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RYAN WHITE CARE ACT

Changes Needed to Improve the Distribution of Funding

Statement of Marcia Crosse
Director, Health Care

April 27, 2006

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Highlights

Highlights of GAO-06-703T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

The CARE Act, a federal effort to address the HIV/AIDS epidemic, is administered by HHS. The Act uses formulas based upon a grantee's number of AIDS cases to distribute funds to eligible metropolitan areas (EMA), states, and territories. The use of AIDS cases was prescribed because most jurisdictions tracked and reported only AIDS cases when the grant programs were established. HIV cases must be incorporated with AIDS cases in CARE Act formulas no later than fiscal year 2007.

GAO was asked to discuss factors that affect the distribution of CARE Act funding. This testimony is based on *HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds*, GAO-06-332 (Feb. 28, 2006). GAO discusses how specific funding-formula provisions contribute to funding differences among CARE Act grantees and what distribution differences could result from using HIV cases in CARE Act funding formulas.

What GAO Recommends

In its February 2006 report, GAO stated that if Congress wishes CARE Act funding to more closely reflect the distribution of persons living with AIDS, it should consider taking actions that lead to more comparable funding per case by revising the funding formulas. HHS generally agreed with GAO's identification of issues in the funding formulas.

www.gao.gov/cgi-bin/getrpt?GAO-06-703T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marcia Crosse at (202) 512-7119 or crossem@gao.gov.

What GAO Found

Multiple provisions in the CARE Act grant funding formulas as enacted result in funding not being comparable per AIDS case across grantees. First, the CARE Act uses measures of AIDS cases that do not accurately reflect the number of persons living with AIDS. For example, the statutory funding formulas require the use of cumulative AIDS case counts, which could include deceased cases. Second, CARE Act provisions related to metropolitan areas result in variability in the amounts of funding per AIDS case among grantees. For example, AIDS cases within EMAs are counted once for determining funding under Title I of the CARE Act for EMAs and again under Title II for determining funding for the states and territories in which those EMAs are located. As a result, states with EMAs receive more total funding per AIDS case than states without EMAs. Third, CARE Act hold-harmless provisions under Titles I and II and the grandfather clause for EMAs under Title I sustain 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. For example, the CARE Act Title I hold-harmless provision results in one EMA continuing to have deceased AIDS cases factored into its allocation because its hold-harmless funding dates back to the mid-1990s when formula funding was based on a count of AIDS cases from the beginning of the epidemic.

If HIV case counts had been incorporated along with the number of estimated living AIDS cases (ELC) in allocating fiscal year 2004 CARE Act grants instead of ELCs alone, funding would have shifted among jurisdictions. Grantees in the South and the Midwest generally would have received more funding if HIV cases were used in the funding formulas, but there would have been grantees that would have received increased funding and grantees that would have received decreased funding in every region of the country. Although CARE Act grantees have established HIV case-reporting systems, differences between these systems—in their maturity and reporting methods, for instance—would have affected the distribution of CARE Act funds based on ELCs and HIV case counts. Grantees with more mature HIV-reporting systems would tend to receive more funds.

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 affect CARE Act funding of services for those with the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) and program coverage for individuals served by the CARE Act.[2] The Centers for Disease Control and Prevention (CDC) estimate that between 1,039,000 and 1,185,000 people in the United States were living with HIV/AIDS at the end of 2003. The number of people infected with HIV/AIDS is likely to have risen since then, and CDC estimates that, as of December 2004, it included 415,193 individuals with AIDS.

The CARE Act, which is administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), established a number of grant programs through which funds are made available to states—including the District of Columbia—territories,[3] and metropolitan areas to provide health care, medications, and support services to individuals and families affected by HIV/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[4] of the CARE Act through formula-driven base grants in fiscal year 2004 based upon a measure of each

[1]Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff–300ff-111 (2000)). Unless otherwise indicated, references to the CARE Act are to current law.

[2]HIV is the virus that causes AIDS. Throughout this testimony, we use the common term "HIV/AIDS" to refer to HIV disease, inclusive of cases that have progressed to AIDS. When we use these terms alone, HIV refers to the disease without the presence of AIDS, and AIDS refers exclusively to HIV disease that has progressed to AIDS.

[3]In addition to the 50 states, the CARE Act authorizes grants to the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. Throughout this testimony, the term state refers to the 50 states and the District of Columbia, and territory refers to these listed territories.

[4]The 1990 CARE Act added a new Title XXVI to the Public Health Service Act. In general, because Part A of that new title, which authorizes grants to metropolitan areas, was established by Title I of the CARE Act, it is commonly referred to as Title I, and because Part B, which authorizes grants to states and territories, was established by Title II of the CARE Act, it is commonly referred to as Title II.

grantee's estimated living AIDS cases (ELC).[5] Title I provides for funding to eligible metropolitan areas (EMA) while Title II provides for funding to states and territories.[6] Both Titles I and II contain hold-harmless provisions that limit how much funding can decline from one year to the next. Title I also contains a grandfather clause that was added in 1996, which states that areas eligible for Title I funding at that time continue to be eligible even if they no longer meet the eligibility criteria.

