



April 2015

PERSONS WITH HIV

Funding Formula for Housing Assistance Could Be Better Targeted, and Performance Data Could Be Improved

GAO Highlights

Highlights of [GAO-15-298](#), a report to congressional committees

Why GAO Did This Study

Over 1.2 million people in the United States are estimated to have HIV. Research has shown that persons with HIV who lack stable housing are less likely to adhere to HIV care. HUD's HOPWA program and HRSA's Ryan White program provide grants to localities that can be used to fund housing and supportive services specifically for persons with HIV.

GAO was mandated to review housing assistance for persons with HIV. This report addresses (1) the need for housing assistance for persons with HIV and the extent to which assistance reaches communities, (2) results achieved through HOPWA and Ryan White, and (3) federal oversight of these programs. GAO analyzed program data as of 2012, reviewed policies, and visited a non-generalizable sample of four geographically diverse cities that received both HOPWA and Ryan White funding.

What GAO Recommends

If Congress wishes HOPWA funding to be more effectively targeted, it should consider revising the funding formula to reflect the number of living persons with HIV. GAO also recommends that (1) HUD require a consistent methodology for estimating unmet housing needs and (2) both HUD and HRSA improve the reliability and use of performance data to manage their programs. HRSA agreed with GAO's recommendations. HUD agreed with the first recommendation but disagreed with the second, stating that it already assesses trends in some program data. GAO clarified that HUD should identify reporting issues by analyzing trends in its unmet housing need data.

View [GAO-15-298](#). For more information, contact Daniel Garcia-Diaz at (202) 512-8678 or garciadiazd@gao.gov.

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What GAO Found

The extent to which persons with human immunodeficiency virus (HIV) need housing assistance is not known, in part because the Department of Housing and Urban Development's (HUD) estimate of the housing needs of persons with HIV, including those with Acquired Immune Deficiency Syndrome (AIDS), is not reliable. HUD does not require Housing Opportunities for Persons with AIDS (HOPWA) grantees to use a consistent methodology to calculate unmet need. The agency has taken steps towards developing a standard methodology, but it has not established time frames for finalizing these efforts. GAO's work on assessing data reliability indicates that data should be consistent. Because HUD does not require grantees to use selected data sources in a consistent manner, the reported information on unmet housing needs of persons with HIV are not comparable across jurisdictions and are not useful and reliable. In addition, the statutory HOPWA funding formula is based on cumulative AIDS cases since 1981, including persons who have died, rather than on current numbers of persons living with HIV (including those with AIDS). This approach has led to areas with similar numbers of living HIV cases receiving different amounts of funding. Because HOPWA funds are awarded based on cumulative AIDS cases, these funds are not being targeted as effectively or equitably as they could be.

Agency data for HOPWA and the Health Resources and Services Administration's (HRSA) Ryan White program indicate most recipients of assistance obtained stable, permanent housing, but Ryan White housing data may have limitations. HRSA, within the Department of Health and Human Services, does not require Ryan White grantees to maintain current data on clients' housing status. However, it uses the data that grantees report to calculate the proportion of clients that have stable housing. HRSA is charged with tracking Ryan White clients' housing status as a part of the White House's National HIV/AIDS Strategy. Federal internal control standards state that events should be promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. Because HRSA does not require grantees to maintain current data on clients' housing status, HRSA's data may be of limited usefulness in tracking the National HIV/AIDS Strategy goal of improving clients' housing status.

HUD and HRSA perform oversight activities but may be missing opportunities to use data to improve performance. HUD staff conduct risk-based monitoring of HOPWA grantees, and HRSA staff have improved monitoring of Ryan White grantees. HUD and HRSA both collect performance data from their grantees and take steps to ensure that the data are complete and submitted in a timely manner. HUD uses performance data to create summaries of program performance but does not have a specific process for comparing individual grantees' year-to-year data for unmet housing need. Federal internal control standards note the importance of such comparisons. By not analyzing these trends, HUD may not be identifying and addressing reporting problems. In addition, HRSA staff responsible for monitoring Ryan White grantees do not review grantee data on housing assistance provided. Federal internal control standards state that activities need to be established to monitor performance measures. By not focusing attention on housing data, HRSA staff with monitoring responsibility are not proactively using available resources to monitor individual grantees' contributions to the National HIV/AIDS Strategy goal of improving clients' housing status.

Contents

Letter		1
	Background	5
	Estimates of Housing Need for Persons with HIV Are Not Reliable, and the HOPWA Formula Does Not Effectively Target Funds	11
	HOPWA and Ryan White Part A Provide Stable Housing for Persons with HIV, but Some Housing Data May Have Limitations	24
	Federal and Local Agencies Generally Coordinate Their Efforts to Deliver Housing Assistance to Persons with HIV	35
	HUD and HRSA Monitor Their Programs but May Be Missing Opportunities to Use Data to Improve Performance	44
	Conclusions	52
	Matter for Congressional Consideration	54
	Recommendations for Executive Action	54
	Agency Comments and Our Evaluation	55
Appendix I	Scope and Methodology	61
Appendix II	Relative Difference between Cumulative AIDS Cases and Living HIV Cases	69
Appendix III	Comments from the Department of Housing and Urban Development	72
Appendix IV	Comments from the Department of Health and Human Services	79
Appendix V	GAO Contact and Staff Acknowledgments	82
Tables		
	Table 1: Selected Demographic Characteristics of HOPWA Clients Who Received Housing Assistance, 2012	27

Table 2: Selected Demographic Characteristics of Ryan White Part A Clients Who Received Housing Assistance, Calendar Year 2012	30
Table 3: Comparison of Selected Eligibility Requirements for Selected Housing Assistance Programs	41
Table 4: Comparison of Services Funded Through Selected Housing Assistance Programs	42
Table 5: Examples of Potential Problems in Reporting Unmet Housing Need Data for Selected Grantees, 2010-2013	49
Table 6: Relative Difference between Cumulative AIDS Cases and Living HIV Cases, by Areas that Received Formula HOPWA Grants in 2012	69

Figures

Figure 1: Flow of HOPWA and Ryan White HIV/AIDS Program Grant Funds and Assistance	10
Figure 2: Rates of Diagnosed HIV Infection by Region, 2012	13
Figure 3: Prevalence Rates of Diagnosed HIV Infection by Region, 2008–2011	14
Figure 4: Relative Differences in Cumulative AIDS Cases and Numbers of Persons Living with HIV, by Metropolitan Statistical Area, Fiscal Year 2012	21
Figure 5: HOPWA Expenditures, Program Year 2012	25
Figure 6: Expenditures for Various Types of HOPWA-Funded Housing Assistance, Program Year 2012	27
Figure 7: Ryan White Part A Supportive Services Expenditures, Fiscal Year 2011	29

Abbreviations

AIDS	acquired immunodeficiency syndrome
CAPER	Consolidated Annual Performance and Evaluation Reports
CARE Act	Ryan White Comprehensive AIDS Resource Emergency Act
CDC	Centers for Disease Control and Prevention
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
HUD-VASH	Department of Housing and Urban Development and Veterans Affairs Supportive Housing
MSA	metropolitan statistical areas
RSR	Ryan White HIV/AIDS Program Services Report

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April 16, 2015

Congressional Committees:

The Centers for Disease Control and Prevention (CDC) estimated that as of December 2011 more than 1.2 million persons in the United States were infected with the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS).¹ HIV infection is now considered a chronic condition that, in most persons, can be effectively managed with regular monitoring and appropriate medical care. However, research has shown that homeless or unstably housed persons often lack access to primary care and may not use health care services appropriately. Housing Opportunities for Persons with AIDS (HOPWA), the only federal program targeted specifically to meeting the housing needs of persons with HIV, was established within the Department of Housing and Urban Development (HUD) under the Cranston-Gonzalez National Affordable Housing Act, enacted in 1990. Congress appropriated \$330 million for the HOPWA program in fiscal year 2014. In addition, the Ryan White HIV/AIDS program, administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS), may use a small portion of funds to support short-term housing for persons with HIV. For fiscal year 2014, Congress appropriated \$2.3 billion for the Ryan White HIV/AIDS program.

House Report 113-136, which accompanied H.R. 2610, Departments of Transportation, and Housing and Urban Development, and Related Agencies Appropriations Bill, 2014, directed GAO to review the ability of federal programs, including HOPWA, to meet the housing needs of persons with HIV. This report discusses our final results on (1) the need for housing assistance for persons with HIV and the extent to which federal assistance reaches communities in need; (2) the results that have been achieved through federal programs that provide housing assistance for persons with HIV and what is known about the strengths and weaknesses of these programs; (3) the extent to which federal programs that provide housing assistance and supportive services for persons with

¹Throughout this report, “persons with HIV” includes both persons with HIV and persons with AIDS. As of January 2015, December 2011 was the most recent date for which data were available on persons estimated to be HIV positive.

HIV coordinate with one another; and (4) the extent of federal oversight of programs that provide housing assistance to persons with HIV.

To evaluate the need for housing assistance for persons with HIV, we reviewed HUD's housing needs estimates for 2010 (the earliest year for which reliable data were available) through 2013 and interviewed HUD officials about the methodology for developing them. We determined that the HUD data were not reliable for purposes of estimating the number of HOPWA-eligible individuals with an unmet housing need. We also analyzed CDC data on geographic and demographic trends for persons with HIV from 2008 through 2012. Prior to analyzing the CDC data, we interviewed CDC officials and reviewed documentation related to the data and determined that they were sufficiently reliable for this purpose. To identify federal programs that provide housing assistance specifically for persons with HIV, we reviewed relevant agency reports and interviewed HUD and HRSA officials as well as HIV advocacy organizations. For HRSA's Ryan White HIV/AIDS program, we focused on Part A, the component of the program that provides most of the housing assistance.² To assess the extent to which HOPWA and Ryan White Part A grants reach communities in need, we reviewed the funding formulas for each program and interviewed HUD and HRSA officials. We compared HUD's methodology for calculating unmet housing need to internal control standards for the federal government, as well as GAO guidance on preparing reliable data.³ We also visited a purposive, or non-generalizable, sample of four cities that met the following criteria: (1) included HOPWA formula grantees and Ryan White Part A grantees that funded short-term housing assistance; (2) were geographically diverse; and (3) had received grant amounts at either the higher end or middle of the range of all grants awarded through HOPWA and Ryan White in fiscal year 2011 (the most recent year that data were available at the time of this analysis). The selected cities were New York City, New York; New Orleans, Louisiana; San Francisco, California; and St. Louis, Missouri. In

²The Ryan White HIV/AIDS program consists of several programs, called Parts. The majority of Ryan White HIV/AIDS program funding for housing assistance has been expended through Part A. Throughout this report, when we refer to the "Ryan White HIV/AIDS program," we are referring to the entire program, inclusive of all Parts. We refer specifically to Part A as "Ryan White Part A."

³GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999) and *Assessing the Reliability of Computer-Processed Data*, [GAO-09-680G](#) (Washington, D.C.: July 2009).

each city, we interviewed HOPWA and Ryan White Part A grantees; at least one HOPWA project sponsor and at least one Ryan White Part A subgrantee; the local HUD field office; the local Continuum of Care grantee; and at least one HIV advocacy organization.⁴

To determine the results that have been achieved through federal programs that provide housing assistance to persons with HIV, we obtained and analyzed HOPWA data on how funds were used and client characteristics for program years 2009 through 2012.⁵ We determined that HUD's data on the way funds were used and client characteristics were sufficiently reliable for our purposes, based on interviews with HUD officials and HUD contractors responsible for processing and testing the data. For the Ryan White Part A program, we obtained and reviewed Ryan White Services Report data for fiscal years 2010 through 2012. We assessed these data by interviewing agency officials and conducting electronic testing and found them to be reliable for purposes of reporting trends in expenditures and client characteristics. We determined that HRSA's data on housing-related outcomes might not be reliable, as discussed further in this report. To describe the strengths of the HOPWA and Ryan White Part A programs, as well as any weaknesses associated with these programs, we reviewed program requirements and studies, interviewed a purposive sample of program grantees, HOPWA project sponsors and Ryan White Part A subgrantees, and interviewed HIV advocates.

To assess the extent to which the HOPWA and Ryan White Part A programs coordinated with one another at the federal level, we identified requirements in the governing legislation for the HOPWA and Ryan White HIV/AIDS programs. We also identified the efforts of HUD and HRSA officials to coordinate the HOPWA and Ryan White Part A programs through interviews with HUD and HRSA staff and documentation reviews.

⁴The Continuum of Care program is a HUD program that funds local "Continuums of Care," community-based homeless assistance program planning networks that are composed of, among other groups, nonprofit homeless providers, faith-based organizations, and state and local governments within the geographic area they operate. Among other things, the Continuums of Care program is designed to provide funding for efforts by nonprofit providers, state and local governments to quickly rehouse homeless individuals and families and connect them with mainstream programs.

⁵Program year refers to the grantees' fiscal year, which may vary from the federal fiscal year.

We compared these efforts to key practices related to coordination and to GAO criteria on program fragmentation, overlap, and duplication.⁶ To describe how the HOPWA and Ryan White Part A programs coordinate with other programs that can fund housing and supportive services for persons with HIV, we identified a selection of six federal programs that could provide housing assistance to persons with HIV and compared program goals, eligibility requirements, and the services provided. To find out whether and how the HOPWA and Ryan White Part A programs coordinate with these programs, we interviewed HUD and HRSA officials, HOPWA and Ryan White Part A grantees, HOPWA project sponsors, Ryan White Part A subgrantees, and local Continuum of Care grantees from our purposive sample of four cities.

To assess HUD's and HRSA's monitoring and oversight efforts, we identified and reviewed the relevant monitoring policies, procedures, and guidance. For the Ryan White Part A program, we focused on HRSA's monitoring and oversight of Part A grantees' housing-related activities. We also interviewed HUD headquarters and field office officials who have responsibilities related to HOPWA grantee monitoring, as well as HRSA staff who have primary responsibility for monitoring Ryan White Part A grantees. We compared HUD's risk assessment policies for program years 2008 through 2013 to documentation of implementing these procedures for the four HOPWA grantees we visited, including documentation of risk assessments and site visits. For the Ryan White Part A program, we reviewed the status of five previously issued GAO recommendations related to program monitoring and oversight and analyzed updated HRSA data on site visits conducted in 2012 and 2013.⁷ We compared HUD's and HRSA's monitoring efforts to federal internal control standards.⁸ We also interviewed both HUD and HRSA officials on

⁶GAO, *Managing for Results: Implementation Approaches Used to Enhance Collaboration in Interagency Groups*, [GAO-14-220](#) (Washington, D.C.: Feb. 14, 2014) and *2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, [GAO 14-343SP](#) (Washington, D.C.: Apr. 8, 2014). To identify criteria related to collaboration, we selected four interagency groups that met our key practices for enhancing and sustaining collaboration and identified successful approaches. To identify potential fragmentation, overlap, and duplication, we considered the extent of potential cost savings, opportunities for enhanced program efficiency or effectiveness, and the level of coordination among agency programs, among other factors.

⁷GAO, *Ryan White Care Act: Improvements Needed in Oversight of Grantees*, [GAO-12-610](#) (Washington, D.C.: June 11, 2012).

⁸[GAO/AIMD-00-21.3.1](#).

their use of program data to monitor HOPWA and Ryan White Part A grantees. Appendix I provides further details of our scope and methodology.

We conducted this performance audit from March 2014 through April 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

Background

First identified in 1981, HIV impairs the immune system and leaves affected individuals susceptible to certain cancers and infections. HIV, the virus that causes AIDS, affects specific cells of the immune system. Over time, HIV can destroy so many of these cells that the body cannot fight off infections and disease, leading to AIDS. A person who has the HIV virus can move in and out of AIDS status, which is the third stage of the disease. Despite the number of deaths from AIDS and the steady increase of HIV prevalence, there have been successes in the fight against the disease. Developments in treatment have enhanced care options and can extend the lives of those with HIV. The introduction of highly active antiretroviral therapy in 1996 was followed by a decline in the number of deaths and new AIDS cases in the United States for the first time since the beginning of the disease. Since 1981, over 1.2 million persons diagnosed with AIDS have been reported to the CDC and over 600,000 of them have died. The CDC estimates that of the more than 1.2 million persons living with HIV in December 2011, some 14 percent had not been diagnosed and might not be unaware of their status.

In 2010, the White House's Office of National AIDS Policy issued a national strategy for addressing HIV and AIDS in the United States.⁹ The strategy has three primary goals: (1) reduce the number of persons who become infected with HIV, (2) increase access to care and improve health outcomes for persons living with HIV, and (3) reduce HIV-related health disparities. To accomplish these goals, the strategy calls for a coordinated national response to the disease.

⁹The White House, *National HIV/AIDS Strategy for the United States* (Washington, D.C.: July 2010).

HOPWA Program

Congress created the HOPWA program in 1990 under the National Affordable Housing Act, authorizing grants for housing activities and supportive services designed to prevent homelessness among persons with HIV. Specifically, HOPWA grants are used to provide a wide range of housing-related services, including rental assistance; operating costs for housing facilities; short-term rent, mortgage, and utility payments; permanent housing placement and housing information services; resource identification (to establish, coordinate and develop housing assistance); acquisition, rehabilitation, conversion, lease, and repair of facilities; new construction (for single-room occupancy dwellings and community residences only); and supportive services (case management and mental health, alcohol and drug abuse, and nutritional services). To be eligible for HOPWA, individuals must be HIV positive and low income (below 80 percent of area median income). HOPWA assists persons who are without stable housing arrangements, including those at severe risk of homelessness (e.g., persons in emergency shelters; persons living in a place not meant for human habitation, such as a vehicle or abandoned building; or persons living on the streets).

HUD awards 90 percent of the annual HOPWA appropriation by formula to eligible metropolitan statistical areas (MSA) and states.¹⁰ On the basis of the statute, MSAs with populations greater than 500,000 and more than 1,500 cumulative cases of AIDS are eligible for HOPWA formula grants. The most populous city in an eligible MSA serves as that area's HOPWA grantee. In addition, states with more than 1,500 cumulative cases of AIDS in areas outside of eligible MSAs qualify for formula funds.¹¹ The other 10 percent of HOPWA's annual appropriation is set aside for grants awarded on a competitive basis.

Ryan White HIV/AIDS Program

Congress enacted the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) to improve the availability and quality of community-based health care and support services for individuals with

¹⁰MSAs are geographic entities delineated by the Office of Management and Budget for use by federal statistical agencies in collecting, tabulating, and publishing federal statistics.

¹¹Cumulative AIDS case counts reflect all reported cases since the first reported AIDS case in 1981, including persons who are deceased.

HIV and their families.¹² The CARE Act was most recently reauthorized through the Ryan White HIV/AIDS Treatment Extension Act of 2009. HRSA administers the Ryan White HIV/AIDS program.¹³ The Ryan White program must be the payer of last resort, meaning that other sources of funds for services, including housing services, must be exhausted before using Ryan White HIV/AIDS program funds.

Ryan White Part A provides formula funds to Eligible Metropolitan Areas and Transitional Grant Areas. To qualify for Eligible Metropolitan Area status, an area must have reported at least a cumulative total of 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000. To be eligible for Transitional Grant Area status, an area must have a cumulative total of 1,000, but fewer than 2,000 cases of AIDS in the most recent 5 years and have a population of at least 50,000.¹⁴ In the absence of a waiver, Ryan White Part A grantees are required to spend at least 75 percent of their grant on core medical services and no more than 25 percent on supportive services, which include housing

¹²Pub. L. No. 101-381, 104 Stat. 576 (codified, as amended, at 42 U.S.C. §§ 300ff through 300ff-121). The 1990 CARE Act added title XXVI to the Public Health Service Act. Unless otherwise indicated, references to the CARE Act refer to current title XXVI. The CARE Act programs have been reauthorized by the Ryan White CARE Act Amendments of 1996 (Pub. L. No. 104-146, 110 Stat. 1346), the Ryan White CARE Act Amendments of 2000 (Pub.L. No. 106-345, 114 Stat. 1319), the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Pub. L. No. 109-415, 120 Stat. 2767), and the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. No. 111-87, 123 Stat. 2885).

¹³Most housing expenditures through the Ryan White HIV/AIDS program have been made through Part A, but the program has several other parts. Part B provides grants to states and territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Part C provides grants to service providers to fund comprehensive primary health care in an outpatient setting for persons with HIV. Part D provides grants to service providers to fund family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS. Part F supports research, technical assistance, and access-to-care programs for oral health programs, special programs of national significance, and AIDS Education and Training Centers. HRSA's Minority AIDS Initiative provides funding to improve access to HIV/AIDS care and health outcomes for disproportionately affected minority populations.

¹⁴Eligible Metropolitan Area and Transitional Grant Area boundaries are based on the U.S. Census designation of MSAs.

assistance.¹⁵ Ryan White HIV/AIDS program-funded housing assistance provides short-term aid to support emergency, temporary, or transitional housing so that an individual or family can gain or maintain health care.¹⁶ HRSA guidance encourages but does not require grantees to limit housing assistance to 24 months. Additionally, housing assistance must be accompanied by a strategy to transition the individual or family to stable, permanent housing.

