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RYAN WHITE CARE ACT

Program Changes Affecting Minority AIDS Initiative and Part D Grantees

Statement of Marcia Crosse
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September 9, 2009

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Highlights

Highlights of GAO-09-1027T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) federal funds are made available to assist those affected by human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Health Resources and Services Administration (HRSA) awards CARE Act grants to states, territories, metropolitan areas, and others. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA) reauthorized CARE Act programs for fiscal years 2007 through 2009. The CARE Act's Minority AIDS Initiative (MAI) provides for grants through five parts (A, B, C, D, and F) with the goal of reducing HIV-related health disparities among minorities. RWTMA changed how HRSA awards MAI grants under Part A and Part B from a formula based on the demographics of the grantee to a competitive process. Part D provides for grants for services to women, infants, children, and youth with HIV/AIDS and their families. RWTMA capped Part D administrative expenses at 10 percent. GAO was asked to testify about CARE Act changes resulting from RWTMA. This testimony discusses (1) the implementation of the MAI provisions and (2) grantees' experiences under the Part D administrative expense cap. This testimony is based on two GAO reports, *Ryan White Care Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315, and *Ryan White Care Act: First-Year Experiences under the Part D Administrative Expense Cap*, GAO-09-140.

View GAO-09-1027T or key components.
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What GAO Found

The new competitive process for awarding MAI grants altered funding for grantees, increased administrative requirements for grantees, and resulted in continued funding for existing initiatives. The new competitive application process for Part A grantees—metropolitan areas—and Part B grantees—states and territories and associated jurisdictions—altered MAI grants from what they would have been under the old formula-based process. In determining the award amounts under the new process, HRSA considered the number of minorities with HIV/AIDS living in the grantee jurisdiction, along with the MAI applications grantees were required to file. The new competitive grant applications sometimes resulted in considerable differences in grantees' share of MAI funds from what they would have received under the old process. For example, in fiscal year 2007, Phoenix received $127,578 (39.8 percent) less than it would have received under the old formula, while Houston received $154,018 (10.9 percent) more. In addition, Part A and B grantees that received MAI funding told GAO that the administrative requirements increased significantly because of the new process. These included a new MAI grant application and reporting requirements. All Part A and B grantees that applied for MAI funding received it, but some Part B grantees decided that the administrative requirements, including a separate application for MAI funds, were not worth the amount of funds that they expected to receive and therefore chose not to apply. Moreover, grantees said that they generally funded the same service providers and initiatives to reduce minority health disparities as they had in prior years. MAI grantees continued to fund a range of core medical services, which include essential medical care services, and support services, which are services needed for individuals with HIV/AIDS to achieve their medical outcomes.

In a survey of Part D grantees, GAO found that grantees provide a range of services to clients, and the majority of these grantees reported that they have not made changes to services in response to the administrative expense cap implemented in fiscal year 2007. These services included both medical services, such as outpatient health services, as well as support services, such as child care. The majority of the 83 grantees that responded to GAO's survey reported that the cap has not affected the services they provide. However, four grantees reported increasing services and three grantees reported reducing client services in response to the cap. In addition, the majority of grantees also reported that the cap has had a negative effect on their Part D programs, even if it has not changed client services, because it has, for example, made it necessary for clinical staff to perform administrative tasks. In addition, about half of the grantees reported that not all of their Part D administrative expenses were covered by the 10 percent allowance.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss reauthorization of Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) programs and consider the results of some of the changes that were instituted by the 2006 reauthorization of CARE Act programs. The CARE Act, administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), was enacted to address the needs of jurisdictions, health care providers, and people with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and their family members.[1] In December 2006 the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWTMA) reauthorized CARE Act programs for fiscal years 2007 through 2009.[2] Each year CARE Act programs provide assistance to over 530,000 mostly low income, underinsured, or uninsured individuals living with HIV/AIDS. Under the CARE Act, approximately $2.2 billion in grants were made to states, metropolitan areas, and others in fiscal year 2009.