The use of AIDS cases in the distribution of formula grants was prescribed because most jurisdictions tracked and reported AIDS cases instead of HIV cases when the grant programs were established. Because of concerns that a jurisdiction's disease burden is not adequately reflected by only counting cases that have progressed to AIDS, the Ryan White CARE Act Amendments of 2000 required the use of HIV/AIDS case counts in the distribution of formula grants not later than fiscal year 2007.[7] We have reported that because CARE Act grants serve persons who have been diagnosed with HIV that has not progressed to AIDS as well as those for whom it has, it would be reasonable to distribute funds on the basis of the total number of persons living with HIV/AIDS.[8] Incorporating HIV data along with AIDS data would result in targeting funds more accurately according to need. However, because there is a lack of HIV data that are sufficiently adequate and reliable to serve as a basis for CARE Act formula grant allocations, as of December 2005, HIV cases have not been used in the distribution of formula grants under CARE Act programs.

To assist the subcommittee as it considers the reauthorization of CARE Act programs, my testimony provides our findings on CARE Act funding formulas. Specifically, I will discuss

[5]HRSA calculates a grantee's ELCs by using data from CDC on the reported AIDS case counts for the last 10 years and weighting those numbers to account for the likelihood of deaths.

[6]Under Title I, a metropolitan area with a population of at least 500,000 and more than 2,000 reported AIDS cases in the last 5 calendar years is eligible to receive Title I funding, and is defined as an EMA.

[7]Pub. L. No. 106-345, § 206(b), 114 Stat. 1319, 1334–35.

[8]GAO, *Ryan White CARE Act: Opportunities to Enhance Funding Equity*, GAO/T-HEHS-00-150 (Washington, D.C.: July 11, 2000), 6.

1. the extent of funding differences among CARE Act grantees, and how specific CARE Act funding-formula provisions contribute to these differences, and

2. what distribution differences could result from using HIV cases in CARE Act funding formulas.

My testimony today is based on our February 2006 report on CARE Act funding.[9] In carrying out the work for our report, we reviewed the CARE Act of 1990, as well as the 1996 and 2000 CARE Act amendments, HRSA documents on CARE Act funding, Institute of Medicine (IOM) reports on the CARE Act, and other related reports. We interviewed CDC, HRSA, and state officials, as well as officials from the National Alliance of State and Territorial AIDS Directors. We analyzed data for fiscal year 2004, obtained from HRSA and CDC, to examine the effects of funding-formula provisions and the use of HIV cases with ELCs in making CARE Act funding allocations.[10] We also collected data on HIV case counts from state and local HIV/AIDS officials. Based on the information HRSA, CDC, and state and local officials provided regarding 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 in accordance with generally accepted government auditing standards. The report's appendix I provides a more detailed explanation of our scope and methodology.

In brief, multiple provisions in the CARE Act grant funding formulas as enacted result in funding not being comparable per AIDS case across grantees. First, the CARE Act uses measures of AIDS cases that do not accurately reflect the number of persons living with AIDS. For example, the statutory funding formulas require the use of cumulative AIDS case counts, which could include deceased cases. Second, CARE Act provisions related to metropolitan areas result in variability in the amounts of funding per AIDS case among grantees. For example, AIDS cases within EMAs are counted once for determining funding under Title I of the CARE Act for EMAs and again under Title II for determining funding for the states and territories in which those EMAs are located. As a result, states with EMAs receive more total funding per AIDS case than states without EMAs. Third,

[9]GAO, *HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds*, GAO-06-332 (Washington, D.C.: Feb. 28, 2006).

[10]Our analyses of CARE Act funding-formula provisions and the use of HIV cases in making CARE Act funding allocations include the states, Puerto Rico, and metropolitan areas eligible for funding.

CARE Act hold-harmless provisions under Titles I and II and the grandfather clause for EMAs under Title I sustain 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. For example, the CARE Act Title I hold-harmless provision results in one EMA continuing to have deceased AIDS cases factored into its allocation because its hold-harmless funding dates back to the mid-1990s when formula funding was based on a count of AIDS cases from the beginning of the epidemic.

If HIV case counts had been incorporated along with ELCs in allocating fiscal year 2004 CARE Act grants, instead of ELCs alone, funding would have shifted among jurisdictions. Grantees in the South and the Midwest generally would have received more funding if HIV cases were used in the funding formulas, but there would have been grantees that would have received increased funding and grantees that would have received decreased funding in every region of the country. Although CARE Act grantees have established HIV case-reporting systems, differences between these systems—in their maturity and reporting methods, for instance—would have affected the distribution of CARE Act funds based on ELCs and HIV case counts. Grantees with more mature HIV-reporting systems would tend to receive more funds.

We reported in February 2006 that if Congress wishes CARE Act funding to more closely reflect the distribution of persons living with AIDS, it should consider taking actions that lead to more comparable funding per case by revising the funding formulas. In accordance with achieving more comparable funding per AIDS case, we raised a number of matters for consideration when Congress reviews the CARE Act. HHS generally agreed with GAO's identification of issues in the funding formulas.

Background

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. The Ryan White CARE Act Amendments of 1996[11] and the Ryan White CARE Act Amendments of 2000[12] modified the original funding formulas. For example, prior to the 1996 amendments, the CARE Act required that for purposes of determining grant amounts a metropolitan area's caseload be measured by

[11]Pub. L. No. 104-146, 110 Stat. 136.