Ryan White Part A grantees are required by the Ryan White HIV/AIDS Treatment Extension Act of 2009 to establish a Ryan White Part A Planning Council, which is appointed by the chief elected official of the city or county. The council is responsible for setting HIV-related service priorities and allocating grant funds based on the needs of persons with HIV. Planning councils are required to develop a comprehensive plan with the Ryan White Part A grantee for the provision of services. The Ryan White HIV/AIDS Treatment Extension Act of 2009 identifies 13 different parties that must be involved in the council, including representatives from community-based organizations serving affected populations, persons with HIV, and grantees providing services in the area under other federal HIV programs.

Local Government Role in the HOPWA and Ryan White HIV/AIDS Programs

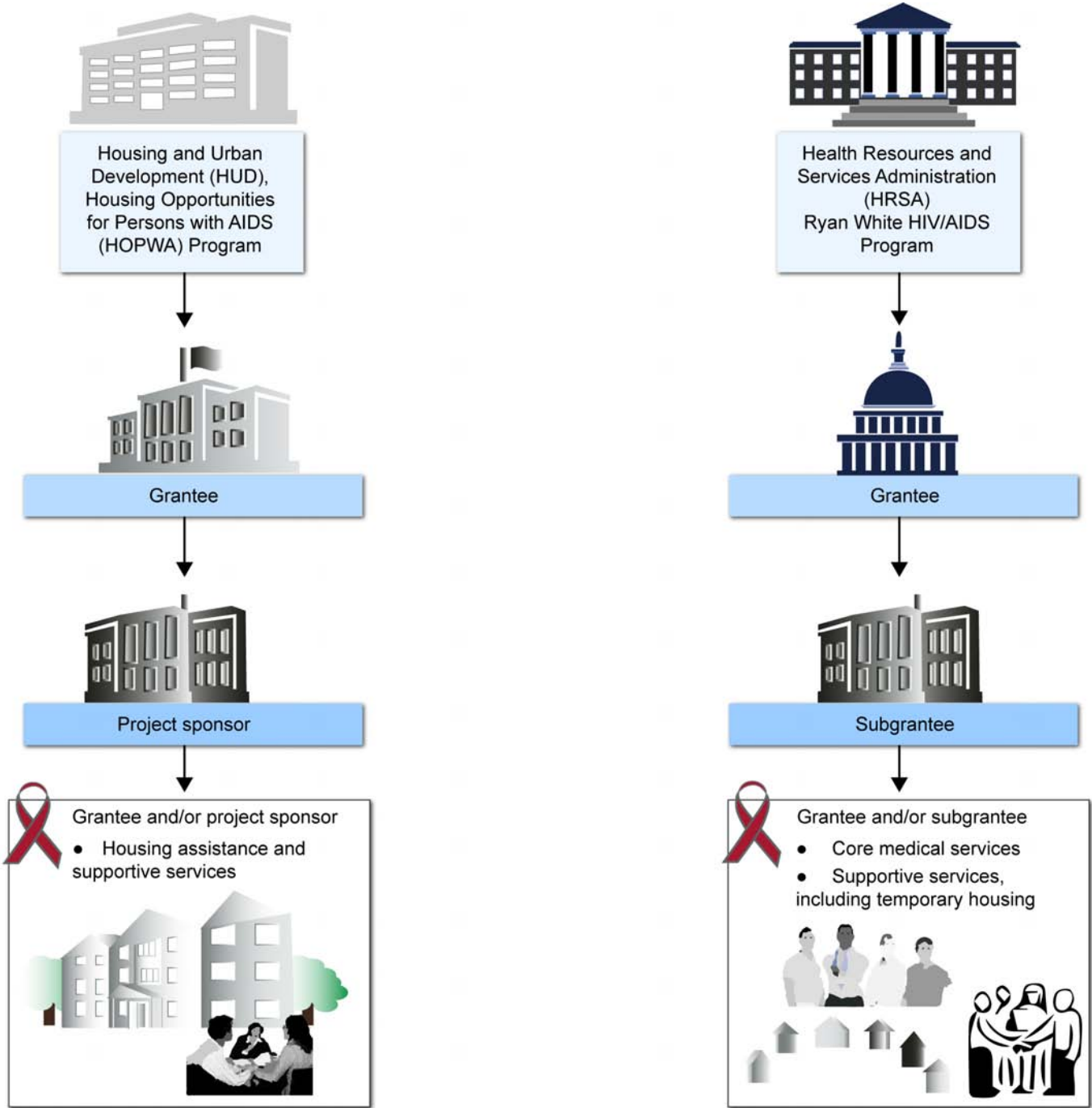
Both HOPWA and Ryan White Part A funds are awarded to government agencies, which are referred to as “grantees” (see fig. 1). For the HOPWA program, the formula grantee is generally either the city office dedicated to housing and community development or the city health department. HOPWA grantees may carry out eligible program activities themselves, through any of their administrative agencies, or through a project sponsor. A project sponsor can be any nonprofit organization or governmental housing agency that receives funds from a grantee to carry out eligible

¹⁵The expenditure requirements do not include grantee administrative and clinical quality management requirements. Core medical services include outpatient and ambulatory health care, oral health care, home health care, hospice care, mental health services, medical case management, substance abuse services, health insurance premium and cost-sharing assistance, and prescription medications, among other things. Whereas HOPWA considers supportive services and housing assistance to be separate categories, the Ryan White HIV/AIDS program considers housing assistance to fall within supportive services necessary to promote effective medical care.

¹⁶HRSA guidance states that short-term or emergency housing is understood as transitional in nature. Such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, or ensure that the individual or family is moved to, or capable of maintaining, a long-term, stable living situation.

HOPWA activities. The grantees and project sponsors may also contract with for-profit entities to provide services associated with their HOPWA activities.

Figure 1: Flow of HOPWA and Ryan White HIV/AIDS Program Grant Funds and Assistance



Source: GAO analysis. | GAO-15-298

For the Ryan White Part A program, grants are awarded to the chief elected official of the city or county that provides health-care services. The chief elected official is legally the grantee but usually chooses a department or other entity to manage the grant, and that entity is then referred to as the grantee. Ryan White Part A grantees are generally county or city health departments or public departments with responsibility for health. Part A grants consist of formula and supplemental components. Formula grants are based on reported living cases of HIV and AIDS in eligible areas. Supplemental grants are awarded competitively and are based on the ability of Eligible Metropolitan or Transitional Grant Areas to document both a demonstrated need for additional funds and the capacity to use them to meet community needs. Ryan White Part A grantees can deliver services to persons with HIV (clients) directly or through a subgrantee. Subgrantees are generally community-based, nonprofit organizations. In some cases, a city's formula HOPWA grantee and Ryan White Part A grantee are the same entity. Also, in some cases local community-based organizations receive both HOPWA and Ryan White Part A funding.

Estimates of Housing Need for Persons with HIV Are Not Reliable, and the HOPWA Formula Does Not Effectively Target Funds

As the number of persons with HIV in the United States continues to increase, research finds that stable housing is critical for effective medical care and is associated with improved health outcomes for persons with HIV. The extent to which persons with HIV need housing assistance is not known, in part because HUD's estimates of the housing needs of persons living with HIV are not reliable. In addition, the statutory HOPWA funding formula may not be effectively distributing grant funds to communities with the greatest need because the formula counts persons who are deceased. As a result, HOPWA funds may not be targeted as effectively as they could be.

With the Number of HIV Cases Increasing, Stable Housing Is Critical

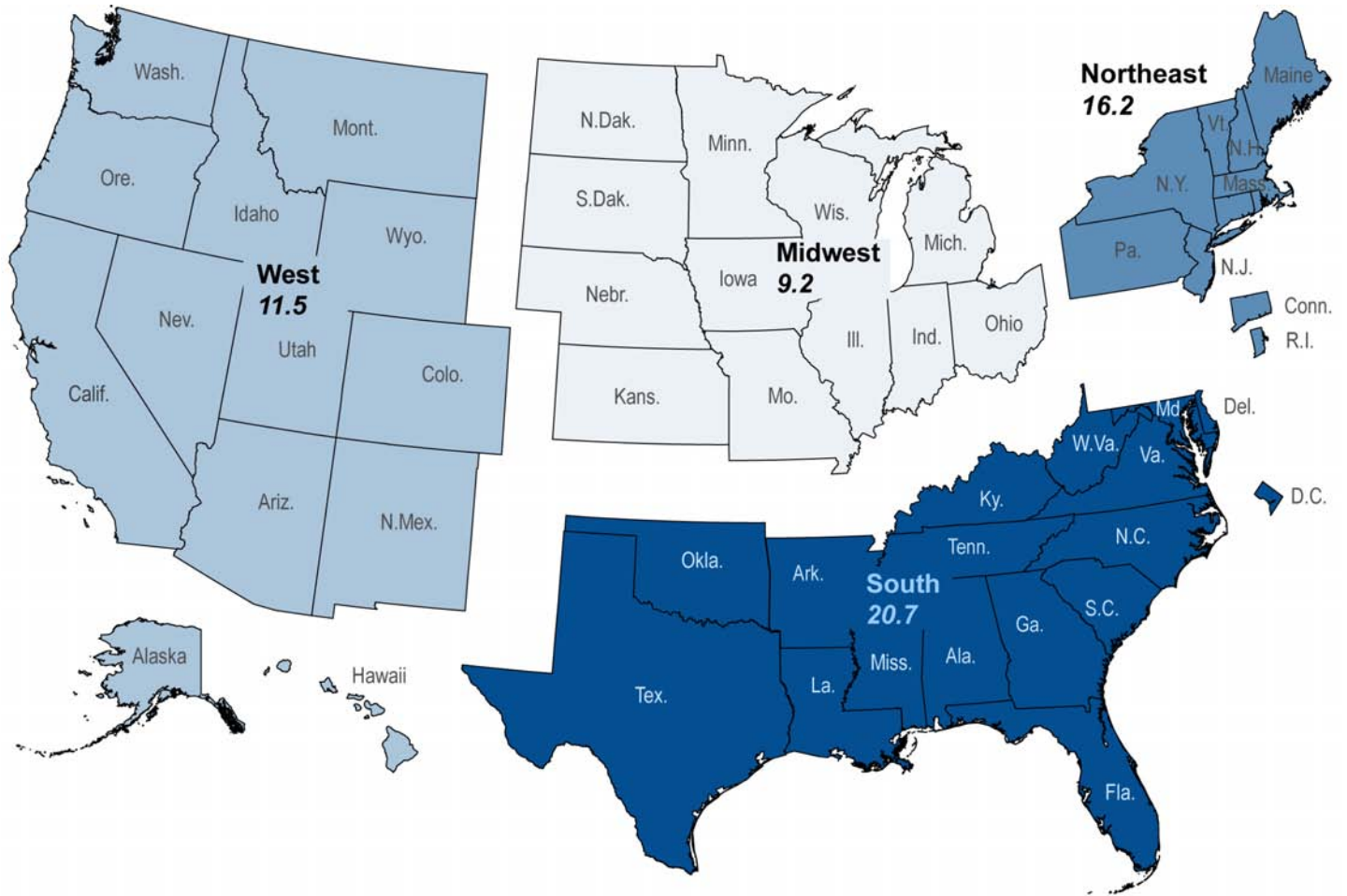
According to CDC estimates, there were about 50,000 HIV diagnoses each year from 2008 to 2012.¹⁷ In 2012, the estimated rate of diagnosed HIV infections in the United States was 15.3 per 100,000 population. Rates of diagnosis of HIV infection have varied by region from 2008 to 2012. For example, the rate of diagnosis of HIV infection increased from

¹⁷CDC, *HIV Surveillance Report, 2012*, vol. 24, November 2014. The most recent CDC data available at the time of our review were for calendar years 2008 to 2012.

2008 through 2012 in the Midwest, and decreased during this period in the Northeast, South, and West. In 2012, the rates of diagnosed HIV infection were highest in the South, followed by the Northeast, West, and Midwest, as shown in figure 2.¹⁸

¹⁸CDC, *HIV Surveillance Report*, 2012, p. 7.

Figure 2: Rates of Diagnosed HIV Infection by Region, 2012



Rates are per 100,000 population

Rates of newly diagnosed HIV infections

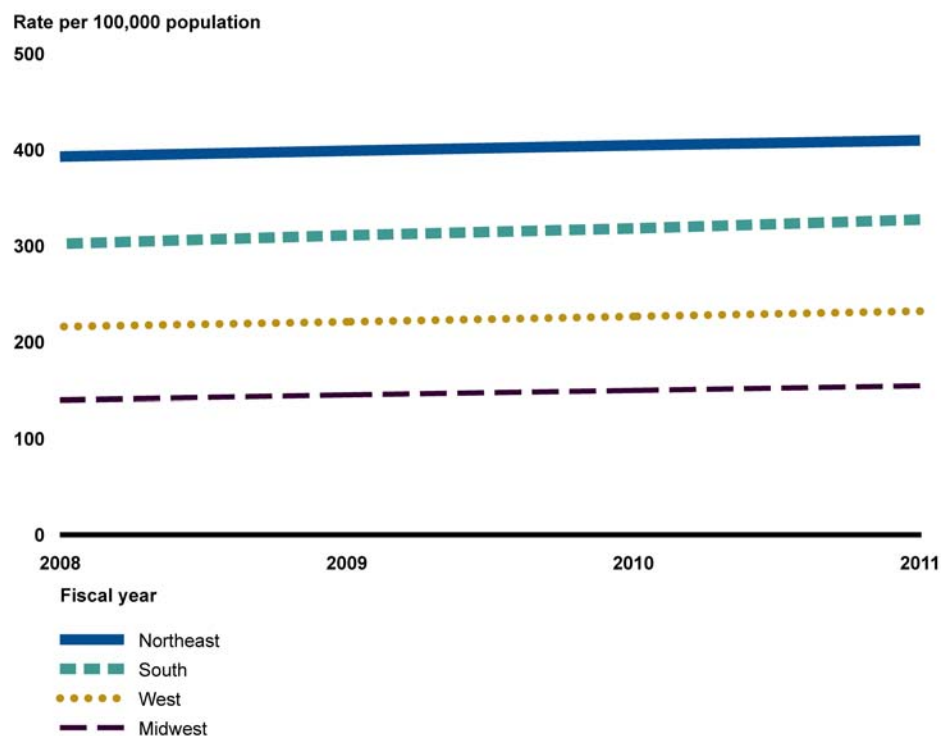


Sources: CDC Surveillance data, 2012; Map Resources (map). | GAO-15-298

According to CDC data, from 2008 through 2011, the estimated number of persons in the United States living with a diagnosed HIV infection, or the prevalence of diagnosed HIV infection, increased. The prevalence

rate, or the number of persons living with diagnosed HIV infection per 100,000 population, was estimated to be nearly 283 at the end of 2011.¹⁹ Prevalence rates vary by region, and regional differences have remained relatively stable from 2008 through 2011. As shown in figure 3, prevalence rates of diagnosed HIV infection are highest in the Northeast, followed by the South, West, and Midwest.

Figure 3: Prevalence Rates of Diagnosed HIV Infection by Region, 2008–2011



Source: CDC HIV Surveillance data, 2012. | GAO-15-298

The estimated rates of HIV diagnoses have varied over time across different demographic groups. For example, from 2008 through 2012 the rates of diagnosed HIV infection increased among persons aged 13 to 14 and 20 to 29 and either remained stable or decreased among other age groups. Rates of diagnoses during this period also increased for

¹⁹At the time of our review, 2011 was the most recent year for which prevalence data were available.

American Indian/Alaska natives and Asians, while decreasing for African-Americans, Hispanics/Latinos, and persons of multiple races. In 2012, the estimated rate of HIV diagnoses for African-Americans was 58 per 100,000 population—the highest rate compared to other racial and ethnic groups.²⁰ From 2008 through 2012, rates of HIV diagnoses decreased among females and remained stable for males. In 2012, males accounted for 80 percent of all diagnoses newly reported among adults and adolescents.

Stable housing is critical for persons with HIV. Staff from several HIV/AIDS advocacy groups told us that stable housing was important because many persons with HIV were required to adhere to strict regimens for taking medicine. Some medicines require refrigeration, and some cause debilitating side effects. Health care officials from CDC told us that without stable housing, persons may not reach viral suppression or remain connected to medical care.²¹ In addition, the National HIV/AIDS Strategy states that access to housing is an important precursor to getting many people into a stable treatment regimen. Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care, are less likely to receive optimal antiretroviral therapy, and are less likely to adhere to therapy. A 2007 study emphasized the relationship between housing assistance provided to persons living with HIV and increased access to medical care and appropriate treatment. The need for housing is prevalent among persons living with HIV, and there is strong evidence that receipt of housing assistance has a direct impact on improved medical care outcomes.²² Research has also indicated that persons with HIV who live in stable

²⁰In 2012, the rates per 100,000 population were 19 for Hispanics/Latinos, 17 for persons of multiple races, 15 for Native Hawaiians/other Pacific Islanders, 10 for American Indians/Alaska Natives, 7 for white persons, and 6 for Asians.

²¹Viral suppression means having very low levels of HIV in the body. Achieving viral suppression greatly reduces the chance of transmitting the virus.

²²Angela A. Aidala, Gunjeong Lee, David M. Abramson, Peter Messeri, and Anne Siegler. "Housing Need, Housing Assistance, and Connection to HIV Medical Care," *AIDS Behavior* 11 (June 2007).

housing have better health outcomes than those who are homeless or unstably housed.²³

However, while stable housing is critical for effective medical care, persons with HIV often have difficulty maintaining stable housing because of the financial vulnerability that can be associated with the disease. As individuals become ill, they may find themselves unable to work, while at the same time facing health care expenses that leave few resources to pay for housing. According to a recent study, housing challenges for a person living with HIV may include the growing disparity between income and the cost of rental housing, loss of income due to inability to maintain employment, and loss of spouse or partner due to HIV-related death, among other things.²⁴ As result, there is a greater likelihood of homelessness among persons with HIV. In addition, those who are homeless may be more likely to engage in activities through which they could transmit HIV.

We identified HOPWA and the Ryan White HIV/AIDS program as the only two federal programs that target housing assistance to persons with HIV. According to a recent study related to housing assistance and HIV, about 1 in 10 persons with HIV were receiving housing assistance from HOPWA or the Ryan White HIV/AIDS program in 2010.²⁵ According to studies we reviewed, there continues to be a need for housing assistance for persons with HIV, despite advances in drug therapies.²⁶ Several staff

²³Daniel P. Kidder, Richard J. Wolitski, Michael L. Campsmith, and Glenn V. Nakamura, "Health Status, Health Care Use, Medication Use, and Medication Adherence Among Homeless and Housed People Living with HIV/AIDS," *American Journal of Public Health* 97 (December 2007).

²⁴Aidala and others, "Housing Need."

²⁵Mathematica Policy Research (Margaret Hargreaves and Vanessa Oddo) and The Cloudburst Group (Lindsey Stillman, Jonathan Sherwood, and Steven Sullivan), prepared for the Dept. of Health and Human Services, *Analysis of Integrated HIV Housing and Care Services*, Mathematica Policy Research, Ref. no. 40148.400 (Cambridge, Mass.: February 2014).

²⁶David Buchanan, Romini Kee, Laura S. Sadowski, and Diana Garcia, "The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial", *American Journal of Public Health* 99, No. S3 (2009); Richard J. Wolitski, Daniel P. Kidder, Sherri L. Pals, Scott Royal, Angela Aidala, Ron Stall, David R. Holtgrave, David Harre, and Cari Courtenay-Quirk, prepared for the Dept. of Health and Human Services and the Centers for Disease Control and Prevention, "Randomized Trial of the Effects of Housing Assistance on the Health and Risk Behaviors of Homeless and Unstably Housed People Living with HIV," *AIDS Behavior* (December 2009).

members from HOPWA and Ryan White Part A grantees we interviewed told us that there was an increasing need for housing assistance for persons with HIV. Some staff told us that infected persons were living longer as a result of advances in medical care. Moreover, staff from several grantees told us that these persons generally needed both medical and nonmedical supportive services. Additionally, HUD officials noted that as local housing costs increased, the need for programs that provided affordable housing increased for all low-income people, including those with HIV.

HUD Does Not Reliably Estimate the Extent of Housing Needs among Persons with HIV

HUD's estimate of the number of persons with HIV who have a housing need is not reliable. HUD requires each formula and competitive HOPWA grantee to report annually the number of HOPWA-eligible persons who have an unmet housing need within the grantee's jurisdiction. HUD then develops an estimate of the number of persons nationwide with HIV who have an unmet housing need by totaling the numbers reported by each grantee. For 2013, HUD reported that approximately 131,000 HIV-positive persons had unmet housing needs. HUD uses this information to justify its HOPWA budget requests and to report on the program's performance. HIV advocacy groups use HUD's estimates in their publications and outreach efforts to Congress.

