Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE RYAN WHITE CARE ACT:

FUNDING FORMULAS

JUNE GIBBS BROWN
Inspector General

APRIL 1994
OEI-05-93-00330

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EXECUTIVE SUMMARY

PURPOSE

To examine the current Ryan White CARE Act funding formulas, propose options for changing the formulas, and examine their potential impact on the distribution of funds in Fiscal Year 1995.

BACKGROUND

On August 18, 1990, Congress passed Public Law 101-381 entitled The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (the Act). The purpose of the Act was to provide "emergency assistance to localities ... disproportionately affected by the Human Immunodeficiency Virus (HIV) epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease."

The Act was created to establish services for patients with Acquired Immune Deficiency Syndrome (AIDS) or HIV who would otherwise have no access to health care. It was also meant to provide emergency relief funding to communities with the highest number of reported AIDS cases. Congress funded the Act at $221 million for Fiscal Year (FY) 1991, $276 million for FY 1992, $348 million for FY 1993, and $579.4 for FY 1994. The President's FY 1994 budget proposes funding at $672 million.

The Act has four titles. The bulk of the funds fall under Titles I and II. Title I provides emergency relief grants to cities disproportionately affected by the HIV epidemic. Title II provides formula grants to States and territories to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease. Formulas govern the distribution of half of the Title I funds (the other half is distributed competitively), and all Title II funds.

SCOPE AND METHODOLOGY

The Ryan White Act will be reauthorized in FY 1996. This is the first in a series of studies which will provide information for the discussion surrounding reauthorization. Other studies examine the distribution of FY 1992 Ryan White funding by type of service and Title II consortia activities. A future study will survey grantees concerning several general aspects of the implementation of the program.

Concerns about the funding formulas were raised by many people we talked to as we designed the study: congressional staffers, representatives of national organizations, experts, grantee staff, and Federal officials. We expect the formulas to be an important focus for discussions during reauthorization. In this study, we analyze how Title I and

Title II funds have been targeted during the 3 years of the program and how changes in the formulas might affect targeting in the future.

FINDINGS

As the number of high incidence cities increases, the proportion of Title I funds going to cities with the largest caseloads is likely to decrease.

The number of high incidence cities eligible for Ryan White funding increased from 16 in FY 1991 to 25 in FY 1993 and 34 in FY 1994; HRSA expects an increase by as many as 4 to 7 in FY 1995. With all of these eligible metropolitan areas, or EMAs, receiving funding, the proportion of funds going to those with by far the greatest number of cases (i.e. New York, San Francisco, Los Angeles) can be expected to decline in the future, even in the face of increases in total dollars. Some respondents were concerned that such dilution of funding for cities with the most cases may conflict with Congressional intent to target funds to cities experiencing the greatest burden of the epidemic.

The current formulas have led to inequities in funding between grantees on a per-new-case basis. We found this to be especially true for Title I, and less so for Title II.

The cumulative case counts in the Title I formula have produced significant inequities in funding between EMAs on a per-new-case basis. For example, between FY 1991 and 1993, on average, San Francisco received $4,354 per new case reported and Chicago, $1,673. Also during that period, 12 of the 16 EMAs received less than the average amount per new case of $2,639.

The Title II formula produces considerably more equity in funding levels. Two-thirds of the grantees received close to the average amount per case in that 3 year period.

ALTERNATIVE FUNDING OPTIONS

We present four basic options for formulas that could be used to address the inequities described and target funds to greatest need. These options are not mutually exclusive; we realize that it could be valuable to combine various ideas to develop an effective formula. We also recognize that factors other than the ones we have used could be incorporated into the formulas. Our purpose is to present some general ideas that might be helpful in constructing a final allocation methodology.

Readers might ask why we propose changing the Title II formula, since it produces more equitable funding than the Title I formula. We believe that while the new-case count in the current Title II formula does significantly reduce inequity, the options we propose more purposefully ensure equitable funding.

We examined each option against five criteria. These criteria are:

Equity: The amount of funding should be the same per case to minimize inequities between and across geographical areas. Some readers may disagree with this criterion, believing that formulas should include variables to deliberately target different amounts of funding to grantees based on their varying circumstances and need. However, we believe that reliable data to establish such variables is lacking. It is also difficult to know which of many potential variables are most important, and to what extent they should be built into national formulas. Therefore we have chosen "equity" as a starting point for national formulas, which Congress could then modify as it sees the need.

Targeting: Funds should be targeted to areas with the greatest concentration of cases, and in amounts sufficient for grantees to develop the mandated continuum of care.

Flexibility: Funding formulas should be flexible enough to respond to demographic changes in the epidemic.

Reasonable Data Requirements: Data used in the formulas to distribute funds should be readily available and reliable.

Stability: Aggregate funding to various geographic areas should not fluctuate significantly from year to year.

OPTION 1: Distribute Title I Formula Funds on a Per-New-Case Basis to Cities with a Significant Proportion of All New Cases Reported Nationally.

This option targets funds to 41 cities with 72 percent of new cases reported in the 2 years prior to FY 1995, consistent with Congressional intent to target cities most affected. It also creates equitable per-case funding.

OPTION 2: Distribute Title I Funds on a Per-New-Case Basis, Including an Income Factor.

This option applies the Title II formula to Title I formula funds. The formula is based on each city's new cases reported for 2 years prior to FY 1995 and includes a per capita income adjustment. We select the same cities as under Option 1 to demonstrate this option.

OPTION 3: Distribute Title II Funds on a Per-New-Case Basis, Excluding an Income Factor and A Funding Floor.

This option establishes an average amount per case by dividing the dollars available by the number of new cases reported nationally for 2 years prior to FY 1995 and allocates funds to each State based on its new-case count. It also eliminates both the income factor in the formula and the $100,000 funding floor currently available to States.

OPTION 4: Distribute Title I and Title II Formula Funds on a Per-New-Case Basis as a Single Formula Grant.

This option combines formula funds and distributes them on a per-new-case basis to both States and high-incidence cities. We use the same cities as in Options 1 and 2 to

demonstrate this option. We also set a $200,000 floor to ensure a minimum amount of funding for every State.

COMMENTS

The PHS commented on this report; the full text of their comments is in Appendix D. The Assistant Secretary for Planning and Evaluation commented verbally. We thank all those who commented.

In response to the comments we received, and in view of information now available on the FY 1995 budget request, we recasted our four proposed formulas looking forward to FY 1995. We believe this updated view will be more helpful during reauthorization discussions. We also made other editorial changes in the report in response to the comments received.

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INTRODUCTION

PURPOSE

To examine the current Ryan White CARE Act funding formulas, propose options for changing the formulas, and examine their potential impact on the distribution of funds in Fiscal Year 1995.

BACKGROUND

As of March 1990, the year in which the Ryan White C.A.R.E. Act was passed, over 128,000 cases of Acquired Immune Deficiency Syndrome (AIDS) had been reported to the Centers for Disease Control (CDC). Some 78,000 people had died of the disease and nearly one million were infected with the Human Immunodeficiency Virus (HIV) virus. The rate of acceleration of the disease and the cost of care were both cause for alarm.

Until 1990, the Federal response to the AIDS epidemic had been primarily prevention, through the CDC, and research, through the National Institutes of Health (NIH). In Fiscal Year (FY) 1990, the Public Health Service (PHS) as a whole spent $1.6 billion on AIDS/HIV; the CDC spent $443 million of this on prevention and NIH spent $744 million on research.

In the first decade of the epidemic, financing of AIDS-related health care shifted increasingly to the public sector as those affected turned to Medicaid and Medicare to finance their care. In FY 1990, the Federal Medicaid share of spending for HIV/AIDS was $670 million, and Medicare spending was $110 million. Social Security expenditures for HIV/AIDS in that year totalled $249 million, with $210 million for the Disability Insurance program and $39 million for the Supplemental Security Income program.

Towards the end of the first decade, while the vast majority of AIDS cases were still reported in metropolitan areas, rural areas were beginning to experience an increase in cases. The AIDS/HIV population also began to change, with an increasing rate of growth in new cases among groups which historically have difficulty accessing care: the poor, minorities, homeless and intravenous drug users.

On August 18, 1990, Congress passed Public Law 101-381 entitled The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (the Act). The purpose of the Act was to provide "emergency assistance to localities disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease."

The Act was created as a comprehensive response to the HIV epidemic and its impact on individuals, families, communities, cities, and States. It was to establish services for AIDS and HIV patients who would otherwise have no access to health care. It was also meant to provide emergency relief funding to communities with the highest number of reported AIDS cases.

The Act is multifaceted, with four titles directing resources to various entities and allowing grantees maximum flexibility in the use of funds, particularly at the local level. The Federal role is minimized in favor of State and local control. The Health Resources and Services Administration (HRSA) in the Public Health Service administers Titles I, II, and III(b) of the Act. The CDC was to administer Title III(a), which has not been funded to date.

Congress funded the Act at $221 million for FY 1991, $276 million for FY 1992, $348 million for FY 1993, and $579 million for FY 1994. The President's FY 1995 budget proposes funding at $672 million.

Title I

Title I provides emergency relief grants to cities (eligible metropolitan areas (EMAs)) which have reported a cumulative total of more than 2,000 AIDS cases, or a per capita incidence of 25 AIDS cases per 100,000, to the CDC by March 31 of the year preceding grant awards.

Within 60 days after an appropriation becomes available, HRSA is required to allocate (formula) funds to grantees. Grants are for HIV-related outpatient and ambulatory health and support services. In-patient services are not permitted except for case management that prevents unnecessary hospitalization or expedites discharge.

Half of the funds are distributed through a formula and the other half competitively, as supplemental grants, to EMAs which have demonstrated a severe need for financial assistance to address the epidemic and the ability to allocate funds expeditiously to areas of greatest need.

Title I funds comprised 56 percent of the FY 1994 Ryan White appropriation. In FY 1991, 16 grantees received $88 million. In FY 1992, 18 grantees received $120 million. In FY 1993, 25 grantees received $185 million. Congress appropriated $325.5 million for 34 grantees in FY 1994, an increase of 76 percent over FY 1993. The President has requested $364.5 million for up to 41 grantees in FY 1995.

Title II

Title II, including Special Projects of National Significance (SPNS) (see next section), comprised 33 percent of the FY 1993 Ryan White appropriation. This title provides formula grants to States and territories to improve the quality, availability, and

organization of health care and support services for individuals and families with HIV disease.

