United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m. EDT
Thursday, June 23, 2005

RYAN WHITE CARE ACT

Factors that Impact HIV and AIDS Funding and Client Coverage

Statement of Marcia Crosse
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June 23, 2005

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Highlights

Highlights of GAO-05-841T, a testimony before the Subcommittee on Federal Financial Management, Government Information, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

The Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) was enacted in 1990 to respond to the needs of individuals and families living with the Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS). In fiscal year 2004, over $2 billion in funding was provided through the CARE Act, the majority of which was distributed through Title I grants to eligible metropolitan areas (EMA) and Title II grants to states, the District of Columbia, and territories. Titles I and II use formulas to distribute grants according to a jurisdiction's reported count of AIDS cases. Title II includes grants for state-administered AIDS Drug Assistance Programs (ADAP), which provide medications to HIV-infected individuals.

GAO was asked to discuss the distribution of funding under the CARE Act. This testimony presents preliminary findings on (1) the impact of CARE Act provisions that distribute funds based upon the number of AIDS cases in metropolitan areas, (2) the impact of CARE Act provisions that limit annual funding decreases, (3) the potential shifts in funding among grantees if HIV case counts were incorporated with the AIDS cases that are currently used in funding formulas, and (4) the variation in eligibility criteria and funding sources among state ADAPs.

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To view the full product, including the scope and methodology, click on the link above. For more information, contact Marcia Crosse at (202) 512-7118.

What GAO Found

Under the CARE Act, GAO's preliminary findings show that the amount of funding per AIDS case varied among states and metropolitan areas in fiscal year 2004. Some CARE Act provisions that distribute funds based on the AIDS case count within metropolitan areas result in differing amounts of funding per case. In particular, when a state or territory has an EMA within its borders, the cases within that EMA are counted twice during the distribution of CARE Act funds—once to determine the EMA's funding under Title I, and once again to determine a state's Title II grant.

The hold-harmless provisions under Titles I and II guarantee a certain percentage of a previous year's funding amount, thus sustaining the funding levels of CARE Act grantees based upon previous years' measurements of AIDS cases. Title I's hold-harmless provision for EMAs has primarily benefited the San Francisco EMA, which received over 90 percent of the fiscal year 2004 Title I hold-harmless funding. San Francisco alone continues to have deceased cases factored in to its allocation, because it is the only EMA with hold-harmless funding that dates back to the mid-1990s when formula funding was based on the cumulative count of diagnosed AIDS cases.

If HIV case counts had been incorporated with AIDS cases in allocating Title II funding to the states in fiscal year 2004, about half of the states would have received an increase in funding and half of the states would have received less funding. Many of those states receiving increased funding would have been in the South, a region that includes 7 of the 10 states with the highest estimated rates of individuals living with HIV. However, wide variation in the maturity of states' HIV reporting systems could limit the adequacy of their HIV case counts for the distribution of CARE Act funding.

Among state ADAPs, there is wide variation in the criteria used to determine who is eligible for ADAP medications and services, and in the additional funding received beyond the Title II grant for each state ADAP. States have flexibility to determine what drugs they will cover for their ADAP clients and what income level will entitle a person to eligibility, among other criteria, and the resulting variation can contribute to client coverage differences among state ADAPs. There is similar variation in additional funding sources and eligibility criteria among states that have established waiting lists for eligible clients. The Centers for Disease Control and Prevention and the Health Resources and Services Administration provided comments on the facts contained in this testimony and GAO made changes as appropriate.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act).[1] I will specifically address factors that impact CARE Act funding of services for those with the Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) and program coverage for CARE Act clients. As of December 2003, over 1 million individuals within the United States are estimated to be infected with HIV, including about 406,000 individuals with AIDS. Administered by the Health Resources and Services Administration (HRSA), the CARE Act makes funds available to states and localities to provide health care, medications, and support services to individuals and families affected by HIV and AIDS.

In fiscal year 2004, more than $2 billion was provided through the CARE Act for these health care and support services. The majority of these funds were distributed under Title I and Title II within the CARE Act through formula-derived base grants, which distribute funding to all eligible jurisdictions, and through supplemental grants, which distribute funding to a subset of all eligible jurisdictions. Title I provides funding to all eligible metropolitan areas (EMA) according to an EMA's number of AIDS cases.[2] Title II provides funding to all states, territories, and the District of Columbia. Within both of these titles are formula grants intended to distribute funds proportionally to grantees based upon a measure of each grantee's share of AIDS cases. Grantees' reports of AIDS cases are used in funding formulas because when the CARE Act was enacted in 1990, most jurisdictions tracked and reported AIDS cases instead of HIV cases.

The CARE Act's reauthorizations in 1996 and 2000 modified the original funding formulas. Prior to the 1996 reauthorization, the CARE Act measured a jurisdiction's caseload by its cumulative count of AIDS cases, which is the number of AIDS cases recorded since reporting began in 1981. The 1996 reauthorization changed the measurement of a jurisdiction's

[1]Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff—300ff–101 (2000). The CARE Act added a new title XXVII to the Public Health Service Act. In general, because Title I of the CARE Act authorized grants to metropolitan areas and Title II authorized grants to states, these programs are referred to as Title I and Title II programs, respectively.

[2]Under Title I, a metropolitan area with a population of at least 500,000 and 2,000 reported AIDS cases in the last 5 calendar years becomes eligible to receive a portion of Title I funding.

caseload to an estimation of the number of living AIDS cases.[3] This switch would have resulted in large shifts of funding away from jurisdictions with a longer history of the disease and a higher proportion of deceased cases than other jurisdictions. The CARE Act includes hold-harmless provisions under Title I and Title II that protect grantees from decreases in funding from one year to the next. Title I of the CARE Act also includes a grandfather clause for EMAs. A type of hold-harmless itself, this grandfather clause guarantees that once a metropolitan area has become an EMA, it will continue to receive funding under Title I, even if its caseload drops below the threshold for eligibility. The most recent reauthorization of the CARE Act in 2000 maintained these modifications, and it further specified that HIV cases should be used in funding formulas no later than fiscal year 2007. As of June 2005, HIV case counts have not been used to distribute funding under the CARE Act.

A portion of Title II funding is for state AIDS Drug Assistance Programs (ADAP), which provide medications to infected individuals. In fiscal year 2004, Title II base ADAP grants—the ADAP grant given to all states—totaled $728 million, accounting for 36 percent of all CARE Act funding. The programs are administered at the state level and each state is allowed flexibility in determining its program eligibility criteria and the drugs it provides. Some ADAPs establish waiting lists for eligible individuals for a period of time when the ADAP cannot provide covered drugs.

To assist the subcommittee in its consideration of the CARE Act, my testimony provides our preliminary findings on some of the issues we are reviewing for the Chairman and other requesters. My remarks today will focus on selected provisions of the CARE Act and ADAP. Specifically, I will discuss

1. the impact of CARE Act provisions on the distribution of funds that is based upon the number of AIDS cases in metropolitan areas,

2. the impact of the CARE Act's hold-harmless provisions and a grandfather clause on the distribution of funds,

[3]HRSA calculates a jurisdiction's estimated living AIDS cases by using data from the Centers for Disease Control and Prevention on the reported AIDS case counts for the last 10 years and weighting those numbers to account for the likelihood of deaths. We used this estimate in our analyses of CARE Act funding formula allocations, and we refer to this measure as the number of AIDS cases in our discussion of these analyses.

3. the potential shifts in funding among grantees if HIV case counts had been incorporated in fiscal year 2004 funding formulas, and

4. the variation in eligibility criteria and funding sources among the state ADAPs.

To address these issues and those within our broader review of the CARE Act, we interviewed officials from HRSA and the Centers for Disease Control and Prevention (CDC). CDC collects HIV and AIDS case counts from states and territories. We also interviewed officials from the National Alliance of State and Territorial AIDS Directors. We obtained and analyzed data from HRSA regarding the distribution of CARE Act funding and from CDC regarding AIDS and HIV case counts.[4] We obtained and analyzed HIV case counts from those states from which CDC does not accept these data because they do not use names to identify the cases. CDC and the states provided us with case counts that were available as of June 30, 2003, the cutoff date for data used to determine fiscal year 2004 funding. HRSA provided us with CARE Act funding distributions for fiscal year 2004.[5] Based on the information HRSA, CDC, and the states provided regarding its verification of the reliability of these data, we determined these data to be sufficiently reliable for the purposes of our analyses. We performed our work from July 2004 through June 2005 according to generally accepted government auditing standards. CDC and HRSA provided comments on the facts contained in this statement, and we made changes as appropriate.

In brief, our analysis shows that certain CARE Act Title I and Title II provisions related to the distribution of funds to metropolitan areas result in variability between the amounts of funding per case among grantees. States and territories that have EMAs within their borders receive more funding per estimated living AIDS case than those without EMAs because cases within EMAs are counted twice—once to determine Title I funding to EMAs, and once again to determine a state's Title II grant. Metropolitan areas that have been affected by the epidemic but do not have the necessary number of AIDS cases to become EMAs and receive Title I funding may qualify for funding as Emerging Communities under Title II.

[4]The HIV case counts were calculated by subtracting the number of reported deaths among HIV cases from the number of reported HIV cases.

[5]Our analyses include CARE Act funding and programs in the 50 states, the District of Columbia, and Puerto Rico.

However, the allocation of these grants is made by separating eligible jurisdictions into two tiers based on their reported number of AIDS cases. Because one half of the total Emerging Communities grant award is allocated to each tier regardless of how many cases are in each tier, in fiscal year 2004 jurisdictions in one tier received $1,052 per case while jurisdictions in the other tier received $313 per case.

The hold-harmless provisions under Titles I and II and the grandfather clause for EMAs under Title I sustain the funding and eligibility of CARE Act grantees on the basis of a previous year's measurements of the number of AIDS cases in these jurisdictions. By guaranteeing either a certain percentage of previous years' funding amounts or an EMA's eligibility to receive funding, these provisions make it more difficult for CARE Act funding to track the most current distribution of the epidemic. The San Francisco EMA has primarily benefited from Title I's hold-harmless provision, receiving over 90 percent ($7,358,239) of the fiscal year 2004 Title I hold-harmless funding. San Francisco's current hold-harmless funding can be traced to its 1995 base grant, which was determined using the cumulative number of AIDS cases, living and dead, reported since 1981. In essence, deceased cases are still being used to determine funding for San Francisco. Hold-harmless provisions under Title II also sustain a state's level of funding based on case counts from previous years. Because funding for one of these Title II hold-harmless provisions is drawn from a set-aside for states with a severe need for drug assistance, this hold-harmless provision could affect the amount of funding received by these severe-need states in the future. The grandfather clause in Title I maintained the funding for 29 of the 51 EMAs that became eligible for Title I base grants in the past. These EMAs, however, would not have qualified for Title I base grants in fiscal year 2004 based upon their case counts, which were below the eligibility threshold of 2,000 reported AIDS cases in the last 5 calendar years.