We found that HOPWA grantees used different methodologies to report unmet housing needs, limiting the reliability of the reported information. Grantees we met with used varying methods to produce the local unmet need estimates that they reported to HUD annually. For example, officials from one HOPWA grantee told us that they summed the unmet housing need data provided by their project sponsors. In contrast, officials from another HOPWA grantee use various data sources to produce both a low and high estimate of unmet housing need and have historically reported both numbers to HUD. In its 2010 and 2011 Consolidated Annual Performance and Evaluation Reports (CAPER) Reports, this grantee reported to HUD that the unmet need in its community could range from a low of approximately 7,500 persons to a high of 15,000.

HUD officials told us that, at the time of our review, they did not require HOPWA grantees to use a consistent methodology to calculate unmet housing need for each jurisdiction. They told us that this policy was intended to allow for local flexibility, so that the data were collected using the most appropriate method for each jurisdiction. According to HUD's CAPER guidance, grantees can use one or more of seven data sources to calculate unmet need, including data from prisons or jails on persons

being discharged with HIV and housing providers' waiting lists.²⁷ Grantees are required to indicate on their CAPERs all of the data sources they use to estimate unmet need. However, HUD does not provide additional guidance on how grantees should use the data sources in a comparable manner. In June 2014 HUD granted a HOPWA technical assistance contractor a 1-year contract extension to help the agency address its unmet needs methodology, to include soliciting community feedback at the U.S. Conference on HIV/AIDS. HUD convened stakeholders and HOPWA grantees at this conference to discuss how unmet needs were estimated, and participants discussed establishing a working group to develop a consistent methodology. According to HUD, as of February 2015, the agency was working with its technical assistance contractor to develop a methodology and provide communities CDC data related to persons with HIV. However, according to HUD, the agency does not have specific goals or time frames for finalizing a standard methodology.

GAO's work on assessing data reliability indicates that data should be consistent—that is, data should be clear and well defined enough to yield similar results in similar analyses. Further, when data are entered at multiple sites or reported using multiple sources (as in the case of HOPWA program), there is a risk that data entry rules may be interpreted inconsistently, resulting in data that, taken as a whole, are unreliable.²⁸ In addition, federal internal control standards state that program managers need operational data to determine whether they are meeting their goals for effective and efficient use of resources.²⁹ In our 1997 report on HOPWA and the Ryan White HIV/AIDS program, we concluded that equitable distribution of resources should be consistent with the current need for such resources.³⁰ Because HUD does not require grantees to use selected data sources in a consistent manner, the resulting

²⁷ HUD's guidance suggests grantees use data from housing planning coordination efforts such as the Continuum of Care program, client information within Homeless Management Information Systems, data from project sponsors including waiting lists, data from local prisons on those being released, data from Ryan White Planning Councils, and data from HIV/AIDS surveillance reports, such as those from CDC.

²⁸ [GAO-09-680G](#).

²⁹ [GAO/AIMD-00-21.3.1](#).

³⁰ GAO, *Housing: HUD's Program for Persons With AIDS*, [GAO/RCED-97-62](#) (Washington, D.C.: Mar. 24, 1997).

information is not comparable. Further, the usefulness and reliability of these data as an indicator of the unmet housing needs of persons with HIV are unclear. Although data on unmet housing needs are not used to determine HOPWA formula funding amounts, such information would be helpful in determining the extent of the need for HOPWA funds in specific areas, as well as the extent to which HOPWA is meeting its goals of addressing the housing needs of persons with HIV.

The HOPWA Formula Does Not Target Funds Based on Persons Living with HIV

As previously discussed, 90 percent of HOPWA funds are awarded through formula grants to eligible states and MSAs.³¹ Seventy-five percent of these formula-based funds are awarded to cities and states that meet certain threshold criteria.³² These criteria are based on each jurisdiction's share of the number of cumulative AIDS cases in all eligible jurisdictions. Cumulative AIDS case counts include both living and deceased AIDS cases reported in the grantees' jurisdiction since the beginning of the AIDS epidemic in 1981.

Use of cumulative AIDS cases rather than living HIV cases has led to MSAs with similar numbers of persons living with HIV receiving markedly different amounts of HOPWA funding. For example, in fiscal year 2012 a grantee in the South and a grantee in the Northeast both had about 2,300 persons living with HIV, according to CDC data. However, the grantee in the Northeast received about \$154,000 more in HOPWA formula funding than the grantee in the South because it had approximately 776 more reported cumulative AIDS cases.³³ Similarly, in the same fiscal year, both a HOPWA formula grantee in the West and one in the South had about 3,500 persons living with HIV. However, the grantee in the West received nearly \$319,000 more in formula funding than the grantee in the South because it had about 1,600 more reported cumulative AIDS cases.

³¹The remaining 10 percent is awarded through competitive grants to (1) jurisdictions that are not eligible for formula funding and (2) states, local government, or nonprofit entities that propose "special projects of national significance."

³²The remaining 25 percent is allocated to cities that meet the threshold criteria in amounts that are based on the rate of new AIDS cases (not the number of cumulative AIDS cases).

³³For the MSAs that received HOPWA funds in 2012, the median grant amount was \$900,656.

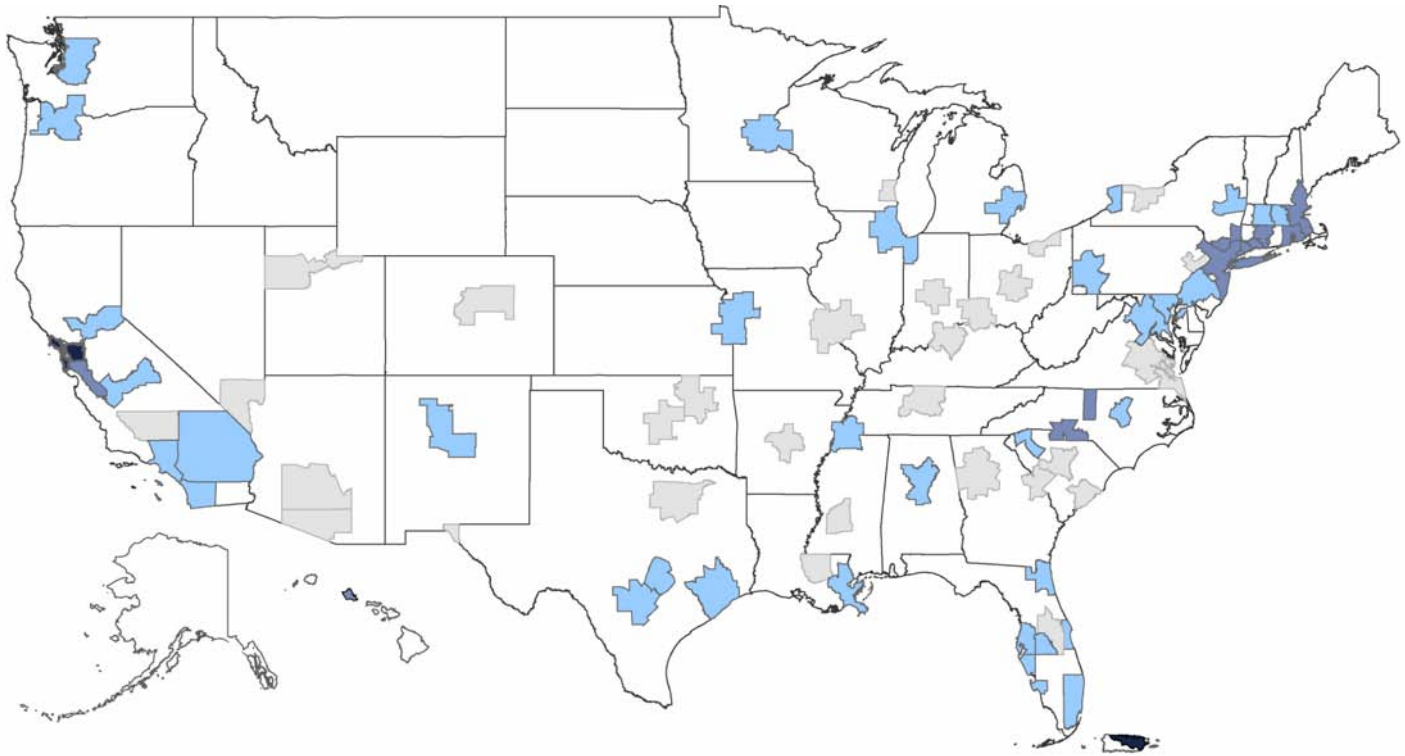
The difference between cumulative AIDS cases and living HIV cases is more pronounced in some MSAs than others. As shown in figure 4, the relative difference ranged from less than 15 percent to more than 43 percent in the MSAs that received HOPWA formula funds in 2012.³⁴ In most of these MSAs (62 of 78), the number of cumulative AIDS cases was greater than the number of persons living with HIV. For example, the New York City MSA had 35 percent more cumulative AIDS cases than cases of persons living with HIV.³⁵ In contrast, about one-fifth of the MSAs that received HOPWA funds in fiscal year 2012 had more persons living with HIV than cumulative AIDS cases. For example, the Charlotte, North Carolina MSA had 43 percent more cases of persons living with HIV than cumulative AIDS cases.³⁶ According to CDC officials, there can be more living HIV cases than cumulative AIDS cases because not all persons with HIV progress to the third stage of the disease (AIDS). Appendix II provides additional information on the numbers of cumulative AIDS cases and living HIV cases for all MSAs that received HOPWA grants in fiscal year 2012.

³⁴The (absolute) relative difference is measured as a ratio of the absolute difference between the two measures to the number of cumulative AIDS cases, expressed as a percentage for areas that received a formula HOPWA grant in 2012. We use absolute value because some MSAs have a higher number of cumulative AIDS cases than living HIV cases, while for other MSAs the reverse is true. This value is a measure of closeness between the cumulative number of AIDS cases and the number of persons living with HIV, and is always greater than or equal to zero. The lower the value, the more similar the number of cumulative AIDS cases is to the number of persons living with HIV in a given MSA. In 58 of the 78 MSAs that received formula HOPWA funding in 2012, the relative difference between cumulative AIDS cases and living HIV cases was 10 percent or higher.

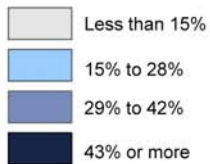
³⁵The MSA associated with New York City includes New York City, Northern New Jersey, and Long Island.

³⁶The Charlotte, North Carolina MSA includes Charlotte, North Carolina; Gastonia, North Carolina, and Concord, South Carolina.

Figure 4: Relative Differences in Cumulative AIDS Cases and Numbers of Persons Living with HIV, by Metropolitan Statistical Area, Fiscal Year 2012



Shading represents the relative difference between the cumulative AIDS cases and the number of persons living with HIV



Sources: GAO analysis of CDC and HUD data; MapInfo. | GAO-15-298

Notes: CDC data on cumulative AIDS cases and persons living with HIV (including AIDS) are as of March 2011 (the most recent comparable data available as of January 2015). Appendix I provides additional information about the data. The relative difference is measured as ratio of the absolute difference between the two measures to the number of cumulative AIDS cases.

We have assessed HOPWA's funding formula in previous work. In 1997, we recommended that HUD consider the legislative changes that would be needed to make the HOPWA formula more reflective of current AIDS

cases.³⁷ We also noted that the general principle of allocating grants on the basis of the estimated number of persons living with HIV, excluding those who are deceased, would ensure a more equitable allocation of the available funds. In response, HUD reviewed potential changes to the formula. It compiled an analysis to show the effects of various alternatives on grantees' funding levels, including use of 10-year weighted numbers to reflect living cases of persons with AIDS. However, at that time, HUD was reluctant to recommend any change that might disrupt funding for those who depended on HOPWA support.

In 2006, we recommended that if Congress wanted HOPWA funding to more closely reflect the distribution of persons living with AIDS, it should consider changing the program so that HOPWA formula grant eligibility would be based on a measure of living AIDS cases.³⁸ Congress changed the funding formula for the Ryan White HIV/AIDS programs in 2006 but did not make the same change for HOPWA. Since our 2006 report, medical treatment for HIV/AIDS and the make-up of the national population with HIV or AIDS have continued to evolve. Additionally, CDC officials now consider HIV case counts to be more accurate and reliable than counts of AIDS cases alone because persons with HIV may live many years before progressing to AIDS and may move between stages as their health changes.

HUD officials and the four HOPWA grantees we met with stated that the HOPWA funding formula was out of date. In its last three congressional budget justifications, HUD has proposed updating the formula. According to HUD's 2015 budget justification, the HOPWA formula should be updated to better reflect the nature of the HIV epidemic that has evolved over the years through advances in HIV care and the increasingly disproportionate impact on impoverished persons with HIV. HUD has proposed basing the funding formula on living HIV rather than cumulative AIDS cases and on consideration of local housing costs and poverty rates. HUD recognized that some communities could lose funds as a result of a redistribution of grant funds. To mitigate any potential negative impacts of large funding reductions on some communities, HUD has also proposed incrementally reducing funding over time.

³⁷[GAO/RCED-97-62](#).

³⁸GAO, *HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds*, [GAO-06-332](#) (Washington, D.C.: Feb. 28, 2006).

HUD's projections based on its proposed formula change—using living HIV cases instead of cumulative AIDS cases and data on housing costs and poverty—show a redistribution of funds that results in funding increases for some communities and decreases for others. For example, based on HUD's 2015 projections of HOPWA award amounts, the New York City MSA's award would decrease by about \$5 million from HUD's 2014 estimated award amount. In contrast, smaller MSAs, such as Charlotte North, Carolina, and Cleveland, Ohio would receive increases of more than \$200,000 from HUD's 2014 estimated award amounts. Although our analysis of CDC data suggests that the proportions of living HIV cases among the cities that received HOPWA funds in 2012 are similar to the proportions of cumulative AIDS cases, these changes could result in meaningful differences in the amounts of funding that some grantees receive.

The Office of Management and Budget has also noted that the current formula for distributing HOPWA funds does not reflect the current nature of the disease. As discussed in GAO's prior work, a cumulative count of AIDS cases that includes deceased persons does not necessarily reflect the number of living HIV cases in a particular year. In contrast, data on the number of persons living with HIV exclude the deceased and include persons in all stages of HIV infection. In addition, regional changes in the number of HIV cases may not be fully accounted for in the current HOPWA formula due to the continued inclusion of deceased persons. Reauthorizations of the Ryan White HIV/AIDS program in 2000, 2006 and 2009 required the use of living cases of both HIV and AIDS in the distribution of formula grants for Ryan White Parts A and B. Because HOPWA funds continue to be awarded based on cumulative AIDS cases, HOPWA funds are not being targeted as effectively or equitably as they could be.

HOPWA and Ryan White Part A Provide Stable Housing for Persons with HIV, but Some Housing Data May Have Limitations

HOPWA grantees have used the majority of their grant funds to provide housing assistance to extremely low-income persons with HIV, primarily in the form rental assistance.³⁹ In general, the majority of individuals who receive housing assistance through HOPWA are male, African-American, and extremely low income. Overall, a small share (about 2 percent) of total Ryan White Part A expenditures is used for housing. Individuals who receive temporary housing assistance through Ryan White Part A generally have the same demographic characteristics as HOPWA housing assistance recipients. Both HOPWA and Ryan White Part A information indicate that the majority of individuals provided with housing assistance became stably housed. However, the reliability of Ryan White Part A housing data is not clear because grantees do not update information on housing status consistently. Stakeholders such as HOPWA and Ryan White Part A grantees, as well as advocacy groups, note both strengths and challenges related to these programs.

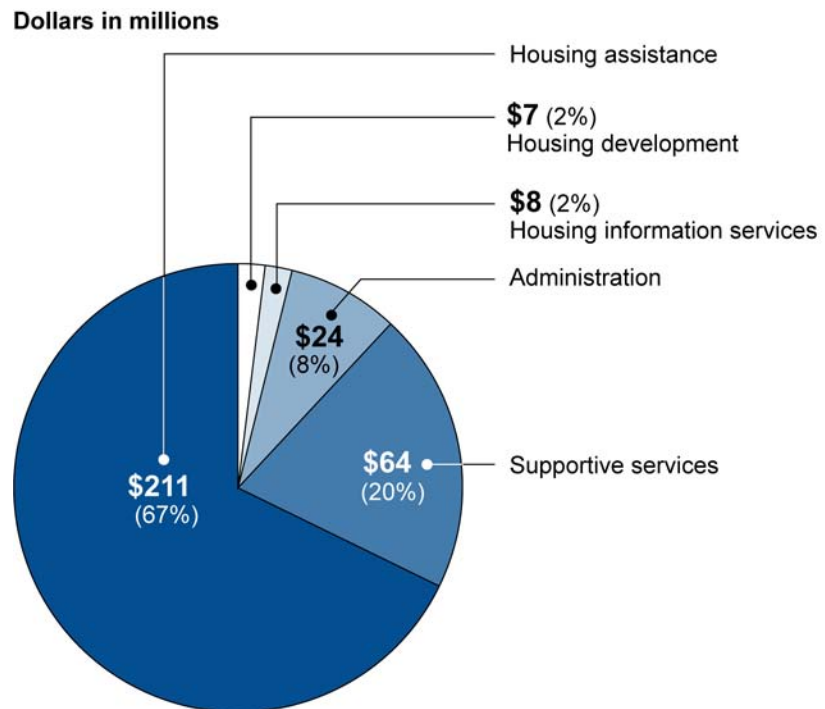
HOPWA Grantees Have Primarily Funded Housing Assistance

HOPWA grantees have primarily used their funds to provide housing assistance. As previously noted, grantees can use HOPWA funds for housing and supportive services and for administrative expenses. In 2012, the most recent program year for which data were available, HOPWA grantees spent nearly \$314 million to assist persons with HIV. Of these expenditures, about \$211 million (67 percent) was spent on housing assistance and \$64 million (20 percent) were spent on supportive services, as shown in figure 5.⁴⁰ The total number of persons with HIV receiving housing assistance decreased from around 60,000 in 2010 to about 56,000 in 2012. According to HUD officials, this decrease is likely due to improved grantee reporting as well as increases in the cost of housing—that is, as housing costs have increased, the program has been able to provide housing assistance to fewer persons.

³⁹For the HOPWA program, HUD defines extremely low income as household earnings of 0-30 percent of area median income (AMI), very low income as household earnings of 31-50 percent of AMI, and low income as 51-80 percent of AMI.

⁴⁰HOPWA grantees generally have 3 years to expend obligated funds. Thus, expenditures for 2012 likely include HOPWA grant funds awarded in 2010, 2011, and 2012.

Figure 5: HOPWA Expenditures, Program Year 2012



Source: GAO analysis of HOPWA program data for formula and competitive grantees. | GAO-15-298

Note: Percentages may not total to 100 percent due to rounding.

The funds HOPWA grantees spent on housing assistance fell into several categories.

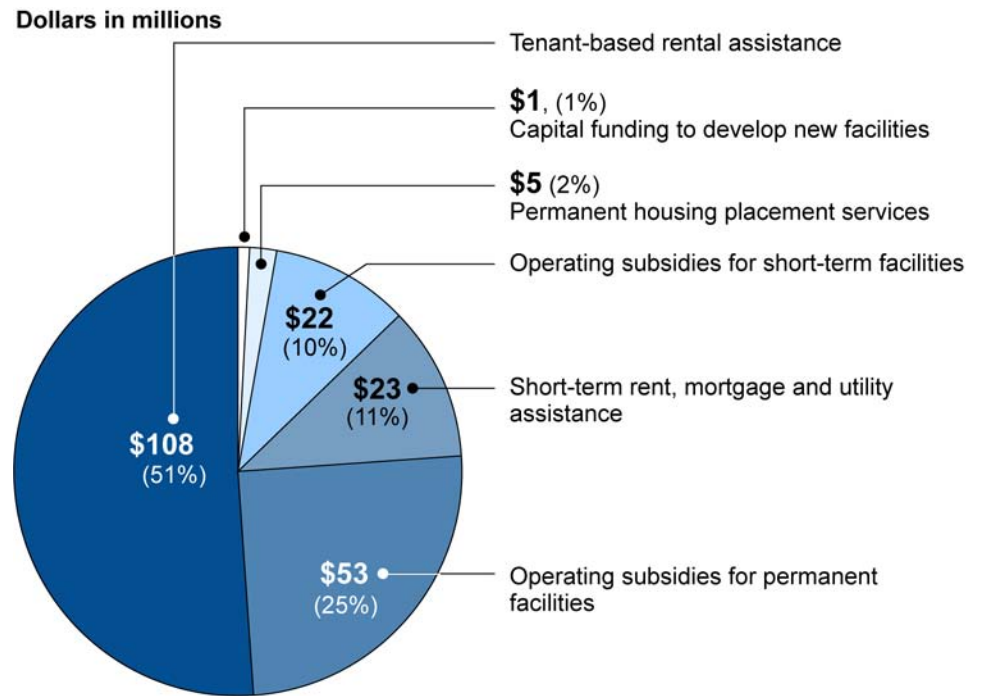
- *Tenant-based rental assistance.* As shown in figure 6, 51 percent was spent on tenant-based rental assistance, which pays the difference between the HUD published Fair Market Rent and the tenant's portion of the rent. Through tenant-based rental assistance, a HOPWA grantee or project sponsor makes rental subsidy payments directly to property owners or property management agencies.
- *Operating subsidies for permanent facilities.* About 25 percent of funds was spent on operating subsidies for permanent facilities. Operating subsidies pay for housing expenses, including utilities, maintenance, equipment, insurance, security, furnishings, supplies, and salary for housing project staff.

