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Report to Congressional Committees

March 2009

# RYAN WHITE CARE ACT

# Implementation of the New Minority AIDS Initiative Provisions


GAO-09-315

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Highlights

Highlights of GAO-09-315, a report to congressional committees

### Why GAO Did This Study

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) makes federal funds available to assist individuals affected by HIV/AIDS. The Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) awards CARE Act funding to grantees that include states, territories, and metropolitan areas. Because minorities have been disproportionately affected by HIV/AIDS, the CARE Act's Minority AIDS Initiative (MAI) provides funding through five parts (A, B, C, D, and F) of the act with the goal of reducing HIV-related health care disparities among minorities.

The reauthorization of CARE Act programs changed the process by which HRSA awards MAI grants under Part A (funding for metropolitan areas) and Part B (for states and territories) from a formula based solely on demographics of the metropolitan area, state, or territory to a competitive process. The CARE Act requires GAO to report on MAI and related issues. This report provides information on (1) the effect on grantees and service providers of the new competitive process for awarding Part A and B MAI funds, (2) the types of services grantees funded under MAI, and (3) barriers to minorities obtaining services from HIV/AIDS programs that were identified by grantees. GAO surveyed CARE Act grantees and interviewed selected grantee and HRSA officials. GAO also reviewed Part A and B MAI applications.

View GAO-09-315 or key components.
For more information, contact Marcia Crosse at (202) 512-7114 or crossem@gao.gov.

### What GAO Found

The new competitive process for Parts A and B altered MAI funding amounts from what they would have been under the old formula-based process, increased administrative requirements for grantees, and resulted in continued funding for existing initiatives to reduce health disparities for minorities. In determining the award amounts under the new process, HRSA considered the number of minorities with HIV/AIDS living in the grantee metropolitan area, state, or territory, along with the MAI applications grantees were required to file. The quality of the grant applications sometimes resulted in considerable differences in grantees' share of MAI funds from what they would have received under the old process. Part A and B grantees that received MAI funding told us that the administrative requirements increased significantly because of the new process. All Part A and B grantees that applied for MAI funding received it, but some Part B grantees decided that the administrative requirements, including a separate application for MAI funds, were not worth the amount of funds that they expected to receive and therefore chose not to apply. Grantees generally funded the same service providers and initiatives to reduce minority health disparities as they had in prior years.

After the reauthorization of CARE Act programs, MAI grantees continued to fund a range of core medical services, which include essential medical care services, and support services, which are services needed for individuals with HIV/AIDS to achieve their medical outcomes. Consistent with HRSA guidance, the types of services funded under MAI generally did not differ from services provided with other CARE Act funds. The five services Part A grantees funded most frequently were medical case management, outpatient and ambulatory health services, outreach services, substance abuse outpatient care, and mental health services—outreach services being the only support service among these. Part B grantees used MAI funds for efforts associated with the CARE Act-funded HIV/AIDS drug program, Part C and D grantees funded a range of core medical and support services with MAI funds, and Part F grantees used MAI funds for education efforts targeting health care professionals who are from, or primarily serve, minority communities.

Grantees identified many barriers that make it more difficult for minorities to obtain services from HIV/AIDS programs, including those funded by the CARE Act. Barriers to HIV/AIDS care can delay or prevent individuals' timely entrance into, or continuation of, core medical or support services, thus reducing the likely success of care. The barriers grantees identified included the presence of other diseases that impact immune systems, housing issues, and poverty.

In commenting on this report, HHS suggested that we identify the law authorizing Ryan White programs as either Title XXVI of the Public Health Service Act (PHSA) or the Ryan White HIV/AIDS program. We continue to refer to the law authorizing Ryan White programs as the CARE Act, but have clarified that it refers to Title XXVI of PHSA.

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**Abbreviations**

| | |
|---|---|
| ADAP | AIDS Drug Assistance Program |
| AETC | AIDS education and training center |
| AIDS | acquired immunodeficiency syndrome |
| CARE Act | Ryan White Comprehensive AIDS Resources Emergency Act of 1990 |
| CBO | community-based organizations |
| CDC | Centers for Disease Control and Prevention |
| EMA | eligible metropolitan area |
| HHS | Department of Health and Human Services |
| HIV | human immunodeficiency virus |
| HRSA | Health Resources and Services Administration |
| MAI | Minority AIDS Initiative |
| PHSA | Public Health Service Act |
| RFP | request for proposal |
| RWTMA | Ryan White HIV/AIDS Treatment Modernization Act of 2006 |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| TGA | transitional grant area |

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**United States Government Accountability Office**
**Washington, DC 20548**

March 27, 2009

The Honorable Edward M. Kennedy
Chairman
The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Henry A. Waxman
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

Racial and ethnic minorities in the United States have been disproportionately affected by acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) since the beginning of the HIV/AIDS epidemic.[1] According to the most recent Centers for Disease Control and Prevention (CDC) data, 60 percent of all estimated AIDS cases since the beginning of the HIV/AIDS epidemic have been among racial and ethnic minorities and in 2006 racial and ethnic minorities represented 69 percent of AIDS cases and 67 percent of estimated new HIV infections. Since the first U.S. cases of what would become known as AIDS were reported in June 1981, over 1 million people in the United States have been infected with HIV, including almost 550,000 who have already died and over 1 million living with HIV/AIDS today. The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act), administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), was enacted to address the needs of jurisdictions, health care providers, and people with HIV/AIDS and their family members.[2] Total CARE Act grant funding was approximately

[1]HIV is the virus that causes AIDS. In 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.

[2]Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff through 300ff-121).

$2.1 billion in fiscal year 2007.[3] The Minority AIDS Initiative (MAI), first known as the Congressional Black Caucus Initiative, originated in fiscal year 1999 and it included the provision of funds to CARE Act grantees to reduce HIV-related disparities in access to health care and to improve health-related outcomes among racial and ethnic minority populations. Total MAI grant funding in fiscal year 2007 was approximately $131.2 million, representing 6 percent of overall CARE Act grant funding. Organizations that provide care to minorities living with HIV/AIDS have suggested that barriers exist for minorities in accessing HIV/AIDS services, which often make it more difficult for minorities living with HIV/AIDS to receive treatment and other HIV/AIDS services. Barriers to HIV/AIDS care can delay or prevent minorities' timely entrance into, or continuation of, HIV/AIDS services, thus reducing the likely success of those services.[4]

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA) reauthorized CARE Act programs for fiscal year 2007 through fiscal year 2009 and included new provisions on MAI.[5] There are five primary sections of the CARE Act under which HRSA awards grants—Parts A, B, C, D, and F.[6] Together, grants made under these provisions annually fund services for approximately 500,000 people living with or affected by HIV/AIDS. CARE Act Part A provides for grants to selected metropolitan areas—known as eligible metropolitan areas (EMA) and transitional grant areas (TGA)—that have been disproportionately affected by the HIV/AIDS

[3]Unless otherwise indicated, references to the CARE Act are to Public Health Service Act Title XXVI.

[4]We focus our discussion on how barriers to access to HIV/AIDS services affect minorities. However, research shows that many of the same barriers apply more generally to all individuals with HIV/AIDS. See, for example, Institute of Medicine, *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White* (Washington, D.C., 2005). Under the CARE Act, as amended, racial and ethnic minority populations include African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.

[5]Pub. L. No. 109-415, § 603, 120 Stat. 2767, 2818. There was no specific statutory provision regarding the distribution of MAI funds prior to RWTMA. CARE Act programs were previously reauthorized by the Ryan White CARE Act Amendments of 1996 (Pub. L. No. 104-146, 110 Stat. 1346) and the Ryan White CARE Act Amendments of 2000 (Pub. L. No. 106-345, 114 Stat. 1319).

[6]The 1990 CARE Act added Title XXVI to the Public Health Service Act. Title XXVI, as enacted, contained several parts, which authorized various HIV/AIDS-related grants. Prior to the enactment of RWTMA, Parts A, B, C, D, and F of the CARE Act were referred to as Titles I, II, III, IV, and the AIDS Education and Training Centers, respectively.

epidemic.[7] Part B provides for grants to states and territories to improve quality, availability, and organization of HIV/AIDS services. Part C provides for grants to public and private nonprofit entities to provide early intervention services, such as HIV testing and ambulatory care. Part D provides for grants to programs for family-centered comprehensive care to children, youth, and women and their families. Part F provides for grants for demonstration and evaluation of innovative models of HIV/AIDS care delivery for hard-to-reach populations and training of health care providers. Part E does not provide for funding for HIV/AIDS services but rather includes provisions to address various administrative functions. To be eligible for MAI funds, grantees must also have received CARE Act Part A, B, C, D, or F funds.

Grantees can arrange with service providers to offer essential medical care, referred to as core medical services, as well as support services needed to achieve positive medical outcomes. Grantees may also provide these services themselves. Grantees and service providers can include states, territories and associated jurisdictions, metropolitan areas, community-based organizations, and academic medical centers.[8]

Prior to the enactment of RWTMA, HRSA awarded Part A and B MAI funds to Part A and B grantees according to a formula that was solely based on the demographic characteristics of the grantees' jurisdictions out of funds otherwise available for Parts A and B;[9] those that received other Part A and Part B funds received MAI funds without having to file separate applications.[10] The CARE Act now requires HRSA to award MAI funds under Parts A and B according to a competitive process. Under this new

[7]EMAs are areas that have a population of 50,000 persons or more and had a cumulative total of more than 2,000 new AIDS cases during the most recent 5-year period. TGAs are areas that have a population of 50,000 persons or more and had a cumulative total of 1,000 to 1,999 new AIDS cases during the most recent 5-year period.

[8]In this report, "grantees" refers to organizations or entities that receive funding directly from HRSA for CARE Act services, and "service providers" refers to organizations awarded contracts or subgrants from grantees to provide services or arrange for another organization to provide services. Grantees may also provide services to minorities living with HIV/AIDS themselves. Therefore, when we use "services," we are referring to services provided by both grantees and their service providers.

[9]In this report, "formula-based process" refers to the process prior to the enactment of RWTMA when the distribution of MAI funds was based solely on the number of minority individuals with AIDS within the jurisdiction.

[10]Prior to RWTMA, U.S. territories and associated jurisdictions did not receive MAI funding.

process, HRSA evaluates grantee applications for MAI funds in addition to the demographic characteristics of the jurisdictions.[11]

The CARE Act requires us to report on MAI and related issues. In this report, we provide information on (1) the effect on grantees and service providers of the new competitive process for awarding Part A and B MAI funds, (2) the types of services grantees funded under MAI, and (3) barriers to minorities obtaining services from HIV/AIDS programs that were identified by grantees. The CARE Act also requires us to report on the challenges of integrating CARE Act–funded programs with HIV/AIDS programs funded from other sources, such as Medicaid, Medicare, CDC, and the Substance Abuse and Mental Health Services Administration. (See app. I for information on the challenges of HIV/AIDS program integration experienced by CARE Act grantees.)

To determine the effect on grantees and service providers of the new competitive process for awarding Part A and B MAI funds, we conducted a Web-based survey of CARE Act fiscal year 2007 Part A and B grantees to learn how the grantees applied for funds, distributed funds to service providers, and provided oversight, and what services they provided prior to and after the enactment of RWTMA.[12] The survey response rates were about 77 percent (43 of 56) for Part A and about 81 percent (48 of 59) for Part B. Also, we created estimated funding amounts for Part A and B grantees based on the old formula-based process and analyzed the difference between these amounts and the actual funding for fiscal year 2007. To create these estimated funding amounts, we reviewed CARE Act MAI funding data for fiscal years 2006 and 2007, case counts of minorities living with AIDS for fiscal year 2006, and case counts of minorities living with HIV/AIDS for fiscal year 2007, all of which were provided by HRSA. We used this information to assess the effect of the new competitive process on MAI funding. (See app. II for more information on the survey and how estimated funding amounts were determined.) To assess the validity of the funding amounts, we compared data we received from

[11]The way HRSA awards MAI funds under Parts C, D, and F remains unchanged. The Part C, D, and F MAI funds are awarded through a competitive process as a component of the competitive grant award for the base parts C, D, and F.

[12]Fiscal year 2007 funds were the only fiscal year funds awarded under the new competitive application process when we began our work in January 2008. Each part of the Care Act has its own defined fiscal year; for example, the fiscal year for Part A funding is March 1 to February 28, and the fiscal year for Part B funding is April 1 to March 31, but the Part A and Part B MAI fiscal year is August 1 to July 31.

HRSA to previously published funding amounts. We provided HRSA officials with a copy of our tables, and they agreed with our methodology. We determined that the funding data and case count data were sufficiently reliable for the purposes of this report.

Additionally, we reviewed HRSA's policies and reporting requirements under MAI for Part A and B grantees. We interviewed HRSA officials and staff from selected grantees for Parts A and B to determine how funds were distributed and how grantees provided oversight. We selected grantees to interview based on the amount of MAI funding they received and their location to ensure geographic diversity. We also interviewed staff from national organizations with HIV/AIDS expertise, including the National Minority AIDS Council, Kaiser Family Foundation, the National Alliance of State and Territorial AIDS Directors, and the Communities Advocating Emergency AIDS Relief Coalition.