A major intent of Title II was to develop service delivery systems to provide essential services throughout the course of HIV disease. Congress envisioned the establishment of community-based, coordinated, continuums of care to which everyone with HIV would have access. Another intent was that funds be directed to both urban and rural areas, with a special emphasis on areas most affected as well as the needs of smaller cities and rural areas. Priority was to be given to low income individuals, children, families, and a variety of special populations. To get the money out quickly to meet the greatest needs, States are required to allocate 75 percent of services within 120 days after an appropriation becomes available.

States may use funds in one or more of four ways. They may establish HIV care consortia consisting of public and nonprofit private organizations and assist in the planning, development, and delivery of comprehensive outpatient health and support services. They may provide home- and community-based care services including outreach services to individuals in rural areas. They may provide assistance to assure the continuity of health insurance coverage. Finally, they may provide approved treatments that prolong life or prevent serious deterioration of health.

Title II was funded at $88 million in FY 1991, $107 million in FY 1992, $115 million in FY 1993, and $183.9 million for FY 1994. There were 54 State and territorial grantees in FY 1993. The President has requested $213.8 million for FY 1995.

Special Projects of National Significance: Title II also establishes a program of Special Projects of National Significance (SPNS), for which up to 10 percent of the Title II appropriation is set aside. These are competitive grants to public and private nonprofit entities for special programs. Funds are provided on a 3 year cycle for projects that contribute to advancing knowledge and skills in the delivery of health and support services. In FY 1991, HRSA awarded approximately $4.4 million for 22 projects. These projects continued in FY 1992 with $5.2 million and four new projects funded with an additional $836,000. In FY 1993, nearly $6.1 million was awarded to support 27 projects. An additional $2.9 million, $4.8 million, and $5.1 million in FY 1991, 1992, and 1993, respectively, was mandated by Congress to be used for reimbursement of dental health providers who provided uncompensated care to people with HIV/AIDS.

Title III

Title III(a), intended to provide formula grants to States for early intervention services on an outpatient basis, and intended to be administered by CDC, has not been funded to date. Title III(b) supports early intervention services on an out-patient basis, including counseling, testing, referrals, clinical and diagnostic services, and other therapeutic services. It provides competitive grants to private non-profit organizations and public migrant, community, and homeless health centers, hemophilia centers, and federally-qualified health centers.

Title III(b) funds comprised 14 percent of the FY 1993 Ryan White appropriation. The title was funded at $45 million (121 grantees) in FY 1991, $49 million (136 grantees) in FY 1992, $48 million (136 grantees) in both FY 1993 and FY 1994. There were 54 State and territorial grantees in FY 1993. The President has requested $66.9 million for FY 1995.

Title IV

Title IV was to provide demonstration grants for research and services for pediatric patients, evaluation and reports, and requires studies on partner notification and HIV disease in rural areas. Congress appropriated $22 million for FY 1994 for existing HRSA pediatric and adolescent AIDS demonstration projects to be folded into Title IV. The President has requested $27 million for FY 1995.

SCOPE AND METHODOLOGY

The Ryan White Act will be reauthorized in FY 1996. This is the first in a series of studies on the implementation of the Ryan White Act which will provide information useful for the discussion surrounding reauthorization. Other reports are: FY 1992 Title I and Title II Expenditures (OEI-05-93-00331); Special Projects of National Significance (OEI-05-93-00332); Consortia Activities (OEI-05-93-00333); and a Technical Report of FY 1992 Expenditures (OEI-05-93-00334).

This study focuses on the formulas governing the distribution of Ryan White Title I and Title II funds, and how certain changes in those formulas would affect distribution in the future. Concerns about this issue were raised by many people we talked to as we designed this study: congressional staffers, representatives of national organizations, experts, grantee staff, and Federal officials. We expect the formulas to be an important focus for discussions during reauthorization.

In the study we compare the relative distribution of Ryan White funding allocations between States and high incidence cities (EMAs) for FY 1991, FY 1992, and FY 1993. We compared trends in funding levels. We use case data provided by CDC for this analysis. Then, based on the President's FY 1995 budget request, we calculate FY 1995 allocations for Titles I and II using formulas based on factors other than cumulative case counts. We assess the impact of these new formulas on allocations to States and EMAs by comparing them to projected FY 1995 allocations under the current formulas.

The next study in this series will survey grantees concerning several general aspects of the implementation of the program.

We conducted this inspection in accordance with the *Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

As a backdrop to this discussion, it is important to understand not only the formula governing each Title, but also a new AIDS case definition implemented by the CDC in January 1993. Because each formula is based on case counts, this new definition is bound to have a significant impact on the distribution of funds.

The CDC's expanded AIDS surveillance case definition of AIDS includes all HIV-infected persons who have <200 CD4+ T-lymphocytes, or a CD4+ T-lymphocyte percentage of total lymphocytes of <14 and pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer, in addition to the clinical conditions included in the AIDS surveillance case definition published in 1987.

Before it was put into effect, the CDC estimated that this expanded definition would lead to a 75 percent increase in the number of newly reported cases in the first year it was in effect; experts then expected the rate of increase to level off. However, in early March 1994, the CDC reported that in the first year of the definition, the number of cases reported grew by 111 percent, from 49,016 in 1992 to 103,500 in 1993.

Half of Title I funds are distributed to high-incidence cities (eligible metropolitan areas, or EMAs) through a formula based on both (1) cumulative AIDS cases reported to CDC as of March 31 of the most recent fiscal year and (2) per capita incidence (cases per 100,000) of cumulative AIDS cases.[3] The formula weights the EMAs' cumulative total of AIDS cases more heavily to target funds to areas experiencing the greatest burden of the epidemic (in the law, the "localities disproportionately affected").[4] The remaining half of Title I funds are distributed to EMAs via competitive supplemental grants.

Title II funds are distributed to all States, Puerto Rico, the District of Columbia, and up to U.S. territories (all referred to as "States" in this report) via a formula. The formula distributes funding on a proportional basis and is a function of: (a) a State's total reported AIDS cases for the 2-year period preceding the fiscal year in which funds are requested, and (b) a State's average per capita income divided by the U.S. average per capita income. States receive the greater amount of the formula calculation or a minimum allocation of $100,000. Unlike Title I, which targets only the cities with the highest (cumulative) case counts, Title II provides funding for all States.

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[3] Appendix A presents the formulas for Title I, Title II, and the four options presented in this report.

[4] In the past year, the Office of Management and Budget has also made changes in the definition of Metropolitan Statistical Areas. These changes affect the number of AIDS cases being reported in metropolitan areas, which in turn affects the distribution of Title I formula funds.

As the number of high incidence cities increases, the proportion of Title I funds going to cities with the largest caseloads is likely to decrease.

The number of EMAs has increased from 16 in FY 1991 to 34 in FY 1994. The President's FY 1995 budget projects an increase of up to 7 EMAs for FY 1995. While this means that more cities can access Title I funds, it also inevitably means that the proportion of formula funds going to the EMAs with by far the most cases will decline, even if total dollars increase. For example, from FY 1991 to FY 1993, New York's proportion of total formula funds declined from 37 to 31 percent despite increased appropriations.

Possible dilution of funding for areas with the largest caseloads concerns some of the people we spoke with at the beginning of our study. They view it as conflicting with the intent of Congress to target funds to areas experiencing the greatest burden of the epidemic. They seek ways to target Title I funds in the face of increasing needs and appropriations which at some time in the future are certain to level off.

The current formulas have led to inequities in funding between grantees on a per-new-case basis. We found this to be especially true for Title I, and less so for Title II.

Some people we spoke with as we designed this study expressed the view that Ryan White funding across grantees should be equitable - that is, that grantees should receive the same amount of funding per case. They also questioned whether the cumulative case count in the Title I formula is the most appropriate way to address the current geography of the AIDS epidemic, since it includes persons who have died. Instead, they proposed funding based on new cases reported.

We examined the distribution of Title I and Title II funds between FY 1991-1993 to learn whether either formula has produced significant funding inequities on a per-case basis (new cases reported).

> *The Title I formula has produced significant inequities in funding on a per-case basis between high incidence cities.*

A look at the 16 cities funded from FY 1991 through FY 1993 shows both a wide range and significant differences in funding levels per case. For example, Table 1 on the next page shows that in these three years, on average, San Francisco received $4,354 per case while Chicago received $1,673, a difference of 160 percent. Furthermore, the national average amount received per case was $2,639 in those years; yet 12 of the 16 EMAs received less than that amount.

These inequities exist primarily due to the cumulative case counts. Cities such as San Francisco and New York, which have been struggling with the AIDS epidemic for many years, have much higher cumulative case counts than other cities which at present are experiencing large rates of increase in their caseloads. This disparity in cumulative case

counts points to a weakness in the Title I formula: it is not flexible enough to meet the changing demographics of the epidemic.

TABLE 1

TITLE I FORMULA FUNDING PER REPORTED CASE
FOR ORIGINAL 16 EMAs
FY 1991-FY 1993

EMA	Funds 1991-1993	New Cases 1990-1992	$/Case
San Francisco	$26,206,255	6019	$4,354
New York	65,188,920	19326	3,373
Jersey City	3,671,757	1124	3,267
Newark	8,099,881	2900	2,793
Houston	7,817,958	3551	2,202
Los Angeles	17,180,530	7882	2,180
Miami	8,852,698	4244	2,086
Dist. of Col.	7,283,634	3543	2,056
Dallas	4,239,970	2093	2,026
Ft. Lauderdale	4,903,566	2517	1,948
San Diego	3,600,036	1877	1,918
San Juan	5,565,320	2929	1,900
Boston	3,776,815	2032	1,859
Philadelphia	4,925,715	2658	1,853
Atlanta	5,297,244	2952	1,794
Chicago	5,892,174	3522	1,673
TOTAL	$182,502,473	69,169	$2,639

Funding Distribution from HRSA; case data from HIV/AIDS Surveillance, First Quarter Edition, Issued April 1991, 1992, and May 1993. Case counts are cases reported as of March 31 of the preceding year.

We also looked at Title I formula and supplemental funds combined (Table 2). The degree of variation in per-case amounts across grantees is roughly the same as for the formula funds alone. However the dollar amounts are much higher: San Francisco received the largest average amount, $9,782 per case, and San Juan the least, $3,394 - a difference of 188 percent. Also, while the average amount received per case was $5,260 between FY 1991-1993, 13 of the 16 EMAs received less than this amount.

