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Report to Congressional Requesters

February 2006

HIV/AIDS

Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds

GAO-06-332

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-332, a report to congressional requesters

Why GAO Did This Study

Among federal efforts to address the HIV/AIDS epidemic are the CARE Act of 1990 and the Housing Opportunities for Persons with AIDS program (HOPWA) administered by the Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD), respectively. Both use formulas based upon a grantee's number of AIDS cases, rather than HIV and AIDS cases, to distribute funds to metropolitan areas, states, and territories. HIV cases must be incorporated with AIDS cases in CARE Act formulas not later than fiscal year 2007.

GAO was asked to examine (1) how CARE Act and HOPWA funds are allocated among types of services, (2) the extent of funding distribution differences among CARE Act and HOPWA grantees, and how funding formula provisions contribute to these differences, and (3) what distribution differences could result from incorporating HIV case counts in CARE Act and HOPWA funding formulas.

What GAO Recommends

If Congress wishes CARE Act and HOPWA 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 and HUD generally agreed with GAO's identification of issues in the funding formulas.

www.gao.gov/cgi-bin/getrpt?GAO-06-332.

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

CARE Act and HOPWA grants are allocated by grantees for health care, housing assistance, and a variety of services for people with HIV/AIDS. These grants provide services for persons who have been diagnosed with HIV that has not progressed to AIDS as well as those for whom it has. In fiscal year 2003, more than half of Title I CARE Act funds awarded to eligible metropolitan areas (EMAs) were allocated for health care services such as outpatient care and home health services, and over two-thirds of Title II CARE Act funds awarded to states and territories were allocated for medications. Two-thirds of HOPWA funds were used for direct housing costs for people with HIV/AIDS and their families.

Multiple provisions in the CARE Act and HOPWA grant funding formulas as enacted result in funding not being comparable per AIDS case across grantees. First, both the CARE Act and HOPWA use 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, 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 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 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. For example, under Title I's hold-harmless provision, one EMA continues 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 AIDS case counts in allocating fiscal year 2004 CARE Act and HOPWA grants, funding would have shifted among jurisdictions. Grantees in the South and the Midwest generally would have received more funding, although 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 and HOPWA grantees have established HIV case reporting systems, differences between these systems—in their maturity and reporting methods, for instance—would impact the appropriateness of using HIV case counts in distributing CARE Act and HOPWA funding. GAO found that CARE Act and HOPWA fiscal year 2004 funding would have shifted to jurisdictions with more mature HIV reporting systems.

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Abbreviations

ADAP	AIDS Drug Assistance Program
AIDS	acquired immunodeficiency syndrome
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act
CDC	Centers for Disease Control and Prevention
ELC	estimated living AIDS case
EMA	eligible metropolitan area
EMSA	eligible metropolitan statistical area
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HOPWA	Housing Opportunities for Persons with AIDS program
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IOM	Institute of Medicine
MSA	metropolitan statistical area
OMB	Office of Management and Budget

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

February 28, 2006

The Honorable Michael B. Enzi
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Mark E. Souder
Chairman
Subcommittee on Criminal Justice, Drug Policy
and Human Resources
Committee on Government Reform
House of Representatives

The Honorable Tom A. Coburn
United States Senate

The Honorable Judd Gregg
United States Senate

It has been nearly 25 years since the first cases of acquired immunodeficiency syndrome (AIDS) in the United States were identified. Treatment advances in combination antiretroviral therapy during the 1990s have significantly reduced AIDS mortality and slowed the progression from a positive human immunodeficiency virus (HIV) diagnosis to AIDS.[1] Yet the number of new HIV infections, which is estimated at 40,000 annually, has not decreased. 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.

Among the federal government's efforts to address the HIV/AIDS epidemic are the Ryan White Comprehensive AIDS Resources Emergency Act of

[1]HIV is the virus that causes AIDS. Throughout this report, 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.

1990 (CARE Act)[2] and the Housing Opportunities for Persons with AIDS program (HOPWA). The CARE Act, which is administered by the Department of Health and Human Services's (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. The AIDS Housing Opportunity Act, which was enacted in 1990 and is administered by the Department of Housing and Urban Development (HUD), established HOPWA.[4] HOPWA provides housing assistance for low-income persons with HIV/AIDS and their families. In fiscal year 2004, over $2 billion was distributed through the CARE Act and $295 million was distributed through HOPWA.

Under the CARE Act and HOPWA, funding is distributed through a combination of competitive grants and, in accordance with CDC data on the number of individuals diagnosed with AIDS, formula grants. Approximately 68 percent of CARE Act funding and 90 percent of HOPWA funding were distributed through formula grants in fiscal year 2004. 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.[5] 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

[2]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.

[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 report, the term state refers to the 50 states and the District of Columbia, and territory refers to these listed territories.

[4]Pub. L. No. 101-625, tit. VIII, subtit. D, 104 Stat. 4079, 4375 (codified as amended at 42 U.S.C. §§ 12901–12912 (2000)). Unless otherwise indicated, references to HOPWA are to the program as administered under current law.

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

total number of persons living with HIV/AIDS.[6] 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 the CARE Act.

Various provisions governing CARE Act and HOPWA grants affect the distribution of funds. As Congress prepares to reauthorize CARE Act programs, you asked us to examine how funds are distributed under the CARE Act and HOPWA. We are reporting on (1) how CARE Act and HOPWA funds are allocated by grantees among the types of services each program supports; (2) the extent of funding differences among CARE Act and HOPWA grantees, and how specific CARE Act and HOPWA funding-formula provisions contribute to these differences; and (3) what distribution differences could result from using HIV cases in CARE Act and HOPWA funding formulas.

To report on these issues, we reviewed the CARE Act of 1990, as well as the 1996 and 2000 CARE Act amendments, the AIDS Housing Opportunity Act of 1990, HRSA and HUD documents on CARE Act and HOPWA funding, HUD memoranda, Institute of Medicine (IOM) reports on the CARE Act, and other related reports. We analyzed data, spanning from 2002 through 2004, obtained from HRSA, HUD, and CDC.[7] We also collected data on HIV case counts from state and local HIV/AIDS officials. We interviewed CDC, HRSA, HUD, and state officials, as well as officials from the National Alliance of State and Territorial AIDS Directors.

To determine how grantees allocate CARE Act and HOPWA funds by type of service, we obtained information from HRSA and HUD on grantees' use of funds. We analyzed these data and, where available, calculated the percentage of total spending represented by each category of service. To assess the reliability of HRSA and HUD data on allocations of CARE Act and HOPWA grant funds, we interviewed agency officials about the data

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

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

and reviewed relevant documentation. We determined that the data were sufficiently reliable for the purposes of our report.

In order to examine the effect of specific funding-formula provisions on the distribution of fiscal year 2004 funds by HRSA and HUD under the CARE Act and HOPWA to grantees, we first assessed the use of 2- and 5-year cumulative AIDS case counts[8] and the use of estimated living AIDS cases (ELC) in CARE Act programs by comparing these measures with living AIDS case counts received from CDC. 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 then examined the effect of the following CARE Act formula provisions: the counting of ELCs in eligible metropolitan areas (EMA) for both Title I and Title II funding,[9] the dividing of Emerging Communities into two tiers for determining funding, the Title I hold-harmless provision, the Title I grandfather clause, and the Title II hold-harmless provision that is funded from amounts that would otherwise be available for states with severe need in their drug programs. To examine the effect of each provision on the distribution of CARE Act and HOPWA funds, we measured differences either on a per case basis, by the amount of funding received, or both. To determine the effects of adopting the Office of Management and Budget's (OMB) 2004 definitions of metropolitan statistical areas (MSA) on EMAs, we compared the boundaries of existing EMAs with those that would be created, and we determined the change in the number of ELCs that would be counted under Title I. In addition, we examined the effect of using living AIDS cases instead of cumulative AIDS cases[10] in making HOPWA base grant distributions by comparing the actual funding distributions with simulated

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

[9]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. Titles III and IV of the Act established Parts C and D, respectively, authorizing grants for early intervention services as well as grants for services to women and children, among other things. 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.

[10]Under HOPWA, cumulative AIDS cases are the total AIDS cases reported in a jurisdiction since the beginning of the epidemic in 1981.

distributions using living AIDS cases.[11] We also assessed the effect of HOPWA bonus grants on funding for eligible metropolitan statistical areas (EMSA) by examining the size of these grants and which EMSAs received them.[12]

In our analyses we used funding per AIDS case to illustrate the effect of certain funding-formula provisions on the distribution of CARE Act and HOPWA funds. There are other considerations that could be included in funding formulas that could justify deviations from equal funding per case. For example, differing health care and housing costs across regions and differences in grantees' capacities to fund services from local resources could be used as bases for distributing program funds and could justify such deviations.[13] Currently, these considerations are not taken into account when distributing formula grants under either the CARE Act or HOPWA, and are not considered here. To assess the reliability of the HRSA and HUD data on the distribution of funds under the CARE Act and HOPWA, we asked agency officials about how the data were developed and reported. We also reviewed relevant documentation. We determined the data were sufficiently reliable for the purposes of our report.

To show how CARE Act and HOPWA funding could be affected by including HIV cases in funding formulas, we examined how CARE Act and HOPWA fiscal year 2004 formula grants would have been affected by using

[11]Under HOPWA there is a single formula grant for each grantee. It consists of funding determined using a base factor and funding determined using a bonus factor (which may be zero). In this report, we use the terms base grants and bonus grants to differentiate between funding determined using these factors.

[12]Bonus grants are awarded to EMSAs that have a higher-than-average per capita incidence of AIDS over the previous year. Allocations are based on the number of cases in excess of the average AIDS incidence rates of EMSAs.

[13]In our November 1995 report, we showed that differences under the CARE Act in funding per living AIDS case were not related to cost differences. For a discussion of this issue as well as criteria for distributing funds, see GAO, *Ryan White CARE Act of 1990: Opportunities to Enhance Funding Equity*, GAO/HEHS-96-26 (Washington, D.C.: Nov. 13, 1995).

HIV cases in addition to living AIDS cases to determine formula funding.[14] We undertook our analyses in light of the statutory requirement that HIV cases be used in CARE Act funding formulas not later than fiscal year 2007. Our analyses, however, rely on data whose reliability has been questioned. The Secretary of Health and Human Services has determined that because of the problems associated with these data, they should not currently be used in determining CARE Act funding. We used these data in our analyses to give a general indication of the effect of using HIV cases in future formula allocations as required by the CARE Act. The extent to which the use of HIV cases could affect formula allocations cannot be determined by these analyses because jurisdictions use different methods to identify HIV cases, and it is unclear to what degree the resulting case counts are comparable. However, we think our approaches in these analyses are informative given the required incorporation of HIV cases into CARE Act funding formulas. To assess the reliability of the case-count data, we asked HRSA, HUD, CDC, state, and local officials a series of questions about how the data were collected and the methods used to ensure their accuracy. On the basis of the information provided regarding the verification of these data, we determined these data to be sufficiently reliable for the purposes of our analyses. Appendix I provides a more detailed explanation of the scope and methodology for this report. We performed our work from July 2004 through February 2006, in accordance with generally accepted government auditing standards.

Background

In 1990, Congress passed the CARE Act and HOPWA legislation to address the needs of jurisdictions, health care providers, and people with HIV/AIDS and their family members. Within the CARE Act and HOPWA legislation, there are provisions for determining the distribution of program funding. Furthermore, amendments in 1996 and 2000 changed some CARE Act provisions, and public debate continues on how best to measure the effect of HIV/AIDS within the United States, and how to distribute funding accordingly.

[14]For our CARE Act analyses, we used ELCs as our measure of living AIDS cases. For HOPWA we used a measure of living AIDS cases calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases. In our analysis of HOPWA, we used living AIDS cases instead of cumulative AIDS cases, which is the measure currently required by law to be used to determine HOPWA base funding. Consequently, our analyses of HOPWA funding reflect the effect of using HIV and living AIDS cases instead of cumulative AIDS cases. We do not compare how allocations could be affected if HIV cases and cumulative cases were used to determine funding.

HIV/AIDS in the United States

Over the course of the last quarter century, the HIV/AIDS epidemic has spread to every region of the country. CDC has estimated that in the 50 states approximately 40,000 persons become infected with HIV annually. While AIDS cases remained concentrated in metropolitan areas through 2004, AIDS prevalence rates in nonmetropolitan areas rose.[15]

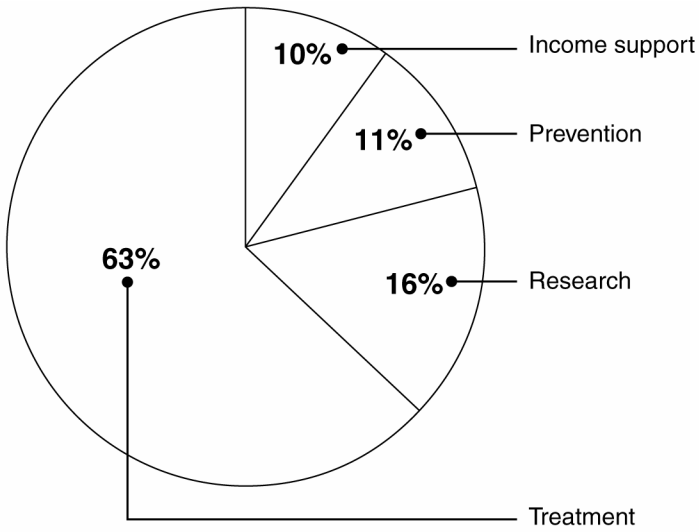
The United States population living with HIV/AIDS is diverse. Racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic, but in 2004 African Americans accounted for more new AIDS cases, more of those estimated to be living with AIDS, and more of those who died with AIDS than any other racial or ethnic group. Latinos also account for a greater proportion of AIDS cases and deaths than their representation in the overall population.

Despite the number of deaths from AIDS and the steady increase of AIDS prevalence, there have been successes in the fight against HIV/AIDS. Developments in treatment have enhanced care options and can extend the lives of those living with HIV/AIDS. The introduction of highly active antiretroviral therapy in 1996 was followed by a decline in the number of deaths and new AIDS cases in the United States for the first time since the beginning of the epidemic.

The federal government's efforts to address the domestic HIV/AIDS epidemic include providing federal funding for the following categories of activities—treatment and income support for individuals with HIV/AIDS, prevention efforts, and research. In fiscal year 2004, federal funding for domestic HIV/AIDS programs was nearly $16.3 billion. Of this total, about $2.1 billion was distributed through CARE Act programs, and $295 million was distributed through the HOPWA program. Medicaid was the largest source of federal assistance for HIV/AIDS health care, with $5.4 billion in federal funding. Other large sources of federal funding for HIV/AIDS are Medicare—$2.6 billion—and the National Institutes of Health—about $2.5 billion. Funding from other federal sources ranged from $1 million from the Department of Labor to more than $1 billion from the Social Security Disability Insurance Program. Figure 1 provides a breakdown of federal HIV/AIDS funding by category.

[15]Prevalence reflects the number of people living with the disease.

Figure 1: Federal HIV/AIDS Funding by Category, Fiscal Year 2004



Source: GAO analysis of HHS data.

The CARE Act

The majority of CARE Act funds are distributed through four different programs, each contained in a separate title, to the states, EMAs, and other entities. Titles I and II of the act provide for formula grants (base grants) to EMAs and states according to each jurisdiction's number of ELCs relative to all EMAs and states. These titles 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.[16] These grants, known as Severe Need Grants, are funded through a set-aside of funds otherwise available for ADAP 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 order to address the effect of the disease on racial and ethnic minorities, HRSA has used funds otherwise available under Title I and Title II for Minority AIDS Initiative grants to EMAs, states, and territories. EMAs may also receive Title I supplemental grants, which are awarded

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

using a competitive application process based on the demonstration of severe need and other criteria.[17] Table 1 describes the purposes and the grantees of each title.

Table 1: CARE Act Programs, 2004

CARE Act program	Grantees	Purpose
Title I. Grants to Eligible Metropolitan Areas (EMAs)	51 EMAs[a]	Support primary health care, medications, and a range of services, such as case management, substance abuse treatment, housing, mental health treatment, and nutritional counseling.
Title II. Grants to States and Territories	States and territories	Support primary and home-based health care, insurance coverage, medications, support services, and early intervention services, such as HIV counseling, testing, and referral. Funding for AIDS Drug Assistance Programs provides medications, treatment adherence and support, and health insurance with prescription drug benefits.
Title III. Early Intervention Services, Capacity Development, and Planning Grants	Primary care providers, including health centers, city and county health departments, and outpatient medical centers	Support comprehensive services including HIV counseling, testing, outpatient medical care, and case management; funds also go toward developing HIV service delivery systems and building capacity to provide services.
Title IV. Services for Women, Infants, Children, Youth, and Their Affected Family Members	Health care facilities, public health agencies, and community-based organizations that serve Title IV target populations	Support family-centered and coordinated health care and support services that benefit children, youth, and women living with HIV, and their families. Also support initiatives to help identify HIV-positive pregnant women and ensure access to prenatal care that could prevent perinatal transmission.
Special Projects of National Significance	University and community clinics, evaluation centers,[b] local and state health departments, community-based organizations, and nonprofit agencies	Support the development of innovative models of HIV/AIDS care that can be replicated, such as interventions for HIV-positive substance abusers.
AIDS Education and Training Center Program	4 national centers and 11 regional centers with 130 associated sites	Conduct education and training programs for health care providers treating people with HIV/AIDS.
Dental Programs	Dental education institutions, hospitals, and other institutions with dental education programs	Improve access to oral health care and enhance dental training on caring for people with HIV/AIDS through the Dental Reimbursement Program and Community-Based Dental Partnership grants.

Source: HRSA.

[a]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 a formula base grant. As a result of the CARE Act Amendments of 1996, EMAs that were eligible for Title I grants in that year are grandfathered: they will be eligible for grants under Title I even if their number of AIDS cases drops below the threshold for eligibility. App. II contains a list of the EMAs.

[b]Evaluation centers support Special Projects grantees and coordinate the evaluation of initiatives under the Special Projects of National Significance program.

[17]All EMAs received a supplemental grant in fiscal year 2004.

CARE Act Amendments

The Ryan White CARE Act Amendments of 1996[18] and the Ryan White CARE Act Amendments of 2000[19] 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 a cumulative count of AIDS cases recorded in the jurisdiction since reporting began in 1981. The 1996 amendments required the use of ELCs instead of cumulative AIDS cases.[20] 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 limit the extent a grantee's funding can decline from one year to the next.

Metropolitan areas heavily affected by HIV/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.[21] 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 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 states' proportion of ELCs outside of EMAs relative to all such ELCs. 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 2 describes CARE Act formula grants for Titles I and II.

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

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

[20]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.

[21]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).

Table 2: 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 critieria.

[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.

Metropolitan Statistical Areas

In determining a metropolitan area's eligibility for Title I funding and for purposes of defining areas served under Title I, the CARE Act uses the OMB 1993 definitions of MSAs. OMB's 1993 definitions were based on applying OMB's 1990 standards for defining an MSA to data from the 1990 census. OMB's standards create a metropolitan classification scheme that includes rules for determining which counties (the basic building block of MSAs) would be designated as the central counties of metropolitan areas and which outlying counties would be associated with particular central counties. The 1996 CARE Act amendments froze the metropolitan areas to those specified in the 1993 OMB definitions.[22]

HIV Case Counts

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.[23] 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. The Secretary cited a 2004 IOM report, which identified several limitations in the ability of states to provide adequate and reliable HIV case counts for use in distributing CARE Act grants.[24]

HOPWA

HOPWA is the only federal program dedicated to providing housing assistance to persons living with HIV/AIDS and their families. Funding under HOPWA supports a variety of services, including rental assistance and the acquisition, rehabilitation, and construction of housing units. HOPWA funds also provide for supportive services, such as health care, substance abuse treatment, and case management. In fiscal year 2004, $295 million was distributed through HOPWA.

[22]In 2005, OMB issued 2004 MSA definitions using fundamentally revised standards issued in 2000 and data from the 2000 census. In an attempt to make the classification of areas simpler and more transparent than the previous standards, OMB's 2000 standards introduced new terminology and employed new criteria for identifying central counties and their outlying counties, and did not seek to conform with past standards nor to preserve past metropolitan status.

[23]42 U.S.C. §§ 300 ff-13(a)(3)(D)(i) and 300ff-28(a)(2)(D)(i) (2000).

[24]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).

Ninety percent of HOPWA funds are distributed through formula grants to states, Puerto Rico, and metropolitan areas. The remaining 10 percent of HOPWA funds are provided through competitive grants to states, Puerto Rico, local governments, and nonprofit organizations. Formula grants under HOPWA incorporate cumulative AIDS case counts, rather than an estimate of persons living with AIDS, such as ELCs as used in the CARE Act. Seventy-five percent of HOPWA formula funding is awarded through base grants to EMSAs, which are jurisdictions with more than 500,000 people and more than 1,500 cumulative AIDS cases, and to states and Puerto Rico that have more than 1,500 cumulative AIDS cases outside EMSAs. The remaining 25 percent of HOPWA formula funding is awarded through bonus grants for EMSAs that meet the eligibility threshold but also demonstrate a higher-than-average per capita incidence of AIDS. These grants are based on the number of cases in excess of the average AIDS incidence rates of EMSAs. HUD first used OMB's new MSA definitions in determining EMSAs for fiscal year 2004 funding.

Results in Brief

CARE Act and HOPWA grants are used for health care, housing assistance, and a variety of services for people with HIV/AIDS. In fiscal year 2003, more than half of the approximately $600 million in Title I CARE Act funds were allocated by grantees for health care services such as outpatient care and home health services, and over two-thirds of the approximately $1 billion in Title II funds were allocated by states and territories for medications. Over three-quarters of the approximately $194 million in Title III fiscal year 2002 funds were allocated for health care services. In fiscal year 2003, about $68 million in Title IV grants was provided for health care and support services for children, youth, and women with HIV/AIDS and their families. Also in fiscal year 2003, about $74 million in funding was provided in total for dental programs, projects that support innovative models of HIV/AIDS care, and AIDS Education and Training Centers for health care providers. HOPWA funds were used for a variety of housing-related expenses, such as rental assistance, and support services. In fiscal year 2003, two-thirds of the approximately $249 million in HOPWA funds were used for direct housing costs, such as rental assistance, for people with HIV/AIDS and their families.

Multiple provisions in the CARE Act and HOPWA grant funding formulas result in funding not being distributed according to the current distribution of the disease. Grantees do not receive the same level of CARE Act or HOPWA funding per person living with AIDS because various formula provisions affect the proportional allocation of funding.

- We found that both the CARE Act and HOPWA use measures of AIDS cases that do not accurately reflect the number of persons living with AIDS. Some CARE Act grants and HOPWA base grant funding are based on case counts that could include deceased cases because the eligibility and allocations are determined using cumulative case counts. In addition, the CARE Act's use of ELCs, which are determined using the most recent 10 years of reported AIDS cases, to distribute the majority of formula funding does not take into account that many AIDS patients now live longer than 10 years after their disease is reported.
- We found that certain CARE Act Title I and II provisions related to metropolitan areas result in variability in the amounts of funding per ELC among grantees. For instance, the counting of ELCs within EMAs once for determining Title I base grants and once again for determining Title II base grants results in states with a higher proportion of ELCs in EMAs and Puerto Rico, which has a similar percentage, receiving more total Title I and Title II funding per ELC than states with no EMA or with comparatively few ELCs located in EMAs. Also, the division of Emerging Communities into two tiers based on their numbers of reported AIDS cases in the past 5 years leads to funding disparities among grantees. This divergence occurs because funding is divided equally between the two tiers regardless of the number of communities or the number of reported AIDS cases in each tier. In fiscal year 2004, the 4 communities in the first tier received $1,052 per reported case while the 25 communities in the second tier received $313 per reported case.
- We found that because of CARE Act hold-harmless provisions under Titles I and II and the grandfather clause for EMAs under Title I, the funding of certain grantees is protected. For example, the CARE Act Title I hold-harmless provision results in the San Francisco EMA's funding being based in part on deceased cases in the EMA in 1995. In addition, a Title II hold-harmless provision, which has had little effect thus far, has the potential to reduce the amount of funding to grantees with severe need for drug treatment funds because the hold-harmless provision is funded from amounts set aside for ADAP Severe Need grants. The Title I grandfather clause protected the funding of more than half of EMAs.

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. If case counts from HIV-reporting systems had been used along with a measure of the number of persons living with AIDS in distributing fiscal year 2004 CARE Act and HOPWA grants, funding would have shifted among jurisdictions. Although CARE Act and HOPWA 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 and HOPWA

funds based on HIV/AIDS case counts. Recently established HIV-reporting systems might not have captured an accurate count of a grantee's HIV cases in part because cases diagnosed prior to the establishment of the reporting system might not have been reported and entered into the system. Also, because CDC does not accept case reports that are reported using a code rather than a person's name to protect their anonymity, those states with code-based systems would not have had their HIV cases counted when funding distributions were made. Accordingly, we developed two approaches to assess the effect of using the HIV case counts, as they currently exist, on CARE Act and HOPWA formula grants. While the extent to which funding may have shifted cannot be determined given the different methods jurisdictions use to identify HIV cases, we think these approaches are informative given the required corporation of HIV cases into CARE Act funding formulas. Using these approaches, we found that up to 13 percent of CARE Act formula funding would have shifted among grantees if HIV cases were included in the funding formulas and the hold-harmless provisions analyzed and minimum-grant provision were maintained. Larger changes for individual grantees would have occurred with some grantees more than doubling their funding. Grantees in the South and Midwest would generally have received more funding from using HIV cases in funding formulas. 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. If, in addition to using HIV data, the hold-harmless provisions we analyzed and minimum-grant provisions were eliminated, the redistribution of program funds would have been more dramatic. Up to 24 percent of funding would have shifted. HOPWA base funding would also have shifted if HIV and living AIDS cases were used to distribute funding. In fiscal year 2004, up to 15 percent of HOPWA base funding would have shifted among grantees, with six grantees more than doubling their funding. Differences in HIV case-reporting systems would affect the distribution of funding, and we found that funding would have tended to shift to jurisdictions with older HIV-reporting systems. Jurisdictions with older HIV-reporting systems tend to have more reported HIV cases compared with their number of AIDS cases than do jurisdictions with newer reporting systems.

If Congress wishes CARE Act and HOPWA funding to more closely reflect the distribution of persons living with AIDS, it should take 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 raise a number of matters for consideration when Congress reviews the CARE Act and HOPWA.

We provided a draft of this report to HHS and HUD. HHS and HUD generally agreed with our identification of issues in the funding formulas. While HHS also generally agreed with our matters for congressional consideration, it expressed concern that our discussion of the Title I grandfather provision in the CARE Act could be interpreted as suggesting that the metropolitan areas that continue to receive grants because of this provision need not be funded. However, these areas could still receive funding through their respective states or territories, which receive funds under Title II. HUD concurred with our matter for congressional consideration that HOPWA formula grant eligibility and base grant funding be based on a measure of living AIDS cases.

CARE Act and HOPWA Funds Allocated for Health Care, Housing Assistance, and a Variety of Other Services

The CARE Act and HOPWA grants fund a variety of treatment and support services for people with HIV/AIDS. For fiscal year 2003, Title I grantees allocated more than half of the approximately $600 million in Title I grants for health care services such as outpatient care and home health care, and over 70 percent of the approximately $1 billion in Title II funds were allocated for medications. Almost 80 percent of the approximately $194 million in Title III fiscal year 2002 funds were allocated for health care services such as physician office visits and HIV counseling and testing.[25] In fiscal year 2003, there was also about $68 million in funding for Title IV grantees and about $74 million for other programs, such as Special Projects of National Significance. Two-thirds of the approximately $249 million in HOPWA fiscal year 2003 funds were used to assist with housing costs for people with HIV/AIDS and their families.