If the HIV case counts from state reporting systems had been used with estimated living AIDS cases in allocating fiscal year 2004 Title II base funding, about half of the states would have received increased funding and the other half would have received decreased funding. Using two different approaches, we found that at least 11 of the states with increased funding were located in the South, the region with the highest estimated number of people living with HIV or AIDS in 2003. All states have established HIV case reporting systems, and the 2000 reauthorization of the CARE Act required that HIV cases be used in determining formula funding no later than fiscal year 2007. However, wide differences between states' HIV case reporting systems—in their maturity and reporting

methods, for instance—could affect the use of HIV and AIDS case counts to distribute CARE Act funding because an immature reporting system might not capture an accurate count of a state's HIV cases. More mature systems have longer histories of collecting newly diagnosed HIV cases and retroactively reporting HIV cases that had been diagnosed before the reporting system existed. We found that funding would have shifted to jurisdictions with more mature HIV reporting systems, which includes many of the reporting systems in the South. However, changes in funding would be largely offset, at least initially, if the funding formulas included hold-harmless and minimum grant provisions.

There is wide variation among state ADAPs in the eligibility criteria they set for their programs and in the additional funding those programs receive from sources other than their Title II base ADAP grant. States determine what drugs they will cover for their ADAP clients and what income level will make a client eligible for ADAP coverage, among other criteria. States also vary in the amount of funding they receive from other sources in addition to their Title II ADAP base grant. State ADAPs can receive funding from a variety of sources, including transfers from other CARE Act grants and contributions from states, that can lead to a wide range of funding amounts per AIDS case. However, we did not find a relationship between any one factor—a particular income eligibility criterion, for example, or a type of additional funding beyond the base grant—and the existence of a waiting list of ADAP clients that could not be served at a particular time.

Background

Over the course of the last quarter century, the epidemic has spread to every region of the country. HIV and AIDS cases have been reported in all states, the District of Columbia, and U.S. territories, but the impact of the epidemic varies by region and within states. The South is estimated to have the highest cumulative number of diagnosed AIDS cases, people living with AIDS, and deaths from AIDS. In 2003, 7 of the 10 states with the highest estimated rates of individuals living with HIV were located in the South.

The CARE Act was enacted in 1990 to respond to the needs of individuals and families living with HIV or AIDS and to direct federal funding to areas disproportionately affected by the epidemic. Titles I and II of the act provide base funding to affected EMAs and states based on the proportion

of each jurisdiction's caseload of AIDS cases. These titles also establish other types of grants to provide supplemental funding.[6] For example, Title II includes Severe Need grants for states with demonstrated need for supplemental funding to support their ADAPs. Title II also includes funding for emerging communities that are affected by AIDS but do not have the 2,000 AIDS cases reported in the last 5 calendar years in order to be eligible for Title I funding as EMAs. In order to address the impact of the disease on racial and ethnic minorities, Minority AIDS Initiative grants are distributed through both Title I and Title II to EMAs and states.

Metropolitan areas heavily affected by HIV or AIDS have always been recognized within the structure of the CARE Act. We previously found that, with combined funding under Title I and Title II, states with EMAs receive more funding per AIDS case than states without EMAs.[7] To adjust for this situation, the 1996 reauthorization instituted a two-part formula for Title II base funding that takes into account the number of AIDS cases that reside within a state but outside of any EMA's jurisdiction. Under this distribution formula, 80 percent of the Title II base grant is based upon a state's proportion of all AIDS cases, and twenty percent of the allocation is based on the number of AIDS cases within that state's borders but outside of EMAs. A second provision included in 1996 protected the eligibility of EMAs. The 1996 CARE Act amendments provided that once a jurisdiction is designated an EMA, that jurisdiction is "grandfathered" so it will always receive some amount of funding under Title I even if its reported number of AIDS cases drops below the threshold for eligibility. Hold-harmless provisions and the grandfather clause were maintained in the 2000 reauthorization of the CARE Act. Table 1 describes selected CARE Act formula grants for Titles I and II.

[6]There are supplemental grants under Title I that are determined by a competitive application process. For purposes of this testimony, these Title I supplemental grants were not included.

[7]See GAO, *Ryan White CARE Act of 1990: Opportunities Are Available to Improve Funding Equity*, GAO/T-HEHS-95-126 (Washington, D.C.: Apr. 5, 1995). See also related GAO products at the end of this statement.

Table 1: Description of Selected CARE Act Title I and Title II Formula Grants

Formula grant	Eligible grantees	Distribution	Minimum grant	Hold-harmless provision[a]
Title I Base Grant	Jurisdictions with 500,000 or more in population and with 2,000 reported AIDS cases in the most recent 5 calendar years become, and remain, EMAs	Distributed among all EMAs based on proportion of all AIDS cases	No	Grant annually declines to 98%, 95%, 92%, and 89% of the base year grant, respectively.[b] In fifth and all subsequent years, EMA receives 85% of base year grant.
Title II Base Grant	All 50 states, the District of Columbia, and U.S. territories	Eighty percent of base grant divided among states/territories based upon their proportion of all AIDS cases. Twenty percent of base grant is divided among states/territories based upon proportion of all AIDS cases that are located outside the EMAs within the states'/territories' borders.	For states with less than 90 AIDS cases, $200,000; states with 90 or more AIDS cases, $500,000; for territories, $50,000	Base formula grant declines by 1% per year from the fiscal year 2000 award. In fifth and subsequent years of provision, grant remains at 95% of 2000 appropriation.
Title II ADAP Base Grant	All 50 states, the District of Columbia, and U.S. territories	Distributed among all states/territories according to their proportion of all AIDS cases	No	Grant declines by 1% per year from the fiscal year 2000 grant. In fifth and subsequent years of provision, funding remains at 95% of 2000 grant.
Title II ADAP Severe Need Grant[c]	States and territories demonstrating a severe need that prevents them from providing medications to clients in a manner consistent with Public Health Service guidelines	Distributed among all qualifying states/territories based upon their proportion of AIDS cases in all qualifying states/territories; eligible states/territories must also agree to match 25% of their Severe Need grant	No	No
Title II Emerging Communities Grant	Jurisdictions with more than 50,000 in population, not eligible for Title I, and with 500-1,999 reported AIDS cases in the most recent 5 calendar years	Funds are divided into two tiers: 50% distributed among communities with 1,000-1,999 AIDS cases, and 50% distributed among communities with 500-999 AIDS cases, based on their proportion of AIDS cases in Emerging Communities within the tier	Minimum of $5 million for each tier	No

Source: HRSA.

[a]If the distribution formula would otherwise result in decreased funding, a hold-harmless provision may be triggered to mitigate the decrease in funding.

[b]The base year is the fiscal year prior to that in which the provision is triggered.

[c]Funding for Severe Need grants may be reduced to maintain funding for some states under a Title II hold-harmless provision.

The 2000 reauthorization specified that CARE Act Title I and Title II funding formulas should use HIV case counts as early as fiscal year 2005 if such data were available and deemed "sufficiently accurate and reliable" by the Secretary of Health and Human Services (HHS).[8] The 2000 reauthorization also required that HIV data be used no later than the beginning of fiscal year 2007. In June 2004 the Secretary of HHS determined that HIV data were not yet ready to be used for the purposes of allocating formula funding under Title I and Title II of the CARE Act. The Secretary cited a 2004 Institute of Medicine (IOM) report, which identified several limitations in the ability of states to provide adequate and reliable HIV case counts for use in CARE Act formula allocations.[9]

CARE Act Funding Provisions Result in Disproportionate Funding

Some CARE Act provisions have led to jurisdictions receiving different amounts of funding per AIDS cases. The counting of AIDS cases within EMAs once to determine Title I funding and once again to determine Title II funding results in states with EMAs receiving more funding per AIDS case than states without an EMA. In addition, Emerging Communities grants are awarded to eligible communities that are separated into two tiers based on each community's AIDS cases reported in the most recent 5 calendar years. Because one half of the total Emerging Communities grant award is allocated to each tier regardless of the total number of reported AIDS cases in each tier, a disproportionate amount of funding per case was distributed among the grantees in fiscal year 2004.

Counting AIDS Cases within EMAs Twice Results in Unequal Funding per Case Across States

States with EMAs receive more funding per AIDS case than jurisdictions without EMAs because cases within EMAs are counted twice. The number of AIDS cases used to allocate CARE Act Title I base grants for EMAs is also used in the allocation of 80 percent of Title II base grants for states. The remaining 20 percent is based on the number of AIDS cases in each state outside of any EMA. This 80/20 split was established by the CARE Act's 1996 amendments to address the fact that states with EMAs received more funding per case than states without EMAs. However, even with the 80/20 split, states with EMAs still receive more funding per AIDS case. States without an EMA receive no funding under the Title I distribution,

[8]42 U.S.C. § 300ff-13(a)(3)(D)(i)(2000).

[9]Institute of Medicine of the National Academies, *Measuring What Matters: Allocation, Planning, and Quality Assessment for the Ryan White CARE Act* (Washington, D.C.: The National Academies Press, 2004).

and thus, when total Title I and Title II CARE Act funds are considered, states with EMAs receive more funding per AIDS case. [10] Appendix I shows the combined fiscal year 2004 funding for all Title I and Title II funding received by each state.

Table 2 illustrates the effect of counting EMA cases twice by comparing the relationship between the percentage of a state's AIDS cases that are within an EMA's jurisdiction and the amount of funding a state receives per AIDS case. Table 2 shows that as the percentage of a state's AIDS cases within EMAs increases, the total Title I and II funding per AIDS case also increases for the state. For example, states with no AIDS cases in EMAs received on average $3,592 per AIDS case. States with 75 percent or more of their cases in EMAs received on average $4,955 per AIDS case, or 38 percent more funding than states with no EMA. If the total Title I and Title II funding had been distributed equally per AIDS case among all grantees, each state would have received $4,782 per AIDS case.

Table 2: Total CARE Act Title I and II Funding per AIDS Case, Fiscal Year 2004

Percentage of state's AIDS cases in EMAs	Average funding per AIDS case[a]
None	$3,592
Less than 50 percent	3,954
50 to 75 percent	4,717
75 percent or more	4,955

Source: GAO analysis of HRSA data.

[a]In order to isolate the effect of counting AIDS cases in EMAs twice, we excluded from our analyses the nine states and six territories that received minimum Title II base grant awards. Under Title II, states with less than 90 cases receive no less than $200,000 in Title II base grant and states with 90 or more cases receive at least $500,000.

The impact of counting EMA cases twice is that states with similar numbers of AIDS cases can receive different levels of combined Title I and Title II funding. For example, for fiscal year 2004 funding, Connecticut had 5,363 AIDS cases while South Carolina had 5,563 AIDS cases. However,

[10]For EMAs that cross state boundaries, we estimated the amount of funding received by each state. Using data obtained from HRSA, we calculated the number of AIDS cases from each state in these EMAs. We then calculated the percentage of AIDS cases in each state and allocated the EMA funding to each state based on this percentage. For example, approximately 96 percent of the cases in the Boston EMA are in Massachusetts and 4 percent are in New Hampshire. Consequently, we allocated 96 percent of the Boston EMA's funding to Massachusetts and 4 percent to New Hampshire.