-
- *Short-term rent, mortgage, and utility assistance.* About 11 percent of housing expenditures went to short-term rent, mortgage, and utility assistance. This support is time-limited housing assistance that is intended to prevent homelessness and increase housing stability. In order to receive assistance, a client must be currently housed, must document the legal right to occupy the premises (or responsibility for the utility payment), and must show documentation proving that he or she lacks the resources to meet rent, mortgage, or utility payments.

The remainder of housing-related expenditures provided operating subsidies for facilities that offered short-term housing (10 percent); permanent housing placement services, including identifying available units and working with private landlords (2 percent); and capital funding for the development of facilities that provided either permanent or short-term housing (1 percent). The amounts of HOPWA housing assistance provided for the categories shown in figure 6 have generally been similar from 2009 through 2012.⁴¹

⁴¹HUD did not have 2009 or 2010 data on dollars expended on permanent housing placement services. Expenditures for tenant-based rental assistance increased from about \$95 million in 2009 to nearly \$108 million in 2012.

Figure 6: Expenditures for Various Types of HOPWA-Funded Housing Assistance, Program Year 2012



Source: GAO analysis of HOPWA program data for formula and competitive grantees. | GAO-15-298

HOPWA program data for 2012 indicate that the majority of the nearly 56,000 clients that received housing assistance were African-American and extremely low-income. Table 1 summarizes selected demographic characteristics of persons who received housing assistance through HOPWA in 2012.

Table 1: Selected Demographic Characteristics of HOPWA Clients Who Received Housing Assistance, 2012

Demographic Characteristic	Percentage of Clients
Sex	
Male	63%
Female	36%
Transgender	2%
Race	
African-American	54%

Demographic Characteristic	Percentage of Clients
White	37%
All other	10%
Ethnicity	
Hispanic or Latino	17%
Non-Hispanic or Latino	83%
Income	
Low income	5%
Very low income	15%
Extremely low income	79%

Source: GAO Analysis of HOPWA program data for formula and competitive grantees. | GAO-15-298

Note: Percentages may not total to 100 percent due to rounding. The table includes demographic information for those clients for whom this information was recorded.

Ryan White Part A Grantees Spent a Small Share of Supportive Services Funds on Housing in 2011

Housing assistance represented about 2 percent (\$14 million) of the total expenditures of \$592 million in fiscal year 2011 for all Ryan White Part A funding categories—including medical and supportive services.⁴² The largest category of program expenditures, \$426 million, was for core medical services, followed by about \$93 million for supportive services and about \$73 million for clinical quality management and grantee administration. Under the Ryan White HIV/AIDS Treatment Extension Act of 2009, Ryan White Part A grantees are generally required to expend the majority of their funds on core medical services but can also fund supportive services (including housing assistance).⁴³ Expenditures for the Ryan White Part A program also reflect the priorities established by Ryan White Part A Planning Councils.

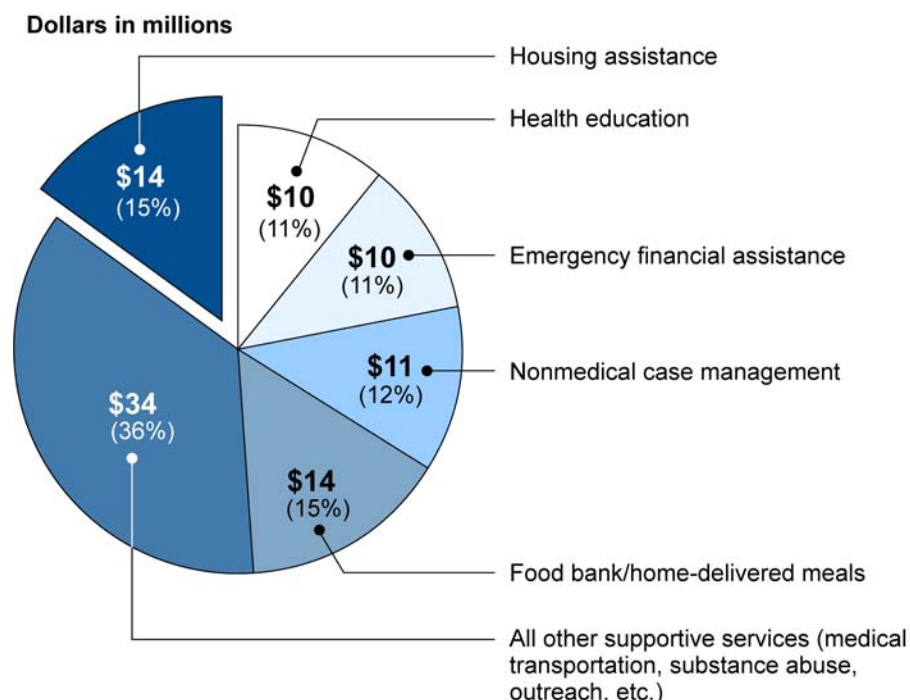
Of the \$93 million grantees spent on supportive services, housing assistance made up about 15 percent (see fig. 7). Ryan White Part A grantees also spent supportive services funds on nonmedical case

⁴²In 2011, Part A grantees spent \$5.7 million from the prior fiscal year's carryover funds and about \$587 million from 2011 funding. Expenditures for fiscal year 2011 were the most recently available data at the time of our review.

⁴³Ryan White HIV/AIDS program-funded supportive services include nonmedical case management, food bank/home delivered meals, health education/risk reduction, transportation services, psychosocial support, child care, pediatric development assessment, emergency financial assistance, housing services, legal services, linguistic services, outreach services, permanency services, rehabilitation services, respite services, residential substance abuse services, and treatment adherence counseling.

management, emergency financial assistance, food bank/home-delivered meals, and health education.

Figure 7: Ryan White Part A Supportive Services Expenditures, Fiscal Year 2011



Source: GAO analysis of Ryan White Part A expenditure data for fiscal year 2011. | GAO-15-298

Ryan White Part A data for calendar year 2012 indicate that the majority of the 13,556 clients who received housing assistance were African-American. The data also indicate that the majority of clients who received housing assistance had incomes at or below the federal poverty level.⁴⁴ Table 2 summarizes selected demographic characteristics of persons who received housing assistance through Ryan White Part A in calendar year 2012.

⁴⁴The Census Bureau publishes *poverty thresholds*—dollar-value benchmarks for determining poverty status—and HHS provides *poverty guidelines*, which are derived from the poverty thresholds. The approaches used to determine these poverty measures affect, respectively, poverty population statistics and income eligibility of individuals and families for certain need-based federal assistance. If a family's income is less than the assigned threshold, the family and each of its members is considered to be in poverty.

Table 2: Selected Demographic Characteristics of Ryan White Part A Clients Who Received Housing Assistance, Calendar Year 2012

Demographic Characteristic	Percentage of Clients
Sex	
Male	67%
Female	32%
Transgender	2%
Race	
African-American	54%
White	33%
Other or race not reported	13%
Ethnicity	
Hispanic or Latino	19%
Non-Hispanic or Latino	80%
Unreported	2%
Earnings Relative to Federal Poverty Level	
Equal to or below	65%
Between 101 and 200 percent	18%
201 percent or more	6%
Not reported	12%

Source: GAO analysis of Ryan White Services Report data for Part A, calendar year 2012. | GAO-15-298

Note: Percentages may not total to 100 percent due to rounding.

HOPWA and Ryan White Information Suggest Positive Outcomes in Housing Stability, but Ryan White Data May Have Limitations

HUD’s 2012 HOPWA performance data show a variety of positive outcomes related to housing stability, access to care, and homelessness. For the HOPWA program, permanent, stable housing includes private housing without a subsidy, subsidized housing, and HOPWA-funded rental assistance or facility-based housing. According to HUD’s 2012 data,

- 96 percent of the households that received tenant-based rental assistance or lived in a HOPWA-funded permanent housing facility had stable housing;
- 92 percent of households had contact with primary care;
- 90 percent of clients accessed medical insurance; and
- 5,736 formerly homeless individuals were placed in housing⁴⁵

⁴⁵51 percent of these individuals were chronically homeless.

Additionally, HUD's 2013 Performance Report indicates that the HOPWA program has contributed to the agency's goal of preserving affordable rental housing.⁴⁶ The report states that HOPWA had funded 25,706 rental units as of the end of fiscal year 2012, helping HUD exceed its fiscal year 2012-2013 agency priority goal of continuing to serve 5.4 million families and serving an additional 61,000 families. According to the performance report, HUD exceeded this goal by nearly 82,000 families. HOPWA officials also told us that the program's contributions to providing permanent supportive housing supported HUD's strategic objective for ending homelessness.⁴⁷ HOPWA officials noted that the HOPWA program helped to keep persons with HIV from becoming homeless.

HUD uses the data that grantees report on outcomes to summarize the achievements of individual grantees and the program as a whole. More specifically, HUD contractors review the information grantees submit and produce grantee-level and national summaries of performance for the formula HOPWA program, the competitive HOPWA program, and both programs combined. HUD posts these summaries, or performance profiles, on a HUD website.

HRSA officials told us that the majority of clients provided with housing assistance through the Ryan White HIV/AIDS program obtained permanent, stable housing. According to a December 2013 White House report addressing the outcomes associated with the National HIV/AIDS Strategy, increasing the percentage of Ryan White HIV/AIDS program clients with permanent housing to 86 percent is one of nine indicators in the National HIV/AIDS Strategy.⁴⁸ For the Ryan White HIV/AIDS program, stable, permanent housing includes unsubsidized rooms, houses, or apartments; subsidized housing; and permanent housing for formerly homeless persons.

⁴⁶HUD, *FY 2013 Annual Performance Report and FY 2015 Annual Performance Plan* (Washington, D.C.: July 2014).

⁴⁷HUD, *Strategic Plan 2014-2018* (Washington, D.C.: April 2014).

⁴⁸The White House, Office of National AIDS Policy, *National HIV/AIDS Strategy: Improving Outcomes: Accelerating Progress along the HIV Care Continuum* (December 2013). Other indicators include lowering new HIV infections, increasing knowledge of HIV-positive status, reducing HIV transmission rates, increasing the linkage of newly diagnosed persons to HIV medical care, increasing the percentage of Ryan White program clients in continuous care, and increasing viral suppression among males who have sex with males, African-Americans, and Latinos.

According to HRSA officials, the National HIV/AIDS Strategy indicator of Ryan White HIV/AIDS program clients with permanent housing is measured using the data on the housing status that HRSA collects annually. HRSA gathers this information from Ryan White HIV/AIDS program grantees through the Ryan White HIV/AIDS Program Services (RSR) report.⁴⁹ However, it is not clear that HRSA's housing status data are current because HRSA does not require or encourage grantees to maintain current data on clients' housing status. RSR instructions state that the housing status data element is the client's housing status at the end of the reporting period. HRSA officials told us that the instructions were not intended to be used as guidance for local jurisdictions in determining how often each client's housing status should be collected. The officials added that the frequency with which a client's housing status should be updated was decided at the local level and that currently HRSA does not require grantees to assess a client's housing status beyond the initial intake period. Staff from one Ryan White Part A grantee told us that information on housing status in the RSR report was not very reliable because each client's housing status was recorded at the point of intake but might or might not be updated subsequently. Another Ryan White Part A grantee told us that some of its subgrantees only reported on clients' housing status at the point of intake, even though they recertified clients' eligibility for the program every 6 months.

Internal control standards for the federal government state that events should be promptly recorded to maintain their relevance and value to management in controlling operations and making decisions.⁵⁰ Because HRSA does not require grantees to ensure that their subgrantees regularly update data on each client's housing status, the usefulness of these data to support housing-related outcomes is unclear. Among these outcomes, for example, the extent to which the Ryan White HIV/AIDS program is contributing to the National HIV/AIDS Strategy goal of improving access to permanent housing. Further, because the Ryan White HIV/AIDS program provides temporary housing assistance and clients' housing status is likely to change frequently, housing data may

⁴⁹The National HIV/AIDS Strategy indicator is calculated based on all Ryan White HIV/AIDS program clients with a reported housing status (not just clients assisted through Part A). The RSR collects housing status data for clients that received outpatient ambulatory medical care, medical case management, nonmedical case management, and housing services.

⁵⁰[GAO/AIMD-00-21.3.1](#).

not be as accurate and current as possible if they are not updated regularly.

Stakeholders Cite Strengths and Weaknesses of Programs That Provide Housing Assistance for Persons with HIV

HOPWA grantees, project sponsors, and HIV advocacy groups noted several strengths of the design of the HOPWA program. For example, three of the eight HOPWA project sponsors that GAO interviewed and an HIV advocacy group stated that one strength of the program was that clients must be provided with supportive services. These stakeholders noted that HOPWA clients or other persons with HIV often had substance abuse issues and a mental illness and that supportive services that helped address these issues were critical to helping some clients become stable. Three HOPWA grantees noted that another strength of the program was the flexibility it offered to grantees, allowing them to fund the type of housing assistance that was most needed in their communities. Grantees that we visited funded a wide range of housing types, including a facility for persons with HIV who had mental, physical, or drug abuse issues; a facility for single adults who had progressed to AIDS and had a history of homelessness; and a hospice for HIV-positive persons. Finally, officials from four organizations that received both HOPWA and Ryan White Part A funding explained that HOPWA worked well with the Ryan White HIV/AIDS program. These officials explained that they took steps to transition Ryan White Part A clients who received temporary housing assistance into the HOPWA program, which offered permanent housing assistance. Also, in one of the cities we visited local program administrators emphasized that the programs were complementary and said that they used Ryan White Part A funds only for core medical services and nonmedical case management and HOPWA funds only for housing assistance.

HOPWA grantees and project sponsors also identified weaknesses in the HOPWA program, including certain requirements, administrative fees, and the funding formula. Specifically, two of the four HOPWA grantees we met with noted that rental assistance generally could not exceed Fair Market Rent amounts, which HUD determined annually. Limiting rental assistance to Fair Market Rents is challenging, particularly in high-cost cities like New York City and San Francisco, where officials noted that the average price of an apartment was double the amount of the Fair Market Rent. Also, two of the four HOPWA grantees that we interviewed and HUD administrators of the HOPWA program stated that the administrative fee of 3 percent that grantees could retain from their HOPWA grant was low. HUD officials stated that other HUD programs had higher fees, including Community Development Block Grants (20 percent) and the

Home Investment Partnerships Program (10 percent). Finally, staff from three HOPWA grantees, five organizations that receive HOPWA or Ryan White Part A funding, and HUD officials with responsibility for administering the HOPWA program told us that the funding formula needed to be updated so that it was based on the number of persons living with HIV. Officials from one HOPWA grantee stated that they understood the need to update the HOPWA funding formula but had concerns about potentially losing funding if cumulative HIV cases were excluded from the formula. As previously discussed, in congressional budget justifications for fiscal years 2013 through 2015, HUD proposed updating the funding formula to incorporate local housing costs and poverty rates. HUD has also proposed increasing the percentage of HOPWA grant amounts that may be used for administrative expenses from 3 percent to 6 percent of the grantee's awarded amount.

Ryan White Part A grantees, subgrantees, and HIV advocacy groups that we met with noted several strengths and weaknesses of the Ryan White HIV/AIDS program. For example, three of the four Ryan White Part A grantees we met with, as well as two HIV advocacy organizations, stated that the Ryan White HIV/AIDS program complemented the HOPWA program. Grantee staff told us that persons with HIV could receive temporary housing assistance through Ryan White Part A and then transition to permanent assistance through HOPWA. Also, members of two HIV advocacy groups with whom we met stated that local Ryan White Part A Planning Councils were beneficial because they identified the unique, local needs of persons with HIV. Some Ryan White Part A subgrantees and staff from an HIV advocacy group stated that the inability to use Ryan White Part A funds for permanent housing assistance created challenges. For example, the subgrantees told us that it was generally difficult to address all of the issues that their clients face, including substance abuse and mental illness, within the 2-year time frame. As previously noted, HRSA guidance encourages but does not require grantees to limit housing assistance to 24 months. Additionally, staff from an advocacy group told us that because the Ryan White Part A program could fund only temporary housing, recipients of this assistance were still faced with a lack of stable, permanent housing.

Federal and Local Agencies Generally Coordinate Their Efforts to Deliver Housing Assistance to Persons with HIV

Responding to the administration's 2010 National HIV/AIDS Strategy, HUD and HRSA have made formal and informal efforts to collaborate by sharing information related to housing for persons with HIV. Coordination in the delivery of housing assistance to persons with HIV also occurs extensively at the local level, helping to ensure that the assistance provided by both programs is complementary and mitigates the potential for programs to provide duplicative services. Persons with HIV may be eligible to receive housing assistance from other federal programs, such as public housing. However, other programs may not be available and may not provide supportive services.

HUD and HRSA Have Coordinated to Address the National HIV/AIDS Strategy, Share Information, and Develop Guidance

The White House's 2010 National HIV/AIDS Strategy and its Implementation Plan encourage coordination among federal agencies and between federal agencies and state, territorial, tribal, and local governments, to achieve a more coordinated response to HIV.⁵¹ To address the National HIV/AIDS Strategy, HUD, HRSA, and other federal agencies have taken several steps. First, they have participated in a federal interagency working group led by the White House Office of National AIDS Policy. According to the July 2010 National HIV/AIDS Strategy Federal Implementation Plan, the working group convened to review public recommendations, assess scientific evidence, and make recommendations related to the National HIV/AIDS Strategy. Additionally, in July 2013, an Executive Order established an HIV Care Continuum Working Group to coordinate federal efforts to improve outcomes nationally across the HIV care continuum.⁵² This group is co-chaired by the White House Office of National AIDS Policy and HHS.⁵³ According to HRSA officials, in September 2014 an HIV Care Continuum Initiative meeting was held to examine best practices in implementing care continuum recommendations and to provide agencies with the opportunity to learn from each other. Staff from HRSA, HUD, and other agencies attended the meeting. We have found that collaboration is enhanced

⁵¹The White House, *National HIV/AIDS Strategy for the United States*, July 2010 and *National HIV/AIDS Strategy: Federal Implementation Plan*, July 2010.

⁵²Executive Order 13569: *Accelerating Improvements in HIV Prevention and Care in the United States through the HIV Care Continuum Initiative*, July 15, 2013.

⁵³Members of the working group include the Department of Justice, the Department of Labor, the Department of Veterans Affairs, HUD, and the Office of Management and Budget.

when common outcomes are defined, mutually reinforcing strategies are established, and roles and responsibilities are agreed upon, among other things.⁵⁴ The efforts of HUD and HRSA to work together to help address the National HIV/AIDS Strategy suggest that they have taken steps to enhance collaboration.

Second, HUD and HRSA have taken steps to share information. HRSA officials told us that, as required by statute, HHS issued a report to Congress in 2012 describing the coordinated efforts at the federal, state, and local levels to address HIV, including a description of barriers to HIV program integration.⁵⁵ According to this report, between 2005 and 2008:

- HRSA worked with several federal agencies including HUD to examine case management models and examples of coordinated and collaborative case management guidelines;
- HRSA and HUD participated in the Interagency HIV/AIDS Case Management Workgroup to develop a set of guidelines around collaborative or coordinated case management services; and⁵⁶
- HUD and CDC collaborated in a study to examine housing assistance for homeless people with HIV to determine the impact of such assistance on the progression of their disease and the risk of transmitting HIV.⁵⁷

HUD and HRSA officials with responsibility for the HOPWA and Ryan White HIV/AIDS programs told us that they had also met informally to share information and data on their grantees. For example, in June 2014 staff from both agencies met to discuss data collection that could be helpful to HUD in assessing the impact of the HOPWA program. During this meeting, HRSA also discussed the results of efforts that began in 2014 to identify HOPWA and Ryan White HIV/AIDS program grantees

⁵⁴[GAO-14-220](#).

⁵⁵Section 2681(b) of the Public Health Service Act (codified at 42 U.S.C. § 300ff-81(b)). As of February 2015, HRSA's draft Report to Congress on the Coordination of Federal HIV Programs, 2009-2013, was undergoing the agency's internal clearance process.

⁵⁶In 2008, the workgroup developed recommendations for case management collaboration in federally funded HIV/AIDS programs.