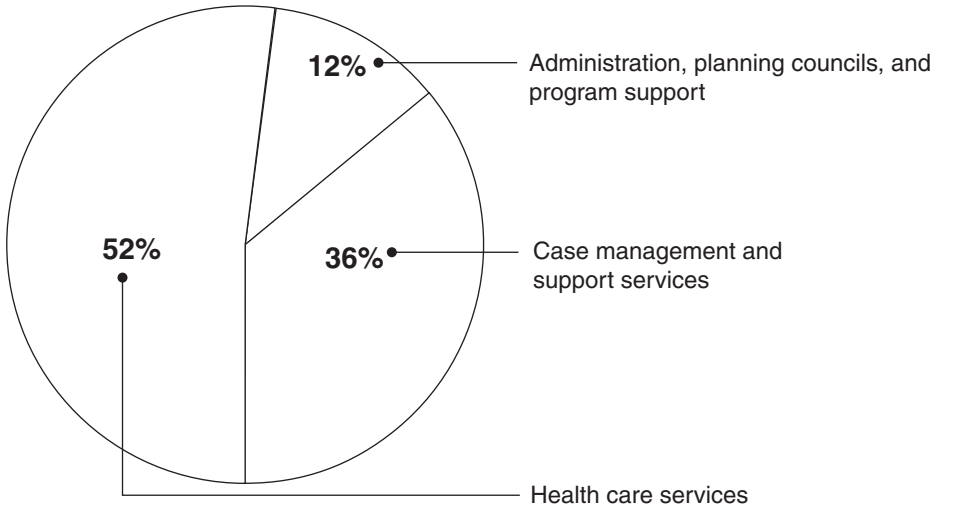
More Than Half of Title I Fiscal Year 2003 Funding Was Allocated for Health Care Services

For fiscal year 2003, HRSA provided about $600 million in grants to EMAs under Title I of the CARE Act to support services for people with HIV/AIDS. Grantees allocated the largest portion of these funds, about 52 percent, for health care services such as outpatient care, home health care, rehabilitation care, and medications. About 12 percent of these Title I health care services funds were allocated for substance abuse treatment and counseling services. For the same year, Title I grantees allocated about 36 percent of those funds for case management and support services. Support services include child care, client advocacy, and emergency financial assistance, among others. The remaining 12 percent

[25]Fiscal year 2002 allocations were the most recent funding data available for Title III.

of Title I funding was allocated for administration, planning councils, and program support.[26] (See fig. 2.)

Figure 2: Allocation of CARE Act Title I Funds, Fiscal Year 2003



Source: GAO analysis of HRSA data.

Note: About $600 million was allocated under Title I.

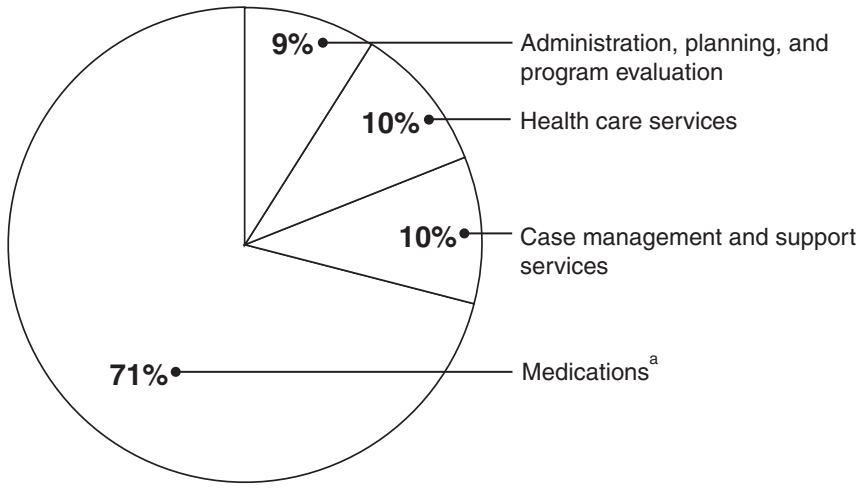
Over Two-thirds of Title II Fiscal Year 2003 Funding Was Allocated for Medications

HRSA provided approximately $1 billion to states and territories under Title II in fiscal year 2003. Title II grantees allocated the majority of these funds, about 71 percent, for medications, which includes ADAP medications, non-ADAP medications, and pharmacy assistance for CARE Act clients. Ten percent of Title II funds were allocated for health care services, similar to those provided under Title I. Grantees allocated about 3 percent of Title II health care services funds for substance abuse treatment services. Case management and support services similar to those provided under Title I accounted for approximately 10 percent of the Title II funds. The remainder of Title II funds, about 9 percent, was

[26]The CARE Act requires that grantees' administrative costs not exceed 5 percent of the Title I funds awarded. Each EMA must establish a planning council, which sets spending priorities according to local unmet needs.

allocated for program administration, planning, and evaluation.[27] (See fig. 3.)

Figure 3: Allocation of CARE Act Title II Funds, Fiscal Year 2003



Source: GAO analysis of HRSA data.

Notes: Approximately $1 billion was allocated under Title II.

[a]Medications includes ADAP medications, non-ADAP medications, and pharmacy assistance.

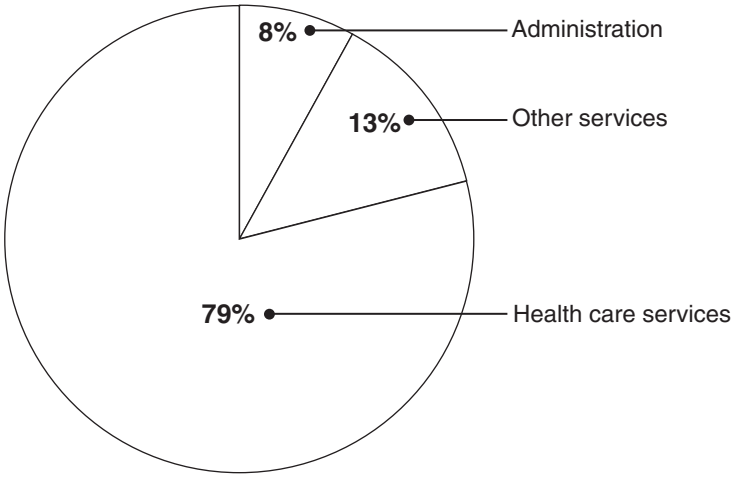
Over Three-quarters of Title III Fiscal Year 2002 Funding Was Allocated for Health Care Services

Under Title III of the CARE Act, HRSA provided about $194 million in grants to certain public and nonprofit primary care providers in support of early intervention services for people with HIV/AIDS for fiscal year 2002. Title III grantees allocated about 79 percent of these funds for health care services such as physician office visits, HIV counseling and testing, and employing primary care personnel. Health care services also included outpatient mental health care and substance abuse treatment. Title III grantees allocated another 13 percent for other activities, including case management and HIV patient education. The remaining 8 percent was allocated for administration.[28] (See fig. 4.)

[27]The CARE Act requires that grantees not use more than 10 percent of Title II funds for administration. The combined funding for administration, planning, and program evaluation may not exceed 15 percent of a Title II grantee's award.

[28]The CARE Act requires that grantees not use more than 10 percent of Title III funds for administration costs, including planning and evaluation.

Figure 4: Allocation of CARE Act Title III Funds, Fiscal Year 2002



Source: HRSA.

Note: About $194 million was allocated under Title III.

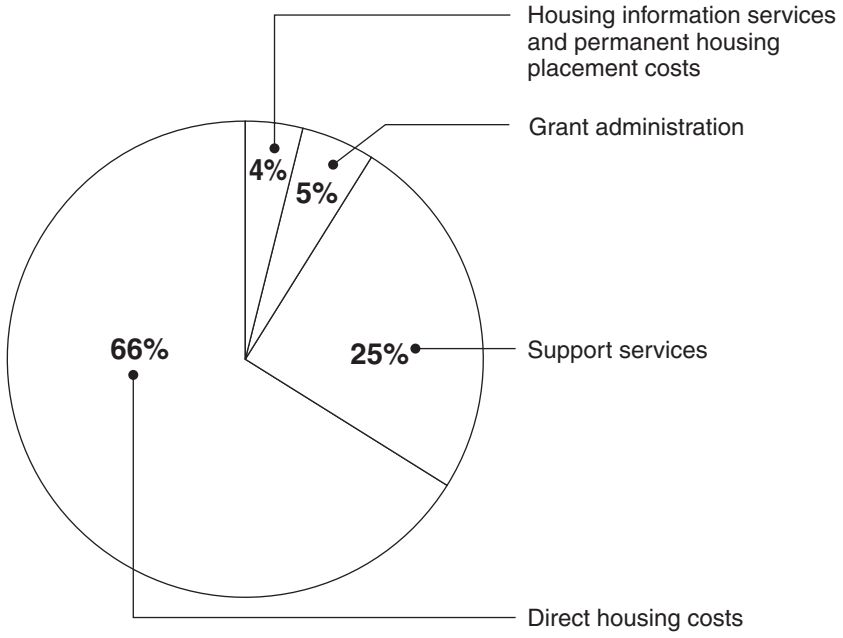
CARE Act Grants Funded Other Activities in Fiscal Year 2003

Grants made under Title IV of the CARE Act address the specific needs of women, infants, children, and youth living with HIV/AIDS. The funds cover primary and specialty medical care, psychosocial services, case management, and other activities. For fiscal year 2003, HRSA provided about $68 million for Title IV programs. Other CARE Act programs include the Special Projects of National Significance Program, funded at about $25 million for fiscal year 2003; the AIDS Education and Training Centers Program, funded at about $36 million for fiscal year 2003; and the HIV/AIDS Dental Reimbursement Program and Community-Based Dental Partnership program funded at nearly $10 million and $3 million respectively for fiscal year 2003.

Two-thirds of HOPWA Fiscal Year 2003 Funds Were Spent on Housing Costs

For fiscal year 2003, HOPWA grantees spent about $249 million to support housing services for people with HIV/AIDS. The largest portion of these funds, about 66 percent, was spent on direct housing costs, such as rental assistance, and housing facility operating costs. Support services accounted for 25 percent of the funds. HOPWA-funded support services include case management, health care, alcohol and drug abuse treatment, and child care, among others. Housing information services and permanent housing placement costs accounted for 4 percent of HOPWA funds, while grant administration was 5 percent of the total. (See fig. 5.)

Figure 5: Allocation of HOPWA Funds, Fiscal Year 2003



Source: GAO analysis of HUD data.

Notes: About $249 million was spent under HOPWA.

Multiple Provisions Contribute to Disproportionate Distribution of CARE Act and HOPWA Formula Funding

Provisions in the CARE Act and HOPWA funding formulas result in a distribution of funds among grantees that does not reflect the relative distribution of AIDS cases in these jurisdictions.[29] CARE Act grantees do not receive the same amount of funding per ELC, and HOPWA grantees do not receive the same amount of funding per living AIDS case. We found that provisions affected the proportional allocation of funding as follows: (1) the AIDS case-count provisions in the CARE Act and HOPWA each 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, (3) the CARE Act hold-harmless provisions and grandfather clause protect the funding of certain grantees, and (4) the ineligibility of grantees other than EMSAs for HOPWA bonus funding restricts the distribution of these funds and limits HUD's ability to fund areas outside of

[29]Unless otherwise indicated, we use the term grantees to indicate the jurisdictions on which our analyses are based, that is, the states, Puerto Rico, and metropolitan areas.

EMSAs with high rates of new AIDS cases. We also considered the provision in the 1996 CARE Act amendments that froze the EMA boundaries to 1993 OMB definitions. We found that the boundaries for more than half of current EMAs would change if OMB's 2004 MSA definitions were adopted for purposes of CARE Act funding.

CARE Act and HOPWA Grants Are Not Distributed Solely in Proportion to Number of Persons Living with AIDS

Funds distributed under Title I of the CARE Act are not distributed proportionally per ELC across EMAs.[30] In fiscal year 2004, the total funding for all Title I grants to EMAs was about $595 million. If this funding had been distributed solely by a grantee's proportion of ELCs, each EMA would have received $2,443 per ELC. However, Title I provisions affect the grant awards so that funding is not distributed strictly on a proportional basis, but instead is allocated in part according to the number of ELCs and in part on other bases, such as the amounts awarded in a prior year, as reflected in the hold-harmless funding. Total funding for EMAs also reflects Minority AIDS Initiative grants and supplemental grants. In fiscal year 2004, total Title I funding for the 51 EMAs ranged from $2,130 per ELC case in Riverside–San Bernardino to $4,137 in San Francisco, with an average of $2,380. Excluding San Francisco, West Palm Beach had the highest Title I funding per ELC at $2,515. Appendix II lists the EMAs and amounts awarded under Title I for fiscal year 2004.

CARE Act Title II funding is also not distributed proportionally per ELC. In fiscal year 2004, the total funding for all Title II grants was about $1.051 billion. If this funding had been distributed solely according to the proportion of ELCs, each grantee would have received $3,053 per ELC. However, minimum-award requirements and hold-harmless provisions affect the distribution of Title II funds. In addition, grants for Emerging Communities as well as the Minority AIDS Initiative are not determined proportionally by the number of ELCs. Total Title II funding for fiscal year 2004 ranged from $2,793 for the District of Columbia to $7,275 for South Dakota, with an average of $3,559. Appendix III shows the grantees and amounts awarded under Title II for fiscal year 2004.

[30]ELCs are the 10-year weighted estimate of living AIDS cases as specified in the CARE Act. HRSA calculates a jurisdiction's ELCs by using data from CDC on the reported AIDS case counts for the last 10 years. Data for each of the 10 years are adjusted to take into account the number of deaths in each year. However, rather that simply subtracting the number of deceased cases in each jurisdiction, the number of reported cases is adjusted by the national average death rate among AIDS cases.

HOPWA formula funding is also disproportionate across grantees. In fiscal year 2004, about $263 million was allocated by formula to 117 grantees. Seventy-five percent of this funding was distributed according to the number of cumulative AIDS cases[31] in a jurisdiction and 25 percent was distributed based on the rate of new AIDS cases in EMSAs. If this funding had been distributed proportionally by the number of cumulative AIDS cases across jurisdictions each grantee would have received $306 per cumulative case. However, 26 grantees received bonus grants that are based on the rate of new AIDS cases in an EMSA, not the number of cumulative AIDS cases. Therefore, the actual amounts grantees received ranged from $230 per cumulative AIDS case for 91 grantees to $626 per case in Baton Rouge, with an average of $260. We also determined how much funding each grantee received per living AIDS case.[32] We found that grantees received an average of $573 per living AIDS case, with funding ranging from $387 per case in Nashville to $1,290 per case in Baton Rouge. These funding differences are due to the use of cumulative AIDS cases to distribute base grant funding and because bonus grants are distributed according to the rate of new cases in EMSAs.[33] Appendix IV identifies the fiscal year 2004 HOPWA formula grantees and award amounts.

[31]In this report, cumulative AIDS cases are the total number of AIDS cases, both living and dead, reported in a jurisdiction in a given period. Under HOPWA, cumulative AIDS cases encompass all reported cases since the beginning of the epidemic in 1981. By statute, 75 percent of HOPWA formula funding is allocated on the basis of cumulative AIDS cases.

[32]In the absence of a measure of living AIDS cases used for HOPWA funding, we used a measure of living AIDS cases calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases. This measure of living AIDS cases is used for illustrative purposes only.

[33]Until fiscal year 2006, bonus funding was based on the per capita incidence of AIDS over a 1-year period. As a result, the amount of bonus funding a grantee received could vary significantly from year to year. With respect to fiscal year 2006 funding, HUD's appropriation act included a provision to help mitigate this variability by changing to the use of data reported over a 3-year period. Pub. L. No. 109-115, § 303(d), 119 Stat. 2396, 2460 (2005).

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

HOPWA and the CARE Act both use measurements of AIDS cases that do not reflect an accurate count of people currently living with AIDS. To determine eligibility for HOPWA formula grants and to distribute base funding, allocations are determined using a measure of AIDS cases that is based on the number of living and deceased AIDS cases reported in the jurisdiction since the beginning of the AIDS epidemic in 1981. Also, eligibility and distribution of certain CARE Act grants are based on the number of reported AIDS cases over either the last 2- or 5-year period,[34] which likely does not reflect all live cases and could include deceased AIDS cases. In addition, Title I, Title II, and ADAP base grants are calculated using ELCs, which can underestimate the number of living cases because many persons with AIDS now live longer than 10 years after their cases are reported.

HOPWA Grants

Eligibility for HOPWA formula grants is determined by the number of cumulative AIDS cases in a metropolitan area, state, and Puerto Rico, and base funding allocations (which represent 75 percent of total HOPWA formula funding) to grantees are determined by the grantee's proportion of the total number of cumulative AIDS cases. As we reported in 1995, the use of cumulative case counts is an inappropriate caseload measure because it includes all AIDS cases, living and dead, reported to CDC for the jurisdiction since the beginning of the epidemic in 1981.[35]

Because the HOPWA funding formula includes deceased persons, the distribution of funds does not reflect the current distribution of people living with AIDS. Using estimates of living AIDS cases obtained from CDC, we calculated how base funding for grantees would have changed in fiscal year 2004 if these estimates had been used instead of the cumulative case counts. Each of the 117 grantees would have received approximately $537 per living AIDS case. We found that 25 grantees received more funding in fiscal year 2004 using cumulative case counts than they would have received if the number of living AIDS cases had been used. The additional funding received by the grantees ranged from approximately $2,000 in San Jose to $4,020,000 in New York City. Conversely, if the number of living cases had been used, 92 grantees would have received increased funding. The funding increases would have ranged from $1,000 in Springfield, Massachusetts, to $1,120,000 in the District of Columbia.

[34]Eligibility for Minority AIDS Initiative grants and grant amounts are determined using the last 2 years of reported AIDS cases.

[35]GAO/HEHS-96-26, 6.

Areas that receive more funding from the use of cumulative case counts include jurisdictions in California, Michigan, New Jersey, and New York. (App. V contains information on funding using cumulative AIDS counts and living AIDS cases.)

Use of cumulative case counts rather than living cases can lead to areas with similar numbers of living AIDS cases receiving markedly different amounts of funding. For example, as of March 31, 2003, Oakland and New Orleans both reported 3,374 living AIDS cases.[36] However, in fiscal year 2004 Oakland received $221,000 more ($66 more per living AIDS case) in HOPWA base funding than did New Orleans. Atlanta and Houston also have similar numbers of living AIDS cases (8,557 and 8,579 respectively). However, in fiscal year 2004 Houston received $806,000 more ($93 more per case) in HOPWA base funding than did Atlanta.

CARE Act Grants

The use of cumulative case counts is not limited to the HOPWA program. Deceased cases can also be included when determining eligibility for CARE Act funding. Eligibility for Title I funding and Title II Emerging Communities grants is based on cumulative totals of AIDS cases reported in the most recent 5-year period, not on the number of ELCs. Funding amounts for Emerging Communities grants are also determined using the most recent 5 years of reported cases. In addition, HRSA determines eligibility and funding amounts of Minority AIDS Initiative grants according to the number of reported AIDS cases in the most recent 2-year period.

The use of the cumulative number of reported cases over a certain period to determine eligibility and allocate funding 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. For example, while the 5-year cumulative case count in Buffalo for

[36]We used living AIDS case counts as of March 31, 2003, because this date was the cutoff for reporting AIDS cases to be used for determining fiscal year 2004 HOPWA formula funding.

determining fiscal year 2004 Emerging Communities eligibility and funding was 581 cases, the number of ELCs was 956. Similarly, the 5-year cumulative case count in Charleston, South Carolina, was 538, but the number of ELCs was 758.

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 case is first reported, and they are not accounted for by this formula.[37] Thus, like the 2- and 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. For example, fiscal year 2004 Title I base funding for the Atlanta EMA was based on 7,589 ELCs, but CDC estimated that there were 8,560 reported living AIDS cases in the EMA.[38] Similarly, funding for the Seattle EMA was based on 2,468 ELCs while CDC estimated that there were 3,273 reported living cases.[39]

[37]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.

[38]The estimate of reported living AIDS cases was calculated by subtracting the number of reported deaths among AIDS cases from the number of reported AIDS cases since the beginning of the epidemic.

[39]For an assessment of three methods for estimating the number of persons living with AIDS, including the method used for the CARE Act, see Centers for Disease Control and Prevention, "AIDS Cases and Persons Living with AIDS," *HIV/AIDS Surveillance Supplemental Report*, vol. 8, no. 3 (2002).

CARE Act Funding Provisions for Metropolitan Areas Result in Disproportionate Funding

The counting of ELCs within EMAs once to determine the amount of the base grant under Title I and once again to determine the amount of the Title II base grant results in states with EMAs and Puerto Rico receiving more total Title I and Title II funding per ELC than states without EMAs.[40] In addition, the formula for awarding Title II Emerging Communities grants results in different levels of funding per AIDS case across grantees.

Counting ELCs within EMAs Twice Results in Disproportionate Funding per ELC across States and Puerto Rico

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 Title II base grants 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.[41] Appendix VI shows the combined Title I and Title II fiscal year 2004 funding received by each state and Puerto Rico.

Table 3 illustrates the effect of counting EMA cases twice by comparing the relationship between the percentage of a state's and Puerto Rico's ELCs that are within EMAs and the amount of total Title I and Title II funding they receive per ELC. Table 3 shows that as the percentage of a state's or Puerto Rico's ELCs within EMAs increases, the total Title I and II funding per ELC also increases. For example, states with no ELCs in EMAs received on average $3,592 per ELC. States with 75 percent or more of their cases in EMAs and Puerto Rico[42] received on average $4,955 per

[40]There are three EMAs in Puerto Rico: Caguas, Ponce, and San Juan.

[41]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 ELCs from each state in these EMAs. We then calculated the percentage of ELCs in each state and allocated the EMA funding to each state according to this percentage. For example, approximately 96 percent of the ELCs 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.

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

ELC, or 38 percent more funding than states with no EMA. If the total Title I and Title II funding had been distributed proportionally per ELC among all states and Puerto Rico, each grantee would have received $4,782 per ELC.

Table 3: 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 effect of counting EMA cases twice is that grantees with similar numbers of ELCs can receive different levels of combined Title I and Title II funding. For example, for fiscal year 2004 funding, Connecticut had 5,363 ELCs while South Carolina had 5,563 ELCs. However, Connecticut had two EMAs that accounted for 91.3 percent of its ELCs while South Carolina had none. Connecticut received $26,797,308 ($4,997 per ELC) in combined Title I and Title II funding while South Carolina, with 200 more cases, received $20,705,328 ($3,722 per ELC). Connecticut received 29 percent more funding than South Carolina, a difference of $6,091,980, or $1,275 per ELC. (See app. VI.)

The Two-tiered Division of Emerging Communities Results in Funding Disparities Among Metropolitan Areas

The two-tiered division of Emerging Communities 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.[43] 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 for a second tier of communities with 1,000 to 1,999 reported cases in that

[43]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 funding.

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. The two tiers and the 50/50 split were meant to ensure that a significant portion of the Emerging Communities funding was allocated to the communities with the largest number of new cases.

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. These 4 communities received 236 percent more funding per reported case than the other 25. If the total $10 million funding for Emerging Communities grants had been distributed equally per reported case among the communities, each would have received $482 per reported case. Table 4 lists the 29 Emerging Communities along with their reported AIDS case counts over the most recent 5 years and their funding.

Table 4: 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.

Similar to the counting of ELCs in EMAs for both Title I and Title II base grant funding, AIDS cases reported in the past 5 calendar years in Emerging Communities are counted more than once for determining Title II funding. For example, these cases are counted once for determining Title II base funding and again for Emerging Communities grants. Title II grantees with Emerging Communities receive an average of $3,443 per ELC while grantees without an Emerging Community receive about $3,089.[44] The Emerging Communities funding accounted for about $125 per ELC of this difference. Other Title II funds that are also not distributed proportionally by the number of ELCs, such as the Minority AIDS Initiative grants, account for the rest of the difference.[45]

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. Title I also contains a grandfather clause that has resulted in a large number of EMAs maintaining their eligibility for grants despite no longer meeting the eligibility criteria. 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. This provision has the potential of reducing the amount of funding to grantees that had demonstrated severe need for drug treatment funds because it is funded out of amounts that would otherwise be used for that purpose.

One EMA Has Been the Primary Recipient of Title I Hold-harmless Funding

The San Francisco EMA has been the primary recipient of Title I hold-harmless funding. An EMA's base funding is determined according to its proportion of ELCs. The hold-harmless provision guarantees each EMA a statutorily specified percentage of the base grant it received in a previous year regardless of how much its proportion of the number of ELCs in all

[44]We excluded from our analyses the nine states that received minimum Title II base grant awards.

[45]HRSA provides Minority AIDS Initiative grants according to the number of nonwhite reported AIDS cases in the most recent 2-year period.

EMAs may have decreased in the current year.[46] 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.[47] The second largest recipient was Kansas City, which received $134,485, or 1.7 percent of the hold-harmless funding under Title I. Table 5 lists the EMAs that received hold-harmless funding in fiscal year 2004.[48]

[46]The hold-harmless provision is triggered when, because of its current number of ELCs, an EMA would not receive at least a specified level of base funding. Hold-harmless funding under Title I is calculated using a base year. The base year is the year preceding the fiscal year in which the hold-harmless provision is triggered for a particular EMA. Because the hold-harmless provision can first be triggered in different years in different EMAs, the base year can differ among EMAs. Under the CARE Act Amendments of 2000, an EMA is guaranteed not less than 98 percent of its base grant in the first year the hold-harmless is triggered, 95 percent in the second year, 92 percent in the third year, 89 percent in the fourth year, and 85 percent in the fifth or subsequent years.

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

[48]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 5: 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.

The effect of the hold-harmless provision varies among the EMAs that receive hold-harmless funding, 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 ELC in fiscal year 2004. Fiscal year 2004 base grant funding per ELC in EMAs that received hold-harmless funding ranged from $1,223 (Newark) to $2,241 (San Francisco). Thus, the San Francisco EMA received $1,020 more in base grant funding per ELC 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 ELCs in fiscal year 2004, received a base grant equivalent to what an EMA with approximately 13,245 ELCs (84 percent more) would have received. Kansas City, the second largest hold-harmless grantee, received about what an EMA with 9 percent more ELCs would have received.

Forty-eight of the 51 EMAs would have received more funding if there had been no hold-harmless provision and if the $8 million that was actually used for hold-harmless funding had been distributed in the same proportions as the supplemental grants.[49] Although 21 EMAs received hold-harmless funding in fiscal year 2004, only 3 (San Francisco, Kansas City, and Santa Rosa) received more funding because of the hold-harmless provision than they would have received through supplemental grants in the absence of the hold-harmless provision. Without the hold-harmless funding, San Francisco would have received $960 less per ELC, Kansas City $70 less, and Santa Rosa $15 less.

In fiscal year 2004 the San Francisco EMA was guaranteed to receive 89 percent of its fiscal year 2000 Title I base grant under the hold-harmless provision. However, the amount of San Francisco's 2000 Title I base grant had been determined by formulas specified in the CARE Act Amendments of 1996, which guaranteed EMAs 95 percent of their 1995 base grant in fiscal year 2000.[50] San Francisco was the only EMA to qualify for hold-harmless funding in 2000 because it was the only EMA that would have

[49]This analysis shows how the hold-harmless funding would have been distributed if it had been allocated in the same proportions as the supplemental grant funding. For example, Newark received about 2.5 percent of the funds available for supplemental grants and, consequently, we allocated 2.5 percent of the $8,033,563 hold-harmless funding to Newark. It is not possible to determine the exact effect of the hold-harmless provision on the amount of supplemental funding for each EMA because it is not known how the funds would have been distributed in the absence of the hold-harmless awards.

[50]The CARE Act Amendments of 1996 guaranteed amounts ranging from 95 to 100 percent of the 1995 base grant. The CARE Act Amendments of 2000 guaranteed amounts ranging from 85 to 98 percent of the grant received in a base year. The base year varies by EMA.

received less than 95 percent of its fiscal year 1995 base grant. Taken together, the hold-harmless provisions mean that in fiscal year 2004 San Francisco was guaranteed approximately 85 percent of its fiscal year 1995 base grant of $19,126,679.[51] Prior to the CARE Act Amendments of 1996, 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 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.

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

More than half of the EMAs received Title I funding in fiscal year 2004 even though they were below Title I eligibility thresholds.[52] 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 table 6). 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.

[51]The guaranteed amount is calculated by multiplying the two percentages (89 and 95) together. 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.

[52]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 determined using the number of ELCs.

Table 6: 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 1998–2002.

The number of EMAs ineligible for Title I funds in the absence of the grandfather clause reflects the combination of the decline in the number of new AIDS cases following the advent of more effective therapies and the more restrictive eligibility standards adopted in the CARE Act Amendments of 1996.[53] No metropolitan areas have become eligible for Title I funding since 1999, when Las Vegas and Norfolk received their initial funding, because no additional metropolitan areas have reported enough new cases to meet the AIDS case-count-eligibility threshold. This decline in the number of new cases reflects the general pattern of AIDS case counts in the country. While the number of people living with AIDS has been increasing as persons with AIDS live longer, the number of new AIDS cases reported each year throughout the country decreased from about 1993 until about 1999 and has since leveled off. In addition, six of the EMAs not meeting the current eligibility threshold became eligible on the basis of their case rates, under the 1990 thresholds, rather than their number of cases. These include Caguas, Dutchess County, Santa Rosa, and Vineland-Millville-Bridgeton, the four EMAs with the fewest reported cases. In addition, the Jersey City and Ponce EMAs also became eligible on the basis of their case rates.