Connecticut had two EMAs that accounted for 91.3 percent of its cases while South Carolina had none. Connecticut received $26,797,308 ($4,997 per AIDS case) in combined Title I and Title II funding while South Carolina, with 200 more cases, received $20,705,328 ($3,722 per AIDS case). Connecticut received 29 percent more funding than South Carolina, a difference of $6,091,980, or $1,275 per AIDS case.

The Tiered Allocation of Title II Funds for Emerging Communities Results in Funding Disparities Among States

The two-tiered division of Emerging Communities grants results in disparities in funding per case among states. In addition to the base grants for states, Title II provides a minimum of $10 million in supplemental grants to states for communities with populations greater than 50,000 that have a certain number of AIDS cases in the last 5 calendar years. The funding is equally split so that half the funding is divided among the first tier of communities with 500 to 999 reported cases in the most recent 5 calendar years while the other half is divided among a second tier of communities with 1,000 to 1,999 reported cases in that period. The funding is then allocated within each tier by the proportion of reported cases in the most recent 5 calendar years in each community.

In fiscal year 2004, the two-tiered structure of Emerging Communities funding led to large differences in funding per case because the total number of AIDS cases in each tier was not equal. Twenty-nine communities qualified for Emerging Communities grants in fiscal year 2004. Four of these communities had between 1,000 and 1,999 reported cases and 25 communities had between 500 and 999 cases. This meant that 4 communities with a total of 4,754 reported cases split $5 million while 25 communities with a total of 15,994 cases split the remaining $5 million. This resulted in the 4 communities receiving $1,052 per reported case while the other 25 received $313 per reported case. These 4 communities received 236 percent more funding per case than the other 25. If the total $10 million Emerging Communities funding had been distributed equally per case among the communities, each would have received $482 per reported case. Table 3 lists the 29 emerging communities along with their AIDS case counts and funding.

Table 3: Title II Emerging Communities in Fiscal Year 2004

State	Metropolitan area	AIDS cases reported in the most recent 5 calendar years	Emerging Communities funding per AIDS case reported in the most recent 5 calendar years
Tenn.	Memphis	1,588	$1,052
Tenn.	Nashville	1,123	1,052
La.	Baton Rouge	1,038	1,052
Ind.	Indianapolis	1,005	1,052
S.C.	Columbia	972	313
N.C.	Charlotte	875	313
Del.	Wilmington	801	313
Va.	Richmond	783	313
N.C.	Raleigh-Durham-Chapel Hill	775	313
Miss.	Jackson	722	313
Ky.	Louisville	705	313
N.Y.	Rochester	681	313
Fla.	Fort Pierce-Port St. Lucie	636	313
N.C.	Greensboro—Winston-Salem	617	313
Ala.	Birmingham	615	313
Okla.	Oklahoma City	608	313
Pa.	Pittsburgh	602	313
Mass.	Springfield	588	313
N.J.	Monmouth-Ocean	582	313
N.Y.	Buffalo-Niagara Falls	581	313
S.C.	Greenville	560	313
Ohio	Columbus	558	313
Wisc.	Milwaukee	558	313
Utah	Salt Lake City	555	313
Fla.	Sarasota	539	313
S.C.	Charleston	538	313
Ohio	Cincinnati	517	313
Fla.	Daytona Beach	514	313
R.I.	Providence	512	313
	Total	**20,748**	

Sources: GAO analysis of HRSA data.

Note: The 5 most recent calendar years are from 1998-2002.

Hold-Harmless Provisions and Grandfather Clause Benefit Certain Grantees

Titles I and II of the CARE Act both contain provisions that benefit certain grantees by protecting their funding levels. Title I has a hold-harmless provision that guarantees that the Title I base grant allocated to an EMA will be at least as large as a legislated percentage of a previous year's funding. The Title I hold-harmless provision has primarily benefited one EMA. Title I also contains a grandfather clause that has resulted in a large number of EMAs maintaining funding despite no longer meeting the eligibility criteria. One hold-harmless provision for Title II ensures that the total of Title II and ADAP base grants awarded to a state will be at least as large as the total of these grants it received the previous year. This provision has had little impact thus far, but it has the potential to reduce the amount of funding to states with severe need in ADAPs because it is funded out of amounts reserved for that purpose. The hold-harmless provision and the grandfather clause in Title I and the hold-harmless provisions in Title II protect grantees from decreases in funding from one year to the next, but they also make it more difficult to shift funding in response to geographic movement of the disease.

Title I Hold-Harmless Provision Has Primarily Benefited One EMA

In fiscal year 2004, the Title I hold-harmless provision primarily benefited the San Francisco EMA. The hold-harmless provision guarantees each EMA a specified percentage, as legislated by the CARE Act, of the base grant it received in a previous year regardless of how much a grantee's caseload may have decreased in the current year. An EMA's base funding is determined according to its proportion of AIDS cases. If an EMA qualifies for hold-harmless funding, that amount is added to the base funding and distributed together as the base grant. The San Francisco EMA received $7,358,239 in hold-harmless funding, or 91.6 percent of the hold-harmless funding that was distributed. The second largest beneficiary was Kansas City, which received $134,485, or 1.7 percent of the hold-harmless funding. Table 4 lists the fiscal year 2004 hold-harmless beneficiaries.

Table 4: Title I Hold Harmless Funding, Fiscal Year 2004

EMA	Hold-harmless funding	Percentage of hold-harmless funding	Hold-harmless funding per AIDS case	Base grant per AIDS case[a]	Percent of base grant due to hold-harmless funding
San Francisco, Calif.	$7,358,239	91.6%	$1,020	$2,241	45.5%
Kansas City, Mo.	134,485	1.7	104	1,325	7.8
Santa Rosa, Calif.	22,614	0.3	47	1,268	3.7
Sacramento, Calif.	36,456	0.5	29	1,251	2.3
Minneapolis-St.Paul, Minn.	33,770	0.4	27	1,248	2.1
Bergen-Passaic, N.J.	55,288	0.7	26	1,248	2.1
Jersey City, N.J.	58,310	0.7	24	1,245	1.9
Oakland, Calif.	50,744	0.6	18	1,239	1.4
New Haven, Conn.	42,573	0.5	14	1,236	1.2
Tampa-St. Petersburg, Fla.	44,908	0.6	12	1,233	0.9
San Jose, Calif.	12,097	0.2	11	1,232	0.9
Boston, Mass.	60,284	0.8	10	1,231	0.8
Nassau-Suffolk, N.Y.	21,212	0.3	8	1,230	0.7
Middlesex-Somerset-Hunterdon, N.J.	8,315	0.1	7	1,228	0.5
Jacksonville, Fla.	12,825	0.2	6	1,228	0.5
San Juan, P.R.	41,011	0.5	6	1,228	0.5
Seattle, Wash.	9,844	0.1	4	1,225	0.3
Denver, Colo.	6,745	0.1	3	1,225	0.3
Cleveland, Ohio	4,616	0.1	3	1,224	0.2
West Palm Beach, Fla.	8,523	0.1	2	1,224	0.2
Newark, N.J.	10,975	0.1	2	1,223	0.1
All Other EMAs	0	0	0	1,221	0.0
Total	**$8,033,563[b]**	**100.0%**			

Source: GAO analysis of HRSA data.

Note: An EMA's base funding is determined according to its proportion of AIDS cases. If an EMA qualifies for hold-harmless funding, that amount is added to the base funding and distributed together as the base grant.

[a]This was calculated by dividing the base formula funding received by each EMA by the number of AIDS cases in the EMA. However, because of rounding error, some of the calculations are slightly different than if the base formula funding per AIDS case without a hold-harmless benefit ($1,221) is added to the hold-harmless funding per AIDS case.

[b]Individual entries do not sum to total because of rounding.

The funding impact of the hold-harmless provision varies among the EMAs that benefit but it can be substantial. In order to place hold-harmless

funding in perspective, it is helpful to consider how much of an EMA's Title I base grant was made up of hold-harmless funding. EMAs that did not receive hold-harmless funding received approximately $1,221 in base grant funding per AIDS case. Fiscal year 2004 base grant funding per AIDS case in EMAs that received hold-harmless funding ranged from $1,223 (Newark) to $2,241 (San Francisco). Thus, San Francisco received $1,020 more in base grant funding per AIDS case than did EMAs that did not receive hold-harmless funding. This hold-harmless funding represents approximately 46 percent of San Francisco's base grant. Because of its hold-harmless funding, San Francisco, which had 7,216 AIDS cases in fiscal year 2004, received a base grant equivalent to what an EMA with approximately 13,245 AIDS cases (84 percent more) would have received based on the proportion of cases. Kansas City, the second largest hold-harmless grantee, received about what an EMA with 9 percent more AIDS cases would have received.

The San Francisco EMA's 2004 hold-harmless funding was linked to cumulative AIDS cases used to determine fiscal year 1995 funding. In fiscal year 2004 San Francisco was guaranteed to receive 89 percent of its fiscal year 2000 Title I base grant, but San Francisco's 2000 allocation was also held harmless under the 1996 CARE Act reauthorization. Under the 1996 reauthorization, EMAs were guaranteed 95 percent of their 1995 base grant in fiscal year 2000.[11] San Francisco was the only EMA to qualify for hold-harmless funding in 2000 because it was the only EMA that would have received less than 95 percent of its fiscal year 1995 base grant. This means that in fiscal year 2004 San Francisco was guaranteed approximately 85 percent of its fiscal year 1995 base grant of $19,126,679.[12] Prior to the 1996 reauthorization, funding was distributed among EMAs on the basis of the cumulative count of diagnosed AIDS cases (that is, all cases reported in an EMA both living and deceased since the beginning of the epidemic in 1981). Because the application of the Title I hold-harmless provision for San Francisco dates back to the 1996 reauthorization, San Francisco's

[11]The amounts guaranteed in the Title I hold-harmless provisions differed in the 1996 and 2000 CARE Act reauthorizations. In the 1996 reauthorization the guaranteed amounts ranged from 95 to 100 percent of the 1995 base grant. In the 2000 reauthorization the guaranteed amounts ranged from 85 to 98 percent of the 2000 base grant.

[12]The guaranteed amount is calculated by multiplying the two percentages (89 and 95) together. In other words, in fiscal year 2004 San Francisco was guaranteed to receive at least 89 percent of its fiscal year 2000 Title I base grant. Its fiscal year 2000 Title I base grant was guaranteed to be no less than 95 percent of its fiscal year 1995 Title I base grant.

Title I base grant is determined in part by the number of cumulative cases in the San Francisco EMA as of 1995.

Grandfathering Maintains Eligibility for EMAs That No Longer Meet Certain Eligibility Criteria

More than one half of the EMAs received Title I funding in fiscal year 2004 even though they were below Title I eligibility thresholds.[13] These EMAs' eligibility was protected under a CARE Act grandfather clause. Under a grandfather clause established by the 1996 amendments to the CARE Act, once a metropolitan area's eligibility is established, the area remains eligible for Title I funding even if the number of reported cases in the most recent 5 calendar years drops below the statutory threshold. We found that in fiscal year 2004, 29 of the 51 EMAs did not meet the eligibility thresholds, but their Title I funding was protected by a grandfather clause (see table 5). The number of reported AIDS cases in the most recent 5 calendar years in the 29 EMAs ranged from 223 to 1,941. Title I funding awarded to these 29 EMAs was about $116 million, or approximately 20 percent of the total Title I funding.

