



Highlights of [GAO-09-1020](#), a report to congressional requesters

Why GAO Did This Study

Under the CARE Act, funds are made available to assist over 530,000 individuals affected by HIV/AIDS. Grantees directly provide services to individuals (clients) or arrange with service providers to do so. The Department of Health and Human Services's (HHS), Health Resources and Services Administration (HRSA), which administers CARE Act programs, is required to cancel balances of grants that are unobligated after one year and redistribute amounts to grantees in need. HRSA began to collect client-level data in 2009. Under the CARE Act, states and territories receive grants for AIDS Drug Assistance Programs (ADAP), which provide HIV/AIDS drugs. GAO was asked to examine elements of the CARE Act. In this report, we review: (1) HRSA's implementation of the unobligated balance provisions, (2) HRSA's actions to collect client-level data, and (3) the status of ADAP waiting lists. GAO reviewed reports and agency documents and interviewed federal officials, officials from 13 state and 5 local health departments chosen based on location and number of cases, and other individuals knowledgeable about HIV/AIDS.

What GAO Recommends

GAO recommends that HRSA take action to ensure it obtains timely and accurate information on grantees' unobligated balances. HHS reviewed a draft of the report, but did not comment on the recommendations.

[View GAO-09-1020 or key components.](#)
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RYAN WHITE CARE ACT

Health Resources and Services Administration's Implementation of Certain Provisions Hampered by Lack of Timely and Accurate Information

What GAO Found

The lack of timely and accurate information reporting by grantees has delayed HRSA's distribution of certain grants and has placed at risk HRSA's ability to obligate these funds. The late submission of actual unobligated balances for the 2007 grant year delayed HRSA's ability to determine grantees' unobligated balances and redistribute these funds to other grantees. A number of grantees were late in their submissions. For example, 21 of the 56 metropolitan areas submitted their information beyond the date initially set by HRSA. Additionally, some grantees reported inaccurate unobligated balances, which required HRSA staff to correspond with grantees and request revised information, creating additional delays. HRSA is authorized to obligate fiscal year 2007 funds for a 3-year period and is at risk of losing the authority to make grants from these funds. HRSA officials said they have made changes to how they implement the unobligated provisions in an effort to avoid these issues in the future.

HRSA has taken actions to collect client-level data by implementing a new data collection and reporting system. However, some grantees and service providers did not submit the initial reports by HRSA's deadline. HRSA set a July 31, 2009, submission deadline for grantees' initial reports, but 100 of 638 grantees did not meet this deadline. Client-level data includes information such as the dates clients were served, the types of services provided, and the clients' health status. HRSA has implemented a system to collect data on the number of unique clients from grantees and service providers that will allow HRSA to determine the services each client received and the outcomes of these services. In order for HRSA to collect this information, grantees and service providers must first collect the data using their own systems, and HRSA has provided technical and financial assistance so that they can develop these systems. For example, under a project initiated in 2009, HRSA awarded approximately \$4 million to CARE Act grantees for the development of their own client-level data collection systems.

The number of ADAPs with waiting lists and the number of individuals on those lists is increasing. In the first quarter of grant year 2008 (April 1, 2008, through June 30, 2008), 2 ADAPs had waiting lists with a total of 55 people on those lists; this grew to 3 ADAPs and a total of 112 people in the fourth quarter of the year, and increased to 4 ADAPs and 136 individuals in August 2009. Kentucky, Montana, Nebraska, and Wyoming were each maintaining a waiting list for ADAP services in August 2009; Nebraska had the largest number of individuals (71), and Wyoming had the smallest number (5). ADAP officials expressed concern that they will have to establish or expand waiting lists or implement other cost-control measures, such as limiting the number of drugs they make available.