As discussed earlier, some metropolitan areas are designated as Emerging Communities under Title II because their numbers of reported AIDS cases in the most recent 5 calendar years 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 EMAs that were eligible for Title I funding because of the grandfather clause.[54] 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. The overall effect is that Emerging Communities received less funding than EMAs with comparable numbers of reported AIDS cases in the most recent 5 calendar years. For example, Baton Rouge, with 1,038 reported cases, received $1,091,976 in Emerging Communities funding

[53]The AIDS case eligibility thresholds contained in the 1990 statute were either that an area had a cumulative total of more than 2,000 AIDS cases (that is, more than 2,000 cases living or deceased) or greater than 25 AIDS cases per 100,000 population reported to CDC. This standard was changed in 1996 to the current threshold of more than 2,000 reported AIDS cases during the most recent 5 calendar years and a population of 500,000 or more.

[54]Both EMA eligibility and Emerging Community funding are based on the number of AIDS cases reported in the most recent 5 calendar years.

while the San Antonio EMA, with 1,034 reported cases, received $3,833,443 in Title I funding.

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

A Title II hold-harmless provision established by the CARE Act Amendments of 2000 could diminish ADAP Severe Need grant amounts in the future because the hold-harmless payments and the grants are funded from the same 3 percent set-aside of Title II funds available for drug treatment programs. If larger amounts are needed to meet this hold-harmless provision in the future, grantees that have demonstrated a severe need for drug treatment funds could get less than the amounts they would otherwise receive.[55]

Fiscal year 2004 was the first time that any grantees triggered the Title II hold-harmless provision funded with amounts that would otherwise be used for Severe Need grants. Severe Need grants are funded with a 3 percent set-aside of the funds appropriated specifically for ADAPs. 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 grantee will be at least as large as the total the previous year.[56] 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 7.) The remaining $20.8 million, or 93 percent of the set-aside amount, was distributed in Severe Need grants.

[55]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.

[56]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 . The ADAP portion 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).

Table 7: 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 further in the future if larger amounts are needed to fund this hold-harmless protection. 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 required match. Consequently, the Severe Need grants were not as small as they would otherwise have been because of the application of the hold-harmless provision. 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.

HOPWA Provision Restricts Bonus Grant Eligibility for Some Grantees

The structure of the HOPWA program restricts states and Puerto Rico from receiving HOPWA bonus grant funding for areas outside EMSAs.[57] Bonus grants, which totaled about $66 million in fiscal year 2004, are awarded only to the EMSAs in which the AIDS epidemic is spreading most rapidly.[58] In fiscal year 2004, EMSAs with more than 19.5 new AIDS cases per 100,000 people over the past year qualified for bonus grants. In fiscal year 2004, 26 EMSAs qualified for bonus grants (see table 8).

Table 8: Fiscal Year 2004 HOPWA Formula Funding

EMSA	Base funding	Bonus funding	Bonus funding as a percent of base funding	Total HOPWA formula funding when calculated per cumulative AIDS case[a]	Total HOPWA formula funding when calculated per living AIDS case
Atlanta, Ga.	$4,262,000	$637,000	15%	$264	$573
Baltimore, Md.	3,940,000	3,996,000	101	463	1,039
Baton Rouge, La.	666,000	1,147,000	172	626	1,290
Bridgeport, Conn.	752,000	27,000	4	238	476
Charleston, S.C.	411,000	7,000	2	234	480
Chicago, Ill.	5,622,000	2,716,000	48	341	805
Columbia, S.C.	626,000	644,000	103	466	824
Detroit, Mich.	1,624,000	355,000	22	280	749
District of Columbia	5,626,000	6,176,000	110	482	939
Fort Lauderdale, Fla.	3,337,000	2,903,000	87	430	954
Jackson, Miss.	449,000	275,000	61	371	728
Jacksonville, Fla.	1,195,000	369,000	31	301	623
Memphis, Tenn.	920,000	1,214,000	132	533	1,000
Miami, Fla.	6,149,000	4,566,000	74	400	934
New Haven, Conn.	937,000	295,000	31	302	605
New Orleans, La.	1,785,000	1,207,000	68	385	887

[57]States and Puerto Rico, as well as EMSAs, receive HOPWA base grants that are determined by the grantee's proportion of the total number of cumulative AIDS cases. CDC reported that there were 5.4 AIDS cases per 100,000 people in nonmetropolitan areas in 2000 and 6.2 cases per 100,000 people in these areas in 2004.

[58]Twenty-five percent of HOPWA formula funding is distributed through bonus grants. Until fiscal year 2006, bonus funding was based on the per capita incidence of AIDS over a one-year period. As a result, the amount of bonus funding a grantee received could vary significantly from year to year. With respect to fiscal year 2006 funding, HUD's appropriation act included a provision to help mitigate this variability by changing to the use of data reported over a 3-year period.

EMSA	Base funding	Bonus funding	Bonus funding as a percent of base funding	Total HOPWA formula funding when calculated per cumulative AIDS case[a]	Total HOPWA formula funding when calculated per living AIDS case
New York, N.Y.	33,487,000	26,868,000	80	414	1,099
Newark, N.J.	4,297,000	885,000	21	277	828
Philadelphia, Pa.	4,340,000	3,292,000	76	404	799
Orlando, Fla.	1,660,000	1,529,000	92	441	913
Wake County, N.C.	345,000	7,000	2	234	408
San Francisco, Calif.	6,698,000	1,864,000	28	294	1,130
San Juan, P.R.	4,585,000	2,555,000	56	358	1,000
Tampa, Fla.	2,221,000	168,000	8	247	569
West Palm Beach, Fla.	2,019,000	1,817,000	90	436	933
Wilmington, Del.	566,000	232,000	41	325	624
All other grantees	[b]	0	0	230	[c]

Source: GAO analysis of CDC and HUD data.

[a]Cumulative AIDS cases are the total number of AIDS cases, both living and dead, reported in the jurisdiction since the beginning of the epidemic in 1981.

[b]Varies by number of cumulative AIDS cases.

[c]Varies by number of living AIDS cases.

Bonus funding can be an important component of an EMSA's HOPWA formula funding. Bonus grants exceeded base funding amounts in five EMSAs (Baltimore, Maryland; Baton Rouge, Louisiana; Columbia, South Carolina; Memphis, Tennessee; and the District of Columbia), and were more than 50 percent of base funding in another nine. EMSAs that did not receive bonus funding received approximately $230 per cumulative AIDS case in fiscal year 2004 formula funding. Because grantees other than EMSAs were not eligible for the bonus funding, they also received $230 per cumulative case. However, the 26 EMSAs that received bonus funding were allocated an average of $367 per cumulative case in total formula funding, ranging from $234 to $626 per case. If all of the formula funding had been allocated on the basis of cumulative AIDS cases, instead of allocating base grants by cumulative cases and bonus grants by incidence rates, each grantee would have received $306 per case. The last column in table 8 shows that EMSAs that received bonus funding also received more

funds per living AIDS case.[59] These EMSAs received an average of approximately $816 per living case, ranging from $408 per case in Wake County, North Carolina, to $1,290 per case in Baton Rouge, Louisiana. Those grantees that did not receive bonus funding received about $503 per living case, ranging from $387 to $627 per case. (See app. IV).

The Use of Revised OMB Metropolitan Area Definitions Would Change Most EMA Boundaries, but Increase in ELCs within EMAs Would Be Minimal

Title I EMA boundaries were made permanent by the 1996 amendments to the CARE Act, and they have not been altered to conform to OMB's 2004 definitions of metropolitan areas.[60] Since existing Title I and Title II organizational and administrative arrangements within states and EMAs are connected to current EMA boundaries, changing EMA boundaries to conform to OMB 2004 metropolitan areas could disrupt those arrangements. On the other hand, adopting the 2004 OMB definitions for EMAs would reflect the same metropolitan areas for which statistical agencies make data available to the public and reflect the 2000 decennial census demographic data. OMB recommends that policymakers review and consider the appropriateness of the new definitions of metropolitan area boundaries for program purposes.

If OMB's 2004 definitions of metropolitan area[61] boundaries were used to establish the area to be considered when defining an EMA under Title I,[62] the service area boundaries would change for the majority of the current

[59]These funding levels were calculated by dividing a grantee's fiscal year 2004 formula allocation by the number of living cases in the jurisdiction. If the funding had been allocated proportionally on the basis of living AIDS cases, each grantee would have received $716 per case.

[60]OMB's new MSA standards and definitions represent a major break with the classification scheme used in the past. In some instances OMB retained a term that was used in the past, such as MSA, but OMB has altered the meaning. As a result, 2004 MSA boundaries of some EMAs are very different from those in 1993.

[61]We use the term "metropolitan area" here in a generic sense to refer to both the MSA (metropolitan statistical area) and the metropolitan division (OMB's newly defined term for a subdivision of the very largest MSAs).

[62]If Title I EMA boundaries were reconfigured to conform with new OMB definitions, those areas outside of EMAs that are currently served by governments under Title II would also be changed. Though the effect on areas outside EMAs can be inferred from the changes to EMAs, we do not explicitly report those results here.

EMAs.[63] To demonstrate the changes involved in reconfiguring EMA boundaries to conform to the new metropolitan areas, we chose a method that could be used for this conversion. As described in appendix I, the method we chose would combine new metropolitan areas so as to minimize changes to current EMA boundaries.[64]

If our method of converting EMA boundaries to metropolitan areas using the 2004 definitions were incorporated in the CARE Act funding formulas, the service area boundaries of more than half of current EMAs would change. In addition, 5 EMAs would be consolidated to 2, reducing the total number of EMAs from 51 to 48.[65] We found that 31 of the 51 current EMAs would add, lose, or both add and lose counties in their service areas. For example, the Atlanta EMA would add 8 counties, the Las Vegas EMA would lose 2 counties, and the Newark EMA (New Jersey) would both add 2 counties and lose 1 other county. Overall, 17 counties would no longer be part of an EMA and 53 counties that were not previously included in an

[63]While we focus on Title I of the CARE Act, the Title II Emerging Communities program also uses metropolitan area definitions and it would also be affected if the new OMB definitions were applied. We also exclude HOPWA from this subsection because these new OMB definitions have already been used to determine fiscal year 2004 HOPWA grant funding. For HOPWA, HUD implemented a different method than we use for the analysis here. HUD provided no grandfathering of eligibility for previously designated EMSAs and instead, among all newly defined metropolitan areas, HUD selected those whose data qualified them to be eligible for HOPWA funding. In contrast, in our method we assume a policy whereby the 51 current EMAs would retain their eligibility for CARE Act Title I grants without needing to qualify on the basis of their number of ELCs or population size, and we selected only those new metropolitan areas (or combinations of those areas) that most closely correspond to the geographic area of each of the 51 existing Title I EMAs.

[64]App. I provides further explanation of the methodology we used for selecting those combinations of metropolitan areas that would minimize changes to current EMAs. As shown in the tables in app. VII, our conversion method would equate some EMAs with more than one newly defined metropolitan area in order to minimize any change in boundaries that would occur. For example, we equate the New Haven EMA with two newly defined units (the New Haven MSA and the Bridgeport MSA) because the two units together have boundaries identical to the New Haven EMA.

[65]The Bergen-Passaic, Jersey City, and New York City EMAs would be consolidated into the new New York City EMA (with no change to the geographic area encompassed and no change to the numbers of ELCs served). The Caguas and San Juan EMAs would be consolidated into the new San Juan EMA (with a net increase of 6 counties and 4 percent in ELCs.) Increases or decreases in the number of outlying counties included in metropolitan area boundaries would mostly have small effect on the numbers of ELCs because such outlying counties have many fewer ELCs than the more populous central counties. In those instances where EMAs would be consolidated, the changes to boundaries would be substantial, though there would be little or no net change in numbers of ELCs within those boundaries.

EMA would be added to the service area of a newly reconfigured EMA. Service area boundaries of 20 current EMAs would not change if the new OMB metropolitan area definitions were adopted. (See app. VII.)

Changing the service area boundaries of current Title I EMAs to reflect the new OMB metropolitan area definitions would result in most EMAs having a change in the number of ELCs within their boundaries, and the total net effect would be an increase of ELCs counted under Title I of less than 1 percent. Any ELCs that would no longer be counted under Title I would continue to be considered for purposes of Title II base grants as ELCs outside an EMA. Our analysis of the change in ELCs resulting from a change in EMA boundaries to the new OMB definitions shows that 19 of the 51 current EMAs would have less than a 2 percent change in their number of ELCs, and 23 EMAs would have no change in the number of ELCs in their service area. In total, these 42 EMAs represent about 88 percent of the total number of Title I ELCs. Of the remaining 9 EMAs, 3 EMAs would experience a gain or loss of more than 9 percentage points in their ELCs. The Dutchess County EMA (New York) would have about a 93 percentage-point increase in ELCs (a gain of 486 in the number of ELCs) as a result of adding Orange County to its service area. In New Jersey, Middlesex would have a 79 percentage-point increase in ELCs (a gain of 979 in the number of ELCs) by adding Monmouth and Ocean Counties. The Boston EMA would have about a 9 percentage-point decrease (a loss of 554 in the number of ELCs) because Bristol County (Massachusetts) would be reassigned from the Boston EMA to the Providence (Rhode Island) metropolitan area, which is not an EMA. Because the overall change in the number of Title I ELCs that would result from EMA service area boundary changes under the new OMB definitions would be an increase of less than 1 percent (a net gain of 1,742 in the number of ELCs), a minimal overall effect on funding per ELC would be expected.

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

CARE Act and HOPWA funding would have shifted among grantees if HIV case counts had been used with a measure of persons living with AIDS to allocate fiscal year 2004 formula grants. While all states and Puerto Rico have established HIV case-reporting systems, IOM identified characteristics of these systems that limit their appropriateness for the distribution of CARE Act and HOPWA funds.[66] We found that up to 13 percent of CARE Act funding would have shifted if HIV case counts had been used with ELCs in the distribution of fiscal year 2004 funds and if the hold-harmless and minimum-grant provisions we considered were maintained.[67] Larger changes for individual grantees would have occurred with some grantees more than doubling their funding. Grantees in the South and Midwest would generally have received more funding from using HIV cases in funding formulas.[68] 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. Larger funding shifts would have occurred without these CARE Act hold-harmless and minimum-grant provisions. HOPWA funding would also have shifted if HIV cases along with living AIDS cases had been used to determine funding rather than cumulative AIDS case counts. Differences in HIV case-reporting systems would affect funding allocations, and we found that funding would have tended to shift to jurisdictions with older HIV-reporting systems. Jurisdictions with older HIV-reporting systems tend to have more reported HIV cases compared with their number of AIDS cases than do jurisdictions with newer reporting systems.

[66]Institute of Medicine, *Measuring What Matters*, 87–134. While IOM examined only the CARE Act, its findings regarding the use of HIV data for determining funding allocations are also relevant for HOPWA.

[67]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.

[68]See app. I for a listing of 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.

Current HIV Case-reporting Systems Have Limitations for Providing Case Counts for Funding Allocations

In order to monitor HIV infection, the states and Puerto Rico have established HIV case-reporting systems under which individuals who have been diagnosed with HIV are reported to health departments by physicians and other practitioners.[69] In 2000 we reported that HIV cases accounted for a much smaller percent of total HIV/AIDS cases in states with newer HIV-reporting systems.[70] In its 2004 report, IOM updated our earlier analysis and identified several limitations in the ability of these jurisdictions to provide accurate HIV case counts to CDC for use in CARE Act funding allocations. Among these limitations, IOM found that the maturity of HIV case-reporting systems continued to vary widely across grantees. The earliest HIV-reporting systems were established in Colorado, Minnesota, and Wisconsin in 1985, followed by most southern and other midwestern states prior to 1995. The newest systems were established after 2003 in six states and Philadelphia, Pennsylvania.[71] Case-reporting systems need several years to become fully operational. Practitioners need to be made aware of the requirement to report new HIV cases and the methods for doing so. Existing cases also need to be reported by practitioners and entered into the system. Grantees with newer systems may not have collected and entered data on existing cases, and, consequently, may underreport the number of HIV cases. Underreporting of HIV cases in states with newer HIV-reporting systems would result in grantees receiving less funding than they would be entitled to receive according to the actual number of HIV/AIDS cases.

IOM also found that differences in how jurisdictions report HIV case counts to CDC preclude HRSA's use of those case counts in the distribution of CARE Act funds.[72] While some HIV case-reporting systems

[69]HIV case-reporting systems are generally either name- or code-based. In name-based systems, cases are collected by name while in a code-based system cases are collected using a coded identifier. Currently, 38 states and Puerto Rico have name-based systems while 8 states have code-based systems. In the remaining 5 states, names are collected and converted to codes by public health authorities.

[70]GAO/T-HEHS-00-150.

[71]Name-based HIV reporting has been established in all parts of Pennsylvania except Philadelphia since 2002. Philadelphia was given permission by the state to establish code-based HIV reporting, and the system began in 2004. However, in August 2005, the Philadelphia Board of Health voted to implement a name-based HIV-reporting system. This system went into effect in October 2005. Philadelphia is in the process of having its HIV surveillance data certified by CDC; once certified, its data will be accepted by CDC.

[72]HRSA uses AIDS case counts provided by CDC for determining CARE Act formula funding. All states and territories report AIDS cases by name.

are code-based, CDC will only accept name-based case counts as no code-based system has met its quality criteria as of January 2006.[73] Therefore, HIV cases reported using codes rather than names would not be counted in distributing CARE Act funds, if HIV case counts were used in funding formulas. As of December 2005, thirteen states have some form of a code-based system rather than a name-based system.[74] 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.[75] Table 9 shows the 39 jurisdictions where HIV case counts are accepted by CDC and the 13 jurisdictions where they are not accepted, and the year in which each jurisdiction established its HIV-reporting system.

[73]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. Some jurisdictions use codes instead of names to secure the privacy of the individuals being counted. In July 2005, CDC began recommending that all states and territories adopt confidential name-based surveillance systems to report HIV infections.

[74]Two of the 13 states, Illinois and Maine, established name-based HIV reporting in January 2006.

[75]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.

Table 9: CDC Acceptance of HIV Case Counts and Year of Establishment of HIV-reporting Systems, December 2005

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

Accepted	Not accepted
Puerto Rico (2003)	
Kentucky (2004)	
Connecticut (2005)[b]	
New Hampshire (2005)[c]	

Sources: CDC, IOM, Connecticut, Kentucky, and Philadelphia. Connecticut, Kentucky, and Philadelphia provided us with updated information about their HIV case-reporting systems.

Notes: Currently, CDC will only accept name-based case counts.

[a]Name-based HIV reporting has been established in all parts of Pennsylvania except Philadelphia since 2002. Philadelphia was given permission by the state to establish code-based HIV reporting, and the system began in 2004. However, in August 2005, the Philadelphia Board of Health voted to implement a name-based HIV-reporting system. This system went into effect in October 2005. Philadelphia is in the process of having its HIV surveillance data certified by CDC; once certified, its data will be accepted by CDC.

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

[c]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.

[d]Illinois established name-based HIV reporting in January 2006. It is in the process of having its HIV surveillance data certified by CDC and, once certified, its data will be accepted by CDC.

[e]Maine established name-based HIV reporting in January 2006. It is in the process of having its HIV surveillance data certified by CDC and, once certified, its data will be accepted by CDC.

The Use of HIV Case Counts in Funding Formulas Would Have Changed the Distribution of Fiscal Year 2004 CARE Act and HOPWA Funds

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 and HOPWA funding formulas. We found that some CARE Act fiscal year 2004 funding would have shifted among grantees if HIV case counts and ELCs had been used to allocate the funds. While our analyses indicate that up to 13 percent of CARE Act funding would have shifted, larger changes for individual grantees would have occurred. Southern and midwestern grantees would generally have received more funding, 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. Funding changes in our model would have been larger without the hold-harmless and minimum-grant provisions that we included. There would also have been at most a 15 percent shift in HOPWA funding if HIV cases were used to allocate funding, although there would have been larger changes for some

grantees.[76] CARE Act and HOPWA funding changes could have resulted from the number of people living with HIV/AIDS in each jurisdiction or differences in HIV case-reporting systems.

Methodological Approaches Used

We used two approaches to examine the effect of using HIV cases in addition to AIDS cases[77] in funding formulas for CARE Act Title I and Title II base grants, ADAP base grants, and HOPWA base funding in the states and Puerto Rico. Under the first approach, we used HIV and AIDS case counts for the 35 grantees from which CDC accepted HIV data.[78] Because CDC did not receive HIV case counts from the other 17 grantees, we used only the AIDS case counts received by CDC for these grantees. Consequently, for some grantees we used HIV and AIDS case counts, but

[76]Unlike the CARE Act, there is currently no law requiring the use of HIV cases in determining HOPWA funding. In our analysis of HOPWA, we used living AIDS cases instead of cumulative AIDS cases, which is the measure currently required by law to be used to determine HOPWA base funding. As we reported in 1995, we believe that cumulative AIDS cases is an inappropriate measure for allocating funds (GAO/HEHS-96-26, 6). Consequently, our analyses of HOPWA funding reflect the effect of using HIV and living AIDS cases instead of cumulative AIDS cases. This measure of living AIDS cases is used for illustrative purposes only.

[77]We used ELCs in our analyses of CARE Act programs, which is the measure of AIDS cases used by HRSA in determining funding for the grants we examined: Title I, Title II, and ADAP base grants. HUD does not have a measure of living AIDS cases that it uses to determine HOPWA funding. Because ELCs are specific to the CARE Act and because of shortcomings in this measure discussed earlier, we calculated an alternative measure of living AIDS cases in our examination of HOPWA funding. For the HOPWA analyses, the living AIDS case counts were calculated by subtracting the number of reported deaths among AIDS cases from the number of reported AIDS cases.

[78]Because HIV-reporting systems in some jurisdictions are changing to name-based systems, CDC now accepts HIV case counts from some jurisdictions from which it did not accept HIV case counts earlier. For our analyses, we classified Connecticut, Kentucky, and New Hampshire as having HIV case counts that are not accepted by CDC. Our analyses were conducted using fiscal year 2004 allocations, which were based on case reports as of June 30, 2003, for the CARE Act and as of March 31, 2003, for HOPWA. At those times, 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. A fourth state, Georgia, had not established any HIV case reporting as of June 30, 2003, but did so in 2004. Consequently, the HIV case count for Georgia is zero in our analyses. Pennsylvania is classified as having its HIV case counts accepted by CDC. However, these counts do not include any cases from Philadelphia, which established its code-based system in 2004. Philadelphia established a name-base HIV-reporting system in October 2005 and is in the process of having its HIV surveillance data certified by CDC; once certified, its data will be accepted by CDC. Illinois and Maine established name-based HIV-reporting systems in January 2006 and are also in the process of having their HIV data certified by CDC; once certified, their data will be accepted by CDC.

for others we used only AIDS case counts. This approach reflects the data that would have been used if funding allocations were based on the HIV and AIDS case counts received by CDC in time for determining fiscal year 2004 formula grants. Under the second approach, we used the same HIV and AIDS case counts as our first approach, but supplemented these data with the code-based HIV case counts collected by the grantees from which CDC did not receive HIV data.[79] We obtained these HIV case counts directly from these jurisdictions.[80]

For both approaches, we calculated the grantee's percentage of the total number of HIV/AIDS cases in each jurisdiction[81] and estimated the fiscal year 2004 formula grants that each would have received. Under each approach, CARE Act formula grants were calculated both with certain hold-harmless and minimum-grant provisions and again without those provisions.[82] Eliminating hold-harmless and minimum-grant provisions

[79]CDC receives, reviews, and processes name-based HIV case reports on individual cases. Potential duplicate reports across jurisdictions are reviewed through a CDC-coordinated process to remove duplicate reports from the national database. Code-based reports cannot be included in this de-duplication process because name-based and code-based systems do not have comparable patient identifiers. Because the name- and code-based case counts are not comparable, in its comments on a draft of this report HHS stated that it would not be appropriate to use the code-based case counts in monitoring HIV/AIDS nationally. Our purpose in using both the name- and code-based case counts was to provide a general indication of how funding would be affected by using HIV and AIDS cases to distribute CARE Act and HOPWA funds in light of the statutory requirement that HIV cases be used in CARE Act funding formulas not later than fiscal year 2007. Our use of the code-based case counts should not be taken as endorsement for their use in monitoring HIV/AIDS or distributing funds. An assessment of the feasibility of using code-based case counts was beyond the scope of our report.

[80]HIV case counts for three states—Georgia, Kentucky, and the District of Columbia—were unavailable. Consequently, their HIV case counts are zero under both approaches. HIV case counts were also unavailable for Philadelphia, and as a consequence HIV counts were incomplete for Pennsylvania.

[81]For example, for CARE Act Title I base funding, we calculated the EMA's percentage of the total number of HIV/AIDS cases in all EMAs.

[82]Under the CARE Act, there is a minimum-grant provision for Title II base grants, but not for Title I and ADAP base funding. However, there are hold-harmless provisions for Title I, Title II, and ADAP base funding. There is no comparable hold-harmless provision in HOPWA and minimum-grant requirements have been effectively waived in recent years. Consequently, the analyses in which the hold-harmless and minimum-grant provisions are maintained are limited to the CARE Act. For purposes of this analysis, we considered the Title I hold-harmless provision and the Title II hold-harmless provision that is 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. The effect on HOPWA allocations are discussed later.

was done to reveal the full effect of distributing fiscal year 2004 funding solely according to HIV/AIDS data available at that time. We also estimated the effect of using HIV cases and living AIDS cases for HOPWA base funding. Although there are limitations associated with the underlying data, the results of our analyses indicate the general effect of using HIV and AIDS cases to distribute CARE Act and HOPWA formula funding. (See app. I for a discussion of the limitations in the data.)

Changes in CARE Act Funding Using HIV Cases and Hold-harmless and Minimum-grant Provisions

Our analyses indicate that for fiscal year 2004 as much as 13 percent of Title I, Title II, and ADAP base grants would have shifted, with southern and midwestern grantees being the primary beneficiaries, if hold-harmless and minimum-grant provisions were maintained. 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. Changes in funding could have resulted from the actual number of HIV/AIDS cases living in each jurisdiction or from differences across jurisdictions in HIV case-reporting systems. The funding changes under each of our approaches would have been larger if we had not applied the hold-harmless and minimum-grant provisions.

Title I Base Funding

Title I base grant funding would have shifted among grantees under both our approaches, but because the funds necessary to meet the hold-harmless provision are taken from funds that would otherwise be used for supplemental grants, the overall effect on Title I EMAs is unclear.[83] The Title I base grant includes (1) funding amounts determined by the number of ELCs and (2) the hold-harmless amounts, if applicable. In fiscal year 2004, a total of about $8.0 million was needed to fund the hold-harmless payments for EMAs. The amount of Title I hold-harmless funding for all EMAs would have increased from $8.0 million to $43.3 million under our first approach in which we used only HIV data received by CDC and ELCs. It would have increased to $29.4 million under our second approach in which we used the HIV case counts collected by CDC, the code-based HIV counts we collected from the grantees, and ELCs. In order to meet the hold-harmless levels, funds would have to be deducted from the amounts otherwise available for Title I supplemental grants. Supplemental grants are divided among all EMAs using a competitive application process based on the demonstration of severe need and other criteria. Because these

[83]There is no minimum funding provision for Title I base grants.

awards are made competitively, it is unclear how the reduction in funding for supplemental grants would have affected individual EMAs and, therefore, what the overall effect on funding for each EMA would have been under our two approaches.