⁵⁷Wolitsky and others, "Randomized Trial of the Effects of Housing Assistance."

that collected both health and housing indicators. Additionally, HUD and HRSA are collaborating to provide both remote and onsite technical assistance to HOPWA grantees and project sponsors on improving program participants' access to health care. We have found that collaboration is enhanced when two or more organizations engage in a joint activity that is intended to produce more public value than could be produced when the organizations act alone.⁵⁸

HUD and HRSA also worked together to refine HRSA's policy related to the length of time individuals can receive housing assistance through the Ryan White HIV/AIDS program. In 2008, HRSA issued a policy that imposed a 24-month cumulative cap on short-term and emergency housing assistance for recipients of Ryan White HIV/AIDS program housing assistance, to be effective beginning in March 2010. In consultation with HUD, HRSA rescinded this policy in February 2010 in response to feedback from Ryan White HIV/AIDS program grantees and others that the time limits could negatively impact recipients of the assistance. Ryan White Part A grantees with whom we met told us that their clients generally had both substance abuse and mental health issues that took time to address. They noted that 2 years was not always sufficient for someone to be able to move out of temporary housing. In May 2011 HRSA released a final notice that encourages, but does not require, grantees to limit assistance to 24 months. HUD's efforts to work with HRSA on this housing policy are consistent with practices that we have found can enhance collaboration among federal agencies.⁵⁹

⁵⁸ GAO-06-15.

⁵⁹ GAO-06-15.

Different Emphases and Local Coordination Help Ensure That the HOPWA and Ryan White Part A Programs Complement Each Other

Although some overlap exists between the HOPWA and Ryan White HIV/AIDS programs, different emphases and local coordination help to ensure that the programs complement rather than duplicate each other.⁶⁰ HOPWA and the Ryan White HIV/AIDS program overlap in the areas of temporary housing and supportive services for persons with HIV, which both programs can fund. However, housing assistance for persons with HIV involves both housing- and health-related issues, and HUD and HRSA bring different types of expertise to these areas. HUD programs focus on the provision of housing assistance and HUD awards the bulk of federal housing-related resources. In contrast, HRSA's primary focus is to provide health care for medically vulnerable people, among others. HRSA's policy indicates that Ryan White HIV/AIDS program funds can be used for short-term or emergency housing only to the extent that such support is necessary for clients to gain or maintain access to medical care. Additionally, the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires Ryan White HIV/AIDS program grantees to be the payer of last resort. In order to receive housing assistance through the Ryan White HIV/AIDS program, individuals must not have HOPWA or other forms of subsidized housing assistance available to them, even if they are eligible for the programs. However, they may receive Ryan White HIV/AIDS program assistance for other needs, such as medical care. The different program emphases and requirements helps prevent duplication between these programs.

Coordination among local entities helps ensure that assistance provided by HOPWA and the Ryan White HIV/AIDS program complement each other and mitigates the potential for the programs to provide duplicative

⁶⁰Since March 2011, GAO has issued annual reports addressing fragmentation, overlap, and duplication across the federal government. In these reports, we define fragmentation as occurring when more than one agency is involved in the same broad area of national need. We define overlap as occurring when multiple agencies or programs have similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries. Finally, we define duplication as occurring when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries. For more information on GAO's work on fragmentation, overlap, and duplication in the federal government, see [GAO 14-343SP](#); GAO, *2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, [GAO-12-279SP](#) (Washington, D.C.: Apr. 9, 2013); *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, [GAO-12-342SP](#) (Washington, D.C.: Feb. 28, 2012); and *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: Mar. 1, 2011).

services.⁶¹ Coordination in the delivery of housing assistance to persons with HIV occurs at the local level through formal planning processes. As a condition of receiving a HOPWA grant, grantees must consult with other public and private entities, as well as local citizens, in implementing the HOPWA program and any other HUD Community Planning and Development grant funds that the community receives.⁶² Community Planning and Development grantees, including HOPWA grantees, contribute to the development of a consolidated plan and annual action plans. Through these plans, the grantees must describe the agencies, groups, and others who participated in the planning process; their consultations with social service agencies and other entities; and their activities to enhance coordination between public and assisted housing providers and private and governmental health, mental health, and service agencies.

The Ryan White Part A program requires local planning councils to help facilitate coordination between Ryan White Part A and HOPWA grantees. As we have seen, the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires planning councils to have members from various groups and organizations. For instance, at least one-third of the planning council members must be persons with HIV who receive Ryan White Part A services and are consumers who do not have a conflict of interest, meaning that they are not staff, consultants, or board members of Ryan White Part A -funded agencies. The planning council and the grantee work together to identify the needs of people with HIV and to prepare a comprehensive plan on how to meet those needs. Both the planning council and the grantee work together to make sure that other sources of funding work well with Ryan White HIV/AIDS program funds and that the Ryan White HIV/AIDS program is the payer of last resort. While the Ryan White HIV/AIDS Treatment Extension Act of 2009 does not require that the HOPWA program be represented on planning councils, there is a

⁶¹GAO has previously noted that interagency mechanisms or strategies to coordinate programs that address crosscutting issues may reduce potentially duplicative, overlapping, and fragmented efforts. See GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, [GAO-12-1022](#) (Washington, D.C.: Sept. 27, 2012), and *Managing For Results: GPRA Modernization Act Implementation Provides Important Opportunities to Address Government Challenges*, [GAO-11-617T](#) (Washington D.C.: May 10, 2011).

⁶²CPD grants include HOPWA, HOME Investment Partnerships Program, Emergency Solutions Grants, and Community Development Block Grants.

requirement that other federal HIV programs be represented on the council (which could include HOPWA). In addition, the 2015 Part A funding announcement and 2013 program manual both indicate that the planning council could include a HOPWA or housing service representative.

Informal efforts to coordinate the delivery of housing assistance also help to reduce the potential for duplication. Staff from four Ryan White Part A subgrantees, which can provide clients with housing assistance for only a limited period of time, told us that they consistently reached out to local providers of subsidized housing. These providers may include other city agencies, nonprofit organizations, and owners of single-room occupancy hotels. Such coordination efforts could help to minimize the potential for program duplication.

Coordination between the HOPWA and Ryan White Part A programs does not appear to require formal agreements and processes when the same local agency is the grant recipient of both programs. In two of the four cities we visited, the same city agency was both the formula HOPWA project sponsor and the Ryan White Part A grantee. As a result, coordination between the activities funded and efforts to move clients from temporary to permanent housing occurred through the agencies' regular business practices. Officials from one of these city agencies stated that different staff members were dedicated to each program, but that they worked together and shared information related to clients' needs and the services provided. Officials from another city agency said that the same city staff focused on both HOPWA and Ryan White Part A funds. In this case, the same staff member reviewed performance information and invoices from the local HOPWA sponsors and Ryan White Part A subgrantees.

Persons with HIV May Be Eligible for Other Housing Programs but May Not Receive Timely or Appropriate Assistance from Them

Persons with HIV may be eligible to receive housing assistance from other federal programs that are focused on assisting persons with low or no income, including the following:

- Public Housing provides housing aid for eligible low-income families, the elderly, and persons with disabilities. HUD administers this federal subsidy to participants of local public housing authorities that manage the housing for low-income residents at rents they can afford.
- The Housing Choice Vouchers program assists very low-income families, the elderly, and persons with disabilities. Participants may

choose any housing that meets the requirements of the program and is not limited to units located in subsidized public housing projects. HUD administers the Housing Choice Voucher program, public housing agencies manage it.

- As we have seen, Continuum of Care is a HUD program that provides funding to nonprofit providers and state and local governments to quickly rehouse homeless individuals and families.
- Emergency Solutions Grant is a HUD program that provides funding to state and local governments for emergency shelters and services for homeless individuals and families. It also provides services to prevent families from becoming homeless.
- The HUD Veterans Affairs Supportive Housing program combines HUD’s Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by the Department of Veterans Affairs.
- Home Investment Partnerships Program is a HUD program that provides formula grants to states and localities to fund a wide range of activities, including building, buying, or rehabilitating affordable housing for rent or ownership or providing direct rental assistance to low-income people.

While these programs have similar goals related to providing housing assistance, they have varying eligibility requirements (see table 3). For example, only homeless veterans are eligible for HUD-VASH, and an individual must be homeless or at risk of homelessness to be eligible for the Continuum of Care and Emergency Solutions Grant programs.

Table 3: Comparison of Selected Eligibility Requirements for Selected Housing Assistance Programs

	Income restricted	HIV positive	Homeless or at risk of homelessness	Veteran
HOPWA	x	x		
Ryan White HIV/AIDS Program (Part A)	^a	x		
Public Housing	x			
Housing Choice Vouchers	x			
Continuum of Care	x		x	
Emergency Solutions Grant	x		x	
HUD-VASH	x		x	x
HOME Investment Partnerships Program	x			

Source: GAO analysis of agency information. | GAO-15-289.

^aIndividual grantees establish their Ryan White HIV/AIDS program income requirement and the program must be the payer of last resort.

Housing assistance programs that are not targeted to persons with HIV, such as Public Housing and the Housing Choice Voucher programs, may not be able to provide timely assistance because they may not be readily available. HOPWA and Ryan White Part A grantees from three of the cities we visited, as well as staff from six organizations that received funding from these grantees, told us that the local public housing agencies had very long waiting lists and sometimes closed their Public Housing and the Housing Choice Voucher programs to new applicants. Staff from one non-profit agency that receives both HOPWA and Ryan White Part A funding told us that they require recipients of HOPWA or Ryan White Part A housing assistance to apply for public housing and the Housing Choice Voucher programs. However, staff said the local public housing agency has a long waiting list for both types of housing, and thus the client would not likely be able to benefit from these programs. Also, two of the HOPWA grantees with whom we met told us that even though the local public housing agencies had set up a preference for homeless persons with HIV, these agencies made few units available through this preference system.

According to officials from organizations that receive HOPWA and Ryan White Part A grant funds, housing assistance programs that are not targeted to persons with HIV, such as public housing and the Housing Choice Voucher programs, may not be appropriate because they are not required to provide supportive services. Table 4 shows the kinds of services these and other housing assistance programs provide, such as substance abuse or mental health counseling. While not required to do so, administrators of these programs may help individuals receive supportive services through other funding sources.

Table 4: Comparison of Services Funded Through Selected Housing Assistance Programs

	Must provide supportive services	Funds temporary housing	Funds permanent housing
HOPWA	x ^a	x ^e	x
Ryan White HIV/AIDS Program (Part A)	^b	x ^f	
Public Housing			x
Housing Choice Vouchers			x

	Must provide supportive services	Funds temporary housing	Funds permanent housing
Continuum of Care	x ^c	x	x
Emergency Solutions Grant	x ^d	x ^g	
HUD-VASH	x		x

Source: GAO analysis of agency information. | GAO-15-298

Note: Temporary housing provides stability and support for a limited time and is not intended to be used for long-term occupancy. In contrast, permanent housing is intended for long-term occupancy and does not limit the length of stay.

^aSupportive services must be provided as a part of any HOPWA housing assistance, but HOPWA funds may also be used to provide services independently of any housing activity.

^bUp to 25 percent of Ryan White HIV/AIDS (Part A) funding may be used for supportive services without a waiver.

^cSupportive services are required in connection with certain housing that the grant recipient may offer. For example, for a transitional housing project (whose purpose is to facilitate the movement of homeless individuals and families into permanent housing within 24 months), supportive services must be made available to residents throughout the duration of their residence in the project.

^dIf the grant recipient offers “street outreach”(reaching out to unsheltered homeless individuals and families), it must offer essential services at least for the period during which the Emergency Solutions Grant funds are provided. For this component, essential services include case management, emergency health and mental health services, and transportation. Similarly, if the grant recipient uses its grant funds solely to provide essential services to homeless individuals and families in homeless shelters, it must provide the services at least for the period during which the funds are provided. For this component, essential services include case management, child care, and education services.

^eHOPWA can fund short-term rent, mortgage, and utility assistance for up to 21 weeks in any 52-week period.

^fA May 2011 HRSA policy notes that HRSA housing assistance is intended to be transitional in nature and cannot be permanent.

^gThe Emergency Solutions Grant program can be used to fund the development of shelters for homeless individuals and families, improve existing shelters, subsidize the costs of operating the shelters, and provide supportive services.

HIV advocates and a researcher told us that providing housing assistance without necessary medical care or other types of supportive services may not effectively facilitate housing stability or improved health for persons with HIV. Several of the organizations that received funding from HOPWA or Ryan White Part A grantees told us that their clients generally had mental health and substance abuse issues and would not thrive without intensive counseling. While some public housing agencies may offer their public housing residents access to a case manager or a staff member who can help the resident obtain the services that they need, public housing agencies are not required to offer this service. Additionally, HIV positive persons with criminal records or who engage in criminal activity

may not be eligible for public housing and HCVs.⁶³ In contrast, both the HOPWA and Ryan White HIV/AIDS programs can provide housing assistance to persons with HIV who have criminal records.

HUD and HRSA Monitor Their Programs but May Be Missing Opportunities to Use Data to Improve Performance

HUD field office staff use a risk-based process to guide their monitoring of grantees and provided evidence that they had implemented these procedures. HRSA headquarters staff with primary responsibility for monitoring Ryan White HIV/AIDS program grants have taken steps to improve their efforts in recent years. Both HUD and HRSA collect data from HOPWA and Ryan White HIV/AIDS program grantees, respectively, including data on the activities funded and clients' housing status (i.e., whether they have stable and permanent housing). HUD summarizes the data it collects but does not evaluate year-to-year changes in unmet housing need for individual grantees. HRSA staff with primary responsibility for monitoring Ryan White Part A grantees assess whether grantee data are submitted to HRSA on time but are not required to review the housing-related data submitted. As a result, both programs may be missing opportunities to use existing data to manage the programs.

HUD Field Office Staff Generally Follow Monitoring Policies for Selected Grantees

HUD's field office staff have primary responsibility for monitoring HOPWA grantees, and we found that they were generally following monitoring policies for the four grantees that we visited. Field staff are responsible for conducting annual risk assessments of all Community Planning and Development grantees, which include recipients of HOPWA grants. To conduct these assessments, field staff must adhere to Risk Analysis Policy Notices and rate each grantee based on specific factors, including financial factors, the physical condition of projects, and staff capacity, among others. HUD field office staff use these factors to assess the risk level for each grantee and assign a numeric score.⁶⁴ Grantees with risk assessments above a certain threshold are to receive onsite monitoring, unless the local HUD field office determines that the grantee can be excepted on the basis of additional HUD criteria and consideration of the

⁶³24 CFR §960.203, §960.204, §982.553.

⁶⁴HUD field staff conduct risk assessments of and produce a numerical score for each Community Planning and Development grant that a grantee receives. All of the scores are averaged to create a total score for the grantee. Scores are based on a 100-point rating scale and are used to place grantees into one of three risk categories: high risk (a total score of 51 or more); medium risk (between 30 and 50); and low risk (less than 30).

field office's travel and staffing resources.⁶⁵ During site visits, HUD staff meet with HOPWA sponsor staff and review documentation related to the sponsor's implementation of the program. HUD staff may identify findings that the sponsor is required to address. In conducting site visits, HUD staff are required to follow specific monitoring guidance related to the HOPWA program.

HUD has documented that it conducted risk assessments and onsite monitoring visits for formula and competitive HOPWA grantees from fiscal years 2008 through 2013. For the four formula HOPWA grantees we visited, HUD's field office staff conducted 24 risk assessments—one assessment per year for each of the four HOPWA grants from 2008 through 2013. Nine of the 24 assessments indicated that the HOPWA grant met HUD's criteria for triggering onsite monitoring. HUD field office staff subsequently conducted onsite monitoring for six of these nine grantees. For the three HOPWA grantees that HUD did not visit for onsite monitoring, the local HUD field office either did not have the resources to conduct the review or the site visit was excepted because the grantee had received a site visit within the previous 2 years, according to HUD.

HUD headquarters monitors HOPWA grantees' compliance with the requirement to submit annual performance reports—the CAPER for formula grantees and the Annual Performance Report for competitive grantees. These reports include information on the activities funded, client characteristics, and outcomes related to housing stability, homelessness, and access to care and support. According to HUD officials and contractor staff, a contractor sends HOPWA grantees reminders prior to report deadlines, tracks receipt of the reports, and reviews the reports for completeness and internal consistency. HUD's contractor also tracks the timeliness of the initial submissions of performance reports. According to the contractor's data, 93 percent of the CAPERs and Annual Performance Reports for program year 2013 were submitted within 30 days of their due date. HUD's contractor staff told us that they assisted grantees with any technical difficulties or internal inconsistencies until the report was submitted and met the contractor's standards for reliability.

⁶⁵Any grantee with an average risk score of 51 or higher or a single program score of 51 or higher is subject to onsite monitoring unless the grant meets the allowable exceptions that are noted in HUD's Risk Analysis Policy Notices.

HRSA Headquarters Staff Monitor Ryan White Part A Grantees and Reported Following Updated Monitoring Policies

HRSA headquarters staff have primary responsibility for routine and onsite monitoring of Ryan White HIV/AIDS program grantees. Routine monitoring includes regularly scheduled phone calls and reviews of grantee reports. The purpose of routine monitoring is to assess grantees' performance and compliance with statutory requirements, regulations, and guidance. HRSA staff are also responsible for conducting site visits with the grantees. Site visits are intended to provide an opportunity to review the grantee's program and may serve as a technical-assistance session for the grantee. HRSA guidance states that site visits should be viewed as an opportunity to expand on information grantees have provided in their grant application, reports, and conference calls. During site visits, HRSA staff meet with grantee staff and may meet with staff from one or more of the subgrantees to obtain feedback on how the program is functioning. HRSA staff may also visit various locations at which subgrantees deliver services and review grantee and subgrantee program documentation.

HRSA staff with responsibility for the four Ryan White Part A grantees we visited reviewed risk-related information, conducted monthly monitoring calls, and provided technical assistance. HRSA staff reviewed single audit documentation, including risk-related information.⁶⁶ Two of the four risk assessments indicated that the grantees had no major issues, and the other two showed deficiencies with internal controls. For the latter two, HRSA determined that these issues did not warrant a restriction in HRSA funding.⁶⁷ HRSA staff also conducted monthly calls to grantees and summarized the discussions in electronic files. Additionally, HRSA staff

⁶⁶The Single Audit Act as amended, 31 U.S.C. §§ 7502 et seq., requires states, local governments, and nonprofit organizations expending \$500,000 or more in federal awards in a year to obtain an audit in accordance with the requirements set forth in the act. A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the Schedule of Expenditures of Federal Awards; (2) gaining an understanding of and testing internal control over financial reporting and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs. We refer to these audits as single audits—they are also commonly referred to as A-133 audits. See Office of Management and Budget Circular No. A-133. Requirements for single audits are currently found at 2 C.F.R. Part 200, Subpart F.

⁶⁷One grantee's single audit report did not include findings specific to its HRSA award, so HRSA determined that the entity did not warrant a drawdown restriction or corrective action. HRSA required that the other grantee take corrective action to address the internal control findings.

provided technical assistance to Ryan White Part A grantees. For example, in 2013 HRSA arranged for a consultant to provide on-site technical assistance to one of the Part A grantees that we visited.

HRSA has increased onsite monitoring visits for Ryan White HIV/AIDS program grantees in response to our past recommendations. Specifically, our June 2012 report found that HRSA did not have written guidance describing its policy for selecting grantees to visit and did not prioritize site visits in the manner described to us. Moreover, 44 percent of all grantees did not receive a site visit from 2008 through 2011.⁶⁸ We recommended, among other things, that HRSA develop a strategic, risk-based approach for selecting grantees for site visits to ensure that the visits were made at regular and timely intervals. HRSA addressed this recommendation by developing a risk-based approach for selecting grantees for site visits. Additionally, beginning in 2012, HRSA implemented a policy that all Part A and Part B grantees would receive site visits at least once every 5 years and more often if needed. According to our analysis of HRSA's Part A site visits through 2013, HRSA staff conducted site visits to 11 of the 13 Part A grantees that had not been visited from 2008 through 2012. Additionally, 32 of 53 Eligible Metropolitan Areas and Transitional Grant Areas received a comprehensive site visit between July 2012 and July 2013.

HRSA has taken additional steps to address four other recommendations we made in 2012 to improve oversight of Ryan White HIV/AIDS program grantees. As of October 2014, all four of these recommendations had been implemented.⁶⁹ The steps taken include the following:

- improved the functionality of an information system, the Electronic Handbook, to enable staff to better document their oversight and monitoring activities, including monthly calls, emails, and technical assistance;

⁶⁸GAO, *Ryan White Care Act: Improvements Needed in Oversight of Grantees*, GAO-12-610 (Washington, D.C.: June 11, 2012).

