Ending the Epidemic: The Role of HRSA Programs and Funding
Learning Objectives

• Understand the role HRSA programs can have in the proposed plan to End the HIV Epidemic through existing funding distribution and new funding opportunities

• Learn the status of state and national progress towards key 2020 indicators

• Discuss how programs can be developed and funding can be directed to optimize success and meet the goals of the EtE
Why This Matters

• HRSA programs provide critical prevention, care, and treatment services that can be expanded upon to make an impact in the plan to EtE by 2030
  • The RWHAP serves more than 500,000 people living with HIV
  • CHCs have an extensive network of 12,000 delivery sites
• Specific geographical areas continue to bear the burden of high incidence of HIV and can benefit from targeted resources and strategic planning
• The HRSA programs have been successful, but new funding is needed and innovative approaches to programs and policies to achieve the ambitious goals of the EtE plan
Ending the Epidemic Key Strategies

**GOAL:**

- HHS will work with each community to establish local teams on the ground to tailor and implement strategies to:
  - **Diagnose** all people with HIV as early as possible.
  - **Treat** the infection rapidly and effectively to achieve sustained viral suppression.
  - **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
  - **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

- 75% reduction in new HIV infections in 5 years and at least 90% reduction in 10 years.
Geographical Impact and Targeted Areas

• The Ending the Epidemic Plan will target 48 counties with the highest burden of HIV along with Washington, D.C. and San Juan, Puerto Rico; and 7 States with substantial rural burden

• In 2017, southern states accounted for more than half of all new HIV diagnosis and 46% of all people living with HIV, despite making up 38% of national population

• Of the 48 targeted counties:
  • South 48%; West 23%; North East 17%; Midwest 13%
Geographical Impact and Target Areas

Rates of Persons living with HIV by County

Targeted Counties and States for the EtE Plan

AIDSVu

www.HIV.gov
2018 Ryan White HIV/AIDS Program Funding Analysis
Current Funding Framework

• Formula awards to cities and states based on case counts
• Competitive grants based on demonstrated need
• Other competitive grants:
  • Minority AIDS Initiative, ADAP Emergency Relief, Special Programs of National Significance, other programs
Purpose

• Examine where current Ryan White Program funding is distributed to determine if it is following the epidemic

• Inform and motivate a discussion about how Ryan White Program funding is being distributed and how it can be better allocated in the future to achieve the goals of ending the HIV epidemic
Methodology

- Examined FY 2018 funding awards:
  - by program part
  - per HIV/AIDS case count
  - nationwide by states
    - Excluded 6 jurisdictions with low case counts: Guam, Palau, American Samoa, Northern Mariana Islands, Federated States of Micronesia, & Marshall Islands

- Analyzed the funding:
  1. Parts A&B per case above/below median
  2. Part B ADAP per case above/below median
  3. Total Part B & ADAP Supplementals
  4. Total Part C & total Part D
  5. Parts A-D funding per case above/below median
  6. Parts A-D funding per case above/below median, multiplied by total number of cases
Methodology

• Ranked states 3 ways:
  1. A-D including ADAP funding per case
  2. A-D including ADAP funding per case multiplied by total cases
  3. A&B including ADAP funding per case

• Medicaid Expansion noted

• Data Limitation:
  • Do not have data breaking down Part A awards and Part B Emerging Community awards distributed to multiple states
  • Credited such awards to only one state; so some state funding amounts shown are higher than actually received while others are lower than actual
Parts A & B including ADAP
(Above the Median)

Median Funding per Case $1890
Parts A & B including ADAP (Below the Median)

Median Funding per Case $1890
Part B ADAP

Median Funding per Case $815

*States that received median funding amount per case not shown
Parts A - D (Above the Median)

Median Funding per Case $2247
Parts A - D
(Below the Median)

Median Funding per Case $2247
Parts A – D x Total Cases (Above the Median)

Median Funding per Case $2247
Parts A – D x Total Cases
(Below the Median)

Median Funding per Case $2247
State Funding Rankings
(Parts A-D Above/Below the Median, Multiplied by Total Cases)
## State Rankings

<table>
<thead>
<tr>
<th>State</th>
<th>Parts A+B Including ADAP per Case</th>
<th>Parts A-D Including ADAP per Case</th>
<th>Parts A-D Including ADAP per Case x Total Cases</th>
<th>Medicaid Expansion</th>
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<tr>
<th>State</th>
<th>Parts A+B Including ADAP per Case</th>
<th>Parts A-D Including ADAP per Case</th>
<th>Parts A-D Including ADAP per Case x Total Cases</th>
<th>Medicaid Expansion</th>
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<tr>
<td>Texas</td>
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<td>44</td>
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<td>No</td>
</tr>
</tbody>
</table>

