United States General Accounting Office

GAO

Report to Congressional Requesters

March 2000

HIV/AIDS

Use of Ryan White CARE Act and Other Assistance Grant Funds

GAO/HEHS-00-54

Contents

Letter 3

Appendixes

Appendix I: CARE Act Criteria for Counseling and HUD Policies on Illicit Drug Use in Housing 34

Appendix II: Methodology and Information on Administrators' Compensation 36

Appendix III: Dates When States and Territories Began Reporting HIV Infection 42

Appendix IV: CARE Act Title I Awards, Fiscal Year 1999 43

Appendix V: CARE Act Title II HIV Grants, Fiscal Year 1999 46

Appendix VI: HOPWA Formula Grantees, Fiscal Year 1999 48

Appendix VII: Characteristics of CARE Act Clients and Persons Living With AIDS at Seven Locations 51

Tables

Table 1: The Ryan White CARE Act's Programs Described 9

Table 2: Selected CDC HIV Prevention Program Funding, Fiscal Year 1998 10

Table 3: Characteristics of Individuals Who Receive Services From Providers Funded and Not Funded by the CARE Act 13

Table 4: Average Percentage of CARE Act Title I and Title II Funds Spent on Services, Fiscal Year 1998 18

Table 5: Available CARE Act Title I and Title II Funds per AIDS Case in Six States, Fiscal Year 1997 23

Table 6: Distribution of HOPWA Funds in Six States and Their EMSAs, Fiscal Year 1997 25

Table 7: Compensation Characteristics at Nonprofit Organizations 31

Table 8: Organizations in Five Locations Funded by CARE Act Title I, Fiscal Year 1998 39

Table 9: Compensation by Type of Nonprofit Organization 41

Figures

Figure 1: Federal HIV/AIDS Funding, Fiscal Year 1999 6

Figure 2: Distribution of CARE Act Title I-III Funds, Fiscal Year 1998 16

Figure 3: Distribution of Selected CDC HIV Prevention Program Funds, Fiscal Year 1998 20

Figure 4: Distribution of HOPWA Funds, 1994-98 22

Figure 5: ADAP Clients and AIDS Cases in Non-MSA Areas, 1998-99 28

Figure 6: Distribution of AIDS Cases and CARE Act Clients in Michigan, 1998 29
Figure 7: Distribution of AIDS Cases and CARE Act Clients in Virginia, 1998 30

Abbreviations

ADAP	AIDS Drug Assistance Program
AHRQ	Agency for Healthcare Research and Quality
AIDS	acquired immunodeficiency syndrome
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990
CBC	Congressional Black Caucus
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
EMA	eligible metropolitan area
EMSA	eligible metropolitan statistical area
HCSUS	HIV Cost and Services Utilization Study
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HOPWA	Housing Opportunities for Persons Living With AIDS
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
MSA	metropolitan statistical area
NCCS	National Center for Charitable Statistics
SSI	Supplemental Security Income

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-282771

March 1, 2000

The Honorable Dick Armey, Majority Leader
House of Representatives

The Honorable Thomas J. Bliley, Jr., Chairman
Committee on Commerce
House of Representatives

The Honorable Tom Coburn, Vice Chairman
Subcommittee on Health and Environment
Committee on Commerce
House of Representatives

Since the first cases of acquired immunodeficiency syndrome (AIDS) were identified in 1981, more than 700,000 persons in the United States have been diagnosed with AIDS. Recent developments in medical and pharmacological therapies have improved the survival of AIDS patients. At the end of 1998, an estimated 300,000 persons were living with AIDS. In addition, it is estimated that hundreds of thousands of people are infected with the human immunodeficiency virus (HIV) but have not progressed to AIDS.

In addition to increasing, the AIDS population has changed over time, with minorities and women representing a larger proportion of cases. For example, for the 12 months ending June 1993, African Americans accounted for 35 percent of reported AIDS cases, women 15 percent. For the 12 months ending June 1999, the figures were 46 percent African Americans and 23 percent women. The AIDS population by exposure category, or how HIV was contracted, has also changed. Men who have sex with men accounted for 48 percent of the reported AIDS cases during the 12 months ending June 1993. This group, however, accounted for only 34 percent of the reported AIDS cases for the period ending June 1999.

A number of federal HIV/AIDS programs provide for research, prevention, health care, and support services to reduce the risk of contracting the disease and to assist those who are infected with the virus. You asked us to provide information on three programs that fund prevention activities, health care, and other assistance: the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (P.L. 101-381) (CARE Act), which is

administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA); the Centers for Disease Control and Prevention's (CDC) HIV/AIDS prevention grants; and the Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons Living With AIDS (HOPWA). You asked us to determine (1) the characteristics of the persons who are served under the CARE Act; (2) how CARE Act, CDC prevention, and HOPWA funds are distributed to treatment, support services, housing, prevention, and program administration; (3) whether the current approach to funding under the CARE Act leads to advantages or disadvantages in particular areas; (4) whether CARE Act services are reaching rural areas; and (5) how the salaries of administrators of organizations providing HIV/AIDS services compare with the salaries of administrators of other similar nonprofit organizations. We also provide information related to your questions about CARE Act requirements for counseling and HUD's policies regarding illicit drug use in HUD-funded housing (see app. I).

To conduct our work, we interviewed officials at HUD and at HHS, including HRSA, CDC, and the Agency for Healthcare Research and Quality (AHRQ). We obtained and analyzed data from these federal agencies. We obtained funding and other data from six states and public tax records on a sample of nonprofit organizations. We reviewed federal legislation and regulations and relevant HIV/AIDS literature. We conducted our work between June 1999 and January 2000 in accordance with generally accepted government auditing standards. Appendix II provides detailed information on our methodology for comparing administrators' compensation for AIDS service organizations and similar nonprofit organizations.

Results in Brief

The CARE Act funds appear to be reaching groups of infected individuals that have generally been found to be underserved, including the uninsured and the poor. African Americans, Hispanics, and women are served by the CARE Act in higher proportions than their representation in the AIDS population. These vulnerable groups make up the majority of CARE Act clients.

The CARE Act funds both health care and support services, such as case management, housing, transportation, and nutrition. Most of the funds, however, are used for medical treatment and medications. CDC supports a wide range of state and local HIV prevention activities. About two-thirds of CDC's fiscal year 1998 HIV prevention funds to states, localities, schools,

and organizations were used for health education and risk reduction, public information, evaluation and research, capacity building and infrastructure development, and community planning. About one-third was used for counseling about the risks of contracting HIV and the need to notify partners about potential HIV infection, testing for the virus, and referring persons who test positive to appropriate care. HOPWA helps low-income people with HIV/AIDS and their families secure housing and provides other services. HOPWA funds may be used for a variety of housing-related expenses, social services, and program development. Between 1994 and 1998, about two-thirds of HOPWA funds were used for housing assistance. All the programs have limitations on how program funds can be used for administrative purposes.

The levels of funding differ in different areas, with urban areas generally receiving higher funding per AIDS case when an area is designated as an eligible metropolitan area (EMA). EMAs receive funds directly from the federal government under title I of the CARE Act, in addition to the funds provided through the states under title II. While HOPWA funds also vary between states and their eligible metropolitan statistical areas (EMSA), HOPWA state awards are allocated to provide assistance in areas of the state that are outside any qualifying metropolitan area that receives a HOPWA allocation.

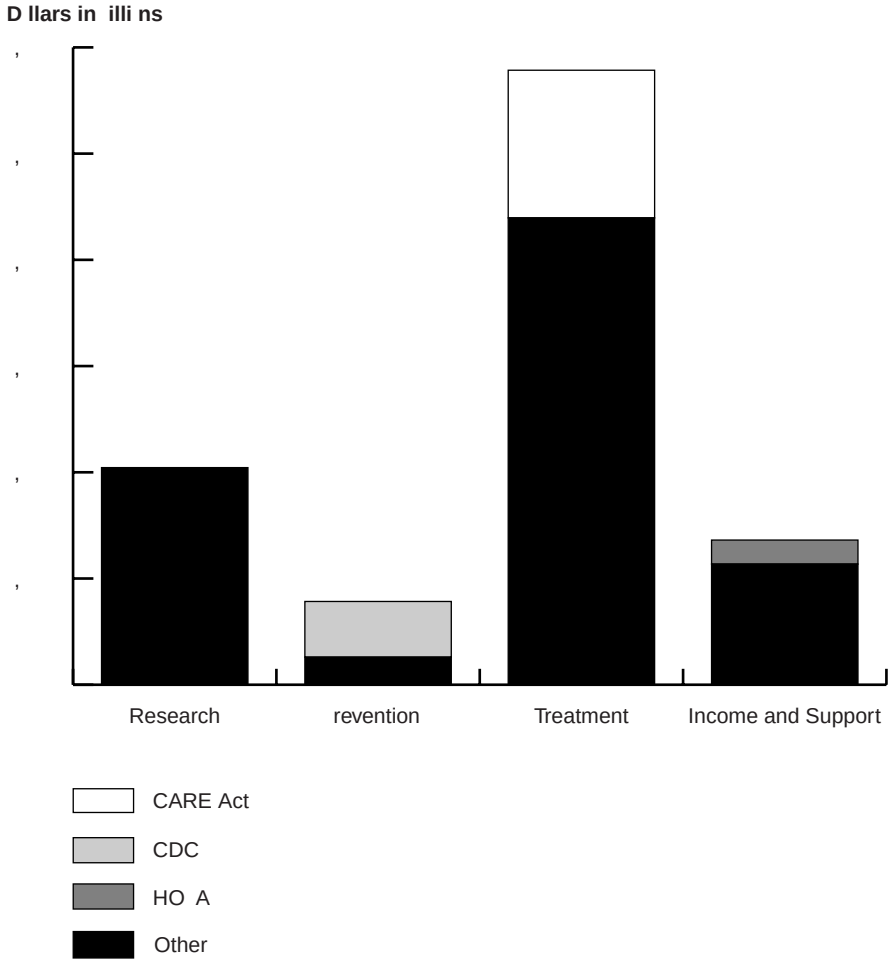
While the vast majority of people with AIDS reside in urban areas, the number of AIDS cases is growing in rural areas, which may offer more limited medical and social services. CARE Act drug assistance services are reaching the rural AIDS population in proportion to the AIDS cases in rural areas. Other services under the CARE Act are being provided to individuals who reside in rural areas, although data do not exist to show where the individuals receive the services.

The compensation for administrators of organizations that received federal HIV/AIDS funds was generally comparable to that of administrators of similar nonprofit organizations. The median compensation for administrators at organizations that received CARE Act or CDC HIV prevention funds was $78,000, and the median at organizations that serve only HIV/AIDS clients was $64,878. The median for other nonprofit organizations providing such services as health care, family planning, and substance abuse prevention and treatment services was $74,203.

Background

The CARE Act, CDC HIV prevention programs, and HOPWA accounted for about 20 percent of the estimated $10 billion in federal spending on HIV/AIDS programs for fiscal year 1999. For that period, estimated federal spending for HIV/AIDS included $2 billion for research, $0.8 billion for prevention activities, $5.8 billion for treatment, and $1.4 billion for income and support. (See fig. 1.)

Figure 1: Federal HIV/AIDS Funding, Fiscal Year 1999



Note: CARE Act funds are assigned to “Treatment.” Some funds are used for support services. “Other” includes primarily Medicaid, Medicare, Social Security Disability Insurance, Supplemental Security Income, and National Institutes of Health research.

Source: Congressional Research Service.

