Overview of the RWHAP, Emergency Relief Funding, and EHE Legislation

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NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Learn the statutory requirements of RWHAP Parts A-D, F
2. Learn the statutory requirements of Emergency Relief Funding (ERF)
3. Learn the statutory requirements of Ending the HIV Epidemic in the U.S. (EHE)
4. Compare the statutory differences between the RWHAP, ERF, and EHE

Sources of Legal & Policy Requirements

- Statute: Title XXVI of the Public Health Service Act (42 USC §§ 300ff-11 to -140)
- Regulation: Uniform Administrative Requirements (45 CFR part 75)
- HHS Grants Policy Statement (2007): covers discretionary awards
- HAB Policy Clarification Notices: guidance to understand and implement program legislative requirements
- NOFO: funding agency requirements and expectations
- NOA: terms and conditions of award

Ryan White

- Ryan White was born in 1971 in Indiana. He was born with hemophilia A, a blood disorder that required him to receive periodic blood injections. Sometime in the early 1980s, he was administered an HIV-contaminated injection. He was diagnosed with AIDS at age 13, with a prognosis of 6 months to live.
- Ryan was initially not permitted to return to his middle school; after winning a lengthy court battle, he returned, but still faced bullying and discrimination.
- Ryan and his family moved to a different part of Indiana in 1987, and Ryan enrolled in a high school that welcomed him.
- Ryan served as an AIDS ambassador to his school community and the American public, fighting AIDS-related stigma and discrimination, until he died on April 8, 1990, one month before his high school graduation.
- President George H.W. Bush signed the Ryan White CARE Act into law on August 18, 1990.
- The RWHAP statute honors Ryan's legacy by providing essential services to people with HIV.

"The biggest contribution I think that Ryan made is, and I didn't know it at that time, that his legacy would be that people are getting their drugs and their treatment and that people are living with AIDS."

Jeanne White Ginder,
Ryan's mom

RWHAP Legislative Overview

- Ryan White Comprehensive AIDS Resources Emergency Act: enacted on August 18, 1990
- Reauthorizations:
  - 1996: Ryan White CARE Act Amendments of 1996
  - 2000: Ryan White CARE Act Amendments of 2000
  - 2006: Ryan White HIV/AIDS Treatment Modernization Act of 2006
  - 2009: Ryan White HIV/AIDS Treatment Extension Act of 2009
- Codified in title XXVI of the Public Health Service (PHS) Act, referred to as the Ryan White HIV/AIDS Program (RWHAP)

RWHAP Legislative Overview, cont.

- Grants under the RWHAP
  - Part A—Mandatory awards to specific cities
  - Part B—Mandatory awards to States/Territories
  - Part C – Discretionary, competitive awards to providers
  - Part D – Discretionary, competitive awards to providers with focus on women, infants, children and youth
  - Part F –SPNS, AETCs, Dental Programs, MAI
- Other Grants
  - Emergency Relief Funding (ERF) – Discretionary, competitive awards to States
  - Ending the HIV Epidemic in the U.S. (EHE) – Discretionary awards to Parts A and B recipients identified by HHS
- Common Provisions
  - Core medical services
  - Payor of last resort
  - Imposition of charges
  - Clinical quality management
  - Administrative Cap

Part A – Mandatory Awards to Specific Cities

Part A

- Funding to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) that are severely and disproportionately affected by the HIV epidemic
  - 24 EMAs (> 2,000 cases of AIDS reported in the most recent 5 years)
  - 28 TGAs (1,000-1,999 cases of AIDS reported in the most recent 5 years)
- Components:
  - Formula funding
  - Supplemental funding
  - Minority AIDS Initiative (MAI) funding

See §§ 2601-2610 and 2693 of the PHS Act

Part A: EMAs and TGAs Losing Status

- Need to fail two-part test for three consecutive years:
  - EMA –
    - cumulative total of more than **2,000** cases in the most recent 5 year period **AND**
    - cumulative total of **3,000** or more living cases of AIDS as of 12/31 of the most recent calendar year
  - TGA –
    - cumulative total of a least **1,000** but fewer than **2,000** cases of AIDS during the most recent 5 year period **AND**
    - cumulative total of between **1,400 -1,500** living cases of AIDS as of 12/31 of the most recent calendar year, if no unobligated balance (UOB) penalty (threshold is 1,500 cases if do have UOB penalty)