[12]Pub. L. No. 106-345, 114 Stat. 1319.

a cumulative count of AIDS cases recorded in the jurisdiction since reporting began in 1981.[13] The 1996 amendments required the use of ELCs instead of cumulative AIDS cases.[14] Because this switch would have resulted in large shifts of funding away from jurisdictions with a longer history of the disease than other jurisdictions, due in part to a higher proportion of deceased cases, the 1996 CARE Act amendments added a hold-harmless provision under Title I, as well as under Title II, that limits the extent to which a grantee's funding can decline from one year to the next.

Titles I and II also provide for other grants to subsets of eligible jurisdictions either by formula or by a competitive process. For example, in addition to AIDS Drug Assistance Program (ADAP) base grants, Title II also authorizes grants for states and certain territories with demonstrated need for additional funding to support their ADAPs.[15] These grants, known as Severe Need grants, are funded through a set-aside of funds otherwise available for ADAP base grants. Title II also authorizes funding for "Emerging Communities," which are communities affected by AIDS that have not had a sufficient number of AIDS cases reported in the last 5 calendar years to be eligible for Title I grants as EMAs. In addition, Title II contains a minimum-grant provision that guarantees that no grantee will receive a Title II base grant less than a specified funding amount.

Metropolitan areas heavily affected by HIV/AIDS have always been recognized within the structure of the CARE Act. In 1995 we reported that, with combined funding under Title I and Title II, states with EMAs receive more funding per AIDS case than states without EMAs.[16] To adjust for this situation, the 1996 amendments instituted a two-part formula for Title II base grants that takes into account the number of ELCs that reside within a state but outside of any EMA. Under this distribution formula, 80 percent

[13]In this statement, cumulative AIDS cases are the total number of AIDS cases, both living and dead, reported in a jurisdiction in a given period.

[14]HRSA calculates a jurisdiction's ELCs by using data from CDC 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 measure as our estimate of living AIDS cases in our analyses of CARE Act funding-formula provisions and the use of HIV cases in CARE Act funding formulas.

[15]In addition to the 50 states, these grants, like ADAP base grants, are authorized to the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Virgin Islands.

[16]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).

of the Title II base grant is based upon a state's proportion of all ELCs, and 20 percent of the base grant is based on a state's proportion of ELCs outside of EMAs relative to all such ELCs in all states and territories. A second provision included in 1996 protected the eligibility of EMAs. The 1996 amendments provided that a jurisdiction designated as an EMA for that fiscal year would be "grandfathered" so it would continue to receive Title I funding even if its reported number of AIDS cases dropped below the threshold for eligibility. Table 1 describes CARE Act formula grants for Titles I and II.

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

Formula grant	Eligible grantees	Distribution	Minimum grant	Hold-harmless provision[a]
Title I Base Grant	Metropolitan areas with 500,000 or more in population and with more than 2,000 reported AIDS cases in the most recent 5 calendar years[b]	Distributed among EMAs according to each EMA's proportion of ELCs relative to all EMAs.	No	Grant annually declines to 98%, 95%, 92%, and 89% of the base year grant, respectively.[c] In the fifth and all subsequent years, EMA receives 85% of base year grant. The funds necessary to meet the hold-harmless requirement are deducted from funds available for supplemental grants under Title I.[d]
Title II Base Grant	States and territories[e]	Eighty percent of base grant funding divided among states/territories according to each grantee's proportion of all ELCs. Twenty percent of base grant funding divided among states/territories according to each grantee's ELCs located outside the EMAs within the state's/territory's borders relative to such ELCs in all states/territories.	For states with fewer than 90 ELCs, $200,000; states with 90 or more ELCs, $500,000; for territories, $50,000	Grant declines by 1% per year from the fiscal year 2000 grant. In fifth year, grant is 95% of 2000 grant.
Title II ADAP Base Grant	States and certain territories[f]	Distributed according to each grantee's proportion of all ELCs.	No	Grant declines by 1% per year from the fiscal year 2000 grant. In fifth year grant is 95% of 2000 grant.
Title II ADAP Severe Need Grant[g]	States and certain territories[f] with a severe need for a grant to increase access to medications	Distributed according to each grantee's proportion of all ELCs: grantees must agree to match 25 percent of their severe need grant and not to impose eligibility requirements stricter than those in place on January 1, 2000.	No	No

Formula grant	Eligible grantees	Distribution	Minimum grant	Hold-harmless provision[a]
Title II Emerging Communities Grant	States and territories with metropolitan areas that are not eligible for Title I, and that have 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. Funding is distributed according to each community's proportion of AIDS cases (reported in the most recent 5 calendar years) in Emerging Communities within the tier.	Minimum of $5 million for each tier	No

Source: HRSA.

