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Ryan White CARE Act [2]

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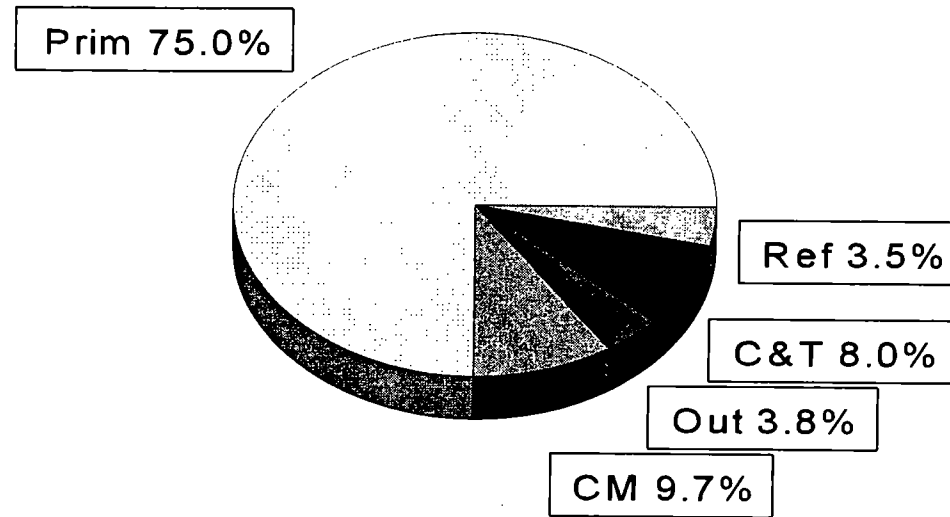
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Title III Allocations for FY '97



Primary Health Care

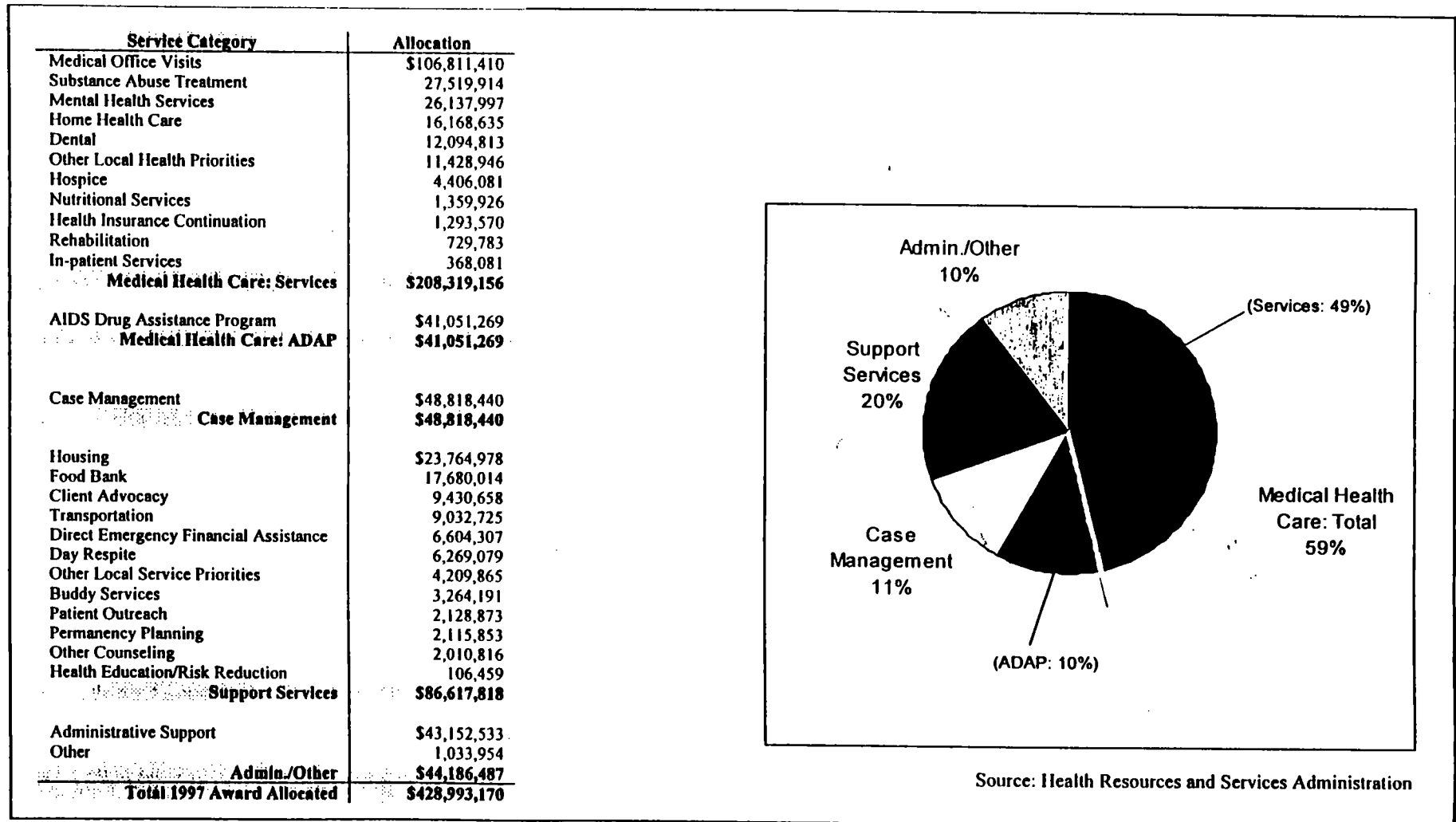
Case Management

Outreach Services

Counseling & Testing

Referrals

**1997 Ryan What CARE Act
Title I Aggregate Allocations
By Service Category and
Percentage of Total Grant**



For more information, please contact CAEAR Coalition, 1413 K Street, NW, Suite 700, Washington, DC 20005
202.789.3565 fax 202.789.4277

Ryan White CARE Act Title III Grantees By State and City/Town

State	Cities/Towns
Alaska	Anchorage
Alabama	Birmingham Hobson City Mobile Montgomery
Arizona	Phoenix Tucson
Arkansas	Pine Bluff
California	Bakersfield Guernville Long Beach Los Angeles Oakland Panorama City San Bernadino San Diego San Francisco San Jose San Marcos Santa Ana Santa Barbara Santa Cruz Stockton Ukiah Venice
Colorado	Denver
Connecticut	Bridgeport New Haven
Delaware	Wilmington
Florida	Fort Lauderdale Immokalee Key West Miami Miami Beach Pompano Beach West Palm Beach
Georgia	Albany Atlanta Augusta Brunswick Savannah Waycross
Idaho	Boise
Illinois	Chicago Peoria Rockford
Indiana	Indianapolis Richmond
Iowa	Davenport Des Moines Iowa City Sioux City
Kansas	Wichita
Kentucky	Paducah

Louisiana	Lake Charles New Orleans
Maine	Portland
Maryland	Baltimore
Massachusetts	Boston Dorchester East Boston Holyoke Lawrence New Bedford Roxbury Somerville Truro Worcester
Michigan	Ann Arbor Detroit Grand Rapids
Mississippi	Biloxi Marks
Missouri	Kansas City Springfield St. Louis
Montana	Billings
Nebraska	Omaha
Nevada	Las Vegas Reno
New Jersey	Hoboken New Brunswick Newark Paterson Trenton
New Mexico	Albuquerque
New York	Albany Amityville Bronx Brooklyn Buffalo Elmhurst Far Rockaway New York City Ossining Peekskill Rochester Syracuse Yonkers
North Carolina	Asheville Durham
Ohio	Chillicothe Cincinnati Columbus
Oklahoma	Oklahoma City Tulsa
Oregon	Portland
Puerto Rico	Arrogo Bayamon

Puerto Rico (cont'd)	Gurabo Humacao Lares Mayaguez Ponce Rio Piedras
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Pennsylvania	Allentown Philadelphia Pittsburgh York
Rhode Island	Providence
South Carolina	Columbia Ridgeland
Tennessee	Rossville
Texas	Austin Dallas El Paso Fort Worth Harlingen Houston San Antonio
Utah	Salt Lake City
Vermont	Burlington
Virginia	Charlottesville Fairfax
Washington	Seattle Yakima
Washington, DC	District of Columbia
Wisconsin	Madison Milwaukee



Ryan White CARE Act Title III Grantees

Alaska

Anchorage

Anchorage Neighborhood Health Center	\$228,988
Total	\$228,988

Alabama

Birmingham

Jefferson County Commission/Cooper Green	\$483,816
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Hobson City

AIDS Services Center	\$335,725
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Mobile

Franklin Memorial Primary Health Center	\$320,970
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Mobile County Health Dept./Family Health Care Clinic	\$407,607
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Montgomery

Montgomery AIDS Outreach/MAO Health Monitoring	\$461,086
Total	\$2,009,204

Arkansas

Pine Bluff

Jefferson Comprehensive Care	\$373,902
Total	\$373,902

Arizona

Phoenix

Maricope County Health System/McDowell Healthcare	\$600,000
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Tucson

El Rio Santa Cruz Neighborhood Health Ctr.	\$622,225
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Kino Community Hospital	\$132,072
Total	\$1,354,297

California

Bakersfield

Clinica Sierra Vista/34th St. Community Health Ctr.	\$222,667
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Guernville

Russian River Health Center	\$357,355
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Long Beach

Catholic Healthcare West/CARE Program	\$487,750
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AIDS Healthcare Foundation	\$530,756
AltaMed Health Services	\$519,626
Goodman Special Care Clinic/LAGLSC	\$600,000
Watts Health Fdn. South LA Comm. AIDS Program	\$400,000
<i>Oakland</i>	
Tri-City Health Center/Alameda Health	\$550,000
<i>Panorama City</i>	
Northeast Valley Health Corp./HIV/AIDS Programs	\$380,699
<i>San Bernardino</i>	
San Bernadino County Department of Public	\$371,298
<i>San Diego</i>	
Logan Heights Fam. Hlth. Ctr./North Park Fam. Hlth.	\$564,874
Univ. of California San Diego Med. Ctr./Owen Clinic	\$378,595
<i>San Francisco</i>	
San Francisco Community Clinic Consortium	\$585,000
<i>San Jose</i>	
Santa Clara Cty. Health & Hosp. Syst./PACE Clinic	\$584,136
<i>San Marcos</i>	
North County Health Services	\$255,000
<i>Santa Ana</i>	
County of Orange Health Care Agency	\$600,000
<i>Santa Barbara</i>	
Santa Barbara County Health Care Services	\$314,640
<i>Santa Cruz</i>	
County of Santa Cruz Health Services	\$363,299
<i>Stockton</i>	
Community Medical Centers	\$283,974
<i>Ukiah</i>	
Mendocino Community Helath Clinic	\$175,772
<i>Venice</i>	
Venice Family Clinic	\$281,380
Total	\$8,806,821

Colorado

Denver

Denver Health and Hospitals	\$600,000
Total	\$600,000

Connecticut

Bridgeport

Bridgeport Community Health Center	\$292,329
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Southwest Community Health Center	\$329,351
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New Haven

Hill Health Center	\$389,796
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Total	\$1,011,476
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District of Columbia

Washington

Family & Medical Counseling	\$339,864
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Unity Health Care	\$499,980
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Whitman-Walker Clinic	\$392,441
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Total	\$1,232,285
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Delaware

Wilmington

Christiana Care Health Services	\$373,634
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Total	\$373,634
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Florida

Fort Lauderdale

North Broward Hospital District	\$434,615
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Immokalee

Colier Health Services	\$309,975
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Key West

Monroe County Health Department	\$420,298
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Miami

Economic Opportunity Family Health Ctr.	\$763,325
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University of Miami Sch. of Med./Dept. of OB-GYN	\$521,836
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Miami Beach

Stanley C. Meyers Community Health Center	\$237,745
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Pompano Beach

Sunshine Health Center	\$500,000
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W. Palm Beach

Florida Community Health Centers	\$424,057
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Total	\$3,611,851
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Georgia

Albany

Albany Area Primary Health/Rural HIV Model	\$453,666
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Atlanta

Hemophilia of Georgia	\$488,962
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St. Joseph's Mercy Care/Mercy Mobile Health Program	\$385,382
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Augusta

Medical Coll. of Georgia Dept. of Med./Infec. Dis. Div.	\$467,921
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Brunswick

Glynn County Board of Health	\$145,253
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Savannah

Chatham County Health Department	\$463,388
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Waycross

Ware County Board of Health	\$535,977
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Total	\$2,940,549
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Iowa

Davenport

Community Health Care/QCR Virology	\$191,525
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Received grants in subsequent years.	\$0
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Des Moines

Primary Health Care/Broadlawns Med. Ctr.	\$271,391
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Iowa City

University of Iowa	\$24,830
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Sioux City

Siouxland Community Health Center	\$228,000
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Total	\$715,746
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Idaho

Bosie

Family Practice Residency of Idaho	\$295,575
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Total	\$295,575
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Illinois

Chicago

Cermack Health Services/Cook Cty. Board of	\$227,574
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Chicago Health Outreach	\$624,250
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City of Chicago Dept. of Health/STD/HIV Prev. Prog.	\$478,000
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Erie Family Health Ctr./Integrated Care Consortium	\$291,798
Hektoen Inst. for Medical Rsrch./CORE Center	\$553,197
Howard Brown Health Center	\$492,193
<i>Peoria</i>	
Univ. of Ill. Coll. of Med./Heart of Ill. HIV/AIDS Ctr.	\$380,846
<i>Rockford</i>	
Crusaders Central Clinic/Living with HIV Program	\$353,450
Total	\$3,401,308

Indiana

Indianapolis

Hlth. & Hosp. Corp. of Marion County/HIV/AIDS Prev.	\$506,032
<i>Richmond</i>	
Total	\$506,032

Kansas

Wichita

University of Kansas School of Medicine	\$433,348
Total	\$433,348

Kentucky

Paducah

Heartland Cares	\$421,050
Total	\$421,050

Louisiana

Lake Charles

Bayou Comprehensive Health Foundn./Ext.Svcs. Prog.	\$348,300
<i>New Orleans</i>	
Charity Hospital Medical Center	\$400,000
Total	\$748,300

Massachusetts

Boston

Fenway Community Health Center	\$473,761
<i>Dorchester</i>	
Harbor Health Services	\$235,970
<i>East Boston</i>	

East Boston Neighborhood Health Center	\$289,518
<i>Holyoke</i>	
Holyoke Health Center	\$434,875
<i>Lawrence</i>	
Greater Lawrence Family Health Center	\$339,250
<i>New Bedford</i>	
Gtr. New Bedford Comm. Health Ctr./HIV Early Intv.	\$323,890
<i>Roxbury</i>	
Dimock Comm. Health Ctr. (NE Hosp.Corp.)	\$459,953
<i>Somerville</i>	
Cambridge Health Alliance	\$426,788
Family Planning Council	\$412,650
<i>Truro</i>	
Outer Cape Health Services	\$157,524
<i>Worcester</i>	
Family Health & Social Service Center	\$312,928
Total	\$3,867,107

Maryland

<i>Baltimore</i>	
Chase-Brexton Health Services/Baltimore Consortium	\$577,400
Total	\$577,400

Maine

<i>Portland</i>	
<i>Received grants in subsequent years.</i>	\$0
Total	\$0

Michigan

<i>Ann Arbor</i>	
Regents of the University of Michigan	\$277,125
<i>Detroit</i>	
Detroit Community Health Connection	\$407,141
Wayne State Univ. Sch. of Medicine/Detroit Med. Ctr.	\$575,075
<i>Grand Rapids</i>	
St. Mary's McAudey Health Center	\$340,863
Total	\$1,600,204

Missouri

Kansas City

Kansas City Free Health Clinic/Gtr. KC Early Intv.	\$800,000
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Springfield

AIDS Project of the Ozarks	\$396,002
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St. Louis

St. Louis Connect Care Infectious Disease Clinic	\$309,974
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Total	\$1,505,976
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Mississippi

Biloxi

Marks

Deportes Delta Ministries	\$122,225
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Total	\$122,225
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Montana

Billings

Yellowstone City-County Health Dept./Dearing Clinic	\$267,715
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Total	\$267,715
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North Carolina

Asheville

Western NC Community Health Services	\$385,725
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Durham

Lincoln Comm. Hlth. Ctr./Durham Early Intv. Clinic	\$354,417
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Total	\$740,142
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Nebraska

Received grants in subsequent years.	\$0
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Omaha

Total	\$0
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New Jersey

Hoboken

Franciscan Health Center	\$332,370
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New Brunswick

Eric B. Chandler Health Center-UMDNJ	\$335,431
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Newark

Newark Community Health Centers	\$700,000
St. Michael's Med. Ctr./Div. of Infectious Disease	\$481,392
Univ. of Med. & Dent. of NJ/Infectious Disease Clinic	\$440,000
<i>Paterson</i>	
St. Joseph's Hospital & Med. Ctr./Comp. Care Ctr.	\$497,158
<i>Trenton</i>	
Barnert Memorial Hospital	\$215,970
Helene Fuld Med. Ctr./Mercer Area Early Intv. Svcs.	\$595,225
Total	\$3,597,546

New Mexico

Albuquerque

Univ. of New Mexico-Univ. Hospital/Partners in Care	\$499,778
Total	\$499,778

Nevada

Las Vegas

University Med. Ctr. of Southern Nevada	\$552,371
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Reno

Northern Nevada HOPES	\$328,215
Washoe County District Health Dept./Early Intervention	\$305,990
Total	\$1,186,576

New York

Albany

Albany Med. Coll. AIDS Prog./Mid-Hudson HIV Care	\$451,262
Whitney M. Young Jr. Health Ctr./CHEER Program	\$220,225

Amityville

Suffolk County Dept. of Health Services	\$145,500
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Bronx

Bronx Community Health Network	\$495,061
Bronx Lebanon Hospital	\$407,543
Montefiore Med. Ctr./AIDS Ambulatory Care	\$540,312
Morris Heights Health Center	\$765,000
NARCO Freedom Neighborhood/Family Comm. Health	\$550,000

