COMMUNITY PLANNING AND DEVELOPMENT
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS
2015 Summary Statement and Initiatives
(Dollars in Thousands)

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS	Enacted/ Request	Carryover	Supplemental/ Rescission	Total Resources	Obligations	Outlays
2013 Appropriation	$332,000	$70,765	-$17,365	$385,400	$302,176	$307,392
2014 Appropriation/Request	330,000	83,224	...	413,224	338,973	322,052
2015 Request	332,000[a]	74,251	...	406,251	330,264	318,136
Program Improvements/Offsets	+2,000	-8,973	...	-6,973	-8,709	-3,916

a/ This number includes an estimated Transformation Initiative (TI) transfer that may be up to 0.5 percent or $15 million, whichever is less, of Budget Authority.

1. What is this request?

The Department requests $332 million for the Housing Opportunities for Persons With AIDS (HOPWA) program to prevent homelessness and sustain housing stability for approximately 52,000 economically vulnerable households living with Human Immunodeficiency Virus (HIV) infection. HIV is a complex chronic and communicable disease that presents a significant public health risk, particularly among those living in poverty and without access to suitable housing, including the homeless and those at risk of homelessness. Issues of stigma and discrimination continue to remain common place that present further challenges to those living with HIV/AIDS. Housing status is a social determinant of health and the provision of HOPWA supportive housing demonstrates that housing stability results in better health outcomes and reduces HIV viral transmission.

The additional $2 million investment from the enacted fiscal year 2014 HOPWA program appropriation of $330 million will help sustain supportive housing to program beneficiaries who are extremely-low to very-low income. Eighty-one percent of households assisted under the HOPWA program are extremely low-income (at or below 30 percent of the Area Median Income (AMI)) and an additional 15 percent are very low-income (between 31-50 percent of the AMI). The program also supports a diverse population. Nearly 54 percent of HOPWA beneficiaries identified as African American, 37 percent as White, and 7 percent as multi-racial. Also, 17 percent of HOPWA clients identified as Hispanic/Latino. The $332 million funding request will support and retain households with permanent housing and transitional/short-term housing and sustain critical investments in supportive services and case management necessary for the housing stability of special needs populations, especially those that are multiply diagnosed with concurrent health

challenges. In addition, the requested funding will help accelerate improvements in HIV prevention and care in the United States through the President's HIV Care Continuum initiative.

Key Outcomes of the HOPWA Program:

- Approximately 24,612 households will continue to receive tenant-based rental assistance and facility-based housing, the latter of whom face significant health and life challenges (e.g. stigma and discrimination) that impede their ability to live independently.

- Approximately 27,796 households will continue to benefit from HOPWA homeless prevention through the provision of short-term rent, mortgage, and utility (STRMU) assistance and transitional/short-term housing facilities in coordination with local efforts to prevent and end homelessness.

- Approximately 96 percent of households in supportive housing interventions were stably housed and 97 percent of households assisted in short-term interventions were stably housed or had a reduced risk of homelessness in fiscal year 2013.

High-Level Summary of HOPWA Legislative Proposal

The President's National HIV/AIDS Strategy tasks HUD to work with Congress to modernize the HOPWA formula. The modernization proposal would enable the HOPWA statute to be updated to better reflect the nature of an epidemic that has been transformed by both advances in HIV health care and surveillance, and by the increasingly disproportionate impact of the virus on communities of poverty and color. The Department anticipates being able to present the proposed formula allocations to Congressional staff and public interest groups in the spring of 2014. Improving the targeting of HOPWA resources would be achieved by basing the funding formula on the Centers for Disease Control (CDC) data on persons living with HIV/AIDS, rather than cumulative AIDS cases (which currently includes deceased individuals), to ensure that funding is distributed equitably among communities with the highest burden of HIV needs, and local housing costs and poverty rates.

The Department's efforts to modernize the HOPWA formula will contribute toward fulfilling a goal within the President's National HIV/AIDS Strategy and in meeting the recommendations set forth in the HIV Care Continuum Initiative. This initiative seeks to accelerate efforts in HIV prevention and care and ensure that federal resources are focused on improving client outcomes along the care continuum.

Salaries and Expenses (S&E) and Full Time Equivalents (FTE) Request

A total of 47 FTE are requested for HUD management and oversight of this program, which is the same staffing level as fiscal year 2014 enacted. For fiscal year 2015, the total S&E funding is approximately $6.277 million. For personnel services, the associated HOPWA request is $6.161 million. The related program's non-personnel service budget request is $116 thousand.

More details on the S&E request are provided in S&E justification for the Office of Community Planning and Development.

2. What is this program?

(a) Program Description and Key Functions

The AIDS Housing Opportunity Act, 42 U.S.C.12901-12912, authorizes HOPWA to provide housing assistance and supportive services to extremely low-income persons living with HIV/AIDS (PLWHA) and their families. HOPWA is an evidence-based supportive housing program that provides critical housing support to a vulnerable population, many of whom face significant health crises and multiple concurrent health and economic challenges. The program demonstrates effective efforts to help program beneficiaries achieve housing stability that reduces the risk of homelessness, enter into and remain in treatment and care, while achieving better health outcomes that yield cost savings to public health and service systems (see Figure 1).

HOPWA funding is awarded annually through formula allocations and competitive awards that enable states, municipalities, and local non-profit and faith-based community organizations to plan, develop, and fund housing projects and supportive services. HOPWA funding provides flexibility with a range of eligible housing activities and support services enabling communities to identify local housing needs and customize program activities to address local need. In addition, communities effectively leverage HOPWA with other funding streams. Published research in combination with HIV providers and consumer testimony affirms housing assistance leads to improved health outcomes.

- *Formula funds.* Ninety percent of funds are allocated to qualifying States and metropolitan areas under a statutory formula that is based on cumulative AIDS cases and incidence. Seventy five percent of formula funds are awarded to metropolitan

Figure 1: Evidence-Based Findings on HIV and Housing

1. **Need**: Persons with HIV are significantly more vulnerable to becoming homeless during their lifetime.
2. **HIV Prevention**: Housing stabilization can lead to reduced risk behaviors and transmission.
3. **Improved treatment adherence and health**: Homeless persons with AIDS provided HOPWA housing support demonstrated improved medication adherence and health outcomes.
4. **Reduction in HIV transmission**: Stably housed persons demonstrated reduced viral loads resulting in significant reduction in HIV.
5. **Cost savings**: Homeless or unstably housed PLWH are more frequent users of high-cost hospital-based emergency or inpatient service, shelters and the criminal justice system.
6. **Discrimination and stigma**: AIDS-related stigma and discrimination add to barriers and disparities in access to appropriate housing and care along with adherence to HIV treatment.