Notes: HRSA has also awarded Minority AIDS Initiative grants to EMAs, states, and territories. HRSA characterizes Minority AIDS Initiative grants to EMAs as Title I grants and Minority AIDS Initiative grants to states and territories as Title II grants. These funds are allocated by formula. Title I funds have been used for grants to EMAs with greater than zero reported nonwhite AIDS cases in the most recent 2 calendar years. The funds are distributed among all EMAs according to each EMA's proportion of nonwhite AIDS cases reported over the most recent 2 calendar years. Title II funds have been used for grants to states and territories with greater than zero reported nonwhite AIDS cases in the most recent 2 calendar years. The funds are distributed among all grantees according to each grantee's proportion of nonwhite AIDS cases reported over the most recent 2 calendar years. There are no minimum-grant or hold-harmless provisions for these grants.

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

[b]A grandfather clause added in 1996 provides that areas eligible at that time continue to be eligible even if they no longer meet the eligibility criteria.

[c]The base year is the fiscal year prior to that in which the EMA first becomes eligible for hold-harmless funding.

[d]Title I also includes supplemental grants, which are awarded to EMAs using a competitive application process based on the demonstration of severe need and other criteria.

[e]In addition to the 50 states, Title II base grants are authorized for the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

[f]In addition to the 50 states, these grants are authorized for the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Virgin Islands.

[g]Funding for Severe Need grants may be reduced to maintain funding for some states under a Title II hold-harmless provision. Severe Need grants are funded by setting aside 3 percent of the funds earmarked specifically for ADAPs.

The 2000 amendments provided for HIV case counts to be incorporated in the Title I and Title II funding formulas 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.[17] They also required that HIV data be used no later than the beginning of fiscal year 2007. In June 2004 the Secretary of Health and Human Services determined that HIV data were not yet ready to be used for the purposes of distributing formula funding under Title I and Title II of the CARE Act.

Multiple CARE Act Provisions Contribute to Disproportionate Funding per AIDS Case

Provisions in the CARE Act funding formulas result in a distribution of funds among grantees that does not reflect the relative distribution of AIDS cases in these jurisdictions. We found that provisions affect the proportional allocation of funding as follows: (1) the AIDS case-count provisions in the CARE Act result in a distribution of funding that is not reflective of the distribution of persons living with AIDS, (2) CARE Act provisions related to metropolitan areas result in variability in the amounts of funding per ELC among grantees, and (3) the CARE Act hold-harmless provisions and grandfather clause protect the funding of certain grantees.

Provisions in CARE Act Funding Formulas Incorporate Measures of AIDS Cases That Do Not Reflect an Accurate Count of Persons Living with AIDS

Provisions in the CARE Act use measurements of AIDS cases that do not reflect an accurate count of people currently living with AIDS. Eligibility for Title I funding and Title II Emerging Communities grants, as well as the amounts of the Emerging Communities grants, is based on cumulative totals of AIDS cases reported in the most recent 5-year period. This results in funding not being distributed according to the current distribution of the disease. For example, because Emerging Communities funding is determined by using 5-year cumulative case counts, allocations could be based in part on deceased cases, that is, people for whom AIDS was reported in the past 5 years but who have since died. In addition, these case counts do not take into account living cases in which AIDS was diagnosed more than 5 years earlier. Consequently, 5-year cumulative case counts can substantially misrepresent the number of AIDS patients in these communities.

[17] 42 U.S.C. §§ 300 ff-13(a)(3)(D)(i) and 300ff-28(a)(2)(D)(i) (2000).

The use of ELCs as provided for in the CARE Act can also lead to inaccurate estimates of living AIDS cases. Currently, Title I, Title II, and ADAP base funding, which constitute the majority of formula funding, are distributed according to ELCs. ELCs are an estimate of living AIDS cases calculated by applying annual national survival weights to the most recent 10 years of reported AIDS cases and adding the totals from each year. This method for estimating cases was first included in the CARE Act Amendments of 1996. At that time, this approach captured the vast majority of living AIDS cases. However, some persons with AIDS now live more than 10 years after their cases are first reported, and they are not accounted for by this formula.[18] Thus, like the 5-year reported case counts, ELCs can misrepresent the number of living AIDS cases in an area in part by not taking into account those persons living with AIDS whose cases were reported more than 10 years earlier.

CARE Act Funding Provisions for Metropolitan Areas Result in Disproportionate Funding

When total Title I and Title II funding is considered, states with EMAs and Puerto Rico receive more funding per ELC than states without EMAs because cases within EMAs are counted twice, once in connection with Title I base grants and once for Title II base grants. Eighty percent of the Title II base grant is determined by the total number of ELCs in the state or territory. The remaining 20 percent is based on the number of ELCs in each jurisdiction outside of any EMA. This 80/20 split was established by the 1996 CARE Act amendments to address the concern that grantees with EMAs received more total Title I and Title II funding per case than grantees without EMAs. However, even with the 80/20 split, states with EMAs and Puerto Rico receive more total Title I and Title II funding per ELC than states without EMAs. States without EMAs receive no funding under Title I, and thus, when total Title I and Title II funds are considered, states with EMAs and Puerto Rico receive more funding per ELC. Table 2 shows that the higher the percentage of a state's ELCs within EMAs, the more that state received in total Title I and Title II funding per ELC.[19]

[18]When determining CARE Act funding for fiscal year 2004, HRSA used a survival weight of .28 for AIDS cases that had been reported 10 years earlier. This figure represents the proportion of persons who had been reported with AIDS 10 years earlier and were known to be alive.