[13]To be eligible for Title I funding, an area must have reported more than 2,000 AIDS cases during the most recent 5 calendar years and have a population of at least 500,000. These criteria differ from those used to calculate funding allocations, which are determined using the number of AIDS cases. AIDS cases are calculated by applying annual national survival weights to the most recent 10 years of reported AIDS cases and adding the totals from each year. In the 1990 CARE Act, EMAs were defined as a metropolitan area with a cumulative count of more than 2,000 AIDS cases or a cumulative count of AIDS cases that exceeded one-quarter of one percent of its population.

Table 5: Grandfathered EMAs, Fiscal Year 2004

EMA	Number of AIDS cases reported in the most recent 5 calendar years	Total Title I funding
Riverside-San Bernardino, Calif.	1,941	$6,823,183
New Haven, Conn.	1,717	7,069,348
Oakland, Calif.	1,633	6,611,607
Nassau-Suffolk, N.Y.	1,560	5,951,789
Norfolk, Va.	1,502	4,820,201
Seattle, Wash.	1,459	5,842,615
Jacksonville, Fla.	1,423	4,863,093
Orange County, Calif.	1,422	5,233,329
St. Louis, Mo.	1,247	4,371,154
Jersey City, N.J.	1,226	5,884,194
Las Vegas, Nev.	1,182	4,473,401
Denver, Colo.	1,167	4,529,097
Austin, Tex.	1,149	3,800,250
Bergen-Passaic, N.J.	1,067	4,814,704
Hartford, Conn.	1,059	4,552,237
San Antonio, Tex.	1,034	3,833,443
Cleveland, Ohio	970	3,486,936
Portland, Oreg.	937	3,567,475
Fort Worth, Tex.	854	3,373,450
Kansas City, Mo.	822	3,240,813
Minneapolis, Minn.	794	3,093,915
Sacramento, Calif.	717	2,968,051
Ponce, P.R.	710	2,718,331
Middlesex-Somerset-Hunterdon, N.J.	682	2,723,697
San Jose, Calif.	656	2,656,550
Caguas, P.R.	411	1,816,647
Dutchess County, N.Y.	255	1,231,242
Vineland-Millville-Bridgeton, N.J.	238	847,898
Santa Rosa, Calif.	223	1,107,428
Total		**$116,306,348**

Source: GAO analysis of CDC and HRSA data.

Note: The 5 most recent calendar years are from 1998-2002.

As discussed earlier, some metropolitan areas are designated as emerging communities because their caseloads are not large enough to make them eligible for Title I funding as EMAs. However, some emerging communities had more reported AIDS cases in the last 5 years than some of the EMAs that have been grandfathered.[14] For example, for fiscal year 2004 Memphis, a designated emerging community, had 1,588 reported AIDS cases during the most recent 5 calendar years, which is more than the number of cases reported in 26 EMAs. This results in variability in funding per case caused by grandfathering EMAs.

Title II Hold-Harmless Funding Could Diminish ADAP Severe Need Grants in the Future

A Title II hold-harmless provision could diminish ADAP Severe Need grant amounts in the future because the provision and the grants are funded from the same set-aside of funds. If larger amounts are needed to fund the hold-harmless provision in the future, the Severe Need grant states could get less than the grant amounts they would otherwise receive.

Fiscal year 2004 was the first time that any states triggered this Title II hold-harmless provision, which was established by the 2000 amendments. Severe Need grants are funded by setting aside three percent of the total CARE Act Title II funding for ADAPs.[15] The Title II hold-harmless provision, also funded by the 3 percent set-aside for Severe Need grants, guarantees that the total of Title II and ADAP base grants made to a state will be at least as large as the grants made the previous year. In fiscal year 2004 eight states became eligible for this hold-harmless funding. To provide these jurisdictions with hold-harmless funding, HRSA officials told us they used funds from the 3 percent set-aside for Severe Need grants. In 2004, the 3 percent set-aside for Severe Need grants was $22.5 million. Of these funds, $1.6 million, or 7 percent, was used to provide this Title II

[14]Both EMA eligibility and emerging community funding are based on the number of AIDS cases reported in the most recent 5 calendar years.

[15]To be eligible for a Severe Need grant, a state must have met at least one of four eligibility criteria as of January1, 2000. It must have limited (1) the eligibility of ADAP clients to those with incomes at or below 200 percent of the federal poverty level, (2) the number of ADAP clients by using medical eligibility restrictions, (3) the number of antiretroviral drugs covered in its drug formulary, or (4) the number of opportunistic infection medications to less than 10 in its drug formulary. (Opportunistic infections are illnesses such as parasitic, viral, and fungal infections, and some types of cancer, some of which usually do not cause disease in people with normal immune systems.) Having met the eligibility criteria, a state can then apply for the Severe Need grants each year by agreeing to provide the statutorily required 25 percent state match through state funds or in-kind services.

hold-harmless protection. (See table 6.) The remaining $20.8 million, or 93 percent of the set-aside amount, was distributed in Severe Need grants.

Table 6: States that Received Title II Hold-Harmless Funding from Severe Need Set-Aside; Fiscal Year 2004

State	Hold-harmless amount
Arkansas	$23,705
Kansas	22,168
New Mexico	55,171
North Dakota	1,820
Oklahoma	96,423
Tennessee	1,300,502
Utah	119,695
Vermont	128
Total	**$1,619,612**

Source: HRSA.

The potential exists for this Title II hold-harmless provision to diminish the size of Severe Need grants in the future if larger amounts are needed to fund the hold-harmless protections. The total amount of Severe Need grant funds available in fiscal year 2004 to distribute among the eligible states was less than it would have been without the hold-harmless deduction. In fiscal year 2004 not all 25 of the states eligible for Severe Need grants made the required match in order to receive the grant. Consequently, the size of the severe need grants received by each state was not less than what they would have received if all eligible states made the match. In future years, if all of the eligible states make the match, and if there are also states that qualify to receive hold-harmless funds, the Severe Need grant states would get less than the amounts they would have otherwise received.

Funding Impact of Using HIV Case Counts Would Depend on the Adequacy of HIV Reporting Systems and the Number of Reported HIV Cases

If HIV case counts had been used with AIDS case counts in allocating Title II base funding, about half of the states would have received increased funding and the other half would have received less funding.[16] Under the 2000 CARE Act reauthorization, HIV case counts are required to be included in CARE Act funding formulas no later than fiscal year 2007. While all states have established HIV case reporting systems, there are currently characteristics of these systems that limit the use of HIV case counts in the distribution of CARE Act funds. In order to gauge the funding impact of using the data as they currently exist, we developed two theoretical approaches for doing so. Using these two approaches, we found that some fiscal year 2004 Title II base funding would have shifted to southern states if HIV case counts had been used with AIDS case counts in the distribution of funds.[17] We also found that funding would tend to shift to jurisdictions with older HIV reporting systems, regardless of their location. Changes in funding due to the inclusion of HIV cases would be largely offset, at least initially, if the funding formulas retained hold-harmless and minimum grant provisions.

Current HIV Case Reporting Systems Have Limitations for Providing Case Counts for Funding Allocations

In its 2004 report, IOM identified several limitations in the ability of states to provide HIV case counts for use in CARE Act funding allocations.[18] Among these limitations, IOM found that the maturity of HIV case reporting systems varies widely across states. The earliest HIV reporting systems were established in Colorado, Minnesota, and Wisconsin in 1985, while five jurisdictions implemented their systems since 2003. Case reporting systems need time to become fully mature and operational, and it takes time to make practitioners aware of the requirement to report new HIV cases and the methods for doing so. Existing cases also need to be reported and entered into the system. States with newer systems may not have collected and entered data on existing cases, and, consequently, may underreport the number of HIV cases in the state. Underreporting of HIV

[16]We chose Title II base grants to illustrate the effect of using HIV case counts in funding formulas. All of our analyses were conducted using estimated living AIDS cases.

[17]The Census Bureau lists the following jurisdictions as being in the South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

[18]Institute of Medicine of the National Academies, *Measuring What Matters: Allocation, Planning, and Quality Assessment for the Ryan White CARE Act* (Washington, D.C.: The National Academies Press, 2004), pp. 87-134.

cases could result in jurisdictions receiving less funding than they would be entitled to based on the actual number of HIV and AIDS cases.

IOM also found that differences in how states report HIV case counts to CDC could preclude their use in the distribution of CARE Act funds. Some state HIV case reporting systems are name-based while others are code-based. Currently, CDC will only accept name-based case counts.[19] Therefore, state-reported HIV cases that use codes rather than names would not be counted in allocating CARE Act funds, if HIV case counts were used in funding formulas. Twelve states, the District of Columbia, and Philadelphia, PA, have some form of a code-based system rather than a name-based system.[20] CDC does not accept the code-based data principally because methods have not been developed to make certain that a code-reported HIV case is only being counted once across all reporting jurisdictions.[21] Table 7 shows whether state HIV case counts are accepted by CDC and the year in which each state established its HIV reporting system.

[19]CDC has established a set of performance standards for accepting case counts from HIV reporting systems. These standards include that case reporting be complete (greater than or equal to 85 percent of cases are reported) and timely (greater than or equal to 66 percent of cases reported within 6 months of diagnosis) and that evaluation studies demonstrate that the approach used to conduct surveillance must result in accurate case counts (less than or equal to 5 percent of reported cases are duplicates). As of June 2005, CDC has determined that the only systems which have been evaluated that meet these standards use confidential, name-based reporting. Some jurisdictions use codes instead of names to secure the privacy of the individuals being counted.

[20]Pennsylvania has a name-based reporting system for all areas of the state except Philadelphia. The city received special permission to establish a code-based system. Philadelphia implemented such a system in 2004, but it is separate from the Pennsylvania reporting system.

[21]CDC also has other concerns about code-based reporting. For example, code-based reporting places a greater burden on health care providers because submitted codes are frequently incomplete and require extensive follow-up by surveillance personnel with providers to resolve potential duplicate reports on the same person.

Table 7: CDC Acceptance of State HIV Case Counts and Year of Establishment of State HIV Reporting Systems

CDC-accepted		Not accepted	
Alabama (1988)	New Hampshire (2005)[b]	California (2002)	Massachusetts (1998)
Alaska (1999)	New Jersey (1992)	Delaware (2001)	Montana (2000)
Arizona (1987)	New Mexico (1998)	District of Columbia (2001)	Oregon (2001)
Arkansas (1989)	New York (2000)	Hawaii (2001)	Rhode Island (2000)
Colorado (1985)	North Carolina (1990)	Illinois (1999)	Vermont (2000)
Connecticut (2005)[a]	North Dakota (1988)	Maine (1999)	Washington (1999)
Florida (1997)	Ohio (1990)	Maryland (1994)	
Georgia (2004)	Oklahoma (1988)		
Idaho (1986)	Pennsylvania (2002)[c]		
Indiana (1988)	Puerto Rico (2003)		
Iowa (1998)	South Carolina (1986)		
Kansas (1999)	South Dakota (1988)		
Kentucky (2004)	Tennessee (1992)		
Louisiana (1993)	Texas (1999)		
Michigan (1992)	Utah (1989)		
Minnesota (1985)	Virginia (1989)		
Mississippi (1988)	West Virginia (1989)		
Missouri (1987)	Wisconsin (1985)		
Nebraska (1995)	Wyoming (1989)		
Nevada (1992)			

Sources: CDC, IOM, Connecticut, Kentucky, and Philadelphia.

