Human Resources Administration
Department of Social Services

Testimony Of Daniel Tietz, Chief Special Services Officer,
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Before the New York City Council General Welfare Committee

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Good morning. Thank you Chairman Levin and members of the General Welfare Committee for giving us this opportunity to testify today.

My name is Daniel Tietz and I am the Chief Special Services Officer for HRA. Joining me today is Jacqueline Dudley, Deputy Commissioner for the HIV/AIDS Services Administration (HASA).

We are here to discuss the provision of benefits and services for New York City residents with HIV and more specifically to testify in regards to Intro. No 684, also known as *HASA for All*. This Introduction would allow the City to expand existing HASA benefits eligibility to New Yorkers with HIV, but who do not have AIDS or clinically symptomatic HIV consistent with current HASA eligibility requirements. We will also address Intro. No 935 relating to the HIV/AIDS Services Administration (HASA) Advisory Board, data reporting, public comment and other non-substantive technical amendments.

HIV/AIDS Services Administration (HASA)

Arguably the world's largest and most comprehensive government program serving people with HIV and AIDS, HASA provides services and support to one of New York City's most vulnerable communities, namely those with clinically symptomatic HIV illness or AIDS. But we know that there are additional low-income New Yorkers with HIV who are not clinically symptomatic consistent with current eligibility requirements, but who would benefit from HASA services.

Much has changed since the early 1980s when a then unknown epidemic was rapidly spreading across the City, State and nation. At the time, there were no effective treatments and people did not live long after they became ill. New York City was among the first municipalities to respond and proudly provided a range of critical services to those affected by HIV and AIDS. HRA's crisis workers were providing emergency benefits and support services, as well as burial assistance, when many service organizations were reluctant to engage people with HIV.

Today's epidemic is very different from that of the 1980s or even the 1990s. What we have learned since then is when people are provided treatment, comprehensive benefits and case management they are able to experience a higher quality of life and live near-to-normal lifespans.

But much remains to be done and we are working with key stakeholders to end New York State's epidemic, which is mostly concentrated in New York City. Indeed, almost 80% of New Yorkers diagnosed with HIV in the State live in the five boroughs.

As this Committee is well aware, there is no cure for HIV and it remains a disease marked by poverty and continued stigma and discrimination. As such, HASA services are essential to ensuring that low-income New Yorkers with HIV obtain the benefits and services they need to remain healthy and live independent lives.

Although HASA presently serves only those with clinical or symptomatic HIV and AIDS, and their families, we are also focused on preventing new HIV infections. HIV transmission does not occur in isolation and although anyone of any age, race, religion, sex, gender or sexual orientation can be at risk, those at greatest risk include:

- individuals without access to culturally competent care, free condoms, clean syringes and new prevention tools, such as pre-exposure prophylaxis or non-occupational post-exposure prophylaxis;
- individuals without medical insurance and related healthcare supports;
- individuals who lack access to HIV and STI testing and screening and who experience delays or barriers in moving from a positive HIV test to linkage and engagement in treatment;
- individuals with a history of incarceration;
- individuals with status as undocumented migrants;
- men who have sex with men (MSM), particularly young black and Hispanic/Latino MSM;
- transgender individuals, especially transgender women;
- women of color;
- those who use injection drugs, but don't have access to clean syringes; and
- sero-discordant couples.

Likewise, mitigating poverty, preventing homelessness and ensuring stable and affordable housing, addressing food insecurity, unemployment and underemployment, and ensuring access to treatment for substance use disorders and mental health care are vital to both averting new HIV cases and ensuring consistent engagement in care and services for all low-income New Yorkers with HIV.

New York City's Response to The Ending the Epidemic Blueprint

In May 2015, Governor Cuomo released the Ending the Epidemic Task Force's 'Blueprint', which is a consensus document the content of which was agreed by all Task Force members, including me and the other participating City officials. The Administration fully supports the Blueprint's goals and concepts and we are working closely with our State partners to ensure the plan is implemented.

The Task Force went beyond its initial charge and included additional recommendations to ensure universal access to HIV prevention, treatment, care and support. These so-called "Getting to Zero" (GTZ) recommendations address key social, legislative and structural barriers and envision a "place where there are zero new infections, zero AIDS-related deaths and where HIV discrimination is a thing of the past." In the Getting to Zero recommendations, the first such recommendation is most directly relevant to HRA and Intro. No 684, under consideration today:

- *GTZ Recommendation 1: Single point of entry within all Local Social Services Districts (LSSDs) across new York State to essential benefits and services for low-income persons with HIV/AIDS*

This recommendation seeks to create in other Local Social Service Districts a version of HASA, which is the single point of entry in New York City for such benefits and services for persons with clinical or symptomatic HIV or AIDS. Under GTZ Recommendation 1, HASA would expand to all low-income New Yorkers with HIV, and not only those with clinical or symptomatic HIV and AIDS who are presently eligible. As with the other Blueprint recommendations we are committed to working closely with our New York State partners, as well as advocates, providers and people with HIV, to determine how best to act on this recommendation.