To identify the types of services funded under MAI, we conducted a Web-based survey of Part A grantees, as described above, and interviewed selected Part A, B, C, D, and F grantees about services they provided under MAI prior to and after the enactment of RWTMA. There was no change in the process for awarding MAI funds under Parts C, D, and F, but we interviewed these grantees to learn about the services they funded. We reviewed HRSA's policies, reporting requirements, and guidance for Parts A, B, C, D, and F, and we interviewed HRSA officials about implementation of MAI. Additionally, we reviewed Part A and B MAI competitive grant applications for fiscal year 2007.

To identify the barriers to minorities obtaining services from HIV/AIDS programs that were identified by grantees, we reviewed Part A MAI and Part B MAI competitive grant applications for fiscal year 2007, which included grantees' responses regarding barriers minorities face in accessing HIV/AIDS services. We interviewed staff from selected Part A, B, C, D, and F grantees to better understand the barriers. We also interviewed staff from the organizations listed above.

We conducted our work from January 2008 to February 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

## Background

MAI, a component of the CARE Act, provides for funds to eligible grantees with the goal of reducing HIV-related health disparities among minority populations. HRSA awards MAI grants to Part A, B, C, D, and F grantees through a competitive process. HRSA provides oversight of these grantees, while the grantees provide oversight of their service providers.

## HRSA Administration of CARE Act Funding

HRSA primarily awards CARE Act funds to grantees for core medical services, support services, and education through five primary sections of the legislation—Parts A, B, C, D, and F. In fiscal year 2007, 22 EMAs and 34 TGAs received grants under Part A; all 50 states, the District of Columbia, Puerto Rico, and 7 U.S. territories received grants under Part B;[13] 354 public and private organizations that provide services directly to individuals with HIV received grants under Part C; and 90 public and private organizations that provide services to families in which at least one member is HIV positive received grants under Part D. For Parts A, B, C, and D, programs funded by the CARE Act are the payers of last resort for care.[14] In addition, some Part B funds are used to provide medication for HIV/AIDS treatment through the AIDS Drug Assistance Program (ADAP) when annual appropriation laws provide funds exclusively for this purpose.[15] Fifteen AIDS education and training centers (AETC), which provide HIV/AIDS education to health professionals such as nurses and physicians, received funding under Part F.[16] For all parts of the CARE Act, grantees may use CARE Act funds to engage service providers that provide HIV/AIDS services to individuals.

[13]The seven U.S. territories and associated jurisdictions that received Part B funding in fiscal year 2007 were 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.

[14]As the "payer of last resort," the CARE Act pays for HIV/AIDS services that are not covered by other resources, such as Medicaid, Medicare, or private insurance. U.S.C. §§ 300ff-15(a)(6), 300ff-27(b)(7)(F), 300ff-64(f)(1). According to HRSA officials, Part D is a payer of last resort by operation of HRSA policy.

[15]42 U.S.C. § 300ff-28(a)(2)(F).

[16]There are 11 regional AETCs and 4 national AETCs, which are funded under Part F. One of the national centers is the National Minority AETC, which receives 100 percent of its funding from MAI.

CARE Act funding for metropolitan areas, states, and territories is distributed in the form of base, supplemental, and MAI grants.[17] CARE Act grant funding totaled approximately $2.1 billion in fiscal year 2007; $131.2 million of that amount was MAI grants, representing 6 percent of overall CARE Act grants. Grantees under Parts A, B, and C must spend at least 75 percent of their grants for core medical services, while no more than 25 percent of these funds can be spent for support services.[18] Table 1 lists core medical service and support service categories.

**Table 1: Core Medical and Support Services Categories**

| Core medical service categories | Support service categories |
|---|---|
| Outpatient and ambulatory health services | Respite care for persons caring for persons living with HIV/AIDS |
| ADAP treatments | Outreach services |
| AIDS pharmaceutical assistance | Medical transportation |
| Oral health care | Linguistics services |
| Early intervention services | Referrals for health care and supportive services |
| Health insurance premium and cost-sharing assistance | |
| Home health care | |
| Medical nutrition therapy | |
| Hospice services | |
| Home and community-based health services | |
| Mental health services | |
| Substance abuse outpatient care | |
| Medical case management | |

Source: HRSA guidance.

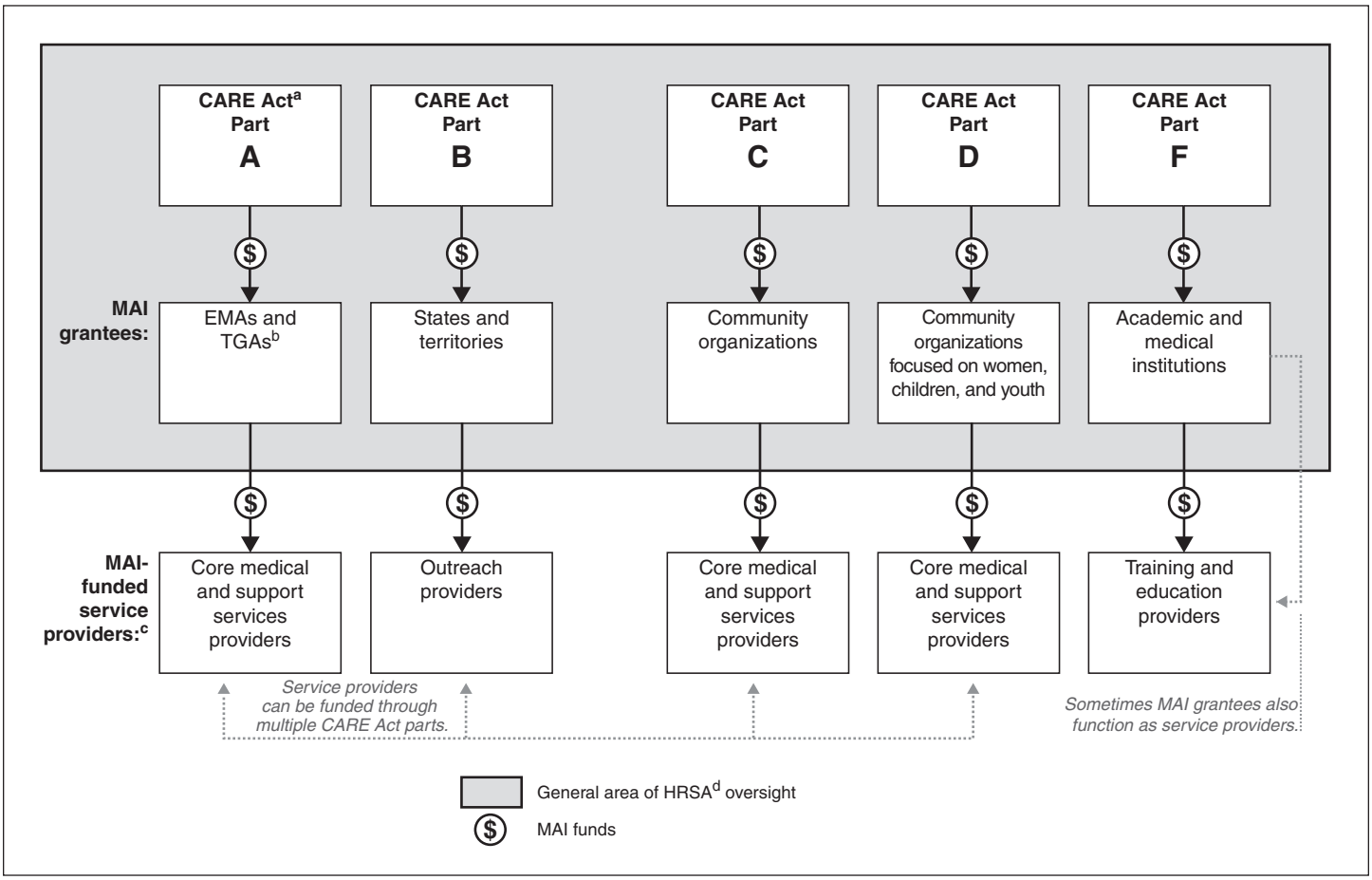
Note: According to HRSA officials, HRSA guidance does not provide an exhaustive list of the core medical and support services that can be provided using CARE Act funds.

[17]Base funding, also known as formula funding, is awarded based on the number of people with HIV/AIDS living in the grantee's jurisdiction, and supplemental funding is awarded on a competitive basis based on demonstrated need, including criteria such as HIV/AIDS prevalence. Base and supplemental funds are awarded separately from MAI funds.

[18]According to HRSA application guidance for the Part A Minority AIDS Initiative Grant Program (issued April 27, 2007), the 75 percent "core medical services" requirement applies to MAI funds. However, an EMA/TGA could allocate and spend up to 100 percent of its MAI funds on support services so long as 75 percent of total Part A funding (base, supplemental, and MAI funding) is allocated and spent on core medical services.

In administering the CARE Act, HRSA issues guidance for applying for and spending MAI grants. HRSA requires MAI grantees to submit reports as a condition of their grant awards. The reports MAI grantees submit to HRSA summarize grantees' MAI activities and include data on individuals served, services offered, budget allocations, and expenditures. For all parts of the CARE Act, HRSA provides oversight of grantees but expects grantees to provide oversight of service providers. (See fig. 1 for HRSA's role in the administration and oversight of MAI funds.)

**Figure 1: Administration and Oversight of Ryan White CARE Act Minority AIDS Initiative (MAI) Funds**




Source: GAO analysis of HRSA guidance.

[a]Ryan White Comprehensive AIDS Resources Emergency Act of 1990, as amended.

[b]EMAs are eligible metropolitan areas, TGAs are transitional grant areas.

[c]Service providers are organizations with which grantees contract or award subgrants to provide services or arrange to have another organization to provide services.

[d]Health Resources and Services Administration.

## Reporting Requirements for CARE Act Grantees

Federal grantees are required to comply with certain audit requirements based upon their total expenditures of federal funding and to submit certain reports at a frequency determined by the agency awarding the grant. HRSA requires CARE Act grantees to submit the following reports:

- quarterly payment management reports, which include grantee spending for the previous 3-month period, and
- a financial status report, which is required within 90 days of the end of each grant year and accounts for expenditures under the project that year.

Additionally, HRSA has grant-specific reporting requirements. For example, Part A and B grantees are required to submit the annual *Ryan White HIV/AIDS Program Data Report*, which requires grantees and their service providers to provide information on

- the number of clients who have received services and demographic information about these clients,
- the services provided by the grantees' service providers,
- the number of clients who received HIV counseling and testing, and
- medical information about the clients who received services.

There are also MAI-specific reporting requirements. Each MAI grantee is required to submit the *Minority AIDS Initiative Report*, which includes

- the final annual MAI plan due within 90 days of the budget start date each year and
- the annual progress report.

Grantees that receive Part A and B MAI grants have some additional reporting requirements since the enactment of RWTMA. Since the enactment of RWTMA, Part A and B MAI grantees have been required to submit separate sets of the payment management reports and financial status reports for their base and supplemental funding.

## MAI Changes Resulting from RWTMA

MAI grants were first distributed in conjunction with CARE Act funding in fiscal year 1999. RWTMA added provisions on MAI funding to the CARE Act, authorizing specific amounts for the purpose of carrying out activities to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The amount of CARE Act funds used for MAI grants has increased from $24 million in fiscal year 1999 to $131 million in fiscal year 2007.

According to HRSA officials, Part A and B MAI funds are to be used to expand the core medical and support services to minorities that might not otherwise be provided through the base funding. Part C, D, and F MAI funds are to be used to expand the number of individuals receiving services as these individuals may not otherwise be served by non-MAI funding.

Prior to the enactment of RWTMA, the MAI funds for Part A and B grantees were awarded according to a formula that solely reflected the number of living minority AIDS cases in the metropolitan area, state, or territory receiving funds. These data are referred to as case counts. RWTMA changed how case counts are defined for other CARE Act programs to include living HIV cases. For Part A and B MAI grants, HRSA changed the case counts from the number of living minority AIDS cases to the number of living minorities with HIV/AIDS for the most recent year available as reported to CDC.

The CARE Act requires HRSA to award Part A and B MAI grants using a competitive process. The Part A and B MAI applications, which are separate from Part A and B base and supplemental applications, require grantees to describe their local needs and the services they would provide using MAI funds. HRSA continues to use minority case counts in determining MAI grant awards, but now does so in combination with application scores. HRSA officials reported that the agency calculates Part A and B MAI grant awards based on both the grantee's application scores and the minority case count in the metropolitan area, state, or territory. HRSA application guidance outlines the points awarded for each

section of the application,[19] and the impact of a grantee's performance in its completion of the application is demonstrated in the MAI funding the grantee receives. The CARE Act does not specifically require Part C, D, and F MAI grants to be awarded on a competitive basis or to be awarded separately from base funds under those parts. HRSA awarded MAI grants under these parts competitively, as a component of the competitive grant award for the base Parts C, D, and F. HRSA did this prior to the enactment of RWTMA and continues to do so.