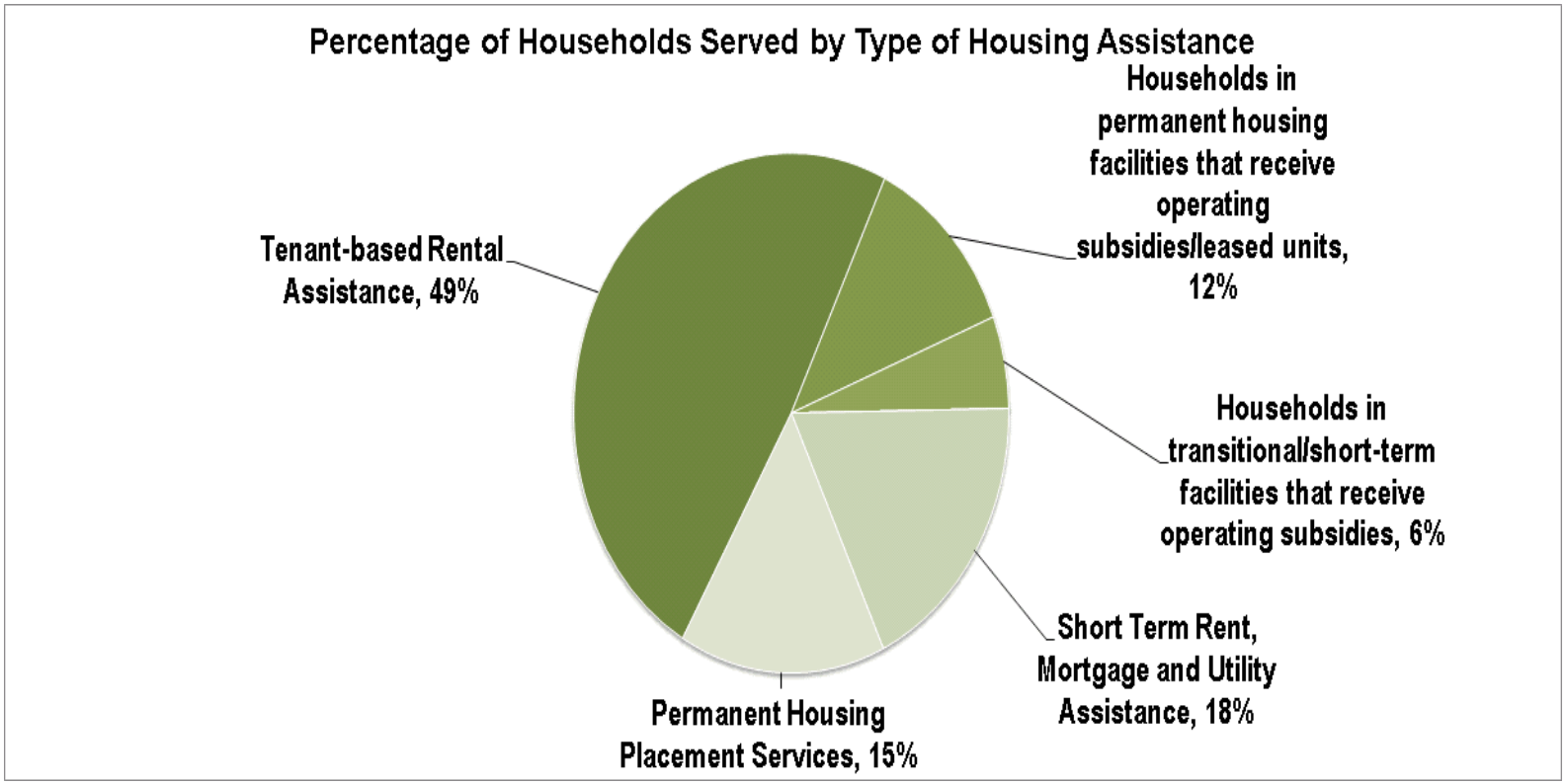
areas with a population of at least 500,000 and with at least 1,500 cumulative AIDS cases, and to states for those areas outside of qualifying metropolitan areas that have at least 1,500 cumulative AIDS cases. Twenty-five percent of formula funds are allocated to eligible jurisdictions based upon a 3-year AIDS incidence rate average. In fiscal year 2015, HUD estimates that it will award $298.8 million to 137 eligible jurisdictions as part of area Consolidated Plans.

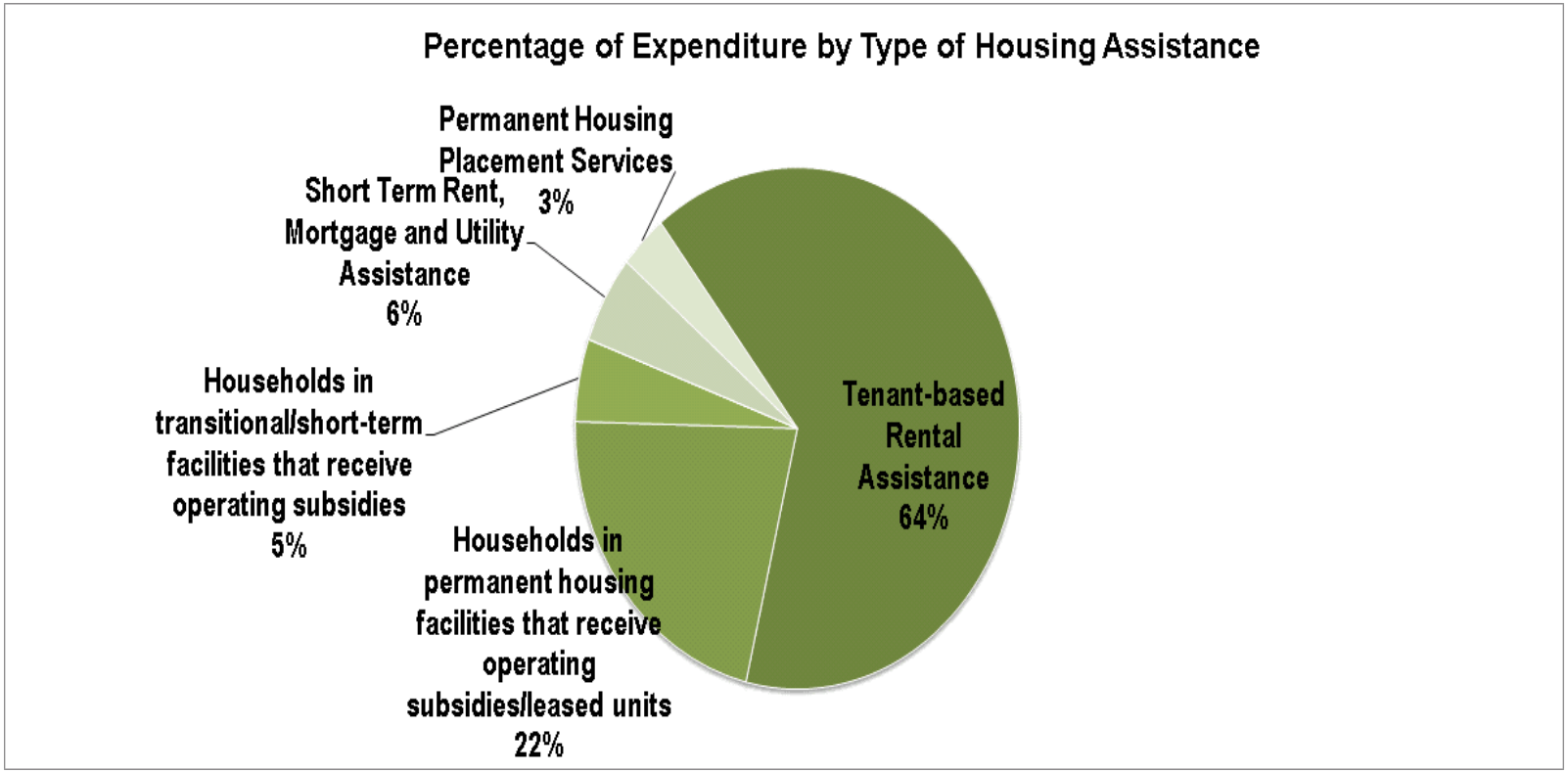
- *Competitive funds.* Ten percent of funds are awarded as competitive grants to areas that are not eligible for formula funding and to innovative, model projects that address special issues or populations. However, HUD appropriation acts prioritize renewal of permanent supportive housing grants, which limits HUD's ability to award funds for new innovative projects. In fiscal year 2015, $33.2 million in competitive funding is expected to support the renewal of 28 expiring permanent supportive housing programs; the Department will not be able to solicit grant proposals for new projects. HOPWA competitive grants are awarded with a 3-year grant cycle, so these 28 projects and 66 other existing competitive grants will continue to provide housing assistance to low-income households.