Medicaid is the largest source of federal assistance for health care for AIDS patients.[1] In 1998, Medicaid was estimated to cover 50 percent of adult AIDS patients and about 90 percent of pediatric AIDS patients. States vary in their Medicaid eligibility requirements. Most adults with AIDS or HIV infection become eligible for Medicaid by meeting the disability criteria of the federal Supplemental Security Income (SSI) program but usually not until they have developed AIDS and have become too disabled by their disease to work.[2] Within broad federal guidelines, states have flexibility in developing their Medicaid programs, including eligibility, services to be covered by the program, and the scope of the prescription drug benefit, if any.

AIDS Rates Vary Geographically

The incidence of AIDS varies from state to state. AIDS cases reported for the 12 months ending June 1999 ranged from less than one case per 100,000 people in North Dakota to 143.4 cases per 100,000 people in the District of Columbia. The rates of AIDS cases also vary within states. For example, for the 12 months ending June 1999, the rate of AIDS cases reported in New York was 42.1 per 100,000 people. A large portion of this was accounted for by the New York City metropolitan area, where the rate was 74.9 per 100,000 people for the same period. A comparison of Florida and Miami shows similar differences. The rate of reported cases in Florida was 38.1 per 100,000 people while in Miami it was 72.5.

[1]Medicaid is a joint federal and state program that pays for health care services for eligible low-income or disabled individuals.

[2]A disabled adult is unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that has lasted (or can be expected to last) at least 12 months or that is expected to result in death. An individual with AIDS or HIV infection could also qualify for Medicaid on the basis of eligibility under another eligibility category such as being a pregnant woman, a child under 21, or a member of a family with a dependent child.

Rural areas still account for only a small portion of AIDS cases, according to CDC information. AIDS rates have increased in nonmetropolitan statistical areas but do not indicate that the epidemic is increasing rapidly there.[3] Of the reported cases, 83 percent were from large metropolitan statistical areas (MSA), where 62 percent of the population lived. Medium-sized MSAs accounted for 10 percent of the AIDS cases and 18 percent of the population. Non-MSAs accounted for 7 percent of the AIDS cases and 20 percent of the population.[4]

The pattern of HIV cases is not as clear as the pattern of AIDS cases because not all states report HIV cases. While information on people with HIV is important in planning for surveillance purposes, only 33 states had implemented HIV reporting as of June 30, 1999. Additionally, the states' reporting practices vary. For example, states began HIV reporting on different dates, and some states reported previously diagnosed cases along with new cases, while others reported only newly diagnosed cases. Two states report only pediatric cases. Appendix III lists the states that have initiated HIV reporting.

The CARE Act Provides Health Care and Support Services

The CARE Act was enacted to improve the quality and availability of medical and support services for individuals with HIV disease and their families. The act was reauthorized in 1996. HRSA administers it. Appropriations for fiscal year 1999 were $1.4 billion. Title I provides funds to EMAs with substantial numbers of AIDS cases. Title II provides funds to states and territories by formula, including for the AIDS Drug Assistance Program (ADAP). Discretionary grants to community health centers and other related entities are available under title III for providing primary medical care, HIV counseling and testing, and a variety of support services. Other discretionary grants are available under title IV for services for women, children, and families. (See table 1.)

[3]This is based on AIDS cases in adults and adolescents 13 years of age or older reported to CDC in 1996 from the 50 states and the District of Columbia.

[4]Large MSAs are defined as having populations larger than 500,000, medium-sized MSAs between 50,000 and 500,000, and non-MSAs smaller than 50,000.

Table 1: The Ryan White CARE Act's Programs Described

Program	Grantee	Fiscal year 1999 funding	Purpose and requirements
Title			
I. HIV Emergency Relief Grant Program (formula and supplemental grants)	51 EMAs in fiscal year 1999 with at least 500,000 population and 2,000 AIDS cases reported in the most recent 5 years	$485.8 million[a]	Provides HIV/AIDS outpatient health care, including medications, and a range of support services, including case management, substance abuse treatment, housing, mental health treatment, transportation, and nutritional services, among others. Each EMA has to establish a planning council of representatives of health care agencies, community-based providers, health care planning agencies, and persons with HIV disease, among others. The planning councils establish priorities for allocating funds.
II. HIV Care Grants (formula grants)	50 states, the District of Columbia, and U.S. territories	$710 million, of which $461 million was for ADAP	In addition to ADAP, services include home and community-based health care and support and health insurance continuation. States provide the services directly or through consortia of service providers. States are required to periodically convene people living with HIV disease, grantees, providers, and public health agencies to develop a statewide coordinated statement of need.
III. Early Intervention Services (discretionary grants)	198 grantees, including community and migrant health centers, hospital or university-based medical centers, and city and county health departments	$94.3 million	Services include risk reduction, counseling, testing, clinical care, medications, and case management.
IV. Coordinated Services and Access to Research for Women, Infants, Children, and Youth (discretionary grants)	55 grantees and projects in fiscal year 1998, including health care facilities, public health agencies, and community-based organizations	$46 million	Health care and social services that benefit children, youths, and women living with HIV and their families.
Other			
Special Projects of National Significance		Funded by set-asides from titles I-IV not to exceed $25 million annually	Supports the development and evaluation of innovative models of HIV/AIDS care.
AIDS Education and Training Centers Program		$20 million	A national network of 15 centers that conduct training and education for health care providers in designated geographic areas.

Continued

Program	Grantee	Fiscal year 1999 funding	Purpose and requirements
Dental Reimbursement Program		$7.8 million	Assists accredited dental schools and postdoctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients.

Continued from Previous Page

[a]Additional funds were available to some EMAs. HHS in collaboration with the Congressional Black Caucus (CBC) provided funds to target and enhance effective HIV/AIDS efforts that directly benefit racial and ethnic minority communities: technical assistance and infrastructure support, increasing access to prevention and care, and building stronger linkages to address the needs of specific populations. For fiscal year 1999, CBC funds to the EMAs totaled $5 million.

Appendix IV lists the EMAs for fiscal year 1999 and title I award amounts; appendix V shows the title II awards to the states, the District of Columbia, and the territories.

CDC Funds HIV Prevention Activities

CDC's role includes vaccine research, research on HIV infection and disease progression, surveillance programs, prevention research, prevention program evaluations, state and local prevention activities, school-based prevention activities, and prevention in occupational settings. In this report, we focus on CDC-funded HIV prevention programs through state and local health departments; national and regional minority organizations; national business, labor, and faith partnerships; and other community-based organizations. State, territory, District of Columbia, and local education agencies also receive funding for prevention activities. The major grantees received $289.8 million in fiscal year 1998, as shown in table 2.

Table 2: Selected CDC HIV Prevention Program Funding, Fiscal Year 1998

Type of grantee	Number of grantees	Funding
State, territorial, and local health departments	65	$252,824,319[a]
State and local education agencies	75	19,414,850
Community-based organizations	93	17,553,983

[a]Excludes funding for surveillance activities.

HOPWA Provides Housing Assistance and Other Services

HOPWA provides housing assistance and supportive services for low-income persons with HIV/AIDS and their families. Formula grants to states and metropolitan areas that exceed thresholds for population and AIDS cases constitute 90 percent of the funding. The remaining 10 percent of funds are awarded competitively. Fiscal year 1999 funding of $200.5 million was distributed to 63 metropolitan areas and 34 states, and $24.5 million in competitive awards went to 24 projects. States, localities, and other grantees provide emergency shelter, shared housing, apartments, single room occupancy units, group homes, and housing combined with support services. Grantees can also use HOPWA funds for a variety of housing-related expenses, social services, and program development costs such as housing information and resource identification, purchase, repair, and construction. HOPWA funds are also used for health care, mental health services, substance abuse treatment, nutritional services, case management, and help with daily living.[5] Appendix VI identifies grantees and fiscal year 1999 award amounts.

The CARE Act Is Assisting Underserved HIV-Infected Populations

African Americans, Hispanics, and women are served by the CARE Act in higher proportions than their representation in the AIDS population. These vulnerable groups, including the uninsured and poor, are the majority of CARE Act clients. According to a recent HIV study, they generally receive less appropriate health care for their disease when assessed in terms of physician visits, emergency room visits, hospitalizations, and antiretroviral and prophylactic drug therapies.

[5]Health care services are limited to persons with HIV/AIDS and not other family members. Further, the cost of these services is limited when payments are made by other sources.

According to the HIV Cost and Services Utilization Study (HCSUS)—a study of a nationally representative sample of HIV/AIDS patients—African Americans, Hispanics, women, the uninsured, and people insured by Medicaid are likely to visit physicians less frequently and to take fewer anti-HIV medications for their HIV disease than other HIV-infected people.[6] HCSUS analyzed usage patterns for six measures of health care: physician visits, emergency room visits, hospitalizations, prophylaxis against Pneumocystis carinii pneumonia, antiretroviral medication, and new classes of pharmaceuticals that include protease inhibitors and nonnucleoside reverse transcriptase inhibitors. The analysis showed that compared with whites, African Americans and Hispanics received less appropriate care for their HIV disease. Types of public and private health insurance coverage also affected care. People who lacked health insurance fared worse on most measures. Also, Medicaid recipients received less care than privately insured persons. Women also did not fare as well as men on most of the measures. Finally, exposure category was a significant factor; those who had acquired their infection by injecting drugs or through heterosexual sex had less favorable patterns of care than did men who had sex with men.[7]

Individuals Served Under the CARE Act Are More Likely to Be Members of Minorities, Uninsured, and Poor

Analyses of the HCSUS data to determine the characteristics of persons served under the CARE Act show that CARE Act clients are more likely to be African American, have no insurance or rely on public insurance, and have a lower income than other HIV/AIDS patients.[8] (See table 3.)

[6]HCSUS is being conducted under a cooperative agreement between RAND and AHRQ. Additional funding has been provided by a number of agencies within HHS, the Robert Wood Johnson Foundation, Merck & Co., and Glaxo-Wellcome Inc. The study is based on a sample of 2,864 respondents representing the 231,400 persons who were at least 18 years old, known to have been infected with HIV, and receiving medical care in the 48 contiguous United States in early 1996.

[7]M. Shapiro and others, "Variations in the Care of HIV-Infected Adults in the United States," *Journal of the American Medical Association*, Vol. 281 (1999), pp. 2305-15.

[8]HCSUS defines CARE Act clients as all patients receiving care from a site that has received CARE Act funds. It is possible that some individuals received services at a CARE Act-funded site that were not funded under the CARE Act. AHRQ performed specific analyses of the HCSUS data at our request.

Table 3: Characteristics of Individuals Who Receive Services From Providers Funded and Not Funded by the CARE Act

Characteristic	Funded	Not funded
Gender		
Male	74%	82%
Female	26	18
Race		
White	40	62
African American	42	19
Hispanic	15	16
Other	3	3
Exposure category		
Men who have sex with men	44	55
Persons who inject drugs	17	14
Men who have sex with men and inject drugs	8	8
Persons who have heterosexual contact	22	13
Other	3	4
Insurance status		
No insurance	30	6
Medicaid only	33	23
Medicare and Medicaid	19	18
Private insurance	19	54
Income (highest income ever, in 1996 dollars)		
$0–$5,000	25	12
$5,001–$10,000	30	20
$10,001–$25,000	27	23
More than $25,000	18	45

Also, a greater percentage of women (26 percent) are served under the CARE Act than are not (18 percent). A greater percentage of persons contracting the disease by injecting drugs or through heterosexual contact were seen by providers funded by the CARE Act. A greater percentage of men who contracted the disease through sexual contact with other men were seen by providers not funded by the CARE Act.