+ State receives Part A and/or Part B funding also distributed to other jurisdictions
- State receives Part A and/or Part B funding from another jurisdiction
Note: A state may receive more than one funding award that crosses jurisdictions, noted by multiple + and -
Observations

• Important to consider all Part A, B, C and D funding together

<table>
<thead>
<tr>
<th>State</th>
<th>A&amp;B:</th>
<th>ADAP +Median</th>
<th>B&amp;ADAP Supplemental:</th>
<th>C&amp;D:</th>
<th>A-D/ case:</th>
<th>A-D / case X total cases:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>#6</td>
<td></td>
<td>#5</td>
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<td>#11</td>
<td>#5</td>
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<td></td>
<td>#19</td>
<td>#5</td>
<td>#44</td>
<td>#53</td>
</tr>
</tbody>
</table>
Observations

• When the funding per case is examined in relation to the median amount, and then multiplied by the total number of cases, the magnitude of funding differentials is amplified.

Examples:
• New York receives $2,304 dollars per case, $56 more than the median amount. When you multiple $56 by the total number of cases, that adds up to $7.4M.
• Florida receives $2,149 dollars per case, $97 less than the median amount. When multiplied by the total number of cases in the state that amounts to $10.7M below the median.
• If states received funding equitably per case, states like Florida and Texas would have the most to gain.
Observations

• Puerto Rico received Supplemental and Emergency Relief funds which accounts for the highest amount of funding per case, when multiplied by the number of cases.

• Despite receiving a large Part B Supplemental award, Florida still fell below the median funding line.

• 16/28 of the EtE states are among those that receive less than the median funding amount per case.
2019 CDC HIV Prevention Progress Report Overview
HIV Prevention Progress Report

• The 2019 HIV Prevention Progress Report includes national and state level data (where available) as a means to assess progress on 21 key indicators
  • Indicators are categorized as: preventing new HIV infections, improve health outcomes for people living with HIV, and reduce HIV-related disparities and health inequalities
• Many of the indicators tie in to the 4 pillars of the EtE plan
### Progress Indicators and National Status Overview

#### Prevent New HIV Infections

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2020 Target</th>
<th>2016 Target</th>
<th>2017 Result</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce new HIV infections</td>
<td>30,800</td>
<td>36,500</td>
<td>38,700</td>
<td>→</td>
</tr>
<tr>
<td>Increase knowledge of HIV+ status</td>
<td>90.0%</td>
<td>86.0%</td>
<td>85.8%</td>
<td>→</td>
</tr>
<tr>
<td>Reduce new HIV diagnoses</td>
<td>32,855</td>
<td>38,878</td>
<td>40,142</td>
<td>→</td>
</tr>
<tr>
<td>Reduce risk behaviors among Young MSM</td>
<td>30.7%</td>
<td>32.6%</td>
<td>29.1%</td>
<td>→</td>
</tr>
<tr>
<td>Reduce high-risk sex among MSM</td>
<td>9.8%</td>
<td>11.2%</td>
<td>11.3%</td>
<td>→</td>
</tr>
<tr>
<td>Reduce non-sterile injection</td>
<td>45.5%</td>
<td>56.9%</td>
<td>60.7%</td>
<td>×</td>
</tr>
<tr>
<td>Increase PrEP prescription</td>
<td>47,832</td>
<td>17,937</td>
<td>64,763</td>
<td>✓</td>
</tr>
</tbody>
</table>

#### Improve Health Outcomes for Persons with HIV

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2020 Target</th>
<th>2016 Target</th>
<th>2017 Result</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase linkage to HIV medical care</td>
<td>85.0%</td>
<td>76.9%</td>
<td>75.9%</td>
<td>→</td>
</tr>
<tr>
<td>Increase retention in care</td>
<td>90.0%</td>
<td>67.1%</td>
<td>57.2%</td>
<td>→</td>
</tr>
<tr>
<td>Increase viral suppression</td>
<td>80.0%</td>
<td>57.9%</td>
<td>59.8%</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce high-risk sex among persons with HIV</td>
<td>5.0%</td>
<td>6.4%</td>
<td>5.9%</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce homelessness</td>
<td>5.0%</td>
<td>6.5%</td>
<td>8.4%</td>
<td>×</td>
</tr>
<tr>
<td>Reduce HIV stigma</td>
<td>28.7%</td>
<td>36.9%</td>
<td>39.0%</td>
<td>×</td>
</tr>
<tr>
<td>Reduce death rate</td>
<td>13.0%</td>
<td>17.2%</td>
<td>14.3%</td>
<td>✓</td>
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</table>

