

December 2008

RYAN WHITE CARE ACT

First-Year Experiences under the Part D Administrative Expense Cap



GAO

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Highlights of [GAO-09-140](#), a report to congressional committees

Why GAO Did This Study

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act) makes federal funds available to assist those infected and affected by HIV/AIDS. Through the CARE Act, the Health Resources and Services Administration (HRSA), part of the Department of Health and Human Services (HHS), 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. The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (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 cap on indirect costs, but grantees must have an indirect cost rate to use funds for indirect costs.

RWTMA directed GAO to examine Part D spending. In this report GAO describes (1) the services that Part D grantees provide and what effect, if any, the administrative expense cap has had on those services and on grantee programs; (2) how Part D grantees report on administrative expenses, indirect costs, and compliance with the cap; and (3) how HRSA implemented the cap and grantees' views on that implementation.

GAO surveyed all Part D grantees, interviewed selected grantees, reviewed Part D grant applications and guidance, and interviewed HRSA officials.

To view the full product, including the scope and methodology, click on [GAO-09-140](#). For more information, contact Marcia Crosse at (202) 512-7114 or crossem@gao.gov.

RYAN WHITE CARE ACT

First-Year Experiences under the Part D Administrative Expense Cap

What GAO Found

Part D grantees reported in our survey that they 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. In addition, about half of the grantees reported that not all of their Part D administrative expenses were covered by the 10 percent allowance.

Part D grantees report planned administrative expenses and indirect costs to HRSA and, starting in fiscal year 2009, HRSA will require additional reporting. In their grant applications, Part D grantees provide HRSA with budgets that include administrative expenses and indirect costs. Grantees must then update HRSA on any changes to that information, and some provide the results of independent financial audits. Starting in fiscal year 2009, HRSA will require all Part D grantees to report more detailed budget information at both the beginning and end of each year. In fiscal year 2007, the first year of the administrative expense cap, grantees reported to HRSA that they were in compliance with the cap. Grantees with approved indirect cost rates could include expenses such as rent and utilities in their indirect costs rather than in their administrative expenses and so were able to spend more than 10 percent of their Part D grants on such expenses.

Beginning in fiscal year 2007, HRSA took multiple steps to implement the administrative expense cap but, while some grantees reported that HRSA's guidance on how to implement the cap was helpful, others reported difficulties in implementing the cap due to unclear guidance from HRSA. HRSA reported revising its grant application guidance and developing training for both its staff and grantees in response to the cap. HRSA also included additional revisions related to the administrative expense cap in the fiscal year 2008 grant application guidance and plans to provide grantees with further guidance in the fiscal year 2009 application. While some grantees reported that HRSA's guidance was helpful, others reported receiving conflicting information. In the first year of the cap, some grantees also indicated a need for additional guidance on the administrative expense cap and reported that they sought such guidance from sources other than HRSA.

HHS provided technical comments on a draft of the report, which GAO incorporated as appropriate.

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Abbreviations

AIDS	acquired immunodeficiency syndrome
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
OMB	Office of Management and Budget
RWTMA	Ryan White HIV/AIDS Treatment Modernization Act of 2006

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United States Government Accountability Office
Washington, DC 20548

December 19, 2008

The Honorable Edward M. Kennedy
Chairman
The Honorable Michael Enzi
Ranking Member
Committee on Health, Education, Labor, & Pensions
United States Senate

The Honorable John D. Dingell
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

Since the first cases of what would become known as acquired immunodeficiency syndrome (AIDS) were reported in the United States in June 1981, over 1 million people in the United States have been infected with human immunodeficiency virus (HIV) as of 2006,¹ including almost 550,000 who have already died.² The HIV/AIDS population has changed over time, with women and youth³ representing a growing number of cases. More than one quarter of all new HIV/AIDS diagnoses are in women, according to the Centers for Disease Control and Prevention (CDC). Additionally, CDC estimated that almost 5,000 youth received a diagnosis of HIV or AIDS in 2004, representing about 13 percent of the persons diagnosed during that year.

Through the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act), federal funds are made available to metropolitan areas, states, and others to assist with the cost of medical and support services for individuals and families infected and affected by HIV/AIDS.⁴

¹Data for 2006 are the most recent available data as of the time of this report.

²HIV is the virus that causes AIDS. In this report, we use the common term HIV/AIDS to refer to HIV disease, inclusive of cases that have progressed to AIDS.

³CDC defines youth as individuals aged 13 through 24 years.

⁴Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff through 300ff-121). Unless otherwise indicated, references to the CARE Act are to current law.