There are five primary sections of the CARE Act under which HRSA awards grants—Parts A, B, C, D, and F. Part A provides for grants to selected metropolitan areas—known as eligible metropolitan areas (EMA) and transitional grant areas (TGA)—that have been disproportionately affected by the HIV/AIDS epidemic.[3] Part B provides for grants to states and territories and associated jurisdictions to improve the quality, availability, and organization of HIV/AIDS services. Part C provides for grants to public and private nonprofit entities to provide early intervention services, such as HIV testing and ambulatory care. Part D provides for grants to organizations for family-centered medical and support services

[1]Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff through 300ff–121). The 1990 CARE Act added Title XXVI to the Public Health Service Act. Unless otherwise indicated, references to the CARE Act are to the current Title XXVI.

[2]Pub. L. No. 109-415, 120 Stat. 2767. The CARE Act programs had previously been reauthorized by the Ryan White CARE Act Amendments of 1996 (Pub. L. No. 104-146, 110 Stat. 1346) and the Ryan White CARE Act Amendments of 2000 (Pub. L. No. 106-345, 114 Stat. 1319).

[3]An EMA is a metropolitan area with a population of 50,000 or more that had more than 2,000 AIDS cases reported in the most recent 5-year period. The 2,000 AIDS cases criterion does not include cases of HIV that have not progressed to AIDS. RWTMA created a new program for TGAs. A TGA is a metropolitan area with a population of 50,000 or more, which had 1,000 to 1,999 AIDS cases reported in the most recent 5-year period. In fiscal year 2007, there were 22 EMAs and 34 TGAs according to HRSA.

for women, infants, children, and youth with HIV/AIDS and their families—including infected and affected family members. Part F provides for grants for demonstration and evaluation of innovative models of HIV/AIDS care delivery for hard-to-reach populations and training of health care providers.[4]

Most CARE Act funding is distributed to grantees either as base or supplemental grants. Base grants are distributed by formula, and HRSA uses a grantee's share of living HIV/AIDS cases to determine the amount of base grants. Supplemental grants are generally awarded through a competitive process based on the demonstration of severe need and other criteria. In addition, Minority AIDS Initiative (MAI) grants are supplemental grants awarded on a competitive basis to address disparities in access, treatment, care, and health outcomes.

RWTMA included provisions that changed how certain funding is awarded to grantees. For example, RWTMA changed the process by which HRSA awards MAI grants under Part A and Part B from a formula based solely on demographics of the grantee jurisdiction to a competitive process. The RWTMA also capped at 10 percent the amount that Part D grantees could spend on administrative expenses.[5]

In 2008 and 2009, we issued two reports on MAI and related issues and how funds are used in Part D programs and what effect the administrative expense cap has had on those services and on grantee programs. Today my remarks are based on our issued reports.[6] Specifically, I will discuss

[4]Part E does not provide for funding for HIV/AIDS services but rather includes provisions to address various administrative functions.

[5]Among other things, RWTMA also changed hold-harmless provisions that protected formula funding for certain metropolitan areas. Subsequent to RWTMA, appropriations acts also limited the decreases in total funding (formula and non-formula) for metropolitan areas. See GAO, *Ryan White Care Act: Impact of Legislative Funding Proposal on Urban Areas*, GAO-08-137R (Washington, D.C.: October 5, 2007); GAO, *Ryan White CARE Act: Estimated Effect of Proposed Stop-Loss Provision on Urban Areas*, GAO-09-472R (Washington, D.C.: March 6, 2009); GAO, *Ryan White CARE Act: Estimated Effect of Proposed Stop-Loss Provision in H.R. 3293 on Urban Areas*, GAO-09-947R (Washington, D.C.: August 3, 2009).

[6]GAO, *Ryan White Care Act: Implementation of the New Minority AIDS Initiative Provisions*, GAO-09-315 (Washington, D.C.: Mar. 27, 2009); and GAO, *Ryan White Care Act: First-Year Experiences under the Part D Administrative Expense Cap*, GAO-09-140 (Washington D.C.: Dec. 19, 2008).