See §§ 2601(b) and 2609 of the PHS Act

Part A: Formula Funding

- Eligibility: all EMAs and TGAs that meet the criterion are eligible for formula funding
- 66 2/3 percent of Part A funds for formula funding
- Formula: relative distribution of living HIV/AIDS cases

See §§ 2603(a)(3) and 2609(d)(2) of the PHS Act

Part A: Supplemental Funding

- Eligibility:
  - Submission of application
  - No formula UOB > 5% in prior FY
- 33⅓ percent of Part A funds for supplemental funding
- Competitive process, but awarded at the same time as Part A formula funding
- FY 2022 will be the first time Part A awards consist of a 3-year period of performance (rather than annual)
  - Reduced burden on recipients
  - Only required to submit non-competing continuation (NCC), but HRSA retains the ability to assess eligibility for supplemental funding

See §§ 2603(b) and 2609(d)(2) of the PHS Act

Part A: Supplemental Funding, cont.

- Notice of funding opportunity describes the review criteria
  - Demonstrated need—weighted 33⅓ percent
  - Early identification of people living with HIV/AIDS–weighted 33⅓ percent
- Division of Independent Review (DIR) conducts the Objective Review Committee (ORC) Process
- Priority funding
  - Funds used to address the decline or disruption of services related to a decline in formula funding as compared to FY 2006, up to the amount of the FY 2006 award
  - Calculated by HRSA as a relative distribution of living HIV/AIDS cases

See §§ 2603(b) and 2609(d)(2) of the PHS Act

Part A: Minority AIDS Initiative (MAI)

- Codified in 2006, the MAI provides additional funding to Parts A, B, C, D and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV
- For Part A, the funds are "to improve HIV-related health outcomes and to reduce existing racial and ethnic health disparities"
- Relative distribution based on living minority HIV/AIDS cases

See § 2693(b)(2)(A) of the PHS Act

Part A: Planning Councils & Planning Bodies

- The Part A recipient must establish a planning council (PC) or planning body (PB) that decides how Part A funds will be used through priority setting and resource allocations (PSRA)
- PC membership must include a representative from each of the 13 legislatively required membership categories
- PB membership must include representatives of the various stakeholders in the TGA, and must reflect the demographics of the population of individuals with HIV in the jurisdiction

See §§ 2602, 2609(d)(1) of the PHS Act, RWHAP PC and PB Requirements and Expectations Letter

Part B – Mandatory Awards to States/Territories

Part B Components

- Part B base formula funding
- AIDS Drug Assistance Program (ADAP) formula funding
- ADAP supplemental formula funding
- Emerging Communities (EC) formula funding
- MAI formula funding
- Part B supplemental funding
  - Issued separately from the five formula awards (above)

See §§ 2611-2623 and 2693 of the PHS Act

Part B Base Formula

- Mandatory award; all States and Territories eligible
- Includes a minimum award for certain States/Territories
- Attempts to address potential double-counting for those States that also contain an area that receives funding under RWHAP Part A
- Uses a *weighted* relative distribution, so HIV/AIDS cases that are also in a Part A area count less than HIV/AIDS cases that are not in a Part A area
  - States with no Part A recipient are not penalized

See § 2618(a) of the PHS Act

Part B: ADAP, EC, MAI Components

- ADAP formula funding
  - Mandatory award; all States and Territories eligible
  - Relative distribution based on living HIV/AIDS cases
- ADAP supplemental formula funding
  - Limited eligibility
  - Relative distribution based on living HIV/AIDS cases
- EC formula funding
  - Limited eligibility
  - Relative distribution based on living HIV/AIDS cases
- MAI
  - "For supplemental support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to medications under ADAP"
  - Relative distribution based on living minority HIV/AIDS cases

See §§ 2618(a)(2)(F)(i) and (ii), 2621, and 2693(b)(2)(B) of the PHS Act

Part B: Matching

- States with more than 1% of the total HIV/AIDS cases in the US are required to match (PR is statutorily excluded)
  - Match applies to Part B Base, ADAP and EC
  - Match varies, depending on length of match, but years do not need to be consecutive
- ADAP Supplemental Match
  - Required at 20 percent (1 state dollar to every 4 federal dollars) by all recipients, unless request waiver
  - Waiver permitted only if required to meet Part B Base match and do meet that match
- For both matches, recipients may request an award amount less than they would otherwise be entitled to, up to the amount that they can match

