other STIs than the general population.[122] For transgender women, those who had ever done sex work were over 25 times more likely to be living with HIV (15.32 percent) than the general population (0.6 percent).[123] This is due to various social and structural factors that create substantial barriers to HIV prevention, treatment, and care, such as criminalization of sex work, lack of employment protections for sex workers, and intersections between poverty and sex work, which may increase vulnerability in the first place.

Criminalization of sex work takes many different forms, including targeted and often racist,[124] homophobic, and/or transphobic policing of people perceived to be engaged in sex work under various forms of loitering laws, "condoms as evidence" laws--which create a structural barrier to sex workers protecting their own sex health-- and intersections with HIV criminalization laws.[125]

Sex workers are also at increased risk for violence from community and from law enforcement,[126] and, in many U.S. states and territories, bear the brunt of HIV-related prosecutions, convictions, and sentence enhancements.[127] Practices such as "cluster detection and response," under the umbrella of MHS activities embedded in the EHE's implementation, have even led to media disclosures that specifically name streets where sex workers and people who use substances live and/or work.[128] HIV services and government programs may themselves stigmatize and structurally exclude people in the sex trade.[129]

To truly end the HIV epidemic, the HIV Plan must assure that competent and non-stigmatizing HIV services are provided to sex workers and that sex workers can safely participate in HIV services and benefit from other publicly funded programs without fear of judgment, criminalization, exclusion, or confidentiality violations. To ensure this is possible, sex work must be fully decriminalized; HIV-related sentence enhancements for sex work must be repealed; and sex workers, especially from Black, Indigenous and people of color communities, should be meaningfully engaged as partners in designing and implementing HIV prevention, care, and anti-stigma efforts.

Immigrants Living with HIV: Defining the Issue

Immigrants have been excluded from most health services due to legislative and regulatory exclusions.[130] Even with the advent of the ACA, millions of undocumented individuals remain unable to access health care and other services that support access to health care.[131] In addition, fear for safety and language injustice persist as barriers, particularly in the last five years.

Regulatory barriers have been erected to prevent immigrants living with HIV from accessing systems of care they need and have a right to, including health care.[132] These barriers have fueled medical mistrust and service avoidance among immigrant communities, specifically Black, Latinx, and Asian communities – communities that intersect with the HIV Plan's named priority populations.[133] For example, in 2019, the Trump administration promulgated a rule radically redefining the "public charge" test, essentially punishing some immigrants for relying on public programs like health care, housing and nutrition programs.[134] While the Trump administration's rule has been blocked, the chilling effect[135] will be long-lasting and will exacerbate health disparities.

In addition to traditional medical service providers, the U.S. Immigration and Customs Enforcement (ICE) has been utilized and is tasked with providing care to immigrants in detention centers.[136] Carceral systems, including ICE detention centers, have consistently failed to provide quality and competent health care to immigrants living with HIV. ICE's gross medical negligence has led to the death of some.[137] Roxsana Hernández and Johana Medina, both transgender women, sought asylum in the U.S. based on their HIV status, but were denied medical care and died in ICE custody. Despite the legal requirement to provide immigrants in detention with medical treatment and care, ICE

refused to provide HIV treatment for Hernandez, resulting in her death.[138] The HIV Plan cannot ignore the detrimental impact detention and incarceration has on migrants living with HIV -- this must be included in any plan to address the HIV epidemic, regardless of someone's immigration status.

For non-English speaking immigrants, language barriers may play a role in exacerbating health disparities for marginalized communities.[139] The HIV Plan briefly mentions language barriers but fails to convey the ways that culture is embedded in language, and thus that translation and interpretation go beyond a straightforward word-for-word translation. Language justice is about access, in terms of its accessibility and engagement with communities. It is about making health terms and information understood and communicated within cultural context, with cultural relevance, so that community members can make thoughtful health choices and assert their decisions. To achieve the prevention and care goals of the HIV Plan, immigrants of any legal status and immigrants who do not speak, read, or write English must be assured high-quality HIV prevention, care and facilitative services; must be able to participate safely and without financial or legal repercussions in HIV programs; and must have unfettered access to treatment.

Opportunities to Strengthen the Federal Domestic HIV Response for Sex Workers and Immigrants

The HIV Plan currently recognizes five populations as "priority populations":

1. gay, bisexual, and other men who have sex with men, in particular Black, Latino, and American Indian/Alaska Native men;
2. Black women;
3. transgender women;
4. youth aged 13-24; and
5. people who inject drugs.[140]

Notably absent from the HIV Plan are sex workers and immigrants, two communities that have specific needs in relation to HIV and which are often structurally absent from decision-making and advisory processes, for a range of reasons.

While the final version of the HIV Plan does minimally mention sex work and immigration status in the context of stigma and discrimination,[141] it fails to articulate a commitment to address these needs systematically throughout the federal response, for example within HIV prevention and care efforts; nor does the HIV Plan articulate concrete strategies that could better meet the goal of reducing HIV-related stigma and discrimination for these populations, improve their engagement in health care, and eliminate barriers to HIV prevention efforts.

Recommendations for Issue Area 4 - Sex Workers and Immigrants as Priority Populations

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
White House/Office of the President	1. Advocate for legislation to prohibit the practice of using condom possession as evidence of sex work 2. Modify or eliminate existing federal policies that conflate sex work and human trafficking and that prevent sex workers from accessing services such as health care, HIV prevention, and support. 3. Work with the Office of the Global AIDS Coordinator to repeal "anti-prostitution pledge" requirements entirely from PEPFAR and anti-trafficking funds. 4. Ensure health care access regardless of an individual's immigration status. 5. Prioritize funding to community-based organizations led by and/or serving immigrant populations.
Department of Health and Human Services	1. Implementation plans for the HIV Plan should address training of health care professionals to end stigma and discrimination against those who are involved in the sex trade. 2. Prioritize funding for harm reduction and rights-based health care services for sex workers of all genders and all ages. 3. Require meaningful engagement of Black, Latinx, Indigenous, and other people of color communities-- especially PLHIV, people who use drugs, immigrants, sex workers, people of trans experience, and gay and bisexual men--in HIV planning and resourcing in every health jurisdiction. 4. Fund CBOs to strategize, inform, and implement programs and policies in the HIV response. 5. Develop and implement community-accountability models for public health jurisdictions to ensure that those most marginalized are indeed reached.
Centers for Disease Control and Prevention	1. Issue a statement that explains how laws that rest on condom possession as evidence of sex work harm HIV prevention, testing, and clinical care efforts and may place sex workers at risk for violence.
Congress	1. Pass the SAFE Sex Worker Study Act of 2021 2. Pass the HEAL for Immigrant Families Act of 2021 3. Pass the American Dream and Promise Act of 2021 4. Repeal exclusions and eliminate policies that prevent and/or hinder individuals with commercial sex and drug-related convictions from applying for and/or receiving student loans, public housing or housing assistance, public assistance, or other government-funded social services.