Brooklyn

Brooklyn Hospital Center	\$400,000
Brooklyn Plaza Med. Ctr./Rising Heights Program	\$338,145
Cumberland Neigh. Fam. Care Ctr./(NYC Hosp.)	\$470,450

Luthern Med. Ctr./Sunset Park Family Health Ctr.	\$359,742
STAR Clinic/Health Science Ctr. at Brooklyn	\$558,964
<i>Buffalo</i>	
Erie County Medical Center/AIDS Designated Center	\$522,562
<i>Elmhurst</i>	
Elmhurst Hospital Center	\$500,000
<i>Far Rockaway</i>	
Joseph P. Addabbo Family Health Center	\$200,722
<i>New York City</i>	
Belances Health Unit	\$400,000
Boniken Neighborhood Health Ctr./East Harlem	\$398,508
Care for the Homeless	\$475,000
Community Healthcare Network	\$480,614
NYU Medical Center/Dept. of Pediatrics/Lower NY	\$536,768
Renaissance Health Care Network/(NYC Hosp.)	\$485,000
Settlement Health and Medical Services	\$190,000
St. Clare's Hospital/The Spellman Center	\$471,133
St. Luke's Roosevelt Hospital	\$400,000
St. Vincent's Hospital & Medical Center	\$550,000
William F. Ryan Community Health Center	\$449,685
<i>Ossining</i>	
Ossining Open Door Health Center	\$100,000
<i>Peekskill</i>	
Peekskill Area Health Center/Genesis Department	\$300,000
<i>Rochester</i>	
Rochester Primary Care Net./Comm. Health Net.	\$303,615
<i>Syracuse</i>	
Syracuse Community Health Center	\$150,909
<i>Yonkers</i>	
Valentine Lane Family Practice	\$152,632
Total	\$12,769,352

	
<i>Chillicothe</i>	
Family Healthcare	\$40,072
<i>Cincinnati</i>	
Cincinnati Health Network/Univ. of Cincinnati	\$621,591
<i>Columbus</i>	
Ross County Health District	\$52,285

Total	\$713,948
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Oklahoma

Oklahoma City

Univ. of Oklahmoa College of Medicine	\$428,894
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Tulsa

Oklahoma State Univ./Coll. of Osteopathic Med.	\$404,513
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Tulsa City/County Department of Health	\$0
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Total	\$833,407
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Oregon

Portland

Muitnemah County Health Dept.	\$559,692
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Total	\$559,692
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Pennsylvania

Allentown

Lehigh Valley Hospital	\$325,725
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Philadelphia

Allegheny Univ. of the Health Sciences	\$400,000
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ChesPenn Health Services	\$368,382
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City of Philadelphia Dept. of Public Helath/AACO-EI	\$600,000
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Greater Philadelphia Health Action	\$534,727
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The Graduate Hospital/Ambulatory Care Services	\$277,764
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Pittsburgh

Univ. of Pittsburgh Med. Ctr./Off of Research	\$549,296
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York

York Health Corp., YHESS! Clinic	\$258,947
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Total	\$3,314,841
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Puerto Rico

Arrogo

Bayamon

Municipality of Bayamon/Epi. Ctr. of Bayamon	\$500,000
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Gurabo

Gurabo Community Health Center	\$260,750
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Humacao

Ryder Memorial Hospital	\$458,076
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Lares

Centro de Salud de Lares	\$567,225
<i>Mayaguez</i>	
Migrant Health Ctr., W. Reg./Programme SSIMA	\$611,850
<i>Ponce</i>	
Consejo de Salud de la Comunidad/Diag. & Treat. Ctr.	\$659,955
<i>Rio Piedras</i>	
Puerto Rico CoNCRA	\$533,209
Total	\$3,591,065

Rhode Island

<i>Providence</i>	
The Miriam Hospital	\$280,195
Total	\$280,195

South Carolina

<i>Columbia</i>	
Richland Community Health Care Assn.	\$320,000
<i>Ridgeland</i>	
Beaufort-Jasper Comprehensive Health Service	\$399,655
Total	\$719,655

Tennessee

<i>Rossville</i>	
<i>Received grants in subsequent years.</i>	\$0
Total	\$0

Texas

<i>Austin</i>	
Austin Hlth. and Hum. Svcs. Dept./Travis County	\$491,155
<i>Dallas</i>	
Dallas Cty. Hosp. Dist./Comm. Oriented Primary Care	\$354,862
<i>El Paso</i>	
Centro de Salud Familiar La Fe	\$399,161
<i>Fort Worth</i>	
Tarrant County Hospital District	\$524,686
<i>Harlingen</i>	
Valley AIDS Council/CASE Project	\$423,480
<i>Houston</i>	
Harris County Hospital District	\$490,002

San Antonio

El Centro del Barrio/South Park Medical Care Center	\$424,071
Total	\$3,107,417

Utah*Salt Lake City*

Community Health Centers	\$375,000
Univ. of Utah Sch. of Med./Div. of Infectious Dis.	\$397,225
Total	\$772,225

Virginia*Charlottesville*

University of Virginia	\$343,025
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Fairfax

INOVA Health Systems	\$400,000
Total	\$743,025

Vermont*Burlington*

Fletcher Allen Health Care	\$333,746
Total	\$333,746

Washington*Seattle*

Country Doctor Community Health Center	\$408,368
Harborview Med. Ctr./Madison Clinic	\$366,070

Yakima

Yakima Valley Farm Workers Clinic/New Hope	\$296,820
Total	\$1,071,258

Wisconsin*Madison*

University of Wisconsin, Madison	\$359,774
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Milwaukee

Milwaukee Health Services/Isaac Coggs Health	\$455,025
Total	\$814,799

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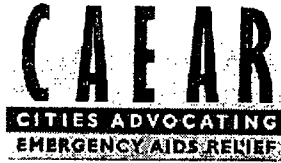
CAEAR

**CITIES ADVOCATING
EMERGENCY AIDS RELIEF**

June 1999

Advocating for CARE Act Title I & Title III

**Policy Position Paper:
Ryan White CARE Act
Reauthorization**



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RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT

TITLE I BACKGROUND

The CAEAR Coalition is a national grassroots organization advocating on behalf of people living with HIV who depend on Ryan White CARE Act Title I and Title III programs for HIV medical health care and support services.

Congress adopted the Ryan White CARE Act in 1990 (Public Law 101-381) by a nearly unanimous vote in both chambers. In so doing, it declared an AIDS emergency and authorized over \$880 million for all titles of the CARE Act. The Congress voted to reauthorize the Ryan White CARE Act in 1995 by a unanimous vote in the House of Representatives and by a vote of 97-3 in the Senate.

Title I of the CARE Act provides that any U.S. metropolitan area with over 2,000 AIDS cases reported during the last five calendar years be declared eligible for emergency assistance. Congress created local Title I planning councils to plan for and allocate this emergency relief assistance in the American communities most severely impacted by the AIDS epidemic. There were 49 Title I eligible metropolitan areas (EMAs) in FY 98. In FY 99, Norfolk, Virginia, and Las Vegas, Nevada, became eligible for Title I assistance, bringing the total number of eligible communities to 51.

Title I is the safety net for thousands of low-income people living with HIV/AIDS who live in metropolitan areas and are ineligible for entitlement programs. Many of these individuals have severe social and economic problems that complicate their ability to manage their HIV disease.

Increased funding of Title I is urgently needed in American communities. As the death rates from AIDS continue to decrease nationwide, the number of people living with HIV

disease increases every day. The 51 AIDS disaster relief communities eligible in FY 99 are home to about 74 percent of the nation's people living with AIDS.

Community-based services funded under Title I include: outpatient health care, including medical and dental care; home health and hospice care; housing; transportation and nutrition services; and case management services which prevent unnecessary hospitalization and expedite discharge from the hospital. The CARE Act mandates that within 150 days after enactment of the appropriations legislation, the Federal Government will fully disburse Title I funds for the fiscal year.

In FY 99, seven EMAs lost funding as compared to FY 98, including Bergen-Passaic, NJ; Denver, CO; Jersey City, NJ; Middlesex-Somerset-Hunterdon, NJ; Minneapolis-St. Paul, MN; San Francisco, CA; and Santa Rosa, CA.

In FY 98, thirteen EMAs lost funding as compared to FY 97, including Atlanta, GA; Austin, TX; Chicago, IL; Denver, CO; Detroit, MI; Kansas City, MO; Miami, FL; Oakland, CA; Orange County, CA; Portland, OR; San Francisco, CA; Tampa-St. Petersburg, FL; Vineland-Millville-Bridgeton, NJ.

In FY 96, fourteen EMAs lost funding as compared to FY 95, including Dallas, TX; Dutchess County, NY; Jersey City, NJ; Kansas City, MO/KS; Los Angeles, CA; Miami, FL; Nassau-Suffolk, NY; New Orleans, LA; New York, NY; Newark, NJ; Ponce, PR; San Juan, PR; Santa Rosa, CA; West Palm Beach, FL.

In FY 95, eight Title I communities - Atlanta, GA; Dallas, TX; Kansas City, KS/MO; Oakland, CA; Orlando, FL; Phoenix, AZ; St. Louis, MO/IL; West Palm Beach, FL - lost formula funding for the first time ever in the history of the CARE Act despite a modest increase in Title I funding.

In FY 92, two cities joined the original 16 AIDS disaster areas, bringing the total to 18. In FY 93, seven cities were added to the list of AIDS disaster communities: Anaheim, CA; Detroit, MI; Nassau/Suffolk, NY; New Orleans, LA; Seattle, WA; Tampa/St. Petersburg, FL; Ponce, Puerto Rico for a total of 25. In FY 94, nine new communities joined those eligible for Title I funding: Denver, CO; Bergen-Passaic, NJ; Kansas City, MO/KS; New Haven, CT; Orlando, FL; Phoenix, AZ; Riverside-San Bernardino, CA; Saint Louis, MO/IL; West Palm Beach, FL, bringing the number of Title I communities to 34. In FY 95, eight more cities became Title I disaster areas - Austin, TX; Caguas, PR; Dutchess County NY; Jacksonville, FL; Portland, OR; San Antonio, TX; Santa Rosa-Petaluma, CA; Vineland, NJ - for a total of 42 eligible communities. In FY 96, forty-nine communities met eligibility requirements for Title I assistance. The new Title I areas in FY 96 were: Cleveland, OH; Hartford, CT; Fort Worth, TX; Middlesex, NJ; Minneapolis-St. Paul, MN; Sacramento, CA; San Jose, CA.

In 1993, there was an 111 percent increase in AIDS diagnoses. The change in the case definition of AIDS by the Centers for Disease Control and Prevention (CDC), in 1993,

was responsible for much of this increase. Reported cases doubled in some Title I communities, including Baltimore, Houston, Nassau-Suffolk, Philadelphia and Seattle, and about tripled in Denver, New Haven and Phoenix. Though AIDS caseloads in the Title I cities before the definition change were averaging an annual 20 to 30 percent increase, Miami's caseload increase alone was almost 50 percent in 1991.

Inadequate resources are being stretched further and further as the Title I cities continue to require millions of dollars in HIV services and care. The shortfall in funding for AIDS care and services means that thousands of HIV-infected Americans will not have access to medical care, and therefore, will not benefit from or consider initiating anti-HIV drug treatments that could save their lives. HIV-positive Americans, who otherwise might remain healthy and working, will progress to AIDS, experience opportunistic infections and burden the already over-stressed hospital emergency facilities. The CDC estimates that only 50 percent of the estimated 900,000 HIV-positive Americans know they are infected, and that even fewer are receiving treatment.

TITLE III BACKGROUND

Title III of the Ryan White CARE Act provides grants directly to existing community-based clinics and public health providers to develop and deliver both early and ongoing comprehensive HIV services to persons with HIV/AIDS on an outpatient basis. Currently, 85,000 people living with HIV receive primary medical care from 181 Title III-funded providers, including community and migrant health centers, city and county health departments, health care for the homeless centers and diverse community-based organizations that specifically target communities of color and other historically underserved individuals and families. Title III grantees are located in 43 states, Puerto Rico and the District of Columbia. Title III services are coordinated with other CARE Act programs through Title I planning councils and statewide coordinated statements of need.

Two-thirds of Title III medical care patients are persons of color, and 27% are women. The Title III programs are the primary point of access to comprehensive health care for the most economically marginal populations from some of the poorest neighborhoods and rural communities in the country. Title III services, clinically and linguistically appropriate, are centralized within a client's existing health care network to build upon historical and familiar relationships between patients and their community health providers. Needs are addressed at the community level, so that individuals will not have to be turned away or put on waiting lists at overburdened public hospitals and clinics, or be forced to use more expensive alternatives such as emergency rooms for care.

Title III providers aggressively target outreach to high-risk communities, incorporate counseling and testing opportunities in the overall scope of services provided to a community, and focus on the earliest intervention possible in the onset of HIV disease. In 1997, Title III providers reached out to about 762,800 individuals. Of that number, about

315,000 received HIV counseling and testing..

Title III clinics create “one-stop-shopping” opportunities for HIV-related comprehensive medical care. Patients newly identified by a clinic’s testing center can stay within the clinic itself and undertake a program of early intervention to treat their HIV infection. For example, HIV-positive pregnant women identified through basic prenatal visits can be counseled on the options for HIV early intervention and provided AZT to reduce the possibility of transmission of the virus to their children - all in one setting. This model seeks to avert wasteful administrative costs associated with fragmented service delivery.

Title III serves as a treatment safety net for thousands needing care. Two-thirds of new Title III patients have incomes below the poverty line, and one-half are uninsured. Furthermore, Title III funds build important health care infrastructure in some communities. Almost one-quarter of Title III programs are the only HIV medical outpatient program in their areas; Title III programs clearly function as the only accessible source of care in a number of states and communities, thus ensuring access to uninsured, indigent urban and rural populations. New planning grants have assisted existing primary care programs, particularly in rural areas, to enhance their capacity to offer HIV medical services to surrounding communities, or expand as demand has increased in urban settings. Title III funding builds on established infrastructure while averting the costly creation of entirely new clinics to treat people with HIV/AIDS.

THE IMPACT OF AIDS ON THE COMMUNITY

The 1998 Midyear HIV/AIDS Surveillance Report issued by the Centers for Disease Control and Prevention reported that the cumulative number of deaths from AIDS recently exceeded 400,000 -- approximately the number of American deaths in the Second World War. To date, about 665,000 persons living with AIDS have been reported to the CDC. The latest statistics indicate that over 270,000 people were reported to be living with AIDS in 1997.

Recent advancements in HIV treatment, including the introduction of anti-HIV combination therapies, have increased the life expectancy of HIV patients. The CDC reports that AIDS-related deaths continue to decline, with a 25 percent decrease between 1995 and 1996 and a 42 percent decrease between 1996 and 1997. In 1998, the U.S. Department of Health and Human Services indicated that HIV infection fell from eighth to fourteenth among leading causes of death in the U.S. between 1996 and 1997. For those aged 25-44, HIV dropped from the leading cause of death in 1995 to third-leading in 1996 and finally to the fifth-leading cause of death in 1997. The consistent decrease of AIDS-related deaths is reflective of the commitment and achievement of the CARE Act in providing medical and support services to people with HIV disease.

In 1997, the CDC reported for the first time a decrease in the occurrence of AIDS by 7 percent between 1995 and 1996. The CDC announced recently that incidence of AIDS

has continued to decline, dropping by 15 percent between 1996 and 1997. These successful outcomes are due in part to the comprehensive medical and support services provided by the Ryan White CARE Act.

HIV, however, continues to spread through the American population unchecked. The result is a startling increase in the number of people with HIV/AIDS who are seeking medical services. The CDC reports that the annual rate of new HIV infection in the United States continues to be approximately 40,000 per year. A 1998 CAEAR study revealed that between 1995 and 1997 the number of HIV/AIDS patients seeking service under the Ryan White CARE Act increased on average 43.5 percent.

Epidemiological studies continue to demonstrate a disproportionate number of AIDS cases among African-Americans, Latinos and Hispanics. The National Institute of Allergy and Infectious Disease reported in July of 1998 that African Americans and Hispanics represented 56 percent of AIDS cases reported among men in 1996 and 78 percent of those in women. For every 100,000 African-Americans, there were 89.7 cases of AIDS reported in 1996. This is about six times higher than among Caucasians (13.5) and about twice as high as the rate among Hispanics (41.3). African-American males exhibited the greatest increase in the number of new infections in 1996.

In October of 1998, the CDC reported that an estimated 240,000-325,000 African Americans are infected with HIV. Of those infected, it is estimated that 93,000 African Americans are living with AIDS. The CDC reports that approximately 1 in 50 African American males and 1 in 160 African American females are believed to be infected with HIV. Through 1997, the CDC had reports approximately 230,000 cases of AIDS among African Americans. Even though that is over 36 percent of the reported cases, African Americans represent an estimated 13 percent of the total U.S. population.

Black and Hispanic women have consistently experienced higher rates of AIDS than have white women. Between 1990 and 1995 new cases of AIDS rose 158 percent among black heterosexual women. In 1996 the CDC reported that over 76 percent of women infected with HIV were women of color. Currently, AIDS cases are approximately thirteen times more prevalent among African-American women than white women. Among women and children with AIDS, African Americans have been especially affected, representing 60 percent of all women with AIDS in 1997 and 62 percent of reported pediatric AIDS cases for 1997.

According to the CDC, the largest number of new infections in females in 1996 were among African American women; the second largest increase for females was among Hispanic women. In 1996, these two minority groups accounted for 78 percent of reported AIDS cases. In addition, in 1997, more African Americans were reported with AIDS than any other racial/ethnic group. Of the total AIDS cases reported to the CDC that year, 45 percent (27,075) were among African Americans, 33 percent (20,197) were among whites and 21 percent (12,466) were among Hispanics. The CDC reported that between 1994 and 1997, Hispanics diagnosed with HIV increased ten percent.