Intro. No 684

Tracking GTZ Recommendation 1 from the Governor's Blueprint, Intro. 684 would require HRA to expand HASA eligibility to include persons with HIV who may otherwise not qualify simply for not being sick enough.

As previously mentioned, every day the comprehensive services provided by HASA are helping New Yorkers with clinically symptomatic HIV and AIDS to live a better quality of life and to live near-to-normal lifespans. Further, by ensuring that clients are not choosing between healthcare and housing or food we are improving public health and decreasing transmission rates through continued attachment to the continuum of care. We agree with the Council that extending HASA benefits would have a similar positive outcome for low-income New Yorkers with

asymptomatic HIV, and their families, and we therefore support the goals and concepts outlined in Intro. No 684.

The costs associated with Intro. No 684 would require significant resources from both the City and State in order to expand HASA to all low-income New Yorkers with HIV. We will continue to work with our New York State partners to seek sufficient funding to expand HASA services to all New Yorkers with HIV. Likewise, we look forward to working with members of this committee and the entire City Council as the budget process begins in Albany to ensure adequate State funding to allow us to extend these lifesaving benefits to every eligible New Yorker in need of such support. Given the consideration of these matters in the upcoming State budget process, we appreciate the provision in Intro. 684 that links implementation to action by the State to provide sufficient funding.

Intro. No. 935

Intro. 935 relates to the expanded function of the HASA Advisory Board, data reporting and other non-substantive technical amendments. We are proud of our new reforms and initiatives at HRA and although it's very early, we believe our reform measures will achieve great success. As such, we want our policies and data to be clearly understood and available on HRA's website. It is a goal that is consistent with the Mayor's focus on an accessible government.

To this end, shortly after Commissioner Banks was appointed, HRA created several Workgroups that include a mix of providers, advocates and HRA leadership to discuss service challenges, barriers and policy issues, as well as potential solutions. Among these Workgroups is the HASA Workgroup, which has met several times since last summer. This Workgroup facilitates advocates and providers bringing HASA-related policy and practice concerns directly to the program and HRA's leadership so that we can collaboratively develop sensible solutions. It is an effective approach to understanding and responding to the community's needs and making policy and service improvements in HASA. The Workgroup presently meets quarterly and will be meeting again tomorrow.

HASA also maintains an Advisory Board in accordance with Local Law 49 of 1997. The Advisory Board consists of 11 individuals with five members appointed by the Council and six appointed by the Mayor, including the chairperson. At least six of the appointees are required to be eligible for HASA services. The board meets quarterly to advise the Commissioner on access and the provision of benefits and services to persons with clinical/symptomatic HIV and AIDS.

In short, HASA's senior team routinely meets with advocates, academics, elected officials, key stakeholders and clients to ensure that we are providing high-quality comprehensive services and we take their recommendations and proposals for improving service delivery, policies and procedures very seriously.

Allowing the Advisory Board additional opportunities to meet and develop robust recommendations to the Commissioner is a concept that we support. However, the bill creates some ambiguity as to whether the Board must meet quarterly and at additional times upon the request of five members, or whether the request of such members serves as an alternative to the board's chairperson convening the already-required quarterly meeting. We suggest revising the language to provide that a simple majority may override the chairperson in the event that the chair declines to call a meeting. We welcome working with you on modified language to accomplish the goal of the legislation without inadvertently impeding the ability of the Advisory Board to work collaboratively.

As previously mentioned, we agree that data reporting, revisions to the HASA Bill of Rights and revisions to policies and procedures should be transparent, available on HRA's website and subject to public comment. We suggest, however, that the proposed requirements regarding prior public review of policy changes be modified so as not to slow reform efforts. Under CAPA, we are already required to hold hearings when considering changes to policies that affect a client's rights and procedures. But as presently drafted, this bill would require more by mandating hearings that will likely serve little purpose. For example, had the proposed provision been in place last year it would have limited our ability to expeditiously implement the 30% rent cap as required by state law. We stand ready to work with the Council on modifications to accomplish our mutual goal of transparency.

Reform Efforts within HASA

At these hearings we like to take the opportunity to discuss agency reforms. As with all program areas at HRA, during the past 21 months we have been determining and implementing reforms and new initiatives within HASA to better serve our clients and ensure the best use of our staff and resources.