Each year, CARE Act programs provide assistance to over 530,000 mostly low-income, underinsured, or uninsured individuals living with HIV/AIDS. The programs are administered by the Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA). Under the CARE Act, HRSA also awards grants to organizations to provide family-centered medical and support services for women, infants, children, and youth with HIV/AIDS and their families—including infected and affected family members (known as Part D grants).⁵ These Part D grantee organizations include government entities, community-based organizations (CBO)—which may or may not be specifically focused on HIV/AIDS—hospitals and medical centers, university/college hospitals and medical centers, and universities/colleges.

In providing medical and support services to women, infants, children, and youth with HIV/AIDS and their families, Part D grantees often incur administrative expenses and indirect costs. The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (RWTMA), which reauthorized CARE Act programs and defined the term “administrative expenses” for Part D grants, included a 10 percent cap on the amount of the Part D grant awards that grantees could spend on administrative expenses beginning with fiscal year 2007.⁶ The purpose of this cap is to maximize the amount of federal funds spent on services for Part D clients. Prior to this, there was no cap on administrative expenses for Part D grantees. Both administrative expenses and indirect costs can include expenses such as those related to rent, utilities, and photocopying; however, if a grantee does not have a federally negotiated indirect cost rate, it must charge (account for) such expenses as administrative expense.⁷

⁵42 U.S.C. § 300ff-71. The 1990 CARE Act added a new title XXVI to the Public Health Service Act and the CARE Act provisions authorizing these grants are found at Part D of title XXVI. Therefore, they are referred to as Part D grants.

⁶RWTMA Pub. L. No. 109-415, § 401, 120 Stat. 2767, 2811. The CARE Act programs were previously 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). Administrative expenses and indirect costs are both capped for certain other CARE Act programs.

⁷RWTMA 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. § 300ff-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.

RWTMA directed us to determine how funds are used in CARE Act Part D programs.⁸ In this report, we describe (1) the services that Part D grantees provide and what effect, if any, the administrative expense cap has had on those services and on grantee programs; (2) how Part D grantees report on administrative expenses, indirect costs, and compliance with the administrative expense cap; and (3) how HRSA implemented the Part D administrative expense cap and grantees' views on that implementation.

To determine what services Part D grantees provide and what effect the administrative expense cap has had on those services and on grantee programs, we surveyed all 90 Part D grantees. The survey response rate was 92 percent based on 83 responses received. The survey covered fiscal year 2007. We conducted the survey from May 14, 2008, through July 10, 2008, collecting information and opinions about the administrative expense cap for fiscal year 2007, the first year the administrative cap was in effect. Fiscal year 2007 was the only full year of information we were able to obtain from grantees. Information for fiscal year 2008 was not available at the time of our review. 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.⁹ We selected the 8 project officers based on unbiased selection criteria by project officers' service areas, excluding those hired in 2008.

To determine how Part D grantees report on administrative expenses, indirect costs, and compliance with the administrative expense cap, we reviewed grantees' fiscal year 2007 grant applications, which contain their proposed budgets for their fiscal year 2007 spending.¹⁰ From these grant

⁸Pub. L. No. 109-415, § 402, 120 Stat. 2767, 2812.

⁹During the course of our audit work, because some project officers resigned or were reassigned, the number of project officers overseeing at least one Part D grant fluctuated between 25 and 34.

¹⁰Although the grant applications and federal funds are released by fiscal year, HRSA refers to grantee spending in each of the 5 years constituting a project period as budget years. Within Part D, there are two types of grants, each of which has a slightly different budget year. For example, in 2007, one Part D budget year ran from August 1, 2007, through July 31, 2008, and another budget year ran from September 1, 2007, through August 31, 2008. The federal fiscal year is from October 1 through September 30. In its grant applications and accompanying guidances, HRSA uses the term fiscal year to refer to the period for which the grantee is funded. For this report, we follow the same practice.

applications we identified the administrative expenses and indirect costs that grantees reported to HRSA in their fiscal year 2007 applications. We also collected grantees' indirect cost rates in the survey of Part D grantees described above. Finally, we interviewed HRSA officials and reviewed relevant agency documents.

To determine how HRSA implemented the Part D administrative expense cap and grantees' views on that implementation, we interviewed representatives of 8 Part D grantees and 1 subgrantee selected as a nongeneralizable sample based on their size, location, and organizational structure. We also conducted two group interviews with representatives of 18 grantees. These grantees volunteered to participate in the group interviews conducted during an AIDS Alliance for Children, Youth & Families conference in May 2008. We also interviewed HRSA officials and reviewed relevant documents, including HRSA's technical assistance tools and training provided to grantees and project officers, as well as fiscal year 2007 and 2008 grant application guidance. See appendix I for a more detailed description of our methodology.