TABLE 2

TITLE I FORMULA AND SUPPLMENTAL FUNDING PER REPORTED CASE
FOR ORIGINAL 16 EMAs
FY 1991 - FY 1993

EMA	Funds 1991-1993	New Cases 1990-1992	$/Case
San Francisco	58,875,136	6,019	$9,782
Jersey City	7,362,801	1,124	6,551
New York	113,821,426	19,326	5,890
Houston	17,333,540	3,551	4,881
Los Angeles	36,826,670	7,882	4,672
Boston	9,214,779	2,032	4,535
Dist. of Col.	15,967,546	3,543	4,507
Newark	13,018,014	2,900	4,489
Miami	18,683,630	4,244	4,402
Dallas	9,041,156	2,093	4,320
San Diego	8,000,908	1,877	4,263
Chicago	14,948,165	3,522	4,244
Philadelphia	10,624,115	2,658	3,997
Ft. Lauderdale	9,464,341	2,517	3,760
Atlanta	10,726,012	2,952	3,633
San Juan	9,940,840	2,929	3,394
TOTAL	$363,849,079	69,169	$5,260

Funding distribution from HRSA; case data from HIV/AIDS Surveillance, First Quarter Edition Issued April 1991, 1992, and May 1993. Case counts are cases reported as of March 31 of the preceding year.

The Title II formula produces greater funding equity than the Title I formula.

At first glance the figures presented in Table 3 would appear to belie this statement, since between FY 1991 and FY 1993, Title II dollars per case ranged from $17,647 in South Dakota to $1,911 in Hawaii, with an average of $2,152. This is an anomaly, however, stemming from a handful of States that have extremely high per-case averages. North and South Dakota, for example, received $17,647 and $16,013 per case respectively. A few States like these have extremely low case counts yet nevertheless are eligible to receive the minimum Title II grant of $100,000.

The more important fact to note is that despite this anomaly, over two-thirds of the 54 Title II grantees received funding between $2,000 and $2,475 per case - close to the average of $2,152. This is because the formula is based on a new-case count rather than a cumulative count.

TABLE 3

TITLE II FUNDS PER REPORTED CASE: FY 1991-FY 1993

STATE	Funds 1991-1993	New Cases 1990-1992	$/Case
South Dakota	300,000	17	17,647
North Dakota	219,872	13	16,913
Wyoming	244,037	34	7,178
Vermont	300,000	59	5,085
Alaska	300,000	64	4,688
Montana	256,197	59	4,342
Puerto Rico	16,520,102	4,712	3,506
Idaho	300,000	86	3,488
Arkansas	1,244,833	503	2,475
Kentucky	1,173,506	483	2,430
Mississippi	1,625,056	679	2,393
Alabama	2,057,855	893	2,304
Utah	738,197	321	2,300
Iowa	490,499	214	2,292
Nebrasks	363,877	159	2,289
Oklahoma	1,396,972	618	2,260
Minnesota	1,276,798	569	2,244
Texas	20,139,425	9,021	2,233
Louisiana	4,824,689	2,162	2,232
North Carolina	3,605,739	1,619	2,227
Delaware	554,356	249	2,226
Wisconsin	1,295,753	586	2,211
West Virginia	416,071	189	2,201
Arizona	2,092,429	952	2,198
Tennessee	2,248,535	1,027	2,189
New Mexico	717,498	328	2,187
Missouri	3,833,362	1,767	2,169
Oregon	1,846,634	853	2,165
Georgia	8,376,328	3,877	2,161
Pennsylvania	7,627,679	3,541	2,154
Nevada	1,305,177	611	2,136
Rhode Island	577,819	271	2,132
New York	48,330,884	22,669	2,132
Guam	10,656	5	2,131
Maine	376,142	178	2,113
Ohio	3,967,672	1,883	2,107
Illinois	8,716,907	4,165	2,093
South Carolina	2,247,710	1,079	2,083
Virginia	3,751,967	1,804	2,080
Florida	28,482,462	13,710	2,077
Virgin Islands	101,464	49	2,071
Indiana	2,104,243	1,021	2,061
Maryland	5,711,996	2,781	2,054
Washington	3,619,091	1,797	2,014
California	45,696,302	22,757	2,008
Colorado	2,497,921	1,249	2,000
New Hampshire	307,027	154	1,994
Dist. of Col.	3,921,396	1,984	1,977
Massachusetts	5,086,166	2,609	1,949
Michigan	3,745,223	1,931	1,940
Kansas	826,931	429	1,928
Connecticut	2,747,197	1,430	1,921
New Jersey	13,432,803	7,012	1,916
Hawaii	1,068,159	559	1,911
TOTAL/AVG	$275,019,614	127,791	$2,152

Funding distribution from HRSA; case data from HIV/AIDS Surveillance Report, First Quarter Edition, Issued April 1991, 1992, and May 1993. Case counts are cases reported as of March 31 of the preceding year.

OPTIONS

We present four options, and some variations of them, for funding formulas that could be used to address the inequities described and target funds to need. We recognize that formulas could be constructed in countless ways; our intention is to present some general ideas that might be helpful in constructing a final allocation methodology. We also do not see these options as mutually exclusive. We believe that it could be valuable to combine various ideas to develop a formula.

We realize that the best reflection of the current geographical impact of the AIDS epidemic would be prevalence data - a count of live AIDS cases by city and State. However, not all States report AIDS-related deaths to CDC, so that reliable prevalence data is not available. Also, data on the number and the proportion of people with AIDS and HIV requiring care, those already in care, and the insurance status of those people, is not available.

Therefore we base our options on 2-year counts of new AIDS cases as reported by CDC and published in their "HIV/AIDS Surveillance Report, First Quarter Edition," issued in October, 1993. The case counts are from October 1991 to September 1993, which includes three quarters (January-September 1993) of reporting using the new CDC definition.[5] These counts are the most up-to-date counts available for cities and States. We view these new-case counts as more accurate than cumulative counts in terms of reflecting those alive with AIDS today who need services.

We examine each option against five criteria which we believe could be useful in assessing any new formula. We recognize that there are inherent tensions between some of these criteria, making it unlikely that a formula could be devised that would fully satisfy all of them. Our purpose in proposing them is to provide a framework within which potential formulas, and the tradeoffs inherent in them, can be evaluated in a systematic manner. The five criteria are:

Equity: The amount of funding should be the same per case to minimize inequities between and across geographical areas.

Targeting: Funds should be targeted to areas with the greatest concentration of cases, and in amounts sufficient for grantees to develop the continuum of care called for in the law.

Flexibility: Funding formulas should be flexible enough to respond to demographic changes in the epidemic.

Reasonable Data Requirements: Data used in the formulas to distribute funds should be readily available and reliable.

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[5] Case counts through March 1994 will be used by HRSA to establish FY 1995 allocations.

Stability: Aggregate funding to various geographic areas should not fluctuate significantly from year to year.

Some readers may question or even disagree that "equity" should be a criterion for evaluating formulas. Instead, they may advocate including variables in formulas to deliberately target funds to cities and States based on the differing demographics of the epidemic and service needs they have. Indeed, both of the current formulas already include such variables: incidence (cases per 100,000) in the Title I formula and per capita income data in the Title II formula. Many other potential variables were mentioned to us during the course of this study: HIV seroprevalence rates (since services are also provided to people with HIV infection but not an AIDS diagnosis), numbers of infected women and children, the cost of health care in different locations, tuberculosis and sexually transmitted disease rates, the migration of people with HIV/AIDS, minority population statistics, poverty statistics, health insurance statistics, and others.

We understand that it could be valuable to include new variables such as these in future formulas, but for several reasons we have chosen not to do so in this report. First, we believe that any national formula governing the distribution of funds among grantees that are by nature so diverse should strive to achieve equity as much as possible. Second, we are concerned that much of the data mentioned above either does not exist or is not completely reliable. Third, based on our reading and discussions for this study, we do not believe there is consensus about which variables are most important or the extent to which they should be factored into a national formula. Finally, as the Act is structured today, monies are available to meet the special circumstances and needs of individual grantees through the Title I supplemental funding mechanism.

For these reasons, we have chosen to present a few simple, basic options, and describe some variations which Congress could use to target funds in response to the changing face of the epidemic and the specific needs of grantees. We present each option looking ahead to FY 1995, which we believe is the most useful approach for the discussion surrounding reauthorization. It is important to note that we present the information available at this time to show how new formulas might affect funding; however the actual amount of the FY 1995 allocations, whether governed by the current formulas or different formulas, will be highly dependent on the size of the actual appropriation, the number of cases reported by cities and States as of March 1994, and, for Title I, the number of cities eligible for funding.

Readers will note that in Tables 4, 5, and 8, we have identified a number of EMAs by letter rather than name (City A, for example). Our FY 1995 projections, under both the current and proposed formulas, are based on CDC data as of September 1993. However, these particular cities may or may not be eligible for Title I funding in FY 1995, since eligibility will be based on case counts and incidence rates not currently available.

All tables show the FY 1994 allocations reported by HRSA, and projected FY 1995 allocations under the current formulas and the proposed options.

OPTION 1: Distribute Title I Formula Funds on a Per-Case Basis to Cities with a Significant Proportion of All New Cases Reported Nationally.

This option targets funds to the cities with the highest numbers of new cases, consistent with Congressional intent. It also eliminates the funding inequities produced by the cumulative case count in the current formula. Table 4 presents the results of applying this option to the proposed Title I formula amount ($182.2 million) for FY 1995.

First we calculate projected FY 1995 formula allocations using the current formula, as a basis for comparison with this Option 1 new formula. We identify seven metropolitan areas that might qualify for Title I funding in FY 1995 based on either a cumulative case count or incidence. These seven cities, combined with the existing 34 grantees, bring the total number of possible EMAs to 41, which is the maximum number of cities that HRSA predicts will be eligible for funding in FY 1995. To identify the cities, we use CDC case counts as of September, 1993.[6] We then calculate projected allocations for all 41 cities using the current formula, which is based on cumulative case counts and incidence.

We next calculate projected FY 1995 allocations under the new formula. We identify the 41 metropolitan areas with the highest number of new AIDS cases reported for the two year period, October 1991 to September 1993. This period includes three quarters of reporting under the new CDC definition. Collectively, these 41 cities reported 72 percent of all new cases nationally in that period and 86 percent of all new cases reported in metropolitan areas (population 500,000 or more).