As mentioned above, we've instituted a HASA Workgroup, which presently meets quarterly and includes a mix of providers, advocates and HRA leadership to discuss service challenges, barriers and policy issues, as well as potential solutions. Arguably of particular relevance to HASA, we also have an LGBTQI Working Group that meets quarterly and is meeting as we speak.

But we've also instituted additional reforms and below are several of these as they relate to HASA and our clients:

- We've implemented a new cultural competency training developed by our Office of LGBTQI Affairs. Approximately 1,200 employees have been trained to date, including

269 in HASA, 825 in FIA and 105 in MICSA, with a goal of training all HRA employees in the coming year.

- We expeditiously implemented the 30% rent cap, which was first approved in the State's FY 2014-15 budget.
- We are now providing HASA clients with access to vocational services and supports to better prepare them for the workplace.
- We are consolidating securing and managing HASA emergency housing under a single master contractor to more efficiently manage this housing and the payments to multiple providers.
- We are working with key stakeholders to act on the Governor's Blueprint recommendations, including expansion of HASA to all low-income New Yorkers with HIV and not only those with clinical or symptomatic HIV and AIDS who are presently eligible.
- We are continuing to consult with the HASA advisory board in efforts to improve HASA services.

I would like to close with an overview summary of HASA services. For further detail concerning the programs and services within HASA, I refer this Committee to my June 24, 2015 testimony which can be found on the HRA website.

Overview of HASA Services

HASA services include assistance in applying for public benefits and services, such as:

- Medicaid;
- Supplemental Nutrition Assistance Program benefits (SNAP);
- Cash Assistance;
- emergency transitional housing;
- non-emergency housing;
- rental assistance;
- homecare and homemaking services;
- mental health and substance use screening and treatment referrals;
- employment and vocational services;
- transportation assistance; and
- SSI or SSD applications and appeals.

HASA clients are assigned a caseworker at one of our HASA centers, which are located in all five boroughs. Caseworkers work face-to-face with clients on applying for Cash Assistance, Medicaid and SNAP and, if eligible for HASA, can receive same-day assistance. Caseworkers assist clients by identifying their needs and creating individualized service plans to secure the necessary benefits and supports specific to addressing their needs and enhancing their well-being, taking into account the complexities of their illness. In addition to securing the public benefits noted

above, HASA caseworkers also refer and link clients to community-based organizations and providers for a host of health, mental health, substance use and housing resources.

Taken together, this investment in HASA's target benefits and services recognizes that preventing disease progression and relieving poverty saves lives, averts costs and advances health and wellness not only for individual clients, but also by helping to limit the further transmission of HIV.

HASA is mandated to provide timely delivery of benefits and services, as well as emergency housing, to all homeless HASA clients. Let me provide a brief snapshot of our current clients.

As of October 6, 2015, HASA provides services to 42,809 individuals, which includes 32,072 clients and 10,737 associated case members.

Here are a few data points regarding HASA's current clients (as of July 2015):

- The median age is 50 with 50% age 50 or older;
- 33% are female;
- More than 95% receive Medicaid and SNAP benefits;
- 24.1% receive federal SSI benefits and another 8.9% receive SSD; 4.9% receive both SSI and SSD;
- 84.7% receive Cash Assistance, including some who are also receiving SSI or SSD and for whom CA helps to cover housing costs; and
- 4.4% of clients have earned income.

Now I'd like to focus on a few key services, including housing assistance, medical assistance and financial assistance.

Housing Assistance

As of September 19, 2015:

- HASA's contracted supportive housing portfolio consists of 5,678 units of which 5,420 units are occupied. HASA spends about $134 million annually for these units.
- There are 2,672 scattered-site units available, including NY/NY III and non-NY/NY III, of which 95% (2,526) are occupied. The average annual cost per unit is $23,957.
- HASA has 2,181 permanent congregate units, including both NY/NY III and non-NY/NY III, of which 96% (2,104) are occupied. The average annual cost per unit is $22,200.
- Of HASA's 825 transitional units, 96% (790 units) are occupied. The average annual cost per unit is $25,160.

- In addition to supportive housing units, HASA is expecting to spend about $33 million this year for clients residing in emergency housing. As of October 3, 2015 of the 2,224 units available, HASA clients occupied 1,923 units, an occupancy rate of 86%.

The vast majority of HASA clients, over 19,000, live in private market apartments, with most receiving rental assistance subsidies to allow them to live independently.

Financial Assistance

Currently, there are:

- 26,786 HASA clients receiving Cash Assistance, which also includes transportation and emergency grants; and
- 30,022 HASA clients receiving SNAP benefits.

Thank you again for this opportunity to testify. I'm happy to answer any questions you may have.