Impact of HHS Ryan White CARE Act (RWCA) Reauthorization Principles on California: A Consolidated Statement of the Nine California RWCA Title I Planning Councils

California received $221 million in Ryan White CARE Act (RWCA) funding for Titles I and II in 2005 (federal funding cycle). These funds included: $31 million for the Title II base, $90 million for the AIDS Drug Assistance Program (ADAP) and an additional $169,000 for the emerging community of Bakersfield. A total of $99 million in Title I funds were awarded to nine eligible metropolitan areas (EMAs) by federal formula and competitive applications. California has supplemented these funds, and regional jurisdictions have also contributed significantly in local matches—demonstrating the commitment of the Governor, the California legislature and locally elected officials throughout the state to the provision of these necessary and critical services.

The HHS Reauthorization Principles significantly alter the underlying concepts of the RWCA, with devastating funding implications for California. Together, the Principles create extremely difficult conditions in California, destabilizing the system of care, dismantling the community planning process and effectively penalizing California for dedicating resources to HIV care and treatment. The nine California Title I planning councils have developed this Consolidated Statement to outline the Principles' implications. The following six areas of the Principles present particular concern:

1. Establish Objective Indicators To Determine Severity Of Need For Funding Core Medical Services
("...develop a "severity of need" for core services index (SNCSI). This index would be based upon objective criteria and be focused on core services. It would take into account not only HIV incidence, but levels of poverty, availability of other resources including local, state and federal programs and support, and private resources...")

Key issues/impact:

- Allocating funds based upon an index that includes an assessment of resources would punish California for its contribution of resources to HIV care and treatment. States and EMAs that have not allocated resources would be rewarded for their past inaction.
- Using HIV incidence (the number of new HIV infections) in the index rather than HIV prevalence (the total number of living HIV cases) creates a disincentive to invest in HIV prevention. HIV prevalence provides a much better indication of the burden of the disease on a health system.

2. Require that 75% of RWCA funds in Titles I – IV be used for core medical services so that Federal funds are first used to support life-saving services for the most impoverished Americans.

Key issues/impact:

- California's Title I EMAs currently allocate the majority of funds to health services. However, a 75% requirement would limit EMAs' ability to respond to local needs within the context of local resources (availability of non-RWCA resources, PLWH eligibility for other public benefits, etc.)
- RWCA has always been defined as the "payer of last resort." A 75% core services funding "floor" encourages jurisdictions to use RWCA first, rather than last.
- Access to medical services is not a matter of "if you build it, they will come." Supportive services are also key to linking underserved populations (including African Americans, specifically referenced in the Principles) to care and retaining them in care.

3. Maintain the Current Statutory Requirement That All States Submit HIV Data by the Start of Fiscal Year 2007

Key issues/impact:

- Including HIV cases in the funding formula will better reflect the current state of the epidemic. However, there are significant challenges associated with HIV reporting. In July 2002, California implemented code-based (non-names) HIV reporting, with the belief that a code-based system would be acceptable to the CDC. The CDC has only recently (July 2005) clarified that it will only recognize HIV cases reported by name.
- An estimated three years is required to implement a names-based system. The 2007 deadline does not allow adequate transition time. Maintaining this deadline will unfairly penalize states without fully implemented names-based reporting systems. If none of California's HIV cases are included, the State Department of Finance estimates the loss to California to be between $50 million and $100 million annually.
- The inclusion of HIV cases in funding formulae does not address the need to link funding to actual living HIV/AIDS cases residing in jurisdictions. Since it is based on the flawed assumption that people diagnosed with AIDS will die within 10 years of diagnosis, the current allocation system using the 10-year weighted case band undercounts living AIDS cases in states like California with effective systems of care that prolong life for PLWH and reduce AIDS deaths.

4. Eliminate The "Double Counting" of HIV/AIDS Cases Between Major Metropolitan Areas and the States.

Key issues/impact:

- The term "double-counting" misrepresents the current formula. The Title II base formula has two components: 1) the number of AIDS cases statewide compared to the number of AIDS cases nationwide (weighted at 80%), and 2) the number of non-EMA cases in the state (weighted at 20%).
- The proposal would change the Title II base funding formula to exclude cases in Title I EMAs. This change would result in an annual decrease of 62% (approximately $19 million of current $31 million award) to California's Title II base budget for care and treatment services.
- The proposal to exclude cases from Title I EMAs in the Title II base funding formula considers the impact of the current formula only as applied to Titles I and II. When the financial impact of *all* RWCA components is considered, RWCA funds are much more evenly distributed throughout the nation. In fact, when all Titles are included in the per capita analysis of RWCA funding allocations, California is actually below the median on a national basis.

5. Eliminate Current Provisions That Entitle Eligible Metropolitan Areas (EMAs) and States To Be "Held Harmless" In Funding Reductions.

Key issues/impact:

- Protection provisions within the RWCA prevent destabilization of service delivery systems. These provisions, included in both the 1996 and 2000 Reauthorizations, allow the affected jurisdictions to plan for funding reductions while permitting funding shifts to areas with recent increases in AIDS cases.
- Destabilizing a system of care in any California EMA would increase burdens on the other EMAs.
- Five of California's nine EMAs are currently protected by the "hold harmless" provision and would lose significant Title I funding.
- Additionally, six of California's nine EMAs are currently protected by the "grandfather" provision (which maintains Title I status for jurisdictions that no longer meet the Title I AIDS prevalence threshold requirements) and could lose all Title I funding, amounting to $25 million in RWCA resources collectively.

6. Allow Planning Councils To Serve As Voluntary and Advisory Bodies To Mayors*. **Although the Principle cites "the Mayor", it is assumed that the reference is an error and was meant to indicate the Chief Elected Official (CEO).*

Key Issues/Impact

- Community planning and local responsiveness to the epidemic have been hallmarks of the RWCA. Community planning is also embedded in other Health Resources and Services Administration (HRSA) and Department of Health and Human Services (HHS) programs. This Principle seems to contradict federal trends which establish mechanisms for community involvement in local programmatic decision-making.
- Community planning is seriously threatened without a national legislative mandate and standard. If planning councils become "optional", EMAs maintaining their planning councils may not be allowed to allocate Title I funds for their activities, and will find waning support for community planning in the face of declining service resources.
- Planning councils are the primary mechanism for consumer participation in local planning for and evaluation of care and treatment services. All parties at the planning council table bring a wealth of information, expertise and experience to the process, making for service systems that best respond to the needs of the community.
- Potential conflict-of-interest is not the same as conflict-of-interest acted upon. For years, HRSA has required - and planning councils have independently taken - numerous measures to control for and address questions of conflict-of-interest.