Targeted Population. Individuals and families that receive assistance must be low-income, and in practice, results show that 81 percent of beneficiaries have extremely low incomes and 15 percent have very low incomes (0-50 percent AMI). HOPWA housing assists persons who are without stable housing arrangements (e.g., persons in emergency shelters or living in a place not meant for human habitation, such as a vehicle, abandoned building, living on the streets, including those at severe risk of homelessness).

Program Components. HOPWA resources are used to provide: rental assistance; operating costs for housing facilities; short-term rent, mortgage, and utility payments; permanent housing placement and housing information services; resource identification (to establish, coordinate and develop housing assistance); acquisition, rehabilitation, conversion, lease, and repair of facilities; and new construction (for single room occupancy dwellings and community residences only) and support services. Area housing projects provide support in the form of permanent and transitional housing assistance, or through short-term payments for rent, mortgage, and utility costs to help households avoid homelessness, based on client needs and available resources. In addition, communities leverage local, state, and private resources to further support and expand the delivery of housing assistance to this special needs population.

In fiscal year 2013, approximately 67 percent of HOPWA funds were used for direct housing assistance, 20 percent on supportive services, and 13 percent on program administration and management services, housing development, and housing information services. The first graph below provides information regarding percentage of households assisted by housing type. Information regarding expenditures in fiscal year 2013 is provided in the second graph below for the two-thirds of HOPWA expenditures spent on direct housing assistance activities.


Percentage of Households Served by Type of Housing Assistance
Households in permanent housing facilities that receive operating subsidies/leased units, 12%
Tenant-based Rental Assistance, 49%
Households in transitional/short-term facilities that receive operating subsidies, 6%
Short Term Rent, Mortgage and Utility Assistance, 18%
Permanent Housing Placement Services, 15%



In fiscal year 2013, the remaining one-third of HOPWA expenditures were used for housing-related components including case management and other supportive services for residents, and for activities related to housing information services and administration and management services. In addition to direct housing costs, HOPWA projects fund *supportive services* that are critical to client stabilization, health, and quality of life. These services include housing case management, mental health, substance abuse, legal, employment-related, and other supportive services, and accounted for about 20 percent of HOPWA expenditures. Supportive services may be provided directly by HOPWA sponsors or by referral to HIV and mainstream providers.

(b) Key Partnerships and Stakeholders

The HOPWA program relies on local networks of non-profit, faith-based, and housing agencies that link beneficiaries to necessary supportive services and case management that promote housing stability. Together, these agencies support adherence to medical regimen, service coordination with medical services and other related services, such as federally funded health care and AIDS drugs assistance provided by the Department of Health and Human Services (HHS) under the Ryan White CARE Act and other programs.

- *National HIV/AIDS Strategy (NHAS) and the HIV Care Continuum Initiative.* HUD is an integral Federal partner in these efforts to develop and implement recommendations within the HIV Care Continuum. This coordinated Federal effort is in response to data that shows only a quarter of people living with HIV in the United States have achieved the treatment goal of controlling the HIV virus and that significant gaps exist between the sequential stages of care from being diagnosed to suppressing the HIV virus. This commitment of resources recognizes the ability to improve lives and reduce costs through the direct impact of housing on increased client entry and retention in HIV care.
- *Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness*. HUD is one of 19 Federal lead agencies that collaborate to develop and invigorate local actions that will address the challenges of homelessness in the U.S. HOPWA grantees contribute to the Opening Doors goals to reduce and eliminate all homelessness and prioritize actions in ending veterans' and chronic homelessness by 2015. In fiscal year 2013, HOPWA grantees report a total of 5,736 households (21 percent) of new households assisted were homeless. Of all HOPWA households receiving housing assistance, 51 percent were chronically homelessness. As a priority population under *Opening Doors*, these persons benefit from HOPWA project coordination with HIV care and treatment and other specialized care.
- *HUD Collaboration with Department of Labor (DOL).* HUD and DOL share a common goal of increasing access of persons living with HIV/AIDS (PLWHA) to employment services and jobs to promote client sufficiency, housing stability and health outcomes. In 2012, these agencies worked together to provide technical assistance to nine HOPWA grantee sites to increase their capacity to link clients to employment services, which resulted in more than 125 clients obtaining jobs in 1 year. Ongoing HUD/DOL collaboration will further expand the capacity of HIV service providers and of workforce agencies to tailor employment services to persons with disabilities, including PLWHA, through development of training curricula and other resources. These resources are expected to be launched in July 2014.

3. Why this program is necessary and what will we get for the funds?

a. What is the Problem We're Trying to Solve?

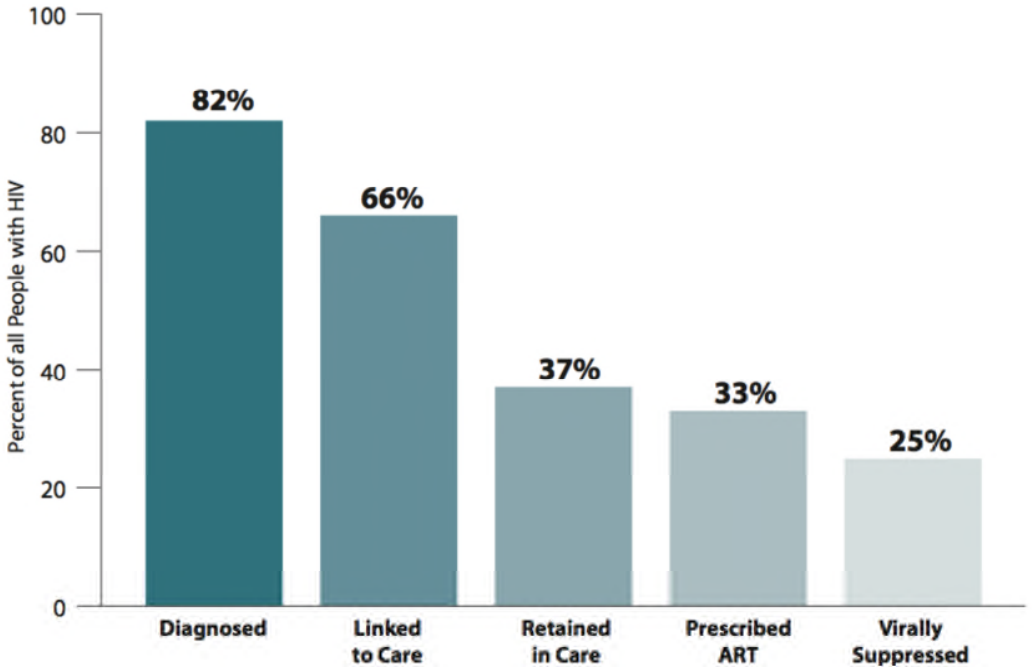
While the rate of new HIV infections has remained relatively constant over the past two decades, the number of persons living with HIV/AIDS has steadily increased. The Centers for Disease Control and Prevention (CDC) estimates that 1.1 million persons aged 13 years and older are living with HIV, of which 18 percent are unaware of their HIV infection. According to CDC data, an estimated 17,774 persons with an AIDS diagnoses died in 2009 (most recent data) and nearly 619,400 persons have died in the United States since the epidemic began. HIV continues to disproportionately impact racial and ethnic populations. In 2010, blacks/African Americans accounted for 44 percent of the new HIV infections, followed by whites (31 percent), and Hispanics/Latinos (21 percent). See the table below.