⁶⁹We recommended that the Administrator of HRSA (1) ensure that the agency was implementing key elements of grantee oversight consistent with agency guidance; (2) assess and revise its record retention program; (3) update and maintain a program manual for grantees; and (4) use the results of HRSA's survey of grantees to identify grantees' training needs.

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- assessed, revised, and updated records management policies for HRSA staff with primary responsibility for monitoring grantees;
 - created updated program manuals and posted the manuals on HRSA’s technical assistance website; and
 - updated its monitoring standards and worked with grantees that faced challenges with implementing the standards.

Additionally, HRSA grantees are responsible for monitoring subgrantees, which are the organizations that grantees contract with to provide services to persons with HIV. In 2011 HRSA developed National Monitoring Standards for Parts A and B of the Ryan White HIV/AIDS program. These standards are designed to help Ryan White Part A and Part B grantees meet federal requirements for program and fiscal management, monitoring, and reporting. The standards were developed because of the need to establish specific standards governing the frequency and nature of grantee monitoring of subgrantees and create a clear role for HRSA staff in monitoring grantee oversight of subgrantees. HRSA staff with whom we met told us that they used these standards and expected grantees to use them to monitor subgrantees.

HUD Collects Performance Data but Does Not Assess Trends in Unmet Housing Need

HUD headquarters staff collect annual performance data from HOPWA grantees on activities funded; client characteristics; and outcomes related to housing stability, access to health care, and unmet housing need. As noted earlier, HUD uses this information to create “performance profiles”—two-page summaries of this information—for each HOPWA grantee for each program year. Additionally, HUD creates annual performance profiles for the formula HOPWA program, the competitive HOPWA program, and both programs combined. Profiles are not cumulative—that is, they do not show the total number of clients served up to a point in time. Rather, the profiles provide data on the clients served during the previous program year. A HUD contractor posts all of the performance profiles on a HUD website.⁷⁰

HUD contractors are responsible for collecting Annual Performance Reports and CAPERs and using the data grantees report to create performance profiles. The contractors review the data for completeness

⁷⁰See <https://www.hudexchange.info/manage-a-program/hopwa-performance-profiles/>.

and follow up with grantees regarding inconsistencies. According to HUD, its contractors also identify and document inconsistencies in data using current and previously submitted data for four areas: access to care, cost per unit, stability, and administrative costs. The contractors also document efforts to clarify and correct data related to these issues. However, HUD’s contractors told us that they do not compare current-year data to prior-year data for unmet housing need. In addition, HUD field office staff with whom we met stated that they did not compare grantee data from year to year to identify any potential data reporting errors.

Our analysis of the unmet housing need data collected through CAPERs from 2010 through 2013 found that some formula grantees reported significant changes in the number of HOPWA-eligible persons with an unmet housing need. For example, HUD data for 2012 indicated that 47 percent of the grantees reported changes of 30 percent or more in the number of persons with an unmet housing need compared with 2011 numbers.⁷¹ According to HUD’s data, in 2011 one grantee had 145 persons with HIV with unmet housing needs and 525,957 in 2012. Although changes in these estimates could be the result of increases or decreases in the need for housing assistance for persons living with HIV, large annual changes could also signal reporting errors. This and other examples are shown in table 5.

Table 5: Examples of Potential Problems in Reporting Unmet Housing Need Data for Selected Grantees, 2010-2013

	2010	2011	2012	2013
Grantee A	121	145	525,957	2,000
Grantee B	721	1,271	8,000	3,901
Grantee C	267	367	3,337	0

Source: HUD summary of data submitted by HOPWA grantees. | GAO-15-298

Notes: In response to our review, HUD officials determined that the unmet need data for Grantee A had been incorrectly recorded by HUD’s contractor. According to HUD, this grantee reported that the numbers of HIV-positive persons with an unmet housing need were 145, 175, 2,000, and 200 in 2010, 2011, 2012, and 2013, respectively. The data presented here reflect Grantee A’s data as it was originally recorded and provided to GAO. Grantee C reported that zero persons had an unmet housing need in 2013.

⁷¹Changes from 2011 to 2012 include both increases and decreases in the number of persons with an unmet housing need.

HUD headquarters officials told us that the dramatic differences could be the result of a change in the methodology used to report the figure, staff turnover among grantees, or changes in grantee capacity. Prior to our review, HUD officials had not followed up with grantees that had reported significant changes in unmet need between 2010 and 2013. In response to our review, HUD officials determined that one of the significant changes in unmet housing need from year to year was the result of a data entry error made by HUD's contractor.⁷² Although HUD staff have requirements for reviewing the accuracy of CAPER and Annual Performance Reports, the requirements do not contain specific instructions for assessing performance data over time.

Federal internal control standards state that monitoring should assess the quality of performance over time and that activities need to be established to monitor performance measures and indicators. These controls could call for comparisons and assessments so that relationships can be analyzed and appropriate actions taken.⁷³ Additionally, as our prior work has shown, leading organizations use performance information to identify gaps in performance, improve organizational processes, and improve their performance.⁷⁴ By not analyzing trends in the unmet housing need data grantees are required to report, HUD may be missing opportunities to identify and address problems in grantee reporting. Moreover, by not following up on significant changes in the unmet housing need data submitted, HUD may be missing indications that these data for the program as a whole may not be reliable.

⁷²In response to our review, HUD determined that its contractor had made data entry errors when recording the information that Grantee A reported. According to HUD, this grantee reported that the numbers of HIV-positive persons with an unmet housing need were 145, 175, 2,000, and 200 in 2010, 2011, 2012, and 2013, respectively. HUD officials told us that, as a result of our review, their contractor would correct the unmet need data in each of the grantees' performance profiles, as well as in the performance profiles for the program as a whole.

⁷³[GAO/AIMD-00-21.3.1](#).

⁷⁴GAO, *Managing for Results: Enhancing Agency Use of Performance Information for Management Decision Making*, [GAO-05-927](#) (Washington, D.C.: September 2005).

HRSA Collects Program Data but Does Not Monitor Housing Information

Although HRSA headquarters staff conduct routine monitoring of Ryan White HIV/AIDS program grantees, they do not focus on housing information. HRSA staff are responsible for overseeing Ryan White HIV/AIDS program grantees by routinely monitoring grantees' performance and compliance with statutory requirements, regulations, and guidance. Routine monitoring includes regularly scheduled monitoring calls, reviews of grantee reports, and the provision of technical assistance to grantees. If during the course of routine monitoring HRSA staff find that a grantee has not met its program or financial requirements, the staff are responsible for determining whether the grantee requires more intensive monitoring. According to HRSA officials, agency staff with responsibility for monitoring can use resources like the National HIV/AIDS Strategy indicators to help grantees assess clients' ability to access HIV care and treatment. HRSA staff are also responsible for monitoring any special conditions that are put in place. HRSA staff with responsibilities related to monitoring are the agency's primary contact with grantees, and they are to communicate with their assigned grantees at least monthly.

HRSA's routine monitoring efforts for the Ryan White HIV/AIDS program do not focus on housing assistance. For example, monthly monitoring calls between HRSA staff and grantees generally follow a standard agenda, and housing is not an agenda item. According to HRSA officials, housing is included when matters pertaining to housing assistance need to be discussed. Also, according to HRSA's 2011 Housing Policy, Ryan White HIV/AIDS program grantees must provide an individualized written housing plan to HRSA staff if they request one. The plan must cover each client who is receiving short-term, transitional, or emergency housing services.⁷⁵ However, the four HRSA staff members we visited who had responsibility for monitoring the grantees told us that they had never requested or reviewed individualized housing plans. According to HRSA officials, documents related to housing are reviewed only if housing needs are identified as a priority by the grantee and HRSA staff. In addition, while HRSA staff are responsible for monitoring grantee reports, including whether RSR reports are submitted to HRSA on time, they are not required to review or monitor the housing-related data submitted in these reports.

⁷⁵HIV/AIDS Policy Notice 11-01, 76 Fed. Reg. 27649 (May 12, 2011). According to HRSA officials, individualized housing plans are to be tracked at the local level unless housing needs have been identified as a priority by the grantee and HRSA staff with responsibility for monitoring the grant.

As noted earlier, federal internal control standards state that activities need to be established to monitor performance measures and indicators. These controls could call for comparisons and assessments so that analysis of the relationships can be made and appropriate actions taken. Controls should also be aimed at validating the integrity of performance indicators.⁷⁶ In addition, our previous body of work has demonstrated the importance of using performance management indicators for various management activities and decision making. We have previously found that there are five leading practices that can enhance or facilitate the use of performance information: (1) aligning agency-wide goals, objectives, and measures; (2) improving the usefulness of performance information; (3) developing agency capacity to use performance information; (4) demonstrating management commitment; and (5) communicating performance information frequently and effectively.⁷⁷

HRSA staff with responsibility for monitoring grantees stated that they did not focus their monitoring efforts on housing because the primary focus of the program was medical care and because grantees spend a small portion of their grant funds on housing assistance. However, as previously noted the National HIV/AIDS Strategy emphasizes the importance of stable housing as a means of improving access to medical care for persons with HIV. The strategy states that access to housing is an important precursor to getting many people into a stable treatment regimen and emphasizes the importance of policies that promote access to housing. By not focusing attention on the housing data that grantees are required to report, such as housing status, HRSA staff with responsibility for program monitoring may be missing an opportunity to improve their management of grantees' performance. Among other things, they may not be monitoring an important indicator in the National HIV/AIDS Strategy—the extent to which grantees are contributing to housing stability for persons with HIV.

Conclusions

HIV continues to pose a serious health threat even with advances in medicine. In order to manage programs that provide housing assistance for persons with HIV, agencies need to have reliable data and effective

⁷⁶GAO/AIMD-00-21.3.1

⁷⁷GAO, *Managing for Results: Agencies' Trends in the Use of Performance Information to Make Decisions*, GAO-14-747 (Washington, D.C.: Sept. 26, 2014).

practices for using that data to manage program performance. First, HUD's estimate of HOPWA-eligible individuals with an unmet housing need is based on data that HOPWA grantees develop using varying methodologies. While HUD advises grantees to use one or more of seven specific data sources, HUD does not require grantees to use these sources in a consistent and therefore comparable manner, as suggested by federal internal control standards and our work on data reliability. HUD has taken steps toward developing a standard methodology but has not established time frames for finalizing these efforts. As a result, the usefulness of HUD's overall estimate is not clear. Furthermore, Congress may not have a complete understanding of the continuing need for programs that provide housing assistance to persons with HIV.

Second, the funding provided under HOPWA has filled important gaps in the availability of affordable housing in communities throughout the country. However, the current statutory formula for HOPWA has not kept pace with the changing nature of the disease. Congress recognized this shift in the 2000, 2006, and 2009 reauthorizations of the Ryan White HIV/AIDS program that required HIV case counts to be used in the distribution of Ryan White HIV/AIDS program funds.⁷⁸ While we recognize that it may not be appropriate to use precisely the same formula for both HOPWA and the Ryan White HIV/AIDS program, the rationale for allocating funds on the basis of those currently living with HIV applies to both grant programs. Because HOPWA funds are awarded based on cumulative AIDS cases, these funds are not being targeted as effectively or equitably as they could be.

Third, HRSA relies on housing data reported by Ryan White HIV/AIDS program grantees to report on its progress in addressing one of the goals of the National HIV/AIDS Strategy but does not require grantees to ensure that these data are current. Internal control standards for the federal government state that events should be promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. Without taking steps to ensure that grantee-reported housing status data are current, HRSA may not have reliable information to use in reporting on the extent to which Ryan White HIV/AIDS program clients are reaching the National HIV/AIDS Strategy goals for attainment of permanent housing.

⁷⁸Pub. L. No. 106-345, Pub. L. No. 109-415, and Pub. L. 111-87.

We also found that HUD had not optimized its use of the performance information it required HOPWA grantees to collect. While HUD has processes in place to review the completeness and internal consistency of each grantee's annual data submission, HUD has not established specific procedures to compare the unmet housing need data individual grantees submit from year to year. The extent to which persons with HIV have an unmet housing need speaks to the continuing need for the HOPWA program. Reported data on unmet housing need may vary significantly, and HUD does not have steps in place to determine if the local unmet housing need has changed or whether the grantee may need technical assistance. Without a specific process to make comparisons among the unmet housing need data individual grantees submit from year to year, in accordance with federal internal control standards, HUD may not be able to ensure that significant changes are identified and addressed if necessary.

Finally, HRSA has missed opportunities to help ensure that HRSA staff are using all available tools to effectively monitor grantee performance related to housing. While housing is not the primary objective of the Ryan White HIV/AIDS program, stable housing is critical to the health of persons with HIV, as HHS has acknowledged. Internal controls for the federal government note that activities need to be established to monitor performance measures and indicators. Moreover, we have reported on the importance of using performance management indicators for management activities and decision making. Without requiring HRSA staff with monitoring responsibility to review the housing data that individual Ryan White Part A grantees submit, HRSA may not be able to proactively identify performance issues, including the extent to which individual grantees are contributing towards housing stability.

Matter for Congressional Consideration

If Congress wishes HOPWA funding to more closely account for the current impact of the HIV, it should consider revising the funding formula used to determine grantee eligibility and grant amounts to reflect a measure of persons living with HIV, including those with AIDS.

Recommendations for Executive Action

We make the following four recommendations:

- To improve information on the unmet housing needs of persons with HIV and follow through on its efforts to develop a standard methodology, we recommend that the Secretary of HUD direct the Assistant Secretary for Community Planning and Development to

require grantees to use comparable methodologies to analyze HUD's recommended data sources on unmet housing need.

- In order to improve the reliability of the housing data HRSA collects from Ryan White HIV/AIDS program grantees, we recommend that the Administrator of HRSA require program grantees that provide housing assistance to reflect each client's current (within the previous 12 months) housing status in the client-level housing status data that they report to HRSA.
- To help ensure that HUD is using grantee performance data to identify and address any irregularities or issues in grantee reporting, we recommend that the Secretary of HUD direct the Assistant Secretary for Community Planning and Development to develop and implement a specific process to make comparisons between the unmet housing need data submitted by individual grantees from year to year, including a process to follow up with grantees when significant changes are identified.
- In order to promote the use of housing assistance data to monitor program performance, we recommend that the Administrator of HRSA require the HRSA staff who have primary responsibility for monitoring Ryan White HIV/AIDS program grants to monitor indicators of grantees' performance in contributing towards housing stability, an HHS-identified indicator of HIV care.

Agency Comments and Our Evaluation

We provided a copy of this report to HUD and HHS for their review. In its written comments, which are reprinted in appendix III, HUD agreed with one of the two recommendations directed toward it and expressed concerns about the report's description of the agency's use of grantee data. In its written comments, which are reprinted in appendix IV, HHS agreed with both of our recommendations.

HUD agreed with our recommendation that it require HOPWA grantees to use comparable methodologies to analyze HUD's recommended data sources on unmet housing need. However, the agency said that our report did not acknowledge the agency's efforts to provide further guidance to communities beginning in the first quarter of fiscal year 2014. We requested documentation of such efforts, but HUD was unable to provide it. Our report notes that the Consolidated Annual Performance and Evaluation Reports (CAPER reports) describe the data sources that grantees can use to estimate unmet need. Our report also acknowledges an October 2014 meeting between HUD, stakeholders, and HOPWA

grantees to discuss identifying and reporting on unmet housing need as well as HUD's efforts to work with a contractor to develop a standard methodology. While these efforts are helpful steps toward developing a standard methodology, HUD does not have specific goals or time frames for finalizing this methodology.

HUD disagreed without our recommendation that it develop and implement a specific process to make comparisons between the data submitted by individual grantees from year to year, including a process to follow up with grantees when significant changes are identified. In its written response, HUD stated that the agency already conducts this type of analysis with contractor support. More specifically, HUD stated that data analysis is conducted using current and previously submitted data. However, HUD's documentation of the contractor's grantee-level analysis indicates that its trend analysis is focused on four areas: access to care, cost per unit, stability, and administrative costs. HUD's documentation of its contractor's analysis of data trends among formula grantees does not include other data elements collected through CAPER reports, including unmet housing need. Moreover, during the course of our review, HUD's contractors told us that they do not assess grantee-level, year-to-year changes in unmet housing need. Based on our analysis of unmet housing need data collected from CAPER reports from 2010 through 2013, we found that some formula grantees reported significant changes in unmet housing need from year to year. As noted in the report, in response to our review HUD determined that its contractor had made data entry errors in some cases. In other cases, HUD had not followed up with the grantee and stated that dramatic differences could be attributed to a variety of causes, including grantee staff turnover or changes in grantee capacity. In addition, staff from the four HUD field offices we visited told us that they review CAPER reports but do not compare the information grantees report from year to year. We revised our recommendation to clarify that we are recommending that HUD analyze year-to-year trends in the unmet housing need data that individual grantees submit.

HUD also agreed with our matter for congressional consideration. Specifically, HUD agreed that HOPWA funds are not being targeted as effectively or equitably as they could be, based on the outdated HOPWA statute. HUD noted that it has continued to seek congressional action on a legislative proposal, which includes statutory changes that reflect advances in both HIV health care and surveillance. Our report acknowledges HUD's efforts by discussing its proposal for updating the formula in its last three budget justifications.

In its general comments, HUD stated that the introductory part of the draft report (highlights page) would benefit from a more balanced approach to the discussion of the HOPWA program's strengths and weaknesses. The report discusses the strengths of the HOPWA program as part of one of our research objectives. Additionally, the section of the report that focuses on coordination describes HUD's and HRSA's efforts to collaborate with one another and provides examples of formal and informal coordination at the local level to avoid providing duplicative services. We also revised our highlights page to note that HUD has taken steps toward developing a standard methodology for grantees to use to assess unmet housing needs.

In its letter, HUD also provided technical comments, which we addressed as appropriate. HUD disagreed that it uses unmet housing need data to justify its HOPWA budget request and to assess the performance of the program. Regarding the first part of this statement—that HUD uses unmet housing need data to justify its HOPWA budget request—we did not make a change to the characterization of HUD's use of the data in its budget requests, and our analysis of HUD's budget requests supports our characterization. While HUD's technical comments characterized the agency's use of unmet need data in its budget requests as an anecdotal data point, HUD uses this information to justify the continuing need for the program. As an example, HUD's 2015 budget request notes that 131,164 HIV-positive households had unmet housing needs in the portion of the budget request that describes why the program is necessary. Regarding the second part of the statement with which HUD disagreed—that HUD uses unmet housing need to assess the performance of the program—we revised the report to state that HUD uses unmet housing need data for reporting on the performance of the program, rather than assessing the performance of the program. Specifically, the agency reports this information to the public not only through budget justification documents, but also through individual grantee and program-wide performance reports.

HUD also disagreed with the statement that the agency does not require HOPWA grantees to use a consistent methodology to calculate unmet need, and noted that formula grantees are required to report this need through CAPER reports. Our analysis of CAPER report guidance and grantees' implementation of this guidance supports our characterization. As described in the report, according to CAPER guidance formula HOPWA grantees can use one or more of seven data sources to calculate unmet need, including housing providers' waiting lists. However, HUD does not provide additional guidance on how these sources should

be analyzed. As a result, grantees could use different methods for analyzing the same data sources. The report provides examples of how HOPWA grantees we interviewed use different methodologies to calculate unmet housing needs.

HUD also disagreed with the statement that agency officials had not followed up with grantees that had reported significant changes in unmet housing needs between 2010 and 2013, and stated that contracted support plays a role in the review and analysis of HOPWA data. Our report acknowledges contractors' efforts to review HOPWA data for completeness and follow up with grantees regarding inconsistencies. However, our work supports our description of HUD's efforts to follow up with grantees that reported significant changes in unmet needs between 2010 and 2013, and therefore we did not make changes. As an example, our analysis of the unmet need data grantees reported to HUD found that one grantee reported an unmet need of 145 persons in 2011 and 525,957 persons in 2012. HUD did not research this anomaly until presented with our analysis. Furthermore, the documentation HUD provided of its follow-up efforts with grantees did not include information about unmet housing need data.

HHS agreed with our recommendation that HRSA require program grantees that provide housing assistance to reflect each client's current (within the previous 12 months) housing status in the client-level housing data that they report to HRSA. In its written comments, HHS also stated that HRSA does require Ryan White HIV/AIDS program grantees to maintain current clients' housing status. As we discuss in the report, HRSA requires grantees to report data on clients' housing status to HRSA every year. However, during the course of our review, HRSA officials told us that the frequency with which this information is updated is determined at the local level, and we found that this information may not be current. In its written comments, HRSA stated that it will update data instructions and provide a webinar for HRSA monitoring staff and Ryan White HIV/AIDS program grantees to help ensure that grantees are collecting data consistently and correctly. These actions, if implemented effectively, would address the intent of our recommendation.