#### Reduce HIV-Related Disparities and Health Inequities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2020 Target</th>
<th>2016 Target</th>
<th>2017 Result</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce HIV diagnosis disparity ratio</td>
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<td>17.4</td>
<td>19.1</td>
<td>22.4</td>
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<td>MSM</td>
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<td>17.4</td>
<td>19.1</td>
<td>22.4</td>
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<tr>
<td>Young black MSM</td>
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<td>93.0</td>
<td>102.0</td>
<td>115.7</td>
</tr>
<tr>
<td>Black females</td>
<td></td>
<td>1.45</td>
<td>1.59</td>
<td>1.11</td>
</tr>
<tr>
<td>Southern United States</td>
<td></td>
<td>0.28</td>
<td>0.31</td>
<td>0.36</td>
</tr>
</tbody>
</table>

| Increase viral suppression               |             |            |             |        |
| Youth                                    | 80.0%       | 48.1%      | 51.2%       | ✓      |
| Persons who inject drugs                 | 80.0%       | 53.7%      | 52.1%       | ✓      |
| Transgender women in care                | 90.0%       | 77.5%      | 80.5%       | ✓      |

**Met Annual Target in most recent data year**

**Progress: Moved toward annual target in most recent data year**

**No Progress: No change or moved away from annual target in most recent data year**
Progress Indicator: Increase Retention in Care

- Increase the percentage of persons with diagnosed HIV infection who are retained in medical care at least 90% by 2020

Florida: 60.8%
New York: 61.4%
Texas: 59.1%
Indiana: 53.0%

FL - no prior year data to determine annual progress
Progress Indicator: Increase Viral Suppression

- Increase the number of persons with diagnosed HIV infection who are virally suppressed to at least 80% by 2020

**Florida:** 60.4

**New York:** 61.3

**Texas:** 59.4

**Indiana:** 62.1

FL - no prior year data to determine annual progress
Progress Indicator: Increase PrEP Prescription

- By 2020, Increase the number of persons prescribed PrEP by 500%

PrEP data provided by AIDSVu
Observations

• Considering states’ progress, is funding being distributed in the best way possible to achieve the goals of the EtE?
  • If funding were distributed based on different factors, would that improve a state such as Texas’ progress on indicators in ‘increasing viral suppression’?

• Even with national and state progress towards annual targets, there are often disparities among populations

• The progress report and missing data highlights the need for HIV surveillance and reporting to be modernized to better reflect the status of the epidemic locally and in real time, and enable resources to be optimized
Community Health Centers

• In 2018, across the Health Center Program;
  • 2 million HIV tests administered
  • 200,000 patients with an HIV diagnosis served
  • 7,866 HIV diagnoses were made

• CHCs will play an instrumental role in the EtE initiative in expanding PrEP and other prevention services
Aligning Funding and Resources to End the Epidemic
Mechanisms to Align Funding with Need

- Non-Formula Funding
  - Under Current Law
  - Part A & B Supplemental Funding
  - Parts C & D
  - Requires changes in law
  - ADAP Supplemental & Emergency Relief Funding

- Formula Funding
  - Distribute Funding based on different factors that align with meeting the goals of the EtE initiative
  - Case Counts and other factors:
    - Death Rate
    - Viral Suppression Rate
    - Number of RWP Clients
    - Insurance Coverage
    - Cost of care
    - Poverty Rate
  - Examine the Part Structure
  - Change proportion of Supplemental Funding and Factors for Distribution
Non-Formula Funding Opportunities

• Part A Supplemental
  • Base funding on 5 factors: # Diagnosed, not Suppressed; Viral Suppression Performance; % Uninsured; Cost of Care; Data Quality
  • Every grant scores well
  • Supplemental Funding is based on “demonstrated need”
    • All Part A Supplemental awards are approximately half of the base funding
  • HRSA examining improvements, but need legislative changes

<table>
<thead>
<tr>
<th>Location</th>
<th>Base</th>
<th>Supplemental</th>
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<tbody>
<tr>
<td>Tampa, FL</td>
<td>$6,230,345</td>
<td>$3,387,211</td>
</tr>
<tr>
<td>San Juan, PR</td>
<td>$6,296,077</td>
<td>$3,422,947</td>
</tr>
<tr>
<td>New Orleans, LA</td>
<td>$4,643,311</td>
<td>$2,545,175</td>
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</table>
Non-Formula Funding Opportunities