The need is expanding for outreach to people of color to ensure they are linked into the health care system as early as possible. Delayed access to care accounts for some of the disparity in health outcomes for historically underserved communities. In 1998, the National Medical Association stated that African-Americans are more likely to receive treatment when an AIDS-related infection requires hospitalization, and that significant numbers of African Americans are diagnosed with AIDS within one month of their death. The Clinton Administration recently reported that from 1995 to 1996, AIDS death rates declined 23 percent for the overall U.S. population, but only declined 13 percent for blacks and 20 percent for Hispanics. In fact, AIDS remains the number one killer among African-American's ages 25 to 44.

Titles I and III of the CARE Act serve as safety nets for people of color and other underserved communities. Approximately two-thirds of the patients served by Title I and Title III in 1998 were people of color.

The CDC reports that the proportion of AIDS cases among women has been increasing steadily. While women made up seven percent of all cases reported in 1985, they represented 22 percent of cases reported between July of 1997 and July 1998. According to the CDC, the number of AIDS cases among American women reported has totaled about 108,000 since 1980. Even though AIDS deaths are declining, nearly 42 percent between 1996 and 1997, the CDC reports that the decrease was less among women than men (32 percent and 44 percent, respectively).

Another disturbing trend is the steady number of new infections among young men and women. In 1996, the CDC reported that 25 percent of all new HIV infections in the United States occurred among young people under age 21. Also reported was that of persons in whom HIV infection was the initial diagnosis between 1994 and 1998, 15 percent were adolescents and young adults aged 13-24 years. As of June 1998, the CDC estimated incidence of AIDS was 24,000 for adolescents and young adults over age 13. In addition, 8,280 pediatric AIDS cases have been reported to the CDC. In 1998, the Office of National AIDS Policy issued a report to the President noting that on average at least one American under age 22 becomes infected with HIV every hour of every day.

In December, 1998, the *New York Times* reported that there have been an estimated 100,000 children orphaned by AIDS nationwide since 1981. The same article noted that New York City reports approximately 28,000 orphaned children and the state legislature predicts a possible increase of 50,000 by 2001. Approximately ten percent of these children are, themselves, infected with HIV.

THE COST OF CARING FOR PEOPLE WITH HIV DISEASE

A 1998 CAEAR study reported that the cost of medical services provided under Title I and Title III of the Ryan White CARE Act increased an average of 89.3 percent between 1995 and 1997. This accelerating cost of care has presented new challenges for health

care providers who are transitioning from providing predominantly acute, palliative treatment of patients with AIDS to more comprehensive, long-term care for many HIV infected individuals as they live longer.

Recent advancements in HIV treatment, specifically the introduction and widespread availability of antiretroviral therapies, have increased the longevity and improved the quality of the lives of many of those infected with the HIV virus. A 1998 report by the New York States AIDS Advisory Council addressed the difficulties faced by the clinician and patient in successful treatment management indicating that new therapies often involve multiple daily doses of seven to eight different drugs with varying time and dietary requirements.

These factors, in addition to the threat of resistance to one or more drugs when treatment is interrupted or discontinued, have prompted a reexamination and reinvention of HIV treatment management. Treatment now requires a deeper participation and understanding of the drug therapy by the patient. In addition, more involved and increasingly frequent physician-patient interactions have become integral to the success of these demanding regimens. Title I and Title III providers have made a serious commitment to respond to those needs by providing comprehensive, effective treatment management programs. The 1998 CAEAR study reported that the average length of medical visits in Title I and Title III communities increased by 65 percent and the number of medical visits per patient grew 27.4 percent between 1995 and 1997.

In addition to increased length in medical visits, comprehensive treatment programs necessitate other essential components for the effective treatment of HIV such as case management, substance abuse treatment, mental health services, nutritional guidance, and providing housing and transportation. The report of the New York State AIDS Advisory Council noted, "every patient with HIV should have access to support services that will enhance readiness to begin therapy and provide the maximum opportunity for effective treatment and maintenance of the treatment regimen." According to the Advisory Council, an interruption of support services "compromises access to HIV treatment, endangering the immediate health and future treatment options of individuals and potentially creates more widespread public health problems."

In 1997, Title III grantees allocated 29 percent of their annual budgets to other necessary services such as case management, counseling and testing, outreach, and referrals. Title I grantees spent eleven percent of their total budgets on case management and 20 percent on support services including transportation, patient outreach, day respite, and food bank and housing services. These services are critical to the successful treatment of HIV and AIDS. Funding for medications without sufficient financing for medical and other services is an ineffective policy which diminishes the efficacy of HIV drug therapy.

The advancements in HIV treatment have resulted in recent reductions in length of stay and hospitalization days. In 1993, the National Association of Public Hospitals and Health Systems estimated that hospitals experienced losses exceeding \$2,000 per AIDS

patient per year. The cost of providing HIV-related care would have escalated even higher without early diagnosis and treatment provided by CARE Act programs. Title III programs have reduced hospital admissions in some locales by as much as 75 percent since 1996.

A direct effect of the new drug therapy is the increased monitoring of patients. For example, viral load testing which helps physicians determine whether and when to begin anti-HIV drug treatment, can cost as much as \$250 per test. Preliminary data from a recent survey of Title III sites indicates that between 1996 and 1997, the volume of viral load tests increased by 37 percent. In 1998 the Health Resources and Services Administration (HRSA) estimated that there were 350,000 Title I clients and at least 30 percent of these clients were expected to use Title I funding to pay for viral load testing.

Another direct effect is the pharmaceutical cost of treating the human immunodeficiency virus. According to a 1998 *Washington Post* article, current estimates predict that in the near future the cost of combination therapy will possibly exceed the already high \$15,000 a year. The same article noted that drugs needed to prevent opportunistic infections nearly double that expense for some. Many infected individuals cannot afford the new drug therapies, including those who have insufficient medical coverage. Each year, Title I transfers millions in funding to Title II AIDS Drug Assistance Programs (ADAPs). In FY 97, ten percent of Title I funds or \$41,059,269 was transferred to ADAP. In addition, millions more in Title I and Title III funds are used to purchase medications not covered by state ADAP programs. Each state decides its own formulary, and some, for example, do not include medications for opportunistic infections.

As burdens mount, responding to the needs of the AIDS epidemic grows more difficult and imperils our ability to meet all the other health needs in our communities. Based on estimates of costs of care and utilization of services across the country, it is estimated that a total gap of over \$4 billion exists between the services that are desperately needed and those which are available.

FY 99 TITLE I AREAS:

Anaheim, CA	Atlanta, GA	Austin, TX
Baltimore, MD	Bergen-Passaic, NJ	Boston, MA/NH
Caguas, PR	Chicago, IL	Cleveland, OH
Dallas, TX	Denver, CO	Detroit, MI
Dutchess Co., NY	Fort Lauderdale, FL	Fort Worth, TX
Hartford, CT	Houston, TX	Jacksonville, FL
Jersey City, NJ	Kansas City, MO/KS	Los Angeles, CA
Las Vegas, NV	Miami, FL	Middlesex, NJ
Minneapolis-St.Paul, MN	Nassau/Suffolk Co., NY	Newark, NJ
New Haven, CT	New Orleans, LA	New York, NY
Norfolk, VA	Oakland, CA	Orlando, FL
Portland, OR/WA	Philadelphia, PA/NJ	Phoenix, AZ
Ponce, PR	Riverside/San Bernardino, CA	Sacramento, CA
St. Louis, MO/IL	San Antonio, TX	San Diego, CA
San Francisco, CA	San Jose, CA	San Juan, PR
Santa Rosa/Petaluma, CA	Seattle, WA	Vineland, NJ
Tampa/St. Petersburg, FL	Washington, D.C.	W. Palm Beach, FL

THE RYAN WHITE CARE ACT SAVES MONEY

The Ryan White CARE Act and its provision of medical, pharmaceutical, and support services provided through community-based organizations, has already saved cities and states millions of dollars by reducing expensive in-patient hospitalizations, utilization of hospital based services, medical specialty care, treatment of opportunistic infections, and physical rehabilitation services.

KEY FACTS

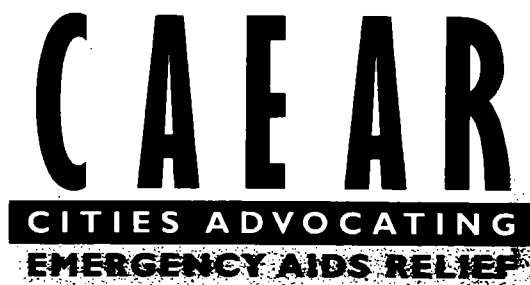
- ▶ About 74 percent of the nation's people living with AIDS reside in Title I cities.
- ▶ In six years, "AIDS Disaster Areas" grew from 16 to 49, and this year became 51.
- ▶ The nation has seen over 650,300 cases of AIDS diagnosed; only two years elapsed between the diagnosis of the first 100,000 cases and the second 100,000 cases in late 1991; and less than two years elapsed when the third 100,000 cases were reported in mid-1993, and again, less than two years elapsed since the diagnosis of the 400,000th case of AIDS was diagnosed at the end of 1994 and the 500,000th case by the end of 1995.
- ▶ It is estimated that as many as 900,000 Americans are infected with the HIV virus.

- ▶ Title I and Title III of the CARE Act serve as safety nets for people of color and other underserved communities. Approximately two-thirds of the patients served by Title I and Title III in 1998 were people of color.
- ▶ Title III programs have reduced hospital admissions in some locales by as much as 75 percent since 1996.
- ▶ A 1998 CAEAR study reported that the cost of medical services provided under Title I and Title III of the CARE Act increased an average of 89.3 percent between 1995 and 1997.

May, 1999

THE ACCELERATING COST OF HIV HEALTH CARE:

**An Analysis of Services Provided
Under Title I and Title III of the Ryan White CARE Act**



**Conducted by
Cities Advocating Emergency AIDS Relief (CAEAR)**

August, 1998

*For more information, contact the CAEAR Coalition, a national coalition supporting
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CAEAR

Cities Advocating Emergency AIDS Relief (CAEAR) is a national grassroots coalition advocating on behalf of people living with HIV who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. CAEAR includes members of Title I planning councils, people living with HIV/AIDS, organizations of people living with HIV, community-based AIDS service organizations, CARE Act grantees and consortia.

OVERVIEW

Over the past few months the CAEAR Coalition conducted the following study of HIV/AIDS related services in order to highlight the changing HIV health care system and subsequent need for increased funding. The analysis concentrated on data collected from 1995 through 1997, during which time combination anti-HIV therapy was introduced and became widely available. The CAEAR data suggest that advancements in HIV treatment have necessitated more comprehensive treatment regimens with greater participation of both the patient population and health care professionals. Through the evaluation of the medical services, patient population and health care cost, the following were identified as key components adding significant weight to the growing HIV health service need:

The Growing HIV Population

- Data show that between 1995 and 1997 there was an average increase of 43.5% in the number of HIV/AIDS patients among a representative sample of Title I and Title III sites, clearly illustrating one of the most obvious challenges to the HIV/AIDS health care community: the growing HIV population.
- In addition to new HIV cases, recently available combination therapies have increased the life expectancy of HIV patients. As the number of AIDS deaths has begun to decrease, the number of people dependent on treatment provided under the CARE Act has grown substantially. The data compiled by the CAEAR Coalition in this study reflects the impact of combination therapies that became widely available during the 1995-1997 period.

Increase in the Number of Patient Visits

- One effect of the swelling patient population is the dramatic increase in the number of patients visits reported by the medical community. CAEAR estimates that the total number of patient visits increased by 55.3% from 1995 to 1997.

- While the growing patient population is certainly contributing to the increasing number of visits, CAEAR found that the number of medical visits per patient also has grown by 27.4%. Individuals under care are finding that treatment requires longer and more frequent visits. The combination of a growing patient population and treatment regimens that necessitate more visits per patient will continue to burden limited Title I and Title III funding.

Costly Medical Care

- The CAEAR study revealed that the average cost of medical care has increased by 89.3%. The study also found that this escalating cost could not be attributed solely to the increase in patients (43.5%), or patient visits (55.3%), which are growing at less significant rates than the accelerating cost of medical care.
- Advancements in HIV treatments, are among the reasons for this increased cost in HIV medical health care. Complex treatment regimens are required, including increased viral load testing and greater emphasis on longer more complex visits to promote adherence to drug dosing and scheduling. Neglecting to take medication as prescribed can lead to the failure of the therapy, the development of resistant viral strains, or both. Communities financially dependent on the CARE Act are, and will continue to be, inundated with patients in need of these costly medical services.

CONCLUSION

The Ryan White CARE Act allocates necessary resources to communities serving under Title I and Title III of the CARE Act. This funding provides HIV patients who are living below the poverty line or who are uninsured access to medical services they could otherwise not afford. The development of anti-HIV combination therapy has led to significant improvements in the length and quality of life of those living with HIV. However, as this study revealed, health care is now a much more intensive and costly process for both the growing patient population and the medical community. Given current funding levels, the communities serving under the Ryan White CARE Act will not have the necessary resources to meet the needs of those it serves nor will they be able to sustain the heightened level of health care necessary for successful treatment.



THE CARE ACT:

- ✓ SAVES LIVES
- ✓ DECREASES AIDS DEATHS
- ✓ INCREASES THE NUMBER OF PEOPLE GOING BACK TO WORK

Support the CAEAR Coalition's FY 1999 appropriations requests for CARE Act Title I and Title III:

- ▶ CARE Act Title I FY 99 appropriation of \$570 million (+\$105 million over FY 1998)
- ▶ CARE Act Title III FY 99 appropriation of \$113 million (+\$36.7 million over FY 1998)

Combination anti-HIV therapy, including protease inhibitors, became available in 1995. In 1998, treatment choices range from 3-drug combinations for new patients to 4- or 5-drug combinations for experienced patients. However, adherence to these new drug regimens requires more complex and costly comprehensive clinical care for people with HIV.

Since 1994, Title I and Title III programs have seen:

- ▶ Up to 166.7 percent increases in patient visits since 1994
- ▶ Up to 254.0 percent increases in average cost per patient for medical care (excluding pharmaceuticals)

Presented below are summary data from selected Title I and Title III CARE Act grantees; see individual reports for details. These data are representative of the 51 CARE Act Title I areas eligible for funding in 1999 and the 183 CARE Act Title III grantees.

<i>More Complex and More Costly Comprehensive Clinical Care for People with HIV Disease</i>				
<i>City/State</i>	<i>Reporting Organization</i>	<i>CARE Act Title I and Title III Funding</i>	<i>Percent Change in Number of Patient Visits</i>	<i>Percent Change in Average Cost of Medical Care Only</i>
Atlanta, Georgia	Grady Health System Infectious Disease Program	Title I	30.9% increase since 1995	68.5% (est) increase since 1995
Baltimore, Maryland	Chase Brexton Health Services	Title I, Title III	21.4% increase since 1995	29.0% increase since 1995
Chicago, Illinois	Chicago Health Outreach	Title I, Title III	214.0% (est) increase in the number of patients since 1994	170.4% increase since 1994
Chicago, Illinois	The CORE Center for the Prevention, Care, and Research of Infectious Disease	Title I, Title III	15.6% increase since 1995	13.3% increase since 1995
Philadelphia, Pennsylvania	Allegheny University Hospitals Hahnemann	Title I	166.7% increase since 1994	254.0% increase since 1994
Philadelphia, Pennsylvania	Health Federation of Pennsylvania	Title I	94.7% increase since 1994	not reported
Philadelphia, Pennsylvania	Department of Public Health	Title I	46.8% increase since 1994	55.7% increase since 1994
Riverside -- San Bernardino, California	Desert AIDS Project	Title I	71.4% increase since 1995	123.3% increase since 1995
San Francisco, California	San Francisco General Hospital	Title I	74.0% increase since 1994	not reported
Santa Cruz, California	Santa Cruz County Health Services Agency	Title III	63.7% increase since 1993	69.4% increase since 1993
Seattle, Washington	Country Doctor Community Health Centers	Title III	20.9% increase since 1995	13.2% increase since 1995
Washington, D.C.	Whitman-Walker Clinic	Title I, Title III	85.6% increase since 1994	177.7% increase since 1994

Sources: Reporting organizations. June - July, 1998.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Grady Health System
Infectious Disease Program
Atlanta, Georgia**

Funded By CARE Act Title I

Year	Number of Patients Receiving Medical Care	Number of Medical Visits	Average Number of Medical Visits per Patient per Year	Average Number of Medical Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combination therapy not available	3,037	22,635	7.5	8.5	\$1,200*
1997 Combination therapy available	3,368	29,146	8.7	9.8	\$2,022
Percent Change Since 1995	10.9% increase	28.8% increase	16.0% increase	15.3% increase	68.5 % increase*

Source: Infectious Disease Program, Grady Health System, Atlanta, Georgia.

* 1995 average cost per patient per year (medical care and labs only -- no drugs) is an estimate, and therefore the percentage change is also an estimated figure.

Notes concerning complexity of visits:

1995:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.
- ▶ While the number of patients was relatively stable (minimal increase), there were significant increases of visits per patient. Also, increases were noticed in patients' CD4 counts and decreases in viral loads.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Chase Brexton Health Services
Baltimore, Maryland**

Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only -- no drugs)
1995 Combination therapy not available	762	4,191 (20 min. each)	5.5	6.6	\$1,187
1997 Combination therapy available	795	5,088 (35 min. each)	6.4	7.2	\$1,532
Percent Change Since 1995	4.3% increase	21.4% increase	16.3% increase	9.0% increase	29.0% increase

Source: Chase Brexton Health Services, Baltimore, Maryland.

Notes concerning complexity of visits:

1995:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ Supportive care for terminal cases.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.
- ▶ Adherence counseling.
- ▶ Adjustments in medications as needed for increased viral loads.
- ▶ Increased labs.
- ▶ Reduced late in life activities (80 per year before combination therapy, 28 in 1997).
- ▶ Increased support staff (addictions, nutrition, case management, nursing and mental health).