[a]Connecticut established mandatory name-based HIV reporting in 2005. Previously, name-based reporting was only required for pediatric cases.

[b]New Hampshire established mandatory name-based HIV reporting in 2005. Previously, HIV cases could be reported using the patient name, a code, or no identifier at all.

[c]Name-based HIV reporting has been established in all parts of Pennsylvania except Philadelphia. Philadelphia was given permission by the state to establish code-based HIV reporting, and the system began in 2004, but data from Philadelphia are not accepted by CDC.

The Use of HIV Case Counts in Funding Formulas Would Change the Distribution of CARE Act Funds

While we are aware of some of the limitations of HIV data, we used two approaches to examine the potential impact of using HIV cases in addition to AIDS cases on fiscal year 2004 Title II base grant distributions. We conducted this analysis in light of the CARE Act requirement that HIV case counts be used for the distribution of Title I and Title II formula grants no later than fiscal year 2007. Some CARE Act fiscal year 2004 funding would have shifted if HIV and AIDS case counts had been used to allocate the

funds. Our analyses indicate that at most 14 percent of CARE Act Title II base funding would have shifted, with southern states being the primary beneficiaries. Changes could have resulted from the number of reported HIV cases and AIDS cases in each jurisdiction or differences in state HIV case reporting systems. However, many of the funding changes in our model would have been negated if we had applied hold-harmless and minimum grant provisions.

Methodological Approaches Used

We used two approaches to examine the impact of using HIV cases in addition to AIDS cases[22] on funding for Title II base grants in the 50 states, the District of Columbia, and Puerto Rico. We chose Title II base grants to illustrate the effect of using HIV case counts in funding formulas. Under the first approach, we used HIV case counts in addition to AIDS case counts for the 36 jurisdictions from which CDC accepted HIV data.[23] We then supplemented these data with only the AIDS case counts CDC received from the other jurisdictions because CDC does not accept their HIV data. Consequently, for some states and metropolitan areas we used HIV and AIDS case counts, but for others we used only AIDS case counts. This approach reflects the data that would be used if funding allocations were based on the HIV and AIDS case counts currently received by CDC. Under the second approach, we used the same HIV and AIDS case counts for the 36 jurisdictions as our first approach, but supplemented these data with the HIV case counts collected by the other 15 states and the District of Columbia from which CDC did not accept HIV data. We obtained these HIV case counts directly from these jurisdictions. For both approaches, we calculated the percentage of cases in each jurisdiction and estimated the fiscal year 2004 Title II base grant that each would have received. Our initial analyses assume that funding was distributed equally per AIDS case and that there were no hold-harmless or minimum grant provisions. We then estimated the impact of the hold-harmless and minimum grant provisions. Although there are limitations associated with each of the

[22]We used estimated living AIDS cases in these analyses, which is the measure used by HRSA in determining Title II base grants.

[23]In these analyses, Connecticut, Kentucky, and New Hampshire are classified as not having their HIV case counts accepted by CDC. Our analyses were conducted using fiscal year 2004 allocations, which were based on case reports as of June 30, 2003. At that time, Connecticut had name-based HIV reporting for only pediatric cases, but established name-based reporting for all cases in 2005. Kentucky had code-based reporting at that time and established name-based reporting in 2004. New Hampshire established mandatory name-based reporting in 2005, but previously accepted reports using the patient name, a code, or no identifier.

approaches, they indicate the general impact of using HIV and AIDS cases to distribute all CARE Act formula funding.

Impact on Title II Base Grants

Both approaches indicated that there would be some shifting of funds if HIV and AIDS case counts had been used to allocate CARE Act Title II base grants, with southern jurisdictions generally being among the areas that would have received increased funding. Under the first approach—using HIV and AIDS cases from 36 jurisdictions and only AIDS cases from 16 jurisdictions—about 14 percent or $38.9 million of Title II base grants would have shifted among grantees. Twenty-seven grantees would have received additional funding in their Title II base grants if HIV and AIDS cases had been used to allocate funding instead of just AIDS cases. Of the 27 that would have received more funding, 12 were in the South. Jurisdictions outside the South that would have received more funding include Colorado, New Jersey, and Ohio. All 3 would have each received more than $2 million in additional funding. Funding increases would have ranged from less than $50,000 in Iowa to almost $5 million in North Carolina, or from less than 5 to almost 100 percent. Twenty-five grantees would have received less funding. California, Georgia, and Illinois would have received the largest decreases in Title II base grants. Decreases would have ranged from about $100,000 in Idaho and Wyoming to almost $12 million in California. Percentage decreases would have ranged from less than 5 percent in New York to almost 80 percent in Montana.

The second approach — including the code-based HIV counts — yields a smaller shift in funding. Under this approach, approximately 10 percent or $28.4 million of fiscal year 2004 Title II base grants would have shifted. Of the 26 grantees that would have received additional funding, 11 are in the South. Funding increases for the 26 grantees that would have received additional funding would have ranged from less than $50,000 in Maine to about $4 million in North Carolina, or from 5 percent in Washington to 80 percent in Colorado. Among the states benefiting from this funding approach, Maryland, North Carolina, and Virginia would each have received increases of more than $2 million. Twenty-six grantees would have received less funding. California, New York, and Georgia, would have received the largest decreases. Decreases would have ranged from less than $50,000 in Iowa to $5 million in California. Percentage decreases would have ranged from less than 5 percent in Florida, Illinois, New Mexico, and Utah to 65 percent in North Dakota. Appendix II shows the results of these analyses for each state.

Differences in Case Reporting Systems Would Affect Distributions

One explanation for the changes in funding allocations when HIV and AIDS cases are used instead of only AIDS cases is the maturity of state HIV case reporting systems. We found that those states that would benefit from the use of HIV cases tend to be those with the oldest HIV case reporting systems. Those states with the oldest reporting systems include 11 southern states whose HIV reporting systems were implemented prior to 1995. As shown in table 8, states with long histories of collecting HIV case counts tend to have many more HIV cases compared with their number of AIDS cases than do states with less mature reporting systems. This is likely because states with newer systems do not have reports on many cases of HIV diagnosed before their reporting systems were established.[24] This can be illustrated by comparing Wisconsin and Delaware, 2 states with similar numbers of AIDS cases. Wisconsin began reporting HIV cases in 1985 while Delaware began in 2001. As of June 2003, the 909 reported HIV cases in Delaware was about 40 percent less than the 1,518 reported AIDS cases. In Wisconsin, there were about 50 percent more reported HIV cases and AIDS cases, or 2,287 HIV cases and 1,507 AIDS cases. This variability could be reduced as Delaware identifies more preexisting HIV cases. However, the variability between HIV cases and AIDS cases would remain if there was a difference in the actual number of HIV cases.

Table 8: Comparison of Reported HIV and AIDS Cases as of June 2003

HIV case reporting system start date	Number of states[a]	Ratio of HIV cases to AIDS cases
1985-1991	21	1.42
1992-1998	11	1.01
1999-2002	17	.68

Source: GAO analysis of CDC, HRSA, and state data.

[a]Georgia and Puerto Rico implemented their HIV reporting systems after 2002. Kentucky changed from a code-based to a name-based system in 2004 and was unable to provide HIV case data. In this table, Connecticut is classified as having established its reporting system in 2001 (and so is included in the 1999-2002 time period) since state officials provided us HIV case counts based on the system in operation as of June 2003. In this table, New Hampshire is classified as having established its reporting system in 1990 (and so is included in the 1985-1991 time period) because state officials provided us HIV case counts based on the system in operation as of June 2003.

[24]Other factors may also affect the ratio of HIV to AIDS cases in a reporting system. For example, some states with newer reporting systems were among the first to be affected by the HIV epidemic. This could mean that in those states there are relatively more AIDS cases and the ratio of HIV to AIDS cases would be lower than in states more recently experiencing an HIV epidemic.

Under either approach, jurisdictions that would receive increased funding allocations because of the use of HIV and AIDS case counts might do so because other jurisdictions did not yet have an accurate measure of HIV case counts. The larger the proportion of HIV cases within the total number of HIV and AIDS cases in a jurisdiction, the more a jurisdiction would benefit from the use of HIV cases in funding allocations. However, this increased funding could simply be the effect of a state's older reporting system, and not necessarily due to actual differences in the number of HIV cases. IOM has reported that it could take from 18 months to several years after the implementation of an HIV reporting system before there would be valid estimates of the number of people living with HIV. However, table 8 suggests that it could take even longer to get accurate case counts. The data in table 8 suggest that as an HIV case reporting system matures, it will record a higher ratio of HIV cases to AIDS cases. One state official we spoke with said that it could take 5 to 6 years before a reporting system's HIV case counts were complete.

Changes in Funding Would be Limited Initially if Certain Formula Provisions Were Maintained

Changes in funding caused by shifting to HIV cases and AIDS cases would be negated, at least initially, if the current hold-harmless or minimum grant amounts were maintained. Consider the situation in which a state received $2 million in its Title II CARE Act base grant award based on its AIDS case count. In the following year, the formula is changed so that HIV and AIDS cases are used to determine funding allocations, and the state is then only entitled to $1 million. However, there is a hold-harmless provision that guarantees the state 98 percent of what it received the previous year. The state would receive 98 percent of its $2 million allocation, or $1.96 million, largely offsetting the reduction in funding due to the shift to HIV and AIDS cases. Minimum award amounts could also affect the impact of using HIV and AIDS counts. If a jurisdiction qualified for $100,000 formula funding using HIV and AIDS case counts, but the minimum award was $500,000, the jurisdiction would not receive less funding because of the change to HIV and AIDS counts.

Under our first approach, 5 percent of Title II base grants would shift among grantees if the hold-harmless and minimum grant provisions were maintained while 14 percent would shift if they were not included. Under our second approach, 4 percent would shift instead of 10 percent. California, which would have had large reductions under both approaches if the hold-harmless provision was not maintained, would have had no change in funding under either approach if the current hold-harmless provisions were maintained. Appendix III shows the results of these analyses for each state.

State ADAP Eligibility Criteria and Funding Sources Vary Widely

Among state ADAP programs, there is wide variation in the eligibility criteria used to determine who is covered for ADAP services and in the funding sources available beyond each state's Title II ADAP base grant. States have flexibility in determining their ADAP program eligibility standards, including the income eligibility ceilings for ADAP clients, caps on spending per client, and the HIV and AIDS drugs included in their formulary. As a result, an individual eligible for ADAP services in one state may not be eligible in another. There is also wide variability in the additional funding sources that ADAPs may receive to help fund their programs. Beyond each state's Title II ADAP base grant for providing HIV and AIDS medications and related services, additional ADAP funding sources may include Title II Severe Need grants, non-federal transfers of Title II state or Title I EMA funds, state contributions, and other funding sources. States with waiting lists for ADAP services do not fit any particular pattern of eligibility criteria and funding sources.