Figure 1. Table - Estimated HIV Incidence in the U.S., 2010

Estimated New HIV Infections, among persons aged 13 and over, by Race/Ethnicity - 2010	Percent of New Infections
American Indian/Alaska Native	< 1
Asian	2
Black/African American	44
Hispanic/Latino	21
Native Hawaiian/Other Pacific Islander	< 1
White	31
Multiple races	1

Source: Centers for Disease Control and Prevention. Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report 2012; 17 (No. 4). Published December 2012.

Figure No. 2: Percentage of HIV-infected persons engaged in selected stages of the continuum of HIV care as of 2009 — United States



(CDC. *Fact Sheet: HIV in the United States: The Stages of Care*. July 2012. http://www.cdc.gov/nchhstp/newsroom/docs/2012/Stages-of-CareFactSheet-508.pdf).

In Figure 2 above, the HIV Care Continuum Initiative, a component of the President's National HIV/AIDS Strategy, depicts the percentage of HIV-infected persons engaged in care along five critical care stages commencing with diagnosis through viral suppression. As shown, there are significant gaps along the HIV Care Continuum commencing with initial diagnosis through each sequential stage. Currently an estimated 82 percent of persons living with HIV are aware of their infection. Only 25 percent of the estimated 1.1 million persons living with HIV are considered virally suppressed – those determined to have the HIV virus under control and are at the lowest risk of viral transmission to others. This disparity precipitated the establishment of increased federal efforts to accelerate improvements in HIV prevention and care through focusing on improving rates of diagnoses and care. Ongoing implementation of the Affordable Care Act will provide healthcare coverage to those living and at risk of HIV infection and offers opportunities to make greater strides in reducing new HIV infections through increased testing and addressing HIV-related health disparities, particularly among gay, bisexual men, blacks, and Latinos. In addressing this chronic illness, PLWHA experience challenges in accessing regular care within communities due to social and economic circumstances , such as poverty and limited access to high quality health-care and affordable housing. The crippling effects of HIV on health and economic well-being, the related barriers due to housing instability, and risks of homelessness all disrupt regular participation in care. The unfortunate and well-documented relationship between HIV and housing instability keeps the need for HOPWA high, for the following reasons:

- *Persons living with HIV/AIDS are highly vulnerable to homelessness and present significant unmet housing needs.* As reported by Continuums of Care in their 2013 applications to HUD, more than two percent of sheltered homeless persons, and approximately two percent of all reported homeless persons, were shown to have HIV/AIDS.[1] These findings were similar to those reported by CoCs in 2012.[2] However, this is understood to undercount the full burden of HIV disease in the homeless population, as persons with HIV infection often are reluctant to reveal their HIV status to others. Starting with the 2014 Point-in-Time Count (PIT), local CoCs will be required to collect subpopulation data on persons living with HIV/AIDS. This will provide HUD with a better estimate of the number and percentage of persons living with HIV/AIDS that are experiencing homelessness.

  The connection of HIV and homelessness is also shown in CDC data for persons living with HIV who have experienced homelessness. In 2011, results from CDC's Medical Monitoring Project – a representative study on PLWHA – were published. This report indicated that, among interviewed participants engaged in HIV care in 2007, 8 percent had been homeless during the prior 12 months. The CDC study also noted that a larger group – 15 percent of participants – reported a need for assistance finding shelter or housing in the past 12 months, and over one-fourth (26 percent) of those individuals still had a housing need during the interview.[3] If these CDC-reported findings are applied to the larger prevalence of HIV, planning estimates would indicate that about 91,900 persons living with HIV will have been in a homeless situation during the prior year and that an additional 172,200 experienced unstable housing challenges in the total U.S. population of persons living with HIV. Studies have shown that approximately half of all persons diagnosed with HIV will face homelessness or experience an unstable housing situation at some point over the course of their illness.

- *HOPWA grantees report significant level of unmet housing needs.* Nationally, HOPWA grantees in 2013 reported that more than 131,164 HIV-positive households had unmet housing needs, as documented through Consolidated Plans, project data, housing waiting lists, and related planning sources. If combined with the 53,865 households served in fiscal year 2013 by HOPWA, it could be estimated that the program currently serves forty-one percent of those households in need.

Poor Health Outcomes. Currently in the U.S., only 25 percent of persons with HIV infection are achieving optimal results through effective treatment, i.e., suppressed viral load, as shown in the CDC's Treatment Cascade (see Figure 2, above). Helping others achieve these optimal results requires many actions for which stable housing serves as a base, including access to and retention in HIV treatment and quality care and other support.

Disparity is shown in data on high-impact cities. In the District of Columbia (2009) HIV surveillance is among the highest in any U.S. city, with at least three percent of District residents diagnosed with HIV/AIDS. This level far surpasses the one percent threshold that constitutes the CDC standard for a "generalized and severe" epidemic. Within certain demographic groups, even higher rates have been noted, with a rate of 12.1 percent for heterosexual African American women living in the District's poorest neighborhoods (2012). A longitudinal study conducted in San Francisco found that 10 percent of AIDS cases were for persons who were homeless at the time the diagnosis was made.[4] Similar findings have

1 U.S. Department of Housing and Urban Development. (2013). HUD's 2013 Continum of Care Homeless Assistance Programs: Homeless Populations and Subpopulations. Retrieved from https://www.onecpd.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf

2 U.S. Department of Housing and Urban Development. (2012). HUD's 2012 Continuum of Care Homeless Assistance Programs: Homeless Populations and Subpopulations Retrieved from https://www.onecpd.info/reports/CoC_PopSub_NatlTerrDC_2012.pdf

3 Centers for Disease Control and Prevention. (2011). Clinical and behavioral characteristics of adults receiving medical care for HIV infection -- Medical Monitoring Project, United States, 2007. *Moribity and Mortality Weekly Report (MMWR),* 60(SS11), 1-20.

4 Schwarcz, S.K., Hsu, L.C., Vittinghoff, E., VU, A., Bamberger, J.D., & Katz, M.H. (2009). Impact of housing on the survival of persons with AIDS. *BMC Public Health*, 9, 220.

been detected in New York City[5] (where HIV rates were 3 to 16 times higher among the homeless and unstably housed) and in Philadelphia[6] (where 3 to 10 percent of all homeless persons were HIV-positive), reflecting rates more than ten times higher than in the general population.

HIV typically co-occurs with other serious health threats that exacerbate challenges to remaining stably housed and connected to care. According to Wolitski et al. (2010), "Homeless and unstably housed persons living with HIV/AIDS represent a vulnerable population that has been shown to be at increased risk for multiple health threats including substance abuse, mental illness, violence, poor access and adherence to HIV medical care, and high-risk sexual practices."[7] Co-occurring mental illness disproportionately affects PLWHA and often establishes further barriers (including stigma and discrimination) to obtaining affordable and appropriate housing. The HIV Cost and Services Utilization Study, which surveyed a nationally representative sample of persons living with HIV, found that nearly half of participants screened positive for one or more of four psychiatric disorders, and about 70 percent were estimated to need some type of mental health care.[8] Nearly 40 percent of persons with HIV reported substance use issues, and more than 13 percent screened positive for substance dependence. The prevalence of mental disorders is even greater among economically disadvantaged racial and ethnic minorities, who represent the majority of new HIV/AIDS cases. In addition, many have chronic illnesses, including conditions that commonly co-occur with HIV, such as tuberculosis and hepatitis C. The HUD-CDC joint Housing and Health Study also reported this high-need client population in research conducted on presenting issues and life history of 665 persons living with HIV in Baltimore, Chicago, and Los Angeles. Intake assessments showed that participants had pervasive challenges; 96 percent were homeless or at severe risk of homelessness, 68 percent had prior incarceration records and a large number with risk behaviors such as recreational and injection drug use.[9]

b. How Does HOPWA Helps Solve the Problem?