HHS also agreed with our recommendation that HRSA staff who have primary responsibility for monitoring Ryan White HIV/AIDS program grants monitor indicators of grantees' performance in contributing towards housing stability. HHS noted that HRSA had taken steps to provide monitoring staff with reports that show grantee-level data and HHS indicators. According to HHS, these reports support the monitoring of

performance indicators, including housing status. Additionally, HHS stated that monitoring staff have begun to be trained on how to interpret these data. These are positive steps that should help HHS to more effectively monitor individual grantees' contributions towards housing stability. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Housing and Urban Development, the Secretary of Health and Human Services, and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-8678 or garcia Diaz@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are listed on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



Daniel Garcia-Diaz
Director, Financial Markets
and Community Investment

List of Committees

The Honorable Susan Collins
Chairman

The Honorable Jack Reed
Ranking Member

Subcommittee on Transportation, Housing and Urban Development, and
Related Agencies

Committee on Appropriations
United States Senate

The Honorable Mario Diaz-Balart
Chairman

The Honorable David E. Price
Ranking Member

Subcommittee on Transportation, Housing and Urban Development, and
Related Agencies

Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

Our objectives were to discuss (1) the need for housing assistance for persons with the human immunodeficiency virus (HIV) and the extent to which federal assistance reaches communities in need; (2) the results that have been achieved through federal programs that provide housing assistance for persons with HIV and what is known about the strengths and weaknesses of these programs; (3) the extent to which federal programs that provide housing assistance and supportive services for persons with HIV coordinate with one another; and (4) the extent of federal oversight of programs that provide housing assistance to persons with HIV.

To identify information on the housing needs of persons living with HIV, we obtained and reviewed available data from the Department of Housing and Urban Development (HUD) on the unmet housing needs of HOPWA-eligible persons for program years 2010 (the earliest year for which HUD considered the data to be reliable) through 2013 (program year refers to grantees' fiscal years, which may vary from the federal fiscal year). To assess the reliability of this information, we interviewed HUD officials, conducted electronic testing of the data to identify outliers as well as missing or duplicated data, and interviewed grantees of HUD's Housing Opportunities for Persons with AIDS (HOPWA) program. We compared HUD's methodology for calculating unmet housing need to internal control standards for the federal government, as well as GAO guidance on preparing reliable data.¹ We determined that HUD's unmet housing need data were not sufficiently reliable for the purposes of estimating the number of HOPWA-eligible individuals with an unmet need because they were based on data developed by HOPWA grantees using inconsistent methodologies.

We also analyzed the Centers for Disease Control and Prevention's (CDC) fiscal year 2012 HIV surveillance data—the most recent data available at the time of our review—to identify and describe geographic trends in persons living with diagnosed HIV infections as well as the

¹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999) and *Assessing the Reliability of Computer-Processed Data*, [GAO-09-680G](#) (Washington, D.C.: July 2009).

demographic characteristics of persons diagnosed with HIV.² To assess the reliability of this information, we interviewed CDC officials and reviewed documentation of CDC's methodology for collecting the data. We determined that the data were sufficiently reliable for the purpose of describing trends in HIV infection. To determine whether the Health Resources and Services Administration (HRSA) assessed the number of HIV-infected persons that might need emergency housing assistance, we reviewed HRSA guidance and interviewed HRSA officials. In addition, we reviewed requirements for Ryan White Planning Councils to assess local needs for HIV-related services. To identify the federal programs that provide housing assistance specifically for persons with HIV, we reviewed Congressional Research Service, GAO, HUD, and HRSA reports issued from 1997 through 2014 on housing for persons with HIV and interviewed HUD and HRSA officials. For HRSA's Ryan White HIV/AIDS program, we focused on Part A because it can fund housing assistance; because Part A grantees expended significantly more of their funding on housing assistance than Part B grantees in 2011, and because, like HOPWA grants, Part A grants are generally awarded to local governments.

To assess whether formula HOPWA grant funds were reaching communities with the greatest number of persons with HIV, we reviewed documentation of the current HOPWA funding formula. Through the current formula, grantees are identified and funds are awarded based on cumulative cases of acquired immunodeficiency syndrome (AIDS) since 1981, which includes deceased persons. We compared the number of cumulative AIDS cases to the number of persons living with HIV by metropolitan statistical areas (MSA) that received HOPWA formula funds in fiscal year 2012.³ For this comparison, we used CDC data on cumulative AIDS cases and persons living with HIV that were current as

²For CDC data, the Northeast includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. The Midwest includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. The South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The West includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Rates are per 100,000 population.

³The MSA delineations are based on the 2000 Office of Management and Budget Standards for Delineating Metropolitan and Micropolitan Statistical Areas (implemented in 2003).

of March 2011. This approach helped ensure that the two data sets were comparable to one another and corresponded to the data that would have been available in fiscal year 2012. These data were not adjusted for reporting delays. According to the CDC, estimates of persons living with HIV (i.e., HIV prevalence data) in a given year are generally more accurate when at least 12 months have elapsed since the end of the measurement period, as both diagnoses and deaths are often subject to reporting delays. The specific direction of any bias is unclear and may vary by jurisdiction. For each MSA, we calculated the absolute relative difference between cumulative AIDS cases and the number of cases of persons living with HIV (including AIDS).⁴ Additionally, we identified examples of MSAs that had similar numbers of persons living with HIV but received notably different amounts of HOPWA formula funds for fiscal year 2012.

We also compared the current HOPWA funding formula to our previous work that addressed funding grants based on cumulative AIDS cases, including the deceased.⁵ To describe HUD's proposed changes to the HOPWA funding formula, we reviewed HUD's congressional budget justifications for fiscal years 2013, 2014, and 2015.

Additionally, we obtained the views of formula HOPWA and Ryan White Part A grantees on the need for the HOPWA and Ryan White HIV/AIDS programs, as well as the extent to which the programs addressed the housing needs of persons with HIV. We visited and interviewed a purposive, or non-generalizable, sample of grantees of each program. To identify the purposive sample, we identified the cities in which all 90 of the 2011 formula HOPWA grantees and 53 of the 2011 Ryan White Part A grantees were located. We then identified 47 common grantees that

⁴The (absolute) relative difference is measured as a ratio of the absolute difference between the two measures to the number of cumulative AIDS cases, expressed as a percentage for areas that received a formula HOPWA grant in 2012. We use absolute value because some MSAs have a higher number of cumulative AIDS cases than living HIV cases and others have a higher number of living than cumulative cases. This value is a measure of closeness between the cumulative number of AIDS cases and the number of persons living with HIV and is always greater than or equal to zero. The lower the value, the closer the number of cumulative AIDS cases is to the number of persons living with HIV in a given MSA.

⁵GAO, *Housing: HUD's Program for Persons with AIDS*, [GAO/RCED-97-62](#) (Mar. 24, 1997) and *HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds*, [GAO-06-332](#) (Feb. 28, 2006).

received both HOPWA and Ryan White Part A grants. We used HRSA's 2011 Ryan White HIV/AIDS program expenditure data to identify grantees that had spent Ryan White Part A funds on housing assistance. We compared the locations of the Ryan White Part A grantees that had funded housing assistance to locations of the formula HOPWA grantees and selected four cities that had both. We based our selection on grant size (i.e., grant amounts at either the higher end or middle of the range in fiscal year 2011), the presence of Ryan White Part A grantees that had expended Ryan White Part A funds on housing assistance, and geographic diversity. Based on this analysis, we selected New York City, New York; New Orleans, Louisiana; San Francisco, California; and St. Louis, Missouri. In each city, we interviewed officials from the formula HOPWA grantees and Ryan White Part A grantees; one or more HOPWA project sponsors; one or more Ryan White Part A subgrantees; the local HUD field office; the local Continuum of Care grantee; and at least one HIV advocacy organization. We selected HOPWA project sponsors and Ryan White Part A grantees based on discussions with grantee staff and selected advocacy organizations based on information from a national HIV advocacy organization about active local HIV advocacy organizations.⁶ We also toured housing that was funded through formula HOPWA funds or Ryan White Part A in each city, including emergency housing, a permanent housing facility, and a hospice, to see how the funds had been used. To obtain views on the impact of the HOPWA and Ryan White HIV/AIDS Programs in rural areas, we also interviewed the State AIDS Directors for California, Louisiana, Missouri, and New York.

To determine the results that have been achieved through federal programs that provide housing assistance to persons with HIV, we obtained and analyzed HOPWA data on how funds were used and client characteristics for program years 2009 through 2012. To assess the reliability of the HOPWA data, we interviewed HUD officials and contractors that had responsibility for processing information about their data reliability procedures. We also conducted electronic testing for missing data, outliers, or obvious errors. We found that most data were reliable for the purposes of describing how funds were used and identifying the characteristics of the persons who benefitted from housing

⁶Continuum of Care is a HUD program that funds, among other groups, nonprofit homeless providers, faith-based organizations, and state and local governments within the geographic area they operate.

assistance. As previously noted, we found that HUD's data on unmet housing need were not sufficiently reliable for our purposes.

For the Ryan White HIV/AIDS program, we obtained and reviewed Ryan White HIV/AIDS Program Services Report (RSR) data for Part A, and for fiscal years 2010 through 2012. Agency officials told us that 2009 data were only available in aggregate form and not by Part A grantee. To assess the reliability of HRSA's Ryan White Part A data related to housing assistance, we reviewed HRSA guidance and policies, interviewed HRSA officials with responsibility for processing the data, interviewed four HRSA Program Officers, and conducted electronic testing. We also compared HRSA's methodology for calculating the percentage of Ryan White HIV/AIDS program clients who had stable housing to internal control standards for the federal government. Because HRSA does not require grantees to regularly update each client's housing status, we determined that housing status data were not sufficiently reliable for our purposes. Also, we obtained and analyzed expenditure data for both programs. For HOPWA and Ryan White Part A, the most recent years of expenditure data were 2012 and 2011, respectively. For HOPWA, we analyzed program data on activities funded (e.g., housing assistance, housing development, supportive services); types of housing assistance funded (e.g., tenant-based rental assistance, permanent facilities); and demographic characteristics (e.g., sex, race, ethnicity, age, income). For the Ryan White HIV/AIDS program, we analyzed RSR data on the number and proportion of clients who received housing assistance through Part A. For those clients who did receive housing assistance, we analyzed demographic characteristics (sex, race, ethnicity, age, earnings relative to the federal poverty level).

To describe the strengths of the HOPWA and Ryan White Part A programs, as well as any weaknesses associated with these programs, we reviewed program requirements; identified studies through a search of various databases using keywords such as "HOPWA" and "Ryan White"; and interviewed a purposive sample of program grantees, HOPWA project sponsors, and Ryan White Part A subgrantees. We also interviewed HIV advocates, HUD and HRSA officials with responsibilities related to the HOPWA and Ryan White HIV/AIDS programs, and an academic researcher on HIV and housing who had co-authored various articles on housing for persons with HIV in New York City. Upon completion of our initial search, we identified eight studies that discussed the effects of housing assistance programs on persons with HIV. We reviewed the studies' methodology, limitations, and conclusions for the purposes of excluding studies that did not ensure a minimal level of

methodological rigor and excluded two studies. Of the six remaining studies, two were randomized control trial studies, one was a cross-sectional study, and one used a quasi-experimental design. Two had weaker research designs but were retained since they were sufficiently rigorous and, given the limited number of empirical studies on this subject, provided useful information on the importance of access to housing for medical outcomes for people living with HIV.

To assess the extent to which the HOPWA and Ryan White Part A programs coordinated with each other at the federal level, we identified program requirements in the governing legislation for the HOPWA and Ryan White HIV/AIDS programs. We also obtained and reviewed documentation of HUD's and HRSA's efforts to coordinate with each other, interviewed HUD and HRSA officials about these efforts, and compared the efforts to GAO's criteria related to coordination and program overlap.⁷

To determine how the HOPWA and Ryan White Part A programs coordinated with other federal housing assistance programs that were not targeted to persons with HIV but could potentially be used by such persons, we took several steps. First, we identified a list of 87 housing assistance programs based on previous GAO reports on fragmentation, overlap, and duplication among housing assistance programs and discussions with HUD and HRSA officials.⁸ Second, we used criteria to narrow the list of programs. For example, we excluded programs that provided mortgage assistance, loan guarantees, and community development assistance that were not focused on housing. We also excluded programs that were not receiving new funding. Based on this methodology, we identified five programs: Public Housing, Housing Choice Vouchers, Continuum of Care, Emergency Solutions Grants, and the HUD-Veterans Affairs Supportive Housing. HUD officials agreed with

⁷GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, [GAO-12-342SP](#) (Washington, D.C.: Feb. 28, 2012) and U.S. Government Accountability Office: *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington D.C.: Mar. 1, 2011).

⁸GAO, *Housing Assistance: Opportunities Exist to Increase Collaboration and Consider Consolidation*, [GAO-12-554](#) (Washington, D.C.: Aug. 16, 2012) and *Housing Assistance: An Inventory of Fiscal Year 2010 Programs, Tax Expenditures, and Other Activities*, [GAO-12-555SP](#) (Washington, D.C.: Aug. 16, 2012), an E-supplement to [GAO-12-554](#).

the list of housing programs. For the five programs, we compared their primary goals, client eligibility requirements, requirements related to supportive services, and the specific types of housing assistance that could be provided. We also discussed whether and how HOPWA and Ryan White Part A grantees coordinated with these programs during our site visits to the purposive sample of cities. Additionally, we reviewed the Catalog of Federal Domestic Assistance program descriptions, program information from each program's website, and prior GAO reports to determine each program's size, administering agency, and assistance type. Finally, we interviewed HIV advocacy groups, HOPWA and Ryan White Part A grantees, HUD and HRSA officials, and an academic researcher about housing assistance and services for persons with HIV.

To assess HUD and HRSA's monitoring and oversight efforts, we identified and reviewed their monitoring policies, procedures, and guidance. We also interviewed HUD headquarters and field office staff with responsibilities related to HOPWA grantee monitoring, as well as HRSA staff who had primary responsibility for monitoring Ryan White Part A grantees. We compared HUD's risk assessment policies for program years 2008 through 2013 to documentation on the implementation of these procedures for the four HOPWA grantees we visited, including documentation of risk assessments and site visits conducted. For the Ryan White HIV/AIDS program, we reviewed the status of five previously issued GAO recommendations related to program monitoring and oversight and summarized HRSA's efforts to address these recommendations.⁹ We also analyzed updated HRSA data on Part A site visits conducted in 2012 and 2013. Additionally, we interviewed both HUD and HRSA officials on how they use performance data to monitor HOPWA and Ryan White Part A grantees. For HOPWA, we reviewed documentation of HUD's use of performance data for program years 2009 through 2013. For the Ryan White HIV/AIDS program, we reviewed published reports on the agency's use of housing-related performance data. We compared HUD and HRSA's monitoring efforts to federal

⁹GAO, *Ryan White CARE Act: Improvements Needed in Oversight of Grantees*, GAO-12-610 (Washington, D.C.: June 11, 2012).

internal control standards as well as practices that leading organizations used related to managing for results.¹⁰

We conducted this performance audit from March 2014 to April 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

¹⁰[GAO/AIMD-00-21.3.1](#); GAO, *Managing for Results: Enhancing Agency Use of Performance Information for Management Decision Making*, [GAO-05-927](#) (Washington, D.C.: September 2005); and *Managing for Results: Agencies' Trends in the Use of Performance Information to Make Decisions*, [GAO-14-747](#) (Washington, D.C.: Sept. 26, 2014).

Appendix II: Relative Difference between Cumulative AIDS Cases and Living HIV Cases

In 2012, the Department of Housing and Urban Development (HUD) awarded formula Housing Opportunities for Persons with AIDS (HOPWA) grants to 78 metropolitan statistical areas (MSA), with the most populous city in each area serving as that area's formula HOPWA grantee. Formula grant funding criteria are based on each MSA's share of cumulative Acquired Immune Deficiency Syndrome (AIDS) cases. Table 6 shows the number of cumulative AIDS cases, the number of persons living with human immunodeficiency virus (HIV), and the relative difference between these two numbers for each MSA.

Table 6: Relative Difference between Cumulative AIDS Cases and Living HIV Cases, by Areas that Received Formula HOPWA Grants in 2012

HOPWA grantee	Cumulative AIDS cases	Persons living with HIV (including AIDS)	Relative difference ^a
Albany-Schenectady-Troy, NY	2,530	2,115	16%
Albuquerque, NM	1,651	1,296	22%
Allentown-Bethlehem-Easton, PA-NJ	1,642	1,521	7%
Atlanta-Sandy Springs-Marietta, GA	26,634	23,650	11%
Augusta-Richmond County, GA-SC	2,152	2,075	4%
Austin-Round Rock, TX	5,560	4,643	16%
Bakersfield, CA	1,945	1,863	4%
Baltimore-Towson, MD	23,728	18,779	21%
Baton Rouge, LA	4,782	4,412	8%
Birmingham-Hoover, AL	2,942	3,503	19%
Boston-Cambridge-Quincy, MA-NH	14,898	10,249	31%
Bridgeport-Stamford-Norwalk, CT	4,191	2,877	31%
Buffalo-Niagara Falls, NY	2,783	2,288	18%
Cape Coral-Fort Myers, FL	2,079	1,699	18%
Charleston-North Charleston, SC	2,482	2,191	12%
Charlotte-Gastonia-Concord, NC-SC	4,199	6,004	43%
Chicago-Naperville-Joliet, IL-IN-WI	34,617	29,390	15%
Cincinnati-Middletown, OH-KY-IN	3,400	3,281	4%
Cleveland-Elyria-Mentor, OH	4,888	4,579	6%
Columbia, SC	4,010	3,986	1%
Columbus, OH	4,012	4,539	13%
Dallas-Fort Worth-Arlington, TX	23,447	21,161	10%
Denver-Aurora, CO	7,954	8,736	10%
Detroit-Warren-Livonia, MI	12,111	9,440	22%
El Paso, TX	1,796	1,686	6%

**Appendix II: Relative Difference between
Cumulative AIDS Cases and Living HIV Cases**

HOPWA grantee	Cumulative AIDS cases	Persons living with HIV (including AIDS)	Relative difference^a
Fresno, CA	1,811	1,357	25%
Greensboro-High Point, NC	1,598	2,189	37%
Greenville, SC	1,502	1,266	16%
Hartford-West Hartford-East Hartford, CT	5,694	3,667	36%
Honolulu, HI	2,415	1,602	34%
Houston-Baytown-Sugar Land, TX	30,155	23,162	23%
Indianapolis, IN	4,526	4,244	6%
Jackson, MS	2,973	3,147	6%
Jacksonville, FL	7,372	6,092	17%
Kansas City, MO-KS	5,636	4,678	17%
Lakeland-Winter Haven, FL	2,280	1,795	21%
Las Vegas-Paradise, NV	5,672	5,900	4%
Little Rock-North Little Rock, AR	1,620	1,745	8%
Los Angeles-Long Beach-Santa Ana, CA	66,034	48,093	27%
Louisville, KY-IN	2,818	2,895	3%
Memphis, TN-MS-AR	6,104	7,260	19%
Miami-Fort Lauderdale-Miami Beach, FL	64,948	51,363	21%
Milwaukee-Waukesha-West Allis, WI	2,926	2,879	2%
Minneapolis-St. Paul-Bloomington, MN-WI	5,152	5,953	16%
Nashville-Davidson—Murfreeseboro, TN	4,551	4,994	10%
New Haven-Milford, CT	5,003	3,308	34%
New Orleans-Metairie-Kenner, LA	10,178	8,002	21%
New York-Northern New Jersey-Long Island, NY-NJ-PA	218,340	140,839	35%
Oklahoma City, OK	2,623	2,382	9%
Orlando, FL	10,654	10,199	4%
Palm Bay-Melbourne-Titusville, FL	1,723	1,288	25%
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	32,963	27,289	17%
Phoenix-Mesa-Scottsdale, AZ	9,141	9,295	2%
Pittsburgh, PA	3,695	3,010	19%
Portland-Vancouver-Beaverton, OR-WA	5,512	4,316	22%
Poughkeepsie-Newburgh-Middletown, NY	3,399	2,302	32%
Providence-New Bedford-Fall River, RI-MA	4,432	2,888	35%
Raleigh-Cary, NC	2,696	3,202	19%
Richmond, VA	4,032	4,262	6%
Riverside-San Bernardino-Ontario, CA	10,014	8,003	20%
Rochester, NY	3,495	3,061	12%

**Appendix II: Relative Difference between
Cumulative AIDS Cases and Living HIV Cases**

HOPWA grantee	Cumulative AIDS cases	Persons living with HIV (including AIDS)	Relative difference^a
Sacramento—Arden-Arcade—Roseville, CA	4,552	3,546	22%
St. Louis, MO-IL	7,049	6,560	7%
Salt Lake City, UT	1,955	1,854	5%
San Antonio, TX	6,003	4,930	18%
San Diego-Carlsbad-San Marcos, CA	14,570	11,654	20%
San Francisco-Oakland-Fremont, CA	44,062	24,100	45%
San Jose-Sunnyvale-Santa Clara, CA	4,438	3,105	30%
San Juan-Caguas-Guaynabo, PR	23,713	13,338	44%
Sarasota-Bradenton-Venice, FL	2,313	1,744	25%
Seattle-Tacoma-Bellevue, WA	10,338	8,565	17%
Springfield, MA	2,396	1,728	28%
Tampa-St. Petersburg-Clearwater, FL	13,251	10,596	20%
Tucson, AZ	2,320	1,975	15%
Tulsa, OK	1,764	1,534	13%
Virginia Beach-Norfolk-Newport News, VA-NC	5,505	6,047	10%
Washington-Arlington-Alexandria, DC-VA-MD-WV	37,422	31,353	16%
Worcester, MA	2,048	1,460	29%

Source: CDC data as of March 2011. | GAO-15-298

^aThe (absolute) relative difference is measured as a ratio of the absolute difference between the two measures to the number of cumulative AIDS cases, expressed as a percentage for areas that received a formula HOPWA grant in 2012. This value is a measure of closeness between the cumulative number of AIDS cases and the number of persons living with HIV, and is always greater than or equal to zero.