Eligibility Criteria Contribute to Coverage Differences Among States

States set different eligibility criteria for their ADAP programs, so a person with HIV or AIDS at a certain income level and needing medication assistance may be an eligible ADAP client in one state, but not in another. Eligibility also varies among state Medicaid programs, which may provide HIV and AIDS services and drug assistance. The interaction between these two programs can affect which clients are eligible for ADAP services, and many individuals seeking ADAP coverage may not be aware that they are eligible for drug assistance through Medicaid.

One eligibility requirement where there is considerable variation among state ADAPs is the client income ceiling. The income ceilings among 52 state ADAPs for fiscal year 2004 ranged from the most restrictive at 125 percent of the federal poverty level,[25] or $11,638, in North Carolina to the most generous at 556 percent, or $51,764, in Massachusetts. Eleven states had eligibility ceilings at 200 percent or less of the poverty level.

Another eligibility criterion where there is wide variation among state ADAPs is the number of HIV and AIDS drugs covered under a state program's drug formulary. The number of drugs included in ADAP formularies in fiscal year 2004 varied widely from Colorado with 20 drugs

[25]The 2004 Department of Health and Human Services' federal poverty level for a single person was $9,310; the poverty levels are higher for Alaska ($11,630) and Hawaii ($10,700). Poverty level is not defined for Puerto Rico.

to four state ADAPs—Massachusetts, New Hampshire, New Jersey, and Washington—with open drug formularies.[26] Thirty-nine ADAPs had 100 or fewer drugs, including 15 with fewer than 50 drugs on their formularies. The CARE Act allows states to purchase health insurance to cover HIV and AIDS drugs for their clients. HRSA requires an ADAP to demonstrate that the insurance includes coverage for drugs comparable to those on the state's ADAP formulary.[27]

Determining whether an individual is eligible for state ADAP or state Medicaid services is important because the ADAPs serve as the individual's HIV and AIDS drug assistance program of last resort. Medicaid programs provide HIV and AIDS health care services, including medications, to eligible disabled individuals with low incomes. If an individual is eligible for a state's Medicaid drug assistance, the state ADAP should not provide the same services under its program. Twenty-three ADAPs reported requiring clients to have been denied Medicaid eligibility before the ADAP will cover them. To ensure that a prospective or current ADAP client is not eligible to be served by Medicaid, 42 of the 52 state ADAPs reported in ADAP grant year 2004[28] that they used a case manager review process to monitor an ADAP client's Medicaid eligibility, and 40 of the 52 ADAPs also reported using computer access to eligibility determinations to verify a client's Medicaid and ADAP eligibility.

Because it is important to ensure continuing therapy for HIV and AIDS clients once they begin taking medications, states may limit the number of ADAP clients they serve to prevent a budget shortfall. This could result in eligible clients being on an ADAP waiting list. States also use a variety of ADAP eligibility restrictions to limit the number of clients they serve. Of the 52 state ADAPs, 36 reported eligibility restrictions for ADAP grant year 2004, and 20 of the 36 used more than one. The restrictions most used were (1) an annual cap on individual incomes by 20 ADAPs, (2) a limitation on an individual's assets by 16 ADAPs, (3) capping ADAP enrollment by 7 ADAPs, (4) sliding scale copayments paid by individuals by 7 ADAPs, and (5) capping the amount expended per client for all HIV

[26]In the state ADAP profile reports for ADAP grant year 2004, Massachusetts, New Hampshire, and New Jersey each reported having 1,000 drugs on their ADAP formularies, and Washington reported it had 125 drugs on its formulary.

[27]In fiscal year 2003, 20 states reported that they used either funds from their Title II base ($3 million) or ADAP ($23.5 million) grants to purchase health care insurance.

[28]ADAP grant year 2004 covers the period April 1, 2004 through March 31, 2005.

and AIDS drugs by 6 ADAPs. Appendix IV provides a state-by-state summary of the reported restrictions.

A Large Percentage of ADAPs' Funds Received from Sources Other than the ADAP Base Grant

In addition to their Title II ADAP base grants, 46 of the 52 states ADAPs received funding from other sources for their programs in fiscal year 2004. There were five sources of additional funding across these 46 state ADAPs: (1) $20.8 million in Title II Severe Need grants (including $4.5 million in state match funds), (2) $26.9 million from Title II state funding transfers, (3) $10.9 million from Title I EMA funding transfers, (4) $194.8 million in state contributions, and (5) $169.3 million in other funds. When the additional funding source totals are compared among states as a percentage of the ADAP's CARE Act base grant, and as an amount per AIDS case, there is a significant range among the states. Appendix V provides a state-by-state summary of additional ADAP funding and the base grant and per AIDS case comparisons.

State ADAPs that received funding from sources other than their Title II base grant award include

- Sixteen of the 25 states eligible for ADAP Severe Need grants received grant amounts ranging from about $37,000 in Montana to about $6 million in Texas. States eligible for these grants must agree to match 25 percent of the funds.[29]
- Eighteen ADAPs reported receiving transfers from their states' Title II base grants ranging from about $65,000 in Maryland to $12.2 million in California.
- Nine of the 24 states with EMAs reported receiving Title I fund transfers from their EMAs for their ADAPs ranging from more than $65,000 for Nevada to about $6 million for New York.
- Thirty-five ADAPs reported receiving state contributions from their states ranging from about $8,000 in Ohio to about $64 million in California.
- Thirty-two ADAPs reported other funding sources ranging from about $7,000 in Montana to $64.5 million in New York. Other funding sources include additional funds from drug rebates[30] and HRSA approved carryover of ADAP CARE Act funds from one year to the next.

[29]According to HRSA, Puerto Rico is not required to provide matching funds for Severe Need grants.

[30]ADAPs can receive drug rebates through (1) the federal Section 340B drug discount program, (2) their states' negotiated rebates, or (3) the National Alliance of State and Territorial AIDS Directors' negotiated rebates.

Among states with additional funding sources, there is a significant range in amounts per AIDS case and percentages of the ADAP base grants. The highest amount of additional funding received per AIDS case was $3,604, or 171 percent of the base grant in Idaho and the lowest was $61 per AIDS case, or 3 percent of the base grant in the District of Columbia. ADAPs in six states did not receive any additional funding—Iowa, New Hampshire, New Mexico, Tennessee, Utah, and Wyoming.

Eligibility Criteria and Funding Sources Also Vary Among States with Waiting Lists

During fiscal years 2002 through 2004, some states had people eligible for their ADAPs' services on waiting lists and the states with ADAP waiting lists have remained relatively static in fiscal years 2002 through 2004. Sixteen, or about one-third, of the 52 states had ADAP waiting lists for at least 1 month during these 3 years. Seven of the 16 states had ADAP waiting lists in all 3 years. (See table 9.)

Table 9: States with ADAP Waiting Lists in at Least 1 Month of a Fiscal Year, Fiscal Years 2002-04

	State	FY2002	FY2003	FY2004
1	Alabama	•	•	•
2	Alaska		•	•
3	Arkansas			•
4	Colorado		•	•
5	Georgia	•		
6	Idaho		•	•
7	Indiana	•	•	•
8	Iowa			•
9	Kentucky	•	•	•
10	Montana	•	•	•
11	Nebraska		•	•
12	North Carolina	•	•	•
13	Oregon	•	•	•
14	South Dakota	•	•	•
15	West Virginia		•	•
16	Wyoming		•	
Total		**8**	**13**	**14**

Source: HRSA and GAO analysis.

The funding sources and eligibility criteria for states with waiting lists have varied just as considerably as for states without waiting lists, and there is no clear pattern between a state's funding sources or eligibility criteria and the existence of a waiting list. While 33 states that received additional funds did not have an ADAP waiting list in 2004, 13 of the 14 states with waiting lists also received additional funding beyond their ADAP base grant. For example, for

- **Title II Severe Need grants**: Eight of the 16 states that received Severe Need grants had waiting lists. Three of the 9 eligible states that did not apply for Severe Need grants in 2004—Alaska, Iowa, and South Dakota—also had ADAP waiting lists.
- **Title I EMA transfers**: One state ADAP of the nine that received a Title I transfer—Colorado—had an ADAP waiting list.
- **Title II state transfers**: Eight of the 18 ADAPs receiving Title II transfers had waiting lists.
- **State funds**: Nine of the 35 ADAPs that received state funds had waiting lists.
- **Other funding**: Of the 32 ADAPs reporting other funding sources, 10 had ADAP waiting lists.

Of the 14 states with ADAP waiting lists, 5 were among the top 10 for additional funding per AIDS case received—Idaho (1), South Dakota (2), Oregon (3), North Carolina (7), and Colorado (8). The remaining 9 states with waiting lists and their per AIDS case ranks were Montana (12), Alabama (18), Nebraska (23), Indiana (24), West Virginia (28), Kentucky (33), Arkansas (34), Alaska (42), and Iowa with no additional funds.

There also seems to be no clear pattern between eligibility criteria—such as a low income eligibility ceiling or a limited drug formulary—and a waiting list of clients that a state ADAP deems eligible but is unable to serve. For example, for

- **Client income eligibility levels**: North Carolina with the most restrictive level at 125 percent of the poverty level had a waiting list, and Massachusetts with the most generous level at 556 percent had no waiting list.
- **Eligibility restrictions**: Among the seven ADAPs that capped their ADAP enrollment, six had waiting lists. Five ADAPs that capped the amount they expend per client for all HIV and AIDS drugs included two states with waiting lists.
- **Drug formularies**: Among the 39 ADAPs with 100 or fewer drugs on their formularies, 13 had waiting lists.

When eligible clients are on state ADAP waiting lists, there are limited medication assistance options available to help them until they can be served by the ADAP. HRSA officials told us that case managers, who are not ADAP employees, are to assist ADAP-eligible clients in accessing options to act as stopgaps until clients can be provided ADAP services. Among the options are pharmaceutical manufacturers' patient assistance programs that provide free or cost-reduced drugs and non-ADAP pharmacy assistance programs provided by some EMAs using their Title I funds.[31]

Concluding Observations

The services provided under the Care Act have filled important gaps in communities throughout the country, but as Congress reviews this act, we believe it is important to understand how variable this funding can be. Today I have highlighted a few of the issues that are relevant to this review. For each of these issues, we found that the provisions of the CARE Act have impacted the extent to which funds have been distributed in proportion to the incidence of HIV and AIDS. It is clear that the level of funding available per case is quite variable depending upon where an individual lives. The way cases from EMAs are counted twice, the tiered allocation of funds to Emerging Communities, the hold-harmless provisions, and the grandfathering of EMAs have all resulted in considerably more funding going to some communities than others with equivalent numbers of cases. The inclusion of HIV cases in the funding formulas, while improving on the basis for funding allocations by reflecting cases that have not progressed to AIDS, would also result in variable funding depending upon the type and maturity of the reporting system used in each state. In addition, the flexibility given to states to shift funds, establish eligibility criteria, place limits on the medications covered, and cap enrollment, has resulted in great variability for ADAP services depending upon where an individual lives.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

[31]In fiscal year 2003, 33 EMAs in 16 states used $33.3 million of their Title I funds to provide HIV and AIDS pharmaceutical assistance.