[19]Approximately 80 percent of Puerto Rico's ELCs are in EMAs.

Table 2: Relationship between ELCs in EMAs and Total CARE Act Title I and II Funding per ELC, Fiscal Year 2004

Percentage of states' and Puerto Rico's ELCs in EMAs	Average funding per ELC[a]
None	$3,592
Less than 50 percent	3,954
50 to 75 percent	4,717
More than 75 percent	4,955

Source: GAO analysis of HRSA data.

[a]We excluded from our analyses the nine states that received the minimum Title II base grant awards. Under Title II, states with fewer 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 two-tiered division of Emerging Communities also results in disparities in funding among metropolitan areas. Title II provides for a minimum of $10 million to states with metropolitan areas that have 500 to 1,999 AIDS cases reported in the last 5 calendar years but do not qualify for funding under Title I as EMAs. 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.

In fiscal year 2004, the two-tiered structure of Emerging Communities funding led to large differences in funding per reported AIDS case in the last 5 calendar years among the Emerging Communities because the total number of AIDS cases in each tier was not equal. Twenty-nine communities qualified for Emerging Communities funds in fiscal year 2004. Four of these communities had 1,000 to 1,999 reported AIDS cases in the last 5 calendar years and 25 communities had 500 to 999 cases. This distribution meant that the 4 communities with a total of 4,754 reported cases in the last 5 calendar years split $5 million while the remaining 25 communities with a total of 15,994 reported cases in the last 5 calendar years also split $5 million. These case counts resulted in the 4 communities receiving $1,052 per reported case while the other 25 received $313 per reported case. Table 3 lists the 29 Emerging Communities along with their reported AIDS case counts over the most recent 5 years and their funding.

Table 3: Title II Emerging Communities in Fiscal Year 2004

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

Source: GAO analysis of HRSA data.

Note: Emerging Communities are metropolitan areas not eligible for Title I grants and that have 500–1,999 reported AIDS cases in the most recent 5 calendar years. The 5 most recent calendar years are 1998–2002.

Hold-harmless Provisions and Grandfather Clause Protect Funding of Certain CARE Act Grantees

Titles I and II of the CARE Act both contain provisions that protect certain grantees' funding levels. Title I has a hold-harmless provision that guarantees that the Title I base grant to an EMA will be at least as large as a statutorily specified percentage of a previous year's funding. The Title I hold-harmless provision has primarily protected the funding of one EMA, San Francisco.

If an EMA qualifies for hold-harmless funding, that amount is added to the base funding and distributed together as the base grant. In fiscal year 2004, the San Francisco EMA received $7,358,239 in hold-harmless funding, or 91.6 percent of the hold-harmless funding that was distributed.[20] The second largest recipient was Kansas City, which received $134,485, or 1.7 percent of the hold-harmless funding under Title I. Table 4 lists the EMAs that received hold-harmless funding in fiscal year 2004.[21] Because San Francisco's Title I funding reflects the application of hold-harmless provisions under the 1996 amendments, as well as under current law, San Francisco's Title I base grant is determined in part by the number of deceased cases in the San Francisco EMA as of 1995.

[20]The funds used to meet the Title I hold-harmless requirement are deducted from the funds otherwise available for Title I supplemental grants before these grants are awarded. Supplemental grants are awarded by HRSA to EMAs using a competitive process based on the demonstration of need and other criteria.

[21]San Francisco was the only EMA that received hold-harmless funding from fiscal year 1999 through fiscal year 2002. In fiscal year 2003, 19 additional EMAs qualified for hold-harmless funding. Twenty-one EMAs received hold-harmless funding in fiscal year 2004. Eleven EMAs qualified in both fiscal years 2003 and 2004.

Table 4: Title I Hold-harmless Funding, Fiscal Year 2004

EMA	Hold-harmless funding	Percent of hold-harmless funding	Hold-harmless funding per ELC	Base grant per ELC[a]	Hold-harmless as a percent of base grant
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%[b]**			

Source: GAO analysis of HRSA data.