## Barriers to Care

Barriers to HIV/AIDS care can delay or prevent individuals' timely entrance into, or continuation of, core medical or support services, thus reducing the likely success of care. Research shows that minorities, in general, often receive a lower quality of health care and face barriers to obtaining health care, including services related to cancer screening, cardiovascular disease, diabetes, and HIV/AIDS.[20] Barriers to HIV/AIDS care can include issues such as histories of substance abuse disorders or domestic violence. For example, research studies show that individuals living with HIV/AIDS who also have substance abuse disorders and are actively using substances are less likely to adhere to medical care.[21] Barriers to care, such as lack of transportation to medical care or social stigma associated with HIV/AIDS, can also affect minority communities. For example, we have found in previous work that lack of transportation was found to delay, prevent, or interrupt HIV/AIDS treatment for American Indian and Alaska Native communities.[22] HRSA required MAI applicants to

[19]Application sections include demonstrated need (grantee description of the severity of the HIV/AIDS epidemic), impact (description of the use and success of previously funded MAI programs), evaluation (of progress toward program goals and client-level outcomes), resources, and administration (description of grantee administration and accountability) and the budget.

[20]See Brian Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academies Press, 2003), and GAO, *Health Care: Approaches to Address Racial and Ethnic Disparities*, GAO-03-862R (Washington, D.C.: July 8, 2003).

[21]Gregory Lucas et al., "Detrimental Effects of Continued Drug Use on the Treatment of HIV-1 Infection." *Journal of Acquired Immune Deficiency Syndromes*, vol. 27, no. 3 (2001); Nancy Sohler et al., "Type and Pattern of Illicit Drug Use and Access to Health Care Services for HIV-Infected People," *AIDS Patient Care and STDs*, vol. 21, supplement 1 (2007) and Chinazo O. Cunningham et al., "Type of Substance Use and Access to HIV-Related Health Care," *AIDS Patient Care and STDs*, vol. 20, no. 6 (2006).

[22]See GAO, *Indian Health Service: HIV/AIDS Prevention and Treatment Services for American Indians and Alaska Natives*, GAO-08-90 (Washington, D.C.: Dec. 14, 2007).

describe barriers to care for minorities in their jurisdictions as part of their MAI applications. Eliminating or decreasing barriers is important to the delivery of comprehensive, integrated, quality HIV/AIDS services.

## The New Competitive Process for Parts A and B Altered MAI Funding Amounts, Increased Administrative Requirements for Grantees, and Generally Funded the Same Initiatives

The new competitive process for Parts A and B resulted in changes in the amount of funding from what grantees would have received under the old formula-based process. Grantees that received MAI funding stated that the administrative requirements of the grant increased significantly in fiscal year 2007, and some grantees chose not to apply for MAI funds. Grantees continued funding existing initiatives to reduce health disparities for minorities rather than funding new initiatives, and grantees generally provided funding to the same service providers as they had in prior years.

### The New Competitive Process Resulted in Changes in the Amount of Funding from What Grantees Would Have Received under the Old Formula-Based Process

The new MAI competitive process resulted in funding amounts that differed from what grantees would have received under the old formula-based process that based funding solely on minority case counts. All Part A and B grantees that applied for MAI funds in fiscal year 2007 received MAI funding.[23] However, since RWTMA changed the process by which MAI funds were awarded, some grantees' MAI grant amounts differed from what they would have been awarded under the previous formula-based process.

Prior to RWTMA, a Part A or B grantee's MAI funding was based on its share of minority AIDS cases relative to the total number of minority AIDS cases in all metropolitan areas or states and territories eligible for funds, and a competitive application was not required. For example, if a Part A grantee's minority case count accounted for 4 percent of the total number of minority AIDS cases in all eligible metropolitan areas, that grantee would receive 4 percent of the total available Part A MAI funds. The new competitive MAI process, as implemented by HRSA, considers the

[23]HRSA officials informed us that one state applied for and was allocated Part B MAI funding in fiscal year 2007 but returned the funding.

minority case count in determining a grantee's MAI award, but does so in conjunction with the grantee's MAI application score. Because a grantee's MAI application score is considered along with the number of HIV/AIDS cases in the metropolitan area, state, or territory, there is no longer a one-to-one relationship between an applicant's proportion of cases and its proportion of MAI grant funding. As a result, we found differences between the amounts many grantees would have received under the old formula-based process and the amounts they received under the new competitive process. For example, in fiscal year 2007, Phoenix received $127,578 (39.8 percent) less than it would have received under the old formula, while Houston received $154,018 (10.9 percent) more. In addition, in some cases we found that grantees with a lower number of HIV/AIDS cases received more funding under MAI than grantees with a higher number of HIV/AIDS cases because of their competitive scores. Table 2 shows Part A MAI grantees' fiscal year 2007 funding levels under the competitive process, and an estimate of what each grantee's funding level would have been under the old formula-based process. For Part A MAI, 30 of the 56 grantees received lower funding amounts under the new competitive process than they would have under the old formula-based process. The median difference for all Part A grantees between the actual fiscal year 2007 funding and the estimated funding based on the old formula-based process was a loss of $3,053. Because of their competitive scores, 20 Part A grantees experienced changes of greater than 10 percent of what they would have received under the old formula-based process.

**Table 2: Ryan White CARE Act Part A MAI Grant Awards for Fiscal Year 2007: Award Amounts Received under the New Competitive Process Compared to Estimates of What Award Amounts Would Have Been under the Old Formula-Based Process**

| EMA/TGA | Actual FY 2007 MAI funding | Estimated FY 2007 MAI under the formula-based process | Difference between actual and estimated | Percentage difference between actual and estimated |
|---|---|---|---|---|
| Atlanta, Ga. | $1,050,229 | $1,176,644 | **$-126,415** | -10.7 |
| Austin, Tex. | 229,065 | 208,591 | **20,474** | 9.8 |
| Baltimore, Md. | 2,100,038 | 1,925,202 | **174,836** | 9.1 |
| Baton Rouge, La. | 249,059 | 327,938 | **-78,879** | -24.1 |
| Bergen-Passaic, N.J. | 287,493 | 310,872 | **-23,379** | -7.5 |
| Boston, Mass. | 814,862 | 802,602 | **12,260** | 1.5 |
| Caguas, P.R. | 121,984 | 125,629 | **3,645** | -2.9 |
| Charlotte-Gastonia-Concord, N.C.-S.C. | 371,535 | 391,582 | **-20,047** | -5.1 |
| Chicago, Ill. | 1,787,310 | 1,983,038 | **-195,728** | -9.9 |
| Cleveland, Ohio | 316,520 | 298,191 | **18,329** | 6.1 |
| Dallas, Tex. | 772,577 | 833,772 | **-61,195** | -7.3 |
| Denver, Colo. | 275,492 | 282,665 | **-7,173** | -2.5 |
| Detroit, Mich. | 644,567 | 662,988 | **-18,421** | -2.8 |
| Dutchess County, N.Y. | 103,571 | 96,710 | **6,861** | 7.1 |
| Fort Lauderdale, Fla. | 1,113,452 | 1,055,045 | **58,407** | 5.5 |
| Fort Worth, Tex. | 204,310 | 217,243 | **-12,933** | -6.0 |
| Hartford, Conn. | 252,944 | 255,406 | **-2,462** | -1.0 |
| Houston, Tex. | 1,571,727 | 1,417,709 | **154,018** | 10.9 |
| Indianapolis, Ind. | 189,079 | 180,858 | **8,221** | 4.5 |
| Jacksonville, Fla. | 393,745 | 387,434 | **6,311** | 1.6 |
| Jersey City, N.J. | 417,858 | 394,308 | **23,550** | 6.0 |
| Kansas City, Mo. | 187,284 | 194,251 | **-6,967** | -3.6 |
| Las Vegas, Nev. | 225,918 | 266,546 | **-40,628** | -15.2 |
| Los Angeles, Calif. | 2,528,561 | 2,441,109 | **87,452** | 3.6 |
| Memphis, Tenn. | 556,225 | 533,330 | **22,895** | 4.3 |
| Miami, Fla. | 2,565,107 | 2,374,858 | **190,249** | 8.0 |
| Middlesex-Somerset-Hunterdon, N.J. | 165,169 | 189,154 | **-23,985** | -12.7 |
| Minneapolis-St. Paul, Minn. | 264,702 | 237,865 | **26,837** | 11.3 |
| Nashville, Tenn. | 207,441 | 234,902 | **-27,461** | -11.7 |
| Nassau-Suffolk, N.Y. | 325,286 | 341,568 | **-16,282** | -4.8 |
| New Haven, Conn. | 321,657 | 385,657 | **-64,000** | -16.6 |
| New Orleans, La. | 541,807 | 559,522 | **-17,715** | -3.2 |

| EMA/TGA | Actual FY 2007 MAI funding | Estimated FY 2007 MAI under the formula-based process | Difference between actual and estimated | Percentage difference between actual and estimated |
|---|---|---|---|---|
| New York, N.Y. | 9,347,777 | 8,494,045 | **853,732** | 10.1 |
| Newark, N.J. | 1,284,886 | 1,267,191 | **-17,695** | -1.4 |
| Norfolk, Va. | 379,699 | 459,967 | **-80,268** | -17.5 |
| Oakland, Calif. | 392,080 | 421,923 | **-29,843** | -7.1 |
| Orange County, Calif. | 292,945 | 282,902 | **10,043** | 3.6 |
| Orlando, Fla. | 578,713 | 551,937 | **26,776** | 4.9 |
| Philadelphia, Pa. | 1,682,127 | 1,627,841 | **54,286** | 3.3 |
| Phoenix, Ariz. | 193,368 | 320,946 | **-127,578** | -39.8 |
| Ponce, P.R. | 153,098 | 200,176 | **-47,078** | -23.5 |
| Portland, Oreg. | 78,536 | 77,155 | **1,381** | 1.8 |
| Riverside-San Bernadino, Calif. | 255,733 | 326,398 | **-70,665** | -21.6 |
| Sacramento, Calif. | 97,469 | 98,488 | **-1,019** | -1.0 |
| San Antonio, Tex. | 264,661 | 303,050 | **-38,389** | -12.7 |
| San Diego, Calif. | 543,389 | 514,248 | **29,141** | 5.7 |
| San Francisco, Calif. | 652,491 | 608,114 | **44,377** | 7.3 |
| San Jose, Calif. | 137,156 | 147,436 | **-10,280** | -7.0 |
| San Juan, P.R. | 741,100 | 1,086,333 | **-345,233** | -31.8 |
| Santa Rosa, Calif. | 50,000[a] | 25,244 | **24,756** | 98.1 |
| Seattle, Wash. | 234,009 | 212,384 | **21,625** | 10.2 |
| St. Louis., Mo. | 378,174 | 352,353 | **25,821** | 7.3 |
| Tampa-St. Petersburg, Fla. | 525,592 | 498,367 | **27,225** | 5.5 |
| Vineland-Millville-Bridgeton, N.J. | 68,510 | 79,762 | **-11,252** | -14.1 |
| Washington, D.C. | 1,976,712 | 2,345,939 | **-369,227** | -15.7 |
| West Palm Beach, Fla. | 576,631 | 646,040 | **-69,409** | -10.7 |
| **Total** | **$42,041,430** | | | |

Sources: HRSA and GAO analysis of HRSA data.

Note: In calculating the estimated funding amounts, we held the total funding allocated for fiscal year 2007, $42,041,430, constant. We did not adjust funding amounts to reflect the minimum grant awards set in fiscal year 2007 because these were not in place when the formula grants were awarded.

[a]Santa Rosa, California, received the minimum grant award of $50,000. The maximum grant award was set at $10,750,000; however, no grantee qualified for the maximum.

Table 3 shows Part B MAI grantees' fiscal year 2007 funding levels under the competitive process and an estimate of what each grantee's funding level would have been under the old formula-based process. For Part B MAI, 20 of the 29 grantees that applied for funding received higher funding amounts under the new competitive process than they would have under

the old formula-based process. For these Part B grantees, the median difference between the actual fiscal year 2007 funding and the estimated funding based on the old formula-based process was a gain of $2,779. (See app. III for a comparison of the fiscal year 2006 and fiscal year 2007 Part A and B MAI funding amounts and MAI as a proportion of total funding.) Because of their competitive scores, 20 Part B grantees experienced changes of greater than 10 percent of what they would have received under the old formula-based process.