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Chicago Health Outreach
Chicago, Illinois**

Funded By CARE Act Title I and Title III

Year	Number of Patients (Actual)	Average Number of Visits per Patient per Year (Estimated for patients with at least two visits)	Average Cost per Patient per Year (Estimated medical care & labs only -- no drugs)
1994 Combination therapy not available	243	4.0	\$740
1997 Combination therapy available	764	8.0	\$2,000
Percent Change Since 1994	214.4% increase	100.0% increase	170.4% increase

Source: Chicago Health Outreach, Chicago, Illinois.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Labs monitoring and education related to medications.
- Providing triple combination therapies and medication(s) for side effects.
- Monitoring interactions between triple combination medications and medications for side effects.
- Changing triple combination medications when viral loads increase.
- Increased lab work involved all monitoring activities.
- Reduction in incidence of opportunistic infections.
- Reduction in late stage and terminal care activities.
- More time involved in adherence issues and nutrition related to the use of new medications.

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Combination Therapy For HIV Disease In The Context Of Comprehensive Clinical Care

The CORE Center for the Prevention,
Care, and Research of Infectious Disease
(formerly known as the
Cook County HIV Primary Care Center)
Chicago, Illinois
Funded By CARE Act Title I and Title III

Year	Number of Patients	Number of Visits	Number of Patients on Protease Inhibitors	Average Cost per Patient per Visit (medical care & labs only – no drugs)
1995 Combination therapy not available	1,796	9,454 (20 min. each)	not reported	\$375
1997 Combination therapy available	2,113	10,933 (30+ min. each)	1,430 (68% of patients)	\$425
Percent Change Since 1995	17.7% increase	15.6% increase	n/a	13.3% increase

Source: The CORE Center for the Prevention, Care, and Research of Infectious Disease (formerly known as the Cook County HIV Primary Care Center (CCHPCC)), Chicago, Illinois.

Notes concerning complexity of visits:

1995:

- ▶ CD4 monitoring, treatment of opportunistic infections and monitoring of small numbers of medications available at the time (e.g., AZT).
- ▶ Palliative care for terminal cases.
- ▶ Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes.

1997:

- ▶ Minimum quarterly monitoring of viral loads. Monitoring CD4 counts.
- ▶ Providing and monitoring combination therapies and medications for side-effects. Ensuring compliance with NIH guidelines and quality standards.
- ▶ When necessary, determining most appropriate changes in medications when viral loads increase or when patients experience side-effects.
- ▶ Increased lab work in all monitoring activities.
- ▶ Establishing individualized adherence plans and follow-up on a regular basis.
- ▶ Engaging in intensive client education about medications and combination therapies.
- ▶ Treating and monitoring care for common health problems in patients such as hypertension, asthma, and diabetes -- ensuring safe interactions between any medications taken for various conditions and HIV/AIDS medications.
- ▶ Reduction in incidence of opportunistic infections.
- ▶ Reduction in late stage and terminal care activities.
- ▶ Delivering preventative interventions, such as vaccine, prophylaxis, annual screening for tuberculosis, and pap smears for women every 6 months.
- ▶ Increasingly complex case management: housing, entitlement, supports, transportation, nutrition, mental health assessment, counseling, intervention, group prescription referral, chemical dependency assessment, counseling and intervention.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Allegheny University Hospitals
Hahnemann
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	297	1,255 (20 min. each)	4.2	\$441
1997 Combination therapy available	650	3,348 (40 min. each)	5.2	\$1,561
Percent Change Since 1994	118.8% increase	166.7% increase	23.8% increase	254.0% increase

Source: Allegheny University Hospitals, Hahnemann, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ Palliative care for terminal cases.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Health Federation of Pennsylvania
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year
1994 Combination Therapy Not Available	270	1,170	4.3
1997 Combination Therapy Available	350	2,274	6.5
Percent Change Since 1994	29.6% increase	94.7% increase	51.1% increase

Source: CareLink (an HIV/AIDS care network comprised of five federally qualified community health centers), The Health Federation of Philadelphia, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- Palliative care for terminal cases.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.

***For more information, contact the CAEAR Coalition,
a national coalition supporting
Ryan White CARE Act Title I and Title III
1413 K Street, NW, Suite 700, Washington, DC 20005
phone (202) 789-3565, or fax (202) 789-4277
Email: CAEARinDC@aol.com***



**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Philadelphia Department of Public Health
Philadelphia, Pennsylvania**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1994 Combination therapy not available	824	4,000	4.85	6.27	\$724
1997 Combination therapy available	1,019	5,874	5.76	7.14	\$1,127
Percent Change Since 1994	23.7% increase	46.8% increase	18.8% increase	13.9% increase	55.7% increase

Source: Ambulatory Health Services, Department of Public Health, Philadelphia, Pennsylvania.

Notes concerning complexity of visits:

1994:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ Palliative care for terminal cases.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Desert AIDS Project
Riverside/San Bernardino,
California**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits (30 min. each)	Average Number of Visits per Patient per Year	Average Cost per Patient per Year (medical care & labs only – no drugs)
1995 Combination therapy not available	638	2,303	3.5	\$450
1997 Combination therapy available	748*	3,360	6.0	\$1,005
Percent Change Since 1995	17.2% increase	45.8% increase	71.4% increase	123.3% increase

Source: Desert AIDS Project, Palm Springs, California.

* 560 of 748 (75%) patients in 1997 were on triple combination therapy.

Notes concerning complexity of visits:

1995:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ 3% (22) of 658 patients were on triple combination therapy through clinical trials.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.
- ▶ Increasing reliance on viral resistance monitoring tools to inform changes of therapy.
- ▶ Addition of substance abuse counselor to enable patients to stay on therapies.
- ▶ Triple, and in some cases quadruple, combinations (as salvage therapy).
- ▶ 75% of patients on triple combination.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**San Francisco
General Hospital/Outpatient Clinic
San Francisco, California**

Funded By CARE Act Title I

Date	Unduplicated Clients	Patient Visits	Visits Per Patient	Percentage on Antiretroviral Therapy	Percentage on Triple Drug Combination
Dec. 1994	988	1,025	1.04	N/A	N/A
Dec. 1995	904	1,674	1.85	50%	None
Oct. 1996	1,037	2,007	1.94	71%	33%
Jun. 1997	1,156	1,781	1.54	82%	59%

Source: San Francisco General Hospital, Ward 86 HIV/AIDS Outpatient Clinic.

Key Findings:

- ▶ From 1994 to 1997, patients seen per month increased by 17%, reflecting increased demand for primary care.
- ▶ The total number of visits to the clinic per month increased more quickly, by 74% between the end of 1994 and mid-1997.
- ▶ The number of visits per patient increased by 50% in the same time frame, after hitting a high point of nearly two visits per patient per month in October 1996.
- ▶ The percent of patients on any antiviral treatment jumped from 50% to 82% in less than two years, for a 61% increase in demand for treatment.
- ▶ The percent of patients on a three drug combination, including a protease inhibitor, increased even more dramatically, from zero in 1995 to 59% of all patients in 1997.
- ▶ In 1995, 42% of the patients on antiretroviral therapy were on monotherapy, taking only one drug. After the development of new treatment guidelines indicating that three or two drug combinations were more effective, the number of patients on monotherapy dropped to zero.

Demand for primary care has increased significantly with the availability of protease inhibitors and combination therapy. Total volume of patients as well as number of visits per patient have increased hand in hand with the proportion of patients on combination antiretroviral therapy.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Santa Cruz County Health Services
Agency
Santa Cruz, California**

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medical care & labs only – no drugs)
1993 Combination therapy not available	123	430 (30 min. each)	3.5	6.2	\$314
1997 Combination therapy available	160	704 (40 min. each)	4.4	8.1	\$532
Percent Change Since 1993	30.0% increase	63.7% increase	25.7% increase	30.6% increase	69.4% increase

Source: Santa Cruz County Health Services Agency, Santa Cruz, California.

Notes concerning complexity of visits:

1993:

- CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.

1997:

- Monitoring CD4 counts.
- Monitoring viral loads and side effects of new medications.
- Additional visits to adjust for "side effects" of new therapies.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Country Doctor
Community Health Centers
Seattle, Washington**

Funded By CARE Act Title III

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Length of Doctor Visit in Minutes	Average Cost per Patient per Year (medical care & labs only – no drugs)
1995 Combination therapy not available	259	1,579	6.0	15	\$2,431
1997 Combination therapy available	282	1,910	6.7	25	\$2,753
Percent Change Since 1995	8.8% increase	20.9% increase	11.6% increase	66.6% increase	13.2 % increase

Source: Country Doctor Community Health Centers, Seattle, Washington.

Notes concerning complexity of visits:

1995:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ During this period, AZT was the major medication for the treatment of opportunistic infections. Combination therapy and various forms of counseling were used for primary health services to patients.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.
- ▶ The monitoring of viral loads has increased lab costs over 600%.

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**Combination Therapy For HIV Disease
In The Context Of
Comprehensive Clinical Care**

**Whitman-Walker Clinic
Washington, D.C.**

Funded By CARE Act Title I

Year	Number of Patients	Number of Visits	Average Number of Visits per Patient per Year	Average Number of Visits per Patient per Year (for patients with at least two visits)	Average Cost per Patient per Year (medicalcare & labs only – no drugs)
1994 Combination therapy not available	1,292	4,639 (20 min. each)	3.6	7.0	\$180
1997 Combination therapy available	1,743	8,613 (40 min. each)	5.0	13.0	\$500
Percent Change Since 1994	34.9% increase	85.6% increase	38.8% increase	85.7% increase	177.7% increase

Source: Whitman-Walker Clinic, Washington, D.C.

Notes concerning complexity of visits:

1994:

- ▶ CD4 monitoring, treatment of opportunistic infections, and some monitoring of medications, i.e., AZT.
- ▶ Palliative care for terminal cases.

1997:

- ▶ Monitoring CD4 counts.
- ▶ Monitoring viral loads and side effects of new medications.
- ▶ Labs monitoring and education related to medications.
- ▶ Providing triple combination therapies and medication(s) for side effects.
- ▶ Monitoring interactions between triple combination medications and medications for side effects.
- ▶ Changing triple combination medications when viral loads increase.
- ▶ Increased lab work involved all monitoring activities.
- ▶ Reduction in incidence of opportunistic infections.
- ▶ Reduction in late stage and terminal care activities.
- ▶ More time involved in adherence issues and nutrition related to the use of new medications.

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HIV's Spread Is Unchecked

AIDS-Slowing Treatments Eclipse Rising Infection Rate, Study Says

By RICK WEISS
Washington Post Staff Writer

Although the number of new AIDS cases in the United States has declined substantially in recent years, HIV continues to spread through the population essentially unabated, according to data released yesterday by the Centers for Disease Control and Prevention.

The first direct assessment of HIV infection trends shows that the recent decline in U.S. AIDS cases is not due to a notable drop in new infections. Rather, improved medical treatments are allowing infected people to stay healthy longer before coming down with AIDS, overshadowing the reality of an increasingly infected populace.

"The findings of this report give us a very strong message, that mortality may be going down—therapy is working—but HIV continues its relentless march into and through our population," said Thomas C. Quinn, an AIDS specialist at the National Institute of Allergy and Infectious Diseases. "These data tell us we have a lot of work to do."

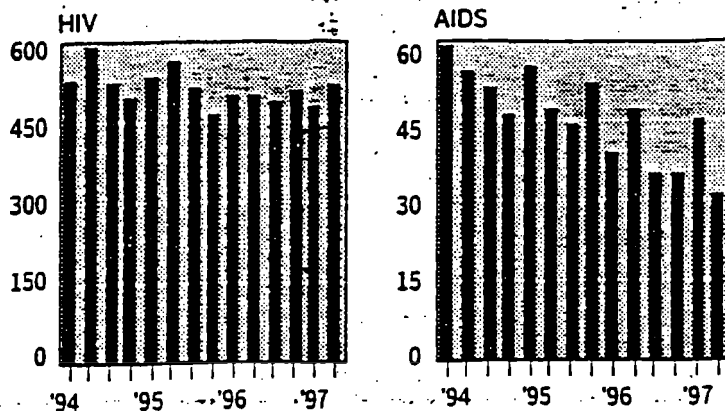
The findings also confirm previously identified trends showing that women and minorities are increasingly at risk. Especially worrisome, officials said, is that the annual number of new infections in young men and women 13 to 24 years old—a group that has been heavily targeted for prevention efforts—is virtually unchanged in recent years.

See AIDS, A17, Col. 1

FRIDAY, APRIL 24, 1998

The Washington Post

Diagnoses in 25 states by quarter, ages 13-24



SOURCE: Centers for Disease Control and Prevention

Who is diagnosed with HIV:

Women	28%
Men	72
Blacks	57
Whites	34
Hispanics	7

How they got it:

Male homosexual sex*	32%
Injecting drugs	18
Heterosexual sex	18
Drugs & homosexual sex	4
Other/unreported	28

* Thought to be underreported.

THE WASHINGTON POST

HIV Spread Not Slowed in U.S.

AIDS, From A1

"It certainly documents that we have ongoing new infections in young people," said Patricia L. Fleming, chief of HIV/AIDS reporting and analysis at the CDC in Atlanta.

The report also shows continuing high numbers of new infections among intravenous drug users, a population that has recently been the focus of a political debate over the value of needle exchange programs that offer drug users clean syringes to prevent the spread of HIV, the virus that causes AIDS. [International financier George Soros on Thursday offered \$1 million in matching funds to support needle exchange programs around the country, the Associated Press reported.]

CDC officials would not comment directly on President Clinton's controversial decision earlier this week to extend a ban on federal funding of needle exchanges. But both Fleming and Quinn said that AIDS prevention programs in this population need to be improved.

"It's clear that something stronger is needed to slow this epidemic," Quinn said.

The new figures, in today's issue of the CDC's Morbidity and Mortality Weekly Report, are based on HIV test results compiled by 25 states from January 1994 to June 1997. They indicate that the number of new infections during that period remained "stable," with just a "slight" decline of 2 percent from 1995 to 1996, the most recent full year included in the new analysis. By contrast, deaths from AIDS declined 21 per-

cent in 1996 and dropped another 44 percent in the first six months of last year.

From 1995 to 1996, the number of HIV infections increased 3 percent in women. And it jumped 10 percent in Hispanics, although officials said that figure was imprecise. Infections declined by 2 percent in whites and 3 percent in African Americans.

All told, the study tallied 72,905 infections during the survey period. The number nationwide is much higher, since participating states account for only about 25 percent of U.S. infections.

The single biggest risk category was men having sex with other men, but heterosexual transmission continued its steady increase. Most of those cases involved women contracting the virus through sex with male drug users, Fleming said.

The survey is the first to track infection trends by looking directly at HIV test results in people coming to clinics and other health care outlets. That's a major change from the previous system, in which officials simply estimated the number of new infections by counting the number of people newly diagnosed with AIDS.

The old "back calculation" method worked fine during the first 15 years of the epidemic, when HIV infection progressed predictably to disease over a period that averaged about 10 years. With drug therapies now slowing disease progression, however, the number of new AIDS cases no longer reflects the number of new infections, and public health officials were becoming uncertain about how they were doing in prevention efforts.

The new reporting system, now spreading to other states, has helped officials regain those bearings, Fleming said. And although everyone wishes the numbers were more encouraging, she said, at least officials now have a clearer picture of the task at hand.

FOR MORE INFORMATION

To read Post coverage about the AIDS academic, click on the above symbol on the front page of The Post's Web site at www.washingtonpost.com



HIV SERVICES

Hombre a Hombre, Jovenes in-Action
& the Mobile HIV Testing Unit

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 615F
Washington, DC 20201

Dear Secretary Shalala:

I am writing to express our organization's dismay and outrage over the Administration's proposed .53% across -the-board reductions to Ryan White CARE Act programs for FY 2000. These critical grant programs serving low-income, uninsured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost \$8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

The Cities Advocating Emergency AIDS Relief (CAEAR) Coalition is a national grassroots organization advocating on behalf of people living with HIV/AIDS who depend on Title I and Title III of the Ryan White CARE Act for health care and support services. We include members of Title I planning councils, people living with HIV/AIDS, community-based AIDS service organizations, providers of HIV/AIDS health care, CARE Act grantees, and consortia. We represent all segments of society that have been impacted by HIV/AIDS. A .53% cut reduction in funding for Title I and Title III would impair member's ability to serve our clients.

As you know, infection rates remain distressingly high, adding new cases constantly to providers of Ryan White CARE services. The cost of care per patient is rising steadily. In addition, we learned just recently that the Public Health Service treatment guidelines will soon require our providers to offer laboratory tests to measure resistance as a part of the standard of HIV care. CARE Act provider must be able to offer this test but the cost is likely to reach \$500 per patient per year. Absorbing this new unanticipated expense in FY 2000 on top of a .53% reduction in grants will place a great burden on local agencies.

By September 30, 2000, Congress must authorize the Ryan White CARE Act. The CAEAR Coalition is greatly concerned about the message Congress may hear as to the Administration's commitment to this important program from a decision to cut programmatic funding in FY 2000.

Continuing The Tradition Of Caring...

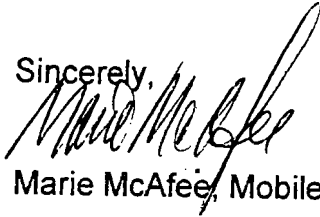
AitaMed Health Services Corporation

15500 SEPULCRAL BLVD.

5055 East Pomona Blvd., Suite 1, East Los Angeles, CA 90022 TEL: (323) 890-8767 FAX: (323) 890-8766

The CAEAR Coalition urges you to reconsider this .53% cut in funding, because of its immediate negative impact on vulnerable people living with HIV and because of its potential negative impact on the williness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely,



Marie McAfee, Mobile Unit Coordinator

Cc: Jacob Lew
Office of Management and Budget

Kevin Thurm
Deputy Secretary
Dept. of Health and Human Services

John Callahan
Assistant Secretary
Management and Budget
Dept of Health and Human Services

Eric Goosby
Director, HIV/AIDS Policy Office

Earl Fox
Administrator Health Resources
And Services Administration

Joe O'Neill
Associate Administrator, HIV/AIDS
Bureau Health Resources
And Services Administration

Sandra Thurman
National AIDS Policy Director

FAX TRANSMISSION
DEMOCRATIC OFFICE OF
THE UNITED STATES SENATE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

TO: Michael + Deborah

FROM: Scott

FAX #: 456 - 2439

DATE: 2/7 TOTAL PAGES (INCLUDING COVER) 28

IF THERE ARE ANY PROBLEMS RECEIVING THIS TRANSMISSION, PLEASE CALL (202) 224-0767.