Contact and Acknowledgments

For future contacts regarding this testimony, please call Marcia Crosse at (202) 512-7118. Other individuals who made key contributions include Robert Copeland, Louise Duhamel, Cathy Hamann, James McClyde, Opal Winebrenner, and Craig Winslow.

Appendix I: Combined CARE Act Title I and Title II Funding by State, Fiscal Year 2004

State/territory	Combined Title I and Title II awards	AIDS cases	Percent of AIDS cases in EMAs	Total Title I and Title II awards per AIDS case
Alabama	$12,142,447	3,320	0%	$3,657
Alaska[a]	974,705	224	0	4,351
Arizona	18,635,537	3,978	73.5	4,685
Arkansas	4,933,831	1,466	0	3,366
California	223,607,373	42,479	88.9	5,264
Colorado	12,949,158	2,658	75.0	4,872
Connecticut	26,797,308	5,363	91.4	4,997
Delaware	5,340,795	1,518	0	3,518
District of Columbia	33,288,417	6,561	100.0	5,074
Florida	182,771,752	38,101	77.3	4,797
Georgia	54,483,301	11,226	67.6	4,853
Hawaii	3,298,130	988	0	3,338
Idaho[a]	1,019,352	220	0	4,633
Illinois	60,837,359	12,203	87.9	4,985
Indiana	11,402,950	3,095	0	3,684
Iowa	2,067,375	619	0	3,340
Kansas	3,881,999	959	34.2	4,048
Kentucky	7,170,005	1,937	0	3,702
Louisiana	29,740,454	6,555	48.1	4,537
Maine[a]	1,333,909	395	0	3,377
Maryland	61,230,030	12,203	93.6	5,018
Massachusetts	34,432,147	6,960	83.2	4,947
Michigan	24,046,130	5,215	68.8	4,611
Minnesota	7,139,028	1,427	88.7	5,003
Mississippi	9,454,950	2,747	0	3,442
Missouri	16,501,234	3,512	76.8	4,699
Montana[a]	847,196	147	0	5,763
Nebraska	1,887,660	525	0	3,596
Nevada	10,757,214	2,246	83.3	4,789
New Hampshire[a]	1,864,452	358	69.0	5,208
New Jersey	80,222,837	16,531	84.8	4,853
New Mexico	3,338,463	982	0	3,400
New York	298,549,361	59,226	88.6	5,041
North Carolina	22,668,734	6,083	0.1	3,727
North Dakota[b]	292,543	43	0	6,803

State/territory	Combined Title I and Title II awards	AIDS cases	Percent of AIDS cases in EMAs	Total Title I and Title II awards per AIDS case
Ohio	20,249,202	5,171	29.2	3,916
Oklahoma	6,343,022	1,687	0	3,760
Oregon	9,084,990	2,003	68.9	4,536
Pennsylvania	59,766,256	12,840	67.4	4,655
Puerto Rico	53,026,882	10,711	79.9	4,951
Rhode Island	3,189,276	906	0	3,520
South Carolina	20,705,328	5,563	0	3,722
South Dakota[a]	705,706	97	0	7,275
Tennessee	21,178,234	5,080	0	4,169
Texas	118,965,938	23,922	74.5	4,973
Utah	3,235,191	882	0	3,668
Vermont[a]	883,059	181	0	4,879
Virginia	32,149,863	6,872	63.2	4,678
Washington	17,349,313	3,776	69.8	4,595
West Virginia	2,335,062	618	11.3	3,778
Wisconsin	5,603,506	1,507	0.4	3,718
Wyoming[b]	360,347	76	0	4,741

Sources: GAO analysis of HRSA data.

[a]State received a Title II base award of $500,000, the minimum it could receive based on the number of AIDS cases in the state.

[b]State received a Title II base award of $200,000, the minimum it could receive based on the number of AIDS cases in the state.

Appendix II: Estimated Funding Changes Using HIV and AIDS Cases without Hold-Harmless and Minimum Grant Provisions

	Change in Title II case funding if CDC-accepted HIV case counts and AIDS case counts were used to distribute funding		Change in Title II base funding if HIV case counts from all states and AIDS case counts were used to distribute funding	
State/territory	**Dollar change**	**Percent change**	**Dollar change**	**Percent change**
Alabama	$2,480,000	61	$1,950,000	48
Alaska[a]	-270,000	-55	-290,000	-58
Arizona	1,220,000	38	810,000	25
Arkansas	840,000	47	630,000	35
California	-11,790,000	-38	-5,020,000	-16
Colorado	2,090,000	99	1,700,000	80
Connecticut	-1,360,000	-36	-1,420,000	-38
Delaware	-750,000	-41	-230,000	-13
District of Columbia	-1,520,000	-35	-1,800,000	-42
Florida	2,920,000	10	-150,000	-1
Georgia	-3,550,000	-38	-4,090,000	-43
Hawaii	-490,000	-41	-180,000	-15
Idaho[a]	-80,000	-17	-120,000	-24
Illinois	-3,210,000	-36	-70,000	-1
Indiana	1,170,000	31	760,000	20
Iowa	20,000	2	40,000	6
Kansas	210,000	21	-110,000	-11
Kentucky	-960,000	-41	-1,070,000	-45
Louisiana	2,070,000	33	1,340,000	22
Maine[a]	-210,000	-43	40,000	9
Maryland	-3,030,000	-36	3,000,000	35
Massachusetts	-1,920,000	-37	510,000	10
Michigan	1,160,000	27	660,000	15
Minnesota	660,000	64	500,000	49
Mississippi	1,580,000	47	1,180,000	35
Missouri	1,260,000	45	880,000	32
Montana[a]	-390,000	-79	-170,000	-34
Nebraska	140,000	23	80,000	13
Nevada	830,000	50	600,000	35
New Hampshire[a]	-310,000	-63	-122,000	-24
New Jersey	2,510,000	20	1,120,000	9
New Mexico	50,000	4	-60,000	-5
New York	-600,000	-1	-4,640,000	-11

	Change in Title II case funding if CDC-accepted HIV case counts and AIDS case counts were used to distribute funding		Change in Title II base funding if HIV case counts from all states and AIDS case counts were used to distribute funding	
State/territory	Dollar change	Percent change	Dollar change	Percent change
North Carolina	4,910,000	66	3,910,000	53
North Dakota[b]	-124,000	-62	-130,000	-65
Ohio	2,360,000	43	1,700,00	31
Oklahoma	980,000	48	730,000	36
Oregon	-630,000	-38	-290,000	-17
Pennsylvania	-2,370,000	-22	-3,120,000	-29
Puerto Rico	-2,970,000	-36	-3,460,000	-42
Rhode Island	-450,000	-41	-180,000	-16
South Carolina	2,280,000	34	1,540,000	23
South Dakota[a]	-290,000	-58	-310,000	-62
Tennessee	2,160,000	35	1,480,000	24
Texas	840,000	4	-1,010,000	-5
Utah	40,000	4	-50,000	-5
Vermont[a]	-370,000	-74	-260,000	-53
Virginia	3,040,000	51	2,260,000	38
Washington	-1,170,000	-38	160,000	5
West Virginia	170,000	24	90,000	13
Wisconsin	910,000	50	690,000	37
Wyoming[b]	-90,000	-47	-100,000	-51

Sources: GAO analysis of CDC and HRSA data for fiscal year 2004.

Notes: Rounded to nearest $10,000. For this testimony, we chose Title II base grants to illustrate the effect of using HIV case counts in funding formulas.

[a]State received a Title II base award of $500,000, the minimum it could receive based on the number of AIDS cases in the state.

[b]State received a Title II base award of $200,000, the minimum it could receive based on the number of AIDS cases in the state.

Appendix III: Estimated Funding Changes Using HIV and AIDS Cases with Hold-Harmless and Minimum Grant Provisions

	Change in Title II base funding if CDC-accepted HIV case counts and AIDS case counts were used to distribute funding		Change in Title II base funding if HIV case counts from all states and AIDS case counts were used to distribute funding	
State/territory	**Dollar change**	**Percent change**	**Dollar change**	**Percent change**
Alabama	$1,120,000	28	$960,000	24
Alaska[a]	0	0	0	0
Arizona	610,000	19	410,000	13
Arkansas	290,000	17	230,000	13
California	0	0	0	0
Colorado	1,530,000	72	1,340,000	63
Connecticut	-150,000	-4	-150,000	-4
Delaware	-410,000	-22	-410,000	-22
District of Columbia	-940,000	-22	-940,000	-22
Florida	-1,380,000	-5	-2,930,000	-10
Georgia	-1,350,000	-14	-1,350,000	-14
Hawaii	-70,000	-6	-70,000	-6
Idaho[a]	0	0	0	0
Illinois	-1,780,000	-20	-790,000	-9
Indiana	130,000	4	20,000	1
Iowa	-90,000	-11	-90,000	-11
Kansas	0	0	0	0
Kentucky	-400,000	-17	-400,000	-17
Louisiana	660,000	11	370,000	6
Maine[a]	0	0	0	0
Maryland	-1,650,000	-20	2,050,000	24
Massachusetts	-620,000	-12	10,000	0
Michigan	350,000	8	120,000	3
Minnesota	460,000	45	370,000	36
Mississippi	550,000	17	430,000	13
Missouri	710,000	26	530,000	19
Montana[a]	0	0	0	0
Nebraska	-20,000	-3	-40,000	-6
Nevada	520,000	31	390,000	23
New Hampshire[a]	0	0	0	0
New Jersey	600,000	5	0	0
New Mexico	-70,000	-6	-70,000	-6
New York	-1,730,000	-4	-1,730,000	-4

	Change in Title II base funding if CDC-accepted HIV case counts and AIDS case counts were used to distribute funding		Change in Title II base funding if HIV case counts from all states and AIDS case counts were used to distribute funding	
State/territory	Dollar change	Percent change	Dollar change	Percent change
North Carolina	2,340,000	32	2,050,000	28
North Dakota[b]	300,000	150	300,000	150
Ohio	890,000	16	660,000	12
Oklahoma	340,000	17	270,000	13
Oregon	-130,000	-8	-130,000	-8
Pennsylvania	-1,840,000	-17	-1,840,000	-17
Puerto Rico	-320,000	-4	-320,000	-4
Rhode Island	-30,000	-2	-30,000	-2
South Carolina	390,000	6	180,000	3
South Dakota[a]	0	0	0	0
Tennessee	420,000	7	220,000	4
Texas	1,140,000	-6	-1,140,000	-6
Utah	-60,000	-6	-60,000	-6
Vermont[a]	0	0	0	0
Virginia	1,510,000	26	1,200,000	20
Washington	-200,000	-7	-180,000	-6
West Virginia	-13,000	-2	-40,000	-5
Wisconsin	340,000	18	270,000	15
Wyoming[b]	300,000	150	300,000	150

Sources: GAO analysis of CDC and HRSA data for fiscal year 2004.