• Part B (Non-ADAP) Supplemental
  • Distributed Based on Need
    • Factors Include (Similar to Part A Supplemental):
      • Prevalence
      • Increasing case numbers, including those in emerging populations
      • Cost and complexity of delivering care
      • Uninsured rates
      • Other access limitations
      • Impact of homelessness, co-morbidities and justice involvement
      • Impact of reductions in base awards
Part B Supplemental

- Due to end of hold harmless available funding has grown
  - 2013: $15.4 million
  - 2014: $44.6 million

- Due to unobligated Part B funds (including ADAP) funding has continued to grow, until this year
  - 2015: $61.4 million
  - 2016: $167 million
  - 2017: $218 million
  - 2018: $170 million
  - 2019: $86 million
Part B Supplemental Awards: 2018

- $170 million available; $165.4 million awarded
  - $40.2m carried over from previous year
  - $35m award cap
- 24 States, PR, US Virgin Islands, and Mariana Islands applied
- DC, OH, OR, Marshall Islands, and Palau not eligible
- Highest awards:
  - NY: $26m; CA: $24m; FL: $21m; PR: $14m; AL: $12m; SC: $12m
- Other Recipients: AK, GA, ID, IN, IA, ME, MA, MS, MN, MO, MT, NE, NJ, NC, ND, RI, TX, UT, WI, US Virgin Islands, Marianna Islands
Part B Supplemental Awards: 2019

- $86 million available
  - $15m award cap
  - $4.6m carried over from previous year
- DC, IN, NH, OR, US Virgin Islands not eligible
- Awards to date:
  - PR $6.7m; MA $2.7m; RI $1.6m
  - AK, DE, ND, RI, VT
ADAP Supplemental

- 5% of ADAP Base award set-aside for states demonstrating “severe need”
- $18.9 million to 6 states in 2018
  - $42.6m to 9 states in 2017
- Highest Awards in 2018
  - GA: $8.9m
  - PR: $4m
- Severe need determined based on one of following:
  - Client population <200% federal poverty level
  - Formulary limitations affecting availability of core ARTs
  - Waiting lists, enrollment caps, expenditure caps
  - Unanticipated increase in eligible individuals
ADAP Emergency Relief Funds

- Pool of money set aside for ADAP through appropriations
- $54 million to 9 states in 2018
- Awards made to eliminate or prevent ADAP waiting lists, and to fund cost-cutting or cost-saving activities
- Funded activities include steps to enroll ADAP clients in insurance plans, as cost-saving measures.
- Highest Awards:
  - CA: $11m; PR: $11m; VA: $11m; TN: $9m
- Not included in Ryan White Program law; can be changed through appropriations or incorporated into law
Part C & D Awards

• Part C Grants
  • Direct grants to clinics for services to underserved populations
    • Preference for grantees in areas with increased HIV/AIDS burden
  • To be considered in determining awards:
    • Balance in allocations between rural and urban areas
    • Supporting early intervention in rural areas
    • Underserved areas

• Part D Grants
  • Direct grants to providers for family-centered health care and supportive services for women, infants, children, and youth
  • HRSA has broad discretion in directing Part D funds
Part C Funding Changes

- Recent HRSA changes include new geographic service areas and “right sizing” funding based on clients served
  - 70% of Funding
    - **Base Funding**: minimum baseline amount per service area augmented by number of clients served
  - 30% of Funding
    - **Demographics**: a service area’s proportion of populations disproportionately impacted by the HIV epidemic with significant disparities in health outcomes and uninsured populations
    - **Presence of RWHAP Part A**: Part C service areas outside of Part A jurisdictions receive additional funding
Part C Awards: 2018

• In May 2018, HRSA awarded $2.8 million in Part C Early Intervention Service (EIS) grants to 10 new geographic areas
  • Augusta, AR; Laredo, TX; Gary, IN; Palm Springs, CA; Greenville, NC; Fairfax, SC; New Orleans, LA; Bakersfield, CA; Panama City, FL; Jackson, MS
  • Six located in the south
Part D Funding Changes

• FY 2019 President’s budget called for accelerating the elimination of perinatal HIV transmission in the US

• HAB received a two-year extension of funding for all Part D recipients in FY2020 and 2021
  • A large focus in Part D has been on the Reimagine Project

• HRSA has hosted Part D listening sessions and posed questions including:
  • In the context of existing resources, what are current gaps that Part D is not meeting for the Women, Infants, Children, Youth population?
  • Are there specific subpopulation challenges that should be approached differently with the Part D funds?