(1) the implementation of the MAI provisions in RWTMA and (2) grantees' experiences under the Part D administrative expense cap.

For our work reviewing the implementation of RWTMA's MAI provisions, we conducted a Web-based survey of fiscal year 2007 Part A and B grantees to learn how the grantees applied for funds, distributed funds to service providers, and provided oversight, and what services they provided prior to and after the enactment of RWTMA. We also analyzed the effect on funding amounts of the changes made by RWTMA to MAI grants. Additionally, we reviewed HRSA's policies and reporting requirements under MAI for Part A and B grantees. We interviewed staff from selected grantees for Parts A and B to determine how funds were distributed and how grantees provided oversight. We interviewed staff from national organizations with HIV/AIDS expertise. We also interviewed selected grantees under Part A, B, C, D, and F about services they provided under MAI prior to and after the enactment of RWTMA. We interviewed HRSA officials about implementation of MAI and reviewed Part A and B MAI competitive grant applications for fiscal year 2007.

For our review of grantees' experiences under the Part D administrative expense cap, we surveyed all 90 Part D grantees, collecting information and opinions about the administrative expense cap for fiscal year 2007, the first year the administrative cap was in effect. We also interviewed selected grantees and officials from AIDS Alliance for Children, Youth & Families, the Part D grantee member organization, as well as HRSA officials responsible for overseeing the Part D program, including 8 of the approximately 30 project officers responsible for overseeing at least one Part D grant. We reviewed grantees' fiscal year 2007 grant applications, which contained their proposed budgets for their fiscal year 2007 spending, and identified the administrative expenses and indirect costs that grantees reported to HRSA in these applications. We also reviewed HRSA's technical assistance tools and training provided to grantees and project officers, as well as fiscal year 2007 and 2008 grant application guidance.

We conducted the work for this statement from January 2008 to February 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our objectives.

Background

MAI grants were first distributed in conjunction with CARE Act funding in fiscal year 1999. The RWTMA added provisions on MAI funding to the CARE Act, authorizing specific amounts for the purpose of carrying out activities to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities. The amount of CARE Act funds used for MAI grants has increased from $24 million in fiscal year 1999 to $131 million in fiscal year 2007. The MAI provides funding through five parts (A, B, C, D, and F) of the CARE Act. Prior to the enactment of RWTMA, HRSA awarded Part A and B MAI funds to Part A and B grantees according to a formula that was solely based on the demographic characteristics of the grantees' jurisdictions, out of funds otherwise available for Parts A and B; those that received other Part A and Part B funds received MAI funds without having to file separate applications. The CARE Act now requires HRSA to award MAI funds under Parts A and B according to a competitive process. Under this new process, HRSA evaluates grantee applications for MAI funds in addition to the demographic characteristics of the jurisdictions.[7]

Through the CARE Act, HRSA awards grants (known as Part D grants) to provide services to women, infants, children, and youth with HIV/AIDS and their families. These grantees incur administrative expenses and indirect costs, such as rent and utilities.[8] The RWTMA, which took effect in fiscal year 2007, capped at 10 percent the amount that Part D grantees could spend on administrative expenses. According to HRSA, there is no

[7]The way HRSA awards MAI funds under Parts C, D, and F remains unchanged. The Part C, D, and F MAI funds are awarded through a competitive process as a component of the competitive grant award for the base parts C, D, and F.