See §§ 2617(d) and 2618(a)(2)(F)(ii)(III) of the PHS Act

Part B: Supplemental Funding

- Issued as a separate, competitive award
- Eligibility:
  - Submission of application
  - No UOB > 5% in prior FY
- Annual notice of funding opportunity describes the review criteria
- DIR conducts the ORC Process

See § 2620 of the PHS Act

Parts A and B: Obligation and Expenditure of Grant Funds

- Added to address the issue of very large unobligated balances (UOB) in cities and States, even as the epidemic was increasing
- To implement, Part A and Part B funds have 3-year availability (unusual for HHS funds)
  - "For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,494,776,000, of which $2,014,698,000 shall remain available to the Secretary through September 30, 2024, for parts A and B of title XXVI of the PHS Act. . . ."
- Gives the Secretary the authority to recoup unused funds, and re-award them without violating appropriation law
- Creates onerous tracking responsibilities on all parties (recipients, POs, and GMOs)

See §§ 2603(c) and 2622 of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Parts A and B: Obligation and Expenditure of Grant Funds, cont.

- Formula UOB funds may be carried over (if request submitted before the end of the grant year)
  - Specific process must be followed
- Supplemental UOB funds may NOT be carried over, and are subject to offset
  - The amount of UOB is reduced from a future award, and made available for reallocation to other recipients through supplemental awards

See §§ 2603(c) and 2622 of the PHS Act

Parts A and B: Obligation and Expenditure of Grant Funds, cont.

- If formula UOB exceeds 5%, two penalties imposed:
  - Future year award is reduced by the amount of UOB less the amount of approved carryover
  - Not eligible for a future year supplemental award
- Any amount of UOB that is not approved for carryover is offset
- Exception for Rebates
  - If the UOB is a result of the expenditure of rebate funds, which are required to be spent prior to grant funds, UOB penalty is reduced

See §§ 2603(c) and 2622 of the PHS Act

Part C – Discretionary, Competitive Awards

Part C Overview

- Recipients are local public and nonprofit community based groups
  - Must be eligible to bill Medicaid unless operate as a free clinic
  - Can provide services directly or through contract
  - May contract with for-profits only if no other provider of quality HIV care in the area
- Recipients must expend grant funds on core medical services, support services, administrative expenses, and a clinical quality management (CQM) program, with a focus on Early Intervention Services (EIS)
- Competitive awards include MAI funding, which is distributed to all recipients based on a relative distribution of living minority HIV/AIDS cases
- In FY 2018, DCHAP implemented the Part C funding methodology to use a data-driven approach to ensure equitable distribution of Part C funds to all service areas, while maintaining the competitive nature of the award, using 4 factors:
  - a minimum base funding amount
  - number of priority populations per NHAS
  - number of uninsured
  - presence of Part A funds

See §§ 2651(b), 2652(a)–(b), 2664(g)(5), 2693(b)(1)(C) of the PHS Act

Part C Early Intervention Services

- Recipients must expend at least 50% of grant funds on Early Intervention Services (EIS)
  - Except counseling and referrals/linkage to care, but the budget allocation for these services cannot be zero
  - EIS is a subset of the 75% core medical services requirement
- EIS definition:
  - Testing
  - Other clinical and diagnostic services regarding HIV/AIDS, and periodic medical evaluations of individuals with HIV/AIDS
  - Providing the therapeutic measures
  - Counseling
  - Referrals/linkage to care
- Recipients must provide each of the EIS directly or through agreements with other providers

See §§ 2651(b)(2), (e) of the PHS Act

Part C Grant Preferences

- Preferences in Making Grants (may improve rank order):
  - Preference to any qualified applicant experiencing an increased burden in providing HIV services in last 2 years. Increased burden means:
    - Number of and rate of increase in HIV cases;
    - Lack of availability of EIS;
    - Number of and rate of increase in other cases of sexually transmitted diseases, number of cases of tuberculosis and of drug abuse, and number of cases of individuals co-infected with HIV and hepatitis B or C;
    - Lack of availability of primary health services from providers other than such applicant; and
    - Distance between such area and the nearest community that has an adequate level of availability of appropriate HIV-related services, and the length of time required to travel such distance
  - Additional preference given to applicants providing EIS in rural areas and applicants in underserved areas with respect to EIS