Under the first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—13 EMAs would have received a total of $2.8 million less in fiscal year 2004 Title I base grants, about 1 percent of the total Title I base grants. Twenty-nine grantees would have received $38.1 million in additional Title I base grant funding, about 13 percent of total Title I base grants, if HIV cases and ELCs had been used to allocate funding instead of just ELCs. The other 9 EMAs would have had no change in their funding. The effect on certain EMAs would have been large, with the Denver EMA more than doubling its Title I base funding and 16 others receiving at least a 25 percent increase in funding. Of the 29 that would have received more funding, 13 are in the South. In addition, 5 of the 6 EMAs in the Midwest and 8 of 12 EMAs in the Northeast would have received increased funding. However, only 3 of 14 EMAs in the West would have received increased funding.[84]

Under the second approach—using the HIV case counts collected by CDC, the code-based HIV counts we collected from the grantees, and ELCs—15 EMAs would have received a total of $1.9 million less in fiscal year 2004 Title I base grants, about 1 percent of the total Title I base grants. Twenty-eight grantees would have received $23.3 million more in fiscal year 2004 Title I base grants, about 8 percent of total Title I base grants. Eight EMAs would have had no change in their funding. Some EMAs would have received large increases in funding, with the Denver EMA more than doubling its Title I base grant funding and 9 others receiving at least a 25 percent increase in funding. Of the 28 EMAs that would have received additional funding, 10 are in the South. All 6 midwestern EMAs would have received additional funding. Seven of 12 EMAs in the Northeast and 5 of 14 EMAs in the West would have received increased funding. Appendix VIII shows the results of the analyses for each EMA under each approach.

[84]See app. I for a listing of the four U.S. Census Bureau regions and the jurisdictions that constitute each region.

Title II Base Funding

There would be some shifting of funds if HIV cases and ELCs had been used to allocate CARE Act Title II base grants while maintaining the hold-harmless and minimum-grant provisions.[85] Most southern and midwestern grantees would receive increased funding under either approach we used for analysis. Under the first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—about 5 percent or $14.3 million of Title II base grants would have shifted among grantees. Unlike funding for the Title I hold-harmless provision, the amounts necessary to fund the Title II base grant hold-harmless and minimum-grant provisions are subtracted from the base grants of those states that did not qualify for funding under these provisions. Consequently, the total amount of funding increases received by some Title II grantees would have to be equal to the total decreases received by other grantees. Twenty-one grantees would have received additional funding in their Title II base grants, and 22 would have received less. Nine grantees would have had no change in their funding. Of the 21 that would have received more funding, 9 are in the South and 7 in the Midwest. Of the 22 that would have received less funding, 6 are in the Northeast and 5 are in the West. Changes in funding for individual grantees would have ranged from a 150 percent increase in North Dakota and Wyoming to a 22 percent decrease in Delaware and the District of Columbia.

The second approach—using the HIV case counts accepted by CDC, the code-based HIV counts we collected from the grantees, and ELCs—would yield a smaller shift in funding. Under this approach, approximately 4 percent or $12.6 million of fiscal year 2004 Title II base grants would have shifted. Of the 22 grantees that would have received additional funding, 10 are in the South and 7 in the Midwest. Among those that would have received less funding, 4 are in the Northeast and 4 are in the West. Twenty grantees would have received less funding and 10 would have received the same amount. Funding changes for individual grantees would have ranged from a 150 percent increase in North Dakota and Wyoming to a 22 percent decrease in Delaware and the District of Columbia.

[85]We assume that the case threshold for determining the size of minimum grants would remain at 90 even if HIV cases were included in the case counts. Currently, states with fewer than 90 ELCs are guaranteed a minimum Title II base grant of $200,000 while states with 90 or more cases are guaranteed at least $500,000. Our analyses assume that the threshold would be a total of 90 HIV cases and ELCs.

Appendix IX shows the results of these analyses for each grantee under each approach.

While a majority of southern grantees would have received increased funding under both approaches, the amount of the increase would have been relatively small. Southern grantees would have received a total of about $430,000 more funding under our first approach and about $640,000 under the second approach. This relatively small shift can be attributed to the fact that southern states generally would not benefit from the minimum-grant and hold-harmless provisions. For example, many southern states would have their grants reduced in order to fund the hold-harmless provision. Midwestern grantees would have received larger dollar and percent increases in funding than the southern grantees under both approaches.

ADAP Base Funding

Our analyses indicate that there would have been some shifting of funding for ADAP base grants if HIV and AIDS case counts had been used to determine allocations while maintaining the hold-harmless provision,[86] with southern and midwestern grantees generally being among the areas that would have received increased funding.[87] Under the first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—about 12 percent or $85.2 million of fiscal year 2004 ADAP base grants would have shifted among grantees. The amounts necessary to fund the ADAP base grant hold-harmless provision are subtracted from the ADAP base grants of those states that did not qualify for hold-harmless funding. Consequently, the total amount of funding increases received by some Title II grantees must be equal to the total decreases received by other grantees. Thirty-one of the 52 grantees would have received additional funding in their ADAP base grants if HIV cases and ELCs had been used to allocate funding instead of just ELCs. Of the 31 that would have received more funding, 12 are in the South and 11 in the Midwest. The funding changes for some grantees would have been large. For

[86]There is no minimum funding provision for ADAP base grants.

[87]The ADAP base grant funding reported to us included any hold-harmless funding taken from funds otherwise set aside for the ADAP Severe Need grants. This hold-harmless funding results from a different Title II hold-harmless provision than that which requires HRSA to consider separately Title II base grants and ADAP base grants. In our analyses, we excluded hold-harmless funding taken from the ADAP Severe Need grants when we estimated the dollar and percent changes in the ADAP base grants.

example, Colorado's allocation would have doubled and South Dakota's would have increased by 84 percent while funding would be reduced by 38 percent in Delaware, the District of Columbia, Illinois, Kentucky, and Maryland.

The second approach—using the HIV case counts accepted by CDC, the code-based HIV counts we collected from the grantees, and ELCs—yields a smaller shift in funding. Under this approach, approximately 9 percent or $65.2 million of fiscal year 2004 ADAP base grants would have shifted. Of the 35 grantees that would have received additional funding, 12 are in the South and 10 are in the Midwest. Funding changes for some grantees would have been large. For example, the allocation for Montana would have increased 93 percent and the allocation for Colorado 84 percent, while funding would have declined by 40 percent in the District of Columbia and by 38 percent in Kentucky. Appendix X shows the results of these analyses for each grantee under both approaches.

Changes in CARE Act Formula Funding Would Be Larger If Hold-harmless and Minimum-grant Provisions Were Not in Effect

Hold-harmless provisions limit how much funding can decline from one grant period to the next. However, while these provisions limit changes in funding they also reduce a program's ability to respond to changing need. Minimum-grant provisions guarantee that no grantee will receive less than a specified funding amount. These provisions also limit how funding can be distributed.[88]

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 AIDS cases would be larger—up to 24 percent—if the current hold-harmless or minimum-grant amounts were not in effect than if they were in effect.[89] Consider the hypothetical situation in which an EMA or Title II grantee received a $2 million base grant award according to its number of ELCs. Assume that in the following year, the formula is changed so that HIV cases and ELCs are used to determine funding allocations, and the grantee is then only entitled to $1 million. However, there is a hold-harmless

[88]For a description of features in funding formulas, see National Research Council, *Statistical Issues in Allocating Funds by Formula: Panel on Formula Allocations* (Washington, D.C.: The National Academies Press, 2003).

[89]In these 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.

provision that guarantees the grantee 98 percent of what it received the previous year. The grantee 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 cases and ELCs. The change in funding with the hold-harmless provision would be a decrease of $40,000, but the loss would grow to $1,000,000 without the hold-harmless provision. If a grantee qualified for $100,000 in formula funding using HIV case counts and ELCs, but the minimum award was $500,000, the grantee would receive $500,000 because of the minimum-grant provision, thereby offsetting the changes due to using HIV cases and ELCs.

Title I Base Funding

Under both our methodological approaches, Title I funding would have been affected by eliminating the Title I base grant hold-harmless provision.[90] If the hold-harmless provision had been eliminated, the number of EMAs that would have received less Title I base grant funding would have increased from 13 to 23 under our first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—and from 15 to 24 under our second approach—using the HIV case counts collected by CDC, the code-based HIV counts we collected from the grantees, and ELCs.[91] The effect of the hold-harmless provision on an individual grantee can be illustrated with the New Haven EMA. New Haven, which would have had no change in base grant funding if the hold-harmless provision was maintained would have had Title I base grant funding reductions of 31 and 35 percent under the first and second approaches, respectively, without the hold-harmless provision. Overall, southern and midwestern EMAs would gain funding under both approaches whether or not the hold-harmless provision was maintained while northeastern EMAs would lose funding only under our second approach and only if the hold-harmless provision was not maintained.[92] However, in all four regions of the country, there would have been EMAs that would have received increased funding and EMAs that would have

[90]There is no minimum funding provision for Title I base funding.

[91]The amount of base grant funding would have been about $8 million less without the hold-harmless provision. This money would have been distributed to EMAs in supplemental grants.

[92]EMAs in the West would gain funding under both approaches if the hold-harmless was maintained but would receive less funding under both approaches if it was not maintained.

received decreased funding. Appendix XI shows the results of our analyses for Title I base grants if the hold-harmless provision was not maintained.

Title II Base Funding

The hold-harmless and minimum-grant provisions have a large effect on funding shifts in Title II base grants. Under our first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—14 percent of Title II base grants would have shifted among grantees if the hold-harmless and minimum-grant provisions had been eliminated, while 5 percent would have shifted if they had been maintained. Under our second approach—using the HIV case counts collected by CDC, the code-based HIV counts we collected from the grantees, and ELCs—10 percent would have shifted if the provisions were eliminated and 4 percent if they had been maintained. The importance of these provisions can be illustrated by examining individual grantees. For example, Vermont, which received a minimum grant of $500,000 in fiscal year 2004, would have had a decrease of 74 percent under approach one and 52 percent under approach two if the hold-harmless and minimum-grant provisions had not been maintained. However, it would have had no change in funding if these provisions had been maintained. California would have received decreases of $11.8 million under our first approach and $5.0 million under our second approach if the provisions had been eliminated, but the state would have had no change in funding if the provisions had been maintained. Conversely, North Carolina would have received $5.0 million in additional funding under our first approach and $4.0 million under our second approach if the hold-harmless and minimum-grant provisions had not been maintained. It would have received $2.4 million and $2.1 million additional under each approach respectively if the provision had been maintained. Southern and midwestern grantees would gain funding under both approaches whether or not the hold-harmless and minimum-grant provisions had been maintained, while northeastern grantees would lose funding.[93] However, in all four regions of the country, there would have been grantees that would have received increased funding and grantees that would have received decreased funding. Appendix XII shows the results of our analyses for Title II base grants if the hold-harmless and minimum-grant provisions were not maintained.

[93]Grantees in the West would gain funding under both approaches if the hold-harmless and minimum-grant provisions were maintained but would receive less funding under both approaches if they were not maintained.

ADAP Base Funding

The overall effect of the hold-harmless provision is smaller on funding shifts for the ADAP base grants.[94] Under our first approach—using ELCs and HIV cases when accepted by CDC and only ELCs elsewhere—14 percent instead of 12 percent of ADAP base funding would have shifted among grantees if the hold-harmless provision was eliminated. Ten percent instead of 9 percent of the funding would have shifted under our second approach—using the HIV case counts collected by CDC, the code-based HIV counts we collected from the grantees, and ELCs. The reason for the smaller effect on the ADAP base grants than on the Title I and Title II base grants is the increase in ADAP base funding since fiscal year 2000. In fiscal year 2000, $528 million was distributed to grantees while $728 million was distributed in fiscal year 2004. Because of these increases, the hold-harmless provision had less effect in our analyses. However, under all our scenarios grantees in the Northeast and West would have received less total funding while grantees in the Midwest and South would have received more. In all four regions of the country, there would have been grantees that would have received increased funding and grantees that would have received decreased funding. For example, in the Northeast, New Jersey would have gained funding and New York would have lost funding under both our approaches. In the South, Alabama would gain funding and Georgia would lose funding under both our approaches. Appendix XIII shows the results of our analyses for ADAP base grants if the hold-harmless provision had not been in effect.

HOPWA Base Funding Would Generally Shift If HIV Cases Were Used in Formula Allocations

There would have been some shifting of funds if HIV and living AIDS case counts[95] had been used to allocate HOPWA base grants instead of cumulative AIDS cases under either of our methodological approaches—with or without the code-based HIV case counts—with southern and midwestern grantees generally being among the jurisdictions that would have received increased funding.[96] Under the first approach—using living

[94]There is no minimum funding provision for ADAP base funding.

[95]For the HOPWA analyses, the living AIDS case counts were calculated by subtracting the number of reported deaths among AIDS cases from the number of reported AIDS cases.

[96]This analysis indicates how HOPWA base funding would have changed if living AIDS cases and HIV cases had been used to distribute funding rather than cumulative case counts. The effect of using living AIDS cases but not HIV cases on HOPWA base funding is shown in app. V.

AIDS cases and HIV cases when accepted by CDC and only living AIDS cases elsewhere—about 15 percent or $30.0 million of fiscal year 2004 HOPWA base grants would have shifted among grantees. Seventy of 117 grantees would have received additional funding in their HOPWA base grants if living HIV and AIDS cases had been used to allocate funding. Six grantees would have more than doubled their funding.[97] Thirty-five of 47 southern grantees[98] and 18 of the 20 midwestern grantees would have received more funding. Southern grantees would have received an additional $15.8 million (22 percent) in funding while those in the Midwest would have received an additional $3.3 million (17 percent). Seventeen of the 24 northeastern grantees and 14 of the 24 western grantees would have received less funding. The northeastern and western grantees would have received $6.3 million (10 percent) and $9.7 million (24 percent) less in funding respectively.

The second approach—using the HIV case counts accepted by CDC, the code-based HIV counts we collected from the grantees, and living AIDS cases—yields an overall smaller shift in funding although changes would have been larger in the Midwest and Northeast. Under this approach, approximately 13 percent or $25.6 million of fiscal year 2004 HOPWA base grants would have shifted, with Maryland and Charlotte, North Carolina, more than doubling their funding. Of the 82 grantees that would have received additional funding, 39 are in the South, 19 in the Midwest, 14 in the West, and 10 in the Northeast. Overall, the South would have received $13.7 million (19 percent) in additional funding and the Midwest would have received an additional $4.0 million (21 percent). The Northeast would have received $8.5 million (14 percent) less in funding and the West $5.8 million (15 percent) less. Appendix XIV shows the results of these analyses for each jurisdiction under both approaches.

Differences in Case-reporting Systems Would Affect Allocations

One explanation for the changes in funding allocations when HIV cases and either ELCs or living AIDS cases are used—whether or not the code-based HIV case counts are included—instead of only AIDS cases[99] is the

[97]These six grantees are the state of Alabama; Birmingham, Alabama; Charlotte, North Carolina; Memphis, Tennessee; the state of North Carolina; and Wake County, North Carolina.

[98]In those cases in which an EMSA included both southern and nonsouthern jurisdictions, we classified the EMSA as not being in the South.

[99]In this instance, AIDS cases refers to ELCs for the CARE Act and cumulative AIDS cases for HOPWA.

maturity of HIV case-reporting systems. 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. As shown in table 10, jurisdictions with long histories of counting HIV cases tend to have many more reported HIV cases compared with their number of ELCs than do jurisdictions with less-mature reporting systems. This difference is likely because jurisdictions with newer systems do not have reports on many cases of HIV that were diagnosed before their reporting systems were established.[100] This divergence can be illustrated by comparing Wisconsin and Delaware, two states with similar numbers of AIDS cases. Wisconsin began reporting HIV cases in 1985 while Delaware began in 2001. In Wisconsin, as of June 2003, there were about 50 percent more reported HIV cases than AIDS cases, or 2,287 HIV cases and 1,507 AIDS cases. As of June 2003, the 909 reported HIV cases in Delaware were about 40 percent less than the 1,518 ELCs. This variability could be reduced as Delaware identifies more preexisting HIV cases. However, the variability between HIV cases and ELCs would remain if there was a difference in the actual number of HIV cases.

Table 10: Reported HIV Cases and ELCs as of June 2003

HIV case-reporting system start date	Number of jurisdictions[a]	Ratio of HIV cases to ELCs
1985–1991	21	1.42
1992–1998	11	1.01
1999–2002	17	0.68

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

[a]Georgia, Kentucky, and Puerto Rico are not included in this table because they established their HIV-reporting systems after 2002. Connecticut and New Hampshire established their name-based HIV-reporting system in 2005. However, 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. 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.

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

Under either approach, grantees might receive increased funding because other grantees did not yet have an accurate measure of HIV case counts. 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.[101]

The maturity of the HIV-reporting systems can be linked to whether a jurisdiction has a name- or code-based system. As discussed earlier, CDC does not currently accept HIV case reports from code-based systems. 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, twelve of the 13 code-based systems were implemented in 1999 or later, compared with 10 of the 39 name-based systems. 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.

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. Without corresponding increases in CARE Act funding, this increase in identified HIV cases could cause grantees with more mature systems to experience funding decreases. Hold-harmless provisions would protect grantees with older reporting systems from funding losses. However, grantees with newer systems could receive less funding per case because funds would be needed to cover hold-harmless provisions.

[101]Institute of Medicine, *Measuring What Matters*, 92.

Conclusions

The funding provided under the CARE Act and HOPWA has filled important gaps in communities throughout the country, but as Congress reviews these programs, it is important to understand how much funding can vary across communities with comparable numbers of persons living with AIDS. While provisions in the formulas have served specific purposes, such as maintaining consistent funding from year to year, it is clear that the level of funding available per AIDS case is quite variable because of these provisions:

- The use of ELCs—AIDS cases reported over the past 10 years weighted by survival rates—and the use of 2- and 5-year cumulative reported AIDS cases for CARE Act funding results in AIDS case counts that do not reflect the number of persons who could be served by the program because many persons with AIDS live longer than 10 years after their disease is reported, deceased cases are included in the case counts, and cases diagnosed prior to the reporting period are not included.
- Considerably more CARE Act funding has gone to some grantees than others even though they have similar numbers of cases because of the counting of ELCs in EMAs for both Title I base funding and Title II base funding, hold-harmless provisions that protect Title I, Title II, and ADAP base grant funding levels, the grandfathering of EMAs so that metropolitan areas designated as EMAs for fiscal year 1996 continue to be eligible for Title I funding, and the division of Emerging Communities into two tiers with equal funding of each tier without regard to the number of communities or the number of reported AIDS cases in each tier.
- The use of cumulative AIDS cases to determine eligibility for HOPWA formula grants, including for bonus grants, and the amount of HOPWA base grants has led to disproportionate funding per living AIDS case because the formula counts deceased cases in addition to living cases, thereby resulting in increased funding for areas with early outbreaks.

The CARE Act Title II hold-harmless provision that is funded from amounts that would otherwise be available for ADAP Severe Need grants has had little effect so far as the amounts needed to fund this provision have been comparatively small. However, reducing funds to be made available for qualifying states could adversely affect the states with severe need in the future if the amounts needed to fund the hold-harmless provision increase.

Congress recognized in the 2000 CARE Act amendments that the CARE Act benefits many people whose HIV infection has not progressed to AIDS when it required that HIV case counts be used in the distribution of funds. The inclusion of HIV cases in the CARE Act funding formulas by fiscal

year 2007 could eventually improve the targeting of funding to needy individuals with HIV disease. However, it could result in significant shifts in program funding that may not be related to the geographic distribution of HIV/AIDS cases because of differences in the type and maturity of the reporting system used in each state.

Matters for Congressional Consideration

While only AIDS case counts are currently used for determining CARE Act formula funding, Congress has required that HIV case counts be incorporated into the funding formulas not later than fiscal year 2007. Regardless of when HIV case counts are incorporated, issues will still exist regarding how AIDS cases are used in the formulas and the effect various provisions have on funding. 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.

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.

If Congress wishes HOPWA funding to more closely reflect the distribution of persons living with AIDS, it should change the program so that HOPWA formula grant eligibility, including for bonus grants, and base grant funding allocations are based on a measure of living AIDS cases.

Agency Comments and Our Evaluation

HHS and HUD provided written comments on a draft of this report. HHS and HUD generally agreed with our identification of issues in the funding formulas. Their comments are reprinted in appendixes XV and XVI. HHS commended us for its comprehensive approach and ambitious analysis that pulled together data from many disparate sources. HUD noted that it appreciated that the report seeks to improve the targeting of federal resources to better assist those with HIV/AIDS.

HHS noted that we identified various deficiencies in the current HIV data. However, HHS suggested that we did not examine the distribution differences that would result from incorporating HIV cases into the CARE Act funding formulas. HHS noted that we did not assess the potential usefulness of HIV data in funding formulas if all jurisdictions participated in the national reporting system coordinated by CDC using standardized methods of reporting. Such a determination was beyond the scope of our work. However, as noted in the draft report, we present analyses showing the impact of using HIV cases on fiscal year 2004 funding for Title I, Title II, and ADAP base grants, which comprise the bulk of CARE Act funding.

While HHS generally agreed with our matters for congressional consideration, HHS made several comments on the issues these matters address. HHS noted that our matters for congressional consideration focus only on potential changes to the use of AIDS cases in formulas but not to the use of HIV cases. The matters for consideration are based on current funding formula provisions that require the use of AIDS cases. Our discussion should not be interpreted as endorsing the superiority of using living AIDS cases instead of HIV/AIDS cases.

Regardless of whether HIV case counts are used, the funding formula provisions we identified will continue to affect proportional funding per case if they are maintained. We believe that the use of AIDS case counts that include deceased cases and do not reflect the current life spans of persons living with AIDS will continue to be of concern. Also, various provisions, such as allocating funding for Emerging Communities by tier and hold-harmless provisions, will affect the distribution of funding regardless of whether HIV cases are used in the formulas.

HHS pointed out that our assessment of the impact of hold-harmless provisions on CARE Act formula funding appears accurate. HHS noted disparities in funding per AIDS case that can result from counting cases in EMAs once for Title I funding, and once again for Title II funding. HHS also agreed with our analysis of the Emerging Communities provision; we

deleted our reference to a population threshold as an eligibility requirement for Emerging Communities in response to its comment on this issue. HHS concurred with our suggestion that the Title II hold-harmless provision should be revised to preserve funding for ADAP Severe Need grants.

HHS raised concerns that our discussion of the Title I grandfather clause in the CARE Act could be interpreted as suggesting EMAs that continue to receive grants because of this provision need not be funded. HHS noted that a cessation of funding could lead to a decline in these areas' systems of care and, by extension, a decline in the progress made in fighting the epidemic. However, we note that these areas could receive funding through their respective states or territories, which receive funds under Title II. In addition, much of the improvement in care for those with HIV/AIDS is due to the improvement in drugs, which, as indicated in Appendix III, are primarily provided through Title II ADAP grants. HHS noted that without Title II minimum grant amounts for states and territories, the number of reported AIDS cases in low prevalence areas would not be sufficient to sustain state-of-the-art HIV/AIDS care and treatment services.

HHS also noted that we do not have a specific matter for congressional consideration regarding the use of OMB's revised definitions of metropolitan boundaries for determining Title I EMAs. HHS stated that the report suggests that the revised definitions be accepted for determining such boundaries. In the report, we discuss the methods used in our analysis and the results of this analysis, but take no position on whether the new definitions should be used in determining the EMA boundaries.

HHS commented that the draft report lacked specificity regarding the process by which CDC receives HIV case counts from the states. We have modified our report to include a discussion of this process. HHS also stated in its comments that it would not be appropriate to use the code-based case counts in monitoring HIV/AIDS nationally. An assessment of whether code-based data should be used for monitoring HIV/AIDS is beyond the scope of our work. Our purpose was to provide Congress with an indication of the impact of using HIV cases in the CARE Act and HOPWA funding formulas in light of the statutory requirement that HIV cases be used in CARE Act funding formulas not later than fiscal year 2007. We have added text to the report discussing HHS's concerns about code-based data.

HUD concurred with our matter for congressional consideration that cumulative AIDS cases no longer be used in the HOPWA formula. HUD pointed out that incorporation of a more current estimate of persons living with HIV/AIDS would be more effective in targeting these HOPWA funds to grantees. HUD stated in its comments that we did not take into account differing housing costs across jurisdictions in the draft report. In response to this comment, we revised the report to note that housing costs are not currently part of the HOPWA funding formula, and consideration of housing costs was not within the scope of our work. However, we have clarified the draft report to note that if housing costs were included in the funding formulas, they could justify deviations from proportional funding per case.

HUD suggested that we not use the terms base grant and bonus grant. We have added a note to our report to reflect that our terminology differs from HUD's, but retained the use of bonus and base grants in order to differentiate between the two formula funding components.

HUD expressed concern that the full effect of incorporating HIV case counts may not be apparent by only stating the amount of funding that would shift among grantees. We have added text to note that the changes could result in some grantees more than doubling their funding. HUD suggested that these analyses could be done based solely on data from jurisdictions with CDC-accepted HIV case counts, or those jurisdictions with mature HIV-reporting systems. However, as noted in the draft report, we present analyses showing the impact of using only CDC-accepted HIV data on fiscal year 2004 HOPWA base grants. We do not include an analysis using only jurisdictions with mature HIV-reporting systems because it would exclude many jurisdictions and we determined that such an analysis would not be appropriate. HUD also pointed out that the draft report did not describe the incremental effect on HOPWA allocations of using HIV cases with living AIDS cases rather than living AIDS cases only. The draft report provided information on this in appendix V, and we have added text to the report to refer the reader to this appendix. HUD suggested that we expand a footnote to further describe our analysis of HIV cases in funding formulas. However, this information is already presented in detail in appendix I and is also described in the text of the report.

In its comments HUD noted bonus funding can provide a significant amount of resources to those eligible and that this funding can have a large effect on formula funding per AIDS case. As noted in the draft report, we show the amount of base funding and bonus funding that each grantee

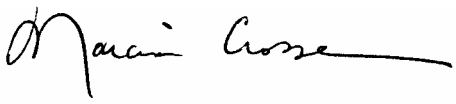
received in fiscal year 2004 and state that funding differences per case are due in part to the bonus grants. HUD suggested that we revise our conclusion to reflect the importance of the bonus grants. However, our conclusion focuses on the base grants because of the use of cumulative AIDS cases in determining these grants. HUD also noted that not all grantees that receive bonus grants sustain the funding from year to year. We have added text to note the instability of the bonus funding and that, with respect to fiscal year 2006 funding, HUD's appropriation act included a provision to mitigate the variability of incidence data by using data reported over a 3-year period.

HUD also suggested that we use different terms to categorize how HOPWA funding was allocated by grantees and provided us with updated information on how grantees allocated fiscal year 2003 HOPWA grants. We have revised the report based on this information.

HHS and HUD also provided technical comments, which we have incorporated where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Secretary of Housing and Urban Development, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and to interested congressional committees. We will also make copies available to others upon request. In addition, the report will be available on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me 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 report. GAO staff who made major contributions to this report are listed in appendix XVII.



Marcia Crosse
Director, Health Care

Appendix I: Objectives, Scope, and Methodology

Objectives

We assessed the distribution of funding for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) and the AIDS Housing Opportunity Act's Housing Opportunities for Persons with AIDS program (HOPWA). Specifically, we are reporting on (1) how CARE Act and HOPWA funds are allocated by grantees among the types of services each program supports; (2) the extent of funding distribution differences among CARE Act and HOPWA grantees, and how CARE Act and HOPWA funding-formula provisions contribute to these difference; and (3) what distribution differences would result from using HIV cases in CARE Act and HOPWA funding formulas.

Scope and Methodology

To report on these three objectives, we reviewed the CARE Act of 1990, as well as the 1996 and 2000 CARE Act amendments, the AIDS Housing Opportunity Act, Health Resources and Services Administration (HRSA) and Department of Housing and Urban Development (HUD) documents on CARE Act and HOPWA funding, HUD memoranda, Institute of Medicine reports on the CARE Act, and other related reports. We interviewed officials from HRSA, the Centers for Disease Control and Prevention (CDC), HUD, and the National Alliance of State and Territorial AIDS Directors. We received information from state government officials regarding their HIV case-reporting systems. Details on the scope of our work and the methods to address each objective follow.

Allocation of CARE Act and HOPWA Funds among Service Categories

To determine how grantees allocate CARE Act and HOPWA funds by types of service, we obtained information on the allocation of these funds from HRSA and HUD.[1] HRSA provided information on grantees' allocation of CARE Act Titles I and II funds for fiscal year 2003, and Title III allocations for fiscal year 2002. HRSA also provided funding amounts for its HIV/AIDS Dental Reimbursement Program, Community-Based Dental Partnership grants, Special Projects of National Significance, and AIDS Education and Training Centers program for fiscal year 2003. HUD provided HOPWA allocation data for fiscal year 2003, these being the most recently available data. We analyzed these data and, where available, calculated the percentage of the total amount each service category represented. To assess the reliability of HRSA and HUD data on the allocations of CARE

[1]Grantees are those entities that receive CARE and HOPWA funding. Grantees vary by program and can include states, territories, metropolitan areas, and primary-care providers.