We conducted this performance audit from January 2008 through November 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, 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 audit objectives.

Results in Brief

Part D grantees reported in our survey that they 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. Grantees reported providing a range of services—both medical and support—to women, infants, children, and youth infected with HIV/AIDS, as well as support services for affected family members in fiscal year 2007. These services included medical services such as ambulatory health services and HIV counseling and testing, as well as support services such as transportation and child care. The majority of the 83 grantees reported that they have not made any changes to the services they provide to their clients in response to the cap. However, in our survey, 4 grantees reported increasing services and 3 reported reducing client services in response to the cap. Nevertheless, the majority of the grantees reported that the cap has had a negative effect on their 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.

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 will require 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, such as rent and utilities. 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.

Beginning in fiscal year 2007, HRSA took multiple steps to implement the administrative expense cap but, while 33 of the 83 grantees surveyed reported that HRSA's guidance on how to implement the cap was helpful, some reported difficulties in implementing the cap due to unclear guidance from HRSA. HRSA reported revising its grant application guidance, approving grants with the condition that the grantee comply with the cap, and developing training for both its staff and grantees in response to the cap. For example, in fiscal year 2007, HRSA issued grant guidance for Part D grantees that included how to define and calculate administrative expenses. HRSA also included additional revisions related to the administrative expense cap in the fiscal year 2008 grant application guidance and plans to provide grantees with further guidance in the fiscal year 2009 application. While some grantees reported that HRSA's guidance was helpful, a roughly equal number of grantees reported that it was not helpful. Some grantees also indicated a need for additional guidance on the administrative expense cap and reported that they sought such guidance from sources other than HRSA, such as the AIDS Alliance for Children, Youth & Families, in fiscal year 2007.

HHS provided technical comments on a draft of the report, which we incorporated as appropriate.

Background

RWTMA reauthorized CARE Act programs for fiscal years 2007 through 2009. Part D grants—one of the types of grants under the act—are for entities that provide HIV/AIDS services to women, infants, children, and youth. In fiscal year 2007, HRSA provided \$68,500,000 in Part D grants to 90 grantees, ranging from about \$230,000 to over \$2 million per grant. This represented about 3 percent of all CARE Act funding.

CARE Act Part D Grantees

Part D grantees compete for grant funding to provide a range of services—both medical and support—to women, infants, children, and youth in a variety of settings. Medical services are those outpatient and ambulatory care services that are part of essential medical care. They can include, for example, primary medical care and HIV/AIDS drug assistance. Support services are nonmedical services necessary to use the medical services. They can include, for example, client transportation to medical appointments, child care, or food assistance services.¹¹

Applicants generally submit applications to HRSA for 5-year project periods. Grantees receive funding for the first year and then submit annual noncompeting applications to HRSA to receive the remaining funding and to update HRSA on their projects' spending and services. Although the grant applications and federal funds are released by fiscal year, HRSA refers to grantee spending in each of the 5 years constituting a project period as budget years. Within Part D, there are two types of grants, each of which has a slightly different budget year. For example, in 2007, one Part D budget year ran from August 1, 2007, until July 31, 2008, and another budget year ran from September 1, 2007, until August 31, 2008. Because the Part D grants discussed in this report are from fiscal year 2007 funds and the grant applications and accompanying guidances use the term fiscal year, we use the term throughout this report.

Part D grantees include state and local government entities, CBOs—which may or may not be specifically focused on HIV/AIDS—hospitals and medical centers, university/college hospitals and medical centers, and universities/colleges. (See app. I for additional information.) Part D grantees can (1) operate a network of Part D subgrantees that provide services, (2) directly provide the services, or, as most do, (3) both operate

¹¹Part D grantees also provide information to their clients about opportunities to participate in HIV/AIDS-related clinical research.

a network of subgrantee service providers as well as directly provide services.