We then calculate an average dollar amount per case ($1,764) based on these case counts and the Title I FY 1995 budget request (formula portion only). Last, we calculate a FY 1995 allocation for each EMA and compare it to the projected allocation under the current formula.

ANALYSIS

Equity: This option provides the same amount per case ($1,764) for each EMA. Under the current formula, dollars per case would range from $3,898 to $1,307; 28 of the 41 cities would receive less than $2,000 per case.

Targeting: This option targets Title I formula funds to the cities with a strong majority of new cases reported both nationally and by metropolitan areas. Up to seven new cities would be funded. The cities with the highest number of newly reported cases would receive the greatest amount of funding.

[6] Appendices B and C contain the case counts, incidence, and per capita income figures used to calculate the four options.

Flexibility: This option provides the flexibility to target aid based on changing case counts, whether increasing or decreasing.

Data Requirements: The data required, new cases reported, is the same as now used in the current Title II formula.

Stability: Funding is somewhat less stable than if based on a steadily growing cumulative case count as it is now, since a new-cases count could conceivably rise or fall in any given year. Using a 3-year case count might lend greater stability.

Ponce, Puerto Rico is the only current grantee that is not eligible for funding under this option, due to a relatively low new-case count of 522. Of the 33 other FY 1994 grantees, 17 receive increased funding under this option, including two of the largest grantees, New York and Los Angeles. Fifteen see decreased funding, including San Francisco. One city sees no change.

VARIATIONS

The incidence factor which is a small part of the current Title I formula could be retained to target relatively more funds to cities with higher incidence rates. This would produce some inequity in funding per case, although less than that produced by the cumulative case count in the current formula.

Alternatively, rather than introducing other variables into the national formula, Congress could continue to use Title I supplemental funds to target the special needs of individual EMAs.

If Congress decided that the impact on the cities that would lose funds (including Ponce) would be too great, they could hold them harmless at FY 1994 funding levels at a cost of about $4 million (and at the expense of City H, which would be displaced by Ponce). Alternatively, Congress could use Title I supplemental funds for this purpose.

Another variation would be to collapse all Title I funds into a single formula grant. This alternative eliminates funding inequities completely and dispenses with the need for Federal personnel to review applications and monitor competitive grants. Option 4 provides a look at this type of approach.

TABLE 4

OPTION 1

TITLE I FORMULA FUNDS DISTRIBUTED ON PER-CASE BASIS TO 41 CITIES
WITH MAJORITY OF REPORTED U.S. CASES IN TWO PRIOR YEARS
(Ranked by size of grant in "New Formula" column.)

FY 1995 Budget Request (Formula Portion): $182,250,000

CITY	CURRENT FORMULA Actual FY 1994	CURRENT FORMULA Projected FY 1995	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
New York	45,835,380	32,980,861	36,066,602	9%
Los Angeles	12,617,337	12,898,418	15,667,483	21%
San Francisco	19,056,960	14,221,979	11,441,989	-20%
Chicago	4,706,676	5,675,881	7,465,157	32%
Washington D.C.	5,225,866	6,157,582	6,886,709	12%
Miami	6,875,102	7,235,526	6,608,066	-9%
Houston	5,676,753	6,293,576	6,366,458	1%
Philadelphia	3,479,453	4,614,459	5,493,495	19%
Boston	3,091,876	4,281,146	5,161,945	21%
Atlanta	4,066,062	4,693,862	4,812,760	3%
San Juan, PR	4,561,223	5,147,513	4,784,543	-7%
Dallas	3,445,177	4,293,970	4,521,772	5%
Newark	5,166,261	5,395,893	4,193,750	-22%
Baltimore	2,232,355	3,663,947	4,050,901	11%
San Diego	2,696,880	3,629,889	3,712,298	2%
Fort Lauderdale	3,555,421	4,340,289	3,550,050	-18%
Tampa-St. Pete	1,955,256	3,215,149	3,449,527	7%
Detroit	1,623,489	2,404,019	3,243,190	35%
Oakland	2,379,546	3,234,108	3,153,248	-3%
Riverside/San Bern.	1,299,021	2,118,013	2,610,071	23%
Seattle	1,617,949	2,760,750	2,587,145	-6%
Nassau/Suffolk Co.	1,403,882	2,426,529	2,433,715	0%
Denver	1,626,755	2,593,940	2,371,991	-9%
West Palm Beach	1,959,886	3,114,023	2,320,847	-25%
New Haven	1,235,428	2,510,956	2,301,448	-8%
Orange Co. CA	1,426,850	2,030,880	2,239,723	10%
City A	0	2,801,110	2,181,526	-22%
Orlando	1,319,944	2,372,680	2,118,038	-11%
Phoenix	1,175,959	1,846,899	2,036,914	10%
Saint Louis	1,178,039	1,785,574	1,994,588	12%
New Orleans	1,691,877	2,375,415	1,918,755	-19%
Kansas City, MO	1,251,712	1,970,528	1,851,740	-6%
Bergen-Passaic NJ	1,277,031	2,243,109	1,664,802	-26%
Jersey City, NJ	2,306,302	3,533,059	1,643,640	-53%
City B	0	1,744,183	1,594,260	-9%
City C	0	2,040,121	1,458,466	-29%
City D	0	0	1,329,726	na*
City E	0	1,352,784	1,305,036	-4%
City F	0	0	1,290,927	na*
City G	0	1,393,140	1,208,040	-13%
City H	0	0	1,158,660	na
Ponce PR	976,793	2,034,804	0	-100%
City I	0	1,422,656	0	-100%
City J	0	1,400,781	0	-100%
TOTAL	$159,994,501	$182,250,000	$182,250,000	

* Not eligible for projected FY 1995 (current formula).

OPTION 2: Distribute Title I Formula Funds on a Per-New-Case Basis, Including an Income Factor.

This option demonstrates the results of applying the Title II formula to Title I formula (only) funds. The Title II formula produces a proportional distribution of funds. We base our calculation on each State or territory's number of cases reported in the past 2 years. Each State's proportion of cases is adjusted by the ratio of U.S. per capita income to the city's 1989 per capita income, reported by the Census Bureau from the 1990 Census.

We use the same cities as in Option 1 to demonstrate this formula. We compare their projected FY 1995 allocations as produced by this formula with the projected allocations under the current formula, based on cumulative case counts and incidence. Table 5 presents the results of these calculations.

ANALYSIS

Equity: This option reduces, although does not eliminate, the funding inequities per case across EMAs described in our findings, since it is based on new cases rather than cumulative counts. The current Title I formula, for example, produces funding per case from $3,898 to $1,307. This option produces a range of $2,320 to $1,554 per case.

Targeting: As with Option 1, EMAs with the largest caseloads and the majority of cases nationally are targeted, consistent with Congressional intent. Since funds are distributed on a proportional basis, EMAs with the most cases continue to receive amounts proportional to their need. In addition, the inclusion of the income factor targets relatively more money to cities with lower per capita incomes.

Flexibility: This option provides the flexibility to target aid based on changing case counts. However, limitations described below relative to the income data, specifically, mean that the income-related portion of the formula is less reflective of current realities.

Reasonable Data Requirements: Data requirements for this option would be the same as now. However, this option requires income data for cities, which is only available through the national census conducted every 10 years. These figures become more outdated the farther the year from the Census.

Stability: The Title II formula is somewhat less stable than the current Title I formula, given fluctuations in the number of new cases reported compared with constantly increasing cumulative case counts.

As with Option 1, Ponce is the only current grantee not eligible for funding under this option. Seventeen current grantees see increased dollars under this option compared with the current formula; this includes all of the largest grantees (those with new-case counts of about 3,000 or above) except San Francisco. Sixteen grantees (San Francisco included) receive less funding.

VARIATIONS

Stability in allocations could be increased by using a 3 year rather than 2 year case count.

Congress could hold harmless those EMAs losing funding, at FY 1994 Title I formula levels, using Title I formula funds and decreasing allocations to other EMAs, or using supplemental funds.

TABLE 5

OPTION 2

APPLY TITLE II FORMULA TO TITLE I FORMULA PORTION FOR 41 CITIES
WITH MAJORITY OF REPORTED U.S. CASES IN TWO PRIOR YEARS
(Ranked by size of grant in "New Formula" column.)

FY 1995 Budget Request (Formula Portion): $182,250,000

CITY	CURRENT FORMULA Actual FY 1994	CURRENT FORMULA Projected FY 1995	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
New York	45,835,380	32,980,861	34,723,675	5%
Los Angeles	12,617,337	12,898,418	15,112,940	17%
San Francisco	19,056,960	14,221,979	10,338,646	-27%
Chicago	4,706,676	5,675,881	7,767,258	37%
Miami	6,875,102	7,235,526	7,535,197	4%
Houston	5,676,753	6,293,576	6,406,124	2%
Washington D.C.	5,225,866	6,157,582	6,310,797	2%
San Juan, PR	4,561,223	5,147,513	6,293,801	22%
Philadelphia	3,479,453	4,614,459	5,840,394	27%
Boston	3,091,876	4,281,146	5,043,079	18%
Newark	5,166,261	5,395,893	4,844,752	-10%
Atlanta	4,066,062	4,693,862	4,732,712	1%
Dallas	3,445,177	4,293,970	4,351,714	1%
Baltimore	2,232,355	3,663,947	4,318,283	18%
Detroit	1,623,489	2,404,019	3,744,121	56%
San Diego	2,696,880	3,629,889	3,565,333	-2%
Tampa-St. Pete	1,955,256	3,215,149	3,461,900	8%
Fort Lauderdale	3,555,421	4,340,289	3,201,286	-26%
Oakland	2,379,546	3,234,108	3,142,701	-3%
Riverside/San Bern.	1,299,021	2,118,013	2,650,211	25%
Seattle	1,617,949	2,760,750	2,395,271	-13%
New Haven	1,235,428	2,510,956	2,390,329	-5%
Denver	1,626,755	2,593,940	2,316,924	-11%
West Palm Beach	1,959,886	3,114,023	2,261,085	-27%
City A	0	2,801,110	2,226,796	-21%
Saint Louis	1,178,039	1,785,574	2,202,012	23%
Nassau/Suffolk Co.	1,403,882	2,426,529	2,156,483	-11%
Orlando	1,319,944	2,372,680	2,150,611	-9%
New Orleans	1,691,877	2,375,415	2,082,035	-12%
Phoenix	1,175,959	1,846,899	2,057,571	11%
Orange Co. CA	1,426,850	2,030,880	2,017,113	-1%
Kansas City, MO	1,251,712	1,970,528	1,883,844	-4%
Jersey City	2,306,302	3,533,059	1,703,098	-52%
City B	0	1,744,183	1,596,138	-8%
Bergen-Passaic	1,277,031	2,243,109	1,467,009	-35%
City C	0	2,040,121	1,466,388	-28%
City F	0	0	1,412,937	na*
City H	0	0	1,346,473	na
City E	0	1,352,784	1,318,551	-3%
City D	0	0	1,265,838	na*
City G	0	1,393,140	1,148,569	-18%
City J	0	1,400,781	0	-100%
City I	0	1,422,656	0	-100%
Ponce PR	976,793	2,034,804	0	-100%
TOTAL	$159,994,501	$182,250,000	$182,250,000	

*Not eligible for projected FY 1995 (current formula).