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

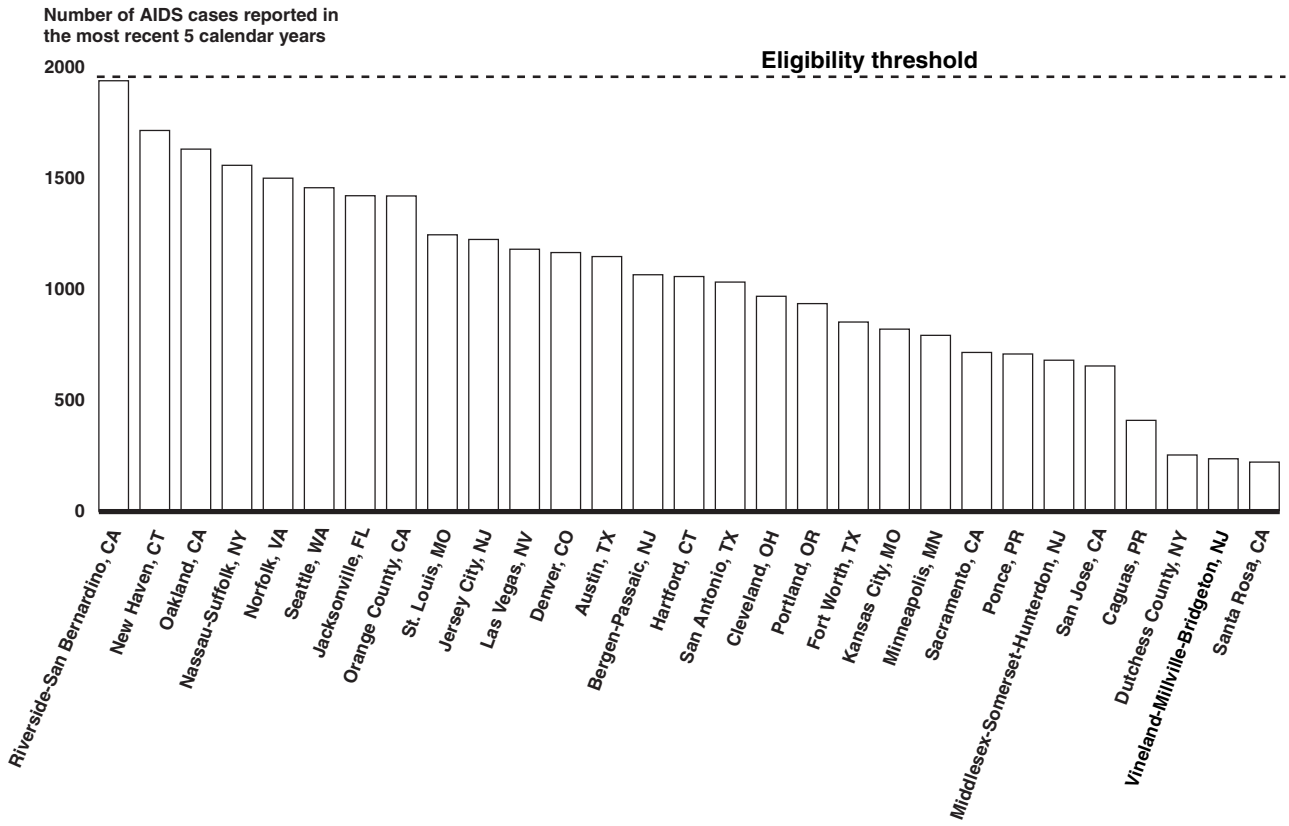
[a]This amount was calculated by dividing the base grant, including any hold-harmless funding, received by each EMA by the number of ELCs in the EMA.

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

More than half of the 51 EMAs received Title I funding in fiscal year 2004 even though they were below Title I eligibility thresholds.[22] The eligibility of these EMAs was protected based on a CARE Act grandfather clause. Under a grandfather clause established by the CARE Act Amendments of 1996, metropolitan areas eligible for funding for fiscal year 1996 remain 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 threshold of more than 2,000 reported AIDS cases during the most recent 5 calendar years but nonetheless retained their status as EMAs (see fig. 1). The number of reported AIDS cases in the most recent 5 calendar years in these 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.

[22]To be eligible for Title I funding, a metropolitan area must have reported a cumulative total of 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 base grant funding allocations, which are calculated using the number of ELCs.

Figure 1: Grandfathered EMAs, Fiscal Year 2004



Source: GAO analysis of CDC and HRSA data.

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

Title II has a hold-harmless provision that ensures that the total of Title II and ADAP base grants awarded to a grantee will be at least as large as the total of these grants a grantee received the previous year.[23] This provision has the potential of reducing the amount of funding to grantees that have demonstrated severe need for drug treatment funds because the hold-harmless provision is funded out of amounts that would otherwise be used for that purpose.[24] Fiscal year 2004 was the first time that any grantees triggered this provision. Severe Need grants are funded by a 3 percent set-aside of the funds appropriated specifically for ADAPs. Eight states became eligible for this hold-harmless funding in fiscal year 2004. 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 hold-harmless protection. (See table 5.) The remaining $20.8 million, or 93 percent of the set-aside amount, was distributed in Severe Need grants.

[23]42 U.S.C. § 300ff-28(a)(2)(I)(ii)(VI) (2000). Title II also contains a hold-harmless provision that requires HRSA to consider separately Title II base grants and ADAP base grants. For the Title II base grants, this hold-harmless provision is funded by proportionately reducing the size of the Title II base grants made to other jurisdictions that did not qualify for this hold-harmless funding or receive a minimum grant. For ADAP base grants, it would be funded by reducing the size of the ADAP base grants made to those grantees that did not qualify for ADAP base grant hold-harmless funding. 42 U.S.C. § 300ff-28(a)(2)(H) (2000).

[24]To be eligible for a Severe Need grant, a jurisdiction must have met one of four eligibility criteria as of January 1, 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 fewer 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.) In addition, a jurisdiction must also have agreed to provide a 25 percent match and not impose eligibility requirements more restrictive than those in place on January 1, 2000. According to HRSA, grantees have provided funds or in-kind services to meet the matching requirement.

Table 5: 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 total amount of Severe Need grant funds available in fiscal year 2004 to distribute among the eligible grantees was less than it would have been without the hold-harmless payments. However, in fiscal year 2004 not all 25 of the Title II grantees eligible for Severe Need grants made the match required to receive such grants. In future years, if all of the eligible Title II grantees make the match, and if there are also grantees that qualify to receive hold-harmless funds under this provision, grantees with severe need for ADAP funding would get less than the amounts they would otherwise receive.