Women Receive CARE Act Services at Higher Rates Than Their Representation in the AIDS Population

Using separate data, we also compared the estimated number of people living with AIDS and people receiving CARE Act-funded services in two states and five metropolitan areas: Los Angeles, San Francisco, and Orange County, California; Middlesex, New Jersey; Michigan; Virginia; and Washington, D.C. These locations were selected because HRSA was able to provide data on the unduplicated population of persons served under the CARE Act.[9] We compared the AIDS population as of June 30, 1998, with the client population receiving services under the CARE Act in 1998.[10]

We found that women were receiving services funded by the CARE Act at rates greater than their representation in the AIDS population as a whole. At all seven locations, a greater percentage of women received such services than their percentage in the AIDS population. Analyses also indicate that minorities and individuals contracting the virus through heterosexual contact are represented at higher rates among those served under the CARE Act than in the AIDS population as a whole. While there is variation across locations in the proportion of African Americans and Hispanics in both the AIDS and client populations, at all seven locations a greater percentage of African Americans are among the CARE Act clients than in the AIDS population. This is also true for Hispanics at two of the seven locations. In three locations, the percentages of Hispanics among CARE Act clients were slightly higher than their representation in the AIDS population. In two locations, they were slightly lower.

[9]HRSA obtains client data from service providers, and clients may seek services from more than one provider. Therefore, an unduplicated count of clients is typically not available. HRSA initiated "Client-Level Data Demonstration Projects" at eight sites that can provide an unduplicated count of clients. For California, however, limited data were available and are therefore not included in our analysis.

[10]While both HIV-infected and AIDS patients can receive services funded under the CARE Act, we are limited to comparing CARE Act clients with persons with AIDS because data on HIV-infected persons are not uniformly reported. The percentage of CARE Act clients with AIDS ranged from about 41 percent at one location to about 49 percent at another. Our analysis of the seven locations shows CARE Act client characteristics and HCSUS data to be similar. Also, we noted that the characteristics of persons with AIDS and CARE Act clients vary by location.

We also found that persons who contracted the HIV virus through heterosexual contact were more likely to receive services funded by the CARE Act.[11] In the HCSUS data, we saw that a greater percentage of people who injected drugs receive their services from providers funded under the CARE Act. However, individuals who contracted HIV by injecting drugs had less representation among individuals served under the CARE Act than in the AIDS population at five of the locations. (See app. VII for detailed results for each location.)

CARE Act, CDC Prevention Programs, and HOPWA Fund an Array of Services

While the CARE Act funds both health care and support services, most of the funds are used for medical treatment and medications. Included in CDC prevention activities are counseling about the risks of contracting HIV and the need to notify partners about potential HIV infection, testing for the virus, and referring those who test positive to appropriate care. About one-third of fiscal year 1998 funds were used for these purposes. HOPWA funds are used primarily for housing assistance; about two-thirds of the funds between 1994 and 1998 were used for this purpose. All the programs have limitations on the administrative use of program funds.

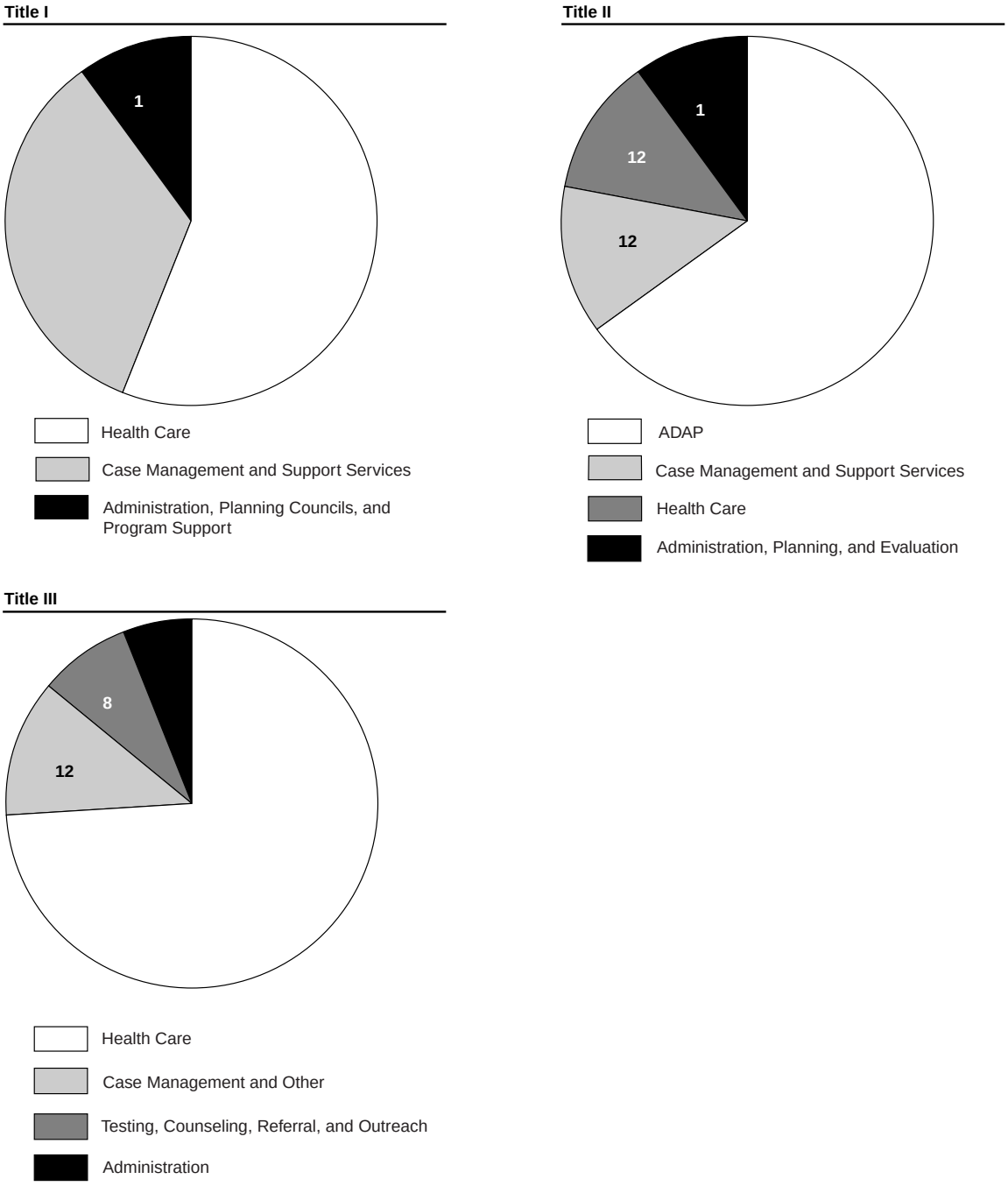
Most CARE Act Funds Are Used for Treatment Services

To determine the distribution of CARE Act funds, we focused on titles I-III. These titles accounted for 95 percent of the act's fiscal year 1999 appropriations.[12] About 56 percent of title I funds were used for health care and medications in fiscal year 1998. For the same year, 34 percent of the funds were used for case management and support services and 10 percent were used for administration, planning councils, and program support. (See fig. 2.)

[11]The proportion of AIDS cases that resulted from heterosexual contact is increasing in the general population. Of the AIDS cases reported for the 12 months ending June 1993, exposure to HIV through heterosexual contact accounted for 9 percent in which exposure category was known. This compares with 15 percent of the AIDS cases reported for the 12 months ending June 1999 for the same exposure group.

[12]HRSA was not able to provide data on the distribution of funds among various services for title IV and demonstration and training programs.

Figure 2: Distribution of CARE Act Title I-III Funds, Fiscal Year 1998



Most title II funds are also used for medications and medical services. About 66 percent of title II funds were devoted to ADAP services in fiscal year 1998. Health services other than ADAP accounted for 12 percent of the funds in the same year. Case management and support services accounted for 12 percent of the funds. Grantees used 10 percent of the funds for administration as well as planning and evaluation.

Most title III funds were also used for health care. In fiscal year 1998, health care services, including medications and laboratory services, accounted for 74 percent of the funds. Another 12 percent were used for case management and other services. About 8 percent were used for testing and counseling, referral, and outreach. The remaining 6 percent went to administration activities.

The Distribution of Funds Has Changed With New Treatment Approaches

Decreases in the number of new AIDS diagnoses and death rates have been greatly influenced by new drug therapies generally administered in combinations of three or more agents. These medications, however, are expensive, with estimated annual costs of $10,000 and more per patient. While the distribution of title I funds among various services has remained relatively constant, title II money is increasingly supporting pharmaceuticals.

Title II's ADAP component provides funds to the states for providing medications to HIV-infected individuals. In response to these expensive therapies, federal funding for ADAP increased from $52 million in fiscal year 1996 to about $461 million in fiscal year 1999, accounting for an increasing proportion of the title II funds. ADAP represented 20 percent of title II funding in fiscal year 1996 and 65 percent in fiscal year 1999. Title II funds used for other health care services remained about the same—$59.3 million in fiscal year 1996 and $60.4 million in fiscal year 1998—but represented a decreasing proportion of title II spending.

States With EMAs Spend Proportionately Less on Medications

The proportions of CARE Act funds spent on services for their HIV-infected populations vary from state to state. For example, the percentage of CARE Act funds devoted to health care services other than medications ranged from 5 percent in one state to 41 percent in another for fiscal year 1998. One state did not use any of its CARE Act funds for health care services. With the majority of title II funds earmarked for ADAPs, states without EMAs have most of their CARE Act funding allocated for medications. In states with EMAs, and therefore title I funding, greater proportions of CARE Act funds are spent, on average, for other services such as health

care and support services. Table 4 shows the average percentage of title I and title II funds spent on different services for fiscal year 1998.

Table 4: Average Percentage of CARE Act Title I and Title II Funds Spent on Services, Fiscal Year 1998

Service	All states	States with EMAs	States without EMAs
Medications	49.9%	38.5%	58.4%
Health care	20.4	24.4	17.6
Administration, planning, and evaluation	9.4	9.7	8.6
Case management	8.9	12.3	6.5
Support services	8.6	14.2	4.5
Health insurance continuation	2.4	0.9	3.5

Source: HHS, HRSA, *Ryan White CARE Act State Profiles* (Washington, D.C.: HHS, 1999).

The CARE Act Limits the Use of Funds That Can Be Used for Administrative Purposes

As shown in figure 2, under each title, not more than 10 percent was used for administrative purposes. Each title contains limitations on the use of funds for administrative activities. The portion of fiscal year 1998 title I-III funds used for administrative purposes was within these limitations.

The CARE Act defines administrative activities as routine grant administration and monitoring, including the development of applications for funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine program and financial reports, and compliance with grant conditions and audit requirements. Also considered administrative activities are all activities associated with a grantee's contract award procedures, including the development of requests for proposals, contract proposal review activities, the negotiation and awarding of contracts, monitoring contracts through telephone consultation, written documentation of onsite visits, reporting on contracts, and funding reallocation activities.

Grantees may not use more than 5 percent of awarded title I funds for administrative activities. In addition, title I EMAs may use funds for carrying out planning council support, program support, and service-

related activities that are subject to a 10 percent aggregate administrative cost cap. While subcontractors are not included in the 10 percent aggregate cap, HRSA strongly recommends that all subcontractors include a cap on administrative expenses.