HOPWA is essential to the nation's effort to reduce the worst case housing needs among PLWHA. According to the Worst Case Housing Needs Report of 2013, HUD reports that in 2011 nearly 8.5 million lower income families paid more than half their monthly income for rent, lived in severely substandard housing, or both. This is a 19 percent increase from 2009.[10] Adequate and affordable housing is a necessity in order to promote stability that enables clients to access HIV services provided under Ryan White CARE Act and other human services programs. HOPWA is the portal into care for unstably housed people and provides on-going support to remain in care.

HOPWA-funded housing is an effective platform for linking PLWHA to care and improving health outcomes. Research continues to demonstrate that housing stability significantly increases HIV-positive clients' entry into and retention in care, and increases their adherence to complex HIV treatment regimens – resulting in improved health outcomes, as well as reduced HIV transmission. A recent Los Angeles study of 14,875 Ryan

5 Kerker, B., Bainbridge, J., Li, W., Kennedy, J., Bennani, Y., Agerton, T., Marder, D., Torian, L., Tsoi, B., Appel, K., Gutkovich, A. (2005). The health of homeless adults in New York City: A report from the New York City Departments of Health and Mental Hygiene and Homeless Services. Retrieved from http:nyc.gov/htm/doh/downloads/pdf/epi/epi-homeless-200512.pdf.

6 Culhane, D., Gollub, E., Kuhn, R., and Shpaner, M. (2011). The co-occurrence of AIDS and homelessness: results from the integration of administrative data for AIDS surveillance and public shelter utilization in Philadelphia. *Journal of Epidemiology and Community Health*, 55(7), 515-520.

7 Wolitski, R.J., Kidder, D.P., Pals, S.L., Royal, S., Aidala, A., Stall, R., Holtgrave, D.R., Harre, D. Courtenay-Quirk, C. (2010) Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV." *AIDS and Behavior,* 14(3), 493-503.

8 Bing, E.G., Burnam, M.A., Longshore, D., Fleishman, J.A., Sherbourne, C.D., London, A.S., Turner, B.J., Eggan, F., Beckman, R., Vitiello, B., Morton, S.C., Orlando, M., Bozzette, S.A., Ortiz-Barron, L., Shapiro, M. (2011). Psychiatric disorders and drug use among Human Immunodeficiency Virus-infected adults in the United States. *Archives of General Psychiatry*, 58(8), 721-728.

9 Wolitski, R.J., et al. (2010). 493-503.

10 U.S Department of Housing and Urban Development, 2013 (August); *Worst Case Housing Needs 2011: Report to Congress*. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2013/HUDNo.13-028

White clients who had at least one medical outpatient visit found that those who were living in unstable housing (homeless or transitional housing) were 1.4 times more likely to fall out of care than those with permanent housing.[11] Homeless persons with HIV/AIDS experienced increased morbidity and mortality, more hospitalizations, and decreased adherence to antiretroviral treatment, as compared to PLWHA who are stably housed.[12] Research shows that persons who are chronically homeless for more than 6 months and have a chronic health condition (including HIV/AIDS) have a high chance of premature death without housing and supportive services.[13] HOPWA data shows that 96 percent of persons in supportive housing programs have a stable outcome. Research conducted by the AIDS Foundation of Chicago has shown that homeless persons living with AIDS had significantly improved medication adherence, health outcomes, and viral loads when provided with HOPWA housing assistance, as compared to persons who remained homeless or unstably housed.

Stable housing is one of the most cost-effective strategies for driving down soaring national HIV/AIDS costs. The number of persons living with HIV in the United States continues to grow annually. Recent estimates put the annual direct costs of HIV medications at between $17,000 and $41,000 per person per year[14], depending on the severity of an individual's infection.[15] Lifetime treatment costs per person are estimated to be $367,134.[16] The federal government spent over $21.4 billion in HIV prevention, care, and research in fiscal year 2012[17]. By investing in affordable housing and preventive supports, HOPWA assistance safeguards this national investment in HIV care.

PLWHA who are homeless or unstably housed have been shown to be more likely to demonstrate frequent and prolonged use of high-cost hospital-based emergency or inpatient services, as compared to PLWHA who are stably housed.[18] In a randomized control trial, homeless adults with chronic illnesses were provided with permanent housing and case management. Results showed that compared to the control group that was not provided these services, the intervention group had a relative reduction of 29 percent in the number of hospitalizations, 29 percent in the number of hospital days, and 24 percent reduction in number of emergency department visits. [19] In addition, housing stabilization can lead to reduced risk behavior and reduced HIV transmission (as described below), a significant consideration for federal HIV prevention efforts. It is estimated that

---

11 Los Angeles County Department of Public Health (2011). Los Angeles County Enhanced Comprehensive HIV Prevention Plan (ECHPP). Retrieved from http://www.lapublichealth.org/AIDS/PPC/ECHPP/ECHPPWorkbook1.pdf.

12 Kidder, D.P., Wolitski, R.J., Campsmith, M.L., Nakamura, G.V. (2007). Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. *American Journal of Public Health*, 97, 2238-2245. See also: Moss, A.R., Hahn, J.A., Perry, S., Charlebois, E.D., Guzman, D., Clark R.A., Bangsberg, D.R. (2004). Adherence to highly active antiretroviral therapy in the homeless population in San Francisco: a prospective study. *Clinical Infectious Diseases*, 39, 1190-1198.

13 Basu, A., Kee R., Buchanan, D., Sadowski L.S., (2011). Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care., *Health Research and Educational Trust,* 1-21.

14 Schackman, B.R., Gebo, K.A., Walensky, R.P., Losina, E., Muccio, T., Sax, P.E., Weinstein, M.C., Seage, G.R.III, Moore, R.D., Freedberg, K.A. (2006). The lifetime cost of current human immunodeficiency virus care in the United States. *Med Care,* 44, 990-997, updated to 2009 dollars.

15 Ibid.

16 Ibid. Also see: Farnham, P.G., Holtgrave, D.R., Sansom, S.L., Hall, I.H. (2010). Medical costs averted by HIV prevention efforts in the United States, 1991–2006. *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, 54(5), 565-567.

17 Kaiser Family Foundation (2014). U.S. Federal Funding for HIV/AIDS: The President's FY 2014 Budget Request. Retrieved from: http://kff.org/hivaids/fact-sheet/u-s-federal-funding-for-hivaids-the-presidents-fy-2014-budget-request/

18 Masson, C.L., Sorenson, J.L., Phibbs, C.S., Okin, R.L. (2004). Predictors of medical service utilization among individuals with co-occurring HIV infection and substance abuse disorders. *AIDS Care,* 16(6), 744-755. See also: Smith, M.Y., Rapkin, B.D., Winkel, G., Springer, C. Chhabra, R., & Feldman, I.S. (2000). Housing status and health care service utilization among low-income persons with HIV/AIDS. *Journal of General Internal Medicine,* 15(10), 731-738; and Fleishman, J.A., Yehia, B.R., Moore, R.D., Gebo, K.A. (2010). The economic burden of late entry into medical care for patients with HIV infection. *Medical Care,* 48(12), 1071-1079.

