June 23, 2005

RYAN WHITE CARE ACT

Factors that Impact HIV and AIDS Funding and Client Coverage

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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.

www.gao.gov/cgi-bin/getrpt?GAO-05-841T.

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.