The states may use title II funds to conduct administrative activities similar to those under title I. The combined costs for administration, planning, and evaluation cannot exceed 15 percent of a state's award.[13] For title III, grantees may not use more than 7.5 percent of the grant amount for administrative costs, including planning and evaluation.

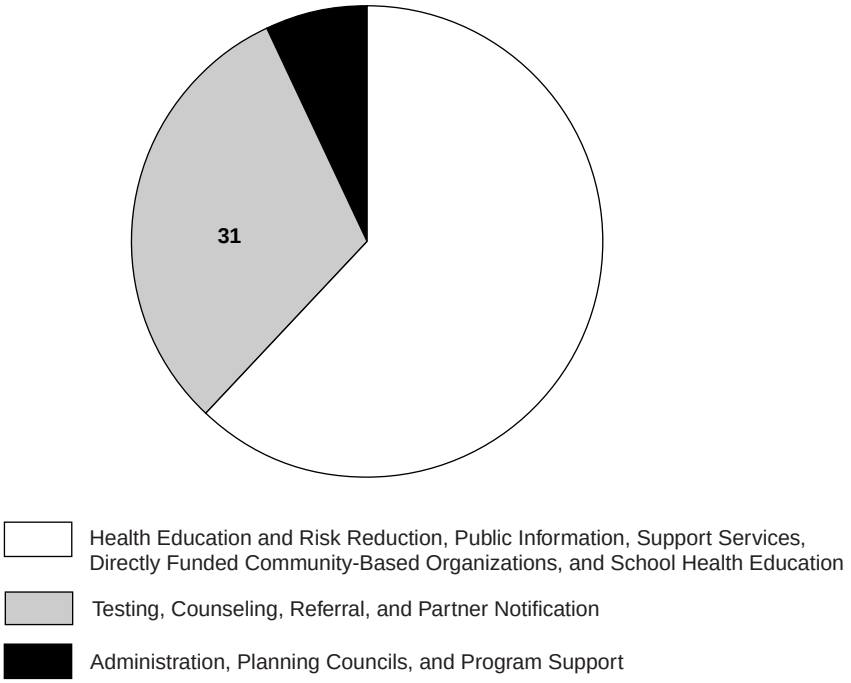
CDC Funds a Range of Prevention Activities

In fiscal year 1998, CDC provided $289.8 million to state and local health departments and education agencies and community-based organizations for HIV prevention activities. Major HIV prevention interventions include counseling, testing, referral, and partner notification; health education and risk reduction; school health; and public information. Evaluation and research, capacity building and infrastructure development, and community planning are support activities. About 62 percent of the fiscal year 1998 funds were used for health education and risk reduction, school health, public information, and support activities. Another 31 percent was devoted to counseling and testing and partner counseling and referral services. Grantees' administrative expenses or indirect costs averaged 7 percent for fiscal year 1998.[14] (See fig. 3.)

[13]States that receive a minimum allotment of title II funds (between $100,000 and $250,000) may spend up to the amount required to support one full-time equivalent employee for administration, planning, and evaluation.

[14]CDC uses a grantee's federal negotiated indirect cost rate. Typical examples of indirect costs are costs of general administrative services, general research and technical support, security, rent, employee health and recreation facilities, and operating and maintenance costs for buildings, equipment, and utilities.

Figure 3: Distribution of Selected CDC HIV Prevention Program Funds, Fiscal Year 1998



CDC places several requirements on its grantees, including requirements related to counseling and testing, and partner counseling and referral services. Public health agencies that receive CDC HIV/AIDS prevention funds are required to offer HIV prevention counseling and testing services to persons potentially infected with HIV, their partners, and others who have high-risk behaviors. CDC criteria require HIV prevention program managers to ensure the confidentiality of the persons who use HIV counseling and testing services. Additionally, persons who seek HIV testing and others who have been determined to be at risk of infection are offered counseling services, regardless of their ability to pay.

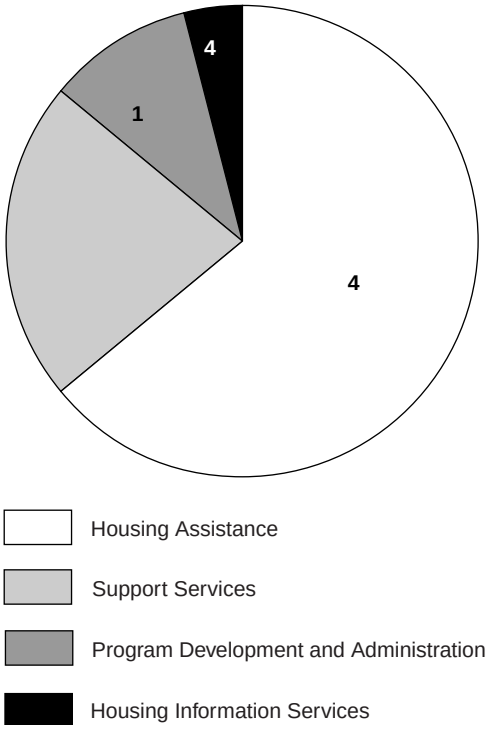
These programs must also refer clients who test either positive or negative for HIV to appropriate services that may include medical care, drug treatment, and support. Additionally, the grantees' counselors are to assist the client in developing a plan that ensures that all partners are counseled about their exposure to HIV.

HOPWA Funds Both Housing Assistance and Supportive Services

According to reports filed with HUD between 1994 and 1998 that accounted for more than $302 million in HOPWA funds, most HOPWA money (64 percent) was spent on housing assistance. Support services accounted for 22 percent of the funds in those years. Support services include case management, adult care and personal assistance, health care, alcohol and drug abuse treatment, and child care, among others. Housing information services accounted for 4 percent of the funds, while program development services and administration expenses were 10 percent of the total. (See fig. 4.) Administrative costs may not exceed 3 percent of the grant amount for grantees and 7 percent for program sponsors.[15] HOPWA grantees reported that 3 percent of grant funds were spent for their administrative expenses and 5 percent were spent for program sponsors' administrative expenses.

[15]Grantees can carry out program activities themselves or by contract with a program sponsor. Program sponsors are nonprofit organizations or governmental housing agencies.

Figure 4: Distribution of HOPWA Funds, 1994-98



Available CARE Act Funds Vary in Different Areas

In general, metropolitan areas designated EMAs and therefore receiving title I funds receive more money per person living with AIDS than non-EMA areas. While we are examining funding formulas in greater detail for you, we include here some analyses of fiscal year 1997 title I and title II funding for EMAs and states.[16]

The level of funding per person living with AIDS differs among states, among EMAs, and between EMAs and states. In general, EMAs, with about

[16]The analysis includes only title I and title II funds. We assigned all ADAP funds, including any title I contributions, to statewide distribution. Remaining title I funds and title II consortia funds for the EMA community were assigned to the EMA. Other title II consortia funds were assigned to the remainder of the state. We did not include title III grants in our analysis because these are not distributed by formula. However, in fiscal year 1999 half of the 26 title III grants in these six states were awarded to organizations located within the EMAs.

three-fourths of all AIDS cases, receive more funding per case. For those areas, the additional money provided through title I is the primary component of the greater availability of funds. (See table 5.)

Table 5: Available CARE Act Title I and Title II Funds per AIDS Case in Six States, Fiscal Year 1997

Location	Estimated number living with AIDS at the end of 1997	Funds per person living with AIDS[a]
Arizona	2,430	$2,830
Phoenix[b]	1,670	3,133
Rest of Arizona	760	2,164
Georgia	8,776	2,846
Atlanta[b]	6,119	3,081
Rest of Georgia	2,657	2,303
Michigan	4,050	2,939
Detroit[b]	2,765	3,296
Rest of Michigan	1,285	2,170
Texas	20,685	2,555
Austin[b]	1,408	3,462
Dallas[b]	4,639	2,769
Fort Worth[b]	1,347	2,514
Houston[b]	7,258	2,457
San Antonio[b]	1,626	2,940
Rest of Texas	4,407	2,072
Virginia[c]	4,710	1,723
Washington	3,562	2,914
Seattle[b]	2,463	3,053
Rest of Washington	1,099	2,603

[a]Funds do not include state match.

[b]Designated an EMA as of 1997.

[c]Parts of Northern Virginia are included in the Washington, D.C., EMA. Those funds are not reflected in the Virginia totals.

Sources: CDC, *HIV/AIDS Surveillance Supplemental Report No. 1* (Atlanta: CDC, 1999); HHS, HRSA, *Ryan White CARE Act State Profiles* (Washington, D.C.: HHS, 1999); HHS, HRSA, Division of HIV Services, data on title I contributions to state ADAPs.

The states have discretion in how they distribute their title II funds. States with EMAs may elect to give more title II money to non-EMA areas or may

choose to distribute title II funds without regard to title I funding. Depending on how the title II funds are distributed, this can increase or decrease the disparity in funding per case between EMA and non-EMA areas. Also, EMAs may contribute a portion of their title I funds to their state ADAP to fund drug assistance services.

For example, in Michigan, some title II money is set aside for consortia while the ADAP and nonconsortia funds are available statewide. Detroit, which has about two-thirds of the estimated persons living with AIDS in the state, got $950,000, or about 37 percent, of the title II money Michigan earmarked for its consortia in fiscal year 1997. However, Detroit is an EMA, so this title II funding was in addition to the title I money of $6 million for the same year. The Detroit EMA transferred $300,000 of its title I funds to the state ADAP in fiscal year 1997. Thus, with the 2,765 people estimated to be living with AIDS at the end of 1997 in the Detroit metropolitan area, the title I and title II money going to Detroit amounts to about $3,296 per AIDS case. This compares with funding of about $2,170 per case for the non-EMA areas in Michigan for fiscal year 1997.

Georgia also has one EMA, Atlanta, that received $12.6 million in title I funds. Unlike Detroit, only 2.5 percent of the title II consortium money went to Atlanta, although 70 percent of the state's persons living with AIDS are in the Atlanta area. Georgia thus allocated its title II consortium funds to areas that do not receive title I funding. In addition, the Atlanta EMA transferred $1.2 million to the state ADAP in fiscal year 1997. However, funding for persons outside the metropolitan area was still below metropolitan area funding. In Georgia, fiscal year funding per AIDS case was estimated at $3,081 for Atlanta and $2,303 for the rest of the state. Virginia, which did not have a designated EMA in 1997, had only title II money to distribute. The funding per person living with AIDS in Virginia was $1,723.

This comparison does not consider the state's rationale for distributing its title II money among EMA and non-EMA areas. States' funding decisions may take into account the incidence of HIV infection as well as AIDS prevalence and the degree of unmet need. Such factors as a state's Medicaid benefit package and the infrastructure investment required for some types of services may also play a role. Further, individuals living outside the EMA may travel to the EMA to receive certain services that would be paid for out of title I funds.

HOPWA Funds Also Vary Among States and Metropolitan Areas

An analysis of the distribution of HOPWA funds in the same six states shows that HOPWA funds also generally vary by AIDS case among EMSAs and the rest of the state. Table 6 shows HOPWA awards per person living with AIDS at the end of 1997.