**Table 3: Ryan White CARE Act Part B MAI Grant Awards for Fiscal Year 2007: Award Amounts Received under the New Competitive Process Compared to Estimates of What Award Amounts Would Have Been under the Old Formula-Based Process**

| State/territory | Actual FY 2007 MAI funding[a] | Estimated FY 2007 MAI under the formula-based process | Difference between actual and estimated | Percentage difference between actual and estimated |
|---|---|---|---|---|
| Alabama | $109,917 | $87,480 | **$22,437** | 25.6 |
| Alaska | 4,412 | 3,390 | **1,022** | 30.1 |
| Arizona | – | 53,634 | **–** | – |
| Arkansas | – | 27,664 | **–** | – |
| California | 856,348 | 658,233 | **198,115** | 30.1 |
| Colorado | 36,113 | 43,562 | **-7,449** | -17.1 |
| Connecticut | 83,285 | 81,697 | **1,588** | 1.9 |
| Delaware | 4,360 | 28,134 | **-23,774** | -84.5 |
| District of Columbia | 204,224 | 157,311 | **46,913** | 29.8 |
| Florida | 1,087,726 | 811,755 | **275,971** | 34.0 |
| Georgia | 267,205 | 225,945 | **41,260** | 18.3 |
| Hawaii | – | 7,465 | **–** | – |
| Idaho | – | 1,610 | **–** | – |
| Illinois | 72,966 | 270,518 | **-197,552** | -73.0 |
| Indiana | – | 44,260 | **–** | – |
| Iowa | 8,377 | 5,598 | **2,779** | 49.6 |
| Kansas | – | 12,564 | **–** | – |
| Kentucky | – | 17,693 | **–** | – |
| Louisiana | 140,731 | 149,946 | **-9,215** | -6.1 |
| Maine | 2,500 | 1,553 | **947** | 61.0 |
| Maryland | 304,838 | 323,141 | **-18,303** | -5.7 |
| Massachusetts | – | 113,893 | **–** | – |
| Michigan | 141,887 | 106,968 | **34,919** | 32.6 |
| Minnesota | 26,875 | 32,679 | **-5,804** | -17.8 |

| State/territory | Actual FY 2007 MAI funding[a] | Estimated FY 2007 MAI under the formula-based process | Difference between actual and estimated | Percentage difference between actual and estimated |
|---|---|---|---|---|
| Mississippi | – | 78,762 | – | – |
| Missouri | 69,743 | 65,899 | **3,844** | 5.8 |
| Montana | – | 399 | – | – |
| Nebraska | – | 7,564 | – | – |
| Nevada | – | 36,283 | – | – |
| New Hampshire | – | 3,390 | – | – |
| New Jersey | 414,015 | 350,235 | **63,780** | 18.2 |
| New Mexico | – | 15,955 | – | – |
| New York | 1,476,866 | 1,216,350 | **260,516** | 21.4 |
| North Carolina | – | 200,047 | – | – |
| North Dakota | – | 556 | – | – |
| Ohio | 62,201 | 99,461 | **-37,260** | -37.5 |
| Oklahoma | 20,313 | 21,610 | **-1,297** | -6.0 |
| Oregon | 14,031 | 10,898 | **3,133** | 28.8 |
| Pennsylvania | – | 152,311 | – | – |
| Puerto Rico | 142,792 | 213,509 | **-70,717** | -33.1 |
| Rhode Island | – | 8,832 | – | – |
| South Carolina | 177,810 | 146,185 | **31,625** | 21.6 |
| South Dakota | – | 1,567 | – | – |
| Tennessee | 130,743 | 106,925 | **23,818** | 22.3 |
| Texas | 597,547 | 480,622 | **116,925** | 24.3 |
| Utah | – | 7,664 | – | – |
| Vermont | – | 527 | – | – |
| Virginia | 203,896 | 164,590 | **39,306** | 23.9 |
| Washington | 34,333 | 36,240 | **-1,907** | -5.3 |
| West Virginia | – | 6,211 | – | – |
| Wisconsin | 41,046 | 31,767 | **9,279** | 29.2 |
| Wyoming | – | 541 | – | – |
| Guam | – | 1,097 | – | – |
| Virgin Islands | – | 6,738 | – | – |
| American Samoa | – | 28 | – | – |
| Marshall Islands | – | 14 | – | – |
| North Marianas | – | 57 | – | – |
| Republic of Palau | – | – | – | – |

| State/territory | Actual FY 2007 MAI funding[a] | Estimated FY 2007 MAI under the formula-based process | Difference between actual and estimated | Percentage difference between actual and estimated |
|---|---|---|---|---|
| Federated States of Micronesia | 2,500[b] | 71 | **2,429** | 3409.9 |
| **Total** | **$6,739,600** | | | |

Sources: HRSA and GAO analysis of HRSA data.

Note: In calculating the estimated funding amounts, we held the total funding allocated for fiscal year 2007, $6,739,600, constant. We did not adjust funding amounts to reflect the minimum grant awards set in fiscal year 2007 because these were not in when the formula grants were awarded.

[a]States that did not apply for funding in fiscal year 2007 have a dash. No difference between actual and estimated or percentage difference between actual and estimated was calculated for these states.

[b]The Federated States of Micronesia received the minimum grant award of $2,500. No maximum grant award was set.

## The New Competitive Process Increased the Administrative Requirements for Grantees, and Some Grantees Chose Not to Apply for MAI Funds

Many MAI grantees said that the new competitive process increased their administrative requirements. Part A and B grantees that applied for MAI grants in fiscal year 2007 reported that the new MAI grant application and reporting requirements are time-consuming and duplicative of the requirements for the Part A and Part B base and supplemental funding. Prior to the implementation of the MAI competitive process, grantees answered a few MAI-related questions on their base and supplemental applications. However, the amount of funding a grantee received was based on the grantee's number of AIDS cases relative to the overall number of AIDS cases among all grantees, not its responses to these questions.

Several grantees we interviewed that did apply and received MAI grants stated that the administrative requirements increased significantly with the new competitive process. Grantees explained that integrating the Part A and Part B base funding program activities with MAI activities has become difficult because under the new process, these activities must be reported separately. Reporting on MAI activities has also been made substantially more difficult because of HRSA's designation of different fiscal years for different CARE Act grant programs. The fiscal year for Part A base and supplemental funding is March 1 to February 28. For Part B base and supplemental funding the fiscal year is April 1 to March 31. The Part A and Part B MAI fiscal year is August 1 to July 31.[24] Some grantees said that the

[24]HRSA officials said that they changed the beginning and ending dates of the MAI fiscal year for 2007 so that HRSA could complete the new guidance necessitated by the changes made by RWTMA.

separate fiscal years increased their administrative requirements. For example, one grantee told us that the separate reporting and different fiscal years act as an "artificial separation" of funding for services to the same client population. While grant guidance states that "HRSA expects grantees to implement and administer MAI-funded services and activities in a manner that is consistent with the Part A and Part B programs,"[25] some grantees stated that the different funding cycles make such integration difficult. Many grantees also explained that the separate applications and different funding cycles complicated the contracting process, thus requiring them to write more contracts, file more reports, and conduct additional monitoring without extra funding for this added administration.

In addition, HRSA officials explained that some states and territories did not apply for MAI funding because in past years they had received relatively small amounts of funding, and would have to undergo increased requirements because of the new competitive application process to receive that funding in fiscal year 2007. In total, 22 states and territories that were Part B grantees in fiscal year 2006 chose not to apply for MAI in fiscal year 2007. Grantees that chose to apply in fiscal year 2007 received MAI funding that amounted to less than 1 percent of their total Part B funding (see app. III for funding tables for total CARE Act awards for Part B grantees). Moreover, some grantees explained that they only had about a month to complete the MAI application after new application guidance was issued, which they did not consider to be enough time to prepare the application. In addition, one grantee we interviewed also explained that the narrow scope of Part B MAI funding, that is, that it could only be used for ADAP-related outreach and education services, also made it less likely to apply. As indicated in table 3, because there was a fixed amount of funding and fewer applications were received, there were more MAI funds available to each grantee that submitted an application.

## The New Competitive Process Generally Resulted in the Funding of the Same Initiatives

Some Part A and B grantees reported that they have continued to fund the same initiatives to reduce minority health disparities that they did prior to the implementation of the new MAI competitive process. Grantees we interviewed whose fiscal year 2007 MAI funding increased from the previous year stated that they funded their service providers to continue

[25]Department of Health and Human Services, Health Resources and Services Administration, *Part A Minority AIDS Initiative Grant Program: Application Guidance for New Competing Discretionary Grants*, HRSA Announcement No. 07-135 (Washington, D.C., 2007).

funding existing initiatives to reduce health disparities for minorities. Some grantees whose fiscal year 2007 MAI funding decreased from the prior year reported to us that they reduced or eliminated the amount of funding they awarded to service providers. One grantee reported that a service provider the grantee had intended to fund declined to provide services because the service provider lacked the resources needed to comply with MAI reporting requirements.

Part A grantees generally used the same request for proposal (RFP) process to select service providers under the new MAI competitive process as they had used before.[26] Of the 43 Part A grantees that responded to our survey, 33 stated that they used an RFP selection process to choose service providers in the first year under the new competitive process, and 35 stated that they used an RFP prior to RWTMA. Of the 8 grantees that did not use an RFP process, 5 generally stated that they did not need RFPs in the first year of the change to the new competitive process because they used an RFP process in an earlier year to select service providers and awarded multiple-year contracts.

Most of the Part B grantees that responded to our survey changed how they selected service providers after the switch to a competitive process. While 20 out of 44 Part B survey respondents that received MAI funding before the change to the new competitive process used an RFP to select service providers, only 7 out of 26 Part B survey respondents that received MAI funding after the change used an RFP process to select service providers. Some grantees stated that they provided funding to one or two organizations with which they were familiar, applied the funds to existing contracts, or used the funds themselves, instead of issuing an RFP.

## Grantees Fund a Range of Core Medical and Support Services under MAI

MAI grantees under all parts of the CARE Act reported funding a range of core medical and support services using MAI funds. These services can be provided either directly by the grantees or through service providers. We found that Part A grantees generally used MAI funds to fund services similar to those funded through base or supplemental grants. This is in accordance with HRSA's guidance, which states that it is appropriate to implement similar types of services using MAI and base and supplemental Part A funds. Only rarely did Part A grantees use MAI funds exclusively to

[26]We use "request for proposal" (RFP) to describe all forms of solicitation whether they are used in conjuction with the award of contracts or subgrants.

fund a specific type of service, such as outreach to minority individuals or nonmedical case management not otherwise supported with CARE Act funds. Some Part A grantees reported that they take a coordinated approach to the prioritization and expenditure of base, supplemental, and MAI funds.

Part A grantees reported funding a range of core medical and support services under MAI. According to our survey, four of the top five services most commonly funded in fiscal year 2007 were categorized as core medical services—medical case management, outpatient and ambulatory health services, substance abuse outpatient care, and mental health services. (See table 4.) Outreach was the only support service among the top five most commonly funded services.[27] In addition, nine Part A grantees responded that they funded a range of services other than those listed in our survey, including early intervention services, residential substance abuse treatment, and psychosocial support.

[27]According to HRSA, CARE Act outreach services help to identify persons at high risk for HIV infection and to bring HIV-infected persons into care. Outreach services include services to both HIV-infected persons who know their status and are not in care and HIV-infected persons who do not know their status and are not in care.

**Table 4: Core Medical and Support Services Funded by Ryan White CARE Act Part A Grantees in Fiscal Year 2007 under the Minority AIDS Initiative**

| Services | Grantees providing services (of 43) |
|---|---|
| **Core medical** | |
| Medical case management | 29 |
| Outpatient and ambulatory health services | 24 |
| Substance abuse outpatient care | 12 |
| Mental health services | 12 |
| AIDS pharmaceutical assistance | 8 |
| HIV counseling and testing | 5 |
| Oral health | 5 |
| Medical nutrition therapy | 4 |
| Home health care | 1 |
| **Support** | |
| Outreach services | 16 |
| Case management (nonmedical) | 10 |
| Medical transportation | 7 |
| Housing services | 6 |
| Referrals to health care/supportive services | 4 |
| Emergency financial assistance | 2 |
| Food bank | 2 |
| Legal services | 2 |
| Child care | 1 |
| Family advocacy | 1 |
| Health insurance premium and cost-sharing assistance | 1 |
| Home and community-based health services | 1 |
| Linguistic services | 1 |

Source: GAO analysis of survey data.

Note: In our survey, the list of services that a grantee could potentially provide was based on information obtained from grantee applications.

Similar to Part A grantees, Part C and D grantees used MAI funding for a range of core medical and support services, while Part B and F grantees used MAI funding for specific services designated by the MAI provisions in the CARE Act. In interviews, Part C and D MAI grantees generally reported funding core medical and support services based on their clients' needs as well as their organizational missions. For example, five Part D MAI grantees reported focusing their services on the needs of women and

youth, including offering child care services and targeted case management. The CARE Act restricts the use of Part B MAI funds to efforts related to increasing the number of minorities in ADAP. Part F MAI grantees told us that they use MAI funds for education efforts targeting health care professionals who are from, or primarily serve, minority communities. These education efforts are similar to services they fund using other CARE Act grants.