See § 2653 of the PHS Act

Part C Confidentiality, Informed Consent, and Counseling Requirements

- Recipients are required to maintain information on the services they provide under the grant in a confidential manner and consistent with applicable law
- Informed consent must be provided with respect to testing
- Specific requirements on information that must be provided when a patient receives a negative HIV test result and a positive test result
  - Counseling may still be provided in the absence of testing, as appropriate
- Opportunities for anonymous testing and counseling

See § 2661(a)–(b), 2662, 2664(b) of the PHS Act

Part D – Discretionary, Competitive Awards

Part D Legislative History: A Walk Down Memory Lane

- Part D began as a demonstration project to combat pediatric HIV/AIDS in 1987
- Part D was added to the original Ryan White CARE Act of 1990 as a demonstration grant program
- Authority given to the HRSA Administrator and Director of NIH to make demonstration grants to community health centers (CHCs) and other public and nonprofit private entities that provided primary health services to the public for:
  - Conducting clinical research on therapies for pediatric patients and pregnant women with HIV
  - Providing outpatient health care to pediatric patients and their families (case management required)
- Cooperative agreement or contract with biomedical research entity required
- Eligible recipients: CHCs and other public and nonprofit private entities that served a significant number of pediatric patients and pregnant women with HIV
- Referrals were required for inpatient hospital services, treatment for substance use disorder, and mental health services, as well as other social and support services, as appropriate

Part D Today

- Discretionary, competitive awards to entities providing family-centered care to women, infants, children and youth (WICY)
- Eligible recipients: Public and nonprofit private entities, including health facilities operated by or through contract with the Indian Health Service
- In FY2022, DCHAP implemented the Part D funding methodology to use a data-driven approach to ensure equitable distribution of Part D funds to all service areas, while maintaining the competitive nature of the award, using 3 factors:
  - Minimum base funding amount
  - Number of WICY clients in service area
  - Presence of Part A resources in service area

See § 2693 of the PHS Act

Part D Award Components

- Grant funds expended on core medical services (CMS), support services (including specific support services only for Part D), administrative expenses, and a clinical quality management (CQM) program
  - CMS, although allowable under Part D, are often mostly covered by other funding sources, thereby freeing up funds for recipients to embrace the unique nature of Part D that allows for more extensive coverage of support and wraparound services
- Additional support services under Part D:
  - Family-centered care
  - Linking clients to HIV-related clinical research programs
- Minority AIDS Initiative
  - Under Part D, MAI funds are "for eliminating racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate" HIV/AIDS care services for women, infants, children, and youth
  - Competitive awards include MAI funding distributed to all recipients based on a relative distribution of living minority HIV/AIDS cases

See §§ 2671(a)–(b), (f) and 2693 of the PHS Act

Common Provisions

Parts A, B, C, and sometimes D

- Recipients must comply with various statutory requirements:
  - Core medical services
  - Imposition of charges
  - Administrative cost caps
  - Clinical quality management
  - Payor of last resort
  - Comprehensive planning processes, which include public input
  - Focus on early identification of individuals with HIV/AIDS
  - Maintenance of effort
  - Audit requirements

Core Medical Services: Parts A, B, and C

- Requirement to use not less than 75 percent of funding for core medical services (defined) unless waiver is granted
- Implemented through Policy Notice 21-01; Secretarial waiver is permitted if
  - core medical services are available and accessible to all individuals identified and eligible for the RWHAP in the service area within 30 days
  - there are no ADAP waiting lists in the service area
  - a public process to obtain input on the waiver request occurred
- Submission requires an attestation form, documentation for which may be required upon HRSA's request

See §§ 2604(c) and 2612(b) of the PHS Act, Policy Notice 16-02, Policy Notice 21-01

Imposition of Charges: Parts A, B, and C

- Recipients must impose a charge for services on patients with an individual annual income of over 100% of the FPL
- Only exception – recipients operating as free clinics with a waiver issued by HHS
- Charges imposed are subject to a cap on charges, which is based on individual annual income
- Charges may be nominal (but the charge itself is required)
- Imposition of charges is not required for ADAP, or Parts D and F

