GAO

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Health, Education and Human Services Division

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March 31, 1995

The Honorable Christopher J. Dodd
United States Senate

Dear Senator Dodd:

On February 22, 1995, the Senate Labor and Human Resources Committee held a reauthorization hearing concerning the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. At that hearing we presented our work on changes that would increase grant formula equity.[1]

On the basis of our testimony, you asked that we answer certain questions for the hearing record. This correspondence contains our responses to the questions you submitted to us in your February 23, 1995, letter.

QUESTION

Have the Centers for Disease Control and Prevention (CDC) raised some concerns about your proxy measure of people living with acquired immunodeficiency syndrome (AIDS)? Does the GAO calculation take into account those who are pre-AIDS but who may need and receive services? Is there a way to build that into GAO's count?

RESPONSE

We have received no official correspondence from CDC regarding the agency's position on the appropriateness of our method for estimating living cases. CDC staff have indicated some concern about the increased administrative burden of having to publish each of the past 10 years of reported cases rather than a single cumulative count. As an alternative, CDC staff suggested we estimate the number of people living with AIDS using a 2- or 3-year interval of reported AIDS cases.

[1]Ryan White CARE Act of 1990: Opportunities Are Available to Improve Funding Equity (GAO/T-HEHS-95-91, Feb. 22, 1995).

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We have evaluated this proxy measure and found that for the most recent 2 years of reported cases, it produces nearly the same result--the correlation between the 2-year count and our estimate of living cases is 0.99. We prefer our method, however, because we believe it can better incorporate potential future changes in mortality resulting from changes in medical care effectiveness. Our proposed method includes cases that span a 10-year rather than 2- or 3-year interval, and the most recently reported cases receive a greater weight than do cases reported in the more distant past. These weights can be adjusted over time to recognize changes in mortality. Also, because we are proposing the use of existing data for estimating living cases, we do not believe our method should significantly increase administrative burdens.

With regard to counting those people who are pre-AIDS, neither our method of estimating living cases nor the existing caseload measure takes these people into account. Presently, it is not possible to do so. Only half the states have actual data on the size of the population with human immunodeficiency virus (HIV). For the remaining states, the HIV population can only be estimated, and we are not aware of any validated means for making these estimates. As a result, we do not believe the pre-AIDS population can be reasonably built into the caseload factor of a formula.

If accurate estimates of the HIV population do become available, however, it will be necessary both to include this population in the caseload estimate and to establish a method of weighting the people with HIV differently than those with AIDS. This is because the cost of treating people in the advanced stages of the disease are substantially higher than for asymptomatic people with HIV.

QUESTION

What will be the effect of the functional approach to allocating Ryan White Act resources on planning activities and service delivery for states and eligible metropolitan areas (EMA)? Will restructuring the act disrupt the current division of responsibilities that has evolved between states and cities? Will the structural changes undermine a state's ability to allocate its resources equitably within the state?

RESPONSE

Under the existing structure for allocating federal funding, states and cities may choose among a variety of administrative and financing arrangements. Cities and states may choose to share responsibility for planning and delivering services in an area, or cities may assume almost all responsibility for these activities. States may choose to use a large portion of their title II funds in EMA areas, or may use none of these funds in these areas.

Our proposal provides a means of allocating federal funding that affords greater equity in its distribution among both states and EMAs. However, it does not change the latitude currently afforded cities and states in deciding how to best use these funds. Hence, the flexibility with which states and EMAs can use the funds they receive is unaffected. EMAs will continue to receive federal assistance under title I of the act and states will receive funding under title II of the act. The only difference is that each state's title II funding will come from two separate formulas: one based on non-EMA caseloads to reflect the need for medical services in the non-EMA portion of the state and the other based on the total caseload of the state to reflect the need for statewide services such as purchases of drugs and home care. States will continue to have the flexibility to program title II funding to meet their highest priority needs.

QUESTION

When cities in states without current title I cities become eligible for title I funds, won't the state see a dramatic loss in title II funding?

RESPONSE

A portion of the title II funding for medical services in such a state would be transferred to the title I EMA. Given that the designation of a metropolitan area as an EMA may involve only a small change in the number of people in need of services, virtually the same total amount of title I and II funds will be available in the state. State governments and EMAs can continue to work cooperatively to direct federal funding to most effectively meet the needs of people with HIV.