Administrative Expenses and Indirect Costs

In addition to spending Part D funds on medical and support services for clients, Part D grantees may also use their Part D grant funds to pay for certain administrative expenses and indirect costs. 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.” HRSA defines administrative expenses as “funds that are to be used by grantees for grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs.”¹²

Some expenses can be considered to be either administrative or indirect. For example, rent and utilities could be considered either administrative expenses or indirect costs. However, for a grantee to claim any expenses as indirect costs, it must have an approved indirect cost rate.¹³ Smaller organizations or ones that receive only one federal grant may not have approved indirect cost rates, but organizations that receive multiple federal grants would need to have approved rates. For example, a university that receives multiple federal grants would have an indirect cost rate to cover different grants’ shares of costs such as rent, utilities, as well as library expenses. However, a small organization that receives only one federal grant might not have an indirect cost rate since it may be able to account for all of those expenses for the single federal grant it receives. If a grantee does not have an approved indirect cost rate agreement, the grantee must charge (account for) expenses such as rent and utilities as administrative expenses in order to pay for those expenses with grant

¹²This is the definition in the CARE Act, added by RWTMA. 42 U.S.C. § 300ff-71(h)(1).

¹³See 42 U.S.C. § 300ff-71(h)(2) and <http://rates.psc.gov/>.

funds. This means that grantees with approved indirect cost rates have greater latitude than those without such rates to pay for expenses that might otherwise be considered administrative expenses as they can spend more than 10 percent of their Part D grant on expenses such as rent and utilities.

The CARE Act now caps at 10 percent the amount of the Part D grant awards that grantees can spend on administrative expenses. HRSA reports that the purpose of this cap is to maximize the amount of federal funds spent on services for Part D clients. HRSA reports that the cap only applies to grantees' administrative expenses; there is no cap on indirect costs. Prior to RWTMA, there was no cap on administrative expenses for Part D grantees.

Oversight of CARE Act Part D Grantees

HRSA project officers¹⁴ are responsible for overseeing the Part D program by reviewing grant applications; writing and revising grant application guidance; responding to grantees' questions; providing technical assistance and training to grantees; monitoring grantees' performance and compliance with grant guidance, program expectations, and legislative requirements; and recommending approval on program budget submissions. Project officers are Part D grantees' primary contact with HRSA, and they are expected to contact their assigned grantees at least once every 3 months.

Required audits assist HRSA in providing financial oversight of some Part D grantees' spending. Organizations that receive Part D grants are generally subject to the requirements of the Single Audit Act, as amended, and the implementing OMB guidance.¹⁵ These provisions require grantees that expend \$500,000 or more in federal awards in a year to have either single or program-specific audits for that year conducted by an independent auditor. Single audits are organizationwide audits, not intended to focus specifically on an individual grant awarded by a

¹⁴Roughly 30 of HRSA's project officers oversee at least one Part D grant in addition to grants made under other parts of the CARE Act.

¹⁵31 U.S.C. §§ 7501-7507; OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations* (June 27, 2003). 45 C.F.R. § 74.26. Organizations that are exempt from these requirements generally must make their records available for review by federal officials. Every 2 years grantees must also submit audits regarding funds expended to the state agency responsible for coordinating all CARE Act programs within each state. 42 U.S.C. § 300ff-71(c)(3).

particular agency. They include a review of the grantee's financial statements, schedule of federal expenditures, internal controls, and compliance with laws and regulations pertaining to major programs that affect all federal funding, including grants—defined with reference to dollar thresholds—for which the grantee expends federal funds. Generally, grantees that expend federal funds under only one federal program may choose to have a program-specific audit. Among other things, such an audit includes a review of compliance with laws and regulations that affect that program.

**Part D Grantees
Reported Providing a
Range of Services,
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That the
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Grantees reported providing a range of medical and support services to women, infants, children, and youth infected with HIV/AIDS, as well as support services for affected family members. The majority of survey respondents reported that they have not made any changes to the services they provide to their clients in response to the cap, which, according to HRSA, was meant to maximize the amount of federal funds spent on services for Part D clients. However, four grantees reported increasing services and three grantees reported reducing client services. While most grantees reported not making changes to client services, the majority reported that the administrative expense cap, by reducing administrative services, has had a negative effect on their programs. Some grantees, however, reported experiencing positive effects on their programs as a result of the cap.

Part D Grantees Reported Providing Both Support and Medical Services to Women, Infants, Children, and Youth with HIV/AIDS and Their Families

Grantees reported providing a range of medical and support services to women, infants, children, and youth infected with HIV/AIDS, as well as their families (see table 1). Survey respondents reported providing medical services¹⁶ such as outpatient and ambulatory health services, medical case management—including treatment adherence services—mental health services, and HIV counseling and testing. They also reported providing support services such as referrals to health care and supportive services, outreach services,¹⁷ transportation, family advocacy,¹⁸ case management services,¹⁹ and child care.