[8]RWTMA defines administrative expenses for Part D grantees as grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs, and indirect costs as costs included in a federally negotiated indirect rate. 42 U.S.C. § 300 ff-71(h)(1-2). HRSA interprets administrative costs as excluding indirect costs. The legislative history indicates that in defining administrative expenses, Congress departed from the standard definition of the term. H.R. Rep. No. 109-695, at 11 (2006), *reprinted in* 2006 U.S. C. C.A.N. 1650, 1660.

cap on indirect costs, but grantees must have an indirect cost rate to use funds for indirect costs.[9]

Implementation of the MAI Provisions

The new competitive process for awarding MAI funds to grantees under Parts A and B, altered MAI funding amounts from what they would have been under the old formula-based process, increased administrative requirements for grantees, and resulted in continued funding for existing initiatives to reduce health disparities for minorities. In determining the award amounts under the new process, HRSA considered the number of minorities with HIV/AIDS living in the grantee metropolitan area, state, or territory or associated jurisdiction, along with the MAI applications grantees were required to file. The new competitive grant applications sometimes resulted in considerable differences in grantees' share of MAI funds from what they would have received under the old process. For example, in fiscal year 2007, Phoenix received $127,578 (39.8 percent) less than it would have received under the old formula, while Houston received $154,018 (10.9 percent) more. Part A and B grantees that received MAI funding told us that the administrative requirements increased significantly because of the new process. These included a new MAI grant application and reporting requirements. All Part A and B grantees that applied for MAI funding received it, but some Part B grantees decided that the administrative requirements, including a separate application for MAI funds, were not worth the amount of funds that they expected to receive and therefore chose not to apply.

Grantees said that they generally funded the same service providers and initiatives to reduce minority health disparities after RWTMA as they had in prior years. MAI grantees continued to fund a range of core medical services, which include essential medical care services, and support services, which are services needed for individuals with HIV/AIDS to achieve their medical outcomes. Consistent with HRSA guidance, the

[9]Indirect costs differ from administrative expenses in that indirect cost rates for specific activities are typically negotiated with the federal agency from which the grantee receives the greatest amount of federal awards and that rate then applies to all relevant federal award programs that permit indirect costs, unless it conflicts with a legislative indirect cost cap. The Office of Management and Budget (OMB) cost principles provide guidance as to the expenses that can be included in indirect costs to the cognizant agencies and grantees according to entity type. Within HHS, the Division of Cost Allocation performs this role. HRSA, following OMB cost principles, defines indirect costs as costs "incurred for common or joint objectives, which cannot be readily identified but are necessary to the operations of the organization."

types of services funded under MAI generally did not differ from services provided with other CARE Act funds.

Implementation of the Part D Administrative Expense Cap

Part D grantees report planned administrative expenses and indirect costs to HRSA in their grant applications. In these applications, Part D grantees provide HRSA with budget documents, such as line-item budgets and budget justifications. HRSA officials review this information and any revisions to it to ensure that grantees adhere to their spending plans. For the 2009 fiscal year, HRSA required Part D grantees to report more detailed budget information, including their administrative expenses, at both the beginning and end of each fiscal year. We found that grantees reported to HRSA that they were in compliance with the administrative expense cap—having spent 10 percent or less on administrative expenses, such as rent and utilities, in fiscal year 2007. However, grantees with approved indirect cost rates could spend more of their Part D grants on expenses that would otherwise be covered by the administrative expense cap. These grantees reported spending up to 26 percent of their Part D grants on such expenses, in addition to the 10 percent allowed under the cap.

In a survey of Part D grantees, we found that grantees provide a range of services to clients, and the majority of these grantees reported that they have not made changes to services in response to the administrative expense cap implemented in fiscal year 2007. These services included both medical services, such as outpatient health services, as well as support services, such as child care. The majority of the 83 grantees that responded to our survey reported that the cap has not affected the services they provide. However, 4 grantees reported increasing services and 3 grantees reported reducing client services in response to the cap. In addition, the majority of grantees also reported that the cap has had a negative effect on their Part D programs, even if it has not changed client services, because it has, for example, made it necessary for clinical staff to perform administrative tasks.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

GAO Contacts and Staff Acknowledgments

For more information regarding this testimony, please contact Marcia Crosse, (202) 512-7114 or crossem@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition, Thomas Conahan, Assistant Director; Robert Copeland, Assistant Director; Helen Desaulniers; Drew Long; Eden Savino; and Jennifer Whitworth made key contributions to this testimony.