Funding Effect of Using HIV Case Counts Would Depend on Multiple Factors

CARE Act funding for Title I, Title II, and ADAP base grants would have shifted among grantees if HIV case counts had been used with ELCs, instead of ELCs alone, to allocate fiscal year 2004 formula grants. Our analyses indicate that up to 13 percent of funding would have shifted among grantees if HIV case counts and ELCs had been used to allocate the funds and if the hold-harmless and minimum-grant provisions we considered were maintained.[25] Some individual grantees would have had

[25]While we are aware of differences in the HIV data across jurisdictions, 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 not later than fiscal year 2007. We used two approaches to examine the potential effect of including HIV cases in addition to persons living with AIDS in fiscal year 2004 CARE Act funding formulas. See GAO-06-332, app. I for more details regarding our methodology.

changes that more than doubled their funding.[26] Grantees in the South and Midwest would generally have received more funding if HIV cases were used in funding formulas along with ELCs.[27] However, there would have been grantees that would have received increased funding and grantees that would have received decreased funding in every region of the country.

Funding changes in our model would have been larger without the hold-harmless and minimum-grant provisions that we included. Changes in CARE Act funding levels for Title I base grants, Title II base grants, and ADAP base grants caused by shifting to HIV cases and ELCs would be larger—up to 24 percent—if the current hold-harmless or minimum-grant amounts were not in effect.

One explanation for the changes in funding allocations when HIV cases and ELCs are used instead of only ELCs is the maturity of HIV case-reporting systems. Case-reporting systems need several years to become fully operational.[28] We found that those grantees that would receive increased funding from the use of HIV cases tend to be those with the oldest HIV case-reporting systems. Those grantees with the oldest reporting systems include 11 southern and 8 midwestern states whose HIV-reporting systems were implemented prior to 1995.

[26]In our analyses, we considered the Title I hold-harmless provision and the Title II hold-harmless provisions that are funded by proportional reductions in Title II base grants and ADAP base grants. We did not include the Title II hold-harmless provision funded by amounts otherwise available for Severe Need grants.

[27]We classified states in accordance with the four U.S. Census Bureau regions and the jurisdictions that constitute each region. Because Puerto Rico is not included in any of these four regions, we excluded it from our regional analyses. Additional details on this analysis are available in GAO-06-332.

[28]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. See 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).

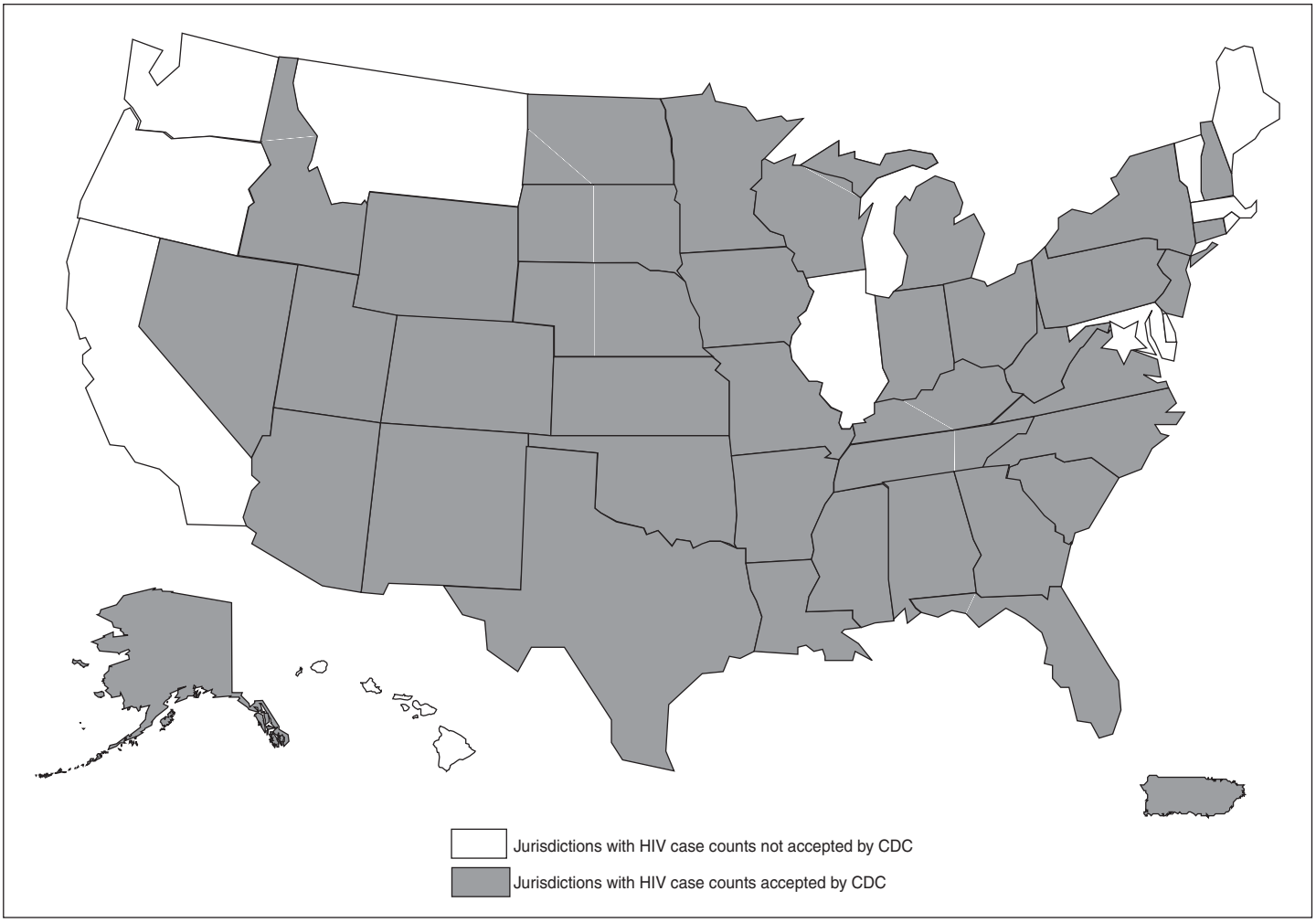
Funding changes can also be linked to whether a jurisdiction has a name- or code-based system. CDC will only accept name-based case counts as no code-based system had met its quality criteria as of January 2006.[29] CDC does not accept the code-based data principally because methods have not been developed to make certain that a code-reported HIV case is only being counted once across all reporting jurisdictions.[30] As a result, if HIV case counts were used in funding formulas, HIV cases reported using codes rather than names would not be counted in distributing CARE Act funds. However, even if code-based data were incorporated into the CDC case counts, the age of the code-based systems could still be a factor since the code-based systems tend to be newer than the name-based systems. As of December 2005, 12 of the 13 code-based systems were implemented in 1999 or later, compared with 10 of the 39 name-based systems.[31] The effect of the maturity of the code-based systems could be increased if, as CDC believes, name-based systems can be executed with more complete coverage of cases in much less time than code-based systems. As a result, jurisdictions with code-based systems could find themselves with undercounts of HIV cases for longer periods of time than jurisdictions with name-based systems. Figure 2 shows the 39 jurisdictions where HIV case counts are accepted by CDC and the 13 jurisdictions where they are not accepted, as of December 2005.