HIV National Strategic Plan	1. Add sex workers as a priority population. 2. Add immigrants, of any legal status, as a priority population. 3. Explicitly recommend resourcing for community-led organizations and programs for people of color, especially in the following communities: people living with HIV, people who use drugs, immigrants, sex workers, people of trans experience, and gay and bisexual men. 4. Discourage "general public" approaches in the HIV response. This "general public" affirms a white, cisgender, able-bodied, middle class norm that excludes everyone else. 5. Explicitly name and call for addressing the criminalization of sex work and stigma and discrimination against sex workers as a barrier to HIV prevention, care, and anti-stigma efforts. 6. Prioritize funding and partnership opportunities with community-based organizations led by and for sex workers. 7. Prioritize funding for in-person interpreters and other translation services for people with limited English proficiency. 8. Prioritize funding immigrant-led and immigrant- serving community-based HIV organizations for communication and health literacy programs. 9. Require AIDS service organizations (ASOs) to staff certified medical interpreters and/or train staff on proper interpreter utilization. 10. Ensure that translation includes understanding cultural contexts and frameworks for health, disease, and treatment options.
End the HIV Epidemic Plan	1. Require EHE-funded jurisdictions to demonstrate a commitment to decriminalizing commercial sex work, including addressing loitering laws and condoms as evidence laws. 2. Require EHE-funded jurisdictions to include resources for community mobilization of sex workers to respond to violence and discrimination.

Issue Area 5. Affirmatively Commit to Improving Quality of Life for People Living with HIV.

Improving Quality of Life for People Living with HIV: Defining the Issue

Although there are more than a million PLHIV in the United States, quality of life for PLHIV has long been an afterthought in the federal HIV response. While the HIV Plan makes "improv[ing] the health-related quality of life" for people aging with HIV a "key commitment"[142] and also seeks to both develop and scale interventions to improve quality of life for people living with HIV,[143] it does not do so in a broad and inclusive way. Both descriptions of quality of life included in the HIV Plan focus on viral loads, viral suppression, and other health-related outcomes.[144] While these biomedical markers are components of the quality of life for PLHIV, they are not an acceptable proxy for a well-rounded understanding of well-being or quality of life.

Instead, the HIV Plan and other federal responses to HIV must value and create concrete metrics for emotional, mental, psychological, spiritual, and physical wellness - irrespective of viral suppression. Quality of life for PLHIV must be measured by a key set of metrics in any plans to address the HIV epidemic, and the federal HIV response must acknowledge that commitments to quality of life for people living with HIV must continue as long as people living with HIV are here. The human right to quality of life for people living with HIV, and the federal government's responsibility to assure that, does not end even when we get to zero new HIV acquisitions. Thus, quality of life for people living with HIV deserves its own pillars in the HIV Plan and the EHE, along with commensurate strategies, metrics, and indicators to measure success.

Quality of life is interrelated with social and structural drivers of the HIV epidemic and of worse health outcomes for some PLHIV. It is interlinked with and inseparable from upholding human rights for people living with HIV, as described above. For decades, far too little attention has been paid in the federal government's HIV response to the social and structural drivers of inequity. While the HIV Plan includes some of these important social and structural factors, such as systemic racism, safe and affordable housing, access to culturally competent, trauma-informed health care, and gender disparities, it could be strengthened by concrete commitments to strategies and solutions. The EHE is completely missing an explicit analysis of and commitment to social and structural drivers of inequity. Until these factors are addressed explicitly and with firm commitments, any plan to address the national HIV epidemic will be unsuccessful and will not adequately address the needs of PLHIV.

There is a lack of consensus in the academic and medical community on the specific dimensions of quality of life, but it is generally understood as being multifaceted and concerning a person's own perception of their well-being and level of functioning in important areas of their life.[145] There are various scales that have been utilized in measuring the quality of life of people living with HIV.[146] One omnipresent problem is that most of these metrics focus on biomedical markers, and inadequate research has been done on what quality of life means for people living with HIV beyond these markers.

Additional research is required to determine what scale and metrics are the best measure(s) of the quality of life for people living with HIV, with an understanding that this metric may be different for individuals who are Black, Indigenous, and other people of color; cisgender; transgender; sex workers; immigrants; and of different geographies, due to racism, poverty, homophobia, transphobia, and lack of language justice.[147]

Opportunities to Strengthen the Federal Domestic HIV Response for Quality of Life for People Living with HIV

Priorities that continue to arise in conversations with our PLHIV networks concerning quality of life include employment; economic justice; health care costs and quality; the availability of non-stigmatizing and high-quality sexual and reproductive health care for PLHIV; access to trauma-informed care and services; and ending enacted, internalized, interpersonal, community, and institutional stigma.

Any plan to end the HIV epidemic must center these priorities and include them as concrete metrics in its plan.

Recommendations for Issue Area 5 - Quality of Life for People Living with HIV

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
Department of Health and Human Services	1. Promulgate regulations requiring private insurers to uphold the HIV Plan's minimum standard of care for all PLHIV. 2. Lead the creation of report cards[148] on the state of quality of life for PLHIV in the country and the quality of care provided by federally funded programs and services.
National Institutes of Health	1. Fund research into developing a standard quality of life assessment for people living with HIV focused on quality of life outside of biomedical indicators.
Centers for Medicare and Medicaid Services	1. Adopt the minimum standard of care developed in the HIV Plan and incorporate it into care provided by CMS.

HIV National Strategic Plan	1. Set a minimum standard for quality of life for PLHIV which includes: a. Opportunities for employment and education for all people living with HIV.[149] b. Increasing the ease of transferring benefits across jurisdictions. c. Access to long-term sustainable housing for people living with HIV.[150] This should include senior housing for aging PLHIV and housing for PLHIV with dependents. d. Services for people living with HIV should incorporate access to nutrition service programs, including SNAP.[151] 2. PLHIV who receive health care from any payer source should have a minimum standard of care[152] which: a. Is culturally relevant and affirms and funds the sexual and reproductive health care needs of people with HIV at all life stages and of all gender identities, including transgender women.[153] This should include reporting mechanisms which are easily understood by and communicated to people living with HIV; b. Provides mental health services and the choice of mental health provider to people living with HIV; c. Provides affordable health care coverage, where total health care costs (inclusive of premiums, medications, copays, etc.) do not exceed 9.83 percent[154] of the income of a person living with HIV; and d. Practices trauma-informed care, including screening and intervention for lifetime abuse and intimate partner violence, in HIV clinical and community-based settings. 3. Express support from the federal government for the repeal of HIV criminalization, which acknowledges the role it played in advancing these laws; education to state legislatures on their harms; and conditioning funding on their modernization or repeal. 4. The incorporation and study of accurate stigma metrics.[155] 5. Require that all materials on HIV-related services be translated into the primary languages spoken in the jurisdiction and incorporate translation services into clinical and supportive service settings for people living with HIV. 6. Incorporate quality of life surveys into federally funded clinical and supportive service settings, with the aim of using the data to connect people to additional support, including psychological, spiritual, and emotional support systems.