OPTION 3: Distribute Title II Funds on a Per-New-Case Basis, Excluding an Income Factor and A Funding Floor.

Readers might ask why we propose changing the Title II formula, since it produces much more equitable funding per case than the Title I formula. We believe that while the new-case count in the formula does significantly even out inequities, this option represents a way to ensure equity more purposefully.

This option establishes an average amount per case by dividing the dollars available by the number of new cases reported nationally for 2 years prior to the year of funding, and then allocating funds to each State based on its case count. Also, this option eliminates both the income factor in the current formula and the $100,000 funding floor available to States.[7]

As a basis for comparison, we first calculate projected FY 1995 allocations using the current Title II formula and based on the FY 1995 budget request less 10 percent for SPNS funding ($192.5 million). We then calculate projected allocations using the new formula. Table 6 on page 18 shows the results of these calculations.

ANALYSIS

Equity: Under this option, every State is funded. Every State also receives the same allocation per case. The current formula produces a wide range in funding per case, in large part due to the $100,000 floor for States with relatively small case counts. For example, funding per case ranges from $845 to $20,000 in FY 1994 and would be $1,192 to $12,500 in FY 1995 under the current formula.

While this option creates equitable Title II funding on a per-case basis, it is also true that States with EMAs in them would receive Title I funds as well. This creates inequity by raising their total allocation per case (Titles I and II dollars combined) compared to non-EMA States.

Targeting: The States with the highest number of new cases receive the most dollars. However, some States might complain that without a minimum allocation, funds are spread too thinly for them to develop the continuum of care called for in the legislation.

Flexibility: This option provides the flexibility to target aid based on changing case counts, whether increasing or decreasing.

Reasonable Data Requirements: The data required - new cases reported - is the same as that used in the current Title II formula.

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[7] Minimum Title II grant awards apply only to States and do not include territories..

TABLE 6

OPTION 3

TITLE II FUNDS DISTRIBUTED ON PER CASE BASIS, NO FLOOR
(Ranked by size of grant in "New Formula column.)

FY 1995 Budget Request (less SPNS): $192,507,300

STATE	CURRENT FORMULA Actual FY 1994	CURRENT FORMULA Projected FY 1995	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
California	28,172,762	33,346,929	34,891,648	5%
New York	26,126,095	30,924,375	32,417,233	5%
Florida	16,361,686	19,366,649	19,533,444	1%
Texas	11,813,825	13,983,535	13,505,065	-3%
New Jersey	6,650,657	7,872,106	8,605,671	9%
Illinois	5,363,921	6,349,051	6,475,965	2%
Puerto Rico	7,521,643	8,903,057	5,901,452	-34%
Georgia	4,527,285	5,358,760	5,270,823	-2%
Pennsylvania	4,421,998	5,234,136	5,202,683	-1%
Maryland	3,625,966	4,291,905	4,608,129	7%
Massachusetts	3,501,905	4,145,060	4,407,718	6%
Michigan	2,874,019	3,401,857	3,388,291	-0%
Missouri	2,716,091	3,214,924	3,111,723	-3%
Connecticut	2,246,095	2,658,609	2,980,788	12%
Virginia	2,403,511	2,844,936	2,934,025	3%
Ohio	2,519,172	2,981,839	2,920,664	-2%
Dist. of Col.	2,155,767	2,551,692	2,797,745	10%
Washington	2,262,586	2,678,129	2,714,908	1%
Louisiana	2,494,411	2,952,531	2,673,490	-9%
South Carolina	2,091,875	2,476,066	2,327,446	-6%
North Carolina	1,996,053	2,362,646	2,280,683	-3%
Arizona	1,855,383	2,196,140	2,151,084	-2%
Colorado	1,794,570	2,124,158	2,148,412	1%
Tennessee	1,675,354	1,983,047	1,882,532	-5%
Indiana	1,394,908	1,651,095	1,604,628	-3%
Alabama	1,421,553	1,682,633	1,563,210	-7%
Oregon	1,170,946	1,386,000	1,356,118	-2%
Oklahoma	1,133,726	1,341,945	1,261,257	-6%
Wisconsin	1,069,752	1,266,221	1,234,535	-3%
Minnesota	970,420	1,148,646	1,150,362	0%
Nevada	924,894	1,094,759	1,116,960	2%
Mississippi	900,115	1,065,429	933,918	-12%
Arkansas	821,978	972,941	877,803	-10%
Kansas	605,134	716,271	698,768	-2%
Kentucky	641,709	759,564	698,768	-8%
Hawaii	545,494	645,679	666,702	3%
Delaware	515,066	609,662	630,628	3%
Utah	511,096	604,964	554,472	-8%
Rhode Island	452,600	535,723	543,783	2%
New Mexico	485,763	574,978	530,423	-8%
Iowa	333,799	395,104	376,774	-5%
Nebraska	292,135	345,788	330,011	-5%
Maine	205,421	243,148	235,150	-3%
New Hampshire	160,060	189,456	196,403	4%
West Virginia	173,904	205,843	185,715	-10%
Idaho	130,115	154,012	142,960	-7%
Vermont	100,000	117,118	114,903	-2%
Alaska	100,000	100,000	104,214	4%
Virgin Islands	68,703	93,655	81,501	-13%
Montana	100,000	100,000	76,156	-24%
Wyoming	100,000	100,000	53,443	-47%
South Dakota	100,000	100,000	41,418	-59%
North Dakota	100,000	100,000	10,689	-89%
Guam	3,379	4,529	4,008	-12%
TOTAL	$162,705,300	$192,507,300	$192,507,300	

Stability: Three of the four largest grantees gain an increase in funding under this option compared with the current formula. Many of the smaller grantees lose funding. However, those losing the most proportionally are States with relatively low case counts that would lose the $100,000 floor. Puerto Rico is adversely affected by the removal of the income factor in the current formula. Their per capita income, at $4,172, is far below that of any other grantee; the next highest is Virgin Islands ($9,440) followed by Mississippi ($9,648).

VARIATIONS

If Congress wished to target States with a higher incidence of AIDS (cases per 100,000), they could introduce an incidence factor into the formula such as that in the current Title I formula. However, this would produce some inequities in funding per case.

As explained under Option 1, Congress could hold harmless the States losing funding, by funding them at the prior year's levels and decreasing allocations to the other States.

Some people we spoke with at the beginning of our study think that States, especially rural States, need a minimum amount of funding two or more times greater than the current $100,000 in order to create a continuum of care. If we apply a $200,000 floor in our FY 1995 example, nine States are eligible. As discussed above under "Equity," however, such a floor would reintroduce funding inequities on a per-case basis.

Congress could decide that similar to Title I, Title II funds should be targeted to the States most affected by the AIDS epidemic. For example, in FY 1995 Congress could fund only the 24 States which collectively reported 91 percent of all new cases nationally from October 1991 to September 1993. The other 30 States, each with less than 1 percent of the cases reported in that period, would not be funded; collectively, these States received $15.5 million in FY 1994, just under 10 percent of the total FY 1994 formula allocation.

OPTION 4: Distribute Title I and Title II Formula Funds on a Per-New-Case Basis as a Single Formula Grant.

This option shows Title I and Title II formula funds (only) combined into a single formula grant, with the funds distributed on a per-new-case basis to both States and cities (EMAs). Our example uses the same 41 cities as Options 1 and 2. We also set a $200,000 floor for States (not territories) to address concerns that some people we spoke to raised that large rural States with low case counts need such a floor to develop the mandated continuum of care.

To calculate the option, we first establish an average amount per case by dividing FY 1995 dollars from the budget request ($374.7 million in Title I and Title II formula funds, minus SPNS) by the number of new cases reported by States for 2 years prior to FY 1995. We then allocate funds to each State based on its new-case count. For the four States with allocations under $200,000, we impose the $200,000 floor and recalculate the

per-case allocation for the other 50 States. We show the projected allocations compared with projected FY 1995 Title II allocations, based on the current formula.

This option shows the dollar distribution of funds across States, and between the various areas in the States with EMAs. Funds could be distributed in a variety of ways. One way would be to give the entire grant to States, with mandated amounts designated for each EMA. Another way would be to grant EMAs their allocations directly, with States granted the balance-of-State portions. We are not recommending any one specific mechanism by which funds should be disbursed under this option.

Tables 7 and 8 show the results of our calculations. Both tables array States alphabetically for ease of reading. Table 7 shows the results of this option for the 32 States without EMAs. Table 8 shows the results for the 22 States with one or more EMAs. This includes Washington, D.C., currently a Title I grantee, which includes the District of Columbia, currently a Title II grantee. Table 8 also includes cities A through J, which as noted under Options 1 and 2, could be eligible for Title I funding in FY 1995 under the current formula or our proposed formulas.

ANALYSIS

Equity: This option greatly reduces per-case funding inequities. First, it eliminates inequities between EMAs by basing funding on a new rather than a cumulative case count and then calculating a per-case allocation. Secondly, it provides a more equitable distribution of funds between EMA States and non-EMA States. This formula only counts the new cases in EMA States once, unlike today when States receive Title I formula funds based on the cumulative case counts of the EMAs there, and Title II funds based on the entire State's new-case count.

The $200,000 floor, however, does produce some funding inequities. Under this option, the average per case allocation for all States excepting the four receiving $200,000 is $2,598. For those four States, their per-case allocations range from $25,000 to $3,509.

Targeting: This option ensures that high-incidence cities are targeted, consistent with Congressional intent. The $200,000 floor ensures that every State receives a minimum amount of funding, helping them accomplish a basic goal of Ryan White by establishing a continuum of care.