This question also raises the issue of which grantees must have their allotments reduced in order to provide funding

for newly eligible EMAs (assuming appropriations remain level or increase only slightly). Under current law, all existing EMAs have their allotments reduced to accommodate new EMAs. Under the functional approach that we have proposed, however, only the state in which the new EMA is located would have its allotment significantly reduced under the medical services appropriation;[2] the other EMAs allotments are largely unaffected.

In our view, the fact that a metropolitan area has become eligible for funding under title I does not mean that the overall funding needs of the state in which the EMA is located have substantially increased. The state may have about the same number of cases as before. The only difference is that one area in that state has reached a certain threshold of AIDS cases and services for these cases will now be funded through title I rather than through title II. It would therefore be unfair to require EMAs located in other states to give up a portion of their funding and put pressure on their respective states to make up for this loss of funding. We believe it would be more equitable for the funding to come from the state in which the new EMA is located since its financial burden is being reduced as the new EMA takes responsibility for serving that portion of the state's caseload that resides in the new EMA.

QUESTION

How does GAO recommend dealing with title I cities that encompass parts of two or even three states when determining which cases to count in which formula? Should the Kansas City, Kansas, cases that are included in the Kansas City, Missouri, EMA be subtracted from the Kansas state count? Similarly, for New Hampshire cases that are in the Boston EMA; New Jersey's cases that are in the Philadelphia EMA; Maryland and Virginia's cases that are in the Washington, D.C., EMA; Illinois cases that are in the St. Louis EMA.

RESPONSE

Our suggested approach proposes two title II allocations--one for medical services and one for statewide services. Under this approach, the Kansas City, Kansas, cases that

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[2]The state's allotment for statewide functions would be unaffected.

are part of the Kansas City EMA would be excluded in determining the title II allocation to the state of Kansas for medical services. However, these cases would be included when determining the title II allocation to the state of Kansas for statewide services.

Under our approach, an EMA would receive funding for medical services based on the number of cases reported in the EMA, which is the same as current law. A state would receive an allotment for medical services funding based on the number of reported cases residing in the state but living outside an EMA. Therefore, the state of Kansas would receive an allotment under the medical services formula based on the count of reported cases living in the state but outside the Kansas City EMA. Similarly, the state of Missouri would receive an allotment for medical services based on the number of reported cases living outside the Kansas City and Saint Louis EMAs. However, each of these states would receive title II funds for statewide services based on their total number of AIDS cases, regardless of whether those cases live in or outside the EMA. Similarly, the state of Illinois would receive a medical services allotment based on the number of cases living outside the Saint Louis and Chicago EMAs; but the state would receive a statewide allotment for all of its cases, including those living in the Saint Louis and Chicago EMAs.

QUESTION

A second option for dealing with the formula and appropriating Ryan White Act funds was presented to congressional staff. That option included a single appropriation which would be divided between states and cities based on their caseloads. Could you explain that option?

RESPONSE

This second option consists of the following features:

-- EMAs would be responsible for all services for cases within their geographic boundaries. That is, former statewide services (for example, medication assistance, insurance continuation, and home health care) would be devolved to the title I cities. Similarly, states would have responsibility for all services for cases living outside EMAs. Thus, title I EMAs would be responsible for serving cases within their geographic boundaries,

and states would be responsible for serving cases outside the title I areas.

-- A single appropriation would then be allocated between EMAs under title I and states under title II based on their respective caseloads.

Like the functional option, this approach would promote funding equity because there would be a clear demarcation between the cases that were the responsibility of the state government and the cases that were to be the responsibility of the EMA. Also, like our functional option, it would eliminate situations in which certain cities and states experience funding changes simply because part of a state's caseload was incorporated into an EMA.

However, this approach also changes the locus of responsibility for delivering services since title I cities would be responsible for services that were once the responsibility of the state. Title I cities would become responsible for providing home health care, insurance continuation, and purchases of medications that, thus far, have primarily been the responsibility of state government.

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We hope this information proves useful to you. We have sent a copy of this correspondence to members of Senator Kassebaum's staff for inclusion in the hearing record. Please contact me on (202) 512-4561 or Jerry Fastrup, Assistant Director, on (202) 512-7211 if you or your staff have any questions.

Sincerely yours,

William J. Scanlon

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