Act and HOPWA grant funds, we interviewed agency officials about the data and reviewed relevant documentation. We determined that the data were sufficiently reliable for the purposes of our report.

Funding-formula Provisions

We examined the effect of specific funding-formula provisions on CARE Act and HOPWA grants. We first assessed the use of 2- and 5-year cumulative counts of AIDS cases and the use of estimated living AIDS cases (ELC) in CARE Act programs by comparing these measures with living AIDS case counts received from CDC.[2] We then examined the following CARE Act formula provisions: the counting of ELCs in eligible metropolitan areas (EMA) for both Title I and Title II funding, the tiered allocation of Emerging Communities funding, the Title I hold-harmless provision, the Title I grandfathering clause, and the Title II hold-harmless provision funded from amounts available for Severe Need grants.[3] To examine the effect of each provision on the CARE Act and HOPWA grant amounts, we measured differences on a per case basis, by the amount of funding received, or both. We calculated each grantee's percentage of the total number of AIDS cases in all relevant jurisdictions, and we used these percentages to determine the funding each grantee would have received. We then compared these amounts with what was actually received to show the effect of a provision in the formula. In addition, we examined the effect of using living AIDS cases instead of cumulative cases in making HOPWA base grant distributions by comparing the actual funding distributions with simulated distributions using living AIDS cases. We also assessed the effect of HOPWA bonus grants on funding for eligible metropolitan statistical areas (EMSA) by examining the size of these grants and which EMSAs received them.

To conduct our analyses of the effect of funding-formula provisions on CARE Act and HOPWA funding and programs in the states, including the District of Columbia, Puerto Rico, and metropolitan areas, we obtained

[2]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 death.

[3]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. The ADAP portion 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.

fiscal year 2004 funding data and AIDS case counts from HRSA and HUD, and supplemented this information with additional AIDS case-count data from CDC. Fiscal year 2004 data were the latest data available at the time of our review. We limited our CARE Act analyses to Titles I and II because grants under other parts of the Act are not formula-driven. Similarly, our HOPWA analyses are also limited to the parts of the program that are formula-based, namely, the base and bonus grants.

Our analyses of funding provisions take into consideration that CARE Act and HOPWA formula grants use different measures of the number of AIDS cases to determine grant amounts. There are three measures used for CARE Act grants—reported AIDS cases over 2 years, reported AIDS cases over 5 years, and ELCs. 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. HOPWA uses two measures—total AIDS cases reported in the jurisdiction since the beginning of the epidemic in 1981 and AIDS incidence rates.

In our analyses of the funding formulas, we used the measure of AIDS cases that is used to determine funding in a particular grant program in order to show the effect of different formula provisions on fund distribution. We also compared the AIDS data used for funding formulas with data on living AIDS cases to assess the effect of not using living AIDS cases on funding allocations. For the CARE Act, we used the measure of living AIDS cases that is required by law to be used by the program when distributing Title I, Title II, and ADAP base grants, that is, the number of ELCs based on 10 years of reported cases and survival rates. In the absence of a measure of living AIDS cases for HOPWA funding, we used a measure of living AIDS cases calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases. This measure of living AIDS cases is used for illustrative purposes only.

In our analysis of counting ELCs in EMAs for both Title I and Title II CARE Act funding, we aggregated Title I and Title II funding received by each of the states and Puerto Rico. Because some EMAs cross state boundaries, we apportioned Title I funding among states according to the proportionate share of an EMA's ELCs in each state. For example, approximately 96 percent of the ELCs 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. We then compared the combined total Title I and Title II funding received by all Title II grantees.

To examine the effect of using living AIDS case counts on funding for HOPWA base grants, we estimated the amount of funding grantees would have received by determining the number of living AIDS cases in each jurisdiction. CDC provided us with living AIDS cases counts for states, Puerto Rico, and EMSAs. To determine each grantee's number of living AIDS cases, we subtracted the number of living AIDS cases in EMSAs in a state from the total number of living AIDS cases in the state.[4] When an EMSA crossed state boundaries, we used information from CDC to determine the number of living AIDS cases in each state within the EMSA. For example, the Memphis EMSA covers parts of Arkansas, Mississippi, and Tennessee. We obtained the living AIDS case counts for each of the states in the Memphis EMSA. We then subtracted the number of living AIDS cases from Arkansas in the Memphis EMSA from the Arkansas state total, and did comparable calculations for the cases from the other two states. After doing similar calculations for all EMSAs that crossed state boundaries, we had living AIDS case counts for all HOPWA grantees. We then calculated each grantee's percentage of the total number of living AIDS cases in all jurisdictions and simulated the HOPWA base grant funding allocations according to this percentage. We then compared the base funding received using cumulative AIDS case counts with the simulated funding allocations using living AIDS cases.

The dates of the AIDS case counts used in our analyses varied by program. Depending on the grant, formula allocations under the CARE Act are based on the number of ELCs in a jurisdiction as of June 30 preceding the start of the fiscal year for which the award is to be made or on the number of reported AIDS cases in either the most recent 2 or 5 calendar years. HOPWA eligibility is based on the number of cumulative AIDS cases as of March 31 preceding the start of the fiscal year. Where appropriate, we used ELCs as of June 30, 2003, to estimate the effect of formula provisions on CARE Act funding for fiscal year 2004, which began on October 1, 2003. For other CARE Act grants, we used reported cases for the appropriate calendar-year period. We used AIDS case counts as of March 31, 2003, to

[4]Unlike the CARE Act in which ELCs in EMAs are counted once for determining Title I funding and a second time for determining Title II funding, under HOPWA AIDS cases in EMSAs are counted only for determining funding for EMSAs. These cases are not counted a second time for determining HOPWA base funding allocations for states and territories. Funding for states and territories is based on the number of cumulative AIDS cases outside of EMSAs. For example, HOPWA base funding for Colorado is based on the number of cumulative AIDS cases in the state minus the number of cumulative cases in the Denver EMSA.

estimate the effect of formula provisions on HOPWA funding for fiscal year 2004.

We used funding per AIDS case[5] to illustrate the effect of certain funding-formula provisions on the distribution of CARE Act and HOPWA funds. There are other considerations that could be included in funding formulas. For example, differing health care and housing costs across regions and differences in grantees' capacities to fund services from local resources could be used as bases for distributing program funds and to justify deviations from proportional funding per case.[6] Without such considerations, regions with the same funding and the same number of AIDS cases could not treat the same number of patients. Currently, these considerations are not taken into account when awarding formula grants under either the CARE Act or HOPWA.

To analyze the effect of retaining the current EMA boundaries, we reviewed documents pertaining to the Office of Management and Budget's (OMB) 2004 metropolitan boundary definitions. In particular, we relied on information generated in our June 2004 report on metropolitan statistical areas (MSA) that reported on the process used to develop the 2000 standards and how the 2000 standards differ from the 1990 standards.[7] Before each decennial census, OMB reviews the standards used in defining the boundaries of these statistical areas to ensure their continued usefulness and relevance and, if warranted, revises them. OMB had determined that a more fundamental examination of the standards was required for 2000, and advisory groups were formed to look at the standards. These groups suggested OMB consider defining less-populated areas, which had been statistically unrecognized. The 2000 standards differ from the 1990 standards in many ways, and the Census Bureau and OMB have stated that the new standards are simpler and more transparent.

[5]The AIDS case count used in the analyses varied by program (e.g., ELCs and cumulative AIDS cases).

[6]In our November 1995 report, we showed under the CARE Act that differences in funding per living AIDS case were not related to cost differences. For a discussion of this issue as well as criteria for distributing funding per case, see GAO, *Ryan White CARE Act of 1990: Opportunities to Enhance Funding Equity*, GAO/HEHS-96-26 (Washington, D.C.: Nov. 13, 1995).

[7]GAO, *Metropolitan Statistical Areas: New Standards and Their Impact on Selected Federal Programs*, GAO-04-758 (Washington, D.C.: June 14, 2004).

To demonstrate the effect on the current boundaries of the 51 CARE Act Title I EMAs if OMB's 2004 definitions of MSAs were used to establish EMA boundaries, we compared the boundaries of existing EMAs with the new MSA boundaries that could be created using the new definitions. Because most EMA boundaries include portions of more than one new metropolitan area, for our analysis we chose two decision rules to serve as a basis for selecting new metropolitan areas to be compared with the existing EMAs.[8] First, we assumed there would be no change in eligibility of the current 51 Title I EMAs. Second, since the number of ELCs within an EMA would change if its boundaries were revised, we chose whatever combination of the newly defined metropolitan areas[9] would result in the least change to the numbers of ELCs within the EMA's boundaries. The results of our method are shown in appendix VII, which lists each of the existing EMAs together with the corresponding new areas, the number of counties constituting the metropolitan areas, and the number of ELCs contained within those areas.

To assess the reliability of the data on HRSA's and HUD's distribution of CARE Act and HOPWA funds, we asked agency officials about how the data were developed and reported. We also reviewed relevant documentation. We determined the data were sufficiently reliable for the purposes of our report.

Use of HIV Cases in Formulas

We examined how CARE Act and HOPWA fiscal year 2004 allocations would have been affected by using HIV cases in addition to living AIDS cases to determine funding. We undertook our analyses in light of the statutory requirement that HIV cases be used in CARE Act funding formulas not later than fiscal year 2007.[10] We examined the effect of using

[8]There is no straightforward way to equate EMAs based on OMB's 1993 metropolitan areas with OMB's 2004 metropolitan areas. In developing its 2000 metropolitan area standards and its 2004 metropolitan area boundary definitions, OMB did not seek to make them conform to past standards and definitions. Moreover, even where OMB employed the same terminology (e.g., the term "metropolitan statistical area" was retained), the terms were given new meanings.

[9]These include combinations of adjoining MSAs or adjoining MSAs and metropolitan divisions. We exclude the use of the smaller micropolitan statistical areas (a new OMB designation for less-populated areas) and also exclude combined statistical areas (a new OMB designation for groupings of adjacent metropolitan and micropolitan areas).

[10]Unlike the CARE Act, there are no requirements regarding the use of HIV cases in determining HOPWA funding.

HIV cases in addition to living AIDS cases on formula funding for CARE Act Title I, Title II, and ADAP base grants, and HOPWA base grants in the states, Puerto Rico, and metropolitan areas.[11] We limited our analyses to these grants because they constitute the majority of the CARE Act and HOPWA formula funding. For the CARE Act, we used the measure of living AIDS cases that is required by law to be used by the program when distributing Title I, Title II, and ADAP base grants, that is, the number of ELCs based on 10 years of reported cases and survival rates. In the absence of a measure of living AIDS cases for HOPWA funding, we used a measure of living AIDS cases calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases. This measure of living AIDS cases is used for illustrative purposes only. We used fiscal year 2004 allocations, which were based on case counts reported as of June 30, 2003, for the CARE Act and as of March 31, 2003, for HOPWA. As of these dates there were 35 jurisdictions[12] from which CDC accepted HIV data and 17 without CDC-approved HIV data. CDC will only accept name-based case counts as no code-based system has yet met CDC's quality criteria.[13]

Because CDC did not accept HIV case counts from 17 jurisdictions, we conducted our analysis using two approaches to measure total HIV/AIDS cases for purposes of formula calculations. Under the first approach, we used HIV and live AIDS case counts for the 35 jurisdictions from which

[11]In our analysis of HOPWA, we used living AIDS cases instead of cumulative AIDS cases, which is the measure currently required by law to be used to determine HOPWA base grant funding. Therefore, our analyses reflect the effect of using HIV cases and living AIDS cases instead of cumulative AIDS case counts on fiscal year 2004 HOPWA base grant funding.

[12]These 35 include 34 states and Puerto Rico.

[13]Some HIV case-reporting systems are name-based while others are code-based. Currently, CDC will only accept name-based case counts as no code-based system has yet met CDC's quality criteria. 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 that 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. In July 2005, CDC began recommending that all states and territories adopt confidential, name-based surveillance systems to report HIV infections.

CDC accepted HIV data.[14] Because CDC did not accept the HIV case counts from the other 17 jurisdictions, we used only the live AIDS case counts received by CDC for these grantees. Consequently, for some grantees we used HIV and AIDS case counts, but for others we used only AIDS case counts. This approach reflects the data that would have been used if funding allocations were based on the HIV and AIDS case counts received by CDC in time for determining fiscal year 2004 allocations. Under the second approach, we used the same HIV and AIDS case counts as our first approach, but supplemented these data with the code-based HIV case counts collected by the grantees from which CDC did not receive HIV data.[15] We obtained these HIV case counts directly from these

[14]Because HIV-reporting systems in some jurisdictions are changing to name-based systems, CDC now accepts HIV case counts from some jurisdictions from which it did not accept HIV case counts earlier. For our analyses, we classified Connecticut, Kentucky, and New Hampshire as having HIV case counts that are not accepted by CDC. Our analyses were conducted using fiscal year 2004 allocations, which were based on case reports as of June 30, 2003, for the CARE Act and as of March 31, 2003, for HOPWA. At those times, 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. A fourth state, Georgia, had not established any HIV case reporting as of June 30, 2003, but did so in 2004. Consequently, the HIV case count for Georgia is zero in our analyses. Pennsylvania is classified as having its HIV case counts accepted by CDC. However, these counts do not include any cases from Philadelphia, which established its code-based system in 2004. Philadelphia establsihed a name-based system in October 2005. Philadelphia is in the process of having its HIV surveillance data certified by CDC; once certified, its data will be accepted by CDC. Illinois and Maine established name-based HIV-reporting systems in January 2006 and are also in the process of having their HIV data certified by CDC; once certified, their data will be accepted by CDC.

[15]HIV case counts for three of these jurisdictions, Georgia, Kentucky, and the District of Columbia, were unavailable. Consequently, their HIV case counts are zero under both approaches. HIV case counts were also unavailable for Philadelphia, and as a consequence HIV counts were incomplete for Pennsylvania.

jurisdictions.[16] These case counts were collected and reported to us by public health authorities. We also received information from them regarding their HIV case-reporting systems.

For both approaches, we calculated the grantee's percentage of the total number of HIV/AIDS cases relative to all grantees for that program and estimated the fiscal year 2004 grants that each would have received.[17] CARE Act formula allocations were calculated both with certain hold-harmless and minimum-grant provisions and again without those provisions.[18] Eliminating hold-harmless and minimum-grant provisions was done to show the full effect of distributing fiscal year 2004 funding solely according to HIV/AIDS data available at that time. We also estimated the effect of using HIV cases and living AIDS cases for HOPWA base funding.

In our analyses of how the use of HIV cases would affect funding by region, we use U.S. Census Bureau definitions to define regions of the country. The Census Bureau divides the country into four regions: Northeast, Midwest, South, and West.[19] Table 11 lists the four regions and the jurisdictions that constitute them.

[16]CDC receives, reviews, and processes name-based HIV case reports on individual cases. Potential duplicate reports across jurisdictions are reviewed through a CDC-coordinated process to remove duplicate reports from the national database. Code-based reports cannot be included in this de-duplication process because name-based and code-based systems do not have comparable patient identifiers. Because the name- and code-based case counts are not comparable, in its comments on a draft of this report HHS stated that it would not be appropriate to use the code-based case counts in monitoring HIV/AIDS nationally. Our purpose in using both the name- and code-based case counts was to provide a general indication of how funding would be affected by using HIV and AIDS cases to distribute CARE Act and HOPWA funds. Our use of the code-based case counts should not be taken as endorsement for their use in monitoring HIV/AIDS or distributing funds. An assessment of the feasibility of using code-based case counts was beyond the scope of our report.

[17]For example, for CARE Act Title I base funding, we calculated the EMA's percentage of the total number of HIV cases and ELCs across all EMAs.

[18]Under the CARE Act, there is a minimum-grant provision for Title II base grants, but not for Title I and ADAP base grants. However, there are hold-harmless provisions for Title I, Title II, and ADAP base grants. There are no comparable hold-harmless provisions in HOPWA and minimum-grant requirements have been effectively waived in recent years. Consequently, the analyses in which the hold-harmless and minimum-grant provisions are maintained are limited to the CARE Act.

[19]Puerto Rico is not included in any of these regions and is, therefore, excluded from these analyses.

Table 11: U.S. Census Bureau Regions

Northeast	
Connecticut	New York
Maine	Pennsylvania
Massachusetts	Rhode Island
New Hampshire	Vermont
New Jersey	
Midwest	
Illinois	Missouri
Indiana	Nebraska
Iowa	North Dakota
Kansas	Ohio
Michigan	South Dakota
Minnesota	Wisconsin
South	
Alabama	Mississippi
Arkansas	North Carolina
Delaware	Oklahoma
District of Columbia	South Carolina
Florida	Tennessee
Georgia	Texas
Kentucky	Virginia
Louisiana	West Virginia
Maryland	
West	
Alaska	Nevada
Arizona	New Mexico
California	Oregon
Colorado	Utah
Hawaii	Washington
Idaho	Wyoming
Montana	

Source: U.S. Census Bureau.

Our analyses of the effect of using HIV case counts for determining CARE Act and HOPWA funding rely on data whose reliability has been questioned. In June 2004, the Secretary of Health and Human Services determined that because of the problems associated with these data, they

should not currently be used in determining CARE Act funding. We used these data in our analyses to give a general indication of the effect of using HIV cases in future formula allocations as required by the CARE Act. By using HIV/AIDS counts in determining CARE Act and HOPWA funding, the number of persons on which funding is based would increase. The effect on individual grantees would depend on the number of reported HIV cases in the jurisdiction compared with the number reported in other jurisdictions. The extent to which the use of HIV cases could affect formula allocations cannot be determined by these analyses because jurisdictions use different methods to identify HIV cases, and it is unclear to what degree the resulting case counts are comparable. However, we think our approaches in these analyses are informative in light of the statutory requirement that HIV cases be used in CARE Act funding formulas not later than fiscal year 2007.

To assess the reliability of the HIV and AIDS case-count data, we asked HRSA, HUD, CDC, state, and local officials a series of questions about how the data were collected and the methods used to ensure their accuracy. We asked state and local officials about their HIV data only when they were not accepted by CDC. On the basis of the information provided regarding the verification of the reliability of these data, we determined these data to be sufficiently reliable for the purposes of our analyses.

Our analyses do not include the different costs of treating patients with HIV and AIDS. The cost of serving persons who have HIV and AIDS can vary substantially, depending on the stage of the disease. Patients whose disease has progressed to AIDS often require more expensive drug therapies and more intensive care than those whose disease has not progressed to AIDS. One study found that the average annual cost of treating an HIV patient was about $18,000 per year. However, the cost ranged from about $14,000 per year for well patients with HIV to $34,000 per year for patients with advanced-stage AIDS.[20]

We performed our work from July 2004 through February 2006, in accordance with generally accepted government auditing standards.

[20]Michael Saag (paper presented at the XIV International AIDS Conference: Plenary Session, HIV/AIDS Treatment and Care in the New Century, Barcelona, July 2002); "UAB Announces Results of First HIV Patient Care Cost Analysis," *UAB Media Relations* (Birmingham, Ala.: University of Alabama at Birmingham, July 2002), http://main.uab.edu/show.asp?durki=51750 (downloaded March 30, 2005).

Appendix II: CARE Act Title I Awards, Fiscal Year 2004

Eligible metropolitan area	Base award	Supplemental award	Minority AIDS Initiative award	Total Title I award	Total Title I award per ELC[a]
Atlanta, Ga.	$9,268,937	$7,518,391	$1,552,404	$18,339,732	$2,417
Austin, Tex.	2,016,473	1,559,617	224,430	3,800,520	2,302
Baltimore, Md.	10,195,952	7,615,994	1,898,933	19,710,879	2,361
Bergen-Passaic, N.J.[b]	2,605,497	2,002,220	206,987	4,814,704	2,306
Boston, Mass.[b, c]	7,434,884	6,630,052	783,761	14,848,697	2,459
Caguas, P.R.	935,565	735,726	145,356	1,816,647	2,372
Chicago, Ill.	12,801,123	10,363,895	2,261,742	25,426,760	2,426
Cleveland, Ohio[b]	1,850,098	1,379,848	256,990	3,486,936	2,308
Dallas, Tex	6,425,600	5,378,653	1,016,330	12,820,583	2,437
Denver, Colo.[b]	2,440,655	1,843,081	245,361	4,529,097	2,273
Detroit, Mich.	4,382,256	3,427,753	780,272	8,590,281	2,394
District of Columbia[c]	14,431,645	9,840,164	2,679,205	26,951,014	2,281
Dutchess County, N.Y.	639,995	512,173	79,074	1,231,242	2,350
Fort Lauderdale, Fla.	7,330,631	6,349,097	1,069,822	14,749,550	2,457
Fort Worth, Tex.	1,805,177	1,386,868	181,405	3,373,450	2,282
Hartford, Conn.	2,386,547	1,899,397	266,293	4,552,237	2,330
Houston, Tex.	9,416,722	8,472,252	1,239,598	19,128,572	2,481
Jacksonville, Fla.[b]	2,517,844	1,873,132	472,117	4,863,093	2,371
Jersey City, N.J.[b]	3,022,562	2,548,825	312,807	5,884,194	2,424
Kansas City, Mo.[b, c]	1,716,152	1,358,374	166,287	3,240,813	2,503
Las Vegas, Nev.[c]	2,375,554	1,832,717	265,130	4,473,401	2,300
Los Angeles, Calif.	18,540,316	16,153,706	1,950,099	36,644,121	2,414
Miami, Fla.	12,806,009	10,268,761	2,465,241	25,540,011	2,436
Middlesex-Somerset-Hunterdon, N.J.[b]	1,520,364	988,206	215,127	2,723,697	2,200
Minneapolis–St. Paul, Minn.[b, c]	1,587,346	1,328,653	177,916	3,093,915	2,432
Nassau-Suffolk, N.Y.[b]	3,182,104	2,402,225	367,460	5,951,789	2,300
New Haven, Conn.[b]	3,639,492	3,012,393	417,463	7,069,348	2,400
New Orleans, La.	3,852,184	2,239,460	695,384	6,787,028	2,152
New York, N.Y.	60,276,790	52,106,068	9,720,259	122,103,117	2,474
Newark, N.J.[b]	8,151,371	6,076,957	1,083,776	15,312,104	2,297
Norfolk, Va.[c]	2,732,193	1,639,148	448,860	4,820,201	2,155
Oakland, Calif.[b]	3,534,076	2,614,717	462,814	6,611,607	2,318
Orange County, Calif.	2,666,239	2,282,192	284,898	5,233,329	2,397
Orlando, Fla.	4,021,954	3,028,863	770,969	7,821,786	2,375

Eligible metropolitan area	Base award	Supplemental award	Minority AIDS Initiative award	Total Title I award	Total Title I award per ELC[a]
Philadelphia, Pa.[c]	12,038,992	10,407,066	2,002,427	24,448,485	2,480
Phoenix, Ariz.	3,480,889	2,975,380	358,158	6,814,427	2,391
Ponce, P.R.	1,414,340	1,002,813	301,178	2,718,331	2,347
Portland, Oreg.[c]	1,889,451	1,572,205	105,819	3,567,475	2,306
Riverside–San Bernardino, Calif.	3,913,252	2,613,404	296,527	6,823,183	2,130
Sacramento, Calif.[b]	1,558,276	1,328,376	81,399	2,968,051	2,382
St. Louis, Mo.[c]	2,412,195	1,646,152	312,807	4,371,154	2,213
San Antonio, Tex.	2,097,083	1,400,297	336,063	3,833,443	2,233
San Diego, Calif.	5,201,792	4,554,583	531,422	10,287,797	2,416
San Francisco, Calif.[b]	16,171,607	13,199,079	479,094	29,849,780	4,137
San Jose, Calif.[b]	1,411,781	1,069,179	175,590	2,656,550	2,318
San Juan, P.R.[b]	8,139,880	5,255,408	1,337,277	14,732,565	2,222
Santa Rosa, Calif.[b]	611,312	469,370	26,746	1,107,428	2,298
Seattle, Wash.[b]	3,024,172	2,605,642	212,801	5,842,615	2,367
Tampa–St. Petersburg, Fla.[b]	4,777,696	3,348,920	593,053	8,719,669	2,250
Vineland-Millville-Bridgeton, N.J.	473,889	297,261	76,748	847,898	2,185
West Palm Beach, Fla.[b]	4,577,648	3,964,724	866,323	9,408,695	2,515
Total[d]	**$305,704,561**	**$246,379,437**	**$43,258,002**	**$595,342,000**	

Source: GAO analysis of HRSA data.

Notes: HRSA has awarded Minority AIDS Initiative grants to EMAs. HRSA characterizes Minority AIDS Initiative grants to EMAs as Title I grants.

[a]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 death. The average total Title I award per ELC was $2,380.

[b]EMA received hold-harmless funding that is included in base award.

[c]EMA boundaries include jurisdictions in more than one state.

[d]Individual entries may not sum to totals because of rounding.

Appendix III: CARE Act Title II Awards, Fiscal Year 2004

Grantee	Base grant award	ADAP base grant award	Minority AIDS Initiative award	Emerging Communities award	ADAP Severe Need award	Total Title II award	Total Title II award per ELC[a]
Alabama	$4,042,811	$7,004,635	$77,828	$192,260	$824,913	$12,142,447	$3,657
Alaska[b]	500,000	472,602	2,103			974,705	4,351
Arizona	3,201,547	8,392,903	54,164			11,648,614	2,928
Arkansas	1,785,169	3,116,716	31,946			4,933,831	3,366
California	31,236,233	89,623,465	565,829			121,425,527	2,858
Colorado	2,117,525	5,607,928	34,181		660,427	8,420,061	3,168
Connecticut	3,779,591	11,315,018	81,114			15,175,723	2,830
Delaware	1,848,490	3,202,722	39,177	250,406		5,340,795	3,518
District of Columbia	4,305,124	13,842,594	175,770			18,323,488	2,793
Florida	29,860,865	80,386,630	893,442	528,011		111,668,948	2,931
Georgia	9,408,492	23,684,951	260,828		2,789,298	36,143,569	3,220
Hawaii	1,203,101	2,084,512	10,517			3,298,130	3,338
Idaho[b]	500,000	464,163	526		54,663	1,019,352	4,633
Illinois	8,837,193	25,746,254	287,121			34,870,568	2,858
Indiana	3,768,825	6,529,924	47,196	1,057,005		11,402,950	3,684
Iowa	753,765	1,305,985	7,625			2,067,375	3,340
Kansas	1,007,120	2,045,495	8,545			3,061,160	3,192
Kentucky	2,358,712	4,086,741	22,875	220,395	481,282	7,170,005	3,702
Louisiana	6,211,002	13,829,935	192,072	1,091,712	1,628,705	22,953,426	3,502
Maine[b]	500,000	833,383	526		36,525	1,370,434	3,469
Maryland	8,446,358	25,746,254	317,359			34,509,971	2,828
Massachusetts	5,223,382	14,684,416	99,257	183,819		20,190,874	2,901
Michigan	4,335,555	11,002,763	117,531			15,455,849	2,964
Minnesota	1,026,762	3,010,727	22,218			4,059,707	2,845
Mississippi	3,345,060	5,795,703	88,477	225,710		9,454,950	3,442
Missouri	2,783,489	7,409,723	56,925			10,250,137	2,919
Montana[b]	500,000	310,145	526			810,671	5,515
Nebraska	639,300	1,107,661	10,254		130,445	1,887,660	3,596
Nevada	1,684,896	4,738,678	32,735			6,456,309	2,875
New Hampshire[b]	500,000	755,319	1,709			1,257,028	3,511
New Jersey	12,302,631	34,877,598	279,365	181,943		47,641,537	2,882
New Mexico	1,195,795	2,127,024	15,644			3,338,463	3,400
New York	42,659,431	124,956,784	1,252,475	394,523		169,263,213	2,858

Grantee	Base grant award	ADAP base grant award	Minority AIDS Initiative award	Emerging Communities award	ADAP Severe Need award	Total Title II award	Total Title II award per ELC[a]
North Carolina	7,403,985	12,834,095	197,593	708,703	1,511,429	22,655,805	3,724
North Dakota[c]	200,000	92,543	0			292,543	6,803
Ohio	5,448,305	10,909,930	67,968	336,063		16,762,266	3,242
Oklahoma	2,054,284	3,655,707	23,795	190,071	419,165	6,343,022	3,760
Oregon	1,664,149	4,225,989	12,489			5,902,627	2,947
Pennsylvania	10,779,206	27,090,216	258,856	188,196		38,316,474	2,984
Puerto Rico	8,238,917	22,598,388	260,697		2,661,337	33,759,339	3,152
Rhode Island	1,103,249	1,911,506	14,461	160,060		3,189,276	3,520
South Carolina	6,774,143	11,736,984	164,858	647,118	1,382,225	20,705,328	3,722
South Dakota[b]	500,000	204,654	1,052			705,706	7,275
Tennessee	6,185,987	12,018,438	122,526	2,851,283		21,178,234	4,169
Texas	19,125,106	50,471,351	469,070		5,943,843	76,009,370	3,177
Utah	1,074,024	1,980,565	7,099	173,503		3,235,191	3,668
Vermont[b]	500,000	382,007	1,052			883,059	4,879
Virginia	5,929,341	14,498,751	145,007	244,779	1,707,470	22,525,348	3,278
Washington	3,118,978	7,966,718	35,890			11,121,586	2,945
West Virginia	713,239	1,303,875	4,733		153,553	2,175,400	3,520
Wisconsin	1,831,726	3,179,514	28,791	174,440	374,441	5,588,912	3,709
Wyoming[c]	200,000	160,347	0			360,347	4,741
Total	**$284,712,863**	**$727,320,929**	**$6,903,797**	**$10,000,000**	**$20,759,721**	**$1,049,697,310**	

Source: GAO analysis of HRSA data.