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Memorandum

January 18, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act**

You requested a comparison of how different methods of estimating the number of people living with acquired immune deficiency syndrome (AIDS) would affect the monies distributed to eligible metropolitan areas (EMA) under Title I of the Ryan White CARE Act in FY99. Attached, please find two tables containing the information that you requested. A comparable comparison for Title II of the CARE Act will follow in a separate memorandum.

This memorandum is divided into three sections. The first section is a brief explanation of the three methods used to estimate the number of people living with AIDS, including assumptions and limitations of the data. The second section is a description of the set-asides that affect the amount of money distributed using the formula and a description of the formula for distributing Title I funds currently in the law. The third section is a brief analysis of the data and discussion of the policy implications of the data.

Three Methods of Calculating AIDS Prevalence

Method 1: Current Law

Current law stipulates that the estimate of prevalence, or the number of people living with AIDS, is to be calculated using data (number of new cases of AIDS) reported to the Centers for Disease Control and Prevention (CDC) for each eligible metropolitan area (EMA) over the most recent 120-month period for which data is available. The data is aggregated into 10 12-month periods. Each 12 month period is weighted by the probability that an individual diagnosed with AIDS is still alive given the year that he or she was diagnosed. Thus, someone diagnosed 10 years ago would have a smaller probability of being alive compared to someone who was diagnosed 1 year ago. The same weights are used for all eligible areas. The weighted values of reported cases are then summed to give the

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estimate of living AIDS cases in each area. The weights used in these calculations are updated biennially.

One limitation of the current method of calculating AIDS prevalence is that it assumes there is no regional variability in survival, which is unlikely to be true. Another limitation is that it assumes all EMAs report *complete* data of incidence and AIDS related deaths for each particular 12 month time period. This is also unlikely to be true. EMAs (or States reporting for EMA and non-EMA areas) depend on thousands of doctors and care providers to report the data to them. The doctors and care providers do not always report promptly. Several years may pass before some doctors report their data to the State or EMA. Thus the data that the EMAs report to the CDC may not reflect the number of AIDS cases and AIDS related deaths for a particular 12 month reporting period. Delayed reporting is the term used to describe cases that are not reported within the 12 month period in which they are diagnosed.¹

Method 2: Cases Reported to be Living.

One alternative method of estimating AIDS prevalence is to calculate the difference between the number of cases of AIDS reported to the CDC and the number of reported deaths of AIDS cases reported to the CDC. This method was used to calculate AIDS prevalence in EMAs and published by the CDC.² This data was used for method 2 of this analysis.

One benefit of method 2 is that it does account for regional differences such as differences in survival and access to care. But, this method does not account for delayed reporting of AIDS cases and deaths.

Method 3: Adjusted Reported AIDS cases.

This estimate of AIDS prevalence adjusts for reporting delays using a maximum likelihood statistical procedure. This adjustment takes into account geographic area, race/ethnicity, age, sex, vital status, and exposure category of reported cases. The adjustment is done to both the reports of AIDS cases, as well as the reports of AIDS deaths. The estimate of prevalence is the difference between the adjusted estimate of cases and the adjusted estimate of deaths. The CDC used this method to calculate AIDS prevalence and published the findings.³ This data was used for method 3 of this analysis.

This statistically adjusted estimate is limited in that it assumes trends in reporting delays by geographic area, race/ethnicity, age, sex, vital status and exposure category are constant within these categories. Another limitation of method 3 is that it is slow to respond

¹ Delayed reporting is sometimes mistaken for incomplete reporting. Incomplete reporting is when a case is never reported. None of the methods of estimating prevalence in this paper adjust for incomplete reporting.

² Centers for Disease Control and Prevention. HIV/AIDS Surveillance Supplemental Report. 1999;5(No.2): 8p.

³ Ibid.

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to changes in reporting patterns. This method is based on historical trends in data reporting patterns. If an area dramatically changes its reporting habits (either to report more promptly or more delayed), the calculation may not reflect this recent change. If the change is sustained, the estimate of prevalence will slowly adjust to this change in reporting behavior.

As with method 2, this method has the benefit of accounting for regional differences in survival. But, according to CDC statisticians, because of the adjustment for reporting delays, method 3 provides a more accurate estimate of the number of AIDS cases in the EMAs.⁴

Set-Asides and the Distribution of Funds Under Current Law

This analysis does *not* assume changes in the underlying formula in the current law. It examines how different data (or estimates of prevalence) used in the same basic formula, result in different distributions of money.

The current law dictates that half of Title I funds are to be distributed using the formula written in the law, and half are to be distributed through supplemental grants. Several set-asides are taken out of the appropriation before it is divided between the formula and supplemental grants. These include Special Projects of National Significance (FY1999 = 1.8% of total Title I appropriated funds), Broad Technical Assistance (FY1999 = 1% of total Title I appropriated funds) and Evaluation (FY99 = 1% of total Title I appropriated funds). For FY1999, after set-asides, \$485,966,900 was available for Title I. Half of this amount, or \$242,983,450 was divided among the eligible metropolitan areas(EMA) under the formula portion of Title I.

The money is divided among the EMAs according to their proportions of estimated AIDS cases. For example, for FY1999, New York city contained approximately 21% of all of the estimated AIDS cases living in EMAs. Therefore, New York city was portioned approximately 21% of the available funds.

Two adjustments take place to the distributed funds. First, new EMAs are offered \$75,000 planning grants.⁵ That amount is then deducted from their formula award. For FY99, two new EMAs received \$75,000 planning grants: Las Vegas, NV-AZ, and Norfolk-Virginia Beach-Newport News, VA-NC. The planning grant is only offered for the EMAs first year of existence. Therefore, the total amount of money distributed under the formula portion of Title I is smaller by \$150,000, but only the two new EMAs are effected by the lower total amount of money. The second adjustment is a hold harmless provision. In the current law, for FY1999, EMAs can not receive less than 3.5% less than what they received in 1995. For FY1999, only one EMA was affected by the hold harmless provision: San Francisco. Under the formula portion of Title I, San Francisco would have received \$9,400,823. Under the hold harmless provision, San Francisco should receive \$18,457,245. Therefore, the *difference between these two amounts is taken from the supplemental grant*

⁴ Phone conversation with CDC statistician.

⁵ Section 2606 (42 U.S.C. 300ff-16)

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portion of Title I and added to the formula portion of Title I. Thus, the formula portion of Title I is larger by that difference, and only San Francisco receives that money.

Why is there a hold harmless provision? The hold harmless provision was added during the re-authorization in 1996, when changes to the Title I formulas were feared to have a large and negative impact on the amount of money some EMAs received.

Why was San Francisco the only EMA to be effected by the hold harmless in FY1999? This may be a reflection of an historical trend. Prior to the re-authorization in 1996, money for Title I was distributed based on the number of AIDS cases that had ever been reported in an area. San Francisco was one of the first metropolitan areas to be impacted by the AIDS epidemic. But, most individuals diagnosed with AIDS at the beginning of the epidemic are very unlikely to be alive today. This may be one reason why San Francisco's formula amount (\$9,400,823), which reflects the estimated number of people living with AIDS today, is so much less than the hold harmless amount it ultimately receives (\$18,457,245), which reflects a portion of how many people were living with AIDS in San Francisco earlier in the epidemic.

Are new EMAs subject to the hold harmless provision? New EMAs are not subject to the hold harmless provision. EMAs that came into existence since 1995 could not be adversely affected by changes in formulas that took place in 1996, because they were not eligible, and did not receive money under the prior formula.

For this examination of methods 2 and 3 (for estimating AIDS prevalence), a different hold harmless level was used. As requested, the hold harmless level for methods 2 and 3 in the attached tables was set at 98% of an EMAs 1995 amount⁶. Therefore, in FY1999, using methods 2 and 3 for estimating AIDS prevalence, an EMA could not receive less than 98% of what it received in 1995. Two EMAs received additional money because of the hold harmless provision under method 2 (New York and San Francisco), and one EMA received a more money under method 3 (San Francisco).

Analysis and Policy Implications of the Data

Table 1 attached compares the amount of money distributed to each EMA using the formula portion of Title I when AIDS prevalence is estimated under the current method (method 1) and under method 2 – both with and without a 2% hold harmless provision. Recall that method 2 is the difference between the reported cases of AIDS, and the reported cases of AIDS deaths. These estimates were made using AIDS prevalence data for FY1999, the only data made available by the CDC. These examinations are not projections of AIDS cases or grant amounts.

⁶ Under current law for FY1999, EMAs can not receive less than 96.5% of what they received in 1995 for the formula portion of Title I.

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Thirty three EMAs would receive more money under method 2 hold harmless⁷ and eighteen would receive less money. The percentage change in money received by EMAs when the hold harmless provision is employed range from a decrease of 15.5% in Norfolk-Virginia Beach-Newport News VA-NC, to an increase of 31.1% in Kansas City, MO-KS. The percentage change between method 1 and method 2 may reflect a variety of things, including, but not limited to such things as regional differences in survival, access to care, and different strains of the virus that may or may not be more likely to respond to currently available drugs.

The hold harmless provision for Method 2 only affected two EMAs – New York, NY and San Francisco, CA. Some EMAs had very large decreases in their money, but were either not subject to the hold harmless because they did not exist in 1995 (e.g., Norfolk-Virginia Beach-Newport News VA-NC, -15.5%), or their decrease was large, but not so large that it was affected by the hold harmless (Chicago, IL, -10.8%⁸). Other EMAs received substantially more under method 2, such as Jacksonville, FL (+24.6%) and Orange County, CA (+24.9%). The committee may wish to consider setting a different criteria for the hold harmless to limit the impact of this data change on some of the EMAs.

Estimated grants are the same under method 2 both with and without the hold harmless provision, *except for New York and San Francisco*. All other EMAs receive the same grant amounts whether the hold harmless in place or not. Without the hold harmless, New York would receive 8.1% less under method 2, relative to current law, and San Francisco would receive 48.1% less under method 2, relative to current law.

Method 2 has at least one major disadvantage in that it provides EMAs with an incentive to delay the reporting of AIDS deaths, if AIDS prevalence was tied to their funding. Such an incentive may jeopardize the reliability of AIDS data received by the CDC in the future.

Table 2 compares the amount of money distributed when the current method (method 1) and method 3 are used to estimate the AIDS prevalence, both with and without a 2% hold harmless provision. Recall that method 3 uses prevalence estimates adjusted for reporting delays.

Thirty-six EMAs received more money under method 3 compared to method 1 while fifteen EMAs received less money. The percentage change in money received by EMAs with a hold harmless provision ranged from a decrease of 16.7% in Caguas, PR to an increase of 23.5% in Kansas City, MO-KS. The percentage change between method 1 and method 3 may reflect a variety of things. Like method 2, method 3 will reflect regional

⁷ The 2% hold harmless provision used for method 2 and method 3 was relative to the funds an EMA received in 1995.

⁸ In FY1995, Chicago received approximately \$4,925,000 from the formula portion of Title I. Under a 2% hold harmless provision, Chicago can not receive less than \$4,829,500 for FY1999. Using method 2 to estimate AIDS prevalence, Chicago would receive \$8,049,000, which is much higher than its hold harmless amount, but yet, 10.8% less than what it would receive under current law for FY1999.

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differences. Unlike method 2, method 3 adjusts for reporting delays. Under the current law (method 1) EMAs that are slower to report their data to the CDC are at a relative disadvantage. Under method 3, those delayed reporters are brought to parity. Because there is a set amount of money to distribute among the EMAs, the EMAs that historically were very prompt to report their data to the CDC were somewhat adversely affected by method 3. For example, according to the CDC, EMAs in Puerto Rico, which promptly reported their data to the CDC relative to other EMAs, were adversely affected by the adjustment for other EMA's reporting delays.

As with method 2, there were several EMAs that would receive substantial drops in their funding under method 3 with the current hold harmless provision. The committee may wish to consider a different hold harmless provision to mitigate the decreases in some EMAs funding.

Under method 3, only San Francisco is affected by the hold harmless provision. All EMAs other than San Francisco receive the same grant amounts under method 3 regardless of whether the hold harmless provision is in place. Without the hold harmless provision San Francisco would receive 45.8% less under method 3 relative to current law.

Data used in method 3, unlike method 2 or 1, take longer for the CDC to calculate. Estimates of AIDS prevalence current through July of 1999 may not be available until February or March of the following year. This lag has to do with the deadlines that EMAs have to report their data to the CDC and the amount of time it takes to generate accurate estimates.

Overall, the data comparing method 3 to method 1 are very similar to the data comparing method 2 to method 1. Slightly more EMAs had an increased percent change under method 3. The range of the percentage changes was very similar between current law and each alternative method. But, different EMA are negatively and positively impacted under each alternative method.

I hope this information is useful. If you have any further questions, please call me. A comparable analysis of Title II of the Ryan White CARE Act will follow.

Paulette Como
202-707-7317

Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 2 Hold Harmless (in thousands)	Percent Change from current law	Method 2 No Hold Harmless (in thousands)	Percent Change from current law
Atlanta, GA MSA	\$6,915	\$7,532	8.9%	\$7,532	8.9%
Austin-San Marcos, TX MSA	\$1,658	\$1,720	3.7%	\$1,720	3.7%
Baltimore, MD PMSA	\$6,956	\$6,402	-8.0%	\$6,402	-8.0%
Bergen-Passaic, NJ PMSA	\$2,401	\$2,135	-11.1%	\$2,135	-11.1%
Boston-Worcester-Lawrence-Lowell-Brockton, MA- NH NECMA	\$5,293	\$5,203	-1.7%	\$5,203	-1.7%
Caguas, PR PMSA	\$859	\$748	-12.9%	\$748	-12.9%
Chicago, IL PMSA	\$9,025	\$8,049	-10.8%	\$8,049	-10.8%
Cleveland-Lorain-Elyria, OH PMSA	\$1,505	\$1,561	3.8%	\$1,561	3.8%
Dallas, TX PMSA	\$5,095	\$5,762	13.1%	\$5,762	13.1%
Denver, CO PMSA	\$2,130	\$2,520	18.3%	\$2,520	18.3%
Detroit, MI PMSA	\$3,324	\$3,303	-0.6%	\$3,303	-0.6%
Dutchess County, NY PMSA	\$608	\$589	-3.1%	\$589	-3.1%
Fort Lauderdale, FL PMSA	\$5,544	\$5,704	2.9%	\$5,704	2.9%
Fort Worth-Arlington, TX PMSA	\$1,503	\$1,632	8.6%	\$1,632	8.6%
Hartford, CT NECMA	\$2,027	\$2,259	11.4%	\$2,259	11.4%
Houston, TX PMSA	\$8,282	\$8,657	4.5%	\$8,657	4.5%
Jacksonville, FL MSA	\$1,887	\$2,351	24.6%	\$2,351	24.6%
Jersey City, NJ PMSA	\$2,931	\$2,584	-11.9%	\$2,584	-11.9%
Kansas City, MO-KS MSA	\$1,476	\$1,938	31.3%	\$1,938	31.3%
Las Vegas, NV-AZ MSA	\$1,775	\$1,917	8.0%	\$1,917	8.0%
Los Angeles-Long Beach, CA PMSA	\$16,905	\$16,783	-0.7%	\$16,783	-0.7%
Miami, FL PMSA	\$10,492	\$11,031	5.1%	\$11,031	5.1%
Middlesex-Somerset-Hunterdon, NJ PMSA	\$1,406	\$1,338	-4.8%	\$1,338	-4.8%
Minneapolis-St. Paul, MN-WI MSA	\$1,288	\$1,484	15.2%	\$1,484	15.2%
Nassau-Suffolk, NY PMSA	\$2,879	\$2,738	-4.9%	\$2,738	-4.9%
New Haven-Bridgeport-Stamford-Danbury- Waterbury, CT NECMA	\$3,115	\$3,631	16.6%	\$3,631	16.6%
New Orleans, LA MSA	\$3,060	\$3,141	2.7%	\$3,141	2.7%
New York, NY PMSA	\$51,212	\$47,663	-6.9% *	\$47,063	-8.1%
Newark, NJ PMSA	\$7,212	\$6,419	-11.0%	\$6,419	-11.0%
Norfolk-Virginia Beach-Newport News, VA-NC MSA	\$1,898	\$1,604	-15.5%	\$1,604	-15.5%
Oakland, CA PMSA	\$3,147	\$3,282	4.3%	\$3,282	4.3%
Orange County, CA PMSA	\$2,173	\$2,713	24.9%	\$2,713	24.9%

Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 2 Hold Harmless (in thousands)	Percent Change from current law	Method 2 No Hold Harmless (in thousands)	Percent Change from current law
Orlando, FL MSA	\$2,759	\$2,931	6.2%	\$2,931	6.2%
Philadelphia, PA-NJ PMSA	\$8,281	\$8,402	1.5%	\$8,402	1.5%
Phoenix-Mesa, AZ MSA	\$2,015	\$1,880	-6.7%	\$1,880	-6.7%
Ponce, PR MSA	\$1,233	\$1,266	2.7%	\$1,266	2.7%
Portland-Vancouver, OR-WA PMSA	\$1,558	\$1,758	12.8%	\$1,758	12.8%
Riverside-San Bernardino, CA PMSA	\$3,232	\$3,493	8.1%	\$3,493	8.1%
Sacramento, CA PMSA	\$1,338	\$1,308	-2.2%	\$1,308	-2.2%
St. Louis, MO-IL MSA	\$1,975	\$2,168	9.8%	\$2,168	9.8%
San Antonio, TX MSA	\$1,858	\$2,012	8.3%	\$2,012	8.3%
San Diego, CA MSA	\$4,502	\$4,764	5.8%	\$4,764	5.8%
San Francisco, CA PMSA	\$18,457 *	\$18,744	1.6% *	\$9,574	-48.1%
San Jose, CA PMSA	\$1,268	\$1,421	12.1%	\$1,421	12.1%
San Juan-Bayamon, PR PMSA	\$6,925	\$6,042	-12.8%	\$6,042	-12.8%
Santa Rosa, CA PMSA	\$604	\$715	18.4%	\$715	18.4%
Seattle-Bellevue-Everett, WA PMSA	\$2,654	\$3,004	13.2%	\$3,004	13.2%
Tampa-St. Petersburg-Clearwater, FL MSA	\$3,597	\$3,947	9.7%	\$3,947	9.7%
Vineland-Millville-Bridgeton, NJ PMSA	\$341	\$333	-2.3%	\$333	-2.3%
Washington, DC-MD-VA-WV PMSA	\$9,877	\$10,415	5.5%	\$10,415	5.5%
West Palm Beach-Boca Raton, FL MSA	\$3,434	\$3,604	4.9%	\$3,604	4.9%
Total	\$251,890 ¹	\$252,603 ²		\$242,833 ³	

Source: Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law, the hold harmless is a value 3.5% below the EMA's 1995 grant. Per request, the method 2 hold harmless is 2% below the EMA's 1995 grant.