Flexibility: This option provides the flexibility to target aid based on changing case counts, whether increasing or decreasing.

Reasonable Data Requirements: The data required, new case counts, would be the same as now.

Stability: Non-EMA States receive proportionately large increases under this option, primarily because (former) Title I formula dollars are added to the funds available. (The

four States receiving $200,000 gain thanks to the floor.) Ten of the 22 EMA States gain increased funding; 12 of the 22, including the 4 largest States, lose funds.

TABLE 7

OPTION 4

STATES WITHOUT EMAs
TITLE I AND TITLE II FUNDS DISTRIBUTED ON A PER CASE BASIS AS A SINGLE FORMULA GRANT
WITH A $200,000 FLOOR

FY 1995 Budget Request (Title I formula portion; Title II less SPNS): $374,757,300

GRANTEE	Cases Oct 91-Sept 93	CURRENT FORMULA Actual FY 1994 Title II	Projected FY 1995 Title II	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
ALABAMA	1170	1,421,553	1,682,633	3,039,501	81%
ALASKA	78	100,000	100,000	202,633	103%
ARKANSAS	657	821,978	972,941	1,706,797	75%
DELAWARE	472	515,066	609,662	1,226,192	101%
GUAM	3	3,379	4,529	7,794	72%
HAWAII	499	545,494	645,679	1,296,334	101%
IDAHO	107	130,115	154,012	277,971	80%
INDIANA	1201	1,394,908	1,651,095	3,120,034	89%
IOWA	282	333,799	395,104	732,598	85%
KANSAS	523	605,134	716,271	1,358,683	90%
KENTUCKY	523	641,709	759,564	1,358,683	79%
MAINE	176	205,421	243,148	457,224	88%
MISSISSIPPI	699	900,115	1,065,429	1,815,907	70%
MONTANA	57	100,000	100,000	200,000	100%
NEBRASKA	247	292,135	345,788	641,672	86%
NEVADA	836	924,894	1,094,759	2,171,814	98%
NEW HAMPSHIRE	147	160,060	189,456	381,886	102%
NEW MEXICO	397	485,763	574,978	1,031,352	79%
NORTH CAROLINA	1707	1,996,053	2,362,646	4,434,554	88%
NORTH DAKOTA	8	100,000	100,000	200,000	100%
OKLAHOMA	944	1,133,726	1,341,945	2,452,383	83%
RHODE ISLAND	407	452,600	535,723	1,057,331	97%
SOUTH CAROLINA	1742	2,091,875	2,476,066	4,525,479	83%
SOUTH DAKOTA	31	100,000	100,000	200,000	100%
TENNESSEE	1409	1,675,354	1,983,047	3,660,390	85%
UTAH	415	511,096	604,964	1,078,113	78%
VERMONT	86	100,000	117,118	223,416	91%
VIRGIN ISLANDS	61	68,703	93,655	158,470	69%
VIRGINIA	2196	2,403,511	2,844,936	5,704,909	101%
WEST VIRGINIA	139	173,904	205,843	361,103	75%
WISCONSIN	924	1,069,752	1,266,221	2,400,426	90%
WYOMING	40	100,000	100,000	200,000	100%
TOTAL	18,183	$21,558,097	$25,437,212	$47,683,648	

TABLE 8

OPTION 4

STATES WITH EMAs
TITLE I AND TITLE II FUNDS DISTRIBUTED ON A PER CASE BASIS AS A SINGLE FORMULA GRANT
WITH A $200,000 FLOOR

FY 1995 Budget Request (Title I formula portion; Title II less SPNS): $374,757,300

GRANTEE	Cases Oct 91-Sept 93	CURRENT FORMULA Actual FY 1994 Title I	Title II	CURRENT FORMULA Projected FY 1995 Title I	Title II	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
ARIZONA							
Phoenix	1155	1,175,959		1,846,899		3,000,533	
Bal. of State	455					1,182,028	
Total	1610		1,855,383	1,846,899	2,196,140	4,182,561	3%
CALIFORNIA			28,172,762				
Los Angeles	8884	12,617,337		12,898,418		23,079,422	
Oakland	1788	2,379,546		3,234,108		4,644,980	
Orange Co.	1270	1,426,850		2,030,880		3,299,287	
Riverside/San Bern.	1480	1,299,021		2,118,013		3,844,838	
San Diego	2105	2,696,880		3,629,889		5,468,503	
San Francisco	6488	19,056,960		14,221,979		16,854,940	
City E	740			1,352,784		1,922,419	
City G	685			1,393,140		1,779,537	
Bal. of State	2675					6,949,286	
Total	26115		28,172,762	40,879,211	33,346,929	67,843,213	-9%
COLORADO							
Denver	1345	1,626,755		2,593,940		3,494,127	
Bal. of State	263					683,238	
Total	1608		1,794,570	2,593,940	2,124,158	4,177,365	-13%
CONNECTICUT							
New Haven	1305	1,235,428		2,510,956		3,390,212	
City F	732			0		1,901,636	
Bal. of State	194					503,986	
Total	2231		2,246,095	2,510,956	2,658,609	5,795,834	11%
FLORIDA							
Fort Lauderdale	2013	3,555,421		4,340,289		5,229,500	
Miami	3747	6,875,102		7,235,526		9,734,196	
Orlando	1201	1,319,944		2,372,680		3,120,034	
Tampa-St. Pete	1956	1,955,256		3,215,149		5,081,422	
West Palm Beach	1316	1,959,886		3,114,023		3,418,789	
City A	1237			2,801,110		3,213,558	
Bal. of State	3150					8,183,271	
Total	14620		16,361,686	23,078,777	19,366,649	37,980,769	-12%
GEORGIA							
Atlanta	2729	4,066,062		4,693,862		7,089,570	
Bal. of State	1216					3,159,002	
Total	3945		4,527,286	4,693,862	5,358,760	10,248,573	2%
ILLINOIS							
Chicago	4233	4,706,676		5,675,881		10,996,758	
Bal. of State	614					1,595,088	
Total	4847		5,363,921	5,675,881	6,349,051	12,591,846	5%
LOUISIANA							
New Orleans	1088	1,691,877		2,375,415		2,826,476	
Bal. of State	913					2,371,850	
Total	2001		2,494,411	2,375,415	2,952,531	5,198,325	-2%
MARYLAND							
Baltimore	2297	2,232,355		3,663,947		5,967,293	
Bal. of State	1152					2,992,739	
Total	3449		3,625,966	3,663,947	4,291,905	8,960,032	11%
MASSACHUSETTS							
Boston	2927	3,091,876		4,281,146		7,603,947	
Bal. of State	372					966,405	
Total	3299		3,501,905	4,281,146	4,145,060	8,570,353	2%

GRANTEE	Cases Oct 91-Sept 93	CURRENT FORMULA Actual FY 1994 Title I	Title II	CURRENT FORMULA Projected FY 1995 Title I	Title II	NEW FORMULA Projected FY 1995	Diff.: Old vs New Formula
MICHIGAN							
Detroit	1839	1,623,489		2,404,019		4,777,472	
Bal. of State	697					1,810,711	
Total	2536		2,874,019	2,404,019	3,401,857	6,588,183	12%
MINNESOTA							
City D	754			0		1,958,789	
Bal. of State	107					277,971	
Total	861		970,420		1,148,646	2,236,761	49%
MISSOURI							
Kansas City	1050	1,251,712		1,970,528		2,727,757	
Saint Louis	1131	1,178,039		1,785,574		2,938,184	
Bal. of State	148					384,484	
Total	2329		2,716,091	3,756,102	3,214,924	6,050,425	-15%
NEW JERSEY							
Bergen-Passaic	944	1,277,031		2,243,109		2,452,383	
Jersey City	932	2,306,302		3,533,059		2,421,209	
Newark	2378	5,166,261		5,395,893		6,177,720	
City J	571			1,400,781		1,483,380	
Bal. of State	1616					4,198,148	
Total	6441		6,650,657	12,572,842	7,872,106	16,732,841	-22%
NEW YORK							
Nassau/Suffolk Co.	1380	1,403,882		2,426,529		3,585,052	
New York City	20451	45,835,380		32,980,861		53,128,913	
Bal. of State	2432					6,318,005	
Total	24263		26,126,095	35,407,390	30,924,375	63,031,970	-5%
OHIO							
City H	657			0		1,706,797	
Bal. of State	1529					3,972,134	
Total	2186				2,981,839	5,678,930	47%
OREGON							
City B	904			1,744,183		2,348,469	
Bal. of State	111					288,363	
Total	1015		1,170,946	1,744,183	1,386,000	2,636,832	-19%
PENNSYLVANIA							
Philadelphia	3115	3,479,453		4,614,459		8,092,346	
Bal. of State	779					2,023,736	
Total	3894		4,421,998	4,614,459	5,234,136	10,116,082	3%
PUERTO RICO							
Ponce	522	976,793		2,034,804		1,356,085	
San Juan	2713	4,561,223		5,147,513		7,048,005	
Bal. of State	1182					3,070,675	
Total	4417		7,521,643	7,182,317	8,903,057	11,474,764	-40%
TEXAS							
Dallas	2564	3,445,177		4,293,970		6,660,923	
Houston	3610	5,676,753		6,293,576		9,378,288	
City C	827			2,040,121		2,148,433	
City I	643			1,422,656		1,670,426	
Bal. of State	2464					6,401,136	
Total	10108		11,813,825	14,050,323	13,983,535	26,259,207	-7%
WASHINGTON STATE							
Seattle	1467	1,617,949		2,760,750		3,811,066	
Bal. of State	565					1,467,793	
Total	2032		2,262,586	2,760,750	2,678,129	5,278,859	-3%
WASHINGTON D.C.		5,225,866					
Dist. of Col.	2094		2,155,767		2,551,692	5,439,927	
Washington D.C.	1811			6,157,582		4,704,731	
Total	3905			6,157,582	2,551,692	10,144,658	14%
TOTAL THESE STATES	125,901	$159,994,501	$166,800,793	$182,250,000	$167,070,088	$327,073,652	

VARIATIONS

Using 3 years of case counts might guard further against fluctuations in year to year allocations.

As noted under previous options, Congress could retain either the current incidence factor in the Title I formula or the income factor in the Title II formula, in order to further target funds under this option. However this would produce further per-case funding inequities.

Alternatively, Congress could use Title I supplemental funds, as now, to meet the special needs of specific States or cities.