5A. Establishing a Strong Safety Net for People Living with HIV

Economic Justice and Employment for People Living with HIV

Economic justice does not have a set definition but can be understood as principles and practice that allow for PLHIV to live without negative employment or economic consequences related to their health status, disability, sex, gender or gender expression, sexual orientation, family responsibilities, and/or race or ethnicity.

Maintaining access to health care and economic stability can entrap PLHIV in poverty. Policies for ongoing eligibility for Supplemental Security Income (SSI)/Social Security Disability Income (SSDI), Medicaid/Medicare, AIDS Drug Assistance Programs (ADAPs), Housing Opportunities for Persons with AIDS (HOPWA), and other programs designed to improve health and well-being, are complex and serve as disincentives to employment for people living with HIV or other chronic health conditions and disabilities.[156] The lack of assistance to understand and navigate these policies can also serve as a disincentive or barrier to employment for enrolled PLHIV concerned about protecting their health and well-being and that of their families.

In addition, the lack of portability of benefits can prevent PLHIV from relocating to environments where they might thrive. PLHIV who are economically reliant on or choose employment receive little to no access to employment-related information, services, or resources to enable well-informed decisions about work or facilitate self-determined plans for employment and economic health and well-being.

Economic justice for PLHIV must also include a commitment to recruiting and training community members to join the expanded HIV workforce. PLHIV are the subject matter experts on programs that support PLHIV and are expert navigators. We encourage a creative approach to valuing lived experience as qualification for these positions beyond formal education requirements. When adding PLHIV to the HIV workforce, they must be at all levels of leadership, not simply relegated to the frontline staff, peer support staff, or testing and outreach.

Access for all PLHIV to non-discriminatory, non-stigmatizing employment-related information, services, and resources has not been developed in most of the country, nor prioritized by public health or workforce development systems, despite more limited access to disability benefits, and high rates of poverty, unemployment, and underemployment for PLHIV. The public health system response to HIV has deferred attention to employment needs of PLHIV to the workforce development system, which does not prioritize health and well-being strategies or outcomes, nor implement policies or training, to ensure effective, responsive service delivery based on understanding distinct needs and issues of priority populations disproportionately impacted by HIV.

Recommendations for Issue Area 5A - Economic Justice and Employment

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
White House/Office of the President of the United States	1. ONAP to be responsible for convening a federal and community workgroup including representation of the Employment and Training Administration (ETA) of the Department of Labor, the Department of Education, the Department of Housing and Urban Development, the Department of Justice, the Social Security Administration, the Centers for Medicaid and Medicare Services (CMS), HHS Health Resources and Services Administration HIV/AIDS Bureau (HRSA/HAB), PLHIV networks, and other community leaders to outline strategies to eliminate economic and employment inequities for PLHIV and facilitate self-determined transitions to work without risk to health and well-being.
HIV National Strategic Plan	1. Establish access to benefits counseling/advisement for PLHIV enrolled in or eligible for SSI/SSDI, Medicaid/Medicare, ADAPs, HOPWA, and other programs designed to improve health and well-being, for well-informed and well-supported employment-related decision-making and transitions of PLHIV allowing maximal protection of health care, financial, and housing supports. 2. Assign responsibility to the Social Security Administration (SSA), CMS, HRSA/HAB, and HUD Office of HIV/AIDS Housing (HUD/OHH) for collaborating with community leaders to evaluate program policies for impacts on considering and navigating employment transitions for PLHIV and for identification of updates needed to policies designed to reduce barriers and disincentives to working and optimize health and well-being. 3. Design portability of benefits between jurisdictions so PLHIV can more as needed or desired. 4. Require a formal HIV workforce recruitment and training program to hire PLHIV and commit to a targeted number or percentage of PLHIV in the HIV workforce. 5. Revise policy of the HRSA/HAB to allow direct service responses to employment needs of PLHIV within the Ryan White HIV/AIDS Program (RWHAP), recategorizing employment services as allowable for funding among RWHAP supportive services addressing core needs of PLHIV. 6. Ensure implementation of a RWHAP-centered community-led PLHIV employment initiative, with designated funding from the ETA, and ETA's collaboration in its implementation with HRSA/HAB. 7. Establish ongoing training in the AIDS Education and Training Centers (AETCs) of HRSA/HAB for HIV service providers on employment service delivery, linking and partnering with the workforce development and vocational rehabilitation systems, and interactions between work earnings and health care/treatment coverage, financial, and housing benefits.

Congress	1. Require SSA to update long-unchanged work incentive policies and calculations to increase the ability of PLHIV and other people with disabilities and chronic health conditions to attempt working with increased health coverage, financial, and housing security. 2. Require SSA to fund the establishment of accessible online information resources accurately reflecting policies applicable in each U.S. state and territory. 3. Allocate additional funds for SSA's Work Incentives Planning and Assistance (WIPA) program to more realistically scale up staffing proportionate to needs of PLHIV and other disabled SSI/SSDI beneficiaries for individualized in-person and remote benefits counseling/advisement, from considering work through transitions to employment. 4. Include designated funds to address employment needs of PLHIV through public health and workforce development collaboration in the upcoming reauthorization of the Workforce Innovation and Opportunity Act (WIOA).

Housing as a Human Right and Necessary Precursor to Care and Treatment for People Living with HIV

It has long been understood by PLHIV, researchers, activists, and policy makers that housing is a form of health care for people living with HIV.[157] Despite this knowledge, housing instability remains a primary concern for PLHIV,[158] as many federal housing programs are underfunded and under-resourced.