Note: The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The total for the current formula ¹ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco harmless at 3.5% of its 1995 amount (+\$9,056,000) which is transferred from the supplemental grants portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title I (-\$150,000). The method 2 hold harmless total ² reflects the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco and New York harmless at 2% of their 1995 amount (+\$9,770,00), adjusted for the new EMA start-up grants (-\$150,000). The method 2 not held harmless ³ reflects the money distributed under the formula portion of Title I (\$242,983,000) adjusted for the new EMA planning grants (-\$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

Note: Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC. See attached memorandum.

**Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)**

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 3 Hold Harmless (in thousands)	Percent Change from current law	Method 3 No Hold Harmless (in thousands)	Percent Change from current law
Atlanta, GA MSA	\$6,915	\$7,363	6.5%	\$7,363	6.5%
Austin-San Marcos, TX MSA	\$1,658	\$1,709	3.1%	\$1,709	3.1%
Baltimore, MD PMSA	\$6,956	\$6,909	-0.7%	\$6,909	-0.7%
Bergen-Passaic, NJ PMSA	\$2,401	\$2,126	-11.4%	\$2,126	-11.4%
Boston-Worcester-Lawrence-Lowell-Brockton, MA- NH NECMA	\$5,293	\$5,582	5.5%	\$5,582	5.5%
Caguas, PR PMSA	\$859	\$715	-16.7%	\$715	-16.7%
Chicago, IL PMSA	\$9,025	\$7,979	-11.6%	\$7,979	-11.6%
Cleveland-Lorain-Elyria, OH PMSA	\$1,505	\$1,537	2.1%	\$1,537	2.1%
Dallas, TX PMSA	\$5,095	\$5,684	11.6%	\$5,684	11.6%
Denver, CO PMSA	\$2,130	\$2,261	6.2%	\$2,261	6.2%
Detroit, MI PMSA	\$3,324	\$3,327	0.1%	\$3,327	0.1%
Dutchess County, NY PMSA	\$608	\$585	-3.8%	\$585	-3.8%
Fort Lauderdale, FL PMSA	\$5,544	\$5,569	0.4%	\$5,569	0.4%
Fort Worth-Arlington, TX PMSA	\$1,503	\$1,613	7.3%	\$1,613	7.3%
Hartford, CT NECMA	\$2,027	\$2,265	11.7%	\$2,265	11.7%
Houston, TX PMSA	\$8,282	\$8,768	5.9%	\$8,768	5.9%
Jacksonville, FL MSA	\$1,887	\$2,211	17.2%	\$2,211	17.2%
Jersey City, NJ PMSA	\$2,931	\$2,514	-14.2%	\$2,514	-14.2%
Kansas City, MO-KS MSA	\$1,478	\$1,823	23.5%	\$1,823	23.5%
Las Vegas, NV-AZ MSA	\$1,775	\$1,833	3.3%	\$1,833	3.3%
Los Angeles-Long Beach, CA PMSA	\$16,905	\$16,951	0.3%	\$16,951	0.3%
Miami, FL PMSA	\$10,492	\$10,703	2.0%	\$10,703	2.0%
Middlesex-Somerset-Hunterdon, NJ PMSA	\$1,406	\$1,281	-8.9%	\$1,281	-8.9%
Minneapolis-St. Paul, MN-WI MSA	\$1,288	\$1,427	10.8%	\$1,427	10.8%
Nassau-Suffolk, NY PMSA	\$2,879	\$2,923	1.5%	\$2,923	1.5%
New Haven-Bridgeport-Stamford-Danbury- Waterbury, CT NECMA	\$3,115	\$3,636	16.7%	\$3,636	16.7%
New Orleans, LA MSA	\$3,060	\$2,941	-3.9%	\$2,941	-3.9%
New York, NY PMSA	\$51,212	\$47,974	-6.3%	\$47,974	-6.3%
Newark, NJ PMSA	\$7,212	\$6,389	-11.4%	\$6,389	-11.4%
Norfolk-Virginia Beach-Newport News, VA-NC MSA	\$1,898	\$1,747	-8.0%	\$1,747	-8.0%
Oakland, CA PMSA	\$3,147	\$3,262	3.6%	\$3,262	3.6%
Orange County, CA PMSA	\$2,173	\$2,617	20.4%	\$2,617	20.4%

**Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
 A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)**

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 3 Hold Harmless (in thousands)	Percent Change from current law	Method 3 No Hold Harmless (in thousands)	Percent Change from current law
Orlando, FL MSA	\$2,759	\$2,844	3.1%	\$2,844	3.1%
Philadelphia, PA-NJ PMSA	\$8,281	\$8,389	1.3%	\$8,389	1.3%
Phoenix-Mesa, AZ MSA	\$2,015	\$2,138	6.1%	\$2,138	6.1%
Ponce, PR MSA	\$1,233	\$1,224	-0.8%	\$1,224	-0.8%
Portland-Vancouver, OR-WA PMSA	\$1,558	\$1,693	8.6%	\$1,693	8.6%
Riverside-San Bernardino, CA PMSA	\$3,232	\$3,413	5.6%	\$3,413	5.6%
Sacramento, CA PMSA	\$1,338	\$1,303	-2.6%	\$1,303	-2.6%
St. Louis, MO-IL MSA	\$1,975	\$2,069	4.8%	\$2,069	4.8%
San Antonio, TX MSA	\$1,858	\$1,981	6.6%	\$1,981	6.6%
San Diego, CA MSA	\$4,502	\$4,662	3.6%	\$4,662	3.6%
San Francisco, CA PMSA	\$18,457 *	\$18,744	1.6% *	\$9,997	-45.8%
San Jose, CA PMSA	\$1,268	\$1,361	7.3%	\$1,361	7.3%
San Juan-Bayamon, PR PMSA	\$6,925	\$6,019	-13.1%	\$6,019	-13.1%
Santa Rosa, CA PMSA	\$604	\$681	12.7%	\$681	12.7%
Seattle-Bellevue-Everett, WA PMSA	\$2,654	\$2,933	10.5%	\$2,933	10.5%
Tampa-St. Petersburg-Clearwater, FL MSA	\$3,597	\$3,817	6.1%	\$3,817	6.1%
Vineland-Millville-Bridgeton, NJ PMSA	\$341	\$308	-9.5%	\$308	-9.5%
Washington, DC-MD-VA-WV PMSA	\$9,877	\$10,300	4.3%	\$10,300	4.3%
West Palm Beach-Boca Raton, FL MSA	\$3,434	\$3,478	1.3%	\$3,478	1.3%
Total	\$251,890 ¹	\$251,581 ²		\$242,833 ³	

Source: Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law the hold harmless is a value 3.5% below the EMA's 1995 grant. Under method 2, the hold harmless is a value of 2% below the EMA's 1995 grant.

Note: The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The current formula total¹ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco harmless at 3.5% of its 1995 amount (+\$9,056,000) which is transferred from the supplemental grant portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title I (-\$150,000.) The method 3 hold harmless total² reflects the the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco harmless at 2% of its 1995 amount (\$8,747,000), adjusted for the new EMA planning grants (-\$150,000). The method 3 *not* held harmless³ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted for the new EMA planning grants (-\$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

Note: Method 3 adjusts the reported cases of AIDS and AIDS deaths for late reporting. The estimate of prevalence is the difference in the adjusted reported cases and adjusted reported deaths. See attached memo for greater detail.



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Memorandum

January 19, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act, Follow-up**

In response to my memorandum dated January 18, 2000 regarding Title I of the Ryan White CARE Act, you requested that I report an additional comparison of grant amounts to eligible metropolitan areas (EMAs) using 1998 as the reference year for the hold harmless provision. Following, please find two tables containing the information you requested.

This memorandum contains a brief analysis of the data. For a review of the three Methods of estimating AIDS prevalence, and a discussion of the Method of distributing funds under current law, please see my previous memorandum.

Analysis and Policy Implications of the Data

More EMAs receive larger grants under the formula portion of Title I when FY1998 is used as the reference year for the hold harmless provision, rather than FY1995. This is true for both alternative Methods of calculating AIDS prevalence.

Table 1 attached compares the grants distributed under the formula portion of Title I when AIDS prevalence is estimated under the current Method (Method 1) and under Method 2 – both with and without a 2% hold harmless provision. Method 2 is the difference between reported AIDS cases and reported AIDS deaths. These estimates were made using data for FY1999. These are not projections. The hold harmless provision for Method 2 references grants EMAs received in 1998. The hold harmless provision prohibits EMAs from receiving less than 98% of the amount of money they received in FY1998.

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Thirty two EMAs would receive more money under Method 2 hold harmless¹ and 19 would receive less money. The percentage change in money received by EMAs with a hold harmless provision range from a decrease of 15.5% (relative to what the EMA would have received under current law) in Norfolk-Virginia Beach-Newport News VA-NC, to an increase of 31.1% in Kansas City, MO-KS. The percentage change between Method 1 and Method 2 may reflect a variety of factors such as regional differences in survival and access to care. The range in the percentage change in this analysis (-15.5% to +31.1%) is identical to the range when 1995 is used as a reference year for the hold harmless provision. The reason is that Norfolk-Virginia Beach-Newport News (Norfolk) VA-NC (-15.5%) is a new EMA as of FY1999. Norfolk did not receive a grant in 1995 or in 1998. Thus, the hold harmless provision does not apply to Norfolk. Las Vegas NV-AZ was the only other EMA to be added in FY1999, and since it would receive an *increase* in funds using Method 2 instead of the Method 1, the hold harmless provision did not effect the grant amount for Las Vegas.

The hold harmless provision referenced to 1998 for Method 2 effected five EMAs – Bergen-Passaic NJ (-6.4%), Chicago IL (-10.6%), Jersey City NJ (-6.8%), Newark NJ (-7.1%), and San Francisco CA (-0.05%). Some EMAs had very large decreases in their money, but were either not subject to the hold harmless because they did not exist in 1995 (e.g., Norfolk-Virginia Beach-Newport News VA-NC, -15.5%), or their decrease was large, but not so large that it was affected by the hold harmless (Caguas PR, -12.9% and San Juan-Bayamon PR, -12.8%). Other EMAs received substantially more under Method 2, such as Jacksonville, FL (+24.6%) and Orange County, CA (+24.9%).

One major disadvantage of Method 2 is that it gives EMAs an incentive to delay the reporting of AIDS deaths. Such an incentive may jeopardize the reliability of AIDS data. Differences in the hold harmless provision would not alter this incentive.

Table 2 compares grants distributed when the current Method (Method 1) and Method 3 are used to estimate the AIDS prevalence, both with and without a 2% hold harmless provision. The hold harmless provision used for Method 3 references 1998. Two EMAs (Las Vegas NV-AZ and Norfolk-Virginia Beach-Newport News VA-NC) are new as of FY1999 and are not held harmless when FY1998 data is used. Recall that Method 3 estimates prevalence with data adjusted for reporting delays.

Thirty-five EMAs received more money under Method 3 compared to Method 1 while 16 EMAs received less money. The percentage change in money received by EMAs with a hold harmless provision ranged from a decrease of 13.2%² in Caguas PR, to an increase of 23.5% in Kansas City, MO-KS. The percentage change between Method 1 and Method 3 may reflect a variety of factors. Like Method 2, Method 3 will reflect regional differences. Unlike Method 2, Method 3 is adjusted for reporting delays. Under the current

¹ The 2% hold harmless provision used for Method 2 and Method 3 was relative to the funds an EMA received in 1998. EMAs can not receive a grant in FY1999 that is smaller than 2% less than the grant they received in FY1998.

² This amount is held harmless. In the absence of the hold harmless provision, Caguas PR would have received a grant under Method 3 that was 16.7% lower than it would have received under current law.

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law (Method 1) EMAs that are slower to report their data to the CDC are at a relative disadvantage. Under Method 3, those delayed reporters are brought to parity. Because there is a set amount of money to distribute among the EMAs, the EMAs that historically were very prompt to report their data to the CDC were somewhat adversely affected by Method 3. For example, according to the CDC, EMAs in Puerto Rico, which promptly reported their data relative to other EMAs, were adversely affected by the adjustment for other EMA's reporting delays. Norfolk-Virginia Beach-Newport News VA-NC, which had the greatest negative percent change from current law under Method 2 has a much smaller negative percent change under Method 3 (-8.0%). This would suggest that Norfolk had been a relatively slow reporter and would see greater grants under Method 3, even *without the hold harmless*.

Nine EMAs receive the hold harmless amount under Method 3 when FY1998 grants are used as the reference: Bergen-Passaic NJ (-6.4%), Caguas PR (-13.2%), Chicago IL (-10.6%), Jersey City NJ (-6.8%), Middlesex-Somerset-Hunterdon NJ (-6.2%), Newark NJ (-7.1%), San Francisco CA (-0.05%), San Juan-Bayamon PR (-13.1%), and Vineland-Millville-Bridgeton NJ (5.6%). Seven EMAs received negative percent changes between Method 3 and Method 1 but were not affected by the hold harmless provision either because they did not exist in FY1998 (Norfolk-Virginia Beach-Newport News VA-NC, -8.0%) or their decrease in grants under Method 3 was not large enough to be affected by the hold harmless (New York NY, -6.3% and Dutchess County NY, -3.8%).

The data used in Method 3, unlike Method 2 or 1, take longer for the CDC to calculate. Estimates of AIDS prevalence current through July of 1999 may not be available until February or March of the following year. This lag has to do with the deadlines that EMAs have to report their data to the CDC and the amount of time it takes to generate accurate estimates. The committee may wish to consider this constraint when formulating legislation.

More EMAs are held harmless when FY1998 grants are used as the reference, rather than FY1995 grants. This is true for both alternative Methods of calculating AIDS prevalence.

I hope this information is useful. If you have any further questions, please call me at 202-707-7317.

Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 2 Hold Harmless (in thousands)	Percent Change from current law	Method 2 No Hold Harmless (in thousands)	Percent Change from current law
Atlanta, GA MSA	\$6,915	\$7,532	8.9%	\$7,532	8.9%
Austin-San Marcos, TX MSA	\$1,658	\$1,720	3.7%	\$1,720	3.7%
Baltimore, MD PMSA	\$6,958	\$6,402	-8.0%	\$6,402	-8.0%
Bergen-Passaic, NJ PMSA	\$2,401	\$2,247	-6.4% *	\$2,135	-11.1%
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA	\$5,293	\$5,203	-1.7%	\$5,203	-1.7%
Caguas, PR PMSA	\$859	\$748	-12.9%	\$748	-12.9%
Chicago, IL PMSA	\$9,025	\$8,066	-10.6% *	\$8,049	-10.8%
Cleveland-Lorain-Elyria, OH PMSA	\$1,505	\$1,561	3.8%	\$1,561	3.8%
Dallas, TX PMSA	\$5,095	\$5,762	13.1%	\$5,762	13.1%
Denver, CO PMSA	\$2,130	\$2,520	18.3%	\$2,520	18.3%
Detroit, MI PMSA	\$3,324	\$3,303	-0.6%	\$3,303	-0.6%
Dutchess County, NY PMSA	\$608	\$589	-3.1%	\$589	-3.1%
Fort Lauderdale, FL PMSA	\$5,544	\$5,704	2.9%	\$5,704	2.9%
Fort Worth-Arlington, TX PMSA	\$1,503	\$1,632	8.6%	\$1,632	8.6%
Hartford, CT NECMA	\$2,027	\$2,259	11.4%	\$2,259	11.4%
Houston, TX PMSA	\$8,282	\$8,657	4.5%	\$8,657	4.5%
Jacksonville, FL MSA	\$1,887	\$2,351	24.6%	\$2,351	24.6%
Jersey City, NJ PMSA	\$2,931	\$2,732	-6.8% *	\$2,584	-11.9%
Kansas City, MO-KS MSA	\$1,476	\$1,938	31.3%	\$1,938	31.3%
Las Vegas, NV-AZ MSA	\$1,775	\$1,917	8.0%	\$1,917	8.0%
Los Angeles-Long Beach, CA PMSA	\$16,905	\$16,783	-0.7%	\$16,783	-0.7%
Miami, FL PMSA	\$10,492	\$11,031	5.1%	\$11,031	5.1%
Middlesex-Somerset-Hunterdon, NJ PMSA	\$1,406	\$1,338	-4.8%	\$1,338	-4.8%
Minneapolis-St. Paul, MN-WI MSA	\$1,288	\$1,484	15.2%	\$1,484	15.2%
Nassau-Suffolk, NY PMSA	\$2,879	\$2,738	-4.9%	\$2,738	-4.9%
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA	\$3,115	\$3,631	16.6%	\$3,631	16.6%
New Orleans, LA MSA	\$3,060	\$3,141	2.7%	\$3,141	2.7%
New York, NY PMSA	\$51,212	\$47,063	-8.1%	\$47,063	-8.1%
Newark, NJ PMSA	\$7,212	\$6,703	-7.1% *	\$6,419	-11.0%
Norfolk-Virginia Beach-Newport News, VA-NC MSA	\$1,898	\$1,604	-15.5%	\$1,604	-15.5%
Oakland, CA PMSA	\$3,147	\$3,282	4.3%	\$3,282	4.3%
Orange County, CA PMSA	\$2,173	\$2,713	24.9%	\$2,713	24.9%

Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 2 Hold Harmless (in thousands)	Percent Change from current law	Method 2 No Hold Harmless (in thousands)	Percent Change from current law
Orlando, FL MSA	\$2,759	\$2,931	6.2%	\$2,931	6.2%
Philadelphia, PA-NJ PMSA	\$8,281	\$8,402	1.5%	\$8,402	1.5%
Phoenix-Mesa, AZ MSA	\$2,015	\$1,880	-6.7%	\$1,880	-6.7%
Ponce, PR MSA	\$1,233	\$1,266	2.7%	\$1,266	2.7%
Portland-Vancouver, OR-WA PMSA	\$1,558	\$1,758	12.8%	\$1,758	12.8%
Riverside-San Bernardino, CA PMSA	\$3,232	\$3,493	8.1%	\$3,493	8.1%
Sacramento, CA PMSA	\$1,338	\$1,308	-2.2%	\$1,308	-2.2%
St. Louis, MO-IL MSA	\$1,975	\$2,168	9.8%	\$2,168	9.8%
San Antonio, TX MSA	\$1,858	\$2,012	8.3%	\$2,012	8.3%
San Diego, CA MSA	\$4,502	\$4,764	5.8%	\$4,764	5.8%
San Francisco, CA PMSA	\$18,457 *	\$18,369	-0.5% *	\$9,574	-48.1%
San Jose, CA PMSA	\$1,268	\$1,421	12.1%	\$1,421	12.1%
San Juan-Bayamon, PR PMSA	\$6,925	\$6,042	-12.8%	\$6,042	-12.8%
Santa Rosa, CA PMSA	\$604	\$715	18.4%	\$715	18.4%
Seattle-Bellevue-Everett, WA PMSA	\$2,654	\$3,004	13.2%	\$3,004	13.2%
Tampa-St. Petersburg-Clearwater, FL MSA	\$3,597	\$3,947	9.7%	\$3,947	9.7%
Vineland-Millville-Bridgeton, NJ PMSA	\$341	\$333	-2.3%	\$333	-2.3%
Washington, DC-MD-VA-WV PMSA	\$9,877	\$10,415	5.5%	\$10,415	5.5%
West Palm Beach-Boca Raton, FL MSA	\$3,434	\$3,604	4.9%	\$3,604	4.9%
Total	\$251,890 ¹	\$252,190	0.1% ²	\$242,833	-3.6% ³

Source: Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law, the hold harmless is a value 3.5% below the EMA's 1995 grant. Per request, the method 2 hold harmless is 2% below the EMA's 1998 grant.

Note: The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The total for the current formula ¹ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco harmless at 3.5% of its 1995 amount (+\$9,056,000) which is transferred from the supplemental grants portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title I (-\$150,000). The method 2 hold harmless total ² reflects the formula portion of Title I (\$242,983,000), adjusted by the amount to hold 5 MSAs harmless at 2% of their 1998 amount (+\$9,356,000), adjusted for the new EMA start-up grants (-\$150,000). The method 2 not held harmless ³ reflects the money distributed under the formula portion of Title I (\$242,983,000) adjusted for the new EMA planning grants (-\$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

Note: Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC. See attached memorandum.

**Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
 A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)**

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 3 Hold Harmless (in thousands)	Percent Change from current law	Method 3 No Hold Harmless (in thousands)	Percent Change from current law
Atlanta, GA MSA	\$6,915	\$7,363	6.5%	\$7,363	6.5%
Austin-San Marcos, TX MSA	\$1,658	\$1,709	3.1%	\$1,709	3.1%
Baltimore, MD PMSA	\$6,956	\$6,909	-0.7%	\$6,909	-0.7%
Bergen-Passaic, NJ PMSA	\$2,401	\$2,247	-6.4% *	\$2,126	-11.4%
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA	\$5,293	\$5,582	5.5%	\$5,582	5.5%
Caguas, PR PMSA	\$859	\$748	-13.2% *	\$715	-16.7%
Chicago, IL PMSA	\$9,025	\$8,066	-10.8% *	\$7,979	-11.6%
Cleveland-Lorain-Elyria, OH PMSA	\$1,505	\$1,537	2.1%	\$1,537	2.1%
Dallas, TX PMSA	\$5,095	\$5,684	11.6%	\$5,684	11.6%
Denver, CO PMSA	\$2,130	\$2,261	6.2%	\$2,261	6.2%
Detroit, MI PMSA	\$3,324	\$3,327	0.1%	\$3,327	0.1%
Dutchess County, NY PMSA	\$608	\$585	-3.8%	\$585	-3.8%
Fort Lauderdale, FL PMSA	\$5,544	\$5,569	0.4%	\$5,569	0.4%
Fort Worth-Arlington, TX PMSA	\$1,503	\$1,613	7.3%	\$1,613	7.3%
Hartford, CT NECMA	\$2,027	\$2,265	11.7%	\$2,265	11.7%
Houston, TX PMSA	\$8,282	\$8,768	5.9%	\$8,768	5.9%
Jacksonville, FL MSA	\$1,887	\$2,211	17.2%	\$2,211	17.2%
Jersey City, NJ PMSA	\$2,931	\$2,732	-6.8% *	\$2,514	-14.2%
Kansas City, MO-KS MSA	\$1,476	\$1,823	23.5%	\$1,823	23.5%
Las Vegas, NV-AZ MSA	\$1,775	\$1,833	3.3%	\$1,833	3.3%
Los Angeles-Long Beach, CA PMSA	\$16,905	\$16,951	0.3%	\$16,951	0.3%
Miami, FL PMSA	\$10,492	\$10,703	2.0%	\$10,703	2.0%
Middlesex-Somerset-Hunterdon, NJ PMSA	\$1,406	\$1,318	-6.2% *	\$1,281	-8.9%
Minneapolis-St. Paul, MN-WI MSA	\$1,288	\$1,427	10.8%	\$1,427	10.8%
Nassau-Suffolk, NY PMSA	\$2,879	\$2,923	1.5%	\$2,923	1.5%
New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA	\$3,115	\$3,636	16.7%	\$3,636	16.7%
New Orleans, LA MSA	\$3,080	\$2,941	-3.9%	\$2,941	-3.9%
New York, NY PMSA	\$51,212	\$47,974	-6.3%	\$47,974	-6.3%
Newark, NJ PMSA	\$7,212	\$6,703	-7.1% *	\$6,389	-11.4%
Norfolk-Virginia Beach-Newport News, VA-NC MSA	\$1,898	\$1,747	-8.0%	\$1,747	-8.0%
Oakland, CA PMSA	\$3,147	\$3,262	3.6%	\$3,262	3.6%
Orange County, CA PMSA	\$2,173	\$2,617	20.4%	\$2,617	20.4%

**Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
 A comparison of the current law (Method 1) versus the adjusted AIDS cases (Method 3)**

Eligible Metropolitan Areas	Current Formula (in thousands)	Method 3 Hold Harmless (in thousands)	Percent Change from current law	Method 3 No Hold Harmless (in thousands)	Percent Change from current law
Orlando, FL MSA	\$2,759	\$2,844	3.1%	\$2,844	3.1%
Philadelphia, PA-NJ PMSA	\$8,281	\$8,389	1.3%	\$8,389	1.3%
Phoenix-Mesa, AZ MSA	\$2,015	\$2,138	6.1%	\$2,138	6.1%
Ponca, PR MSA	\$1,233	\$1,224	-0.8%	\$1,224	-0.8%
Portland-Vancouver, OR-WA PMSA	\$1,558	\$1,693	8.6%	\$1,693	8.6%
Riverside-San Bernardino, CA PMSA	\$3,232	\$3,413	5.6%	\$3,413	5.6%
Sacramento, CA PMSA	\$1,338	\$1,303	-2.6%	\$1,303	-2.6%
St. Louis, MO-IL MSA	\$1,975	\$2,069	4.8%	\$2,069	4.8%
San Antonio, TX MSA	\$1,858	\$1,981	6.6%	\$1,981	6.6%
San Diego, CA MSA	\$4,502	\$4,662	3.6%	\$4,662	3.6%
San Francisco, CA PMSA	\$18,457 *	\$18,369	-0.5% *	\$9,997	-45.8%
San Jose, CA PMSA	\$1,268	\$1,361	7.3%	\$1,361	7.3%
San Juan-Bayamon, PR PMSA	\$6,925	\$6,021	-13.1% *	\$6,019	-13.1%
Santa Rosa, CA PMSA	\$604	\$681	12.7%	\$681	12.7%
Seattle-Bellevue-Everett, WA PMSA	\$2,654	\$2,933	10.5%	\$2,933	10.5%
Tampa-St. Petersburg-Clearwater, FL MSA	\$3,597	\$3,817	6.1%	\$3,817	6.1%
Vineland-Millville-Bridgeton, NJ PMSA	\$341	\$322	-5.6% *	\$308	-9.5%
Washington, DC-MD-VA-WV PMSA	\$9,877	\$10,300	4.3%	\$10,300	4.3%
West Palm Beach-Boca Raton, FL MSA	\$3,434	\$3,478	1.3%	\$3,478	1.3%
Total	\$251,890 ¹	\$252,029	0.1% ²	\$242,833	-3.6% ³

Source: Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law the hold harmless is a value 3.5% below the EMA's 1995 grant. Under method 2, the hold harmless is a value of 2% below the EMA's 1998 grant.

Note: The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The current formula total¹ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted by the amount to hold San Francisco harmless at 3.5% of its 1995 amount (+\$9,056,000) which is transferred from the supplemental grant portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title I (-\$150,000.) The method 3 hold harmless total² reflects the the formula portion of Title I (\$242,983,000), adjusted by the amount to hold 9 EMAs harmless at 2% of their 1998 amount (\$9,196,000), adjusted for the new EMA planning grants (-\$150,000). The method 3 *not* held harmless³ reflects the money distributed under the formula portion of Title I (\$242,983,000), adjusted for the new EMA planning grants (-\$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

Note: Method 3 adjusts the reported cases of AIDS and AIDS deaths for late reporting. The estimate of prevalence is the difference in the adjusted reported cases and adjusted reported deaths. See attached memo for greater detail.



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Memorandum

January 28, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act, Title II**

You requested a comparison of how different methods of estimating the number of people living with acquired immune deficiency syndrome (AIDS) would affect the funds distributed to states and territories under Title II of the Ryan White CARE Act in FY1999. Attached, please find the tables containing the information you requested. This memorandum is the complement to the analysis of Title I which I did for your office on January 18, 2000.

This memorandum is divided into two parts. The first part is an explanation of the set-asides that affect the amount of money distributed and a description of the formula for distributing funds under current law. The second part is a brief analysis of the data. For a more detailed explanation of the different methods of calculating AIDS prevalence, please see my memorandum to your office dated January 18, 2000.

Set-Asides and Distribution of Funds Under Current Law

This analysis does not assume changes in the underlying formula in the current law. It examines how different data (or estimates of prevalence¹) used in the same basic formula result in different distributions of money. The estimates presented in the tables are for FY1999 – they are not projections. They may differ from those presented by other analyses due to rounding error.

¹ Method 1 of calculating AIDS prevalence is the method used under current law. It is described on page 2 of this memorandum. Alternative Method 2 of calculating AIDS prevalence is the difference between reported cases of AIDS and reported AIDS deaths. Alternative Method 3 of calculating prevalence is the difference between reported cases of AIDS adjusted for reporting delays and reported AIDS deaths adjusted for reporting delays.

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Title II provides funds to all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.² Current law states that, unlike Title I, Title II grants are distributed entirely through the formula specified in the law. Several set-asides are taken out of the appropriation before it is divided among the states and territories. These set-asides include Special Projects of National Significance (FY1999 = 1.807% of total Title II appropriated funds), Broad Technical Assistance (FY1999 = 1% of total Title II appropriated funds), and Evaluation (FY1999 = 1% of Title II appropriated funds.) A portion of Title II funds are earmarked for the AIDS Drug Assistance Program (ADAP). For FY1999, \$461,000,000 of the Title II appropriation was earmarked for ADAP. For FY1999, the remaining portion of the Title II appropriation, \$248,904,300 was divided among states and eligible territories using the formula described below.

All of the Title II appropriation (after set-asides and earmarked funds) is divided among states and eligible territories. Under Title II, when a state receives a hold harmless or minimum grant amount, all other states receive less money than they would have otherwise received. The burden of holding some states at the hold harmless level is divided proportionally among all states that are above their hold harmless levels. The discussion that follows will start by describing the formula used to distribute funds, and will then talk about the adjustments that are made when some states receive more money because of the hold harmless provisions.

The estimate of AIDS prevalence for states is calculated the same way for Title II as it is for Title I. The reported cases of AIDS over the previous 120-month period are aggregated into 10 separate 12-month periods. Those 12-month periods are weighted by a factor that represents the probability that individuals who were diagnosed with AIDS are still alive, given the year in which they were diagnosed. Those 10 weighted survival estimates are summed and represent the estimated living cases of AIDS in each state or territory. For Title II, this procedure is done twice. First it is done for all estimated living cases of AIDS in each state, and second for those estimated living cases of AIDS *who do not live within an EMA* in each state.

Non-ADAP Title II appropriations are allocated with a distribution factor which gives greater weight to non-EMA cases. To calculate this distribution factor, each state or territory's total proportion of cases is weighted by 80% and added to each state or territory's proportion of *non-EMA cases*, which is weighted by 20%.

There are two separate provisions in Title II that increase a state's or territory's grant amount above what it would have received through the formula alone. The first provision

² Under current law, several "territories of the United States" are eligible to receive Ryan White grants under Title II, but those territories do not report enough cases to receive funds, and they are not subject the hold harmless provision based on the number of AIDS cases. Those territories include American Samoa, the Commonwealth of the Northern Marianas, and the Republic of the Marshall Islands. There are currently two estimated living cases of AIDS in these three territories combined.

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establishes a minimum payment for states³ based on the estimated number of living cases in the state. States with fewer than 90 living AIDS cases can not receive less than \$100,000. States with 90 or more living AIDS cases can not receive less than \$250,000. In FY99, five states received one of these two floor amounts. Those states were Montana (\$250,000), North Dakota (\$100,000), South Dakota (\$100,000), Vermont (\$250,000) and Wyoming (\$100,000).

The second provision is a hold harmless provision. Under current law for FY1999, no state shall receive less than 96.5% of what it received in FY1995. Though all states and territories were eligible for this provision, none received it. All states and territories received FY1999 grants that were larger than 96.5% of what they received in FY1995.

As stated previously, when one or more states or territories receive more money because of a minimum grant or hold harmless provision under Title II, the grants to other states and territories are decreased to fulfill the minimum grant or hold harmless provision. Therefore, after Montana, North Dakota, South Dakota, Vermont and Wyoming receive the minimum grant amount (which is larger than the grant amount they would have received through the distribution formula alone), all state and territory grants are reduced by a "reduction factor." The reduction factor is equal to the difference between the total amount of money to be distributed and the amount of money reserved to increase state and territory grant amounts under the minimum grant and hold harmless provisions, divided by the total amount of money. This reduction factor is multiplied by each state and territory grant and subtracted from the original grant. The result is again tested against both provisions: the hold harmless provision to ensure that no state receives less than 96.5% of its FY1995 amount and the minimum grant provision to ensure that no state receives less than \$100,000 or \$250,000 depending on the estimated number of AIDS cases in the state. This process is called a ratable reduction.

For the examination of the alternative methods of estimating AIDS prevalence (Method 2 and Method 3) in this memorandum, a different hold harmless level was used. The level of the minimum grant provision remains the same as under current law. But, the hold harmless level for Methods 2 and 3 in the following tables was set at 98% of a state or territory's FY1998 grant, as requested. Therefore, in FY1999, using Method 2 and 3 for estimating AIDS prevalence, a state or territory could not receive less than 98% of what it received in FY1999.

Analysis and Policy Implications of the Data

Table 1 compares the amount of money distributed to each state or territory using the formula in Title II of the CARE Act when AIDS prevalence is estimated under current law (Method 1) and under Method 2, with both the minimum grant provision and the hold harmless provision and without either provision. These estimates do *not* include the funds distributed for the AIDS Drug Assistance Program (ADAP). Method 2 of estimating AIDS prevalence is the difference between reported cases of AIDS and reported AIDS deaths. The

³ This provision is applied to all 50 states, the District of Columbia, and Puerto Rico. Guam and the Virgin Islands are not eligible for this hold harmless provision.

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grant estimates in this analysis were calculated using AIDS prevalence data for FY1999, the only data made available by the Centers for Disease Control and Prevention (CDC). These estimations are not projections.

Most of the data used for the analysis of Method 2 and Method 3 in this memorandum were published by the CDC.⁴ One part of the calculation requires AIDS prevalence estimates for eligible metropolitan areas (EMAs) for each state. Where an EMA spanned more than one state (such as Boston, which includes parts of Massachusetts and New Hampshire) the CDC did not report the estimated number of living AIDS cases in each state within the EMA for Methods 2 and 3. It did publish those estimates for Method 1, current law. For the analysis of Methods 2 and 3 in this memorandum, I assumed that the estimated number of AIDS cases living in each state within an EMA that crossed state boundaries would be proportional to estimated number of AIDS cases living in each state in the same EMA under Method 1.

Twenty eight states and territories would receive more money under Method 2 with the minimum grant and hold harmless provisions and twenty one would receive less money.⁵ The grants for five states would not change. Under current law, three states (North Dakota, South Dakota and Wyoming) would receive the minimum grant award for a state with fewer than 90 estimated living cases of AIDS. Two states (Montana and Vermont) would receive the minimum grant award for a state with 90 or more estimated living cases of AIDS. These states receive the same grant amount under Method 2 with the minimum grant provision as under current law (Method 1). The percentage change in money received by states or territories when the minimum grant and hold harmless provisions are employed range from a decrease of 9.9% in West Virginia to an increase of 42.5% in New Hampshire. The percentage change between Method 1 and Method 2 may reflect a variety of things, including but not limited to regional differences in survival, and access to care.