As noted under Option 1, Congress could fold Title I supplemental funds into this grant to make a single formula grant. This would serve to minimize per-case funding inequities across grantees, as well as simplify administration.

COMMENTS

The PHS commented on this report; the full text of their comments is in Appendix D. The Assistant Secretary for Planning and Evaluation commented verbally. We thank all those who commented.

In response to the comments we received, and in view of information now available on the FY 1995 budget request, we recasted our four proposed formulas looking forward to FY 1995. We believe this updated view will be more helpful during reauthorization discussions. We also made other editorial changes in the report in response to the comments received.

APPENDIX A

FUNDING FORMULAS

TITLE I:

$$\text{Funding EMA}_x = (.75T)\left(\frac{\text{Cumul. AIDS Cases EMA}_x}{\text{Cumul. AIDS Cases EMA}_{TOT}}\right) + (.25T)\left(\frac{\text{Per Capita Incidence of Cumul. AIDS Cases EMA}_x}{\text{Per Capita Incidence of Cumul. AIDS Cases EMA}_{TOT}}\right)$$

TITLE II:

$$\text{Funding State}_x = T\left(\frac{{}^{DF}\text{State}_x}{{}^{DF}\text{State}_{TOT}}\right)$$

$${}^{DF}\text{State}_x = (\#\ \text{New AIDS Cases of State}_x)\left(\sqrt[3]{\frac{\text{Avg. Per Capita Income U.S}}{\text{Avg. Per Capita Income State}_x}}\right)$$

$${}^{DF}\text{State}_{TOT} = \sum_{x=1}^{50} {}^{DF}\text{State}_X$$

OPTION 1

$$\text{Funding EMA}_x = (\#\ \text{of New AIDS cases}^{*}\ \text{EMA}_x)\left(\frac{\text{Total Funds Appropriated}}{\#\ \text{of New AIDS cases EMA}_{TOT}}\right)$$

OPTION 2

$$\text{Funding EMA}_x = T \left\{ \frac{{}^{DF}\text{EMA}_x}{{}^{DF}\text{EMA}_{TOT}} \right\}$$

$${}^{DF}\text{EMA}_x = (\#\text{ New AIDS cases}^* \text{ of EMA}_x) \left\{ \frac{\sqrt[3]{\text{Avg. Per Capita Income U.S.}}}{\sqrt[3]{\text{Avg. Per Capita Income EMA}_x}} \right\}$$

$${}^{DF}\text{EMA}_{TOT} = \sum_{x=1}^{50} {}^{DF}\text{EMA}_X$$

OPTION 3

$$\text{Funding State}_x = (\#\text{ of New AIDS cases}^* \text{ State}_x) \left\{ \frac{\text{Total Funds Appropriated}}{\#\text{ of New AIDS cases State}_{TOT}} \right\}$$

OPTION 4

$$\text{Funding Grantee}_x = (\#\text{ of New AIDS cases}^* \text{ Grantee}_x) \left\{ \frac{\text{Total Funds Appropriated}}{\#\text{ of New AIDS cases Grantee}_{TOT}} \right\}$$

$200,000 Floor Adjustment

Adjusted # of New AIDS cases Grantee $_{TOT}$ = # of New AIDS cases Grantee$_{TOT}$ - # of New Aids cases of Grantees receiving floor

Adjusted Total Funds Appropriated = Total Funds Appropriated - Funds Appropriated to Grantees receiving floor

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NOTE:

* # of New AIDS cases is a two-year case count

EMA = Eligible Metropolitan Area

T = Total Funds Appropriated for Title I or Title II

DF = Distribution Factor

FOR OPTION 1 ONLY: EMA_x = Cities with newly reported AIDS cases nationally in the top two-thirds of the total cases reported.

APPENDIX B

AIDS CASES and PER CAPITA INCOME
FOR METROPOLITAN AREAS*

CITY	Cumulative Cases	Rate	Cases Reported Oct 91-Sept 93	Per Capita Income**
New York	55899	155.3	20451	$16,281
Los Angeles	21850	61.1	8884	16,188
San Francisco	17424	279.8	6488	19,965
Chicago	9376	34.5	4233	12,899
Washington D.C.	9504	58.7	3905	18,881
Miami	9563	120.1	3747	9,799
Houston	9312	72.8	3610	14,261
Philadelphia	7169	42.5	3115	12,091
Boston	6627	40.2	2927	15,581
Atlanta	6879	56.4	2729	15,279
San Juan, PR	6745	87.3	2713	6,383
Dallas	5891	64.4	2564	16,300
Newark	7413	80.6	2378	9,424
Baltimore	4661	66.6	2297	11,994
San Diego	4909	56.7	2105	16,401
Fort Lauderdale	5223	88.4	2013	19,814
Tampa-St. Pete	3834	66.6	1956	14,374
Detroit	3529	28.7	1839	9,443
Oakland	4164	57.2	1788	14,676
Riverside/San Bern.	2754	36.6	1480	13,879
Seattle	3546	49.1	1467	18,308
Nassau/Suffolk Co.	3266	38.4	1380	20,884
Denver	2931	58.9	1345	15,590
West Palm Beach	3023	86.5	1316	15,712
New Haven	2731	60.4	1305	12,968
Orange Co. CA	2832	29.0	1270	19,890
City A	2189	94.7	1237	13,661
Orlando	2291	66.3	1201	13,879
Phoenix	2245	36.9	1155	14,096
Saint Louis	2245	33.3	1131	10,798
New Orleans	2905	46.9	1088	11,372
Kansas City, MO	2206	45.4	1050	13,799
Bergen-Passaic	2476	52.8	944	21,234
Jersey City	3001	111.8	932	13,060
City B	1949	40.3	904	14,478
City C	1719	65.0	827	14,295
City D	1629	20.9	754	16,842
City E	1504	31.5	740	14,087
City F	1414	50.2	732	11,081
City G	1525	33.2	685	16,905
City H	1441	20.6	657	9,258
City I	1605	31.1	643	na
City J	1548	34.2	571	na
Ponce PR	1411	74.5	522	3,735

Avg U.S. Per Capita Income: $14,420

Total Cumulative Cases:	339,250
Cumulative Cases, Metro. Areas:	288,572
Total New Cases:	144,084
New Cases, Metro. Areas:	120,464

*Reported in HIV/AIDS Surveillance Report, Issued October 1993.
Includes three quarters of reporting under new CDC definition.
**Reported by Bureau of the Census as of 1989 (most recent available).

APPENDIX C

AIDS CASES AND PER CAPITA INCOME
FOR STATES AND TERRITORIES*

STATE	Cases Reported from Oct 91-Sept 93*	Per Capita Income**
California	26115	16,409
New York	24263	16,501
Florida	14620	14,698
Texas	10108	12,904
New Jersey	6441	18,714
Illinois	4847	15,201
Puerto Rico	4417	4,172
Georgia	3945	13,631
Pennsylvania	3894	14,068
Maryland	3449	17,730
Massachusetts	3299	17,224
Michigan	2536	14,154
Missouri	2329	12,989
Connecticut	2231	20,189
Virginia	2196	15,713
Ohio	2186	13,461
Dist. of Col.	2094	18,881
Washington	2032	14,923
Louisiana	2001	10,635
South Carolina	1742	11,897
North Carolina	1707	12,885
Arizona	1610	13,461
Colorado	1608	14,821
Tennessee	1409	12,255
Indiana	1201	13,149
Alabama	1170	11,486
Oregon	1015	13,418
Oklahoma	944	11,893
Wisconsin	924	13,276
Minnesota	861	14,389
Nevada	836	15,214
Mississippi	699	9,648
Arkansas	657	10,520
Kentucky	523	11,153
Kansas	523	13,300
Hawaii	499	15,770
Delaware	472	15,854
Utah	415	11,029
Rhode Island	407	14,981
New Mexico	397	11,246
Iowa	282	12,422
Nebraska	247	12,452
Maine	176	12,957
New Hampshire	147	15,959
West Virginia	139	10,520
Idaho	107	11,457
Vermont	86	13,527
Alaska	78	17,610
Virgin Islands	61	9,440
Montana	57	11,213
Wyoming	40	12,311
South Dakota	31	10,661
North Dakota	8	11,051
Guam	3	9,928
TOTAL	144,084	

*Reported in CDC's HIV/AIDS Surveillance Report, Issued October 1993. Includes three quarters of reporting under new CDC definition.
**Reported by Bureau of the Census as of 1989 (most recent available).

APPENDIX D

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date . FEB 22 1994

From Deputy Assistant Secretary for Health Management Operations

Subject Office of Inspector General (OIG) Draft Report "The Ryan White Act: Funding Formulas," OEI-05-93-00330

To Inspector General, OS

Attached are the Public Health Service's comments on the subject draft report. The report contained no recommendations and our comments reflect general concerns and suggest technical revisions to narrative and tables.

Anthony L. Itteilag

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT: "THE RYAN WHITE ACT: FUNDING FORMULAS," OEI-05-93-00330

GENERAL COMMENTS

The PHS appreciates the timeliness of the OIG examination of the formulas governing the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds and proposed options to change the formulas. Since this report is the first in a series of studies intended to provide information that may be useful during the reauthorization of the Ryan White CARE Act, we offer the following comments for your consideration.

Background

Any formula funding approach to distributing HIV/AIDS funds will not fully address the total need for assistance. It is reasonable that a formula should take into account new cases reported, and perhaps include multiple years of reporting, as proposed with the 2 or 3 year case count. Over time, the possible contribution to funding disparity caused by the expanded AIDS case surveillance definition should subside. This decrease in disparity will occur once all States have fully implemented surveillance methods under the new definition and individuals who meet the new case definition are fully incorporated into case counts.

Ryan White funding has provided an incentive to timely reporting of AIDS cases since there is a direct financial incentive for a State to report cases by the funding cut-off date. On the other hand, States have not had sufficient resources to adequately conduct other aspects of AIDS surveillance, such as followup cases reported with no identified risk. Any options which might be proposed and/or adopted that would expand data required of State AIDS surveillance or HIV sero-surveillance programs should concurrently provide sufficient additional resources for strengthening these programs.