PLHIV are at a much higher risk of being unstably housed or homeless than the general population. In 2016, the U.S. Department of Housing and Urban Development (HUD) Office of HIV/AIDS Housing published data showing that an estimated 145,366 PLHIV in the United States, or about 12 percent of all PLHIV, have a current unmet housing need.[159] This data showed that 44 percent needed ongoing assistance to pay rent, 36 percent sought supportive housing placement, and 20 percent had short-term emergency assistance needs to secure or maintain housing.[160]

A lack of stable housing is not only an issue of a lack of shelter for PLHIV. Numerous studies have shown that it has a deleterious effect on the health outcomes for PLHIV, including mental health outcomes.[161] A lack of stable housing also affects a person's ability to obtain and maintain employment.[162]

These effects are not experienced equally by all PLHIV. Instead, there are stark differences in housing instability, and its effects, based upon an individual's race, age, and gender. People of transgender experience are more likely to be unstably housed than cisgender men and women.[163] Black, Indigenous, and other people of color are also more likely to be homeless in America when compared to the national average and white American.[164] In order to effectively implement any federal response to addressing the HIV epidemic and the health and equality of life for PLHIV, housing insecurity will need to be addressed.

Recommendations for Issue Area 5A - Housing

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
White House/Office of the President of the United States	1. Call for HOPWA to be funded at $600 million in the President's Budget Request. 2. Call for Increased funding for federal housing programs relied on by people living with HIV such as Housing Choice Vouchers, rental assistance, and subsidized housing in the President's budget request.
Department of Justice	1. Enforce the Fair Housing Act to address discrimination against women; immigrants; LGBTQ individuals; Black Indigenous, and other people of color; and people with criminal convictions.
HIV National Strategic Plan	1. Include concrete housing metrics in the implementation plan, such as: 90 percent of PLHIV are in long-term stable housing. 2. Include concrete commitments that people aging with HIV have access to senior housing.
Ending the HIV Epidemic Plan	1. Consider housing availability and create metrics and programs to increase housing access among people living with HIV in developing jurisdictional plans. 2. Address the quality of life metrics created by the HIV Plan in creating jurisdictional plans.

Food and Nutrition Security for People Living with HIV

Many PLHIV rely on federally funded programs to access essentials like food and nutrition services, often through the Supplemental Nutrition Assistance Program (SNAP). This can be demonstrated by membership data collected by Positive Women's Network - USA, which consistently indicates that between 40-50 percent of the women and people of trans experience living with HIV who are members of the organization depend on SNAP to feed themselves and their families.[165]

These food assistance programs are critical for PLHIV to receive good nutrition, which in turn supports overall health, helps with immune system function, and can help maintain a healthy weight, which helps with the absorption of HIV medicines. Reducing the stress associated with food insecurity also improves the overall quality of life for PLHIV. Further, a recent study showed that the rate of HIV diagnoses is associated with a state income limit for SNAP eligibility, meaning the higher the income limits a state imposes is related to higher numbers of HIV acquisitions.[166]

Currently, many SNAP eligibility requirements are harsh, and the benefits are insufficient. In 2018, SNAP benefits averaged only $1.40 per person, per meal.[167] Even the maximum benefit, which is the equivalent of $1.86 per meal, does not cover the cost of a meal in 99 percent of continental counties and Washington, DC.[168] Benefits at this level cannot support an individual's or family's nutritional needs. While the benefits are intended to be supplemental, many participants contend that the benefits levels are too low to assist them with purchasing food for the month.

SNAP is a program with very low rates of fraud, but its administrative burdens often make it so those who need the benefits cannot access them. While some of the harsh requirements have been relaxed during the pendency of the COVID-19 pandemic, more long term changes are required for the benefits of the program to be realized by everyone who needs them. These burdens include lengthy applications, high documentation requirements, in-person interviews, and the need to recertify or reapply to maintain benefits.

These requirements prevent some individuals who are eligible for SNAP from receiving them, though they could use the benefits to lift themselves and their families out of poverty. An example of this can be seen in a recent Michigan study, which found that half of SNAP recipients who lost their benefits during their first year of enrollment were still eligible for SNAP when they left the program.[169] These burdens and the inadequate benefits hinder a program which could be an important mechanism to improving the quality of life for PLHIV.

Recommendations for Issue Area 5A - Food and Nutrition Security

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
Department of Agriculture	1. Account for local and regional costs of living in determining SNAP benefit levels. 2. Continue the SNAP extensions of the 3-month work requirement period implemented during the COVID-19 pandemic. 3. Incentivize states to remove additional administrative SNAP burdens and work requirements. 4. Simplify the administrative burdens of SNAP by continuing the elimination of in person visits, permitting online recertification, increasing waivers, telephonic benefits applications, and extending recertification periods. This could also be achieved by providing funding to states to receive the technology required for implementing telephonic benefit applications and online recertifications.
Congress	1. Repeal the ban on SNAP and TANF for individuals with felony drug convictions contained in 21 U.S. Code § 862a. 2. Increase SNAP's maximum allotment by 15 percent and raise the minimum benefit to $30 per month from its current level of $16 per month.

5B. Improving Health Care Access and Quality of Health Care for People Living with HIV

Health Care Access for People Living with HIV

About 50 percent of PLHIV in the U.S. are not receiving regular HIV-related care.[170] It is therefore unlikely that these individuals, and potentially more, are receiving other kinds of care they need, including mental health care, sexual and reproductive health care, and specialty care. A multitude of factors lead to this, but often, the prohibitive costs of health care, stigmatizing experiences in health care settings, and discrimination are to blame.

Twelve states have still not expanded Medicaid,[171] even given the incentives under the ACA and the recent COVID-19 relief packages. In states where Medicaid has been expanded, only 5 percent of people remain uninsured, compared to the 19 percent in states where Medicaid has not been expanded.[172] A majority of the states that have not adopted Medicaid expansion are in the South, where approximately 45 percent of all PLHIV in the United States reside.[173]

Even the Ryan White HIV/AIDS Program fails to adequately provide the wrap-around services that clients need to be successful and live full, healthy lives. Further, out-of-pocket costs for prescription medications[174] and copays for care visits can still be prohibitively expensive for PLHIV. Even with the benefits gained from the ACA, problematic health insurance practices, like copay accumulators,[175] are on the rise, which could also increase cost for PLHIV.

The federal response to HIV does not address the need for quality and non-stigmatizing sexual and reproductive health care for people already living with HIV.[176] People of all genders living with HIV require sexual and reproductive health care; unfortunately, this is one of the areas where people living with HIV suffer from the greatest stigma, lack of understanding, and discrimination from health care providers. High quality, non-stigmatizing sexual and reproductive health care for all PLHIV is crucial to ensure well-being. For transgender people living with HIV, finding gender-affirming care in a non-discriminatory setting is essential to health and well-being.[177] This is especially true as many states are currently undermining the rights of transgender individuals. Further, postnatal people who are living with HIV can face stigma and even criminalization for their choice to breastfeed. Access to abortion care, birth control, and other family planning tools are also severely restricted in many states. Culturally relevant, non-stigmatizing, and comprehensive sexual and reproductive health care is essential to the quality of life of PLHIV.