Some MAI grantees reported changing the mix of services they funded from fiscal year 2005 through fiscal year 2007. Grantees we interviewed said that they changed the mix of services they funded to comply with the requirement added by RWTMA that at least 75 percent of grant funding be spent for core medical services. Among the 43 respondents to our survey of Part A grantees, the number of MAI grantees funding medical case management more than doubled from fiscal year 2005 through fiscal year 2007, while the number funding nonmedical case management decreased by a third.[28] In addition, Part A grantees indicated changes in the types of support services they funded from fiscal year 2005 through fiscal year 2007. Survey results showed increases in the number of grantees providing referrals to health care services and transportation services and a decrease in the number providing outreach services. Some Part A grantees reported that since the enactment of RWTMA, they have had to curtail support services such as housing, emergency financial assistance, and client advocacy as well as capacity building in historically underrepresented communities. Furthermore, in interviews, some grantees reported changing the types of services they funded as a result of RWTMA's enactment. For example, two grantees, one Part A and one Part B, reported changing existing case management services to fit within the medical case management definition, which includes, for example, the coordination and follow-up of medical treatments.

[28]According to HRSA, nonmedical case management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. It does not involve coordination and follow-up of medical treatments as medical case management does.

## MAI Grantees Identified Multiple Barriers to Minorities' Access to the Services Provided by HIV/AIDS Programs

MAI grantees identified multiple barriers that make it difficult for minorities to obtain services through HIV/AIDS programs.[29] Similar to the barriers minorities face, in general, in obtaining health care, these barriers present challenges for individuals in obtaining HIV/AIDS services that may not only prevent or delay entry into care but could also decrease adherence to treatment.[30] Barriers to minorities' access to HIV/AIDS services are often interconnected and include issues such as a lack of transportation to HIV/AIDS services, mistrust of service providers, lacking or insufficient insurance, homelessness, poverty, and language issues. Language issues, for example, suggest the need for the linguistic services of an interpreter or translated materials to receive HIV/AIDS services. If a minority must overcome language issues in order to receive HIV/AIDS services and cannot do so, then these issues become a barrier to obtaining HIV/AIDS services. Complications for care, such as comorbidities, also were reported as barriers to minorities obtaining HIV/AIDS services.[31]

We found that Part A and B grantees generally identified similar barriers in their MAI applications. Table 5 shows the 10 barriers to minorities obtaining HIV/AIDS services most frequently identified by Part A and B MAI grantees. They identified co-morbidities, housing issues, and poverty as the top three barriers to care, with at least 8 out of 10 grantees identifying each barrier. Co-morbidities can include hypertension, mental illness, sexually transmitted infections/diseases, and tuberculosis. Unstable housing can prevent minorities with HIV/AIDS from accessing health care and adhering to complex HIV/AIDS treatments because they often must attend to more immediate needs, such as obtaining food and shelter. Poverty, defined by the federal government according to income thresholds that vary by family size and composition, can have similar implications. Appendix IV provides descriptions and a more complete list of barriers identified by Part A and B grantees in their fiscal year 2007 MAI competitive grant applications.

[29]We focus our discussion on barriers to minorities in obtaining HIV/AIDS services. However, research shows that many of the same barriers apply more generally to all individuals with HIV/AIDS.

[30]Our recent work found that barriers to access to HIV/AIDS services may exist for American Indians and Alaska Natives. These barriers include issues such as stigma associated with HIV/AIDS, lack of transportation, housing issues, and the prevalence of substance abuse disorders. These barriers and others were found to delay, prevent, or interrupt the continuity of HIV/AIDS treatment for these minorities. GAO-08-90.

[31]Comorbidities are conditions that exist at the same time as a primary condition. Comorbidities for individuals with HIV/AIDS include diabetes and tuberculosis.

**Table 5: Ten Barriers to Minorities in Obtaining HIV/AIDS Services Most Frequently Identified by Ryan White CARE Act Part A and B Minority AIDS Initiative Grantees**

| Barrier | Number of Part A grantees reporting this barrier (of 56) | Number of Part B grantees reporting this barrier (of 30) | Total number of grantees reporting this barrier (of 86) |
|---|---|---|---|
| Co-morbidities | 56 | 23 | **79** |
| Housing issues | 55 | 21 | **76** |
| Poverty | 54 | 19 | **73** |
| Lack of insurance | 56 | 12 | **68** |
| Substance abuse | 47 | 20 | **67** |
| Lack of transportation | 51 | 14 | **65** |
| Language issues | 42 | 18 | **60** |
| Prison population issues | 45 | 15 | **60** |
| Stigma/fear | 45 | 14 | **59** |
| Lack of health information | 41 | 12 | **53** |

Source: GAO analysis of HRSA applications.

In our interviews, grantees under Parts C, D, and F also described many of the issues in table 5 as barriers to minorities obtaining HIV/AIDS services. Grantees explained that HIV/AIDS care may not be the primary issue on an individual's list of needs or concerns. Without overall programs to support these competing needs, minorities will experience barriers to obtaining HIV/AIDS medical services. For example, some grantees discussed barriers related to language issues within some minority communities. A Part C grantee identified the lack of bilingual health care providers as a major barrier to care for minorities served by the grantee. The director of a Part C grantee explained that stigma associated with HIV/AIDS is a barrier for some minorities because they are less likely to seek services within their communities for fear of revealing that they have HIV/AIDS. Part F grantees we interviewed stated that the barriers to care included the lack of specialty care, mistrust of health systems by patients, and the lack of insurance.

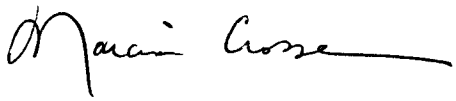
## Agency Comments and Our Evaluation

HHS provided comments on a draft of this report. The comments are reprinted in appendix V. In its comments, HHS suggested that we identify the law authorizing Ryan White programs as either Title XXVI of the Public Health Service Act or the Ryan White HIV/AIDS program. Consistent with our previous work, we continue to refer to the law authorizing Ryan White programs as the CARE Act. As noted in the report, the current program is

authorized under the CARE Act, as amended. We have added the Public Health Service Act title to our footnote providing the legal citation to the statute. In addition, HHS provided technical comments on the report draft, which we have incorporated as appropriate.

We are sending a copy of this report to the Acting Secretary of Health and Human Services. The report is also available at no charge 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) 512-7114 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. Other staff who made major contributions to this report are listed in appendix VI.



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# Appendix I: Grantees Reported Few Challenges to Program Integration

The Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) requires us to report information on the challenges to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) program integration experienced by CARE Act grantees. Challenges to program integration are issues that can prevent grantees and service providers from working together to coordinate HIV/AIDS service provision and can prevent clear communication between these organizations regarding funding and program requirements. To identify the challenges to HIV/AIDS program integration experienced by CARE Act grantees, we interviewed staff from selected Part A, B, C, D, and F grantees.[1] To gather background information about the challenges to HIV/AIDS program integration experienced by CARE Act grantees, we interviewed officials from the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services and staff of the National Minority AIDS Council, Kaiser Family Foundation, the National Alliance of State and Territorial AIDS Directors, and the Communities Advocating Emergency AIDS Relief Coalition.

Grantees reported that few challenges exist to HIV/AIDS program integration. Many grantees and service providers funded under different parts of the CARE Act interact with other grantees, service providers, and federal and state HIV/AIDS programs to provide services. However, few problems were identified. For example, an official from a grantee told us that the organization promotes program integration by designing its services to create a "seamless flow" of care for individuals. This includes using targeted outreach programs to bring minorities into care and providing case management services. The service provider then follows up with minority individuals through case management services as well as mental health, substance abuse, and psychosocial support services, as needed.

[1]CARE Act Part A provides for grants to selected metropolitan areas—known as eligible metropolitan areas and transitional grant areas—that have been disproportionately affected by the HIV/AIDS epidemic. Part B provides for grants to states and territories to improve quality, availability, and organization of HIV/AIDS services.
Part C provides for grants to public and private nonprofit entities to provide early intervention services, such as HIV testing and ambulatory care. Part D provides for grants to programs for family-centered comprehensive care to children, youth, and women and their families. Part F provides for grants for demonstration and evaluation of innovative models of HIV/AIDS care delivery for hard-to-reach populations and training of health care providers.

Grantees reported few challenges to HIV/AIDS program integration even though they receive funding from multiple sources to provide HIV/AIDS services. Funding for HIV/AIDS programs to provide services can come from Medicaid, Medicare, Centers for Disease Control and Prevention (CDC) grants, Substance Abuse and Mental Health Services Administration (SAMHSA) grants, and state programs. Grantees we interviewed may receive funding from a variety of federal and state sources. However, CARE Act grants are designated as the "payer of last resort" and therefore pay for HIV/AIDS services that are not covered by other resources, such as Medicaid, Medicare, or private insurance.[2] Some grantees reported in interviews that they have mechanisms in place to ensure that these CARE Act programs are the payers of last resort, which usually consists of closely tracking funding and expenditures on services rendered for individuals, and to identify the appropriate program to pay for HIV/AIDS services for individuals, including those with specific needs.

One challenge some grantees identified was a lack of uniform data collection and reporting requirements across the multiple parts of the CARE Act, even though the required data are similar. Some grantees we interviewed told us that differences in data collection and reporting systems are challenges to program integration across the multiple parts of the CARE Act.

Another challenge to achieving program integration is that definitions of services may differ between the CARE Act and other federal and state funding sources. Officials from a Part B grantee told us that differing definitions present challenges to collaboration and integration because grantees and service providers may be referencing different services despite using the same term. For example, the definition of "case management" is different depending on whether one uses the term in reference to the CARE Act or to another federally funded program, such as the Housing Opportunities for Persons with AIDS program.

[2]As the "payer of last resort," the CARE Act pays for HIV/AIDS services that are not covered by other resources, such as Medicaid, Medicare or private insurance. U.S.C. §§ 300ff-15(a)(6), 300ff-27(b)(7)(F), 300ff-64(f)(1). According to HRSA officials, Part D is a payer of last resort by operation of HRSA policy.

# Appendix II: Objectives, Scope, and Methodology

The CARE Act requires us to report on the Minority AIDS Initiative (MAI) and related issues. In this report, we are providing information on (1) the effect on grantees and service providers of the new competitive process for awarding Part A and B MAI funds, (2) the types of services grantees funded under MAI, and (3) barriers to minorities obtaining services from HIV/AIDS programs that were identified by grantees. The CARE Act also requires us to report on the challenges of integrating CARE Act–funded programs with HIV/AIDS programs funded from other sources such as Medicaid, Medicare, the Centers for Disease, Control and Prevention and SAMHSA. (See app. I for information on the challenges of HIV/AIDS program integration experienced by CARE Act grantees.)

To determine the effect of the new competitive process for awarding MAI funds on grantees and service providers, we conducted a Web-based survey of CARE Act grantees under Parts A and B. We obtained contact information for Part A and Part B grantee officials, including names and e-mail addresses, from HRSA. The survey questions focused on how grantees applied for MAI funds, distributed funds to service providers, and provided oversight, and what services they provided prior to and after the passage of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA). We included in the survey Part B grantees that did not apply for MAI funding for fiscal year 2007 in order to obtain their reasons for not applying. The survey response rates were about 77 percent (43 out of 56) for Part A grantees and about 81 percent (48 out of 59) for Part B grantees.

During the development of our survey, we conducted pretests with two Part A grantees (in Washington, D.C., and Baltimore, Maryland) and two Part B grantees (in Georgia and Pennsylvania). We opened the survey on May 15, 2008, and closed it on June 27, 2008. While the survey was open, we contacted each nonrespondent by e-mail to follow up and subsequently contacted any remaining nonrespondents by telephone to follow up as a way to address any problems and to encourage nonrespondents to complete the survey. Because this survey was conducted with all of the Part A and B grantees, it is not subject to sampling error. However, there are practical difficulties in conducting any survey that may introduce other types of errors, such as nonsampling errors. For example, nonsampling error may introduce unwanted variability or bias in the survey results and can result when survey respondents inconsistently interpret particular survey questions. We took steps to minimize nonsampling errors in developing the questionnaire and in data collection and analysis. While the response rates of 77 and 81 percent are high, if those not responding differed materially from those responding on any particular question we analyzed, our analysis may not accurately represent the group surveyed.

Therefore, our results are representative only of those responding to our survey and are not generalizable to a larger population.

In addition, we reviewed HRSA's policies and reporting requirements for Parts A, B, C, D, and F. We interviewed HRSA officials and staff from selected grantees for Parts A and B to determine how funds were distributed to service providers.