Table 6: Distribution of HOPWA Funds in Six States and Their EMSAs, Fiscal Year 1997

Location	Estimated number living with AIDS at the end of 1997	Award[a]	Funds per person living with AIDS
Arizona			
Phoenix	1,670	$851,000	$510
Rest of Arizona	222	0	0
Georgia			
Atlanta	6,119	4,090,000	668
Rest of Georgia	2,657	1,106,000	416
Michigan			
Detroit	2,765	1,374,000	497
Rest of Michigan	861	603,000	700
Texas			
Austin	1,408	704,000	500
Dallas	4,639	2,640,000	569
Fort Worth	1,347	582,000	432
Houston	7,258	3,316,000	457
San Antonio	1,626	709,000	436
Rest of Texas	3,856	1,709,000	443
Virginia			
Richmond	930	429,000	461
Virginia Beach-Norfolk	1,496	556,000	372
Rest of Virginia	2,284	0	0
Washington			
Seattle	2,463	1,317,000	535
Rest of Washington	789	434,000	550

[a]We assume that the HOPWA awards for the EMSAs and states were spent in the award year.

Sources: CDC, *HIV/AIDS Surveillance Supplemental Report No. 1* (Atlanta: CDC, 1999), and HUD data on HOPWA formula awards for fiscal year 1997.

Awards per AIDS case in Texas ranged from $432 in Fort Worth to $569 in Dallas. The average award in Texas was $443 per AIDS case. Washington and Seattle were very similar, at $550 and $535, respectively. Other states had a wider range of awards per case—for example, Michigan at $700 and Detroit at $497. However, unlike the CARE Act title II funds, the HOPWA state awards are allocated to provide assistance in areas of the state that are outside any qualifying metropolitan area that receives a HOPWA allocation.

CARE Act Services Appear to Be Reaching Less Populated Areas

While the vast majority of people with AIDS reside in urban areas, HIV infection and AIDS are growing in rural areas, especially in the southern states. The CARE Act is assisting in providing services for HIV-infected populations living in rural areas. Although data on HIV/AIDS services in rural areas are limited, it appears that both drug assistance services and other services are reaching rural residents.

Rural areas, with smaller populations, may offer more limited medical and social services, although access to medical care and support services is critical for the well-being of both the HIV-infected populations and individuals with other medical conditions in these areas. In some instances, rural residents may be traveling to urban areas to receive services.

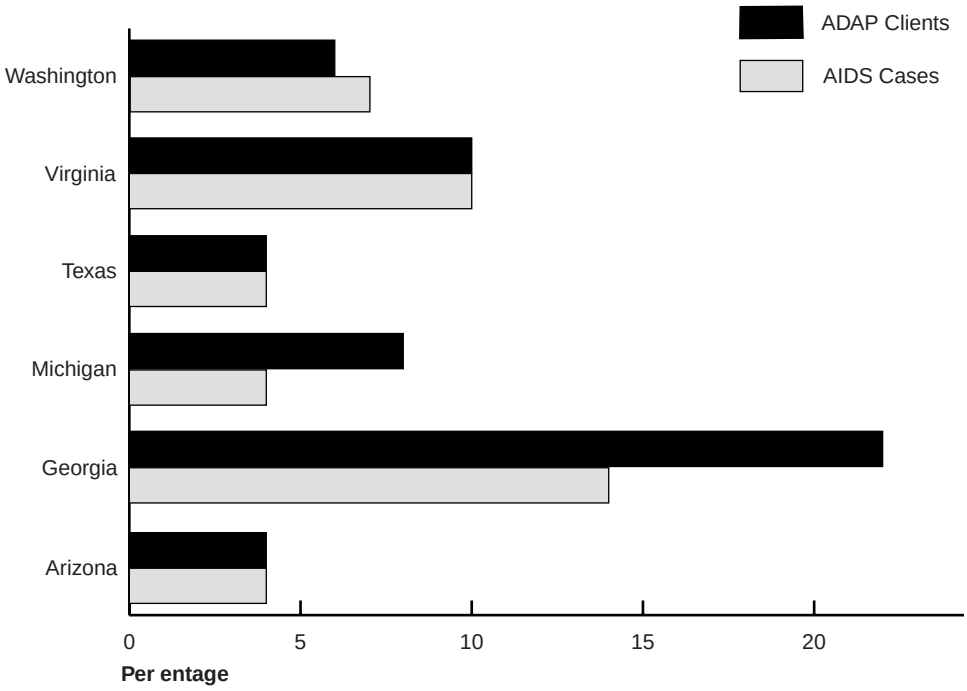
Our analysis of Arizona, Georgia, Michigan, Texas, Virginia, and Washington showed that the incidence of AIDS cases in rural areas was proportionately smaller than in metropolitan areas. In three of these states, 4 percent of the AIDS cases were in non-MSA areas as of June 30, 1998. The 1990 non-MSA populations for these states ranged from about 13 percent to 16 percent of the states' populations. In the three other states, AIDS cases in non-MSAs accounted for 7, 10, and 14 percent, and their 1990 non-MSA populations were about 16, 25, and 33 percent.

CARE Act Drug Assistance Services Are Reaching Rural Areas

Coverage for expensive combination drug therapies under the CARE Act is available primarily through the ADAPs. Our analysis of AIDS cases and ADAP clients in the six states shows that CARE Act drug assistance services are reaching the rural AIDS population generally in proportion to AIDS cases. We found that in five states the percentages of ADAP clients in non-MSA areas were the same as or greater than the percentages of people living with AIDS in non-MSA areas. In one state, there were 1 percent fewer ADAP clients than the estimated number of people living with AIDS, while in another state there were 8 percent more.[17] (See fig. 5.)

[17]Reporting periods for ADAP clients varied: Two states provided number of clients receiving medications during June 1999, two states included clients enrolled during June 1999, and two states provided the number of clients enrolled as of June 30, 1999. The estimated number of people living with AIDS is as of June 30, 1998. As with other comparisons in this report, we are not including people with HIV infection who have not progressed to AIDS, since not all states report HIV cases.

Figure 5: ADAP Clients and AIDS Cases in Non-MSA Areas, 1998-99



Other CARE Act Services Appear to Be Reaching Rural Areas

We were able to take a closer look at Michigan and Virginia because client-level data (unduplicated counts of clients) exist for them. We compared individuals receiving CARE Act services in 1998 with the estimated numbers of persons living with AIDS as of June 30, 1998. As figures 6 and 7 show, the distributions of the AIDS populations and CARE Act clients appear to be reasonably similar.[18] However, these data show where the clients lived and do not necessarily reflect where the services were provided. Rural clients may be traveling to urban areas to receive certain services.

[18]CARE Act client data are by zip codes; AIDS population data are by county.

Figure 6: Distribution of AIDS Cases and CARE Act Clients in Michigan, 1998

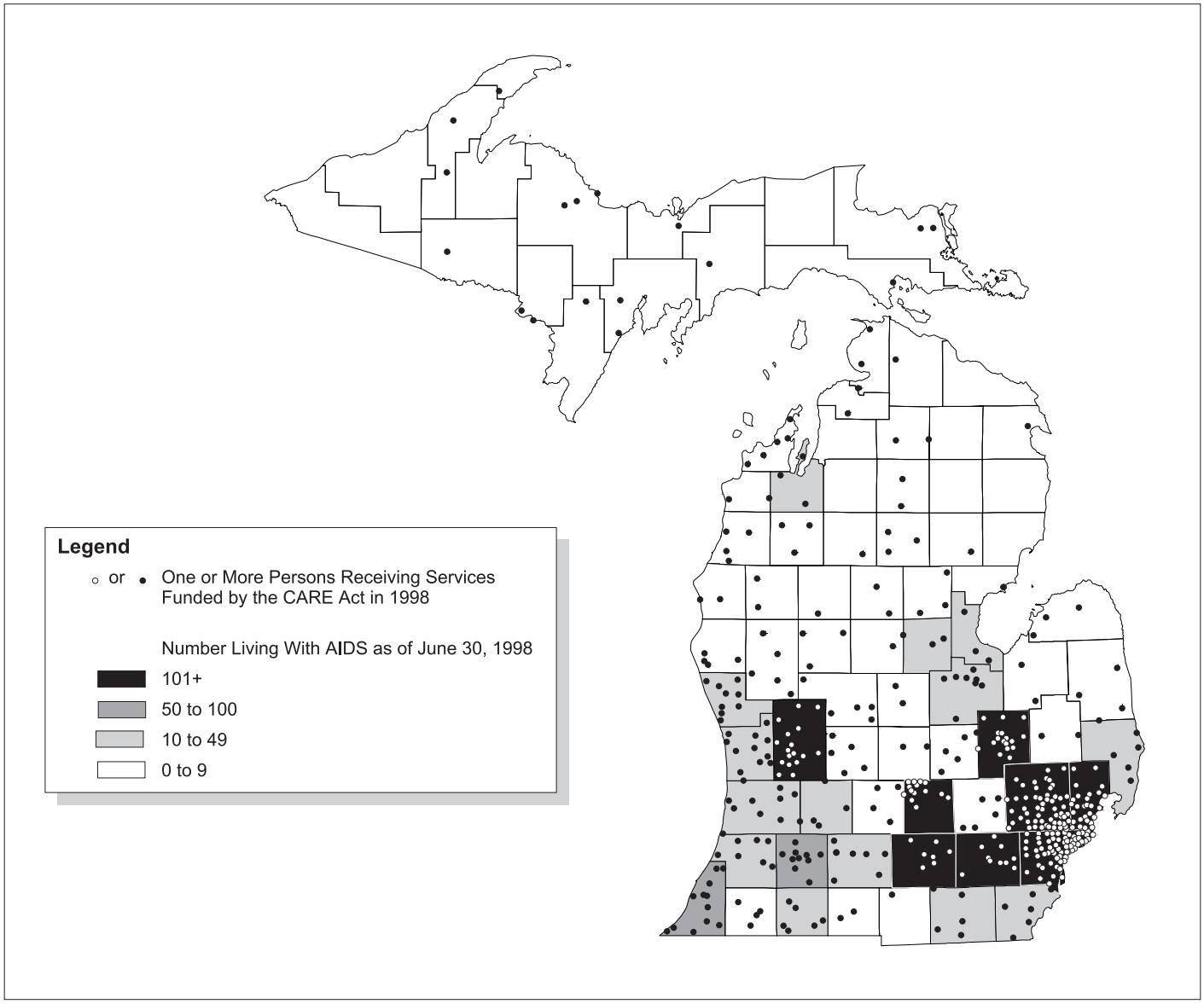
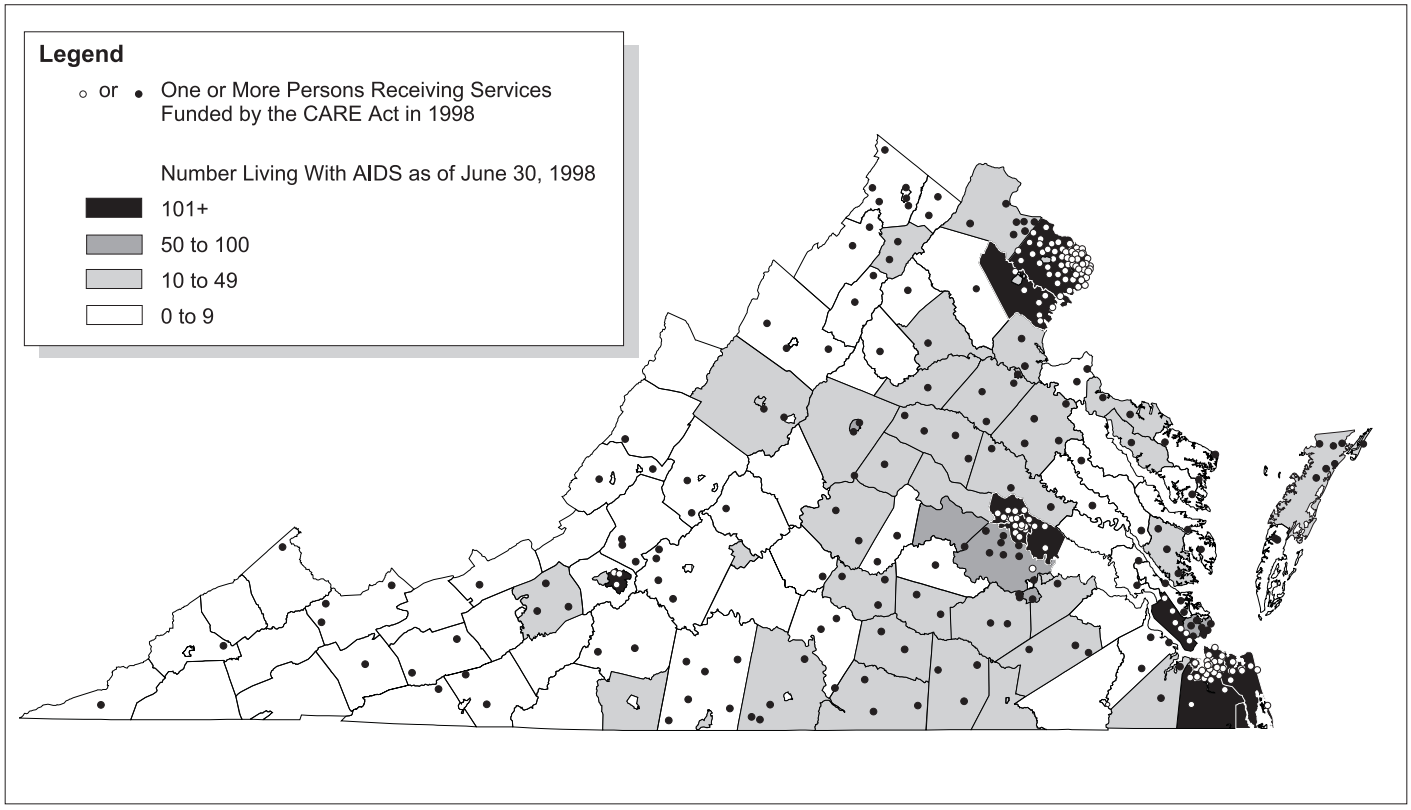