Notes: HRSA has awarded grants for Minority AIDS Initiative grants to states and territories. HRSA characterizes Minority AIDS Initiative grants to states and territories as Title II grants.

In addition to the grantees listed, American Samoa, the Federated States of Micronesia, Guam, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, and the Virgin Islands also received Title II funding ranging from a total of $50,000 to $1,048,657.

[a]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 death. The average total Title II award per ELC was $3,559.

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

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

Appendix IV: HOPWA Formula Grantees and Award Amounts, Fiscal Year 2004

Grantee	Base funding	Bonus funding[a]	Total formula funding	Total formula funding per cumulative AIDS case[b]	Total formula funding per living AIDS case[c]
Alabama	$1,139,000		$1,139,000	$230	$444
Albany, N.Y.	429,000		429,000	230	497
Arizona	164,000		164,000	230	474
Arkansas	752,000		752,000	230	418
Atlanta, Ga.	4,262,000	$637,000	4,899,000	264	573
Augusta, Ga.	373,000		373,000	230	455
Austin, Tex.	988,000		988,000	230	520
Baltimore, Md.	3,940,000	3,996,000	7,936,000	463	1,039
Baton Rouge, La.	666,000	1,147,000	1,813,000	626	1,290
Birmingham, Ala.	520,000		520,000	230	461
Boston, Mass.	1,829,000		1,829,000	230	563
Bridgeport, Conn.	752,000	27,000	779,000	238	476
Buffalo, N.Y.	472,000		472,000	230	523
California	3,042,000		3,042,000	230	518
Cambridge, Mass.	659,000		659,000	230	518
Camden, N.J.	657,000		657,000	230	567
Charleston, S.C.	411,000	7,000	418,000	234	480
Charlotte, N.C.	571,000		571,000	230	450
Chicago, Ill.	5,622,000	2,716,000	8,338,000	341	805
Cincinnati, Ohio	550,000		550,000	230	523
Cleveland, Ohio	854,000		854,000	230	479
Colorado	366,000		366,000	230	462
Columbia, S.C.	626,000	644,000	1,270,000	466	824
Columbus, Ohio	584,000		584,000	230	619
Connecticut	251,000		251,000	230	479
Dallas, Tex.	3,192,000		3,192,000	230	496
Delaware	164,000		164,000	230	463
Denver, Colo.	1,424,000		1,424,000	230	547
Detroit, Mich.	1,624,000	355,000	1,979,000	280	749
District of Columbia	5,626,000	6,176,000	11,802,000	482	939
Florida	4,063,000		4,063,000	230	489
Fort Lauderdale, Fla.	3,337,000	2,903,000	6,240,000	430	954
Fort Worth, Tex.	835,000		835,000	230	500

Grantee	Base funding	Bonus funding[a]	Total formula funding	Total formula funding per cumulative AIDS case[b]	Total formula funding per living AIDS case[c]
Gaithersburg, Md.	535,000		535,000	230	467
Georgia	1,515,000		1,515,000	230	469
Hartford, Conn.	1,023,000		1,023,000	230	460
Hawaii	181,000		181,000	230	439
Honolulu, Hawaii	452,000		452,000	230	571
Houston, Tex.	5,068,000		5,068,000	230	591
Illinois	864,000		864,000	230	466
Indiana	836,000		836,000	230	500
Indianapolis, Ind.	759,000		759,000	230	476
Iowa	347,000		347,000	230	511
Islip, N.Y.	1,660,000		1,660,000	230	577
Jackson, Miss.	449,000	275,000	724,000	371	728
Jacksonville, Fla.	1,195,000	369,000	1,564,000	301	623
Kansas	363,000		363,000	230	562
Kansas City, Mo.	978,000		978,000	230	506
Kentucky	423,000		423,000	230	418
Las Vegas, Nev.	916,000		916,000	230	455
Los Angeles, Calif.	10,476,000		10,476,000	230	622
Louisiana	940,000		940,000	230	488
Louisville, Ky.	462,000		462,000	230	443
Maryland	345,000		345,000	230	453
Massachusetts	525,000		525,000	230	521
Memphis, Tenn.	920,000	1,214,000	2,134,000	533	1,000
Miami, Fla.	6,149,000	4,566,000	10,715,000	400	934
Michigan	911,000		911,000	230	546
Milwaukee, Wis.	512,000		512,000	230	511
Minneapolis, Minn.	839,000		839,000	230	508
Minnesota	110,000		110,000	230	529
Mississippi	756,000		756,000	230	484
Missouri	496,000		496,000	230	471
Nashville, Tenn.	737,000		737,000	230	387
Nevada	238,000		238,000	230	499
New Haven, Conn.	937,000	295,000	1,232,000	302	605
New Jersey	1,106,000		1,106,000	230	593
New Mexico	533,000		533,000	230	501

Grantee	Base funding	Bonus funding[a]	Total formula funding	Total formula funding per cumulative AIDS case[b]	Total formula funding per living AIDS case[c]
New Orleans, La.	1,785,000	1,207,000	2,992,000	385	887
New York	1,776,000		1,776,000	230	500
New York, N.Y.	33,487,000	26,868,000	60,355,000	414	1,099
Newark, N.J.	4,297,000	885,000	5,182,000	277	828
North Carolina	2,082,000		2,082,000	230	437
Oakland, Calif.	2,006,000		2,006,000	230	595
Ohio	1,041,000		1,041,000	230	524
Oklahoma	518,000		518,000	230	521
Oklahoma City, Okla.	466,000		466,000	230	509
Orlando, Fla.	1,660,000	1,529,000	3,189,000	441	913
Pennsylvania	1,540,000		1,540,000	230	445
Philadelphia, Pa.	4,340,000	3,292,000	7,632,000	404	799
Phoenix, Ariz.	1,434,000		1,434,000	230	490
Pittsburgh, Pa.	626,000		626,000	230	568
Portland, Oreg.	1,006,000		1,006,000	230	523
Poughkeepsie, N.Y.	604,000		604,000	230	556
Providence, R.I.	807,000		807,000	230	498
Puerto Rico	1,748,000		1,748,000	230	584
Richmond, Va.	692,000		692,000	230	527
Riverside, Calif.	1,772,000		1,772,000	230	462
Rochester, N.Y.	597,000		597,000	230	460
Sacramento, Calif.	844,000		844,000	230	574
St. Louis, Mo.	1,217,000		1,217,000	230	491
Salt Lake City, Utah	386,000		386,000	230	455
San Antonio, Tex.	1,027,000		1,027,000	230	480
San Diego, Calif.	2,683,000		2,683,000	230	522
San Francisco, Calif.	6,698,000	1,864,000	8,562,000	294	1,130
San Jose, Calif.	792,000		792,000	230	538
San Juan, P.R.	4,585,000	2,555,000	7,140,000	358	1,000
Santa Ana, Calif.	1,436,000		1,436,000	230	489
Sarasota, Fla.	397,000		397,000	230	501
Seattle, Wash.	1,688,000		1,688,000	230	524
South Carolina	1,387,000		1,387,000	230	446
Springfield, Mass.	461,000		461,000	230	535
Tampa, Fla.	2,221,000	168,000	2,389,000	247	569

Grantee	Base funding	Bonus funding[a]	Total formula funding	Total formula funding per cumulative AIDS case[b]	Total formula funding per living AIDS case[c]
Tennessee	739,000		739,000	230	438
Texas	2,736,000		2,736,000	230	454
Tucson, Ariz.	402,000		402,000	230	515
Utah	120,000		120,000	230	467
Virginia	640,000		640,000	230	499
Virginia Beach, Va.	1,022,000		1,022,000	230	505
Wake County, N.C.	345,000	7,000	352,000	234	408
Warren, Mich.	405,000		405,000	230	571
Washington	652,000		652,000	230	480
West Palm Beach, Fla.	2,019,000	1,817,000	3,836,000	436	933
Wilmington, Del.	566,000	232,000	798,000	325	624
Wisconsin	405,000		405,000	230	509
Woodbridge, N.J.	1,462,000		1,462,000	230	627
Worcester, Mass.	369,000		369,000	230	480
Total	$197,288,000	$65,751,000	$263,039,000		

Sources: GAO analysis of CDC and HUD data.

[a]Bonus grants were awarded to EMSAs that have a higher-than-average per capita incidence of AIDS over the previous year.

[b]The average formula funding per cumulative AIDS case was $260.

[c]The number of living AIDS cases was calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases. The average formula funding per living AIDS case was $573.

Appendix V: HOPWA Base Funding Allocations Using Cumulative and Living AIDS Cases, Fiscal Year 2004

Grantee	Base funding	Cumulative AIDS cases	Percent of cumulative AIDS cases	Living AIDS cases[a]	Percent of living AIDS cases	Funding if allocated using living AIDS cases	Difference in funding[b]
Alabama	$1,139,000	4,969	0.58%	2,568	0.70%	$1,378,278	-$239,278
Albany, N.Y.	429,000	1,867	0.22	864	0.24	463,720	-34,720
Arizona	164,000	712	0.08	346	0.09	185,703	-21,703
Arkansas	752,000	3,274	0.38	1,799	0.49	965,546	-213,546
Atlanta, Ga.	4,262,000	18,554	2.16	8,557	2.33	4,592,649	-330,649
Augusta, Ga.	373,000	1,623	0.19	819	0.22	439,568	-66,568
Austin, Tex.	988,000	4,302	0.50	1,899	0.52	1,019,217	-31,217
Baltimore, Md.	3,940,000	17,150	2.00	7,641	2.08	4,101,020	-161,020
Baton Rouge, La.	666,000	2,898	0.34	1,405	0.38	754,081	-88,081
Birmingham, Ala.	520,000	2,265	0.26	1,127	0.31	604,875	-84,875
Boston, Mass.	1,829,000	7,960	0.93	3,248	0.88	1,743,242	85,758
Bridgeport, Conn.	752,000	3,275	0.38	1,637	0.45	878,598	-126,598
Buffalo, N.Y.	472,000	2,053	0.24	902	0.25	484,115	-12,115
California	3,042,000	13,240	1.54	5,870	1.60	3,150,502	-108,502
Cambridge, Mass.	659,000	2,868	0.33	1,271	0.35	682,162	-23,162
Camden, N.J.	657,000	2,861	0.33	1,159	0.32	622,050	34,950
Charleston, S.C.	411,000	1,788	0.21	870	0.24	466,940	-55,940
Charlotte, N.C.	571,000	2,486	0.29	1,269	0.35	681,088	-110,088
Chicago, Ill.	5,622,000	24,471	2.85	10,362	2.82	5,561,415	60,585
Cincinnati, Ohio	550,000	2,394	0.28	1,051	0.29	564,085	-14,085
Cleveland, Ohio	854,000	3,718	0.43	1,784	0.49	957,495	-103,495
Colorado	366,000	1,595	0.19	792	0.22	425,076	-59,076
Columbia, S.C.	626,000	2,727	0.32	1,541	0.42	827,074	-201,074
Columbus, Ohio	584,000	2,542	0.30	944	0.26	506,657	77,343
Connecticut	251,000	1,092	0.13	524	0.14	281,237	-30,237
Dallas, Tex.	3,192,000	13,895	1.62	6,436	1.75	3,454,282	-262,282
Delaware	164,000	716	0.08	354	0.10	189,996	-25,996
Denver, Colo.	1,424,000	6,200	0.72	2,602	0.71	1,396,526	27,474
Detroit, Mich.	1,624,000	7,068	0.82	2,641	0.72	1,417,458	206,542
District of Columbia	5,626,000	24,490	2.85	12,570	3.42	6,746,476	-1,120,476
Florida	4,063,000	17,686	2.06	8,306	2.26	4,457,934	-394,934
Fort Lauderdale, Fla.	3,337,000	14,527	1.69	6,541	1.78	3,510,636	-173,636

Grantee	Base funding	Cumulative AIDS cases	Percent of cumulative AIDS cases	Living AIDS cases[a]	Percent of living AIDS cases	Funding if allocated using living AIDS cases	Difference in funding[b]
Fort Worth, Tex.	835,000	3,635	0.42	1,670	0.45	896,310	-61,310
Gaithersburg, Md.	535,000	2,328	0.27	1,146	0.31	615,073	-80,073
Georgia	1,515,000	6,593	0.77	3,233	0.88	1,735,192	-220,192
Hartford, Conn.	1,023,000	4,455	0.52	2,222	0.60	1,192,575	-169,575
Hawaii	181,000	786	0.09	412	0.11	221,126	-40,126
Honolulu, Hawaii	452,000	1,966	0.23	791	0.22	424,540	27,460
Houston, Tex.	5,068,000	22,063	2.57	8,579	2.33	4,604,457	463,543
Illinois	864,000	3,761	0.44	1,855	0.50	995,602	-131,602
Indiana	836,000	3,638	0.42	1,673	0.46	897,920	-61,920
Indianapolis, Ind.	759,000	3,302	0.38	1,595	0.43	856,056	-97,056
Iowa	347,000	1,509	0.18	679	0.18	364,428	-17,428
Islip, N.Y.	1,660,000	7,226	0.84	2,877	0.78	1,544,122	115,878
Jackson, Miss.	449,000	1,953	0.23	994	0.27	533,492	-84,492
Jacksonville, Fla.	1,195,000	5,202	0.61	2,509	0.68	1,346,612	-151,612
Kansas	363,000	1,582	0.18	646	0.18	346,716	16,284
Kansas City, Mo.	978,000	4,256	0.50	1,933	0.53	1,037,465	-59,465
Kentucky	423,000	1,841	0.21	1,011	0.28	542,616	-119,616
Las Vegas, Nev.	916,000	3,986	0.46	2,014	0.55	1,080,939	-164,939
Los Angeles, Calif.	10,476,000	45,601	5.31	16,834	4.58	9,035,018	1,440,982
Louisiana	940,000	4,091	0.48	1,926	0.52	1,033,708	-93,708
Louisville, Ky.	462,000	2,011	0.23	1,044	0.28	560,328	-98,328
Maryland	345,000	1,501	0.17	762	0.21	408,975	-63,975
Massachusetts	525,000	2,287	0.27	1,007	0.27	540,469	-15,469
Memphis, Tenn.	920,000	4,006	0.47	2,133	0.58	1,144,808	-224,808
Miami, Fla.	6,149,000	26,766	3.12	11,477	3.12	6,159,849	-10,849
Michigan	911,000	3,966	0.46	1,669	0.45	895,773	15,227
Milwaukee, Wis.	512,000	2,228	0.26	1,001	0.27	537,249	-25,249
Minneapolis, Minn.	839,000	3,654	0.43	1,650	0.45	885,576	-46,576
Minnesota	110,000	480	0.06	208	0.06	111,636	-1,636
Mississippi	756,000	3,291	0.38	1,563	0.43	838,882	-82,882
Missouri	496,000	2,157	0.25	1,053	0.29	565,158	-69,158
Nashville, Tenn.	737,000	3,208	0.37	1,902	0.52	1,020,827	-283,827
Nevada	238,000	1,034	0.12	477	0.13	256,012	-18,012
New Haven, Conn.	937,000	4,077	0.47	2,036	0.55	1,092,747	-155,747
New Jersey	1,106,000	4,778	0.56	1,864	0.51	1,000,432	105,568

Grantee	Base funding	Cumulative AIDS cases	Percent of cumulative AIDS cases	Living AIDS cases[a]	Percent of living AIDS cases	Funding if allocated using living AIDS cases	Difference in funding[b]
New Mexico	533,000	2,319	0.27	1,064	0.29	571,062	-38,062
New Orleans, La.	1,785,000	7,769	0.90	3,374	0.92	1,810,868	-25,868
New York	1,776,000	7,730	0.90	3,553	0.97	1,906,940	-130,940
New York, N.Y.	33,487,000	145,769	16.97	54,900	14.94	29,465,516	4,021,484
Newark, N.J.	4,297,000	18,704	2.18	6,262	1.70	3,360,894	936,106
North Carolina	2,082,000	9,065	1.06	4,761	1.30	2,555,288	-473,288
Oakland, Calif.	2,006,000	8,731	1.02	3,374	0.92	1,810,868	195,132
Ohio	1,041,000	4,533	0.53	1,985	0.54	1,065,374	-24,374
Oklahoma	518,000	2,254	0.26	995	0.27	534,029	-16,029
Oklahoma City, Okla.	466,000	2,027	0.24	916	0.25	491,629	-25,629
Orlando, Fla.	1,660,000	7,228	0.84	3,494	0.95	1,875,273	-215,273
Pennsylvania	1,540,000	6,702	0.78	3,463	0.94	1,858,635	-318,635
Philadelphia, Pa.	4,340,000	18,890	2.20	9,546	2.60	5,123,457	-783,457
Phoenix, Ariz.	1,434,000	6,244	0.73	2,924	0.80	1,569,347	-135,347
Pittsburgh, Pa.	626,000	2,723	0.32	1,103	0.30	591,994	34,006
Portland, Oreg.	1,006,000	4,378	0.51	1,925	0.52	1,033,172	-27,172
Poughkeepsie, N.Y.	604,000	2,630	0.31	1,087	0.30	583,406	20,594
Providence, R.I.	807,000	3,514	0.41	1,622	0.44	870,548	-63,548
Puerto Rico	1,748,000	7,608	0.89	2,995	0.81	1,607,454	140,546
Richmond, Va.	692,000	3,012	0.35	1,312	0.36	704,167	-12,167
Riverside, Calif.	1,772,000	7,714	0.90	3,834	1.04	2,057,756	-285,756
Rochester, N.Y.	597,000	2,599	0.30	1,297	0.35	696,116	-99,116
Sacramento, Calif.	844,000	3,676	0.43	1,470	0.40	788,967	55,033
St. Louis, Mo.	1,217,000	5,297	0.62	2,481	0.67	1,331,584	-114,584
Salt Lake City, Utah	386,000	1,680	0.20	849	0.23	455,669	-69,669
San Antonio, Tex.	1,027,000	4,469	0.52	2,138	0.58	1,147,491	-120,491
San Diego, Calif.	2,683,000	11,677	1.36	5,136	1.40	2,756,555	-73,555
San Francisco, Calif.	6,698,000	29,156	3.40	7,577	2.06	4,066,671	2,631,329
San Jose, Calif.	792,000	3,446	0.40	1,472	0.40	790,041	1,959
San Juan, P.R.	4,585,000	19,960	2.32	7,141	1.94	3,832,664	752,336
Santa Ana, Calif.	1,436,000	6,250	0.73	2,939	0.80	1,577,398	-141,398
Sarasota, Fla.	397,000	1,730	0.20	792	0.22	425,076	-28,076
Seattle, Wash.	1,688,000	7,347	0.86	3,221	0.88	1,728,751	-40,751
South Carolina	1,387,000	6,039	0.70	3,108	0.85	1,668,102	-281,102

Grantee	Base funding	Cumulative AIDS cases	Percent of cumulative AIDS cases	Living AIDS cases[a]	Percent of living AIDS cases	Funding if allocated using living AIDS cases	Difference in funding[b]
Springfield, Mass.	461,000	2,005	0.23	861	0.23	462,109	-1,109
Tampa, Fla.	2,221,000	9,670	1.13	4,201	1.14	2,254,729	-33,729
Tennessee	739,000	3,218	0.37	1,689	0.46	906,507	-167,507
Texas	2,736,000	11,911	1.39	6,024	1.64	3,233,156	-497,156
Tucson, Ariz.	402,000	1,749	0.20	780	0.21	418,636	-16,636
Utah	120,000	524	0.06	257	0.07	137,935	-17,935
Virginia	640,000	2,788	0.32	1,282	0.35	688,065	-48,065
Virginia Beach, Va.	1,022,000	4,450	0.52	2,024	0.55	1,086,306	-64,306
Wake County, N.C.	345,000	1,502	0.17	863	0.23	463,183	-118,183
Warren, Mich.	405,000	1,763	0.21	709	0.19	380,529	24,471
Washington	652,000	2,839	0.33	1,357	0.37	728,319	-76,319
West Palm Beach, Fla.	2,019,000	8,789	1.02	4,112	1.12	2,206,962	-187,962
Wilmington, Del.	566,000	2,459	0.29	1,278	0.35	685,919	-119,919
Wisconsin	405,000	1,761	0.21	795	0.22	426,686	-21,686
Woodbridge, N.J.	1,462,000	6,363	0.74	2,332	0.63	1,251,614	210,386
Worcester, Mass.	369,000	1,607	0.19	768	0.21	412,195	-43,195
Total	$197,288,000	858,752		367,586		$197,288,000	

Sources: GAO analysis of CDC and HUD data.

Notes: By law HOPWA base grants are distributed according to cumulative AIDS case counts.

[a]The number of living AIDS cases was calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases.

[b]This was calculated by subtracting the amount that would have been received if living AIDS cases had been used from the amount that was received using cumulative AIDS cases. A positive value indicates that the jurisdiction received more funding using cumulative AIDS cases than it would have received if living AIDS cases had been used. A negative value indicates that the jurisdiction would have received more funding if living AIDS cases had been used.

Appendix VI: Total CARE Act Title I and Title II Funding by State and Territory, Fiscal Year 2004

State/territory	Total Title I and Title II awards	ELCs[a]	Percent of ELCs in EMAs	Total Title I and Title II awards per ELC
Alabama	$12,142,447	3,320	0%	$3,657
Alaska[b]	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[b]	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[b]	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[b]	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[b]	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[c]	292,543	43	0	6,803

State/territory	Total Title I and Title II awards	ELCs[a]	Percent of ELCs in EMAs	Total Title I and Title II awards per ELC
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[b]	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[b]	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[c]	360,347	76	0	4,741

Source: GAO analysis of HRSA data.

Notes: Our analysis is limited to the states and Puerto Rico.

[a]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 death.

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

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

Appendix VII: HRSA's Title I EMAs, GAO-Identified Set of Comparable 2004 OMB-Defined Metropolitan Areas, and Changes

Table 12: EMAs with Service Area Changes

HRSA 2004 EMA			GAO-identified comparable OMB newly defined 2004 MSA(s) or MDIV(s)[a]			Changes		
OMB's 1993 full title of metropolitan area	Number of counties in EMA	ELCs in EMAs	OMB's 2004 full title of metropolitan area(s)	Number of counties in EMA	ELCs in EMAs	Decrease in counties	Increase in counties	Change in ELCs (percent)
Atlanta, Ga. MSA	20	7,589	Atlanta–Sandy Springs–Ga. Marietta, Ga. MSA	28	7,663	0	8	1%
Boston-Worcester-Lawrence-Lowell-Brockton, Mass.-N.H. NECMA	10	6,038	Boston-Cambridge-Quincy, Mass-N.H. MSA; Worcester, Mass. MSA; and Manchester-Nashua, N.H. MSA	9	5,484	1	0	-9
Chicago, Ill. PMSA	9	10,481	Chicago-Naperville-Joliet, Ill. MDIV; and Lake County–Kenosha County, Ill.-Wis. MDIV	10	10,534	0	1	1
Cleveland-Lorain-Elyria, Ohio PMSA	6	1,511	Cleveland-Elyria-Mentor, Ohio MSA	5	1,484	1	0	-2
Dallas, Tex. PMSA	8	5,261	Dallas-Plano-Irving, Tex. MDIV	8	5,229	1	1	-1
Denver, Colo. PMSA	5	1,993	Denver-Aurora, Colo./ MSA	10	2,017	0	5	1
Detroit, Mich. PMSA	6	3,588	Detroit-Warren-Livonia, Mich. MSA and Monroe, Mich. MSA	7	3,601	0	1	0[b]
Dutchess County, N.Y. PMSA	1	524	Poughkeepsie-Newburgh-Middletown, N.Y. MSA	2	1,010	0	1	93
Fort Worth–Arlington, Tex. PMSA	4	1,478	Fort Worth–Arlington, Tex. MDIV	4	1,475	1	1	0[b]
Houston, Tex. PMSA	6	7,710	Houston–Sugar Land–Baytown, Tex. MSA	10	8,106	0	4	5
Jacksonville, Fla. MSA	4	2,051	Jacksonville, Fla. MSA	5	2,080	0	1	1
Kansas City, Mo.-Kans. MSA	11	1,295	Kansas City, Mo.-Kans. MSA	15	1,305	0	4	1
Las Vegas, Nev.-Ariz. MSA	3	1,945	Las Vegas–Paradise, Nev. MSA	1	1,857	2	0	-5
Middlesex-Somerset-Hunterdon, N.J. PMSA	3	1,238	Edison, N.J. MDIV	4	2,217	1	2	79
New Orleans, La. MSA	8	3,154	New Orleans–Metairie–Kenner, La. MSA	7	3,130	1	0	-1
Newark, N.J. PMSA	5	6,665	Newark-Union, N.J.-Pa. MDIV	6	6,735	1	2	1

HRSA 2004 EMA			GAO-identified comparable OMB newly defined 2004 MSA(s) or MDIV(s)[a]			Changes		
OMB's 1993 full title of metropolitan area	Number of counties in EMA	ELCs in EMAs	OMB's 2004 full title of metropolitan area(s)	Number of counties in EMA	ELCs in EMAs	Decrease in counties	Increase in counties	Change in ELCs (percent)
Norfolk–Virginia Beach–Newport News, VA-N.C. MSA	15	2,237	Virginia Beach–Norfolk–Newport News, Va.-N.C. MSA	16	2,240	0	1	0[b]
Philadelphia, Pa.-N.J. PMSA	9	9,857	Philadelphia, Pa. MDIV and Camden, N.J. MDIV	8	9,782	1	0	-1
Ponce, P.R. MSA	6	1,158	Ponce, P.R. MSA and Yauco, P.R. MSA	7	1,202	0	1	4
Portland-Vancouver, Oreg.-Wash. PMSA	6	1,547	Portland-Vancouver-Beaverton, Oreg.-Wash. MSA	7	1,548	0	1	0[b]
Sacramento, Calif. PMSA	3	1,246	Sacramento-Arden-Arcade-Roseville, Calif. MSA	4	1,321	0	1	6
St. Louis, Mo.-Ill. MSA	12	1,975	St. Louis, Mo.-Ill. MSA	16	1,993	0	4	1
San Antonio, Tex. MSA	4	1,717	San Antonio, Tex. MSA	8	1,750	0	4	2
San Jose, Calif. PMSA	1	1,146	San Jose–Sunnyvale–Santa Clara, Calif. MSA	2	1,163	0	1	1
Seattle-Bellevue-Everett, Wash. PMSA	3	2,468	Seattle-Bellevue-Everett, Wash. MDIV	2	2,445	1	0	-1
Washington, D.C.-Md.-Va-W.Va. PMSA	25	11,816	Washington-Arlington-Alexandria, D.C.-Va.-Md. MSA	22	11,732	3	0	-1
Bergen-Passaic, N.J. PMSA	2	2,088	New York–White Plains–Wayne, N.Y.-N.J. MDIV	11	53,867	0	0	0
Jersey City, N.J. PMSA	1	2,427						
New York City, N.Y. PMSA	8	49,352						
Caguas, P.R. PMSA	5	766	San Juan–Caguas–Guaynabo, P.R. MSA	41	7,724	3	9	4
San Juan–Bayamon, P.R. PMSA	30	6,631						
Subtotal of changed areas	239	158,952	Not applicable	275	160,694	17	53	1
Subtotal of unchanged areas (see table 13)	57	84,768	Not applicable	57	84,768	0	0	0
Total	**296**	**243,720**	**Not applicable**	**332**	**245,462**	**17**	**53**	**1**

Sources: GAO analysis of CDC, HRSA, and OMB data.