While the HIV Plan mentions trauma-informed care and service delivery models, no explicit commitments are mentioned, and it is not included in other areas of the federal response to HIV. It is well documented that people living with HIV live with trauma and its downstream effects at rates well above the general population. A lack of explicit commitments to providing care and services that are trauma-informed will lead to stigmatizing and harmful experiences for the PLHIV who access these care programs.

It is important to note that issues related to HIV related health care are not equally distributed among PLHIV. The brunt of these problems is borne by Black, Indigenous, and other people of color, LGBTQ individuals, immigrants, cisgender women, and transgender women living with HIV, who face co-occurring oppressions like racism, sexism, and economic oppression.

Recommendations for Issue Area 5B - Improving Health Care Access

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
HIV National Strategic Plan	1. Revise the definition of quality of care to include a quality of life metric and a standard of care that is easily understood by PLHIV. 2. Make explicit commitments to integrate trauma-informed service delivery for people living with HIV in all federal plans to end the HIV epidemic, such as mandatory trainings on trauma-informed approaches for clinicians, providers and administrators; data collection on rates of intimate partner violence, post-traumatic stress disorder symptoms, substance use, depression, stigma, social isolation; implementation and evaluation of trauma-informed primary care models in clinics serving people living with HIV; integration of evidence-based responses to PTSD into existing funded clinical services, including therapy, psychiatry, medication adherence, and substance abuse treatment; and fostering collaborations between organizations addressing violence and trauma and those providing care and services to people living with HIV. 3. Develop a minimum standard of care for people with HIV who receive health care from any payer source. Such a standard should be adopted by CMS as well as by the Ryan White Program and any other payers. The following components should be included: a. Culturally relevant care that affirms the sexual and reproductive health care needs of people with HIV at all life stages and of all gender identities, including transgender women. b. High-quality clinical care – including affordable, accessible medication and insurance payment in areas where Medicaid has not been expanded under the ACA. c. Trauma-informed care practices, including screening and intervention for lifetime abuse and intimate partner violence, in HIV clinical and community-based settings. d. Services that facilitate PLHIV access to care as needed, including: childcare, transportation, substance use and mental health services, and housing. e. Define and implement a standard of gender-responsive care for people with HIV that includes the above sets of services. Prioritize funding for models that meet this standard within programs, such as the Ryan White Program. 4. Acknowledge racial injustice as a driver of the epidemic and include these factors in the response. 5. Expand the response beyond biomedical solutions and consider the role of culture, structural drivers of health, and solving for root cause analysis.
White House/Office of the President of the United States	1. Support increased funding for the Ryan White HIV/AIDS Program to $2.768 billion in FY 2022.[178] 2. Support universal health care plans, including Medicare for All.

Department of Health and Human Services	1. Remove barriers to accessing 75/25 waivers through the Ryan White HIV/AIDS Program. 2. Rescind 85 FR 29164, which expressly permits insurers to adopt copay accumulator adjustment policies (CAAPs), and implement a rule disallowing this practice.
Congress	3. Pass the HIV Epidemic Loan-Repayment Program (HELP) Act of 2021 4. Pass the Medicare For All Act of 2021 5. Pass the Equality Act of 2021

5C. Inclusion of Sexual and Reproductive Health and Rights for People Living with HIV

People of all genders living with HIV require sexual and reproductive health care; unfortunately, this is one of the sites where people living with HIV suffer from the greatest stigma, lack of understanding, and discrimination from health care providers. High quality, non-stigmatizing sexual and reproductive health care for all people living with HIV is crucial to ensure well-being and overall health. Yet, there is little mention in the HIV Plan ensuring quality and non-stigmatizing sexual and reproductive health care for people living with HIV, limited to how it pertains to raising awareness of HIV and improving integrated services.[179] The inclusion of the sexual and reproductive health and rights of people living with HIV is essential to ending the epidemic.

Ensuring High-Quality, Non-Stigmatizing, Trans-Inclusive, and Culturally Relevant Sexual and Reproductive Health Care for People Living with HIV

The first goal of the HIV Plan is "to prevent new HIV infections" by, in part, increasing awareness of HIV, increasing knowledge of HIV status, and increasing capacity of health care delivery systems to prevent and diagnose HIV.[180] To meet this goal, the HIV Plan notes the need to better utilize non-primary care providers, such as STD specialty clinics, Title X family planning sites, and OB-GYN visits.[181] We echo the need to utilize opportunities and to increase competency of the public health workforce in providing care for people living with HIV, especially to people who may not have regular access to a primary care provider for whom these encounters may be one of their rare entry points into the health care system.

But more than just utilizing these providers as ways to diagnose and prevent HIV, the HIV Plan should prioritize the overall sexual and reproductive health needs of people living with HIV, regardless of viral suppression. Sexual health, sexual pleasure, and reproductive health care and rights are cornerstone human rights[182] which must be a priority in the HIV response. It is not enough to increase testing and awareness in sexual and reproductive health care settings. The HIV Plan must consider the distinct sexual and reproductive health needs of people living with HIV. Also, cisgender women living with HIV who are receiving HIV-related medical care frequently are not offered sexual and reproductive health services or are referred elsewhere, even though women living with HIV are at elevated risk for gynecological complications.[183]

For transgender people living with HIV, it is especially important that gender-affirming care is provided and that providers and clinicians are well-versed on their options and rights. Transgender people face high rates of discrimination, stigma, and lack of trans-competent care in health care settings. According to the National Transgender Discrimination Survey, of surveyed participants, one in three transgender people delayed or avoided preventive health care out

of fear of discrimination or disrespect.[184] Moreover, in the reproductive health care context, in a study of obstetrician-gynecologists, 80 percent had no trans-specific health care training in residency and only 33 percent reported feeling comfortable in providing care to transmasculine patients.[185]

Addressing Breast/Chest-feeding for People Living with HIV

The HIV Plan does not address breast/chest-feeding anywhere, although it does discuss HIV care as it relates to pregnant women[186] on two occasions.[187] These discussions focus on testing pregnant people for HIV, on which the health care system already receives a high rating,[188] and biomedical research into tools to prevent both HIV and pregnancy in women. The HIV Plan ignores and fails to advance whole swaths of the experience that must be navigated by people living with HIV who would like to become pregnant and parent.