Figure 7: Distribution of AIDS Cases and CARE Act Clients in Virginia, 1998



Administrators' Compensation Is Generally Comparable

Our analysis shows that compensation to administrators of organizations serving persons with HIV/AIDS is generally comparable in similar nonprofit organizations. The median compensation for administrators for all organizations that received CARE Act or CDC funds was $78,000, and the median at organizations that serve only HIV/AIDS clients was $64,878. The median for other nonprofit organizations was $74,203.

The organizations vary by services provided, funds available to provide these services, and the salaries and benefits provided to their administrators. These nonprofit organizations provided health care, drug treatment services, counseling, nutritional services, and legal and other assistance to a diverse group of clients, including people with HIV/AIDS. Revenues, as an indicator of organization size, varied from $206,000 to more than $30 million. Compensation also varied, ranging from $23,434 to $527,807.[19] The average compensation among organizations that received federal HIV/AIDS funds and other nonprofit organizations also varied. (See table 7.)

Table 7: Compensation Characteristics at Nonprofit Organizations

	Receiving CARE Act and CDC funds			
Item	**All organizations**	**Serving HIV/AIDS clients only**	**Serving HIV/AIDS and other clients**	**Not receiving CARE Act or CDC funds**
Revenue range	$15,312–$27.7 million	$415,312–$17.6 million	$1.4 million–$27.7 million	$206,142[a]–$30.9 million
Compensation as percentage of revenue	0.4–13	1–13	0.4–5	0.3–20
Compensation range	$37,450–$223,804	$37,450–$197,014	$56,663–$223,804	$23,434–$527,807
Compensation median	$78,000	$64,878	$89,783	$74,203
Compensation mean	$92,490	$72,871	$104,751	$89,996

[a]We limited our analysis to organizations with revenues of $300,000 or more. However, in some cases, the Internal Revenue Service (IRS) file used to identify the organizations had revenue amounts different from those in the file used for the analysis.

Organizations that received CARE Act or CDC funds and served only HIV/AIDS clients compensated their administrators $72,871 on average, while organizations that served persons with HIV/AIDS and other clients paid their administrators an average of $104,751. However, the average compensation at all organizations that received either CARE Act or CDC funds was $92,490. This compares with an average compensation of $89,996 for other nonprofit organizations that did not receive CARE Act or CDC funds. A more complete description of our analysis is in appendix II.

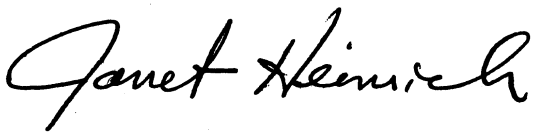
[19]IRS Form 990 instructions state that compensation includes salary, fees, bonuses, and severance payments. For this report, we included in the computation of total compensation contributions to employee benefit plans, deferred compensation, and expense account and other allowances.

Agency Comments

We provided HHS and HUD the opportunity to comment on a draft of this report. HHS said that it agreed with most aspects of the report but thought it should provide more information on the role of Medicare, Medicaid, and State Children's Health Insurance in meeting the needs of HIV/AIDS patients. We agree that these programs, especially Medicaid, do play important roles in the care of HIV/AIDS patients. Our emphasis was on the CARE Act program, however, although we do include some information on other programs that also serve HIV/AIDS patients.

HUD provided technical comments, as did HHS, and we incorporated them where appropriate.

As we agreed with your offices, unless you publicly announce the report's contents earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Claude Earl Fox, Administrator of the Health Services and Resources Administration; the Honorable Jeffrey P. Koplan, Director of the Centers for Disease Control and Prevention; the Honorable Andrew M. Cuomo, Secretary of Housing and Urban Development; and others who are interested. If you have any questions or would like additional information, please call me at (202) 512-7114. Marcia Crosse, Roy Hogberg, and Donna Bulvin made major contributions to this report.



Janet Heinrich
Associate Director, Health Financing and
Public Health Issues

CARE Act Criteria for Counseling and HUD Policies on Illicit Drug Use in Housing

This appendix briefly describes the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) criteria for counseling people with human immunodeficiency virus (HIV) and referring them to appropriate care and federal policies related to substance abuse in federally subsidized housing.

The CARE Act Has Requirements for Counseling About HIV

Grantees receiving title III (early intervention services) money are statutorily required to provide certain counseling services for persons who test positive and negative for HIV. As stated earlier in this report, about 8 percent of fiscal year 1998 title III money was spent on counseling, testing, referral, and outreach.

Counseling and testing services include pretest counseling and counseling individuals with either negative or positive test results. Before testing for HIV, counselors are to provide information on preventing HIV as well as on how the virus is transmitted. They are also to convey information on the accuracy and reliability of test results. Other information includes the benefits of testing, the significance of test results, and encouragement to undergo testing. Counselors should also stress the confidentiality of receiving early intervention services, the availability of anonymous testing, and laws related to discrimination against individuals with HIV disease.

Post-test counseling for individuals who test negative for HIV should contain information about reducing the risk of contracting the virus, the accuracy and reliability of test results, and their significance. The counseling should also include information on the appropriateness of further HIV counseling, testing, and education and referral to HIV prevention services.

People who test positive for the virus need counseling in addition to the information on risk reduction and significance and the reliability of HIV test results. Important information that should be conveyed is the availability of appropriate health care, including antiretroviral therapies, mental health care, and social and support services. In addition to telling them about the availability of early intervention services and primary care, counselors should make them aware of the benefits of counseling others whom they may have exposed to HIV and assist them in locating those persons.

HUD's Policy Against Illicit Drug Use in HUD-Funded Housing

Federal law authorizes the secretary of the Department of Housing and Urban Development (HUD) to make grants to public housing agencies, for-profit and nonprofit owners of federally assisted low-income housing, and others for use in eliminating drug related and violent crime (42 U.S.C. 11902(a)). The grants may be used to employ security personnel, reimburse local law enforcement agencies for additional security, make physical improvements for security, conduct training and buy equipment for volunteer tenant patrols, among other things (42 U.S.C. 11903(a)). The secretary is required to establish a clearinghouse to respond to inquiries from the public requesting assistance in investigating, studying, and working on substance abuse problems. The clearinghouse is also to collect and disseminate information on programs to assist the public in this area. Federal law also requires the secretary to establish regional training programs to educate and prepare officials to confront drug abuse in housing.

In addition, HUD has a zero tolerance policy regarding illegal activities in HUD-funded programs. Housing Opportunities for Persons Living With AIDS (HOPWA) is subject to all federal criminal statutes and procedures regarding the sale, possession, and use of illegal substances. Grantees, project sponsors, and other contracted agents are required to comply with them and have no ability to waive or modify them in order to condone on-site use of illegal substances. HUD may use established remedies to enforce compliance on these matters, such as suspending grant awards. According to an Office of HIV/AIDS Housing official, HUD has not taken any enforcement actions against HOPWA-funded housing grantees.

Methodology and Information on Administrators' Compensation

To compare the compensation of top administrators of organizations receiving CARE Act and Centers for Disease Control and Prevention (CDC) HIV prevention funds with those of other nonprofit organizations, we first randomly selected five eligible metropolitan areas (EMA)—Dallas, Kansas City, Philadelphia, St. Louis, and San Francisco—that received title I CARE Act funds for fiscal year 1999.[1] We identified grantees that received at least $250,000 in title I fiscal year 1998 funds from a list of grant recipients in each of the five EMAs that the Health Resources and Services Administration (HRSA) provided. We excluded hospitals, state and county health departments, and universities from our sample because their size, types of services, and range of clients would not have been comparable to those of most of the organizations that receive CARE Act funds or CDC HIV prevention funds. Through an EMA representative, we requested copies of the latest tax filing, Internal Revenue Service (IRS) Form 990, for the 49 organizations that met our selection criteria. We could not obtain the form for seven. In addition, because of incomplete or insufficient information, we excluded eight more organizations from our analysis. As a result, our analysis includes 34 organizations that received title I CARE Act funds in fiscal year 1998.

We identified seven additional organizations that received $250,000 or more in CDC HIV prevention grants for fiscal year 1998.[2] We were able to obtain a Form 990 for six of these grantees, but we eliminated one because of incomplete information. In total, we identified 39 organizations that received more than $250,000 in CARE Act or CDC prevention funds in fiscal year 1998. Of the 39 organizations, 15 served only HIV/AIDS clients, and 24 served both HIV/AIDS and other clients.

[1]The compensation line item from IRS Form 990 includes salary, fees, bonuses, and severance pay. We also included as part of total compensation contributions to employee benefit plans, deferred compensation, and expense account and other allowances. These line items were also obtained from Form 990.

[2]Because of the limited number of CDC prevention grantees, we included these grantees; they are in San Antonio, Tex.; Jersey City, N.J.; New York, N.Y.; Hartford, Conn.; and San Francisco, Calif.

To select nonprofit organizations for comparison, we contracted with the Urban Institute's National Center for Charitable Statistics (NCCS). NCCS identified and provided data for 273 nonprofit organizations whose annual revenue was at least $300,000, located in the same five cities, that provided health care, family planning services, and drug abuse prevention and treatment services.[3] We eliminated 24 organizations that serve HIV/AIDS clients. We also eliminated 121 because of incomplete or questionable information. Therefore, we used 128 organizations in our analysis.