19 Sadowski, L., Kee, R., VanderWeele, T., Buchman, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalization among chronically ill homeless adults. *Journal of the American Medical Association (JAMA),* 301(17), 1771-1778.

preventing approximately 40,000 new HIV infections in the United States each year would avoid expending $12.1 billion annually in future HIV-related medical costs, assuming the current standard of care.[20]

Stable housing reduces an individual's risk of contracting HIV and of transmitting the virus to others. Homelessness is known to increase the probability that a person will engage in sexual and drug-related risk behaviors that put themselves and others at heightened risk for HIV. One recent study showed, for example, that among PLWHA, an improved housing situation led to reduced drug-related and sexual risk behaviors by as much as 50 percent, while those whose housing status worsened actually increased their risk behaviors.[21] In addition, people with HIV who have access to stable housing are more likely to receive and adhere to antiretroviral medications, which lower viral load and reduce the risk of HIV transmission.[22] A study published in May 2011 by the National Institutes of Health found that persons who begin antiretroviral treatment at an earlier stage of disease are 96 percent less likely to transmit the infection than those who begin treatment later.[23] Housing is critical because it has been repeatedly shown to help people enter care sooner.

4. How do we know this program works?

(a) Evaluations and Research

HOPWA Results are based on Research and Evaluation

As discussed throughout this justification, a large body of research demonstrates the impact of HOPWA on housing stability and positive health outcomes for persons living with HIV/AIDS. Housing stability, in general, and supportive housing in particular, significantly improves health outcomes among people living with HIV or AIDS and can create cost savings. Housing stability among PLWHA: (a) reduces the frequency and duration of emergency department visits and inpatient services;[24] (b) increases HIV-positive participants' entry into and retention in care that results in improved health outcomes and reduced HIV transmission;[25] and (c) reduces morbidity and mortality, hospitalizations, and increases adherence to treatment.[26] A randomized study in Chicago found that homeless persons living with HIV who were discharged from the hospital were 63 percent more likely to be alive with intact immunity after one year of placement in respite care and permanent housing with case management.[27]

HUD-CDC Housing and Health (H&H) Study. The HUD-CDC joint Housing and Health study was a multi-site randomized trial undertaken to examine the health, housing, and economic impacts of providing HOPWA assistance to homeless and unstably housed persons living with HIV/AIDS. As

20 Schackman, B.R., et al. 990-997.
21 Aidala, A., Cross, J.E., Stall, R., Harre, D., Sumartojo, E. (2005). Housing status and HIV risk behaviors: implications for prevention and policy. *AIDS and Behavior*, 9(3), 251-265.
22 Lima,V.D., Johnston, K., Hogg, R.S., Levy, A.R., Harrigan, P.R., Anema, A., Montaner, J.S. (2008). Expanded access to highly active antiretroviral therapy: a potentially powerful strategy to curb the growth of the HIV epidemic. *Journal of Infectious Diseases*, 198(1), 59-67; Kidder, D.P., et al. (2007). 2238-2245; Holtgrave, D.R., Curran, J.W. (2006). What works, and what remains to be done, in HIV prevention in the United States. *Annual Review of Public Health*, 27, 261-275. See also: Kidder, D.P., Wolitski, R.J., Pals, S.L., Campsmith, M.L. (2008). Housing status and HIV risk behaviors among homeless and housed persons with HIV. *Journal of Acquired Immune Deficiency* Syndromes, 49(4), 453-454.
23 National Institute of Allergy and Infectious Diseases (NIAID). (2011). Treating HIV-infected people with antiretrovirals significantly reduce transmission to partners: findings result from NIH-funded international Study. *National Institutes of Health News*. Retrieved from http://www.nih.gov/news/health/may2011/niaid-12.htm.
James J. O'Connell. 2007. "The Need for Homelessness Prevention: A Doctor's View of Life and Death on the Streets," Journal of Primary Prevention 28, no.3: 199–203.
24 Masson, C.L., et al. (2004).
25 Los Angeles County Department of Public Health (2011).
26 Schwarcz, S.K., et al. (2009). 220; Kidder, D.P., et al. (2007). 2238-2245.
27 Buchanan, D., Kee, R., Sadowski, L.S., Garcia, D. (2009). The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial. *American Journal of Public Health,* 99(6), S675-680.

published in peer-reviewed journals in recent years, findings from the study demonstrated that HOPWA housing assistance serves as an efficient and effective platform for improving the health outcomes of persons living with HIV/AIDS and their families.[28] The Housing and Health study of HOPWA and other supportive housing programs for PLWHA found that housing was associated with 41 percent fewer visits to emergency departments, a 23 percent reduction in detectable viral loads, a 10 percent reduction in perceived stress, and a 19 percent reduction in unprotected sex with partners whose HIV status was negative or unknown.[29] A cost utility study published in 2012 found that HIV housing assistance compares favorably in cost effectiveness to other well accepted medical and public health services.[30]

HOPWA prevents and reduces risk of homelessness. Research and HUD experience has shown that homelessness prevention activities can aid in avoiding loss of housing and cost savings through the avoidance of emergency care. These achievements are demonstrated by the Homelessness Prevention and Rapid Re-housing (HPRP) Recovery Act program, which helped save over 1.2 million Americans from homelessness. HPRP provided rapid re-housing supports to families in homeless situations as well as short-term rental assistance and case management support to prevent homelessness. HOPWA's short-term rent, mortgage, and utility assistance and emergency housing programs effectively provide similar services that avert evictions or other actions that precipitate a loss in housing stability and places households at a higher risk of homelessness.

HUD is also conducting several new studies of homelessness that will expand the evidence base. The *Homelessness Prevention Study* will survey communities implementing prevention programs using HPRP funding and will propose alternative research designs for an empirical study of homeless prevention. The study will be released in April 2014. The *Evaluation of the Veterans Homeless Prevention Demonstration* will study best outreach and service provision models to meet the specific needs of homeless veterans. The study will be released in early 2015. HUD is also improving collaboration across programs in support of *Opening Doors* to end homelessness. A census of all public housing agencies (PHAs) will document current PHA engagement in serving homeless households and will identify mechanisms to address barriers to increasing the number of homeless households served. Study results will contribute to improving homelessness prevention and increasing access to assisted housing across all homeless groups, including persons also living with HIV.

HOPWA Performance Measures Demonstrate Results

HOPWA is highly targeted to serve persons with the lowest incomes and worst case housing needs. Fiscal year 2013 performance data shows that 96 percent of assisted households are extremely low- or very low-income.

HOPWA clients achieve high levels of stable housing outcomes and access to care. End of year performance results in fiscal year 2013 show that 95 percent of assisted households had a housing plan, 92 percent had contact with a healthcare provider, and nearly 90 percent of clients accessed and maintained medical insurance.

HOPWA programs are successful in leveraging other resources to supplement HOPWA funding. In fiscal year 2013, over $665.6 million in other funds was leveraged to assist HOPWA households. For every $1 spent on HOPWA eligible services, an additional $2.12 of leveraged funds is used to benefit this vulnerable population. Program income ($4.7 million) and receipt of resident rents ($11.1 million) are tracked to augment support for this supportive housing program.

28 Wolitski, R.J., et al. (2010). *495-503.*

29 Kidder, Daniel. (2009). *The Housing and Health Study: Background, Methods, and Outcomes*. Presentation at National AIDS Housing Coalition conference.

30 Holtgrave, D.R., Hall, H.I., Wehrmeyer, L., Maulsby, C. (2012). Costs, consequences and feasibility of strategies for achieving the goals of the National HIV/AIDS Strategy in the United States: A closing window for success? *AIDS and Behavior*, 16(6), 1365-1372.

Housing Opportunities for Persons With AIDS

HOPWA programs are working to link clients to jobs. In fiscal year 2013, projects reported that nearly 5 percent of clients (5,851 households) obtained jobs as a result of the services provided. A technical assistance pilot provided to nine grantees to enhance service provider capacity to link clients to employment services resulted in: 79 partnerships with employment programs created; 463 new clients received employment-related services, 413 clients received job readiness assessments; 99 clients received job skills training; and 110 employment placements.