Ten states and territories received grant amounts determined by the hold harmless provision.⁶ Because of this provision (as well as the minimum grant provision mentioned in the previous paragraph), all states that do not receive a grant amount resulting from the minimum grant provision or the hold harmless provision receive less money under Method 2 with both of these provisions than under Method 2 without either provision. The grant amounts for two states, Illinois and Maryland decreased to the point where they too became eligible for the hold harmless provision under Method 2 when they were not previously eligible for it. This is because of the ratable reduction. Under Method 2 with the minimum grant and hold harmless provisions, if a state qualifies for either provision and it would increase the amount of grant money it received, then the state would receive this higher grant amount. Because there is a finite amount of money to be allocated between the states and

⁴ Centers for Disease Control and Prevention, HIV/AIDS Surveillance Supplemental Report. 1999;5(No. 2): [1-8].

⁵ Under current law, states and territories can not receive less than 96.5% of the grant amount they received in FY1995. The hold harmless provisions used for analysis of Methods 2 and 3 was 98% of the FY1998 grant amount. Both current law and the Method 2 analysis also include a minimum grant amount provision based on the number of cases of AIDS in the state.

⁶ No state shall receive less than 98% of the grant amount it received in FY1998.

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territories, if a state or territory is given more money because of the minimum grant provision or the hold harmless provision, all other states receive proportionally less money. For Method 2 without either provision, states and territories receive the grant amounts they would receive due to the formula alone. Illinois would have received 8.2% less money under Method 2 (without the minimum grant or hold harmless provisions) than Method 1. But, with the minimum grant and hold harmless provisions in place, Illinois will get even less money (a decrease of 8.4%) because it will be contributing part of its grant to other states and territories to meet their minimum grant or hold harmless levels, until the point at which it qualifies for the minimum grant or hold harmless provision itself. Once Illinois became eligible for a hold harmless provision, its grant amount stopped decreasing while other state and territory grant amounts might have continued to decrease proportionally to fulfill other state and territory minimum grant and hold harmless provisions. The same is true for Maryland.

New York and West Virginia receive an approximately 9.9% decreases under Method 2 with the minimum grant and hold harmless provisions relative to current law. Though their decrease would be large, it is not so large that it would be affected by either provision.

Nevada and Virginia would receive substantially higher grant amounts – 35.5% and 9.9%, respectively – because of the hold harmless provision. Under current law for FY1999, Nevada would receive approximately \$1,569,000, which is less than it received in FY1998, approximately \$2,170,000. One possible explanation for this is that the estimated number of people living with AIDS in Nevada as a percent of the national total has decreased relative to other states between FY1998 and FY1999. Under Method 2 without the minimum grant and hold harmless provisions, Nevada would receive a larger grant than it would under current law (\$1,665,000.) But with the hold harmless provision, which stipulates a maximum 2% reduction relative to the FY1998 grant, Nevada would receive a much larger grant. Virginia would similarly have received a smaller grant under current law in FY1999 relative to FY1998. Under Method 2 without the minimum grant and hold harmless provisions, Virginia would receive an even smaller grant than it would have received in FY1999 under current law, but with the hold harmless provision, Virginia would receive 9.9% *more* under Method 2 with the minimum grant and hold harmless provisions than it would relative to current law.

Table 2 compares the amount of money distributed when the current method (Method 1) and Method 3 are used to estimate AIDS prevalence, with both the minimum grant and the hold harmless provisions and without either provision. Method 3 is an estimate of AIDS prevalence which has been adjusted for reporting delays.

Thirty two states and territories would receive more money under Method 3 with the minimum grant and hold harmless provisions and 17 would receive less money under Method 3 with both provisions relative to Method 1. States that receive a minimum grant amount of \$100,000 or \$250,000 under current law would receive the same amount under Method 3 with the hold harmless. Six states receive minimum grant amounts under Method 3. The percentage change in money received by states or territories when the minimum grant and hold harmless provisions are employed range from a decrease of 12.4% in West Virginia and a decrease of 11.5% in Mississippi, to an increase of 35.5% in Nevada. The percentage change between Method 1 and Method 3 may reflect a variety of things. Like Method 2,

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Method 3 reflects regional differences in survival. Unlike Method 2, Method 3 also adjusts for reporting delays. Under current law, states that are slower to report their data to the CDC are at a relative disadvantage. Under Method 3, those delayed reporters are brought to parity. States that had historically reported their data promptly to the CDC will be relatively disadvantaged by this method of estimating AIDS prevalence. According to CDC statisticians, Method 3 is a more accurate method of estimating AIDS prevalence than Method 1.⁷

The minimum grant and hold harmless provisions for Method 3, like Method 2, affect fifteen states and territories. However, some of the states affected under each method are different. Under Method 3, one more state receives the minimum grant allowed to a state with 90 or more cases of AIDS than under Method 2: Idaho would receive a \$250,000 grant under Method 3 with the minimum grant provision, a 5.4% decrease compared to current law. Nine states and territories receive a Method 3 hold harmless grant amount that is 98% of their FY1998 grant.

As with Method 2, there are several states that would receive a more substantial decrease in funds under Method 3 with the minimum grant and hold harmless provisions than without provisions. Louisiana, for example, would receive an 8.0% decrease under Method 3 with the minimum grant and hold harmless provisions relative to current law. Louisiana would receive only a 6.9% decrease under Method 3 without either provision. Again, the ratable reduction is the cause. As some states and territories receive more money because of the minimum grant and hold harmless provisions than they would have received by the distribution factor alone, the grants for other states and territories are proportionally reduced to compensate for those higher grant amounts. The ratable reduction process continues until all states and territories are either at a the minimum grant level, the hold harmless level, or above their hold harmless level and the correct total amount of money is distributed.

Method 3 is also similar to Method 2 in that some states receive substantially more money because of the hold harmless provision. Nevada, for example, would have received less money under the formula portion of Title II in FY1999 using Method 1 to calculate AIDS prevalence than it did in FY1998. Because of the hold harmless provision used to analyze Method 3, Nevada would receive a much larger grant amount under Method 3 hold harmless than it would under current law (+35.5%).

Overall, the same number of states and territories receive grants designated by the minimum grant and hold harmless provisions under Methods 2 and 3. Under both methods, the hold harmless provision causes some states and territories to receive more money than they would have without the provision, while some states and territories receive less money than they would have received without the hold harmless provision. The ratable reduction is the cause for this dichotomous result.

I hope this information is useful. If you have any further questions, please call me at 202-707-7317.

⁷ Telephone conversation with CDC, January 2000.

Table 1. Estimates of Ryan White CARE Act Title II Grants

A Comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

(in thousands)

State	Current Formula	Method 2 hold harmless and minimum amount	Percent change from current law	Method 2 no hold harmless or minimum amount	Percent change from current law
Alabama	\$3,315	\$3,496	5.5%	\$3,541	6.8%
Alaska	\$270	\$311	15.4%	\$315	16.9%
Arizona	\$2,224	\$2,054	-7.7%	\$2,081	-6.5%
Arkansas	\$1,505	\$1,829	21.5%	\$1,853	23.1%
California	\$30,670	\$31,301	2.1%	\$31,704	3.4%
Colorado	\$1,968	\$2,278	15.7%	\$2,307	17.2%
Connecticut	\$3,630	\$4,075	12.3%	\$4,128	13.7%
Delaware	\$1,393	\$1,378	-1.2%	\$1,393	0.0%
District of Columbia	\$3,319	\$3,781	13.9%	\$3,830	15.4%
Florida	\$24,977	\$26,191	4.9%	\$26,529	6.2%
Georgia	\$7,658	\$8,106	5.8%	\$8,210	7.2%
Hawaii	\$1,102	\$1,120	1.6%	\$1,134	2.9%
Idaho	\$264	\$260	-1.5%	\$264	-0.3%
Illinois	\$6,968	\$6,386	-8.4% **	\$6,395	-8.2%
Indiana	\$3,254	\$3,407	4.7%	\$3,451	6.1%
Iowa	\$659	\$723	9.7%	\$732	11.1%
Kansas	\$982	\$940	-4.2% **	\$889	-9.5%
Kentucky	\$1,852	\$1,719	-7.2%	\$1,741	-6.0%
Louisiana	\$5,011	\$4,840	-3.4%	\$4,902	-2.2%
Maine	\$441	\$539	22.3%	\$546	23.9%
Maryland	\$6,497	\$5,967	-8.2% **	\$6,039	-7.0%
Massachusetts	\$4,214	\$4,133	-1.9% **	\$3,953	-6.2%
Michigan	\$3,738	\$3,654	-2.3%	\$3,701	-1.0%
Minnesota	\$970	\$1,114	14.8%	\$1,129	16.3%
Mississippi	\$2,270	\$2,101	-7.4%	\$2,128	-6.2%
Missouri	\$2,682	\$3,299	23.0%	\$3,342	24.6%
Montana	\$250 *	\$250	0.0% *	\$203	-18.7%
Nebraska	\$548	\$547	-0.3%	\$554	1.0%
Nevada	\$1,569	\$2,127	35.5% **	\$1,665	6.1%
New Hampshire	\$310	\$442	42.5%	\$448	44.4%
New Jersey	\$12,427	\$11,877	-4.4% **	\$11,345	-8.7%
New Mexico	\$1,125	\$1,107	-1.6%	\$1,121	-0.4%

Table 1. Estimates of Ryan White CARE Act Title II Grants

A Comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

State	Current Formula	(in thousands)			
		Method 2 hold harmless and minimum amount	Percent change from current law	Method 2 no hold harmless or minimum amount	Percent change from current law
New York	\$41,146	\$37,108	-9.8%	\$37,587	-8.6%
North Carolina	\$5,301	\$4,962	-6.4%	\$5,026	-5.2%
North Dakota	\$100 *	\$100	0.0% *	\$57	-42.6%
Ohio	\$4,921	\$4,555	-7.4% **	\$4,349	-11.6%
Oklahoma	\$1,773	\$1,941	9.5%	\$1,966	10.9%
Oregon	\$1,543	\$1,638	6.1%	\$1,659	7.5%
Pennsylvania	\$8,590	\$8,297	-3.4%	\$8,404	-2.2%
Rhode Island	\$1,070	\$1,121	4.8%	\$1,136	6.2%
South Carolina	\$4,868	\$5,044	1.5%	\$5,109	2.8%
South Dakota	\$100 *	\$100	0.0% *	\$82	-17.5%
Tennessee	\$4,461	\$4,726	5.9%	\$4,787	7.3%
Texas	\$17,246	\$17,834	3.4%	\$18,064	4.7%
Utah	\$946	\$1,053	11.2%	\$1,066	12.7%
Vermont	\$250 *	\$250	0.0% *	\$224	-10.5%
Virginia	\$4,847	\$5,328	9.9% **	\$4,538	-6.4%
Washington	\$2,834	\$3,209	9.4%	\$3,251	10.8%
West Virginia	\$625	\$563	-9.9%	\$570	-8.7%
Wisconsin	\$1,731	\$1,963	13.4%	\$1,988	14.9%
Wyoming	\$100 *	\$100	0.0% *	\$85	-14.6%
Guam	\$9	\$11	21.3% **	\$7	-17.5%
Virgin Islands	\$284	\$275	-3.2%	\$278	-2.0%
Puerto Rico	\$7,896	\$7,378	-6.6% **	\$7,095	-10.1%
Total	\$248,904,300	\$248,904,300		\$248,904,300	

Source: Table prepared by the Congressional Research Service based on data from the Centers for Disease Control and Prevention (CDC).

* EMA was affected by the minimum grant provision based on the number of cases of AIDS in the state. States with less than 90 living cases of AIDS can not receive less than \$100,000. States with 90 or more living AIDS cases can not receive less than \$250,000. Guam and the Virgin Islands are not eligible for this provision.

** EMA was affected by the hold harmless provision based on a percent of a previous grant amount. Under current law, states and eligible territories shall not receive less than 96.5% of the FY1995 grant amount. For analysis of Method 2, states and eligible territories do not receive less than 98% of the FY1998 grant amount, per request.

Note: Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC by states and EMAs.

Table 2. Estimates of Ryan White CARE Act Title II Grants
A Comparison of the current law (Method 1) versus the adjusted number of AIDS cases reported to be living (Method 3)
(In Thousands)

State	Current Formula	Method 3 hold harmless and minimum amount	Percent change from current law	Method 2 no hold harmless or minimum amount	Percent change from current law
Alabama	\$3,315	\$3,377	1.9%	\$3,418	3.1%
Alaska	\$270	\$296	9.8%	\$300	11.2%
Arizona	\$2,224	\$2,300	3.4%	\$2,329	4.7%
Arkansas	\$1,505	\$1,770	17.6%	\$1,792	19.0%
California	\$30,670	\$31,549	2.9%	\$31,935	4.1%
Colorado	\$1,968	\$2,087	6.0%	\$2,113	7.3%
Connecticut	\$3,630	\$4,081	12.4%	\$4,131	13.8%
Delaware	\$1,393	\$1,325	-4.9% **	\$1,332	-4.4%
District of Columbia	\$3,319	\$3,692	11.2%	\$3,737	12.6%
Florida	\$24,977	\$25,451	1.9%	\$25,762	3.1%
Georgia	\$7,658	\$7,987	4.3%	\$8,085	5.6%
Hawaii	\$1,102	\$1,132	2.8%	\$1,146	4.0%
Idaho	\$284	\$250	-5.4% *	\$248	-7.1%
Illinois	\$6,988	\$6,386	-8.4% **	\$6,390	-8.3%
Indiana	\$3,254	\$3,312	1.8%	\$3,353	3.1%
Iowa	\$659	\$681	3.3%	\$689	4.6%
Kansas	\$982	\$940	-4.2% **	\$829	-15.6%
Kentucky	\$1,852	\$1,750	-5.5%	\$1,771	-4.3%
Louisiana	\$5,011	\$4,609	-8.0%	\$4,688	-6.9%
Maine	\$441	\$503	13.9%	\$509	15.3%
Maryland	\$6,497	\$6,291	-3.2%	\$6,368	-2.0%
Massachusetts	\$4,214	\$4,231	0.4%	\$4,283	1.6%
Michigan	\$3,738	\$3,803	1.7%	\$3,849	3.0%
Minnesota	\$970	\$1,069	10.2%	\$1,082	11.5%
Mississippi	\$2,270	\$2,017	-11.2%	\$2,041	-10.1%
Missouri	\$2,682	\$3,185	18.7%	\$3,224	20.2%
Montana	\$250 *	\$250	0.0% *	\$206	-17.5%
Nebraska	\$548	\$524	-4.4%	\$530	-3.3%
Nevada	\$1,569	\$2,127	35.5% **	\$1,591	1.4%
New Hampshire	\$310	\$401	29.3%	\$406	30.9%
New Jersey	\$12,427	\$11,877	-4.4% **	\$11,115	-10.6%
New Mexico	\$1,125	\$1,162	3.3%	\$1,176	4.5%

Table 2. Estimates of Ryan White CARE Act Title II Grants
A Comparison of the current law (Method 1) versus the adjusted number of AIDS cases reported to be living (Method 3)
(In Thousands)

State	Current Formula	Method 3 hold harmless and minimum amount	Percent change from current law	Method 2 no hold harmless or minimum amount	Percent change from current law
New York	\$41,146	\$38,160	-7.3%	\$38,627	-6.1%
North Carolina	\$5,301	\$5,037	-5.0%	\$5,099	-3.8%
North Dakota	\$100 *	\$100	0.0% *	\$56	-44.4%
Ohio	\$4,921	\$4,555	-7.4% **	\$4,388	-10.8%
Oklahoma	\$1,773	\$1,948	9.9%	\$1,972	11.2%
Oregon	\$1,543	\$1,577	2.2%	\$1,596	3.4%
Pennsylvania	\$8,590	\$8,508	-1.0%	\$8,612	0.2%
Rhode Island	\$1,070	\$1,089	1.8%	\$1,103	3.1%
South Carolina	\$4,968	\$4,784	-3.7%	\$4,842	-2.5%
South Dakota	\$100 *	\$100	0.0% *	\$81	-18.6%
Tennessee	\$4,461	\$4,622	3.6%	\$4,678	4.9%
Texas	\$17,246	\$18,025	4.5%	\$18,246	5.8%
Utah	\$946	\$1,033	9.2%	\$1,046	10.5%
Vermont	\$250 *	\$250	0.0% *	\$221	-11.6%
Virginia	\$4,847	\$5,328	9.9% **	\$4,869	0.4%
Washington	\$2,934	\$3,190	8.7%	\$3,229	10.1%
West Virginia	\$625	\$549	-12.1%	\$556	-11.1%
Wisconsin	\$1,731	\$1,861	7.6%	\$1,884	8.9%
Wyoming	\$100 *	\$100	0.0% *	\$73	-26.8%
Guam	\$9	\$11	21.3% **	\$7	-24.0%
Virgin Islands	\$284	\$284	0.0%	\$288	1.3%
Puerto Rico	\$7,896	\$7,378	-6.6% **	\$7,027	-11.0%
Total	\$248,904,300	\$248,904,300		\$248,904,300	

Source: Table prepared by the Congressional Research Service based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the minimum grant provision based on the number of cases of AIDS in the state. States with less than 90 living cases of AIDS can not receive less than \$100,000. States with 90 or more living AIDS cases can not receive less than \$250,000. Guam and the Virgin Islands are not eligible for this provision.

** EMA was affected by the hold harmless provision based on a percent of a previous grant amount. Under current law, states and eligible territories shall not receive less than 96.5% of the FY1995 grant amount. For analysis of Method 2, states and eligible territories do not receive less than 98% of the FY1998 grant amount, per request.

Note: Method 3 is the difference between the number of AIDS cases adjusted for reporting delays and AIDS deaths adjusted for reporting delays.