Choices on how parents feed their infants are complex and multifaceted. People who parent should be given the full range of options, and a complete understanding of the risks and benefits of each, prior to making these decisions. In other countries, PLHIV are not discouraged from breast/chest-feeding; rather, they are educated on their options to do so safely. Yet, the CDC discourages PLHIV from breast/chest-feeding and has not provided guidance to medical professionals on ways to assist patients who would like to breast/chest-feed their children.[189] We know PLHIV can have healthy, HIV-negative babies, and are capable of making informed decisions about breast/chest-feeding.[190] However, they must be given support and information from their care team. Further, they should not fear criminalization or interventions from medical professionals or child protection systems in response to how they choose to feed their children.

These inadequacies in our systems of navigating pregnancy and breast/chest-feeding disproportionately affect Black and Latinx women, transgender, and gender non-conforming people, who acquire HIV at higher rates than the rest of the country and contend with the intersecting oppressions of racism, stigma, and sexism in encounters with the health care system. They face higher maternal mortality rates, and once they have children, BIPOC individuals are also more likely to be limited in options of how to feed their children and steered away from breast/chest-feeding. The HIV Plan must recognize the impact that racial health disparities, including structural racism, and poverty has on options PLHIV have children and to breast/chest-feed their children.

Recommendations for Issue Area 5C - Sexual and Reproductive Health and Rights

Recommended Agency, Federal Body, or Policy	Recommended Action(s)
Department of Health and Human Services	1. Finalize and implement the proposed rule, "Ensuring Access to Equitable, Affordable, Client- Centered, Quality Family Planning Services," RIN 0937-AA11, which would strengthen the Title X family planning grant program and reverse the domestic gag rule. 2. Fully integrate comprehensive sexual and reproductive health care throughout the Ryan White Program. 3. Work with networks of people living with HIV to develop HIV-related guidelines on breast/chest-feeding to ensure they are up to date, reflect best practices and complexities of child feeding, and are consistent across disciplines; develop comprehensive postpartum guidelines for people living with HIV.[191]
National Institutes of Health	1. Develop and promote a research agenda on breast/chest-feeding that leverages existing findings, seeks novel applications of relevant data, and addresses knowledge gaps. 2. Partner with other agencies to disseminate research findings in an accessible way to providers and people living with HIV.
HIV National Strategic Plan	1. Include goals and metrics that focus on improving the sexual and reproductive health of PLHIV, including metrics for increased rates of recommended second Pap smear screening for newly diagnosed women, counseling on fertility desires and intentions, and increased rates of screening for intimate partner violence among women living with HIV in care. 2. Support informed consent standards that accurately and fully inform people of the implications of transition-related care, regardless of age, gender, or gender expression. 3. Discuss and fund research into safe practices for people living with HIV to breast/chest-feed children.
Ending the HIV Epidemic Plan	1. Require jurisdictions to create and provide sexual and reproductive health care guidance for providers to deliver to people living with HIV which includes information on how to access transition-related care, pregnancy care, breast/chest-feeding care, and contraceptive care. 2. Require jurisdictions to fund programs for providing comprehensive, culturally competent sexual and reproductive health care to people living with HIV, such as training programs for providers and ways for people living with HIV to access funds to pay for transition-related care, pregnancy care, breast/chest-feeding care, and contraceptive care. 3. Require jurisdictions to take a firm stance against the criminalization of breast/chest-feeding for people living with HIV and to take affirmative steps to educate child welfare agencies within the jurisdiction on the science around people living with HIV breast/chest-feeding.

Congress	1. Pass the Real Education and Access for Healthy Youth Act of 2021 2. Pass the Women's Health Protection Act of 2021 3. Pass the Equal Access to Abortion Coverage in Health Insurance (EACH) Act of 2021 4. Pass the Abortion Is Health Care Everywhere Act of 2021

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151 *See infra*, Issue Area 5A, pp. 42-44 , for more on providing nutrition services for people living with HIV.

152 For more information on how to achieve these health care metrics, *see infra*, Issue Area 5B, pp. 44-47.

153 For more on what sexual and reproductive health care needs entail, *see infra*, Issue Area 5C, pp.47-51.

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https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

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View this monthly update on our website here.

Federal Updates

A federal policy agenda created by and for people living with HIV

The U.S. People Living with HIV Caucus, of which Positive Women's Network-USA is a member, released Demanding Better: An HIV Federal Policy Agenda by People Living with HIV in July.

This federal policy agenda lays out a clear roadmap for the Biden administration, Congress, and federal agencies to achieve their goal of ending the HIV epidemic by 2030 with a focus on improving quality of life for people already living with HIV.

The U.S. People Living with HIV Caucus is a "network of networks" of people living with HIV, which includes representatives from the Global Network of People Living with AIDS – North America, International Community of Women with HIV/AIDS – North America, National Working Positive Coalition, Positively Trans, the Reunion Project, SERO Project, and THRIVE SS. These networks collectively represent tens of thousands of people living with HIV, who have informed the agenda.

The agenda was released through an event with the Center for American Progress which was followed by a community-focused Facebook Live conversation.

Appropriations update

Two of the appropriations bills for Fiscal Year 2022 passed the House of Representatives and there have been a lot of updates to ones that are waiting to be voted on, so let's quickly run through some highlights:

- The Helms Amendment and global gag rule, which work together to ban federal funding for abortion services internationally, were not included in the FY22 bill which passed the House
- The Hyde and Weldon Amendments, which ban domestic funding of abortion services, were left out of their respective funding bills
- A bill funding the Department of Health and Human Services would end the prohibition on using federal funds for syringes for safe drug use programs
- A provision was added that would limit funds to foster care programs that don't comply with nondiscrimination regulations including gender identity and sexual orientation, undercutting the Supreme Court's recent decision in *Fulton v. City of Philadelphia*
- Funding for the Housing Opportunities for People with AIDS program was increased by $170 million, $150 million over the President's budget request.

You can check out the updates in the appropriations process here.

Health Care Access

CVS Pharmacy v. Doe to be heard by the Supreme Court next year

The Supreme Court agreed to hear a case this fall which has huge implications for people living with HIV. In *CVS Pharmacy v. Doe*, the Supreme Court will decide whether both the Rehabilitation Act--a law which prohibits discrimination based on a disability by organizations receiving federal funds--and

the Affordable Care Act (ACA) allow individuals to bring claims arguing a policy is discriminatory because it disproportionately affects people with disabilities.

The case was brought by a class of people living with HIV who receive heath insurance through their employers. Their health plan gives individuals with disabilities, including people with HIV, in-network medication prices if they receive their HIV medication by mail or if they pick it up at a CVS pharmacy. If they chose to use an out-of-network pharmacy, they must pay the out-of-network price. Individuals without disabilities are not limited to these two methods to receive in-network pricing for their prescriptions.