We estimated funding amounts for Part A and B grantees based on the old formula-based process and analyzed the difference between these amounts and the actual funding for fiscal year 2007. To create these estimated funding amounts, we reviewed CARE Act MAI funding data for fiscal years 2006 and 2007, case counts of minorities living with AIDS for fiscal year 2006, and case counts of minorities living with HIV/AIDS for fiscal year 2007, all of which were provided by HRSA. To estimate funding amounts for each Part A and Part B grantee, we followed the old formula-based process, which used a proportion that represented the relationship between a grantee's minority HIV/AIDS case count for fiscal year 2007 and the total minority HIV/AIDS case count for all jurisdictions, and then multiplied that proportion by the total amount of MAI funding available. This gave us the estimated amount of funding for each grantee. We then determined the difference between the actual funding the grantee received under the new competitive process for 2007 and our estimated funding amount to establish the impact of the change to the new competitive process. To assess the validity of the funding amounts, we compared data we received from HRSA to previously published funding amounts. To assess the reliability and validity of the computer-generated estimated funding amounts, we provided HRSA officials with a copy of our tables. They agreed with our methodology and were able to duplicate our funding amounts. We determined that the funding data and case count data were sufficiently reliable for the purposes of this report.

To identify the types of services grantees funded under MAI, we conducted a Web-based survey of Part A and B grantees, as described above, and interviewed selected Part A, B, C, D, and F grantees about services they provided under MAI prior to and after the passage of RWTMA. We interviewed HRSA officials and staff from six Part A and six Part B grantees to determine how funds were distributed. Although there was no change in the process for awarding funds under Parts C, D, and F, we interviewed grantees under those parts to learn about the services they funded. We interviewed staff from six Part C, six Part D, and three Part F grantees. We selected grantees to interview based on the amount of MAI funding they received and to ensure geographic diversity. All interviews

were conducted over the telephone using a structured interview guide that was provided to the interviewees in advance. Question topics included the relationship between HRSA and the grantee and between the grantee and service providers, the services grantees funded, evaluation of services funded by grantees, barriers minorities with HIV/AIDS face in obtaining services through HIV/AIDS programs, and program integration barriers. We also interviewed staff of the National Minority AIDS Council, Kaiser Family Foundation, the National Alliance of State and Territorial AIDS Directors, and the Communities Advocating Emergency AIDS Relief Coalition.

To identify the barriers to minorities obtaining services from HIV/AIDS programs that were identified by grantees, we reviewed Part A MAI and Part B MAI competitive grant applications for fiscal year 2007, which included grantees' responses regarding barriers minorities face in accessing HIV/AIDS services. We interviewed staff from selected Part A, B, C, D, and F grantees about barriers minorities with HIV/AIDS face in obtaining services through HIV/AIDS programs and budget allocations to different HIV/AIDS services. We requested and received from HRSA fiscal year 2007 MAI grant applications from all Part A and Part B applicants. We conducted content analyses on selected sections of the MAI applications in which grantees described barriers, co-morbidities, unmet needs, coordination of services, implementation plans, and impact of MAI services. During the content analyses, we collected information from the fiscal year 2007 Part A MAI and Part B MAI applications regarding barriers to HIV/AIDS services, co-morbidities for individuals with HIV/AIDS, and factors that were complications for care. We also interviewed staff from the organizations listed above.

We conducted our work from January 2008 to February 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

# Appendix III: Ryan White CARE Act Title I and II Funding for Fiscal Year 2006 and Part A and B Funding for Fiscal Year 2007

Table 6 shows funding for Title I grant awards for fiscal year 2006. Since the enactment of RWTMA, CARE Act Title I has been referred to as Part A. In fiscal year 2006, 51 Title I grantees received MAI funding, and the grant amounts ranged from $29,264 to $11,936,248. Overall, MAI grants accounted for 13 percent or less of a Title I grantee's total CARE Act funding.

**Table 6: Ryan White CARE Act Title I Grant Awards and Minority AIDS Initiative (MAI) Grant Awards, Fiscal Year 2006**

| EMA/TGA | Total Title I grant | MAI grant | MAI as percentage of total Title I funding |
|---|---|---|---|
| Atlanta, Ga. | $18,869,561 | $1,609,533 | 8.5 |
| Austin, Tex. | 3,719,076 | 213,718 | 5.7 |
| Baltimore, Md. | 20,628,895 | 1,652,985 | 8.0 |
| Baton Rouge, La.[a] | – | – | – |
| Bergen-Passaic, N.J. | 4,485,650 | 210,170 | 4.7 |
| Boston, Mass. | 13,339,141 | 544,492 | 4.1 |
| Caguas, P.R. | 1,648,356 | 208,397 | 12.6 |
| Charlotte-Gastonia-Concord, N.C.-S.C.[a] | – | – | – |
| Chicago, Ill. | 25,044,633 | 1,878,231 | 7.5 |
| Cleveland, Ohio | 3,349,096 | 241,208 | 7.2 |
| Dallas, Tex. | 13,196,377 | 1,071,248 | 8.1 |
| Denver, Colo. | 4,283,042 | 186,227 | 4.3 |
| Detroit, Mich. | 8,428,477 | 597,700 | 7.1 |
| Dutchess County, N.Y. | 1,367,584 | 112,623 | 8.2 |
| Fort Lauderdale, Fla. | 14,963,638 | 1,058,833 | 7.1 |
| Fort Worth, Tex. | 3,409,819 | 219,925 | 6.4 |
| Hartford, Conn. | 4,666,281 | 266,925 | 5.7 |
| Houston, Tex. | 19,953,520 | 1,631,702 | 8.2 |
| Indianapolis, Ind.[a] | – | – | – |
| Jacksonville, Fla. | 4,913,816 | 409,699 | 8.3 |
| Jersey City, N.J. | 5,145,142 | 265,152 | 5.2 |
| Kansas City, Mo. | 2,916,485 | 125,038 | 4.3 |
| Las Vegas, Nev. | 4,323,627 | 253,623 | 5.9 |
| Los Angeles, Calif. | 34,895,377 | 2,507,856 | 7.2 |

| EMA/TGA | Total Title I grant | MAI grant | MAI as percentage of total Title I funding |
|---|---|---|---|
| Memphis, Tenn.[a] | – | – | – |
| Miami, Fla. | 23,999,914 | 2,048,496 | 8.5 |
| Middlesex-Somerset-Hunterdon, N.J. | 2,595,663 | 135,680 | 5.2 |
| Minneapolis-St. Paul, Minn. | 3,046,512 | 197,755 | 6.5 |
| Nashville-Davidson-Murfeesboro, Tenn.[a] | – | – | – |
| Nassau-Suffolk, N.Y. | 6,148,307 | 464,680 | 7.6 |
| New Haven, Conn. | 6,684,594 | 342,303 | 5.1 |
| New Orleans, La. | 7,434,812 | 593,266 | 8.0 |
| New York, N.Y. | 120,423,326 | 11,936,258 | 9.9 |
| Newark, N.J. | 14,752,254 | 811,417 | 5.5 |
| Norfolk, Va. | 4,414,760 | 235,887 | 5.3 |
| Oakland, Calif. | 5,735,837 | 352,944 | 6.2 |
| Orange County, Calif. | 4,858,579 | 214,604 | 4.4 |
| Orlando, Fla. | 8,561,273 | 669,530 | 7.8 |
| Philadelphia, Pa. | 22,384,551 | 1,585,589 | 7.1 |
| Phoenix, Ariz. | 6,519,338 | 328,114 | 5.0 |
| Ponce, P.R. | 2,391,444 | 246,529 | 10.3 |
| Portland, Oreg. | 3,401,956 | 94,887 | 2.8 |
| Riverside-San Bernadino, Calif. | 7,074,521 | 274,906 | 3.9 |
| Sacramento, Calif. | 2,778,729 | 55,868 | 2.0 |
| San Antonio, Tex. | 3,325,881 | 305,057 | 9.2 |
| San Diego, Calif. | 9,269,256 | 450,492 | 4.9 |
| San Francisco, Calif. | 27,964,864 | 534,737 | 1.9 |
| San Jose, Calif. | 2,304,762 | 110,849 | 4.8 |
| San Juan, P.R. | 13,470,347 | 1,191,852 | 8.8 |
| Santa Rosa, Calif. | 1,028,634 | 29,264 | 2.8 |
| Seattle, Wash. | 5,445,484 | 204,850 | 3.8 |
| St. Louis. Mo. | 4,502,572 | 250,076 | 5.6 |
| Tampa-St. Petersburg, Fla. | 9,571,830 | 567,549 | 5.9 |
| Vineland-Millville-Bridgeton, N.J. | 849,715 | 71,833 | 8.5 |
| Washington, D.C. | 26,923,066 | 2,667,479 | 9.9 |
| West Palm Beach, Fla. | 8,276,018 | 673,964 | 8.1 |

| EMA/TGA | Total Title I grant | MAI grant | MAI as percentage of total Title I funding |
|---|---|---|---|
| **Total** | **$579,686,392** | **$42,912,000** | **7.4** |

Sources: HRSA and GAO analysis of HRSA data.

Note: Since the enactment of RWTMA, CARE Act Title I has been referred to as Part A. EMAs are eligible metropolitan areas; TGAs are transitional grant areas.

[a]Baton Rouge, Louisiana; Charlotte-Gastonia-Concord, North Carolina/South Carolina; Indianapolis, Indiana; Memphis, Tennessee; and Nashville-Davidson-Murfreesboro, Tennessee, were newly designated as TGAs in fiscal year 2007 and, therefore, did not receive Part A funding in fiscal year 2006.

Table 7 shows Part A grant awards for fiscal year 2007. In addition, we provide information on the percentage change from fiscal year 2006 through fiscal year 2007 in Part A MAI grant awards. This change is based on several factors in addition to the new competitive process. (See pages 13-19 for our analysis of fiscal year 2007 funding that isolates the effect of this change.) The reasons for the changes in funding from fiscal year 2006 through fiscal year 2007 include the following:

- The addition of five Part A TGAs, which decreased the amount of individual funding for all Part A grantees.
- Increases or decreases in grantees' proportion of the total number of living minority HIV/AIDS cases, which is used as part of the determination of the demonstrated need for funding. From fiscal year 2006 through fiscal year 2007, HRSA changed the case count method from using the number of living minority AIDS cases to using the number of living minorities with HIV/AIDS for the most recent year available as reported to CDC.
- Scoring of grantees' competitive applications. The competitive process determines the funding level of each grantee partly by the score of its application.

In fiscal year 2007, 56 Part A grantees received MAI funding, and the grant amounts ranged from $50,000 to $9,347,777. Overall, MAI grants accounted for 10 percent or less of a Part A grantee's total CARE Act funding in fiscal year 2007.

**Table 7: Ryan White CARE Act Part A Grant Awards and Minority AIDS Initiative (MAI) Grant Awards for Fiscal Year 2007, Including Percentage Change from Fiscal Year 2006**

| EMA/TGA | Total Part A grant | MAI grant | MAI as percentage of total Part A funding | Percentage change in MAI funding from FY 2006 to FY 2007 |
|---|---|---|---|---|
| Atlanta, Ga. | $17,124,514 | $1,050,229 | 6.1 | -35 |
| Austin, Tex. | 3,614,135 | 229,065 | 6.3 | 7 |
| Baltimore, Md. | 20,388,061 | 2,100,038 | 10.3 | 27 |
| Baton Rouge, La.[a] | 3,259,580 | 249,059 | 7.6 | – |
| Bergen-Passaic, N.J. | 3,869,966 | 287,493 | 7.4 | 37 |
| Boston, Mass. | 13,675,999 | 814,862 | 6.0 | 50 |
| Caguas, P.R. | 1,082,464 | 121,984 | 11.3 | -41 |
| Charlotte-Gastonia-Concord, N.C.-S.C.[a-] | 4,200,378 | 371,535 | 8.8 | – |
| Chicago, Ill. | 25,153,442 | 1,787,310 | 7.1 | -5 |
| Cleveland, Ohio | 3,983,088 | 316,520 | 7.9 | 31 |
| Dallas, Tex. | 13,550,581 | 772,577 | 5.7 | -28 |
| Denver, Colo. | 7,061,342 | 275,492 | 3.9 | 48 |
| Detroit, Mich. | 8,366,462 | 644,567 | 7.7 | 8 |
| Dutchess County, N.Y. | 1,162,194 | 103,571 | 8.9 | -8 |
| Fort Lauderdale, Fla. | 14,284,795 | 1,113,452 | 7.8 | 5 |
| Fort Worth, Tex. | 3,443,293 | 204,310 | 5.9 | -7 |
| Hartford, Conn. | 3,170,527 | 252,944 | 8.0 | -5 |
| Houston, Tex. | 19,472,799 | 1,571,727 | 8.1 | -4 |
| Indianapolis, Ind.[a] | 3,230,389 | 189,079 | 5.9 | – |
| Jacksonville, Fla. | 4,886,573 | 393,745 | 8.1 | -4 |
| Jersey City, N.J. | 4,535,846 | 417,858 | 9.2 | 58 |
| Kansas City, Mo. | 3,724,815 | 187,284 | 5.0 | 50 |
| Las Vegas, Nev. | 4,670,529 | 225,918 | 4.8 | -11 |
| Los Angeles, Calif. | 35,263,560 | 2,528,561 | 7.2 | 1 |
| Memphis, Tenn.[a] | 5,574,928 | 556,225 | 10.0 | – |
| Miami, Fla. | 25,061,316 | 2,565,107 | 10.2 | 25 |
| Middlesex-Somerset-Hunterdon, N.J. | 2,465,279 | 165,169 | 6.7 | 22 |
| Minneapolis-St. Paul, Minn. | 4,468,112 | 264,702 | 5.9 | 34 |
| Nashville-Davidson-Murfeesboro, Tenn.[a] | 3,688,043 | 207,441 | 5.6 | – |
| Nassau-Suffolk, N.Y. | 4,814,937 | 325,286 | 6.8 | -30 |
| New Haven, Conn. | 5,101,747 | 321,657 | 6.3 | -6 |
| New Orleans, La. | 7,256,199 | 541,807 | 7.5 | -9 |
| New York, N.Y. | 110,213,357 | 9,347,777 | 8.5 | -22 |