• HAB expects to re-compete the entire Part D in FY 2022
• FY 2019 and 2020 Budgets propose a reauthorization of the RWHAP to ensure federal funding is allocated to targeted populations experiencing high or increasing rates of HIV, while continuing to support Americans living with HIV across the US
  • HRSA’s Budget Justification offered additional information on the proposed statutory changes through the program reauthorization including changes to Part A and B funding methodologies, and modernization and standardization of requirements and definitions across all Parts

• The 2020 Budget proposed a $70m increase above FY2019 for the RWHAP, accounting to support the EtE initiative
New Funding Required to Achieve EtE Goals

- The President’s budget requested $120 Million for HRSA programs to support the first year of the EtE plan.
- The funding request is expected to expand significantly in future years.
- The $50 Million requested for the CHC Program would be to support the distribution of PrEP.
EtE Parts A & B Funding Announcement

• August 13th NOFO:
  • To be used in conjunction with RWHAP funding, to allow for broader approach to addressing HIV in their communities than what exists in services authorized by the current law
    • RWHAP eligibility requirements waived; apply beyond the scope of service categories
    • Address EtE Pillars 2 and 4
  • 47 awards to eligible TGAs, EMAs and States identified in EtE plan
  • Total funding available: $55,125,000
  • Application due date: October 15, 2019

• Other funding announcements:
  • HRSA-20-079 Technical Assistance Provider (TAP)
  • HRSA-20-089 Systems Coordination Provider (SCP)
  • HRSA Community Health Center Funding Announcement – pending
**Award Recipients and Funding Amounts**

- **Average award amount based on $55.1m**
- **$1.17m for 47 awards**
- **Part B states are eligible for $750,000 – $2,000,000**
- **Unclear how funding for tiers were determined**

### Appendix B: Funding Ranges (for Year One ONLY)

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceiling: $9,000,000</td>
<td>Ceiling: $4,000,000</td>
<td>Ceiling: $2,000,000</td>
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<tr>
<td>Minimum: $750,000</td>
<td>Minimum: $750,000</td>
<td>Minimum: $750,000</td>
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</tbody>
</table>

- **RWHAP Part A and Ohio:**
  - Atlanta EMA, GA
  - Baltimore EMA, MD
  - Boston EMA, MA
  - Chicago EMA, IL
  - Dallas EMA, TX
  - Fort Lauderdale EMA, FL
  - Houston EMA, TX
  - Los Angeles EMA, CA
  - Miami EMA, FL
  - New York EMA, NY
  - Philadelphia EMA, PA
  - Washington EMA, DC

- **RWHAP Part B:**
  - Austin TGA, TX
  - Baton Rouge TGA, LA
  - Charlotte-Gastonia TGA, NC
  - Cleveland-Lorain-Elyria TGA, OH
  - Columbus TGA, OH
  - Fort Worth TGA, TX
  - Indianapolis TGA, IN
  - Jacksonville TGA, FL
  - Jersey City TGA, NJ
  - Las Vegas TGA, NV
  - Memphis TGA, TN
  - Oakland TGA, CA
  - *Ohio (for Hamilton Co.):
    - Orange County TGA, CA
    - Sacramento TGA, CA
    - San Antonio TGA, TX
    - Seattle TGA, WA
  - Alabama
  - Arkansas
  - Kentucky
  - Mississippi
  - Missouri
  - Oklahoma
  - South Carolina
Future Funding

- HRSA-20-078 period of performance is 5 years
  - (Mar 1, 2020 – Feb 28 2025)
- Anticipated increase from $55m to an amount that achieves the EtE 5-year goal:
  - 75% reduction in new HIV infections; sufficient resources addressing social determinants of health to those newly diagnosed, not virally suppressed, or those not yet in HIV care
- Funding ceilings and award amounts may be adjusted
- Funding availability in subsequent years is dependent on satisfactory performance and that continued funding is in best interest of federal government
- Potential performance-based bonus
Resources

• TAI RWHAP Funding Analysis and Presentation
  https://www.theaidsinstitute.org/capacity-building/conference-resources/usca/aids-institute-united-states-conference-aids-2019

• HRSA RWHAP website
  https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program

• CDC HIV Prevention Progress Report

• End the HIV Epidemic website
Round Table Discussion

• Antigone Dempsey, HRSA HIV/AIDS Bureau
• Jen Joseph, HRSA Bureau of Primary Health Care
• John Sapero, Arizona Department of Health Services
• Sean Cahill, The Fenway Institute
• Lance Toma, San Francisco Community Health Center