Options

In reviewing the options for funding formulas presented in the OIG report, a clarification on reporting of AIDS-related deaths would be useful. The PHS agrees that a reasonable approach would be to base funding formulas on persons living with AIDS, as opposed to cumulative or incident AIDS cases which may include deceased persons. The reason stated in the report however, that this is not feasible since reporting of AIDS-related deaths is not required by Federal law is incorrect. Indeed, neither reporting of AIDS cases nor AIDS-

related deaths is required by Federal law. However, ascertainment of vital status of persons reported with AIDS is done routinely by all State health departments through review of death certificates. States voluntarily share such information with the Centers for Disease Control and Prevention (CDC). Accurate State-specific data prevalence (the number of persons living with AIDS) by city and State would require that: (1) AIDS-case reports be updated promptly when persons die, and (2) movements of persons with AIDS from city-to-city or State-to-State be accurately monitored. While States use death certificates to update AIDS case reports, to base funding on such updates may create a disincentive to complete death reporting. In addition, tracking the movement of individuals from one geographic area to another during the course of their HIV illness would be beyond the scope of affected communities (e.g., this would require making a change of residence in a person with AIDS a reportable event to health departments).

Criteria

The OIG report examines each option against five criteria that they consider useful in assessing any new allocation methodology: **equity, targeting, flexibility, reasonable data requirements and stability.** In the case of "targeting," the report states that "funds should be targeted to areas with the greatest concentration of cases, and is not spread so thin as to be ineffective." The PHS disagrees that $1 million to $2 million for new Title I grantees is ineffective. There is substantial evidence that funds to new Title I grantees are extremely useful in creating a community planning process as well as filling gaps in a continuum of care.

The criterion of "stability" seems inconsistent with the criterion of "flexibility." The tables clearly demonstrate that proposed changes in funding formulas result in substantial disruptions of current funding and future funds. The "flexibility" criterion, combined with the "targeting" criterion will create a scenario in which certain States and eligible metropolitan areas could move in and out of funding as demographic changes occur, resulting in major disruptions in "stability."

In the past, the formula was based on cases reported from statistical units (Metropolitan Statistical Areas - MSAs) as published in CDC's HIV/AIDS Surveillance Reports. Because these MSAs are not administrative units, MSAs frequently cross administrative/legal jurisdictions. The result is that CDC receives numerous ad hoc requests by the various agencies that

use the Ryan White formula (e.g., HRSA, HUD) to parcel out these cases across State/county/city lines.

In addition, part of the formula requires calculation of a rate to ensure equitable distribution of funds. However, because it is difficult to obtain accurate denominator data, these rates are only crude estimates of the impact of the epidemic in the targeted areas, and they are not responsive to changes in the demographics of the affected populations. Denominators for the calculation of rates are not readily available, especially by geographic and demographic subgroups. There are necessary delays following the decennial census until stratified population counts are made available to CDC by the Bureau of the Census. Official estimates of annual population change by demographic/geographic substrata are frequently unavailable. Therefore, CDC is required to develop crude estimates of annual population change with limited statistical resources.

Another criterion to be considered in developing funding options is "reasonable data requirements." Data used in the formulas to distribute funds should be readily available and reliable. It is reasonable to base funding formulas on AIDS statistics because national AIDS surveillance is currently the only system that collects data completely and consistently on persons who are in care, or require care, for severe HIV disease. However, these data are "readily available and reliable" only insofar as concerted collaborative efforts among CDC and other State/local health departments continue to prioritize the collection of AIDS surveillance data.

If, in the future, AIDS surveillance were deemphasized or the quality and completeness of the data were compromised due to fiscal or personnel constraints at Federal/State/local levels, then long term legislation tied to these data could result in inequitable distribution of resources. The data are available and reliable and are dependent on the continued support for the AIDS surveillance system.

Methods

The tables provided in the report do not include comparative data necessary for any meaningful analysis and the inclusion of Fiscal Year (FY) 1994 data would provide the needed clarification. Specifically, for Tables 4 through 7:
(1) formulas proposed should be based on FY 1993 data for comparison of actual FY 1993 awards and changes that would have occurred if proposed formulas had been used; and
(2) actual data on FY 1994 awards should have been provided, again to highlight how proposed formulas would have changed

the funding picture. If actual FY 1994 data had been used, major funding disruptions that would result from formula changes would have been highlighted, e.g., a 31 percent decline in funding for New York City and a 46 percent decline in funding for San Francisco in Table 4. By comparing proposed FY 1994 to actual FY 1993, any funding disruptions caused by the formula change were masked by the 76 percent Title I funding increase from FY 1993 to FY 1994, an increase not likely to be repeated in future years.

TECHNICAL COMMENTS

(1) Definitions: The report uses the words "equity" and "parity" as if they mean the same thing. Equity means fairness, and is not an absolute term. Parity means equality as in amount, status or character. Equal funding for each recently reported AIDS case is one interpretation of equity, but many other interpretations are equally valid. For example, an interpretation inconsistent with the stated purpose of the Ryan White CARE Act is in the report itself, "to establish services for AIDS and HIV patients who would otherwise have no access to health care." It may be useful to provide a more extensive discussion of why "equity" was selected as the principal determinant for the analysis and driving force behind the proposed allocation formulas. Is this the factor that best describes the need for Ryan White services?

(2) The cover page should be more accurately titled, "**The Ryan White CARE Act: Funding Formulas.**"

(3) Page 2, second full paragraph. The last sentence should read: "**The Health Resources and Services Administration (HRSA) in the Public Health Service administers Titles I and II of the Act. The HRSA and the Centers for Disease Control and Prevention (CDC) were to administer Title III of the Act.**"

(4) Page 2, second paragraph under Title I Section. The last sentence should be rewritten as follows: "**HRSA is required to allocate funds to grantees within 60 days after an appropriation becomes available.**"

(5) Page 2, third paragraph under Title I Section should be amended to read, "**as supplemental grants to eligible metropolitan areas which have demonstrated a severe need for additional financial assistance to address the epidemic and the ability to allocate funds expeditiously to areas of greatest need.**"

(6) On Page 3, Line 2, insert "**areas most affected as well as**" between the words "**on**" and "**the.**"

(7) Page 3, first paragraph. The last sentence should be deleted and replaced with: "**To get the money out quickly to meet the greatest needs, States are required to allocate 75 percent of services within 120 days after an appropriation becomes available.**"

(8) Page 3, Title III Section, first sentence should read: "**Title III(a), intended to provide formula grants to States for early intervention services on an outpatient basis, and intended to be administered by CDC, has not been funded to date.**"

(9) Page 3, second paragraph. The last sentence: delete the word "**drugs**" and insert the words "**approved treatments.**"

(10) Under the heading of Special Projects of National Significance rewrite the last two sentences as follows: "**In FY 1991, HRSA awarded approximately $4.4 million for 22 projects. These projects continued in FY 1992 with $5.2 million and four new projects funded with an additional $836,000. In FY 1993, nearly $6.1 million was awarded to support 27 projects. An additional $2.97 million, $4.84 million, and $5.10 million in FY 1991, 1992, and 1993, respectively, was mandated by Congress to be used for reimbursement of dental health providers who provided uncompensated care to people with HIV/AIDS.**"

(11) Page 4, SCOPE AND METHODOLOGY. The first line in the first paragraph should read: "**The Ryan White Act will be reauthorized in FY 1996.**"

(12) Page 4, first paragraph, second sentence, third line. Replace the word "**debate**" with "**discussion.**"

(13) Page 5, first paragraph, mentions the implementation of the January 1993 AIDS case definition as an important backdrop with significant impact on the distribution of funds. Another important backdrop factor with significant impact which has not been mentioned is the December 31, 1992 Office of Management and Budget (OMB) definition of Metropolitan Statistical Areas. The new definitions in many cases are substantially different than the definitions they replaced, and they significantly affect the numbers of AIDS cases being reported in affected metropolitan areas. For example, New Haven, CT now includes Bridgeport/Stamford CT, which increases the number of AID cases reported in this metropolitan area, and would affect any funding based on AIDS cases reported.

(14) Page 5. Rewrite the first sentence of the third paragraph as follows: "**Title II funds are distributed to all States, Puerto Rico, the District of Columbia, and up to five U.S. territories via a formula.**"

(15) Page 5, fourth paragraph is not accurate. The CDC's expanded AIDS surveillance case definition includes all HIV-infected persons who have < 200 CD4+ T-lymphocytes/uL or <u>have CD4+ T-lymphocytes, 14 percent of total T-lymphocytes</u>, and adds pulmonary TB, recurrent pneumonia, and invasive uterine cervical cancer. The CD4+ T-cell percentage has been omitted in the OIG report.

(16) Page 6. The second sentence in the second paragraph should read: "**Partly as a result of the new CDC definition, the number of eligible cities increased to 34 in FY 1994 and HRSA expects an increase by as many as 4 to 7 in FY 1995.**"

(17) Page 10. Add to the second paragraph: "**Additionally, the number and the proportion of people with AIDS and HIV requiring care, those already in care, and the insurance status of those people, is not available.**"

(18) Page 10, third paragraph, last sentence. The report never acknowledges that services are also provided to people with HIV infection who do not have an AIDS diagnosis.

(19) Page 11. The first paragraph under Option I needs clarification; denominator is cases reported to Title I eligible metropolitan areas (EMA).

(20) Page 11 second paragraph, last sentence. The proposed variation is the way supplemental funds are currently awarded.

(21) Page 12, Table 4. A column giving the actual FY 1994 formula allocation, which is now available, would be helpful.

(22) Page 13. In regard to the methodology for Option I, second paragraph, comparison should also be made to the actual 1994 distribution. This distribution would help identify instances of service delivery disruption in cities which get level or decreased funding and data which does not take into account full year funding of services providers.

(23) Page 14, second paragraph. The statement to "**hold [cities that would lose funds] harmless**" at the FY 1993 levels, fails to recognize that changes may occur in FY 1996.

(24) Page 14, third paragraph. The variation collapsing all Title I funds into a formula grant fails to take into account the role of the supplemental grant.

(25) Page 15. Table 5 should add a column for actual distribution of 1994 dollars.

(26) Page 16. Option 3: first paragraph. This option does not examine the impact of dollars per case from Title I in the "equity" discussion.

(27) Page 17. Table 6 should include a column with actual FY 1994 dollars.

(28) Pages 21-22, Table 7. States without EMA include the District of Columbia. Under the CARE Act, the District of Columbia receives Title II funds and also qualifies as an EMA and receives Title I funds. The amounts proposed for Guam and the Virgin Islands fail to take into account that the minimum Title II grant awards apply only to States and do not include territories.

(29) Tables 7 and 8. Add a column with FY 1994 actual dollars.

(30) Table 8 should include the District of Columbia.