| EMA/TGA | Total Part A grant | MAI grant | MAI as percentage of total Part A funding | Percentage change in MAI funding from FY 2006 to FY 2007 |
|---|---|---|---|---|
| Newark, N.J. | 13,927,385 | 1,284,886 | 9.2 | 58 |
| Norfolk, Va. | 5,054,931 | 379,699 | 7.5 | 61 |
| Oakland, Calif. | 5,837,061 | 392,080 | 6.7 | 11 |
| Orange County, Calif. | 4,966,678 | 292,945 | 5.9 | 37 |
| Orlando, Fla. | 8,062,483 | 578,713 | 7.2 | -14 |
| Philadelphia, Pa. | 21,639,722 | 1,682,127 | 7.8 | 6 |
| Phoenix, Ariz. | 6,974,852 | 193,368 | 2.8 | -41 |
| Ponce, P.R. | 1,699,838 | 153,098 | 9.0 | -38 |
| Portland, Oreg. | 3,156,465 | 78,536 | 2.5 | -17 |
| Riverside-San Bernadino, Calif. | 6,720,094 | 255,733 | 3.8 | -7 |
| Sacramento, Calif. | 2,259,806 | 97,469 | 4.3 | 74 |
| St. Louis. Mo. | 5,273,629 | 378,174 | 7.2 | 51 |
| San Antonio, Tex. | 3,655,732 | 264,661 | 7.2 | -13 |
| San Diego, Calif. | 10,224,751 | 543,389 | 5.3 | 21 |
| San Francisco, Calif. | 19,459,344 | 652,491 | 3.4 | 22 |
| San Jose, Calif. | 2,338,369 | 137,156 | 5.9 | 24 |
| San Juan, P.R. | 12,709,679 | 741,100 | 5.8 | -38 |
| Santa Rosa, Calif.[b] | 1,040,934 | 50,000 | 4.8 | 71 |
| Seattle, Wash. | 5,953,167 | 234,009 | 3.9 | 14 |
| Tampa-St. Petersburg, Fla. | 9,201,080 | 525,592 | 5.7 | -7 |
| Vineland-Millville-Bridgeton, N.J. | 783,864 | 68,510 | 8.7 | -5 |
| Washington, D.C. | 27,631,723 | 1,976,712 | 7.2 | -26 |
| West Palm Beach, Fla. | 8,295,497 | 576,631 | 7.0 | -14 |
| **Total** | **$578,686,334** | **$42,041,430** | **7.3** | **-2** |

Sources: HRSA and GAO analysis of HRSA data.

[a]Baton Rouge, Louisiana; Charlotte-Gastonia-Concord, North Carolina/South Carolina; Indianapolis, Indiana; Memphis, Tennessee; and Nashville-Davidson-Murfreesboro, Tennessee, were newly designated as TGAs in fiscal year 2007 and, therefore, did not receive Part A funding in fiscal year 2006.

[b]Santa Rosa, California, received the minimum grant award of $50,000. The maximum grant award was set at $10,750,000; however, no one qualified for the maximum.

Table 8 shows funding for Title II grant awards for fiscal year 2006. Since the enactment of RWTMA, CARE Act Title II has been referred to as Part B. In fiscal year 2006, 51 Title II grantees received MAI funding, and funding amounts ranged from $415 to $1,606,289. Overall, MAI grants

accounted for 1 percent or less of a Part B grantee's total CARE Act funding.[1]

**Table 8: Ryan White CARE Act Title II Grant Awards and Minority AIDS Initiative (MAI) Grant Awards, Fiscal Year 2006**

| State/territory | Total Title II grant | MAI grant[a] | MAI as percentage of total Part B funding |
|---|---|---|---|
| Alabama | $12,379,760 | $71,621 | 0.58 |
| Alaska | 1,038,349 | 3,425 | 0.33 |
| Arizona | 12,732,077 | 53,353 | 0.42 |
| Arkansas | 5,161,119 | 18,580 | 0.36 |
| California | 121,734,064 | 587,814 | 0.48 |
| Colorado | 8,042,203 | 28,960 | 0.36 |
| Connecticut | 15,824,810 | 76,604 | 0.48 |
| Delaware | 5,432,326 | 26,676 | 0.49 |
| District of Columbia | 19,495,237 | 180,403 | 0.93 |
| Florida | 116,883,905 | 798,318 | 0.68 |
| Georgia | 37,822,590 | 294,166 | 0.78 |
| Hawaii | 3,298,130 | 8,719 | 0.26 |
| Idaho | 987,627 | – | – |
| Illinois | 36,322,297 | 244,239 | 0.67 |
| Indiana | 11,631,445 | 42,454 | 0.36 |
| Iowa | 2,181,764 | 6,124 | 0.28 |
| Kansas | 3,130,712 | 10,587 | 0.34 |
| Kentucky | 7,190,340 | 19,514 | 0.27 |
| Louisiana | 23,891,181 | 167,947 | 0.70 |
| Maine | 1,333,909 | 1,972 | 0.15 |
| Maryland | 36,055,252 | 303,301 | 0.84 |
| Massachusetts | 20,190,874 | 73,697 | 0.37 |
| Michigan | 15,983,050 | 85,842 | 0.54 |
| Minnesota | 4,318,987 | 25,742 | 0.60 |
| Mississippi | 10,679,221 | 77,642 | 0.73 |
| Missouri | 10,500,632 | 44,011 | 0.42 |

[1]We did not include the Federates States of Micronesia in this analysis because they received the minimum grant award.

| State/territory | Total Title II grant | MAI grant[a] | MAI as percentage of total Part B funding |
|---|---|---|---|
| Montana | 824,817 | – | – |
| Nebraska | 1,815,394 | 7,162 | 0.39 |
| Nevada | 6,654,115 | 32,593 | 0.49 |
| New Hampshire | 1,281,115 | 2,595 | 0.20 |
| New Jersey | 47,641,537 | 234,586 | 0.49 |
| New Mexico | 3,489,677 | 16,400 | 0.47 |
| New York | 175,602,454 | 1,606,289 | 0.91 |
| North Carolina | 24,681,830 | 175,005 | 0.71 |
| North Dakota | 320,858 | 727 | 0.23 |
| Ohio | 16,858,517 | 82,001 | 0.49 |
| Oklahoma | 6,121,483 | 16,712 | 0.27 |
| Oregon | 5,943,054 | 13,079 | 0.22 |
| Pennsylvania | 39,891,047 | 217,355 | 0.54 |
| Puerto Rico | 33,850,327 | 242,163 | 0.72 |
| Rhode Island | 3,189,276 | 15,985 | 0.50 |
| South Carolina | 21,163,384 | 128,607 | 0.61 |
| South Dakota | 734,916 | 1,453 | 0.20 |
| Tennessee | 21,178,234 | 102,969 | 0.49 |
| Texas | 76,656,747 | 533,838 | 0.70 |
| Utah | 3,329,533 | 4,463 | 0.13 |
| Vermont | 883,059 | – | – |
| Virginia | 21,832,964 | 106,913 | 0.49 |
| Washington | 11,198,763 | 33,631 | 0.30 |
| West Virginia | 2,167,287 | 5,190 | 0.24 |
| Wisconsin | 5,404,657 | 20,137 | 0.37 |
| Wyoming | 372,887 | 623 | 0.17 |
| Guam | 147,415 | 415 | 0.28 |
| Virgin Islands | 1,007,176 | 5,398 | 0.54 |
| American Samoa | 50,000 | – | – |
| Marshall Islands | 50,000 | – | – |
| Northern Marianas Islands | 50,000 | – | – |
| Republic of Palau | 50,000 | – | – |

| State/territory | Total Title II grant | MAI grant[a] | MAI as percentage of total Part B funding |
|---|---|---|---|
| Federated States of Micronesia | 50,000 | – | – |
| **Total** | **$1,078,734,384** | **$6,858,000** | **0.64** |

Sources: HRSA and GAO analysis of HRSA data.

Note: Since the enactment of RWTMA, CARE Act Title II has been referred to as Part B.

[a]States and territories that did not receive MAI funding in fiscal year 2006 have a dash.

Table 9 shows funding for Part B grant awards for fiscal year 2007. In addition, we provide information on the percentage change from fiscal year 2006 through fiscal year 2007 in Part B MAI grant awards. This change is based on several factors in addition to the new competitive process. (See pages 13-19 for our analysis of fiscal year 2007 funding that isolates the effect of this change.) The reasons for the changes in funding include the following:

- A decreased number of Part B MAI grantees applying for and accepting MAI funding, which increased the funds available to all Part B MAI grantees.
- Increases or decreases in grantees' proportion of the total number of living minority HIV/AIDS cases, which is a factor used as part of the determination of the demonstrated need for funding. From fiscal year 2006 through fiscal year 2007, HRSA changed the case count method from using the number of living minority AIDS cases to using the number of living minorities with HIV/AIDS for the most recent year available as reported to CDC.
- Scoring of grantees' competitive applications. The competitive process determines the funding level of each grantee partly by the score of its application.

In fiscal year 2007, 30 Part B grantees received MAI funding, and grant amounts ranged from $2,500 to $1,476,866. Overall, MAI grants accounted for 1 percent or less of a Part B grantee's total CARE Act funding.

**Table 9: Ryan White CARE Act Part B Grant Awards and Minority AIDS Initiative (MAI) Grant Awards for Fiscal Year 2007, Including Percentage Change from Fiscal Year 2006**

| State/Territory | Total Part B grant | MAI grant[a] | MAI as percentage of total Part B funding | Percentage Change in MAI funding from FY 2006 to FY 2007 |
|---|---|---|---|---|
| Alabama | $19,791,847 | $109,917 | 0.56 | 53 |
| Alaska | 1,129,894 | 4,412 | 0.39 | 29 |
| Arizona | 13,543,748 | – | – | – |
| Arkansas | 7,901,902 | – | – | – |
| California | 122,936,034 | 856,348 | 0.70 | 46 |
| Colorado | 13,396,954 | 36,113 | 0.27 | 25 |
| Connecticut | 15,044,081 | 83,285 | 0.55 | 9 |
| Delaware | 5,270,515 | 4,360 | 0.08 | -84 |
| District of Columbia | 18,834,754 | 204,224 | 1.08 | 13 |
| Florida | 117,413,102 | 1,087,726 | 0.93 | 36 |
| Georgia | 40,350,086 | 267,205 | 0.66 | -9 |
| Hawaii | 3,237,348 | – | – | – |
| Idaho | 1,105,364 | – | – | – |
| Illinois | 36,392,873 | 72,966 | 0.20 | -70 |
| Indiana | 12,996,706 | – | – | – |
| Iowa | 2,874,145 | 8,377 | 0.29 | 37 |
| Kansas | 3,434,675 | – | – | – |
| Kentucky | 7,608,908 | – | – | – |
| Louisiana | 21,542,485 | 140,731 | 0.65 | -16 |
| Maine | 1,399,166 | 2,500 | 0.18 | 27 |
| Maryland | 35,050,493 | 304,838 | 0.87 | 1 |
| Massachusetts | 19,567,006 | – | – | – |
| Michigan | 16,950,334 | 141,887 | 0.84 | 65 |
| Minnesota | 7,088,148 | 26,875 | 0.38 | 4 |
| Mississippi | 13,997,861 | – | – | – |
| Missouri | 13,786,156 | 69,743 | 0.51 | 58 |
| Montana | 866,238 | – | – | – |
| Nebraska | 2,381,505 | – | – | – |
| Nevada | 8,010,232 | – | – | – |
| New Hampshire | 1,502,980 | – | – | – |
| New Jersey | 45,995,066 | 414,015 | 0.90 | 76 |

| State/Territory | Total Part B grant | MAI grant[a] | MAI as percentage of total Part B funding | Percentage Change in MAI funding from FY 2006 to FY 2007 |
|---|---|---|---|---|
| New Mexico | 4,065,724 | – | – | – |
| New York | 169,488,721 | 1,476,866 | 0.87 | -8 |
| North Carolina | 34,000,911 | – | – | – |
| North Dakota | 343,556 | – | – | – |
| Ohio | 23,352,802 | 62,201 | 0.27 | -24 |
| Oklahoma | 9,110,963 | 20,313 | 0.22 | 22 |
| Oregon | 6,709,281 | 14,031 | 0.21 | 7 |
| Pennsylvania | 38,649,989 | – | – | – |
| Puerto Rico | 32,563,575 | 142,792 | 0.44 | -41 |
| Rhode Island | 3,348,666 | – | – | – |
| South Carolina | 29,068,516 | 177,810 | 0.61 | 38 |
| South Dakota | 805,924 | – | – | – |
| Tennessee | 18,374,749 | 130,743 | 0.71 | 27 |
| Texas | 89,342,110 | 597,547 | 0.67 | 12 |
| Utah | 4,275,389 | – | – | – |
| Vermont | 902,212 | – | – | – |
| Virginia | 28,922,603 | 203,896 | 0.70 | 91 |
| Washington | 11,757,722 | 34,333 | 0.29% | 2 |
| West Virginia | 2,457,104 | – | – | – |
| Wisconsin | 9,475,779 | 41,046 | 0.43 | 104 |
| Wyoming | 680,188 | – | – | – |
| Guam | 291,084 | – | – | – |
| Virgin Islands | 1,272,874 | – | – | – |
| American Samoa | 51,979 | – | – | – |
| Marshall Islands | 52,968 | – | – | – |
| Northern Mariana Islands | 53,958 | – | – | – |
| Republic of Palau | 50,000 | – | – | – |
| Federated States of Micronesia[b] | 57,447 | 2,500 | 4.35 | – |
| **Total** | **$1,150,927,400** | **$6,739,600** | **0.59** | |

Sources: HRSA and GAO analysis of HRSA data.