[29]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 must result in accurate case counts (less than or equal to 5 percent of reported cases are duplicates). CDC has determined that the only systems which have been evaluated that meet these standards use confidential, name-based reporting. In July 2005, CDC began recommending that all states and territories adopt confidential name-based surveillance systems to report HIV infections.

[30]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 with providers to resolve potential duplicate reports on the same person.

[31]Two of the 13 states, Illinois and Maine, established name-based HIV reporting in January 2006. Both states are in the process of having their HIV surveillance data certified by CDC and, once certified, their data will be accepted by CDC.

Figure 2: CDC Acceptance of HIV Case Counts, December 2005



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

The use of HIV cases in CARE Act funding formulas could result in fluctuations in funding over time because of newly identified preexisting HIV cases. Grantees with more mature HIV-reporting systems have generally identified more of their HIV cases. Therefore, if HIV cases were used to distribute funding, these grantees would tend to receive more funds. As grantees with newer systems identify and report a higher percentage of their HIV cases, their proportion of the total number of ELCs and HIV cases in the country would increase and funding that had shifted away from states with newer HIV-reporting systems would shift back, creating potentially significant additional shifts in program funding.

Concluding Observations

The funding provided under the CARE Act has filled important gaps in communities throughout the country, but as Congress reviews CARE Act programs, it is important to understand how much funding can vary across communities with comparable numbers of persons living with AIDS. In our report, we raised several matters for Congress to consider when reauthorizing the CARE Act. We reported in February 2006 that if Congress wishes CARE Act funding to more closely reflect the distribution of persons living with AIDS, and to more closely reflect the distribution of persons living with HIV/AIDS when HIV cases are incorporated into the funding formulas, it should take the following five actions:

- revising the funding formulas used to determine grantee eligibility and grant amounts using a measure of living AIDS cases that does not include deceased cases and reflects the longer lives of persons living with AIDS,
- eliminating the counting of cases in EMAs for Title I base grants and again for Title II base grants,
- modifying the hold-harmless provisions for Title I, Title II, and ADAP base grants to reduce the extent to which they prevent funding from shifting to areas where the epidemic has been increasing,
- modifying the Title I grandfather clause, which protects the eligibility of metropolitan areas that no longer meet the eligibility criteria, and
- eliminating the two-tiered structure of the Emerging Communities program.

We also reported that if Congress wishes to preserve funding for the ADAP Severe Need grants, it should revise the Title II hold-harmless provision that is funded with amounts set aside for ADAP Severe Need Grants. In commenting on our draft report HHS generally agreed with our identification of issues in the funding formulas.

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.

Contact and Acknowledgments

For further information regarding this statement, please contact Marcia Crosse at (202) 512-7119 or crossem@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. James McClyde, Assistant Director; Robert Copeland; Cathy Hamann; Opal Winebrenner; Craig Winslow; and Suzanne Worth contributed to this statement.

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