Notes: Rounded to nearest $10,000. For this testimony, we chose Title II base grants to illustrate the effect of using HIV case counts in funding formulas.

[a]State received a Title II base award of $500,000, the minimum it could receive based on the number of AIDS cases in the state.

[b]State received a Title II base award of $200,000, the minimum it could receive based on the number of AIDS cases in the state.

Appendix IV: ADAP Program Eligibility Restrictions Reported by 52 ADAPs, ADAP Grant Year 2004

	Restrictions						
ADAPs	Capped enrollment	Fixed copayment	Sliding scale copayment	Asset limitation	Annual income cap	Capped HIV/ AIDS expenditures per patient	Capped HIV/ AIDS expenditures or had wait lists or both for protease inhibitor drugs
Alabama							
Alaska							
Arizona							
Arkansas	•				•		
California			•		•		
Colorado	•			•	•		•
Connecticut							
Delaware			•	•			
District of Columbia				•	•		
Florida				•	•		
Georgia				•	•		
Hawaii				•			
Idaho	•					•	
Illinois						•	
Indiana							
Iowa							
Kansas		•					
Kentucky				•	•		
Louisiana				•			
Maine							
Maryland			•		•		
Massachusetts					•		
Michigan							
Minnesota				•	•		
Mississippi					•		
Missouri						•	
Montana	•						
Nebraska							
Nevada				•	•		
New Hampshire							
New Jersey					•		

	Restrictions						
ADAPs	Capped enrollment	Fixed copayment	Sliding scale copayment	Asset limitation	Annual income cap	Capped HIV/ AIDS expenditures per patient	Capped HIV/ AIDS expenditures or had wait lists or both for protease inhibitor drugs
New Mexico				•	•		
New York				•	•		
North Carolina	•						•
North Dakota					•		
Ohio					•		
Oklahoma	•					•	
Oregon			•	•	•		
Pennsylvania					•		
Puerto Rico							
Rhode Island					•		
South Carolina			•				
South Dakota	•					•	
Tennessee				•			
Texas		•					
Utah			•	•			
Vermont							
Virginia							
Washington			•	•			
West Virginia							
Wisconsin							
Wyoming							
Total	**7**	**2**	**7**	**16**	**20**	**5**	**2**

Source: HRSA and state ADAP profile reports.

Note: The ADAP 2004 grant year covers April 1, 2004, through March 31, 2005.

Appendix V: Additional ADAP Funding and its Percentage of the CARE Act Title II ADAP Base Grants and per AIDS Case by State

Table 10: Additional ADAP Funding Sources, Fiscal Year 2004

	Title II Severe Need grant						
State ADAP	ADAP Severe Need grant	State matching funds for Severe Need grant	Title II non-ADAP base grant transfer	Title I EMA transfer	State funding	Other funding sources	Total additional ADAP funding
Alabama	$824,913	$206,228	$0	B	$2,500,000	$0	$3,531,141
Alaska	0	0	0	B	50,000	0	50,000
Arizona	0	0	0	0	1,000,000	78,546	1,078,546
Arkansas	A	A	0	B	330,810	393,000	723,810
California	A	A	12,168,628	0	63,934,245	47,370,750	123,473,623
Colorado	660,427	165,107	136,000	560,254	934,134	3,212,522	5,668,444
Connecticut	A	A	0	0	606,678	0	606,678
Delaware	A	A	0	B	0	832,382	832,382
D.C.	A	A	0	0	400,000	0	400,000
Florida	A	A	1,916,336	0	9,000,000	0	10,916,336
Georgia	2,789,298	697,324	0	1,540,022	11,305,339	0	16,331,983
Hawaii	A	A	0	B	440,535	0	440,535
Idaho	54,663	13,666	261,150	B	163,461	300,000	792,940
Illinois	A	A	0	0	7,000,000	5,619,843	12,619,843
Indiana	A	A	2,720,419	B	0	102,331	2,822,750
Iowa	0	0	0	B	0	0	0
Kansas	A	A	0	B	400,000	550,000	950,000
Kentucky	481,282	120,320	100,000	B	90,000	199,462	991,064
Louisiana	1,628,705	407,176	0	0	0	422,638	2,458,519
Maine	0	0	0	B	57,638	125,327	182,965
Maryland	A	A	65,250	105,925	0	2,100,000	2,271,175
Massachusetts	A	A	0	104,819	747,990	1,900,000	2,788,809
Michigan	A	A	0	0	0	5,500,000	5,500,000
Minnesota	A	A	0	0	1,100,000	2,743,522	3,843,522
Mississippi	A	A	1,093,008	B	750,000	0	1,843,008
Missouri	A	A	771,167	1,549,422	669,000	1,913,547	4,921,136
Montana	36,525	9,131	178,548	B	0	7,120	231,324
Nebraska	130,445	32,611	74,000	B	115,938	160,000	512,994
Nevada	A	A	0	65,250	1,350,947	0	1,416,197
New Hampshire	A	A	0	B	0	0	0
New Jersey	A	A	0	0	0	13,050,000	13,050,000
New Mexico	A	A	0	B	0	0	0

State ADAP	Title II Severe Need grant		Title II non-ADAP base grant transfer	Title I EMA transfer	State funding	Other funding sources	Total additional ADAP funding
	ADAP Severe Need grant	State matching funds for Severe Need grant					
New York	A	A	2,524,145	5,870,000	33,000,000	64,500,000	105,894,145
North Carolina	1,511,429	377,857	0	B	8,355,195	3,338,000	13,582,481
North Dakota	0	0	85,400	B	0	32,000	117,400
Ohio	A	A	0	300,000	7,843	20,000	327,843
Oklahoma	419,165	104,791	486,486	NA	786,000	361,000	2,157,442
Oregon	A	A	0	0	300,000	5,650,000	5,950,000
Pennsylvania	A	A	0	0	10,452,000	6,044,000	16,496,000
Puerto Rico	2,661,337	0[a]	3,455,671	0	2,093,000	0	8,210,008
Rhode Island	A	A	0	B	0	700,000	700,000
South Carolina	1,382,225	345,556	0	B	500,000	0	2,227,781
South Dakota	0	0	330,744	B	0	0	330,744
Tennessee	0	0	0	B	0	0	0
Texas	5,943,843	1,485,961	500,000	0	28,538,504	0	36,468,308
Utah	0	0	0	B	0	0	0
Vermont	0	0	0	B	175,000	130,000	305,000
Virginia	1,707,470	426,867	0	0	2,612,200	0	4,746,537
Washington	A	A	0	800,487	4,842,484	925,000	6,567,971
West Virginia	153,553	38,388	75,000	B	0	180,000	446,941
Wisconsin	374,441	93,610	0	B	186,658	855,317	1,510,026
Wyoming	A	A	0	B	0	0	0
Total	**$20,759,721**	**$4,524,593**	**$26,941,952**	**$10,932,179**	**$194,795,599**	**$169,334,307**	**$427,288,351**

Source: HRSA and GAO analysis.

A State was not eligible for a grant.

B State did not have an EMA.

[a]Puerto Rico is not required to provide match funds.

Table 11: Additional ADAP Funding as Percentage of ADAP Base Grant and per AIDS Case, Fiscal Year 2004

State ADAP	Total additional ADAP funding	ADAP base grant	Total additional ADAP funding as percentage of the ADAP base grant	Total additional ADAP funding per AIDS case
Alabama	$3,531,141	$7,004,635	50%	$1,064
Alaska	50,000	472,602	11%	223
Arizona	1,078,546	8,392,903	13%	271
Arkansas	723,810	3,116,716	23%	494
California	123,473,623	89,623,465	138%	2,907
Colorado	5,668,444	5,607,928	101%	2,133
Connecticut	606,678	11,315,018	5%	113
Delaware	832,382	3,202,722	26%	548
D.C.	400,000	13,842,594	3%	61
Florida	10,916,336	80,386,630	14%	287
Georgia	16,331,983	23,684,951	69%	1,455
Hawaii	440,535	2,084,512	21%	446
Idaho	792,940	464,163	171%	3,604
Illinois	12,619,843	25,746,254	49%	1,034
Indiana	2,822,750	6,529,924	43%	912
Iowa	0	1,305,985	0%	0
Kansas	950,000	2,045,495	46%	991
Kentucky	991,064	4,086,741	24%	512
Louisiana	2,458,519	13,829,935	18%	375
Maine	182,965	833,383	22%	463
Maryland	2,271,175	25,746,254	9%	186
Massachusetts	2,788,809	14,684,416	19%	401
Michigan	5,500,000	11,002,763	50%	1,055
Minnesota	3,843,522	3,010,727	128%	2,693
Mississippi	1,843,008	5,795,703	32%	671
Missouri	4,921,136	7,409,723	66%	1,401
Montana	231,324	310,145	75%	1,574
Nebraska	512,994	1,107,661	46%	977
Nevada	1,416,197	4,738,678	30%	631
New Hampshire	0	755,319	0%	0
New Jersey	13,050,000	34,877,598	37%	789
New Mexico	0	2,127,024	0%	0
New York	105,894,145	124,956,784	85%	1,788
North Carolina	13,582,481	12,834,095	106%	2,233

State ADAP	Total additional ADAP funding	ADAP base grant	Total additional ADAP funding as percentage of the ADAP base grant	Total additional ADAP funding per AIDS case
North Dakota	117,400	92,543	127%	2,730
Ohio	327,843	10,909,930	3%	63
Oklahoma	2,157,442	3,655,707	59%	1,279
Oregon	5,950,000	4,225,989	141%	2,971
Pennsylvania	16,496,000	27,090,216	61%	1,285
Puerto Rico	8,210,008	22,598,388	36%	767
Rhode Island	700,000	1,911,506	37%	773
South Carolina	2,227,781	11,736,984	19%	400
South Dakota	330,744	204,654	162%	3,410
Tennessee	0	12,018,438	0%	0
Texas	36,468,308	50,471,351	72%	1,524
Utah	0	1,980,565	0%	0
Vermont	305,000	382,007	80%	1,685
Virginia	4,746,537	14,498,751	33%	691
Washington	6,567,971	7,966,718	82%	1,739
West Virginia	446,941	1,303,875	34%	723
Wisconsin	1,510,026	3,179,514	47%	1,002
Wyoming	0	160,347	0%	0
Total	$427,288,351	$ 727,320,929	59%	-

Source: HRSA and GAO analysis.

Related GAO Products

Ryan White CARE ACT: Title I Funding for San Francisco. GAO/HEHS-00-189R. Washington, D.C.: August 24, 2000.

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HIV/AIDS Drugs: Funding Implications of New Combination Therapies for Federal and State Programs. GAO/HEHS-99-2. Washington, D.C.: October 14, 1998.

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Ryan White CARE Act: Access to Services by Minorities, Women, and Substance Abusers. GAO/T-HEHS-95-112. Washington, D.C.: July 17, 1995.

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