The nonprofit organizations were limited to the following IRS National Taxonomy for Exempt Organization classifications:

- health treatment facilities, primarily outpatient;
- ambulatory health centers and community clinics;
- family planning centers;
- public health programs (includes general health and wellness promotion services);
- alcohol, drug, substance abuse, and dependency prevention and treatment;
- alcohol and drug abuse prevention only; and
- alcohol and drug abuse treatment only.

Our analysis contains a number of qualifiers that limit drawing any conclusions about the appropriateness of compensation among HIV/AIDS service providers and other nonprofit organizations. First, although IRS Form 990 is the most commonly used data source of such financial information about nonprofit organizations, it can contain numerous errors. Several studies have shown that a sizable number of these forms contain errors and omissions. Also, we limited our selection of the organizations that were funded by the CARE Act to five locations, which resulted in a sample of 34 organizations that received $250,000 or more in CARE Act funds. We obtained data for only five of the seven organizations that received $250,000 or more in CDC HIV prevention funds. We compared the organizations that received CARE Act or CDC funds with 128 nonprofit organizations with total revenues of at least $300,000 in the same locations. Further, our analysis is based only on salary and other compensation and does not consider other factors such as differences in job responsibilities, working conditions, and job satisfaction that would be needed for a more

[3]Of the 273 organizations, 107 were in San Francisco, 31 in Dallas, 92 in Philadelphia, 21 in Kansas City, and 22 in St. Louis.

complete analysis. Additionally, because of the small number of organizations in each location, we did not perform separate analyses by location. Therefore, we did not take into account geographical differences in cost of living.

The 15 organizations that provided services exclusively to HIV/AIDS clients gave their top administrators compensation ranging from $37,450 to $197,014. However, only one organization in this group paid its administrator more than $100,000. While the median compensation was $64,878, the average compensation was $72,871. Revenue at these organizations ranged from $415,312 to $17.6 million, and about 73 percent of them reported revenues between $1 million and $4 million. The organization with the lowest revenue ($415,312) paid its top administrator the fourth lowest compensation ($54,600), while the organization with the highest revenue paid its top administrator the highest salary ($197,014). As a portion of total revenue, their compensation accounted for 13 and 1 percent, respectively.

In the HIV/AIDS dedicated organizations, we also found that the portion of CARE Act or CDC funds as a percentage of total revenue ranged from 12 percent to 77 percent. At the organization with the highest revenue ($17.6 million), CARE Act or CDC funds accounted for 18 percent of total revenue, while at the organization with the lowest revenue ($415,312), CARE Act or CDC funds accounted for 77 percent of total revenue.

The 24 organizations that served HIV/AIDS and other clients gave their top administrators compensation ranging from $56,663 to $223,804. Further, nine top administrators earned $100,000 or more in compensation. The median was $89,783, and the average compensation among these organizations was $104,751. Revenue at these organizations ranged from $1.4 million to $27.7 million. As a percentage of total revenue, top administrator compensation ranged from 0.4 percent to 5 percent of total revenue. The organization with the lowest revenue ($1.4 million) paid its top administrator the lowest compensation ($56,663), but this was not true of the organization with the highest revenue, which paid its top administrator the fifth highest compensation ($129,927) in the group.

At these 24 organizations, CARE Act or CDC funds accounted for from 1 percent to 51 percent of total revenue. At the organization with the highest revenue, CARE Act or CDC funds accounted for 2 percent of total revenue, while at the organization with the lowest total revenue, CARE Act or CDC funds accounted for 20 percent of total revenue. Table 8 provides

information on the organizations in the five locations that received at least $250,000 in CARE Act title I funds in fiscal year 1998.

Table 8: Organizations in Five Locations Funded by CARE Act Title I, Fiscal Year 1998

Location	Total revenue	Title I funds	Salary	Benefits and expenses	Total compensation	Total compensation as a % of revenue	Title I funds as a % of revenue
Dallas							
1	$514,196	$253,433	$40,000	0	$40,000	8%	49%
2	415,312	318,723	54,600	0	54,600	13	77
3	1,691,200	282,500	54,041	$1,923	55,964	3	17
4	2,007,229	642,600	50,000	7,190	57,190	3	32
5	1,137,791	496,822	60,000	2,397	62,397	6	44
6	3,773,898	1,526,053	64,878	0	64,878	2	40
7	2,610,912	349,900	70,258	0	70,258	3	13
8	4,112,524	500,984	85,326	0	85,326	2	12
Kansas City							
1	2,254,491	304,493	63,656	340	63,996	3	14
Philadelphia							
1	2,331,515	433,233	52,982	0	52,982	2	19
2	1,433,529	566,863	51,896	4,767	56,663	4	20
3	1,611,038	269,863	58,266	0	58,266	4	35
4	18,509,917	363,999	74,770	0	74,770	0.4	2
5	3,400,227	1,524,141	73,798	3,567	77,356	2	45
6	4,718,978	384,607	85,750	2,315	88,065	2	8
7	4,307,284	778,872	87,063	10,560	97,623	2	18
8	22,106,787	528,252	110,250	6,951	117,201	1	3
9	27,742,432	440,993	119,657	10,270	129,927	0.5	2
10	25,480,535	287,975	169,825	31,672	201,497	1	1
San Francisco							
1	1,107,951	373,912	65,000	0	65,000	6	34
2	1,971,651	334,395	68,275	3,343	71,618	4	17
3	4,483,191	430,000	71,769	2,153	73,922	2	10
4	1,558,470	278,051	78,000	0	78,000	5	18
5	2,353,199	276,827	75,000	3,000	78,000	3	12
6	4,104,965	2,108,102	65,747	13,903	79,650	2	51

Continued

Location	Total revenue	Title I funds	Salary	Benefits and expenses	Total compensation	Total compensation as a % of revenue	Title I funds as a % of revenue
7	1,505,562	595,113	86,798	300	87,098	6	40
8	13,375,684	252,033	86,700	4,800	91,500	1	2
9	4,603,175	517,398	92,292	0	92,292	2	11
10	10,487,800	979,699	108,925	0	108,925	1	9
11	16,669,156	1,660,850	120,450	0	120,450	1	10
12	16,311,005	1,122,477	141,428	11,999	153,427	1	7
13	17,589,710	3,078,915	183,892	13,122	197,014	1	18
14	19,497,658	1,699,928	130,384	93,420	223,804	1	9
St. Louis							
1	2,471,436	321,894	75,210	4,528	79,738	3	13

Continued from Previous Page

Compensation for top administrators in the 128 other nonprofit organizations ranged from $23,434 to $527,807. Further, 33 organizations paid the top administrator $100,000 or more. Total revenues of the organizations ranged from $206,142 to $30.9 million.[4] The median compensation was $74,203 and the average was $89,996. As a percentage of total revenue, total compensation ranged from 0.3 percent to 20 percent. The organization with the highest revenue ($30.9 million) did not pay its administrator the highest compensation. Nor did the organization with the lowest revenue pay its administrator the lowest compensation. Table 9 provides information on compensation at nonprofit organizations by type.

[4]We limited our analysis to organizations with revenues of $300,000 or more. However, in some cases, the IRS file we used to identify the orgnizations had revenue amounts different from those in the file used for analysis.

Table 9: Compensation by Type of Nonprofit Organization

Category	Range	Number of organizations
Alcohol and drug abuse prevention only	$54,266–$125,916	7
Alcohol and drug abuse treatment only	$33,390–$135,844	30
Alcohol, drug, and substance abuse dependency prevention and treatment	$29,500–$131,994	23
Family planning center	$63,568–$267,867	8
Public health programs (includes general health and wellness promotion services)	$28,577–$318,625	16
Ambulatory health center, community clinic	$23,434–$346,339	33
Health treatment facility, primarily outpatient	$36,000–$527,807	11

To further compare the compensation of top administrators for organizations receiving CARE Act or CDC funds, we considered two surveys of nonprofit organizations that show salaries. One survey by the Congressional Budget Office includes salary and benefits. This study, which considered large nonprofit organizations with annual revenue of $50 million or more, found that chief executive officer salary and benefits averaged about $212,000 per year.[5] Another survey by *The NonProfit Times*, a publication by the NPT Publishing Group, which conducts annual salary surveys, found that chief executive salaries averaged $73,687.[6] In comparing different types of nonprofit organizations, *The NonProfit Times* reported that foundation executives averaged $103,976, followed by chief executives at health organizations at $89,044.

[5]Congressional Budget Office, *Comparing the Pay and Benefits of Federal and Nonfederal Executives* (Washington, D.C.: CBO, Nov. 1999).

[6]The NonProfit Times Online, *The 1998 Salary Survey* (Cedar Knolls, N.J.: The NonProfit Times Online, Feb. 1999).

Dates When States and Territories Began Reporting HIV Infection

State and territory	Date
Alaska	Jan.-June 1999
Arizona	Jan. 1987
Arkansas	July 1989
Colorado	Nov. 1985
Connecticut	July 1992[a]
Florida	July 1997
Idaho	June 1986
Indiana	July 1988
Iowa	July 1998
Louisiana	Feb. 1993
Michigan	April 1992
Minnesota	Oct. 1985
Mississippi	Aug. 1988
Missouri	Oct. 1987
Nebraska	Sept. 1995
Nevada	Feb. 1992
New Jersey	Jan. 1992
New Mexico	Jan. 1998
North Carolina	Feb. 1990
North Dakota	Jan. 1988
Ohio	June 1990
Oklahoma	June 1988
Oregon	Sept. 1988[b]
South Carolina	Feb. 1986
South Dakota	Jan. 1988
Tennessee	Jan. 1992
Texas	Jan. 1999
Utah	April 1989
Virginia	July 1989
Virgin Islands	Dec. 1998
West Virginia	Jan. 1989
Wisconsin	Nov. 1985
Wyoming	June 1989

[a]Confidential HIV infection reporting for pediatric cases only.

[b]Confidential infection reporting for children younger than 6 years old.

CARE Act Title I Awards, Fiscal Year 1999

Eligible metropolitan area	Title I award	CBC[a]
Arizona		
Phoenix	$3,865,319	$19,445
California		
Los Angeles	33,540,737	261,519
Oakland	6,218,532	55,004
Orange County	4,300,690	23,586
Riverside-San Bernardino	6,463,388	36,460
Sacramento	2,578,873	12,423
San Diego	8,872,685	52,934
San Francisco	36,218,513	67,788
San Jose	2,486,136	15,214
Santa Rosa	1,127,018	0
Colorado		
Denver	4,150,341	19,265
Connecticut		
Hartford	4,019,409	48,703
New Haven	6,100,471	62,746
District of Columbia[b]	18,322,558	259,988
Florida		
Fort Lauderdale	10,810,324	118,291
Jacksonville	3,683,146	41,591
Miami	21,248,387	279,163
Orlando	4,907,180	54,824
Tampa-St. Petersburg	7,236,728	48,163
West Palm Beach	6,711,944	87,953
Georgia		
Atlanta	13,147,268	157,991
Illinois		
Chicago	18,227,884	191,570
Louisiana		
New Orleans	5,695,360	68,148
Maryland		
Baltimore	13,478,549	202,463
Massachusetts		
Boston[b]	10,647,381	68,508

Continued

Eligible metropolitan area	Title I award	CBC[a]
Michigan		
Detroit	6,585,744	73,909
Minnesota		
Minneapolis-St. Paul[b]	2,548,603	12,783
Missouri		
Kansas City[b]	2,952,910	16,204
St. Louis[b]	3,664,771	33,669
Nevada		
Las Vegas	3,402,697	25,747
New Jersey		
Bergen-Passaic	4,320,176	48,163
Jersey City	5,015,785	63,737
Middlesex-Somerset-Hunterdon	2,555,029	26,467
Newark	14,390,269	192,110
Vineland-Millville-Bridgeton	688,648	8,732
New York		
Dutchess County	1,220,662	12,153
Nassau-Suffolk	5,632,012	49,963
New York	96,961,856	1,260,780
Ohio		
Cleveland	2,933,058	31,148
Oregon		
Portland[b]	3,115,251	0
Pennsylvania		
Philadelphia[b]	16,011,451	205,884
Puerto Rico		
Caguas	1,610,314	29,348
Ponce	2,487,768	33,849
San Juan	11,912,865	217,047
Texas		
Austin	3,175,509	27,997
Dallas	10,164,078	82,552
Fort Worth	2,935,543	21,606
Houston	15,489,996	177,707
San Antonio	3,014,654	44,742
Virginia		
Norfolk[b]	3,665,087	49,963

Continued from Previous Page

Eligible metropolitan area	Title I award	CBC[a]
Washington		
Seattle	5,303,343	0
Total	**$485,846,900**	**$5,000,000**

Continued from Previous Page

[a]Included in title I award. A Department of Health and Human Services (HHS) and Congressional Black Caucus (CBC) initiative to further address HIV/AIDS in racial and ethnic communities.