Notes: HRSA's Title I EMAs are based on OMB's 1993 metropolitan area definitions.This table uses OMB's terminology for classifying types of metropolitan areas. Specifically, it includes metropolitan statistical area (MSA), primary metropolitan statistical area (PMSA), New England county metropolitan area (NECMA), and metropolitan division (MDIV). The terms used and meaning of those terms differ between1993 and 2004 because of OMB's fundamental revisions of metropolitan concepts. For further explanation, see GAO-04-758.

[a]We chose whatever combination of the newly defined metropolitan areas that would result in the least change to the numbers of ELCs within the EMA's boundaries.

[b]Percent change that rounds to zero, but does not equal zero percent.

Table 13: EMAs with No Service Area Changes

HRSA 2004 EMA			GAO-identified comparable OMB newly defined 2004 MSA(s) or MDIV(s)[a]			Changes		
OMB's 1993 full title of metropolitan area	Number of counties in EMA	ELCs in EMAs	OMB's 2004 full title of metropolitan area(s)	Number of counties in EMA	ELCs in EMAs	Decrease in counties	Increase in counties	Change in ELCs (percent)
Austin–San Marcos, Tex. MSA	5	1,651	Austin–Round Rock, Tex. MSA	5	1,651	0	0	0%
Baltimore, Md. PMSA	7	8,348	Baltimore-Towson, Md. MSA	7	8,348	0	0	0
Fort Lauderdale, Fla. PMSA	1	6,002	Fort Lauderdale–Pompano Beach–Deerfield Beach, Fla. MDIV	1	6,002	0	0	0
Hartford, Conn. NECMA	3	1,954	Hartford–West Hartford–East Hartford, Conn. MSA	3	1,954	0	0	0
Los Angeles–Long Beach, Calif. PMSA	1	15,180	Los Angeles–Long Beach–Glendale, Calif. MDIV	1	15,180	0	0	0
Miami, Fla. PMSA	1	10,485	Miami–Miami Beach–Kendall, Fla. MDIV	1	10,485	0	0	0
Minneapolis–St. Paul, Minn.–Wis. MSA	13	1,272	Minneapolis–St. Paul–Bloomington, Minn.–Wis. MSA	13	1,272	0	0	0
Nassau-Suffolk, N.Y. PMSA	2	2,588	Nassau-Suffolk, N.Y. MDIV	2	2,588	0	0	0
New Haven–Bridgeport–Stamford–Waterbury–Danbury, Conn. NECMA	2	2,945	Bridgeport-Stamford-Norwalk, Conn. MSA and New Haven–Milford, Conn. MSA	2	2,945	0	0	0
Oakland, Calif. PMSA	2	2,852	Oakland-Fremont-Hayward, Calif. MDIV	2	2,852	0	0	0
Orange County, Calif. PMSA	1	2,183	Santa Ana–Anaheim–Irvine, Calif. MDIV	1	2,183	0	0	0
Orlando, Fla. MSA	4	3,293	Orlando-Kissimmee, Fla. MSA	4	3,293	0	0	0
Phoenix-Mesa, Ariz. MSA	2	2,850	Phoenix-Mesa-Scottsdale, Ariz. MSA	2	2,850	0	0	0
Riverside–San Bernardino, Calif. PMSA	2	3,204	Riverside–San Bernardino–Ontario, Calif. MSA	2	3,204	0	0	0

HRSA 2004 EMA			GAO-identified comparable OMB newly defined 2004 MSA(s) or MDIV(s)[a]			Changes		
OMB's 1993 full title of metropolitan area	Number of counties in EMA	ELCs in EMAs	OMB's 2004 full title of metropolitan area(s)	Number of counties in EMA	ELCs in EMAs	Decrease in counties	Increase in counties	Change in ELCs (percent)
San Diego, Calif. MSA	1	4,259	San Diego–Carlsbad San Marcos, CA MSA	1	4,259	0	0	0
San Francisco, Calif. PMSA	3	7,216	San Francisco–San Mateo–Redwood City, Calif. MDIV	3	7,216	0	0	0
Santa Rosa, Calif. PMSA	1	482	Santa Rosa–Petaluma, Calif. MSA	1	482	0	0	0
Tampa–St. Petersburg–Clearwater, Fla. MSA	4	3,875	Tampa–St. Petersburg–Clearwater, Fla. MSA	4	3,875	0	0	0
Vineland-Millville-Bridgeton, N.J. PMSA	1	388	Vineland-Millville-Bridgeton, N.J. MSA	1	388	0	0	0
West Palm Beach–Boca Raton, Fla. MSA	1	3,741	West Palm Beach–Boca Raton–Boynton Beach, Fla. MDIV	1	3,741	0	0	0
Total	57	84,768	Not applicable	57	84,768	0	0	0

Sources: GAO analysis of CDC, HRSA, and OMB data.

Notes: This table uses OMB's terminology for classifying types of metropolitan areas. Specifically, it includes metropolitan statistical area (MSA), primary metropolitan statistical area (PMSA), New England county metropolitan area (NECMA), and metropolitan division (MDIV). The terms used and meaning of those terms differs between1993 and 2004 because of OMB's fundamental revisions of metropolitan concepts. For further explanation, see GAO-04-758.

[a]We chose whatever combination of the newly defined metropolitan areas that would result in the least change to the numbers of ELCs within the EMA's boundaries.

Appendix VIII: Estimated CARE Act Title I Funding Changes from Use of HIV Case Counts and ELCs with Hold-harmless

	Change in Title I base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless provision		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless provision[a]	
Eligible metropolitan area	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Atlanta, Ga.	-$210,000	-2%	-$210,000	-2%
Austin, Tex.	260,000	13	-10,000	0[c]
Baltimore, Md.	-240,000	-2	3,210,000	32
Bergen-Passaic, N.J.	600,000	23	210,000	8
Boston, Mass.	0	0	1,180,000	16
Caguas, P.R.	-50,000	-5	-50,000	-5
Chicago, Ill.	-950,000	-7	510,000	4
Cleveland, Ohio	940,000	51	610,000	33
Dallas, Tex.	1,630,000	25	660,000	10
Denver, Colo.	3,210,000	132	2,530,000	104
Detroit, Mich.	1,520,000	35	810,000	19
District of Columbia	-750,000	-5	-750,000	-5
Dutchess County, N.Y.	40,000	7	-30,000	-5
Fort Lauderdale, Fla.	2,060,000	28	940,000	13
Fort Worth, Tex.	350,000	19	90,000	5
Hartford, Conn.	-80,000	-3	-80,000	-3
Houston, Tex.	1,130,000	12	-20,000	0[c]
Jacksonville, Fla.	570,000	23	200,000	8
Jersey City, N.J.	590,000	20	160,000	5
Kansas City, Mo.	870,000	51	560,000	32
Las Vegas, Nev.	1,460,000	61	1,000,000	42
Los Angeles, Calif.	-10,000	0c	-10,000	0[c]
Miami, Fla.	3,580,000	28	1,620,000	13
Middlesex-Somerset-Hunterdon, N.J.	400,000	26	170,000	11
Minneapolis–St. Paul, Minn.	1,130,000	71	810,000	51
Nassau-Suffolk, N.Y.	40,000	1	40,000	1
New Haven, Conn.	0	0	0	0
New Orleans, La.	1,950,000	51	1,250,000	33
New York, N.Y.	5,660,000	9	-310,000	-1
Newark, N.J.	2,360,000	29	1,100,000	14
Norfolk, Va.	1,560,000	57	1,040,000	38
Oakland, Calif.	0	0	0	0

	Change in Title I base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless provision		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless provision[a]	
Eligible metropolitan area	Dollar change[b]	Percent change	Dollar change[b]	Percent change
Orange County, Calif.	-30,000	-1	-30,000	-1
Orlando, Fla.	1,190,000	30	570,000	14
Philadelphia, Pa.	-230,000	-2	-230,000	-2
Phoenix, Ariz.	2,020,000	58	1,360,000	39
Ponce, P.R.	-30,000	-2	-30,000	-2
Portland, Oreg.	-20,000	-1	-20,000	-1
Riverside–San Bernardino, Calif.	-90,000	-2	-90,000	-2
Sacramento, Calif.	0	0	0	0
St. Louis, Mo.	1,120,000	47	830,000	34
San Antonio, Tex.	180,000	8	-20,000	-1
San Diego, Calif.	-120,000	-2	800,000	15
San Francisco, Calif.	0	0	0	0
San Jose, Calif.	0	0	0	0
San Juan, P.R.	0	0	0	0
Santa Rosa, Calif.	0	0	0	0
Seattle, Wash.	0	0	640,000	21
Tampa–St. Petersburg, Fla.	1,000,000	21	310,000	7
Vineland-Millville-Bridgeton, N.J.	130,000	28	60,000	12
West Palm Beach, Fla.	530,000	12	0	0

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: The estimated dollar and percent changes are based on what the EMAs received in their base grants, including any hold-harmless funding, and what they would have received if HIV cases and ELCs had been used to allocate funding. In fiscal year 2004, the amount of hold-harmless funding was $8,033,563. Because the amounts needed to fund the Title I hold-harmless provision are taken from funds that would otherwise be available for supplemental grants, the total funding actually allocated as base grants and our estimated base grant funding differ by the amounts necessary to fund the hold-harmless provision. The hold-harmless funding was $43,300,968 when only CDC-accepted HIV case counts and ELCs were used and $29,413,708 when the HIV case counts from all grantees were used.

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 death.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]Percent change that rounds to zero, but does not equal zero percent.

Appendix IX: Estimated CARE Act Title II Base Funding Changes from Use of HIV Case Counts and ELCs with Hold-harmless

	Change in Title II base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless and minimum-grant provisions		Change in Title II base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless and minimum-grant provisions[a]	
Grantee	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Alabama	$1,170,000	29%	$1,000,000	25%
Alaska[c]	0	0	0	0
Arizona	620,000	19	410,000	13
Arkansas	320,000	18	250,000	14
California	0	0	0	0
Colorado	1,540,000	73	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	-1,330,000	-4	-2,910,000	-10
Georgia	-1,350,000	-14	-1,350,000	-14
Hawaii	-70,000	-6	-70,000	-6
Idaho[c]	0	0	0	0
Illinois	-1,780,000	-20	-780,000	-9
Indiana	180,000	5	50,000	1
Iowa	-90,000	-11	-90,000	-11
Kansas	0	0	0	0
Kentucky	-400,000	-17	-400,000	-17
Louisiana	700,000	11	390,000	6
Maine[c]	0	0	0	0
Maryland	-1,650,000	-20	2,060,000	24
Massachusetts	-620,000	-12	20,000	0[d]
Michigan	370,000	9	130,000	3
Minnesota	460,000	45	370,000	36
Mississippi	590,000	18	460,000	14
Missouri	720,000	26	520,000	19
Montana[c]	0	0	0	0
Nebraska	-10,000	-2	-30,000	-5
Nevada	520,000	31	400,000	24
New Hampshire[c]	0	0	0	0
New Jersey	370,000	3	0	0
New Mexico	-70,000	-6	-70,000	-6

	Change in Title II base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless and minimum-grant provisions		Change in Title II base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless and minimum-grant provisions[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
New York	-1,730,000	-4	-1,730,000	-4
North Carolina	2,440,000	33	2,120,000	29
North Dakota[e]	300,000	150	300,000	150
Ohio	940,000	17	690,000	13
Oklahoma	370,000	18	290,000	14
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	470,000	7	230,000	3
South Dakota[c]	0	0	0	0
Tennessee	490,000	8	270,000	4
Texas	-1,140,000	-6	-1,140,000	-6
Utah	-60,000	-6	-60,000	-6
Vermont[c]	0	0	0	0
Virginia	1,100,000	19	750,000	13
Washington	-200,000	-7	-170,000	-5
West Virginia	-20,000	-3	-50,000	-7
Wisconsin	360,000	20	290,000	16
Wyoming[e]	300,000	150	300,000	150

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: 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 death.

For purposes of this analysis, we considered the Title II hold-harmless provision that is funded by proportional reductions in Title II base grants. We did not include the Title II hold-harmless provision funded by amounts otherwise available for Severe Need grants.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]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.

[d]Percent change that rounds to zero, but does not equal zero percent.

[e]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 X: Estimated CARE Act ADAP Base Funding Changes from Use of HIV Case Counts and ELCs with Hold-harmless

	Change in ADAP base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless provision		Change in ADAP base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless provision[a]	
Grantee	Dollar change[b]	Percent change	**Dollar change[b]**	**Percent change**
Alabama	$4,810,000	69%	$3,860,000	55%
Alaska	-60,000	-13	-90,000	-20
Arizona	3,180,000	38	2,260,000	27
Arkansas	1,670,000	54	1,290,000	42
California	-18,530,000	-21	-13,400,000	-15
Colorado	5,610,000	100	4,710,000	84
Connecticut	-2,970,000	-26	-2,970,000	-26
Delaware	-1,210,000	-38	-280,000	-9
District of Columbia	-5,240,000	-38	-5,490,000	-40
Florida	7,570,000	9	530,000	1
Georgia	-8,120,000	-34	-8,120,000	-34
Hawaii	-610,000	-30	-230,000	-11
Idaho	290,000	62	230,000	49
Illinois	-9,750,000	-38	-520,000	-2
Indiana	2,400,000	37	1,690,000	26
Iowa	90,000	7	-20,000	-2
Kansas	570,000	28	360,000	18
Kentucky	-1,550,000	-38	-1,550,000	-38
Louisiana	4,840,000	35	3,350,000	24
Maine	-260,000	-32	150,000	18
Maryland	-9,750,000	-38	7,340,000	29
Massachusetts	-4,760,000	-32	1,360,000	9
Michigan	2,710,000	25	1,610,000	15
Minnesota	1,750,000	58	1,370,000	46
Mississippi	3,120,000	54	2,410,000	42
Missouri	3,260,000	44	2,400,000	32
Montana	-80,000	-25	290,000	93
Nebraska	310,000	28	200,000	18
Nevada	2,180,000	46	1,630,000	34
New Hampshire	-170,000	-22	200,000	26
New Jersey	5,210,000	15	2,000,000	6
New Mexico	170,000	8	-10,000	0[c]
New York	-4,960,000	-4	-14,570,000	-12

	Change in ADAP base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding with hold-harmless provision		Change in ADAP base funding if HIV case counts from all grantees and ELCs were used to distribute funding with hold-harmless provision[a]	
Grantee	Dollar change[b]	Percent change	**Dollar change[b]**	**Percent change**
North Carolina	9,470,000	74	7,680,000	60
North Dakota	50,000	52	40,000	40
Ohio	5,010,000	46	3,730,000	34
Oklahoma	1,930,000	54	1,490,000	42
Oregon	-1,230,000	-29	-640,000	-15
Pennsylvania	-7,180,000	-27	-8,780,000	-32
Puerto Rico	-5,900,000	-26	-5,900,000	-26
Rhode Island	-520,000	-27	-230,000	-12
South Carolina	4,660,000	40	3,350,000	29
South Dakota	170,000	84	140,000	69
Tennessee	4,400,000	41	3,180,000	30
Texas	1,760,000	4	-2,430,000	-5
Utah	260,000	14	90,000	5
Vermont	-130,000	-35	50,000	12
Virginia	5,610,000	39	4,000,000	28
Washington	-2,220,000	-28	630,000	8
West Virginia	330,000	25	200,000	15
Wisconsin	1,790,000	56	1,400,000	44
Wyoming	30,000	20	20,000	11

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: The ADAP base grant funding levels reported to us included any hold-harmless funding that would otherwise be used for ADAP Severe Need grants. The estimated dollar and percent changes presented here are based on what grantees received in their ADAP base grants without this hold-harmless funding.

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 death.

For purposes of this analysis, we considered the Title II hold-harmless provision that is funded by proportional reductions in ADAP base grants. We did not include the Title II hold-harmless provision funded by amounts otherwise available for Severe Need grants.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]Percent change that rounds to zero, but does not equal zero percent.

Appendix XI: Estimated CARE Act Title I Base Funding Changes from Use of HIV Case Counts and ELCs without Hold-harmless

	Change in Title I base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless provision		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless provision[a]	
Eligible metropolitan area	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Atlanta, Ga.	-$2,830,000	-31%	-$3,600,000	-39%
Austin, Tex.	260,000	13	-10,000	0[c]
Baltimore, Md.	-3,110,000	-31	3,210,000	32
Bergen-Passaic, N.J.	600,000	23	210,000	8
Boston, Mass.	-2,310,000	-31	1,180,000	16
Caguas, P.R.	-260,000	-28	-340,000	-37
Chicago, Ill.	-3,900,000	-31	510,000	4
Cleveland, Ohio	940,000	51	610,000	33
Dallas, Tex.	1,630,000	25	660,000	10
Denver, Colo.	3,210,000	132	2,530,000	104
Detroit, Mich.	1,520,000	35	810,000	19
District of Columbia	-2,330,000	-16	-1,390,000	-10
Dutchess County, N.Y.	40,000	7	-40,000	-6
Fort Lauderdale, Fla.	2,060,000	28	940,000	13
Fort Worth, Tex.	350,000	19	90,000	5
Hartford, Conn.	-730,000	-31	-800,000	-34
Houston, Tex.	1,130,000	12	-140,000	-1
Jacksonville, Fla.	570,000	23	200,000	8
Jersey City, N.J.	590,000	20	160,000	5
Kansas City, Mo.	870,000	51	560,000	32
Las Vegas, Nev.	1,460,000	61	1,000,000	42
Los Angeles, Calif.	-5,660,000	-31	-2,660,000	-14
Miami, Fla.	3,580,000	28	1,620,000	13
Middlesex–Somerset–Hunterdon, N.J.	400,000	26	170,000	11
Minneapolis–St. Paul, Minn.	1,130,000	71	810,000	51
Nassau-Suffolk, N.Y.	-940,000	-29	-1,210,000	-38
New Haven, Conn.	-1,140,000	-31	-1,270,000	-35
New Orleans, La.	1,950,000	51	1,250,000	33
New York, N.Y.	5,660,000	9	-2,240,000	-4
Newark, N.J.	2,360,000	29	1,100,000	14
Norfolk, Va.	1,560,000	57	1,040,000	38
Oakland, Calif.	-1,100,000	-32	-680,000	-19

	Change in Title I base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless provision		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless provision[a]	
Eligible metropolitan area	Dollar change[b]	Percent change	Dollar change[b]	Percent change
Orange County, Calif.	-810,000	-31	-190,000	-7
Orlando, Fla.	1,190,000	30	570,000	14
Philadelphia, Pa.	-2,620,000	-22	-3,750,000	-31
Phoenix, Ariz.	2,020,000	58	1,360,000	39
Ponce, P.R.	-420,000	-29	-540,000	-38
Portland, Oreg.	-580,000	-31	-90,000	-5
Riverside–San Bernardino, Calif.	-1,190,000	-31	-170,000	-4
Sacramento, Calif.	-500,000	-32	-330,000	-21
St. Louis, Mo.	1,120,000	47	830,000	34
San Antonio, Tex.	180,000	8	-100,000	-5
San Diego, Calif.	-1,590,000	-31	800,000	15
San Francisco, Calif.	-10,050,000	-62	-8,470,000	-52
San Jose, Calif.	-440,000	-31	-30,000	-2
San Juan, P.R.	-2,430,000	-30	-3,120,000	-38
Santa Rosa, Calif.	-200,000	-33	-30,000	-5
Seattle, Wash.	-930,000	-31	640,000	21
Tampa–St. Petersburg, Fla.	1,000,000	21	310,000	7
Vineland-Millville-Bridgeton, N.J.	130,000	28	60,000	12
West Palm Beach, Fla.	530,000	12	-80,000	-2

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: The estimated dollar and percent changes are based on what the EMAs actually received in their base grants, which includes hold-harmless funding, and what they would have received using HIV cases and ELCs if there had been no hold-harmless provision. Because hold-harmless funding is taken from amounts otherwise available for supplemental grants, the total funding actually allocated as base grants and our estimated funding differ by the amount of the hold-harmless funding ($8,033,563).

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 death.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]Percent change that rounds to zero, but does not equal zero percent.

Appendix XII: Estimated CARE Act Title II Base Funding Changes from Use of HIV Case Counts and ELCs without Hold-harmless

	Change in Title II base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless and minimum-grant provisions		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless and minimum-grant provisions[a]	
Grantee	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Alabama	$2,550,000	63%	$2,010,000	50%
Alaska[c]	-270,000	-54	-290,000	-58
Arizona	1,220,000	38	810,000	25
Arkansas	870,000	49	650,000	37
California	-11,750,000	-38	-4,980,000	-16
Colorado	2,100,000	99	1,700,000	81
Connecticut	-1,360,000	-36	-1,410,000	-37
Delaware	-740,000	-40	-220,000	-12
District of Columbia	-1,520,000	-35	-1,800,000	-42
Florida	2,970,000	10	-110,000	0[d]
Georgia	-3,530,000	-38	-4,060,000	-43
Hawaii	-480,000	-40	-170,000	-14
Idaho[c]	-80,000	-16	-110,000	-23
Illinois	-3,200,000	-36	-60,000	-1
Indiana	1,210,000	32	810,000	21
Iowa	30,000	3	-40,000	-5
Kansas	210,000	21	110,000	11
Kentucky	-940,000	-40	-1,060,000	-45
Louisiana	2,110,000	34	1,380,000	22
Maine[c]	-210,000	-42	50,000	10
Maryland	-3,020,000	-36	2,980,000	35
Massachusetts	-1,910,000	-37	530,000	10
Michigan	1,180,000	27	680,000	16
Minnesota	650,000	64	490,000	48
Mississippi	1,630,000	49	1,220,000	37
Missouri	1,260,000	45	880,000	32
Montana[c]	-390,000	-79	-170,000	-33
Nebraska	150,000	24	90,000	14
Nevada	840,000	50	600,000	36
New Hampshire[c]	-310,000	-63	-120,000	-24
New Jersey	2,140,000	17	760,000	6
New Mexico	60,000	5	-50,000	-4

	Change in Title II base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless and minimum-grant provisions		Change in Title I base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless and minimum-grant provisions[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
New York	-600,000	-1	-4,640,000	-11
North Carolina	5,030,000	68	4,020,000	54
North Dakota[e]	-120,000	-62	-130,000	-65
Ohio	2,420,000	45	1,750,00	32
Oklahoma	1,010,000	49	760,000	37
Oregon	-620,000	-37	-280,000	-17
Pennsylvania	-2,320,000	-22	-3,080,000	-29
Puerto Rico	-2,950,000	-36	-3,450,000	-42
Rhode Island	-440,000	-40	-170,000	-15
South Carolina	2,370,000	35	1,620,000	24
South Dakota[c]	-290,000	-58	-310,000	-62
Tennessee	2,250,000	36	1,550,000	25
Texas	870,000	5	-990,000	-5
Utah	110,000	10	10,000	1
Vermont[c]	-370,000	-74	-260,000	-52
Virginia	2,370,000	40	1,620,000	27
Washington	-1,170,000	-37	170,000	5
West Virginia	150,000	21	80,000	11
Wisconsin	940,000	51	710,000	39
Wyoming[e]	-90,000	-46	-100,000	-51

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: 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 death.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]State received a Title II base award of $500,000, the minimum it could receive based on the number of ELCs in the state. The estimated changes compare this amount with what the state would have received if HIV case counts and ELCs had been used to determine funding and if there had been no hold-harmless and minimum-grant provisions.

[d]Percent change that rounds to zero, but does not equal zero percent.

[e]State received a Title II base award of $200,000, the minimum it could receive based on the number of ELCs in the state. The estimated changes compare this amount with what the state would have received if HIV case counts and ELCs had been used to determine funding and if there had been no hold-harmless and minimum-grant provisions.

Appendix XIII: Estimated CARE Act ADAP Base Funding Changes from Use of HIV Case Counts and ELCs without Hold-harmless

	Change in ADAP base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless provision		Change in ADAP base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless provision[a]	
Grantee	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Alabama	$5,190,000	74%	$3,970,000	57%
Alaska	-50,000	-10	-90,000	-19
Arizona	3,550,000	42	2,370,000	28
Arkansas	1,820,000	59	1,330,000	43
California	-32,150,000	-36	-12,590,000	-14
Colorado	5,970,000	106	4,820,000	86
Connecticut	-4,060,000	-36	-4,240,000	-38
Delaware	-1,150,000	-36	-250,000	-8
District of Columbia	-4,970,000	-36	-5,850,000	-42
Florida	10,400,000	13	1,390,000	2
Georgia	-8,500,000	-36	-10,010,000	-42
Hawaii	-750,000	-36	-210,000	-10
Idaho	310,000	68	240,000	51
Illinois	-9,240,000	-36	-250,000	-1
Indiana	2,690,000	41	1,770,000	27
Iowa	140,000	10	-10,000	-1
Kansas	650,000	32	390,000	19
Kentucky	-1,470,000	-36	-1,730,000	-42
Louisiana	5,440,000	39	3,530,000	26
Maine	-300,000	-36	160,000	19
Maryland	-9,240,000	-36	7,700,000	30
Massachusetts	-5,270,000	-36	1,530,000	10
Michigan	3,150,000	29	1,740,000	16
Minnesota	1,910,000	63	1,420,000	47
Mississippi	3,410,000	60	2,490,000	43
Missouri	3,600,000	49	2,510,000	34
Montana	-110,000	-36	300,000	95
Nebraska	360,000	32	210,000	19
Nevada	2,400,000	51	1,700,000	36
New Hampshire	-270,000	-36	210,000	28
New Jersey	6,500,000	19	2,390,000	7
New Mexico	250,000	12	20,000	1

	Change in ADAP base funding if CDC-accepted HIV case counts and ELCs were used to distribute funding without hold-harmless provision		Change in ADAP base funding if HIV case counts from all grantees and ELCs were used to distribute funding without hold-harmless provision[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
New York	-1,110,000	-1	-13,400,000	-11
North Carolina	10,190,000	79	7,900,000	62
North Dakota	50,000	57	40,000	41
Ohio	5,520,000	51	3,890,000	36
Oklahoma	2,100,000	59	1,540,000	43
Oregon	-1,520,000	-36	-600,000	-14
Pennsylvania	-6,540,000	-24	-8,540,000	-32
Puerto Rico	-7,890,000	-35	-9,350,000	-41
Rhode Island	-690,000	-36	-210,000	-11
South Carolina	5,190,000	44	3,510,000	30
South Dakota	180,000	90	150,000	71
Tennessee	4,880,000	46	3,330,000	31
Texas	3,440,000	7	-1,920,000	-4
Utah	330,000	18	110,000	6
Vermont	-140,000	-36	50,000	14
Virginia	6,260,000	43	4,200,000	29
Washington	-2,860,000	-36	720,000	9
West Virginia	380,000	29	210,000	16
Wisconsin	1,950,000	61	1,440,000	45
Wyoming	40,000	24	20,000	12

Sources: GAO analysis of CDC, HRSA, state, and local data.

Notes: The ADAP base grant funding levels reported to us included any hold-harmless funding that would otherwise be used for ADAP Severe Need grants. The estimated dollar and percent changes presented here are based on what grantees received in their ADAP base grants without this hold-harmless funding.