See §§ 2605(e), 2617(c), and 2664(e) of the PHS Act

Administrative Costs and Clinical Quality Management: Parts A, B, C, D

- Administrative costs: capped at 10%
  - For Part B, combined planning and evaluation plus administrative costs: capped at 15% (or one full-time-equivalent employee)
  - For Parts A and B, the aggregate total of subrecipient administrative expenditures must not exceed 10% of the aggregate total of funds awarded to subrecipients
  - For Parts C and D, cap does not apply to subrecipients
  - Cap does not include all indirect costs; those costs can be attributed to the appropriate service category
- Clinical Quality Management (CQM)
  - For Parts A and B, capped at 5% or $3,000,000 (whichever is less)
  - For Parts C and D, capped at a reasonable amount

See §§ 2604(h), 2618(b), 2664(g)(3), (5) of the PHS Act, PCN 15-01, PCN 15-02

Payor of Last Resort: Parts A, B, C, D

- By statute, RWHAP funds may not be used *"for any item or service to the extent that payment has been made, or can reasonably be expected to be made. . . under any State compensation program, under an insurance policy, or under any Federal or State health benefits program. . . . or by an entity that provides health services on a prepaid basis"* (statutory exception for Indian Health Service)
- RWHAP recipients and subrecipients must ensure that reasonable efforts are made to use non-RWHAP resources whenever possible
- RWHAP recipients and subrecipients can continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued
- RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured in order to maintain access to care and treatment services. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer, even when those services are provided at the same visit
- Puts onus on RWHAP recipients and subrecipients to create and maintain policies and documentation

See §§ 2605(a)(5), 2617(b)(7)(F), 2664(f), 2671(i) of the PHS Act, PCN 21-02

Part F – SPNS, AETCs, and Dental Programs

Part F: Special Projects of National Significance

- Statutory set-aside for projects that:
  - Quickly respond to emerging needs of individuals receiving RWHAP assistance
  - Improve the ability to electronically report client-level data to HHS
- Requirement for replication
- Eligible entities: entities eligible for funding under Parts A-D

See § 2691 of the PHS Act

Part F: AIDS Education and Training Centers

- Provide health professional and allied personnel training and technical assistance in HIV care, including curriculum development and protocols for women with HIV
- Eligible entities: public and nonprofit private entities and schools and academic health centers

See § 2692(a) of the PHS Act

Part F: Dental Reimbursement Program and Community-Based Dental Partnership Program

- DRP provides unreimbursed costs of oral health care provided to people with HIV by eligible entities
- CBDPP provides grants to eligible entities that partner with community-based dentists as adjunct faculty to provide dental care to people with HIV in underserved areas and train dental students and residents
- Eligible entities: accredited dental schools and dental hygiene programs

See § 2692(b) of the PHS Act

Emergency Relief Funding – Discretionary, Competitive Awards to States

Emergency Relief Funding

- Purpose:
  - Provide funding to States/Territories to prevent, reduce, or eliminate ADAP waiting lists, including through cost-containment measures
  - These funds are to be used to support the Part B ADAP
- Background:
  - HRSA first funded the ERF initiative in August 2010, when numerous states/territories were experiencing ADAP waiting lists

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Emergency Relief Funding, cont.

- Discretionary awards to States to address potential ADAP waiting lists
  - Awarded under § 311(c) of the PHS Act pursuant to appropriation law, and § 2616 of the PHS Act (ADAP)
    - "For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,494,776,000, of which $2,014,698,000 shall remain available to the Secretary through September 30, 2024, for parts A and B of title XXVI of the PHS Act, and of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act . . . ."
  - Not part of title XXVI of the PHS Act, but supports the ADAP activities
  - Three-year availability of funds, one-year period of performance
  - Separate competitive application process

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Emergency Relief Funding, cont.

- Eligibility is determined by policy; currently listed as those RWHAP Part B states/territories that:
  - have reported to HRSA an existing ADAP waiting list,
  - have used the ADAP ERF to prevent, reduce, or eliminate an ADAP waiting list between January 2011 and July 2021,
  - need additional funding for a projected increase in treatment needs aligned with ending the HIV epidemic in the U.S., or
  - need additional funding for other unanticipated increases in the number of clients in the program due to new diagnosis, re-engagement in care, loss of income, and/or loss of health care coverage
- Budget:
  - Determined by policy, currently $75M for up to 25 awards
  - Ceiling capped at $7M, minimum award of $100K
- Funding:
  - Applications are scored by the ORC
  - Awards are first made to any states with an imposed waiting list and a fundable ORC score
  - All other awards are then funded based on ORC score

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Emergency Relief Funding, cont.