[a]States and territories that did not apply for funding in fiscal year 2007 have a dash.

[b]Federated States of Micronesia received the minimum grant award of $2,500. No maximum grant award was set.

# Appendix IV: Explanation of Barriers to Minorities Obtaining HIV/AIDS Services

We analyzed fiscal year 2007 Part A MAI and Part B MAI grant applications to identify the barriers to minorities obtaining HIV/AIDS services identified most frequently by grantees. Barriers are issues that can delay or prevent clients from receiving HIV/AIDS services on a timely basis, thus reducing the likely success of those services. Table 10 provides definitions for each barrier identified by Part A and B MAI grantees in their fiscal year 2007 MAI grant applications and the number of grantees from each part that identified the barrier.

**Table 10: Barriers to Minorities in Obtaining HIV/AIDS Services Identified by Ryan White CARE Act Part A and B Minority AIDS Initiative (MAI) Grantees**

| Barrier | Description | Number of Part A MAI grantees identifying this barrier (of 56) | Number of Part B MAI grantees identifying this barrier (of 30) |
|---|---|---|---|
| The 75/25 core medical/support services split | Parts A, B, and C grantees may not use less than 75 percent of funding to provide core medical services that are needed in the eligible area for individuals with HIV/AIDS. This requirement could be a barrier to obtaining services because it may limit the ability of grantees to provide services that are responsive to the needs of individuals they serve. | 5 | 0 |
| Co-morbidities | Co-morbidities are other diseases or conditions that an individual with a primary condition, such as HIV/AIDS, may also have, including hypertension, mental illness, sexually transmitted infections/diseases, and tuberculosis. Co-morbidities may complicate the delivery of or access to medical care. | 56 | 23 |
| Cultural or religious barriers | Culture and religion influence health beliefs and behaviors, which may affect compliance with medical treatment. For example, an individual may have an aversion to revealing personal information, which could hamper provider-patient communication. In addition, prior adverse experiences may make some individuals distrustful of the health care system. | 40 | 18 |
| Data collection and reporting | CARE Act grantees and service providers report information on programs and the individuals they serve to HRSA. These efforts may divert resources from the delivery of HIV/AIDS services. | 16 | 0 |
| Discrimination | Prejudicial and unequal treatment of individuals living with HIV/AIDS may occur because HIV/AIDS is a life-threatening disease, people are afraid of contracting HIV, and some believe that HIV/AIDS has been contracted because of unacceptable lifestyle choices. | 12 | 0 |

| Barrier | Description | Number of Part A MAI grantees identifying this barrier (of 56) | Number of Part B MAI grantees identifying this barrier (of 30) |
|---|---|---|---|
| Familial responsibilities | Responsibilities involving children, partners, grandparents, and other family members may present competing needs that potentially compromise access to and continuing in HIV/AIDS care. | 10 | 0 |
| Geographic factors | The geographic variation in the availability of HIV/AIDS services can limit individuals' access to those services. This is especially true in rural areas that lack health care providers or services, thus requiring individuals to travel long distances to access HIV/AIDS services. | 21 | 9 |
| Housing issues | Persons living with HIV/AIDS may lose their housing because of compounding factors, such as increased medical costs and limited incomes or reduced ability to keep working because of HIV/AIDS and related illnesses. The instability that stems from homelessness can compromise access to and continuing in HIV/AIDS care. | 55 | 21 |
| Immigrant issues | Undocumented workers and other immigrants may face barriers to accessing and maintaining continuity of care for HIV and other health care because these individuals may lack proper documentation, fear legal action, or lack insurance or other means to pay for care. This population is also vulnerable to barriers caused by limited English proficiency. | 31 | 10 |
| Increasing cost to treat HIV/AIDS | The increasing cost to treat HIV/AIDS is usually borne by the grantee and could result in the grantee being unable to serve all those in need. | 6 | 0 |
| Lack of adequate nutrition | Inadequate nutrition can contribute to impaired immune response, accelerate disease progression, and impede the effectiveness of medications. | 31 | 7 |
| Lack of child care | Individuals, most often women, caring for children can have problems securing reliable, affordable child care in order to attend medical appointments and therefore may delay or miss such HIV/AIDS care. | 16 | 0 |
| Lack of funds (source not specified) | Low amounts or lack of available funding challenges grantees' provision of HIV/AIDS services and therefore may prevent individuals from receiving these services. | 0 | 5 |
| Lack of health information | If individuals with HIV/AIDS are not provided with services that educate them about HIV transmission or the medical and support services that are designed to improve health status, they might not access or continue HIV/AIDS care. | 41 | 18 |

| Barrier | Description | Number of Part A MAI grantees identifying this barrier (of 56) | Number of Part B MAI grantees identifying this barrier (of 30) |
|---|---|---|---|
| Lack of insurance | Individuals without insurance or those who are underinsured may delay, never seek, or not continue HIV/AIDS care. | 56 | 12 |
| Lack of providers with nontraditional hours | Clients who work during typical business hours may have difficulty accessing HIV/AIDS services from medical and social service programs that are open only during these times. | 13 | 0 |
| Lack of qualified organizations or physicians | Without adequately qualified organizations or physicians to serve individuals with HIV/AIDS, individuals may not be able to access specialized care or HIV/AIDS-specific services. | 21 | 0 |
| Lack of transportation | Lack of reliable transportation, including affordable and convenient public transportation, and the need to travel long distances to receive HIV/AIDS services can prevent minorities from accessing or continuing HIV/AIDS services. | 51 | 14 |
| Language issues | Language issues include limits to understanding, speaking, or reading English. Individuals with limited English proficiency often require interpretation and translation to receive HIV/AIDS services, but these may not be readily available. | 42 | 18 |
| Late entry into care | Many individuals do not know their HIV status or do not seek care immediately when they do know their status. Those who delay care are often sicker when they do enter care, thus presenting more complex care needs. Such needs may make it difficult for the available HIV/AIDS services to be successful. | 25 | 0 |
| Limited psychosocial support | Social and emotional support includes counseling activities, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Limited provision of these support services may negatively affect an individual's adherence to HIV/AIDS care. | 11 | 0 |
| Mental illness | Individuals with mental illness and HIV/AIDS often delay medical treatment and require complex management of both illnesses, which may not all be addressed by HIV/AIDS services. | 36 | 13 |
| Physical abuse | Some women may not seek HIV/AIDS or other medical care out of fear of being abused by a partner. | 9 | 0 |

| Barrier | Description | Number of Part A MAI grantees identifying this barrier (of 56) | Number of Part B MAI grantees identifying this barrier (of 30) |
|---|---|---|---|
| Poverty | Poverty is defined by the federal government according to income thresholds that vary by family size and composition. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. Poverty increases the likelihood of unemployment, inadequate or no health insurance, and limited access to high quality health care. | 54 | 19 |
| Prison population issues | Current and newly released inmates have increased prevalence of HIV/AIDS. Newly released inmates may experience difficulties accessing HIV/AIDS services. | 45 | 15 |
| Restrictive Medicaid[a] or Medicare[b] eligibility or benefit reductions | Most adults are not eligible for Medicaid, though some states have applied for a waiver to expand Medicaid eligibility for low-income individuals with HIV prior to disability. Medicaid beneficiaries often lose eligibility for Medicaid if they return to work as a result of effective medical care. Those who are not eligible but cannot afford insurance may be unlikely to access or continue HIV/AIDS care.<br>Eligibility criteria for Medicare are restrictive, but once an individual becomes eligible, not all HIV/AIDS-related services may be covered. For example, Medicare has limited support for nonmedical services that are important for HIV/AIDS care, such as case management. | 27 | 0 |
| Ryan White CARE Act funding decline | A grantee's Ryan White Care Act funding might decline or remain level, but if the number of HIV positive individuals to whom the grantee must provide services increases, the grantee might not be able to provide services to all those in need. | 25 | 1 |
| Service appointment wait times | Long waits to schedule appointments may discourage individuals from accessing or continuing HIV/AIDS care. | 5 | 0 |
| Staff turnover | Frequent turnover in management and staff can hinder program implementation. Additionally, staff turnover can adversely affect the knowledge and experience of the organization. The increased caseload makes it more difficult for case managers to monitor their clients and ensure that they are continuing care. | 6 | 6 |
| Stigma/fear | HIV-related stigma refers to all unfavorable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS. HIV/AIDS-related stigma affects individuals' willingness to be tested for HIV and individuals' responses to testing positive, and can lead to delays in accessing HIV/AIDS services. | 45 | 14 |

| Barrier | Description | Number of Part A MAI grantees identifying this barrier (of 56) | Number of Part B MAI grantees identifying this barrier (of 30) |
|---|---|---|---|
| Substance abuse disorders | Substance abuse disorders are defined as dependence on or abuse of a substance. Associated problems may include negative health consequences, such as an increase in HIV transmission and a delay in seeking medical care. | 47 | 20 |
| Unemployment | Unemployment may result in an individual's loss of health insurance or have financial consequences that may affect access to and continuation of HIV/AIDS care. | 26 | 8 |
| Waiting lists for services | Individuals may not receive care because of long waits for medical services. Additionally, not being eligible to participate in programs such as Medicaida because of income requirements may prevent individuals from accessing or continuing HIV/AIDS care. | 12 | 5 |

Source: GAO analysis of Part A and Part B MAI fiscal year 2007 competitive grant applications.

Note: Barriers reported by fewer than five Part A grantees or five Part B grantees were not included in the table. If five or more grantees from either part reported the barrier, the barrier is included in the table with the number of grantees reporting the barrier for both parts.

[a]Medicaid is a jointly funded, federal-state health program that covers certain low-income individuals, including those who are aged or disabled, and families.

[b]Medicare is a federal health program for people 65 years of age and older and for certain disabled adults.

# Appendix V: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 24 2009

Marcia G. Crosse
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Crosse:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "RYAN WHITE CARE ACT: Implementation of New Provisions in the Minority AIDS Initiative (GAO-09-315).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville MD 20857

MAR 2 3 2009

TO: Marcia Crosse
Director, Health Care
Government Accountability Office

FROM: Administrator

SUBJECT: Government Accountability Office Draft Report: "RYAN WHITE CARE ACT: Implementation of New Provisions in the Minority AIDS Initiative" (GAO-09-315)

Thank you for the opportunity to provide comments on the above subject draft report. Attached please find the Department's comments.

Questions may be referred to Gail Lipton in HRSA's Office of Federal Assistance Management at (301) 443-6509.

Mary Wakefield

Mary K. Wakefield, Ph.D., R.N.

Attachment

The Department of Health and Human Services' Comments on the Government Accountability Office Draft Report: "RYAN WHITE CARE ACT: Implementation of New Provisions in the Minority AIDS Initiative"(GAO-09-315)

**General Comments**

The Department of Health and Human Services(DHHS) recommends using consistent terminology to refer to the program and avoid confusion, as either Title XXVI of the PHS Act or the Ryan White HIV/AIDS program.

# Appendix VI: GAO Contact and Staff Acknowledgments

## GAO Contact

Marcia Crosse, (202) 512-7114 or crossem@gao.gov

## Acknowledgments

In addition to the contact named above, Tom Conahan, Assistant Director; Romonda McKinney Bumpus; Stefanie Bzdusek; Melanie Egorin; Jill Evancho; Cathleen Hamann; Martha Kelly; Justin Mausel; Deborah Miller; and Jennifer Whitworth made key contributions to this report.

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