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City Council Holds Hearing on Legislation to Expand the Availability of HASA Services

Pictured: VillageCare's Tassy Carilice testifying before City Council

The City's HIV/AIDS Services Administration (HASA) has endured many challenges. The agency has faced criticism from the clients who rely on them that range from discourteous case workers to inaccurate information, byzantine rules, long delays and the mishandling of paperwork. For all of its shortcomings, however, HASA has enabled thousands of New Yorkers living with HIV to become stably housed, while granting them enhanced food assistance and transportation. The agency also offers a limited supply of supportive housing. It has long been the envy of many other low income and disability communities.

The qualifications to become eligible for HASA services include demonstration of extremely low or no income, and proof that they have an AIDS diagnosis or must be HIV-symptomatic to qualify. Healthy HIV-positive individuals do not benefit from HASA services. This has led to clients, who desperately fear being homeless, deliberately avoiding treatment so they may get sick enough to qualify.

For years, HIV advocates have argued that the best approach would be to allow all low-income individuals living with HIV to qualify for HASA services — not just those who are sicker. This appeal was ignored during the Giuliani and Bloomberg Administrations, but with a very progressive City Council and Mayor de Blasio, change may finally be coming.

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The City Council is moving through the legislative process on two HIV-specific bills — both of which would impact the delivery of services at HASA.

Intro. 684 would dramatically expand who is eligible for HIV-specific services at the Human Resources Administration (HRA). This legislation would expand HASA eligibility to all low-income individuals living in NYC that are HIV-infected. If passed, it would result in potentially thousands of low-income individuals becoming eligible for greater enhanced rental assistance and other services.

To address some HASA shortcomings, the other legislation, Intro. 935, would require the HRA Commissioner to consult with the Division's advisory board before updating the Division's policy and procedures manual and the client bill of rights. It would also allow the chairperson or five members of the advisory board to call a meeting. More importantly, the legislation would also require display of the "Client Bill of Rights" and the "List of Clients Entitlements" in every center. The inconsistency in services provided between HASA centers and different case workers has long been a point of frustration. This legislation would help empower clients with the knowledge of exactly what services are available.

House of Cards?

While the U.S. House of Representatives has become far more civilized from its days when duels were held in the chamber, the chaos of the recent few weeks has highlighted that a less than civilized relationship still exists between some members of the party of Lincoln.

On September 25, 2015 House Speaker John Boehner abruptly and surprisingly announced his resignation as Speaker. This followed right after a series of contentious meetings with the Republicans' "Freedom Caucus", otherwise known as the Tea Party members of the House of Representatives. Freedom Caucus members had been threatening to remove John Boehner from the Speakership for quite some time, believing that he was not conservative enough for their tastes. Apparently, at the last meeting between the Speaker and the Caucus, which many insiders had described as increasingly acrimonious meetings, the Speaker finally had enough – and announced his resignation pending the election of a new Speaker.

Replacement in waiting and second in line, Representative Kevin McCarthy, announced his desire to run, but was also rejected by the Freedom Caucus. For many days, it was hard to predict what the leadership fights would disgorge. Representative Paul Ryan (R-WI), who had initially rejected calls to run for Speaker, finally relented and offered to run, on the condition that he not be subjected to the Speaker's normally grueling fundraising calendar.

Paul Ryan was elected Speaker on October 28, 2015 with the votes of 236 of his fellow members. In the end, only nine fellow Republicans did not vote for him, all from the Freedom Caucus. He is the youngest Speaker (aged 45) in over 100 years.

Representative Paul Ryan, while very willing to negotiate with Democrats over the budget and entitlement reform, is a major advocate of wholesale changes to the federal government's Medicaid and Medicare programs and restructuring the U.S. federal tax code. Past positions have included block granting Medicaid, replacing Medicare with a voucher system for seniors (that many criticized as short-cutting funding for beneficiaries), and major reductions in the tax rate for high income taxpayers. With Paul Ryan as potentially the new Speaker, mostly likely these public policy proposals will be granted new life. Advocates should expect a tough time ahead for non-defense discretionary programs – Representative Ryan more than once advocated for significant reductions in domestic spending.

As his last act, John Boehner did manage to negotiate an agreement with his Senate colleagues and the White House over a debt extension and two-year budget agreement. The clock was rapidly approaching the alarm buzzer on a deadline for an agreement or the U.S. would default on its obligations. With this agreement, which has passed both chambers and was signed by the President, the threat of a U.S. default has been eliminated for the next two years.

As part of the agreement, sequester caps on both defense and non-defense discretionary funding were increased for the next two years, pleasing (in the face of seven harsher cuts) both defense hawks and advocates for domestic needs. As a pay-for offset, the agreement does extend the Medicare 2%, for an additional two years, across the board cut to

reimbursements, but this has already been in effect for several years. There was also a major Medicare reimbursement change enacted because of this deal. Hospitals who provided outpatient medical care were paid a significantly higher rate by Medicare for those same services than in any other setting, such as community health centers or private doctors' offices. Some physician groups had long argued this was not only unfair, it also encouraged hospitals to aggressively acquire physician groups to gain the higher Medicare hospital rate. These changes will essentially align Medicare outpatient medical care reimbursement to the non-hospital rate. Hospitals decried the reductions in reimbursement, but to no avail.

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