- Cost-containment strategies employed by ADAPs can include cost-cutting measures and cost-saving measures. Eligible states/territories may request ADAP ERF funding to implement measures to help reverse cost-cutting measures and/or enhance cost-saving measures.
- Examples of cost-cutting measures include:
  - reductions in ADAP financial eligibility below 300 percent of the FPL;
  - capped enrollment;
  - formulary reductions with respect to antiretroviral and/or medications to treat opportunistic infections and complications of HIV disease; and/or
  - restrictions with respect to ADAP funded health care coverage assistance eligibility criteria
- Examples of cost-saving measures include:
  - RWHAP Part B structural or operational changes such as expanding health care coverage;
  - strategies to increase enrollment in health care coverage;
  - improved systems and procedures for the collection of rebates and/or program income; and
  - data-sharing agreements to facilitate coordination of benefits

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

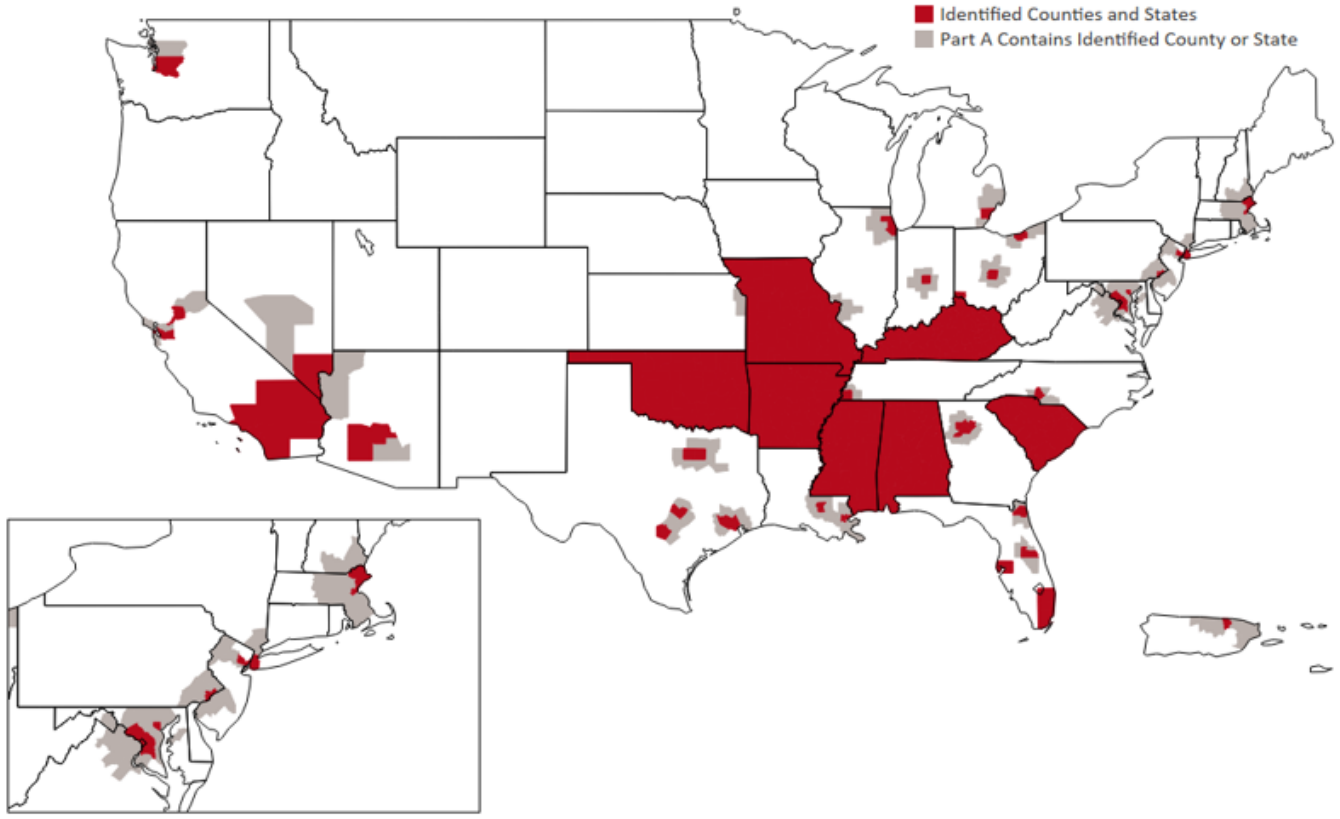
Ending the HIV Epidemic in the U.S. – Discretionary, Competitive Awards

