April 27, 2006

RYAN WHITE CARE ACT

Changes Needed to Improve the Distribution of Funding

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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.