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

CARE Act Title II HIV Grants, Fiscal Year 1999

State and territory	Formula	ADAP[a]	Total
Alabama	$3,314,520	$3,980,313	$7,294,833
Alaska	269,662	323,829	593,491
Arizona	2,224,423	4,057,517	6,281,940
Arkansas	1,505,463	1,807,868	3,313,331
California	30,669,853	65,267,693	95,937,546
Colorado	1,968,440	3,787,302	5,755,742
Connecticut	3,629,583	7,793,350	11,422,933
Delaware	1,392,956	1,672,761	3,065,717
District of Columbia	3,319,351	7,690,410	11,009,761
Florida	24,976,515	48,505,772	73,482,287
Georgia	7,658,435	13,815,288	21,473,723
Guam	8,929	10,723	19,652/
Hawaii	1,101,864	1,323,197	2,425,061
Idaho	264,304	317,396	581,700
Illinois	6,967,711	14,548,730	21,516,441
Indiana	3,253,801	3,907,398	7,161,199
Iowa	658,975	791,345	1,450,320
Kansas	981,136	1,426,136	2,407,272
Kentucky	1,851,917	2,223,914	4,075,831
Louisiana	5,010,641	8,061,420	13,072,061
Maine	441,103	529,708	970,811
Maryland	6,496,978	14,175,575	20,672,553
Massachusetts	4,213,646	8,413,129	12,626,775
Michigan	3,740,253	6,712,489	10,452,742
Minnesota	971,008	2,024,469	2,995,477
Mississippi	2,269,803	2,725,742	4,995,545
Missouri	2,683,738	5,127,655	7,811,393
Montana	250,000	227,324	477,324
Nebraska	548,253	658,381	1,206,634
Nevada	1,568,357	3,079,595	4,647,952
New Hampshire	308,492	553,298	861,790
New Jersey	12,427,002	25,275,844	37,702,846
New Mexico	1,125,079	1,351,076	2,476,155
New York	41,145,958	85,949,879	127,095,837
North Carolina	5,301,431	6,371,503	11,672,934

Continued

State and territory	Formula	ADAP[a]	Total
North Dakota	100,000	75,060	175,060
Ohio	4,920,576	6,914,078	11,834,654
Oklahoma	1,773,340	2,129,553	3,902,893
Oregon	1,543,178	2,790,079	4,333,257
Pennsylvania	8,590,475	15,041,980	23,632,455
Puerto Rico	7,895,807	15,505,206	23,401,013
Rhode Island	1,069,718	1,284,594	2,354,312
South Carolina	4,968,208	5,966,180	10,934,388
South Dakota	100,000	105,084	205,084
Tennessee	4,461,029	5,357,124	9,818,153
Texas	17,245,801	32,998,423	50,244,224
Utah	946,495	1,136,619	2,083,114
Vermont	250,000	238,047	488,047
Virginia	4,847,006	8,252,286	13,099,292
Virgin Islands	283,949	340,986	624,935
Washington	2,933,765	5,400,015	8,333,780
West Virginia	624,763	797,778	1,422,541
Wisconsin	1,730,610	2,082,373	3,812,983
Wyoming	100,000	96,506	196,506
Total	**$248,904,300**	**$461,000,000**	**$709,904,300**

Continued from Previous Page

[a]AIDS Drug Assistance Program.

HOPWA Formula Grantees, Fiscal Year 1999

State and territory	Grantee	Amount
Alabama	State of Alabama	$796,000
	Birmingham	365,000
Arizona	State of Arizona	366,000
	Phoenix	923,000
Arkansas	State of Arkansas	552,000
California	State of California	2,427,000
	Los Angeles	8,769,000
	Oakland	1,670,000
	Riverside	1,372,000
	Sacramento	656,000
	San Diego	2,168,000
	San Francisco	8,510,000
	San Jose	649,000
	Santa Ana (for Orange County)	1,143,000
Colorado	Denver	1,164,000
Connecticut	State of Connecticut	920,000
	Hartford	1,413,000
	New Haven	1,214,000
Delaware	State of Delaware	113,000
	Wilmington	485,000
District of Columbia	Washington, D.C.	6,475,000
Florida	State of Florida	3,164,000
	Fort Lauderdale	4,186,000
	Jacksonville	983,000
	Miami	8,418,000
	Orlando	1,753,000
	Tampa	1,661,000
	West Palm Beach	2,635,000
Georgia	State of Georgia	1,297,000
	Atlanta	3,407,000
Hawaii	State of Hawaii	132,000
	Honolulu	364,000
Illinois	State of Illinois	534,000
	Chicago	4,219,000

Continued

State and territory	Grantee	Amount
Indiana	State of Indiana	636,000
	Indianapolis	579,000
Kentucky	Commonwealth of Kentucky	561,000
Louisiana	State of Louisiana	1,063,000
	New Orleans	2,031,000
Maryland	Baltimore	4,689,000
Massachusetts	Boston	1,890,000
Michigan	State of Michigan	677,000
	Detroit,	1,526,000
Minnesota	State of Minnesota	92,000
	Minneapolis	670,000
Mississippi	State of Mississippi	769,000
Missouri	State of Missouri	396,000
	Kansas City	813,000
	St. Louis	944,000
Nevada	State of Nevada	190,000
	Las Vegas	1,308,000
New Jersey	State of New Jersey	1,430,000
	Dover (for Monmouth)	595,000
	Jersey City	2,271,000
	Newark	5,777,000
	Paterson (for Bergen-Passaic)	1,160,000
	Woodbridge (for Middlesex)	671,000
New Mexico	State of New Mexico	391,000
New York	State of New York	2,218,000
	Buffalo	352,000
	Islip (for Nassau-Suffolk)	1,362,000
	New York City	48,668,000
	Rochester	542,000
North Carolina	State of North Carolina	1,212,000
	Charlotte	397,000
	Raleigh	386,000
Ohio	State of Ohio	822,000
	Cincinnati	395,00
	Cleveland	670,000
	Columbus	458,000
Oklahoma	State of Oklahoma	723,000

Continued from Previous Page

State and territory	Grantee	Amount
Oregon	Portland	803,000
Pennsylvania	Commonwealth of Pennsylvania	1,135,000
	Philadelphia	3,428,000
	Pittsburgh	491,000
Puerto Rico	Commonwealth of Puerto Rico	1,841,000
	San Juan	5,891,000
Rhode Island	Providence	424,000
South Carolina	State of South Carolina	1,657,000
Tennessee	State of Tennessee	525,000
	Memphis	538,000
	Nashville	479,000
Texas	State of Texas	2,086,000
	Austin	767,000
	Dallas	2,505,000
	Fort Worth	655,000
	Houston	6,466,000
	San Antonio	805,000
Utah	State of Utah	368,000
Virginia	Commonwealth of Virginia	463,000
	Richmond	492,000
	Virginia Beach (for Norfolk)	702,000
Washington	State of Washington	487,000
	Seattle	1,401,000
Wisconsin	State of Wisconsin	325,000
	Milwaukee	393,000

Continued from Previous Page

Characteristics of CARE Act Clients and Persons Living With AIDS at Seven Locations

Characteristic	Orange County, Calif.		Los Angeles		San Francisco		Middlesex, N.J.		Michigan		Virginia		Washington, D.C.	
	CARE Act	AIDS	CARE Act	AIDS	CARE Act	AIDS	CARE Act	AIDS	CARE Act	AIDS	CARE Act	AIDS	CARE Act	AIDS
Gender														
Male	85.0	89.6	84.9	90.5	88.5	93.8	59.6	67.7	74.3	82.0	64.9	80.8	67.4	77.9
Female	15.0	10.4	15.1	9.5	11.5	6.2	40.4	32.3	25.7	18.0	35.1	19.2	32.6	22.1
Race														
White	53.7	63.0	37.5	43.0	56.7	67.4	35.9	40.0	32.7	41.4	30.1	38.9	17.4	23.4
African American	6.0	5.2	21.7	21.4	24.1	16.0	42.4	36.5	63.0	54.8	66.3	56.4	76.6	71.0
Hispanic	37.0	29.0	38.1	32.7	14.0	12.7	20.5	22.5	3.6	3.3	3.0	3.9	5.3	4.9
Asian Pacific or Native American	3.3	2.7	2.7	2.5	5.1	3.9	1.2	0.8	0.8	0.4	0.6	0.8	0.7	0.6
Exposure category														
Men who have sex with men	56.2	71.1	66.1	73.6	59.7	71.8	23.3	25.3	44.7	53.2	37.3	48.9	31.5	44.8
Persons who inject drugs	15.8	13.3	7.1	9.6	17.5	12.8	36.2	43.2	19.0	24.6	18.0	21.5	19.7	28.9
Men who have sex with men and inject drugs	4.4	5.6	5.3	6.1	12.4	11.9	4.7	4.4	5.0	6.7	7.2	6.2	5.4	4.6
Persons who have heterosexual contact	22.3	7.7	14.9	8.1	8.7	2.7	34.9	21.4	26.6	12.1	34.8	19.2	39.8	17.9
Other	1.4	2.2	6.7	2.7	1.6	0.8	0.8	5.6	4.8	3.4	2.7	4.3	3.6	3.8
Stage of illness														
HIV but not AIDS	50.6		59.3		52.0		58.1		57.9		57.3		58.7	
AIDS	49.4		40.7		48.0		41.9		42.1		42.7		41.3	

Note: Numbers are percentages.

Ordering Information

The first copy of each GAO report is free. Additional copies of reports are $2 each. A check or money order should be made out to the Superintendent of Documents. VISA and MasterCard credit cards are accepted, also.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:
U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

Orders by visiting:
Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders by phone:
(202) 512-6000
fax: (202) 512-6061
TDD (202) 512-2537

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

Orders by Internet:
For information on how to access GAO reports on the Internet, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web home page at:

http://www.gao.gov

To Report Fraud, Waste, or Abuse in Federal Programs

Contact one:

- **Web site: http://www.gao.gov/fraudnet/fraudnet.htm**
- **e-mail: fraudnet@gao.gov**
- **1-800-424-5454 (automated answering system)**

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Correction Requested

Bulk Rate
Postage & Fees Paid
GAO
Permit No. GI00