Ending the HIV Epidemic

- Purpose:
  - To implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States, with the overarching goal to reduce new HIV infections in the United States to less than 3,000 per year by 2030. The first phase focuses on 48 counties, Washington, D.C., San Juan, PR, and 7 states that have a substantial rural HIV burden (EHE jurisdictions). By focusing on these EHE jurisdictions in the first phase of the initiative, HHS plans to reduce new HIV infections by 75 percent within 5 years.
  - The EHE has four pillars, or key strategies:
    - Pillar One: Diagnose all people with HIV as early as possible;
    - Pillar Two: Treat people with HIV rapidly and effectively to reach sustained viral suppression;
    - Pillar Three: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs);
    - Pillar Four: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

EHE Jurisdictions



Ending the HIV Epidemic, cont.

- Background:
  - First announced in February 2019, funding began in FY 2020
  - Authority is not fully constrained by the RWHAP legislation, giving recipients a broader approach to addressing HIV in their communities, including expanded eligibility for services, and not limited to using the RWHAP service categories
  - Recipients are encouraged to be innovative and creative as they design ways to use these funds to end the HIV epidemic in their jurisdictions
- Awarded under § 311(c) of the PHS Act pursuant to appropriation law, in conjunction with title XXVI of the PHS Act
  - "For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, $2,494,776,000 . . .; and of which $125,000,000, to remain available until expended, shall be available to the Secretary for carrying out a program of grants and contracts under title XXVI or section 311(c) of such Act focused on ending the nationwide HIV/AIDS epidemic, with any grants issued under such section 311(c) administered in conjunction with title XXVI of the PHS Act, including the limitation on administrative expenses"

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Ending the HIV Epidemic, cont.

- Expand (build from RWHAP) existing comprehensive system of HIV care, support services, and medication delivery infrastructures to implement effective and innovative strategies, interventions, approaches, and services to reduce new HIV infections in the United States. Key strategies include:
  - Implementing evidence-informed and emerging strategies shown to increase linkage, engagement, and retention in care targeted to those not yet diagnosed, those diagnosed but not in HIV care, and those who are in HIV care but not yet virally suppressed;
  - Re-engaging people with HIV who were in care, but are no longer in ongoing care and are not virally suppressed

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Ending the HIV Epidemic, cont.

- In order to be effective, and encourage innovation and broader collaboration and thought, EHE also includes additional grants and required coordination:
  - Technical Assistance Provider (TAP): assists with implementation of work plan activities, innovative approaches, and interventions
  - Systems Coordination Provider (SCP): assists with coordination of initiative planning, other EHE funders and the existing HIV infrastructure. Helps recipients implement best practices, innovative approaches, and interventions identified by the TAP
  - AIDS Education and Training Center supplements

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Ending the HIV Epidemic, cont.

- Eligibility is determined by policy, those RWHAP Part A EMAs and TGAs and Part B states/territories that have a substantial rural HIV burden (47 EHE jurisdictions)
  - 39 RWHAP Part A funded EMAs or TGAs in an EHE jurisdiction including Washington, D.C. and San Juan, PR
  - 7 RWHAP Part B funded States/Territories identified as having a substantial rural HIV burden: Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina
  - The RWHAP Part B Program of the State of Ohio on behalf of Hamilton County
- Budget:
  - In FY 2021, $99 million was awarded to these 47 HAB EHE recipients, two technical assistance providers, and 12 RWHAP AIDS Education and Training Centers (AETC) recipients
  - Additional funds awarded by other Federal partners, including BPHC
- Funding:
  - Stratified with ceilings and minimums; designed to accommodate appropriations increases (if available)

See § 311(c) of the PHS Act; Consolidated Appropriations Act, 2022, Pub. L. 117-103, Division H, Title II

Questions?

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