HOPWA also promotes cross-program collaborations within HUD by supporting efforts to advance fair housing goals and sharing information with the provider network and with clients about legal protections available to combat forms of housing discrimination. HUD has issued guidance to promote equal access to housing and to address issues of stigma as seen in housing discrimination facing lesbian, gay, bi-sexual, and transgender persons and couples. The Department published a proposed rule in July 2013 related to Affirmatively Furthering Fair Housing. This rule will provide state and local grantees with the capacity to improve outcomes for low-income citizens from fair housing policies and sets clear expectations for this principle. HOPWA grantees will utilize this policy to ensure low income PLWHA have access to fair housing.

(b) Utilizing IT to Make Investment Decisions

In 2012, CPD overhauled and automated the Consolidated Planning process for 1,208 grantees using a new module of IDIS called the eCon Planning Suite. The Consolidated Plan is designed to help states and local jurisdictions to assess their affordable housing and community development needs and market conditions, and to make data-driven, place-based investment decisions. The consolidated planning process serves as the framework for a community wide dialogue to identify housing and community development priorities. These enhancements increase the effectiveness of CPD's four formula block grant programs, including HOPWA, by providing grantees with expanded data and a web-based mapping tool and planning template to improve up-front planning and back-end performance reporting. These updates provide grantees with the resources necessary to support need-driven, place-based decisions. For example, the new electronic Consolidated Plan template now automatically provides HOPWA grantees with CDC surveillance data and HIV Housing Need data to assist them to make HOPWA funding decisions. Overall, the updated Consolidated Plan systems will allow grantees to leverage resources and maximize program outcomes, and, for some communities, lessen the need to rely on contractors to assemble the Consolidated Plan. CPD plans to enhance the eCon Planning Suite with a Field Office review module for the Con Plan, Annual Action Plan (AAP) and Consolidated Annual Performance and Evaluation Report (CAPER) in IDIS. This capability will replace the paper-based review process and further reduce the workload on CPD Field staff associated with plan review. The enhancement will more comprehensively document the plan review process in IDIS. Please refer to the Information Technology Portfolio Justification for more details.

5. Legislative Proposals

Highlights of the HOPWA Legislative and Modernization Proposal
The HOPWA funding formula would be updated to better reflect the nature of the HIV epidemic that has evolved over the years through advances in HIV care and surveillance, and the increasingly disproportionate impact of HIV on communities of poverty. HUD has estimated the projected formula allocations based upon this legislative proposal (See Section 6 Formula Allocation Tables for more information). It is anticipated that these allocations would be available for discussion in the spring of 2014. The HOPWA legislative proposal is envisioned to better target HOPWA funding by:

- Basing the funding formula on CDC data on persons living with HIV rather than cumulative AIDS cases;
- Incorporating local housing costs and poverty rates into the formula;

- Expanding eligible activities to include new short and medium-term housing interventions as cost-effective options for meeting the diverse stabilization needs of vulnerable households, including homeless individuals and families living with HIV/AIDS; and
- Aligning the percentage of HOPWA grant amounts that may be used for administrative expenses with homeless assistance grant programs (10 percent of project sponsors' awarded amount and 6 percent for grantees).

All grantees eligible for HOPWA formula funding prior to the formula change would continue to be eligible for formula allocation. Formula adjustments would also be phased in over a period of three years. As the new formula is phased in, grantees will not lose more than 10 percent or gain more than 20 percent of the average share of the total formula allocation of the previous fiscal year.

General Provisions

Section 203: This provision carries forward HUD's authority to honor agreements between the cities that are initially designated to be HOPWA formula grant recipients and their state, giving the state the right to assume the grant responsibility, and make other allocation adjustments.

6. **Formula Allocation Tables**

Distribution of Funds by Grantees. The distribution of the 2015 appropriation request for HOPWA formula funds is according to 2013 actual grantees and their 2013 awarded amounts (as rounded to nearest thousand), 2014 estimated allocations are based upon the current formula (and revised metropolitan statistical areas, where applicable), and 2015 projections are based upon the new formula outlined in the HOPWA legislative proposal.

Grantee Name	State	FY2013 Actual	FY2014 Estimate	FY 2015 Revised Formula
Birmingham	AL	$555,158	$589,170	$722,770
Alabama State Program	AL	1,369,305	1,466,345	1,798,854
Phoenix	AZ	1,721,974	1,799,656	2,207,747
Tucson	AZ	433,227	453,063	555,800
Arizona State Program	AZ	221,444	230,855	283,204
Little Rock	AR	302,548	317,332	389,290
Arkansas State Program	AR	515,426	533,336	654,276
Anaheim	CA	1,471,369	1,536,466	1,884,876
Bakersfield	CA	372,171	386,889	474,620
Fresno	CA	355,403	378,994	464,935
Los Angeles	CA	13,304,984	15,919,579	14,414,455
Oakland	CA	2,083,392	2,176,582	2,172,347
Riverside	CA	1,879,263	1,981,069	2,430,297
Sacramento	CA	862,627	901,050	1,105,373
San Diego	CA	2,726,216	2,837,753	3,481,243
San Francisco	CA	8,633,125	8,241,932	7,462,695
San Jose	CA	838,752	872,663	1,032,826
California State Program	CA	2,577,494	2,991,531	3,470,411
Denver	CO	1,481,394	1,554,138	1,906,555
Colorado State Program	CO	404,613	432,572	530,662
Bridgeport	CT	776,237	803,106	985,219
Hartford	CT	1,056,186	1,095,059	1,343,375
New Haven	CT	936,442	967,600	1,187,013
Connecticut State Program	CT	$269,924	$219,764	$269,598

Grantee Name	State	FY2013 Actual	FY2014 Estimate	FY 2015 Revised Formula
Wilmington	DE	604,550	630,341	725,900
Delaware State Program	DE	192,829	247,210	252,300
District Of Columbia	DC	12,479,642	10,733,477	9,718,676
Cape Coral	FL	388,939	405,501	497,453
Deltona	FL	0	372,602	456,197
Ft Lauderdale	FL	8,308,550	7,378,513	6,680,908
Lakeland	FL	585,138	516,741	525,754
Miami	FL	11,381,465	11,349,577	10,276,526
Orlando	FL	3,533,678	3,008,297	2,890,985
Palm Bay	FL	322,779	335,003	374,544
Port St Lucie	FL	0	0	554,831
Sarasota	FL	429,582	448,363	516,905
Tampa	FL	2,798,725	2,828,946	3,042,524
West Palm Beach	FL	3,103,022	3,039,552	2,752,176
Jacksonville-Duval County	FL	2,608,329	2,303,227	2,085,467
Florida State Program	FL	3,536,718	3,353,606	3,377,754
Atlanta	GA	6,613,557	14,245,508	12,898,660
Augusta-Richmond County	GA	413,361	938,098	849,405
Georgia State Program	GA	1,964,378	2,204,781	2,704,738
Honolulu	HI	450,724	436,708	535,736
Hawaii State Program	HI	168,042	205,288	220,151
Chicago	IL	6,107,650	7,695,835	7,705,080
Illinois State Program	IL	975,081	1,174,204	1,440,467
Indianapolis	IN	852,603	947,108	1,161,875
Indiana State Program	IN	934,984	947,296	1,162,105
Iowa State Program	IA	395,682	422,044	517,747
Kansas State Program	KS	366,886	393,093	482,231
Louisville-CDBG	KY	530,918	572,250	702,014
Kentucky State Program	KY	487,176	523,748	642,513
Baton Rouge	LA	$2,563,587	$2,625,279	$2,377,071