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



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

OFFICE OF COMMUNITY PLANNING
AND DEVELOPMENT

MAR 2 5 2015

Mr. Daniel Garcia-Diaz
Director
Financial Markets and Community Investment Team
U.S. Government Accountability Office
441 G Street, NW Room A2828
Washington, DC 20548

Dear Mr. Garcia-Diaz:

Thank you for your letter received on March 2, 2015, requesting HUD review and comment on the proposed report *Housing for Persons with HIV* (GAO 15-298). HUD is committed to continuing efforts to improve overall accountability for programs serving persons living with HIV/AIDS. The Office of HIV/AIDS Housing that administers the Housing Opportunities for Persons With AIDS (HOPWA) program appreciates the opportunity to comment and provide clarification on the report recommendations.

General Comments

GAO was tasked by Congress to evaluate the ability of federal programs, specifically HUD's HOPWA program and the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS program to meet the housing needs of those living with HIV/AIDS. GAO was also asked to address the relative strengths and weaknesses of these programs, inventory programs that provide services to HIV-infected persons, and discuss the extent of any overlap or program coordination issues.

Overall, the report would benefit from a more balanced approach to its discussion of strengths and weaknesses, especially in the introductory statements. This would provide the reader with a more comprehensive view of how these important programs are meeting the needs of persons living with HIV and AIDS - including the Department's ongoing efforts to improve the program - rather than focusing only on those areas that GAO has determined need improvement.

Specifically, HUD recommends that the introductory section, titled "What GAO Found" include statements supporting GAO review conclusions that the HOPWA program's administrative oversight and collaboration with other federal agencies is effective and specifically, the HOPWA and Ryan White programs "complement rather than duplicate each other." The report also highlights collaboration between HUD and HRSA to implement National HIV/AIDS Strategy recommendations, including steps taken to share program performance data, along with efforts by HUD to advise HRSA on their housing policy. More importantly, the review determined through consultation with organizations administering supportive housing programs for those living with HIV that while there may be other forms of federal housing resources, such as public housing and Housing Choice Voucher programs, they generally do not provide supportive services. The provision of supportive services is an integral component of facilitating housing stability and

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promoting improved health outcomes within both the HOPWA and Ryan White programs. As drafted, the report does not summarize these program accomplishments to accurately reflect on the program's notable successes.

The report recommendations are reasonable and generally coincide with past and current Departmental efforts. HUD recommends that the GAO acknowledge the Department's ongoing efforts to seek congressional action to modernize the HOPWA program formula, develop a standard methodology to assist communities in identifying and reporting unmet housing needs, and implement a trend analysis of grantee performance data.

With respect to the report recommendations regarding methodology and performance data, it is important to note that the Office of HIV/AIDS Housing secured technical assistance resources nearly 14 months ago to assist the office in working with communities to develop a standard methodology to identify and report on unmet housing needs, as well as conducting trend data analysis using the past three years grantee annual performance reporting data. Given this ongoing work, the GAO statements that the current unmet housing need data is not reliable and that HUD is not comparing previous year's grantee performance data should be significantly revised. Both of these conclusions are factually inaccurate.

Response to HOPWA program recommendations

Matter for Congressional Consideration: "If Congress wishes HOPWA funding to more closely account for the current impact of the HIV, it should consider revising the funding formula used to determine grantee eligibility and grant amounts using a measure of persons living with HIV, including those with AIDS."

HUD Response: HUD agrees with the statement that HOPWA program funds "are not being targeted as effectively or equitably as they could be" based on an outdated HOPWA statute in which formula funding is distributed based on cumulative AIDS cases and does not consider those living with HIV. Currently, 53 percent of the statutorily required cumulative AIDS cases used to run the program formula represents deceased individuals. The HOPWA legislative proposal seeks to distribute funding more equitably to reflect the HIV epidemic's impact among communities with the highest burden of HIV cases, notably Southern states and rural areas, while addressing the increasingly disproportionate impact of HIV on communities of poverty and color.

The Department continues to seek Congressional action on the HOPWA legislative proposal, which includes statutory changes that reflect an epidemic transformed by advances in both HIV health care and HIV surveillance. The President's *National HIV/AIDS Strategy* tasks HUD to work with Congress to modernize the HOPWA formula and in meeting the recommendations set forth in the *HIV Care Continuum Initiative* which seeks to accelerate efforts in HIV prevention and care and ensure that federal resources are focused on improving client outcomes along the care continuum. This would enable the HOPWA program to use current HIV surveillance data from the Centers for Disease Control and Prevention based on those living with HIV, inclusive of those with AIDS, while aligning with the Ryan White program for the distribution of grant resources. HUD is committed to

the enactment of a HOPWA statutory formula change and has included this legislative proposal within each of the four last HOPWA congressional budget justifications (FY2013-2016).

Recommendation: “To improve information on the unmet housing needs of persons with HIV, we recommend that the Secretary of HUD direct the Assistant Secretary for Community Planning and Development to require grantees to use comparable methodologies to analyze HUD’s recommended data sources on unmet housing need.”

HUD Response: HUD agrees with the recommendation to develop and implement a standard methodology for the calculation of a community’s unmet housing needs for those living with HIV, and has already taken significant steps towards this goal. The GAO draft report fails to acknowledge the ongoing Departmental efforts as communicated during this review that were initiated in the first quarter of fiscal year 2014 to provide communities with further guidance in identifying and reporting unmet housing needs. All recipients of Community Planning and Development formula funding – notably local and state governments are required to prepare and submit a five year Consolidated Plan document which is supplemented with an annual Action Plan. These planning documents require communities to assess local housing needs and develop strategic approaches to address unmet housing needs.

Currently, the HOPWA formula annual grantee performance report, *Consolidated Annual Performance Evaluation Report (CAPER)*, requires communities to conduct an assessment of unmet housing needs while providing them with flexibility to calculate this number based on most current data available through the Consolidated or Annual Plan(s), account for local housing issues, and changes in HIV/AIDS cases. The CAPER report identifies recommended data sources for unmet housing needs. HUD acknowledges that this guidance to grantees requires revision and efforts are underway to solicit grantee input while at the same time ensuring that this unmet need methodology conform with other Departmental efforts to compile and evaluate local community needs data.

Recommendation: “To help ensure that HUD is using grantee performance data to identify and address any irregularities or issues in grantee reporting, we recommend that the Secretary of HUD direct the Assistant Secretary for Community Planning and Development to develop and implement a specific process to make comparisons between the data submitted by individual grantees from year to year, including a process to follow up with grantees when significant changes are identified.”

HUD Response: HUD already conducts this type of analysis, and therefore disagrees with the basis for this recommendation. With contracted support, HUD currently maintains a comprehensive HOPWA annual performance reporting database for both formula and competitive grants in which annual grantee performance reports are received on a timely basis, data is entered and validated, and data analysis is conducted using current and previously submitted data. This enables the preparation of annual formula and competitive program profiles, along with individual grantee performance profiles that are posted on the HUD website for public transparency and to facilitate comparisons of program performance

one year to another. In addition, HUD field office staff is assigned responsibility for reviewing and assessing the accuracy of these annual HOPWA grantee performance reports. These reports are a valuable resource tool for the Department when the annual grantee risk assessment is conducted to identify grantees for on-site compliance monitoring.

Technical comments

Page 15, in reference to unmet housing needs, “HUD uses this information to justify its HOPWA budget request and for assessing the performance of the program.”

HUD Response: This statement is factually incorrect. Within the HOPWA program's annual congressional budget justification, the estimated unmet housing need is provided as an anecdotal data point and is not used to either justify the requested budget amount or support efforts to assess program performance outcomes. (Source: FY2016 budget justification, page X-7 “Grantees report an estimated unmet housing need of more than 127,000 households/individuals, as reported by grantees through Consolidated Plan estimates, project data, housing waiting lists, and related planning sources.”)

Page 15, “HUD officials told us that they do not require HOPWA grantees to use a consistent methodology to calculate unmet housing need for each jurisdiction. They told us that this policy is intended to allow for local flexibility, so that data are collected using a method that is most appropriate for each jurisdiction.”

HUD Response: This statement is factually incorrect. The HOPWA *Consolidated Annual Performance and Evaluation Report (CAPER)* used by formula grantees to report and measure program performance outcomes contains specific guidance to conduct an assessment of unmet housing needs through the Consolidated or Annual Action Plan submissions. The Department recognized prior to the start of this review that additional guidance to communities was necessary to ensure consistency on how communities identified and reported on unmet housing needs to meet the requirements of the Consolidated Plan and Annual Action Plan submissions to HUD.

Page 30, “HOPWA grantees and project sponsors also identified weaknesses in the HOPWA program, including certain requirements, administrative fees, and the funding formula.”

HUD Response: The HOPWA legislative proposal seeks to address an outdated HOPWA program formula that also provides communities with an expansion of the provision of short-term housing options to enable communities to meet the housing needs of the homeless living with HIV, in addition to updating program administrative fees for grantees and program sponsors.

Page 46, “Although HUD collects performance information on HOPWA grantees, HUD does not effectively evaluate year-to-year changes in the performance data for the individual grantees to identify potential problems or mistakes in grantee reporting.” In addition, “The contractors review the data for completeness and

follow-up with grantees regarding inconsistencies. However the contractors are not required to compare current year data to prior year data.”

HUD Response: The Office of HIV/AIDS Housing issues annual HOPWA formula and competitive grant operating instructions that contains guidance and direction with respect to annual grantee performance reporting along with reconciliation of IDIS financial reporting. With the assistance of contractor support, HUD maintains on-line (<https://www.hudexchange.info/manage-a-program/hopwa-performance-profiles/>) grantee performance profiles that are updated annually to provide grantees and the general public, including program beneficiaries and stakeholders, with an overview of how program resources are expended, as well as program beneficiary outcomes. These profiles are an integral tool for both grantees and HUD personnel to evaluate and measure program performance from one year to the next while guiding the use of technical assistance, including other grants management activities such as on-site HUD field office compliance monitoring.

HUD field office personnel are assigned responsibility for receiving and reviewing grantee annual performance reports. They are responsible for the review of the performance data in the context of grants management and oversight. Contracted support is responsible for data entry into the HOPWA national performance data base, in addition to data verification that considers previously submitted data to ensure accuracy and completeness. All submitted reports are assigned a data quality ‘Tier’ status (Tier 1 – passes all data checks through Tier 4 – missing or unusable data) which is logged in the database (refer to Appendix A – Grantee Annual Performance Report – Verification Process).

In addition, the competitive permanent supportive housing renewal grants are also assessed rigorously as part of the three-year cycle for renewal to identify and measure the accuracy of program accomplishment and expenditure data.

Page 47, “Prior to our review, HUD officials had no follow-up with grantees that had reported significant changes in unmet needs between 2010-2013.”

HUD Response: This statement is factually incorrect. HUD has a GSA 8A contract to assist with HOPWA annual performance reporting. Contracted support is tasked with ensuring that all HOPWA grantee performance data submitted is timely, accurate, and complete. In addition to receipt of reports, data entry, data validation, and preparation of summary reports, these efforts are supplemented with ongoing data management and analysis. All performance data is reviewed and validated, including the reporting of unmet housing needs. Data is analyzed and compared from one reporting year to another. The HOPWA database includes functionality that tests performance data across several parameters and assists in identifying errors through consistency within tables, consistency across the report, and mathematical errors. It is routine for contracted support to inquire with HUD field office personnel and grantee staff to clarify reporting discrepancies and significant changes from one reporting year to another.

Page 48, “HUD field office staff with whom we met stated that they do not compare

grantee data from year to year to identify any potential data reporting errors.” “By not effectively analyzing trends in the data elements grantees are required to report, HUD may be missing the opportunity to identify and address problems in grantee reporting. Moreover, by not following up on significant changes in data submitted, HUD may be missing indications that the data on the program as a whole may not be reliable.” Page 51, “We also found that HUD has not optimized its use of the performance information it requires HOPWA grantees to collect.” “...HUD has not established specific procedures to effectively make comparisons between the performance data individual grantees submit from year to year. As a result, reported data may vary significantly, and HUD does not have steps in place to determine if the grantees’ performance has changed or whether the grantee may need technical assistance.”

HUD Response: HUD disagrees with these statements based on the explanation provided in the above comment. As stated during the review, the Office of HIV/AIDS Housing has administrative oversight over a rigorous effort to manage HOPWA annual performance reporting data. Contractor protocols are in place specifying how data is received, stored, reviewed, validated, and analyzed, including roles and work flow information. Annual performance data is maintained in a database which includes an electronic record of the all performance year data.

With respect to comments cited from HUD field staff regarding review of grantee performance reporting, this is likely related to workload and staffing issues in individual field offices rather than a lack of clarity from the Office of HIV/AIDS Housing. Many field offices are overwhelmed with a high workload and have competing priorities. Operating instructions outline how field offices should receive and review annual grantee performance reports, and in many cases the review of these reports is included in staff annual performance evaluation metrics. Furthermore, grantee reports are an invaluable resource to field offices when they conduct their annual risk assessment of all grantees within their portfolio to determine those that meet the requirements for an on-site compliance monitoring.

Page 50, Conclusions, in reference to unmet housing needs, “... Congress may not have a complete understanding of the continuing need for programs that provide housing assistance to persons with HIV.”

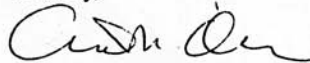
HUD Response: The Department is committed to ensuring sustained program accountability with effective measuring and reporting of program results and beneficiary outcomes. Research shows that housing status is a social determinant of health and the provision of HOPWA supportive housing demonstrates that housing stability results in better health outcomes and reduced HIV viral transmission. The HOPWA program was designed to provide communities with latitude and flexibility in addressing the housing needs of those living with HIV. States and localities develop long-term comprehensive strategies which includes understanding and identifying community need and targeting resources to address community priorities.

Page 7 of 7

As stated in the FY 2016 HOPWA congressional budget justification, the program services 26,152 households with permanent supportive housing through tenant-based rental assistance and facility-based housing and 26,514 households with transitional/short-term housing to address and prevent homelessness while working in tandem with local homeless Continuum of Care efforts. The budget request also makes reference to the fact that communities remain challenged to sustain existing program beneficiaries and are limited in assisting new incoming households. An analysis of grantee performance reporting over the past three years evidences increasing housing costs associated with serving greater numbers of extremely-low income households along with aging program beneficiaries. When factoring in per unit cost increases for permanent supportive housing (tenant-based rental assistance and facility-based housing) and a housing inflation rate in high cost housing markets (which represents an inherent rising annual cost factor), particularly for long-term rental subsidies, these variables translate into high housing subsidies and program costs.

The Department appreciates the opportunity to review this report prior to publication. If you have further questions, please contact Will Rudy, Acting Director, Office of HIV/AIDS Housing, at william.g.rudy@hud.gov.

Sincerely,



Ann Marie Oliva
Deputy Assistant Secretary
For Special Needs

Appendix IV: 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 16 2015

Daniel Garcia-Diaz
Director, Financial Markets and
Community Investment Team
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Garcia-Diaz:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*HIV: Funding Formula for Housing Assistance Could Be Better Targeted and Performance Data Could Be Improved*" (GAO-15-298).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: PERSONS WITH HIV: FUNDING FORMULA FOR HOUSING ASSISTANCE COULD BE BETTER TARGETED AND PERFORMANCE DATA COULD BE IMPROVED (GAO-15-298)

The U.S. Department of Health and Human Services (HHS) appreciates the Government Accountability Office (GAO) for the opportunity to review and comment on this draft report.

HHS, like GAO, recognizes that housing is a critical service for people living with HIV (PLWH), and the provision of housing services by the Ryan White HIV/AIDS Program (RWHAP) helps assure access to and retention in high quality, integrated care and treatment services. However, while stable housing is critical for quality medical care, HHS's primary aim is to provide medical care, which GAO acknowledges in its report. Grantees receiving funds under Part A are required to spend at least 75 percent of grant service dollars on core medical services with the remaining 25 percent being spent on support services such as housing.¹ As noted by GAO, the RWHAP Part A funded providers spend about 2 percent of all Part A funds on housing services.

Through the RWHAP, housing services are prioritized on a local level to respond to needs of RWHAP clients and is one of 16 supportive services that encompass a system of care. These services assist RWHAP clients' access to needed health care and adherence to treatment regimens, so they can become virally suppressed and have improved health outcomes.

To ensure that HHS meets the goals and legislative requirements of the RWHAP, Project Officers are required to monitor RWHAP grantees for compliance with federal requirements and programmatic expectations. The Part A program provides national monitoring standards to help grantees meet federal requirements for program and financial management and to improve program efficiency. Housing is monitored per these standards in order for PLWH to achieve better health outcomes.

GAO Recommendation 1

In order to improve the reliability of the housing data the Health Resources and Services Administration (HRSA) collects from Ryan White HIV/AIDS program grantees, we recommend that the Administrator of HRSA require program grantees that provide housing assistance to reflect each client's current (within the previous 12 months) housing status in the client-level housing status data that they report to HRSA.

HHS Response 1

HHS concurs with this recommendation. HRSA does require Ryan White HIV/AIDS Program grantees to maintain current data on client's housing status—albeit with the flexibility that allows grantees to collect status as of any point in time within the last 12 months, but not any older. Grantees providing outpatient/ambulatory medical care, medical case management and case management services are required to report on the "client's housing status at the end of the reporting period" through the Ryan White Program Services Report (RSR). These data are due to HRSA in March of every year. Instructions direct grantees to submit the most recent housing

¹ This provision also applies to grants under Parts B and C of the RWHAP.

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status available to them. RWHAP's grantees are responsible for creating local policies for updating client's housing status. To ensure that grantees are collecting data consistently and correctly, HRSA will provide additional technical assistance by updating data instructions and providing a targeted webinar on the collection of housing status for Project Officers and grantees in the next six months.

GAO Recommendation 2

In order to promote the use of housing-assistance data to monitor program performance, we recommend that the Administrator of HRSA require the HRSA staff who have primary responsibility for monitoring Ryan White HIV/AIDS program grants to monitor indicators of grantees' performance in contributing towards housing stability, an HHS-identified indicator of HIV care.

HHS Response 2

HRSA agrees with the recommendation related to the monitoring of housing stability as part of the RWHAP grantee performance. Within the overall context of the RWHAP, Project Officers communicate with grantees through regularly scheduled monitoring calls and comprehensive site visits to review the system of care provided through the grant. Project Officers also review and use allocation and expenditure reports as a part of regular oversight. These reports track both expenditures based on service categories (including housing status) and any increases or decreases in allocations versus expenditures. If Project Officers detect that there is an issue in the provision of services, they follow up with grantees to discuss the issue and help identify appropriate resources and/or technical assistance.

HRSA has been working to put mechanisms in place for stronger oversight. Beginning in early 2015, the RWHAP began providing data reports for Project Officers and grantees on RWHAP grantee-level data and HHS indicators. These reports are another tool that supports the monitoring of performance indicators, including housing status. Project Officers have begun to be trained on how to interpret and understand these data at state-wide discussion forums, organized by HRSA, to increase collaboration across Part programs. To strengthen these efforts, HRSA is currently planning a training webinar for Project Officers on grantee data reports that will occur in March 2015. Following this training, Project Officers are scheduled to release to their grantees' grantee-level data reports which contain retrospective, merged data across a jurisdiction. The grantee-level data reports contain Part A service utilization information such as clients served, services funded, and performance indicators such as the National HIV/AIDS Strategy goals, by provider. Housing data will be specifically highlighted as a component of this training.

Using all available resources, data, and opportunities for review (monitoring calls, comprehensive site visits, etc.), Project Officers will ensure that, within the context of the overall program, housing status will be monitored appropriately on a continuing basis, while assuring that no additional burdens are placed on grantees.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Paul Schmidt, Assistant Director; Lisa M. Moore, Analyst-in-Charge; Imoni Hampton, John McGrail, John Mingus, Roberto Pinero, Jennifer Schwartz, and Jena Sinkfield made key contributions to this report.

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