The people living with HIV involved in the case argue that these terms disproportionately harm people living with HIV who cannot receive in-network prices at the pharmacy of their choice. Obviously, these are incredibly important considerations, and the broader question of whether these kinds of discrimination claims are allowed under the Rehabilitation Act and ACA could significantly impact when people can claim disability discrimination.

This case will not be argued until after October 2021, and then an opinion will likely not be released until 2022. You can read more and follow case updates here.

Missouri Supreme Court upholds Medicaid expansion

The Missouri Supreme Court ruled that the state's Medicaid expansion amendment which was passed by voters last August did not violate the state constitution. This decision overturned a lower court finding that Amendment 2, a ballot initiative passed by in 2020 by 53 percent of Missouri voters, was unconstitutional.

Medicaid expansion will allow about 275,000 additional people in Missouri to access health care, including some of the 13,000 people estimated to be living with HIV there.

This is the second piece of celebratory news to come out of Missouri this month. Governor Mike Parson signed SB 53, a police reform bill that also makes important updates to HIV criminalization laws. The bill raises the level of intent required to convict someone of violating the law and reduces the minimum sentence from 10 to 3 years. This bill is a strong step in the right direction for HIV criminalization in Missouri. The updated law goes into effect August 28 and you can read more about it here.

NHeLP's new brief on the Medicaid coverage gap

The National Health Law Program (NHeLP) released a new white paper called "Closing the Medicaid Coverage Gap: Preventing a Separate and Unequal Result" which provides recommendations for closing the Medicaid coverage gap in an equitable manner. The Medicaid coverage gap is generally defined as describing adults from 18-64 who are above their state's income cap for receiving Medicaid but below the poverty line, meaning they are ineligible for tax credits through the ACA marketplace.

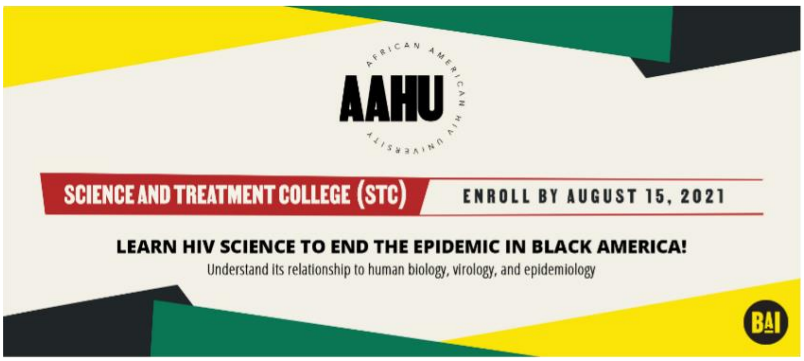
This is especially an issue for people living in the 12 states which have not expanded Medicaid. In non-expansion states, about 19% of people living with HIV are uninsured as compared to 5% in expansion states.

Some of NHeLP's recommendations for equitability closing the gap include:

- Ensuring the enrollment structure incorporates Medicaid's protections such as the right to apply and enroll at any time and to retroactively apply.
- Maintaining Medicaid's strict limits on premiums, copayments, deductibles, and balance billing, and providing specific outreach and education.
- Ensuring the full scope of mandatory and "gold standard" optional Medicaid services covered by state plans, which include dental, vision, and supportive housing services.

This piece is full of information that advocates can use when evaluating the equity of any Medicaid coverage gap plan that is released. Be sure to check it out!

BAI's African American HIV University program accepting applications



Black AIDS Institute (BAI) re-launched its African American HIV University (AAHU) program earlier this month. This program aims to build Black leadership and mobilization skills as a way to end the epidemic in Black America in alignment with BAI's "We The People: A Black Strategy to End HIV."

Two parts of the AAHU program, the Science and Treatment College and the Community Mobilization College, are accepting applications through August 15. Read more and apply here.

Economic Justice

HRSA's Black Women First Initiative

The demonstration sites for a $3.8 million initiative, "Improving Care and Treatment Coordination: Focusing on Black Women with HIV"--also referred to as the Black Women First Initiative--were announced this month. The initiative provides grants and support to 12 organizations to design, implement, and evaluate the use of culturally competent interventions to improve HIV care and treatment coordination for cis- and transgender Black women.

Positive Women's Network - USA Co-Executive Director Venita Ray serves as a member of the advisory council for the initiative and has provided training for grantees on the meaningful involvement of people living with HIV.

This initiative is an important step forward, but it is important to recognize that only 10% of the funding went to organizations explicitly founded and run by Black women, and none of the organizations are trans-founded or trans-led. Read more about the organizations who received the grants here.

Sexual and Reproductive Health, Rights and Justice

Sterilization reparations bill funded in California

California passed a budget bill which included $7.5 million to provide reparations to survivors of state-sponsored forced or involuntary sterilizations. California is the third state in the nation to provide monetary compensation to survivors who were sterilized under state eugenics laws and the first state to both provide notification of coerced sterilization and reparations to survivors who were sterilized while incarcerated in its state women's prisons.

These sterilization practices affected many Black, Indigenous, and other people of color, people with disabilities, LGBTQ people, and people living in poverty. These funds are estimated to provide approximately $25,000 each to about 150 individuals. This amazing work has been led by California Latinas for Reproductive Justice, the Disability Rights Education and Defense Fund, and the California Coalition for Women Prisoners.

SEPTEMBER 2021

QUICK TAKE

ENSURING COMPLIANCE WITH NEW FEDERAL USPSTF PrEP GUIDANCE

PRE-EXPOSURE PROPHYLAXIS (PrEP) IS A CRITICAL COMPONENT OF COMPREHENSIVE HIV PREVENTION. Achieving widespread and sustained use of PrEP by individuals for whom it is recommended is critical to preventing new HIV infections, providing both individual and public health benefits. As such, PrEP has the potential to protect communities from HIV infection and strengthen them with lifelong benefits. Delivering PrEP effectively, however, requires overcoming multiple obstacles, not the least of which is ensuring affordable and hassle-free access to PrEP medications and related care.

In 2019, following an evidence-based review, the United States Preventive Services Task Force (USPSTF) issued a final recommendation and gave daily oral PrEP its strongest rating, an A. Pursuant to the Affordable Care Act (ACA), most private health plans and all Medicaid-expansion programs must cover USPSTF grade A and B-recommended services free-of-charge for the plan year beginning one year after the issue date of the recommendation. State

REQUIRED PrEP SERVICES

Effective PrEP involves more than taking medication. Per federal guidance, most private plans and all Medicaid expansion plans **must provide the following care, without cost-sharing**, to insured persons. These standards reflect CDC clinical practice guidelines and help ensure safe and effective prescribing.