Grantee Name	State	FY2013 Actual	FY2014 Estimate	FY 2015 Revised Formula
New Orleans	LA	3,741,338	4,014,664	3,635,096
Louisiana State Program	LA	1,223,134	1,295,271	1,588,987
Baltimore	MD	7,312,098	7,846,648	7,104,783
Frederick	MD	675,631	689,934	846,384
Maryland State Program	MD	387,481	397,793	484,963
Boston	MA	2,087,647	2,245,539	2,754,738
Lowell	MA	685,108	1,087,727	1,334,380
Lynn	MA	345,197	0	0
Springfield	MA	446,897	454,567	557,645
Worcester	MA	384,200	457,011	560,643
Massachusetts State Program	MA	188,819	210,928	258,758
Detroit	MI	1,978,226	2,351,205	2,128,909
Warren	MI	480,432	514,349	630,983
Michigan State Program	MI	1,009,892	1,067,988	1,310,165
Minneapolis	MN	971,800	1,040,917	1,276,956
Minnesota State Program	MN	139,245	147,574	181,038
Jackson	MS	1,123,975	1,084,846	982,279
Mississippi State Program	MS	940,452	963,464	1,181,940
Kansas City	MO	1,055,457	1,087,727	1,334,380
St Louis	MO	1,322,829	1,389,080	1,704,068
Missouri State Program	MO	501,756	541,796	664,654
Nebraska State Program	NE	339,000	356,999	437,952
Las Vegas	NV	1,074,776	1,133,597	1,390,652
Nevada State Program	NV	238,211	249,843	306,498
Camden	NJ	677,818	708,357	867,773
Edison	NJ	1,405,027	0	0
Jersey City	NJ	2,810,245	2,566,221	2,078,110
Newark	NJ	6,419,016	6,473,685	5,861,628
Paterson	NJ	1,294,558	1,356,181	1,836,022
New Jersey State Program	NJ	$1,120,158	$1,125,514	$1,233,222

Grantee Name	State	FY2013 Actual	FY2014 Estimate	FY 2015 Revised Formula
Albuquerque	NM	319,681	335,003	410,968
New Mexico State Program	NM	273,934	288,945	354,466
Albany	NY	470,955	493,857	591,091
Buffalo	NY	524,721	549,691	674,339
Islip Town	NY	1,684,976	1,750,966	1,803,968
New York City	NY	53,533,071	48,441,549	43,499,044
Poughkeepsie	NY	624,416	0	0
Rochester	NY	657,405	687,866	843,847
Syracuse	NY	279,037	289,509	343,546
New York State Program	NY	1,698,098	2,155,715	2,463,016
Charlotte	NC	873,634	1,060,906	1,301,478
Greensboro	NC	301,455	316,956	388,829
Wake County	NC	510,323	536,156	657,735
North Carolina State Program	NC	2,347,849	2,387,886	2,929,364
Cincinnati	OH	643,006	672,639	825,167
Cleveland	OH	906,552	950,680	1,166,257
Columbus	OH	761,839	820,777	1,006,897
Dayton	OH	274,481	285,937	350,776
Ohio State Program	OH	932,797	979,255	1,201,311
Oklahoma City	OK	496,106	530,140	650,355
Tulsa	OK	334,444	353,051	433,109
Oklahoma State Program	OK	235,842	248,339	304,652
Portland	OR	1,035,226	1,081,147	1,326,308
Oregon State Program	OR	363,787	379,182	465,165
Allentown	PA	306,923	315,828	387,445
Bensalem Township	PA	0	511,529	627,524
Harrisburg	PA	279,584	291,013	357,003
Philadelphia	PA	7,518,686	9,465,012	8,570,138
Pittsburgh	PA	689,847	723,773	887,896
Pennsylvania State Program	PA	$1,256,305	$1,294,519	$,588,065

Grantee Name	State	FY2013 Actual	FY2014 Estimate	FY 2015 Revised Formula
Providence	RI	831,644	867,399	1,064,091
Charleston	SC	571,190	584,563	646,739
Columbia	SC	1,421,084	1,413,542	1,279,898
Greenville	SC	284,687	360,382	442,102
South Carolina State Program	SC	1,406,850	1,387,200	1,701,762
Memphis	TN	2,530,686	2,849,305	2,579,916
Nashville-Davidson	TN	852,786	914,398	1,121,747
Tennessee State Program	TN	902,360	939,213	1,152,189
Austin	TX	1,048,348	1,112,354	1,364,592
Dallas	TX	4,393,520	5,375,659	4,887,177
El Paso	TX	341,187	360,758	442,564
Fort Worth	TX	911,655	995,987	1,221,837
Houston	TX	8,956,121	10,895,746	9,865,603
San Antonio	TX	1,138,748	1,212,178	1,487,052
Texas State Program	TX	2,724,029	2,922,538	3,585,254
Salt Lake City	UT	367,068	366,398	449,483
Utah State Program	UT	122,295	153,214	187,957
Richmond	VA	1,159,168	1,087,441	1,239,878
Virginia Beach	VA	1,030,852	1,078,515	1,323,080
Virginia State Program	VA	696,044	729,037	894,354
Seattle	WA	1,706,482	1,779,541	2,183,071
Washington State Program	WA	690,758	728,661	893,893
West Virginia State Program	WV	321,686	342,899	420,655
Milwaukee	WI	554,247	587,478	720,695
Wisconsin State Program	WI	441,611	466,598	572,404
San Juan Municipio	PR	5,309,668	5,654,929	5,120,281
Puerto Rico	PR	1,693,542	1,808,116	1,651,227
Total		**$283,170,968**	**$297,000,000**	**$298,800,000**

COMMUNITY PLANNING AND DEVELOPMENT
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS
Summary of Resources by Program
(Dollars in Thousands)

Budget Activity	2013 Budget Authority	2012 Carryover Into 2013	2013 Total Resources	2013 Obligations	2014 Budget Authority/ Request	2013 Carryover Into 2014	2014 Total Resources	2015 Request
Formula Grants	$283,172	$69,892	$353,064	$269,840	$297,000	$83,224	$380,224	$298,800
Competitive Grants	31,463	873	32,336	32,336	33,000	...	33,000	33,200
Transformation Initiative (transfer)	...	...	...	...	...	...	...	[1,660]
Total	314,635	70,765	385,400	302,176	330,000	83,224	413,224	332,000

COMMUNITY PLANNING AND DEVELOPMENT
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS
Appropriations Language

The fiscal year 2015 President's Budget includes proposed changes in the appropriation language listed and explained below. New language is italicized and underlined, and language proposed for deletion is bracketed.

For carrying out the Housing Opportunities for Persons with AIDS program, as authorized by the AIDS Housing Opportunity Act (42 U.S.C. 12901 et seq.), [$330,000,000,]*$332,000,000*, to remain available until September 30, [2015]*2016*, except that amounts allocated pursuant to section 854(c)(3) of such Act shall remain available until September 30, [2016]*2017*: *Provided*, That the Secretary shall renew all expiring contracts for permanent supportive housing that initially were funded under section 854(c)(3) of such Act from funds made available under this heading in fiscal year 2010 and prior fiscal years that meet all program requirements before awarding funds for new contracts under [each]*such* section[, and if amounts provided under this heading pursuant to such section are insufficient to fund renewals for all such expiring contracts, then amounts made available under this heading for formula grants pursuant to section 854(c)(1) shall be used to provide the balance of such renewal funding before awarding funds for such formula grants*: Provided further*, That the Department shall notify grantees of their formula allocation within 60 days of enactment of this Act]. *(Department of Housing and Urban Development Appropriations Act, 2014.)*