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 death.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

Appendix XIV: Estimated HOPWA Base Funding Changes from Use of HIV and Living AIDS Case Counts, Fiscal Year 2004

	Change in HOPWA base funding if CDC-accepted HIV case counts and living AIDS case counts were used to distribute funding		Change in HOPWA base funding if HIV case counts from all grantees and living AIDS case counts were used to distribute funding[a]	
Grantee	**Dollar change[b]**	**Percent change**	**Dollar change[b]**	**Percent change**
Alabama	$1,150,000	101%	$960,000	84%
Albany, N.Y.	80,000	18	30,000	8
Arizona	60,000	39	40,000	27
Arkansas	630,000	84	520,000	69
Atlanta, Ga.	-1,160,000	-27	-1,420,000	-33
Augusta, Ga.	10,000	3	-20,000	-6
Austin, Tex.	70,000	7	-20,000	-2
Baltimore, Md.	-1,170,000	-30	1,770,000	45
Baton Rouge, La.	470,000	71	370,000	56
Birmingham, Ala.	550,000	106	460,000	89
Boston, Mass.	-650,000	-36	110,000	6
Bridgeport, Conn.	-160,000	-21	-180,000	-24
Buffalo, N.Y.	30,000	6	-10,000	-3
California	-1,150,000	-38	-600,000	-20
Cambridge, Mass.	-200,000	-30	110,000	16
Camden, N.J.	180,000	27	110,000	16
Charleston, S.C.	290,000	72	230,000	57
Charlotte, N.C.	900,000	158	780,000	137
Chicago, Ill.	-1,860,000	-33	-10,000	0[c]
Cincinnati, Ohio	200,000	36	130,000	24
Cleveland, Ohio	410,000	48	300,000	35
Colorado	350,000	97	290,000	80
Columbia, S.C.	600,000	96	490,000	80
Columbus, Ohio	360,000	61	280,000	48
Connecticut	-60,000	-24	-70,000	-28
Dallas, Tex.	590,000	19	270,000	9
Delaware	-40,000	-22	30,000	18
Denver, Colo.	1,210,000	85	990,000	69
Detroit, Mich.	270,000	17	110,000	7
District of Columbia	-230,000	-4	20,000	0[c]
Florida	-660,000	-16	-950,000	-23
Fort Lauderdale, Fla.	820,000	24	460,000	14
Fort Worth, Tex.	110,000	13	30,000	3

	Change in HOPWA base funding if CDC-accepted HIV case counts and living AIDS case counts were used to distribute funding		Change in HOPWA base funding if HIV case counts from all grantees and living AIDS case counts were used to distribute funding[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
Gaithersburg, Md.	-120,000	-22	190,000	35
Georgia	-340,000	-23	-440,000	-29
Hartford, Conn.	-220,000	-21	-230,000	-23
Hawaii	-30,000	-17	10,000	5
Honolulu, Hawaii	-160,000	-37	-70,000	-16
Houston, Tex.	-260,000	-5	-660,000	-13
Illinois	-190,000	-22	140,000	17
Indiana	470,000	56	360,000	43
Indianapolis, Ind.	420,000	56	320,000	42
Iowa	60,000	17	30,000	8
Islip, N.Y.	-300,000	-18	-410,000	-25
Jackson, Miss.	450,000	99	370,000	82
Jacksonville, Fla.	290,000	24	160,000	14
Kansas	90,000	25	50,000	15
Kentucky	-60,000	-13	-90,000	-21
Kansas City, Mo.	360,000	36	240,000	25
Las Vegas, Nev.	710,000	77	570,000	62
Los Angeles, Calif.	-4,370,000	-42	-3,660,000	-35
Louisiana	580,000	62	460,000	49
Louisville, Ky.	-40,000	-9	-80,000	-17
Maryland	-70,000	-20	710,000	204
Massachusetts	-160,000	-30	60,000	12
Memphis, Tenn.	940,000	102	780,000	85
Miami, Fla.	1,140,000	19	520,000	9
Michigan	370,000	41	270,000	29
Milwaukee, Wis.	340,000	66	260,000	52
Minneapolis, Minn.	350,000	42	250,000	30
Minnesota	60,000	56	50,000	43
Mississippi	630,000	84	520,000	68
Missouri	270,000	55	210,000	42
Nashville, Tenn.	680,000	93	560,000	77
Nevada	130,000	55	100,000	41
New Haven, Conn.	-200,000	-21	-220,000	-24
New Jersey	-770,000	-70	-800,000	-72
New Mexico	110,000	21	60,000	11

	Change in HOPWA base funding if CDC-accepted HIV case counts and living AIDS case counts were used to distribute funding		Change in HOPWA base funding if HIV case counts from all grantees and living AIDS case counts were used to distribute funding[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
New Orleans, La.	760,000	43	550,000	31
New York	300,000	17	130,000	7
New York, N.Y.	-3,040,000	-9	-5,610,000	-17
Newark, N.J.	40,000	1	-330,000	-8
North Carolina	2,130,000	103	1,780,000	85
Oakland, Calif.	-780,000	-39	-670,000	-33
Ohio	500,000	49	370,000	36
Oklahoma	430,000	83	350,000	67
Oklahoma City, Okla.	180,000	39	130,000	27
Orlando, Fla.	610,000	37	420,000	25
Pennsylvania	-50,000	-4	-180,000	-12
Philadelphia, Pa.	-730,000	-17	-1,040,000	-24
Phoenix, Ariz.	920,000	65	730,000	51
Pittsburgh, Pa.	-120,000	-19	-160,000	-26
Portland, Oreg.	-300,000	-30	-110,000	-11
Poughkeepsie, N.Y.	-30,000	-5	-80,000	-13
Providence, R.I.	-220,000	-27	40,000	5
Puerto Rico	-1,080,000	-62	-1,130,000	-65
Richmond, Va.	490,000	71	390,000	57
Riverside, Calif.	-380,000	-22	-90,000	-5
Rochester, N.Y.	170,000	29	110,000	18
Sacramento, Calif.	-310,000	-37	-280,000	-33
St. Louis, Mo.	450,000	37	370,000	30
Salt Lake City, Utah	120,000	32	80,000	21
San Antonio, Tex.	100,000	10	0[d]	1
San Diego, Calif.	-820,000	-31	20,000	1
San Francisco, Calif.	-3,950,000	-59	-3,420,000	-51
San Jose, Calif.	-260,000	-33	-100,000	-13
San Juan, P.R.	-1,990,000	-44	-2,210,000	-48
Santa Ana, Calif.	-370,000	-26	-130,000	-9
Sarasota, Fla.	40,000	11	10,000	1
Seattle, Wash.	-520,000	-31	170,000	10
South Carolina	1,040,000	75	840,000	61
Springfield, Mass.	-150,000	-32	90,000	20
Tampa, Fla.	330,000	15	110,000	5

	Change in HOPWA base funding if CDC-accepted HIV case counts and living AIDS case counts were used to distribute funding		Change in HOPWA base funding if HIV case counts from all grantees and living AIDS case counts were used to distribute funding[a]	
Grantee	Dollar change[b]	Percent change	Dollar change[b]	Percent change
Tennessee	490,000	67	390,000	53
Texas	780,000	29	480,000	18
Tucson, Ariz.	210,000	53	160,000	40
Utah	30,000	26	20,000	15
Virginia	320,000	50	240,000	37
Virginia Beach, Va.	720,000	71	580,000	56
Wake County, N.C.	360,000	105	300,000	88
Warren, Mich.	120,000	31	80,000	20
Washington	-160,000	-25	70,000	10
West Palm Beach, Fla.	270,000	14	80,000	4
Wilmington, Del.	-70,000	-13	110,000	19
Wisconsin	220,000	54	170,000	41
Woodbridge, N.J.	50,000	4	-80,000	-5
Worcester, Mass.	-90,000	-25	80,000	22

Sources: GAO analysis of CDC, HUD, state, and local data.

Notes: The number of living AIDS cases was calculated by subtracting the number of reported deaths among AIDS cases in a jurisdiction from the number of reported cases.

[a]In some jurisdictions, HIV cases are collected by name while in others HIV cases are collected using a coded identifier. We used both name- and code-based case counts for this estimate. CDC only accepts name-based case counts as no code-based system has yet met its quality criteria.

[b]Rounded to nearest $10,000.

[c]Percent change that rounds to zero, but does not equal zero.

[d]Dollar change that rounds to zero, but does not equal zero.

Appendix XV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

FEB 6 2006

Ms. Marcia Crosse
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Crosse:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds" (GAO-06-332). These comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for U.S. Government Accountability Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED, "HIV/AIDS: CHANGES NEEDED TO IMPROVE THE DISTRIBUTION OF RYAN WHITE CARE ACT AND HOUSING FUNDS" (GAO-06-332)

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the draft report and commends the U.S. Government Accountability Office (GAO) for its comprehensive approach and ambitious analysis that pulls together data from many disparate sources. As GAO has noted, HHS's Health Resources and Services Administration (HRSA) administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act through grantees. HRSA utilizes, among other elements, surveillance data published by HHS's Centers for Disease Control and Prevention (CDC) in making decisions regarding CARE Act funding activities. The draft report identifies the issues with respect to many of the provisions in the current Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Public Law 106-345).

However, the draft appears to disregard the potential usefulness of including HIV data in the CARE Act formula. HHS suggests that GAO has not fully addressed its charge to "examine what distribution differences could result from incorporating HIV case counts in the CARE Act" by omitting analyses of reported living HIV disease cases and HIV disease estimated living cases (ELCs) as specified in the current formula for Title I and Title II allocations.

GAO has done an excellent job of identifying various deficiencies in the current HIV data, which suggests that HIV data should be used for funding purposes. Although GAO states that HIV data used seem sufficiently accurate for purposes of the presented analysis, no assessment is provided regarding the potential usefulness of such information, if all areas participated in the national reporting system coordinated by CDC using standardized methods of reporting. Moreover, the matters for Congressional consideration (page 65) focus only on AIDS cases and potential changes to a formula that reflect the use of AIDS case counts and not HIV disease. In this latter discussion, GAO appears to endorse the superiority of the "Living AIDS Case" counts provided by CDC, i.e., cumulative cases subtracting cases reported as deceased. Congress is presented no similar formal consideration for the use of HIV disease data in response to its request regarding distribution differences that could result from incorporating HIV case counts in CARE Act and Housing Opportunities for Persons with AIDS program (HOPWA) funding formulas.

In discussions throughout the draft regarding data accepted and not accepted by CDC because of differences between jurisdictions in the methods used to report HIV-only cases (i.e., names versus codes), GAO does not make clear that CDC does not receive case counts from reporting areas. CDC receives, reviews, and processes case reports, which

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do not contain personal identifiers, on individual cases. Potential duplicate reports across jurisdictions are then manually reviewed by the relevant reporting areas through a CDC-coordinated process to remove duplicate reports from the national database. In GAO's analysis, comparable data were not received from code-based States. These States cannot participate in a manual, CDC-coordinated, de-duplication process because they do not have comparable patient identifiers to those maintained in name-based States. Therefore, it would be scientifically indefensible for CDC in its monitoring of HIV/AIDS nationally to replicate the process used by GAO in this study of accepting only case counts from areas using code-based reporting. The infeasibility of simply accepting case counts from areas using code-based methods, both in terms of assuring data quality and compiling data, is not made clear in the GAO report.

Regarding the matters for Congressional consideration, HHS submits the following.

GAO Statement

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 life spans of persons living with AIDS.

HHS Comment

The current CARE Act requires the use of differing formulas using ELCs compiled over a 10-year period, AIDS cases for the most recent 2-year period, or AIDS cases over the most recent 5-year period. HRSA has sought to comply with the legislative intent of the specific program goals and would welcome any recommendations that would simplify the formulas or make them similar with respect to the time period and type of HIV and AIDS case data used.

GAO Statement

Eliminating the counting of cases in [eligible metropolitan areas] EMAs for Title I base funding and again for Title II base funding.

HHS Comment

In its analysis of the impact of CARE Act funding, GAO used as its measurement dollars per AIDS case. In so doing, the draft points out the disparity in AIDS case amounts, which occurs in those States or Territories that have an EMA or multiple EMAs.

GAO Statement

Modifying the hold-harmless provisions for Title I, Title II, and ADAP base funding to reduce the extent to which they prevent funding from shifting to areas where the epidemic has been increasing.

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HHS Comment

The intent of the hold-harmless provisions was to prevent the loss of funding from a jurisdiction as a result of significant changes in the number of ELCs or AIDS cases used in the formulas for calculating funding amounts. GAO's analysis of the impact of the hold-harmless provisions appears to provide an accurate assessment of these provisions. HHS would like to add that the mandated minimum award amounts for Title II States or Territories is a result of the recognition that a certain level of funding was needed in order to establish and sustain a system that provides HIV/AIDS care and treatment in the jurisdictions. If the grant amount depended solely on the number of reported AIDS cases or ELCs in these low prevalence areas, the amount of the award would not be sufficient to sustain state of the art HIV care and treatment services.

GAO Statement

Modifying the Title I grandfathering provision that protects the eligibility of metropolitan areas that no longer meet the eligibility criteria.

HHS Comment

The draft report states on page 38, "The number of EMAs ineligible for Title I funds in the absence of the grandfathering clause reflects the combination of the decline in the number of new AIDS cases following the advent of more effective therapies." HHS believes that much of the decline in new AIDS cases would not have been made if not for the establishment and expansion of the systems of care supported by CARE Act funds awarded to the 29 EMAs that would no longer meet eligibility criteria. The suggestion that since these 29 EMAs no longer meet the current eligibility criteria and, by extension, need not be funded means that the systems of care now in place would in many cases cease to exist. Such a circumstance would run counter to the progress that has been made in fighting the epidemic in these areas.

GAO Statement

Eliminating the two-tiered structure of the emerging communities (EC) program.

HHS Comment

HHS believes that GAO's analysis of the ECs provision of the CARE Act is correct but notes that there is no reference to a population requirement under the ECs legislation other than such ECs cannot be eligible for Title I funding. The reference to "communities with populations of 50,000 or more" on page 31, paragraph 2, of the draft report should be deleted.

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GAO Statement

If Congress wishes to preserve funding of the [AIDS Drug Assistance Program] ADAP Severe Need grants, it should revise the Title II hold-harmless provision that is funded with amounts set aside for the ADAP Severe Need Grants.

HHS Comment

HHS concurs with GAO's assessment cited in the above statement; however, GAO made no specific recommendation with regard to its analysis of the use of revised Office of Management and Budget (OMB) Metropolitan Area Definitions for determining the boundaries of Title I EMAs.

In the 1996 amendments to the CARE Act, Congress made clear its intent that EMAs deemed eligible prior to 1996 would remain EMAs, and their boundaries would remain as they were when first designated. This was a direct response to the problem of the changing boundaries of what were then called Metropolitan Standard Statistical Areas by OMB as a result of the 1990 census. The changes in boundaries would have resulted in combining several EMAs into very large EMAs, covering broad geographical areas and stretching across State boundaries. Such changes would result in considerable disruption to established grantee structures, planning council memberships, and the planning and needs assessment activities conducted by both the grantee and planning councils.

The current GAO report suggests that the new OMB definitions should be accepted for use in determining EMA boundaries. GAO does not recognize in the draft that combining current EMAs into a single EMA would present significant program administration difficulties. For example, in one case, the geographic area of a newly designated EMA for New York City would result in an EMA comprised of all of New York City and a significant portion of northern New Jersey. It is our belief that the resulting disruption to the grantee and planning council activities, as well as the need for several intergovernmental agreements among multiple jurisdictions, would impede the progress made in providing care services within the existing EMAs.

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Appendix XVI: Comments from the Department of Housing and Urban Development

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-7000

ASSISTANT SECRETARY FOR
COMMUNITY PLANNING AND DEVELOPMENT

FEB 14 2006

Ms. Marcia Crosse
Director, Health Care
United States Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Crosse:

On behalf of Secretary Jackson, thank you for the opportunity to review the Draft Report, *GAO-06-332, HIV/AIDS, Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Fund.* This draft report reviews the allocation of federal resources made available under the Housing Opportunities for Persons With AIDS (HOPWA) program administered by HUD, as well as the Ryan White Care Act program administered by HHS.

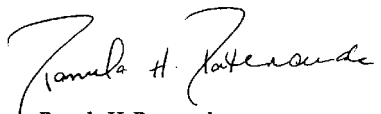
HUD agrees with the report's recommendation to update the HOPWA program formula and has been actively exploring options that would incorporate a more current estimate of persons living with HIV/AIDS, coupled with a housing cost factor to reflect differences in area housing needs. This formula change would achieve a more equitable distribution of resources and would better reflect housing cost differences experienced by the recipient communities. The use of data on persons living with HIV/AIDS would be more effective and efficient in targeting these housing resources to program beneficiaries. In addition to recommending formula improvements in 1999, HUD has proposed technical formula edits to maintain eligibility and funding stability for current housing programs and these have been enacted in recent years.

The Department appreciates that the report seeks to improve the targeting of federal resources to better assist this special needs population. HUD's experience demonstrates that the needs of HOPWA beneficiaries are being addressed through the types of supportive housing activities undertaken by the recipient communities. These local HOPWA projects are supporting stable housing arrangements for very low-income clients that result in improved access to health care and other needed support. The Department will consider the information provided in this review in developing a recommendation on this program component.

Thank you for your thoughtful work on reviewing the HOPWA formula and in providing an opportunity to comment on this draft report. HUD provided GAO with specific program information that was incorporated into this review. Since that information was submitted, additional data verification actions were taken that have resulted in some adjustment to the data illustrated in the report. Enclosed are our comments to the draft report, including notations to specific technical corrections.

If you have questions or would like to discuss our comments, please contact David Vos, Director, Office of HIV/AIDS Housing, at (202) 708-1934.

Sincerely,



Pamela H. Patenaude
Assistant Secretary

Enclosure

U.S. Department of Housing and Urban Development
Office of Community Planning and Development
Office of HIV/AIDS Housing

HUD's comments on GAO's January 12, 2006 draft report, *Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds* are shown below in "italics".

- The summary report notes that more than half of HOPWA funds are used for housing assistance (and a similar comment is found on page 16).

HUD recommends that this summary point be clarified. All HOPWA funding is directed towards addressing the housing needs of eligible low-income persons who are living with HIV/AIDS and their family. While grantees may report under different activity types, such as direct housing costs or related supportive services, these are all activities that are directly connected to the nature of this program's effort to provide supportive housing for a special needs population.

Further, the summary and report could note that the availability of relevant data has changed over time and that the Centers for Disease Control and Prevention (CDC) have made recommendations on use of such data, as collected under their guidance. As required by the authorizing statute for the HOPWA program, the use of AIDS surveillance data provides a unique data source that is tied directly to the size and location of the population eligible to be assisted by this federal program. HUD agrees that updated and relevant data sources should be used for this program. In addition, as the program addresses housing needs, data on the costs for carrying out the housing activities would also be highly relevant in distributing these federal housing resources. The Department looks forward to recommending needed improvements to this program component.

- Page 6 – the second paragraph of this page proposes examining funding per person living with AIDS (PLWA) to measure the equity of the formula for program clients. The report points out that there are considerations that might justify deviations from constant funding per PLWA. The report mentions health care costs as an example, but not housing. The report indicates that it did not consider such factors in the study.

HUD recommends that the report specifically note that differences in area housing costs were not considered in the review on the HOPWA program. In the Department's view, housing costs are an important consideration in allocating resources in accomplishing the HOPWA program mission of providing supportive housing to this special needs population. For example, in providing rental assistance to an eligible household, a provider in rural Alabama would use the HUD fair market rent standard of $491 per month to determine the amount of HOPWA subsidy, the amount above the resident's own rent payment (at 30 percent of adjusted income) and the actual rent,

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limited to units at that cost. This would compare to a similar household located in Philadelphia with an FMR at $873, or another in San Diego with a FMR at $1,183. As HOPWA grantees undertake assistance in their communities, the housing cost factor will play a significant role in determining the number of households that can be assisted with the allocated resources. Based on the areas served by HOPWA grantees, the current range of FMRs is at the lowest in Puerto Rico at $355 and highest in San Jose, CA at $1,739.

- Page 9 - The first paragraph breaks down funding for HIV/AIDS but includes Medicare, Medicaid and Social Security, as programs assisting persons with HIV/AIDS. The paragraph indicates that $295 was designated for HOPWA.

HUD recommends that the paragraph note if HOPWA funding is included in the income support or, more appropriately, as "treatment costs" if a separate section on housing is not to be displayed on the pie chart (a 1.8% slice). Also, the word "million" should be inserted after the "$295" to clarify that number.

- Page 15 - This page provides a general explanation of the HOPWA formula.

The report would benefit in referring to HOPWA funds distributed under the base and bonus "factors" rather than as stated or implied as two separate "grants". In contrast to the RWCA, there is only one formula grant awarded under HOPWA. To avoid confusion, we recommend revising base grant and bonus grant terminology to refer to base and bonus "factors" which added together compose the formula grant. This matter is repeated in other parts of the report and in the appendices and should be revised in a similar way throughout the document.

- Page 18 - The bottom of the first paragraph on this page summarizes the effect of using data on HIV (including PLWA estimates) for the base funding. It indicates that up to 15% of HOPWA base funding would have shifted. It suggests that the change is a result of shift to HIV data as compared to cumulative data.

This statement about the 15% shift may not fairly describe the effect on HOPWA grant amount in replacing the cumulative case factor and incidence factor. The impact on funding would seem to be more significant than suggested by the 15% figure if the changes shown in Appendix XI are useful. HUD would be concerned that the HIV data that is missing from those states that do not report HIV surveillance data or those that do not use name-based reporting are excluded in the data used to calculate the table. This would automatically mean significant reductions in amounts shown for those states, adding to the seeming significance of this funding shift. Perhaps a comparison could be developed on the state data for only those areas with acceptable HIV reporting systems, or like systems based on their maturity in use. There may be sufficient data to observe the extent of change possible for those recipients. Appendix XI does display losses and gains for more than two-thirds of HOPWA grantees are in excess of 15%. Out of the 117 grantees, there are 22 with losses more than 15% and 58 with gains more than 15%.

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Also, the report does not describe the incremental effect on HOPWA allocations of using HIV data for persons not diagnosed with AIDS on top of the effect of PLWA data. Use of PLWA data alone, as a validated national data source for a revised HOPWA allocation, would redistribute funds among grantees in a similar pattern. A review of the incremental effect might be of use in considering the transition to use of HIV data for HOPWA funding, once it is available on a valid and nationally consistent basis from CDC.

- Pages 22 and 23 – The funding distribution of HOPWA is characterized as "more than half for housing assistance". This same characterization is stated in the summary.

HUD recommends that this be revised to state that HOPWA grantees use the program to undertake housing activities, including supportive housing efforts, to address the needs of this special needs population. Although shown as a distinct eligible activity, and eligible as such, the supportive services undertaken with HOPWA funds are a vital part of efforts to stabilize and maintain clients in their housing. Further, since HUD provided the data to GAO, some addition data collection and verification efforts were made with grantee to validate the information on expenditures by type of activity. As shown on the chart on page 23, HUD will now be showing that HOPWA grantee performance for that 2003-04 operating year is 66% in direct housing costs, with an additional 4% for housing information services and permanent housing placement costs, along with 25% for related supportive services and 5% for grant administration. Some additional actions are pending on a few of these grantee reports.

- Pages 25 and 26 - the allocations for 2004 are characterized as varying from the average funding when examined relative to PLWA ($573). The description notes one case, Baton Rouge with $1,290 per PLWA, and Nashville as the other extreme at $387.

While the numbers demonstrate a per person effect, the paragraph does not comment that this reflects the impact of the bonus factor and note that grantees receiving this bonus, do not all sustain that funding from year to year. In the example, the allocation to Baton Rouge was reduced by 13 percent in the subsequent FY05 allocation, due to a change in AIDS incidence data reported for that metropolitan area, a reduction of $155,000 due to this factor. For Nashville, the other example used, funding in FY2005 involved an increase of 14 percent as that area qualified for one year for a bonus factor addition of $113,000 to their grant funding. While the data shown may reflect a point in time, formula funding concerns have also occurred in its use over time. HUD would observe that the bonus funding provides a significant amount of resources to those eligible for that factor, as 25 percent of formula funds are distributed on this basis. In FY2004, this involved 26 of the 117 formula grantees. It should be noted that 14 of these 26 areas are in the South. For FY06, the Department's Appropriation Act included an administrative provision that was requested by HUD to help mitigate the variability of incidence data by using data reported over a three-year period. That adjustment in the bonus factor will have a beneficial impact as used over time to reduce unexpected grant

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funding swings. In a general manner, the factor results in three groups of grant recipients, those with the status as a recipient in the higher-than-average incidence group, those that are recipients of the basic allocation, and a few that switch between the others from year to year.

HUD would recommend replacing the term "bonus grant" with "bonus" and consider a more general reference to this matter, something on the line of "more than a $1,000 per case for grantees that receive the bonus such as Baton Rouge, New York City, San Francisco, Baltimore, Memphis, San Juan etc". Also would recommend revising the penultimate sentence in the top paragraph on page 26 to say that "There are existing funding differences authorized in the HOPWA formula that result in a higher level of grant funding to the metropolitan areas with a higher-than-average incidence of AIDS. The incidence factor has a distinct impact from that attributed to the use of cumulative cases on AIDS in this analysis."

- Pages 26, 27, and 28 – these pages describe the effect of using cumulative cases and the inequity of distribution funds based on persons who are deceased.

- Pages 41, 42, and 43 - these pages describe the effect of bonus funding.

HUD recommends a few clarifications. As noted, the term bonus or bonus factor should be used rather than bonus grant. Second, it would be helpful to note the instability in year to year allocations that results from the bonus for some grantees whose incidence rates are near the national average incidence rate. A grantee that newly qualifies for the bonus in one year may not in a later year. Third, as a technical correction to the end of the last sentence of footnote on page 41, add the phrase "with more than 500,000 population". As described in HOPWA regulations, the average incidence is based on this subset of EMSAs.

- Page 50 - The last sentence in the first paragraph states that "there would have been at most a 15% funding shift if HIV cases were used to allocate funding".

This matter was addressed in comments above. It is recommended that the footnote number 73 be expanded to clarify that GAO used two methods to examine the effect of HIV data. Neither estimate uses data from CDC for all grantees, perhaps tagging those for which this data is absent. Under the first method the HIV data was based on data from CDC for 35 areas with name-based reporting and under the second method GAO also used data provided to GAO by the other areas.

- Page 60 – addresses how HOPWA funding for the base factor would generally shift if HIV cases were used in funding.

As noted in the comment for page 18, it would be useful to observe the effect on funding if the data can be reviewed only on those for which HIV data is available.

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- Page 64 – the only conclusion for HOPWA is that cumulative case data has led to disproportionate funding when examining grants with respect to PLWA.

The conclusion may overstate the impact of the base factor alone, and HUD would observe that the incidence factor is a significant part of the allocation. As noted in earlier comments, the grantee group with the highest funding per PLWA are the grantees that receive a bonus, and not all maintain this status year to year. HUD would recommend expanding the statement to indicate, " The use of cumulative AIDS cases and the incidence has led to some level of disproportionate funding on a per person basis comparing funding to data on persons living with AIDS and, where available, data on persons living with HIV. This view on the disproportionate effect does not consider how differences in area housing costs would also impact on a fair distribution of support under this housing program in assisting eligible households."

If you have questions on these comments, please contact David Vos, Director, Office of HIV/AIDS Housing, at (202) 708-1934.

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Appendix XVII: GAO Contact and Staff Acknowledgments

GAO Contact

Marcia Crosse, (202) 512-7119 or crossem@gao.gov

Acknowledgments

In addition to the contact above, James McClyde, Assistant Director; Robert Copeland; Robert Dinkelmeyer; Louise Duhamel; Cathy Hamann; Opal Winebrenner; Craig Winslow; and Suzanne Worth made key contributions to this report.

Related GAO Products

Ryan White CARE Act: Factors that Impact HIV and AIDS Funding and Client Coverage. GAO-05-841T. Washington, D.C.: June 23, 2005.

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

Ryan White CARE Act: Opportunities to Enhance Funding Equity. GAO/T-HEHS-00-150. Washington, D.C.: July 11, 2000.

HIV/AIDS: Use of Ryan White CARE Act and Other Assistance Grant Funds. GAO/HEHS-00-54.Washington, D.C.: March 1, 2000.

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

Revising Ryan White Funding Formulas. GAO/HEHS-96-116R. Washington, D.C.: March 26, 1996.

Ryan White CARE Act of 1990: Opportunities to Enhance Funding Equity. GAO/HEHS-96-26. Washington, D.C.: November 13, 1995.

Ryan White CARE Act: Access to Services by Minorities, Women, and Substance Abusers. GAO/T-HEHS-95-212. Washington, D.C.: July 17, 1995.

Ryan White CARE Act of 1990: Opportunities Are Available to Improve Funding Equity. GAO/T-HEHS-95-126. Washington, D.C.: April 5, 1995.

Follow-up on Ryan White Testimony. GAO/HEHS-95-119R. Washington, D.C.: March 31, 1995.

Ryan White CARE Act of 1990: Opportunities Are Available to Improve Funding Equity. GAO/T-HEHS-95-91. Washington, D.C.: February 22, 1995.

Ryan White Funding Formulas. GAO/HEHS-95-79R. Washington, D.C.: February 14, 1995.

Ryan White CARE Act: Access to Services by Minorities, Women, and Substance Abusers. GAO/HEHS-95-49. Washington, D.C.: January 13, 1995.

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