Office Visits: Office visits associated with each recommended preventive service when the primary purpose of the office visit is the delivery of the preventive service.

HIV Testing: Individuals must be tested to confirm that they are HIV negative before starting PrEP, and current guidelines call for repeat testing every 3 months while on PrEP.

Hepatitis B and C Testing: Individuals should be tested for Hepatitis B and C when initiating PrEP. Persons with an ongoing risk for Hepatitis C should be screened regularly.

Creatinine Testing and Calculated Estimated Creatine Clearance (eCrCl) or Glomerular Filtration Rate (eGFR): These tests of kidney function must be performed before starting PrEP and should be checked periodically.

Pregnancy Testing: Persons with childbearing potential must be tested before enrolling in PrEP and should be tested again periodically.

Sexually Transmitted Infection (STI) Screening and Counseling: All persons must be tested for STIs when starting PrEP and should be retested periodically. This includes testing for all symptomatic individuals. Sexually active adults and adolescents should be screened every six months. Asymptomatic gay and bisexual men at high risk for STIs should be screened every 3 months with 3-site specimen collection (i.e. pharyngeal, rectal, and genital/urine specimens).

Adherence Counseling: Individuals on PrEP must be offered regular behavioral counseling and adherence support.

CRITICAL COMPONENTS OF THE FEDERAL PrEP GUIDANCE

Coverage of PrEP-related ancillary services without cost-sharing

See text box above for details.

Frequency of services must follow CDC guidelines and no restrictions on restarting PrEP

Plans must cover, free-of-charge, baseline and monitoring services that includes HIV testing every three months and sexually transmitted infection (STI) screening consistent with CDC guidelines.

Plans cannot restrict individuals from continuing or re-starting PrEP as long as their own health care provider determines that PrEP is medically indicated.

Access to medically appropriate PrEP medication without cost sharing, as determined by the individual's health care provider

Reasonable medical management is permitted to give preference to a specific PrEP medication, such as by offering one product without cost-sharing and imposing cost-sharing for other products. Plans are required, however, to accommodate any individual for whom a particular PrEP medication (generic or brand name) would be medically inappropriate, *as determined by the individual's own health care provider*. This requires plans to have a mechanism for waiving the otherwise applicable cost sharing for the brand or non-preferred brand version.

Easy and timely exceptions process if plans limit PrEP services

If plans use medical management techniques to limit access to specific PrEP products or services, they must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual (or authorized representative) or provider. The FAQs provide the example of an exceptions process that allows for prescribing and accessing PrEP medications on the same day that an individual receives a negative HIV test and decides to start a PrEP regimen.

ACTIONS NEEDED TO SUPPORT COMPLIANCE AND ENFORCE THE LAW

PrEP USERS AND PROVIDERS

If patients or providers observe that a plan is not complying, they should bring the federal guidance to the attention of the plan or plan sponsor. In addition, they can contact the state and federal regulators indicated below.

Private-Employer Group Health/ERISA Plans: Persons with private employer group health plans can file a complaint with the Department of Labor Employee Benefits Security Administration (EBSA) at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or 1-866-444-EBSA (3272).

Non-ERISA Group Plans and Individual Plans: Persons with these kinds of plans (including persons with ACA marketplace plans) should contact their state insurance regulator. A directory is available from the National Association of Insurance Commissioners (NAIC) at https://content.naic.org/state-insurance-departments.

State and Local Government Employee Plans: In addition to state and local government oversight, HHS enforces federal requirements. Complaints can be emailed to NonFed@cms.hhs.gov.

Federal Government Employee Plans: The federal Office of Personnel Management (OPM) requires plans in the Federal Employees Health Benefits Program (FEHB) to provide ACA-required preventive services. Complaints can be made at 202.606.1800 or FEHB@opm.gov.

HEALTH DEPARTMENTS AND INSURANCE REGULATORS

State and local health departments and state and federal insurance regulators should develop compliance tools, conduct audits, and monitor activities to ensure plan compliance with federal rules. As regulators may be less familiar with the complexities of HIV prevention and clinical practices in PrEP services delivery, HIV experts in health departments can be an important resource for regulators in ensuring compliance with these requirements.

Audits, assessments, and enforcement actions should be released to the public, including any enforcement actions taken.

FEDERAL AGENCIES

The Centers for Medicare and Medicaid Services (CMS) should issue a State Health Officials Letter describing the critical importance of PrEP, available federal resources, and describing compliance obligations of Medicaid programs and ACA marketplace health plans.

The FAQs rely heavily on Centers for Disease Control and Prevention (CDC) clinical practice guidelines. CDC should write to all health plans describing their clinical practice guidelines and how to use them to comply with federal requirements. This could help to greatly increase the public health impact of PrEP.

Medicaid programs also can extend this coverage to all non-expansion Medicaid beneficiaries. Fifteen states and the District of Columbia currently do (NASTAD, July 2021). This recommendation does not apply to a small set of private "grandfathered plans." While the recommendation also does not apply to Medicare, most Medicare plans cover PrEP, but with applicable cost sharing.

In July 2021, the US Departments of Health and Human Services (HHS), Labor, and Treasury jointly issued frequently asked questions (FAQs) to clarify coverage obligations without cost sharing for PrEP medications and services. Enforcement actions may be taken by state and federal regulators starting on September 17, 2021 to ensure compliance with these requirements.

WHILE THESE FAQs PROVIDE HELPFUL CLARIFICATION, THEY ARE ONLY MEANINGFUL TO THE EXTENT THAT HEALTH PLANS UNDERSTAND AND COMPLY WITH THEM. Individuals, PrEP providers and care teams, health departments, insurance regulators, advocacy groups, and others must take action to support compliance with these requirements. Improving the health of communities and preventing new HIV infections is a large and complex undertaking. Enforcement of this clarifying guidance will benefit individuals by helping to address barriers to PrEP uptake and will move us closer to ending the HIV epidemic in the United States.

TO LEARN MORE

The new guidance, *FAQs About Affordable Care Act Implementation Part 47*, was released on July 19, 2021. It can be accessed at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf and at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-47.pdf.

The USPSTF's Final Recommendation Statement for PrEP is available at https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

For clinical practice guidelines, see the US Public Health Service/CDC Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update, available at https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf. NOTE: CDC is updating its guidelines. New guidelines are anticipated to be published before the end of 2021.

For additional background information, please read our Quick Take, The USPSTF PrEP Recommendation, March 2020, and our Big Ideas Brief, *Achieving Sufficient Scale of PrEP Use is Critical to Ending the HIV Epidemic*, August 2019, at the link below.

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