¹⁶In a May 2008 letter to all Part D grantees, HRSA stated that all grantees are required to provide primary medical care either directly or through contracts with Part D subgrantees. A HRSA official said that the focus of the Part D program is moving from support services to medical care. HRSA officials reported that there is no minimum amount or percentage of a Part D grant that HRSA requires grantees to spend on primary medical care.

¹⁷CARE Act outreach services help to identify persons at high risk for HIV and to bring HIV-infected persons into care. Outreach services include services to both HIV-infected persons who know their status and are not in care and HIV-infected persons who do not know their status and are not in care.

¹⁸According to HRSA, family advocacy is “the process and provision of assistance used for obtaining needed services for family members of infected individuals not to include follow-up on medical treatment.”

¹⁹Case management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. It does not involve coordination and follow-up of medical treatments as medical case management does.

Table 1: Medical and Support Services Part D Grantees Reported Providing, Fiscal Year 2007

Type of service	Grantees providing the service (of the 83 grantees that responded to our survey)
Medical services	
Outpatient and ambulatory health services	81
Medical case management, including treatment adherence services	78
Mental health services	69
HIV counseling and testing	57
Other core medical services	57
Medical nutrition therapy	38
Substance abuse outpatient care	28
Oral health care	27
AIDS pharmaceutical assistance	18
Home- and community-based health services	14
Home health care	9
Health insurance premium and cost-sharing assistance	8
Hospice services	2
Support services	
Referrals to health care/supportive services	74
Outreach services	71
Transportation	69
Family advocacy	63
Case management services	59
Child care	43
Linguistics services	34
Emergency financial assistance	23
Food bank/home-delivered meals	14
Housing services	12
Legal services	12
Respite care	11
Rehabilitation services	6

Source: GAO analysis of survey data.

Note: Eighty-three of the 90 Part D grantees responded to our survey.

Grantees reported in our survey that they spent an average of 53 percent of their fiscal year 2007 Part D grants on medical services for clients, ranging from 0 percent to 95 percent. They also reported spending an average of about 33 percent of their fiscal year 2007 Part D grants on support services for their clients, ranging from 1 percent to 90 percent. Grant money not spent on medical and support services was used to pay for administrative expenses, indirect costs, and other services not directly related to clients.

Grantees reported serving a range of clients with their Part D funds, including affected family members of HIV-infected individuals. Grantees reported serving varying numbers of clients ranging from 75 to over 10,000 clients. Of those clients, grantees reported serving an average of 37 infants less than 24 months of age; an average of 59 children from 2 to 12 years old; an average of 194 youths from 13 to 24 years old; and an average of 443 adults over 25 years of age. The number of clients served varied by type of grantee, with CBOs and universities/colleges serving fewer clients on average (667 and 554, respectively) and government entities, hospital/medical centers, and university/college hospital/medical centers serving more clients on average (1,047, 1,471, and 1,125, respectively). In addition, grantees varied in the types of clients they served. For example, several grantees had no infant or child clients, while one grantee served over 300 infants and another served over 1,100 children.

Representatives of Part D grantees, including the AIDS Alliance for Children, Youth & Families, stated that providing both HIV-infected individuals and their uninfected family members with medical and support services makes grantees of the Part D program unique compared to other CARE Act programs. Some grantees stated that this family-centered care can include educating the family members of HIV-infected individuals and providing prevention information, medical care, and HIV counseling and testing to family members. These grantees told us that by providing medical and support services to uninfected family members, Part D programs help to keep the infected family member's support system intact and help to eliminate barriers to the infected family member receiving care.

Grantees Generally Reported That the Administrative Expense Cap Has Not Changed the Services They Provide but Has Created a Negative Effect on Their Programs

The majority of survey respondents (63 of the 83) reported that they have not altered the amount or type of services that they provide to their clients in response to the administrative expense cap. In addition, all eight of the HRSA project officers we interviewed reported that they were aware of only minor or no changes to the services that their Part D grantees provided in response to the administrative expense cap. Of the 19 grantees that said they made changes to their services in response to the cap (1 grantee did not respond to this question), 4 described spending more on client services, such as oral health care. However, 3 described reducing client services. For example, 1 grantee reported that, because of the cap, the grantee has been unable to upgrade older computers, causing delays in services, and reducing staff time spent on client services.²⁰

Grantees also reported effects that the administrative expense cap had on their programs other than changes to services. In our survey, 57 of the 83 respondents reported that the administrative expense cap has had a negative effect on their programs that did not involve reducing client services. Fifty-two of the 57 provided specific examples of how the cap has had a negative effect at a time when some commented they are seeing more clients. For example, one grantee commented that the cap has reduced its ability to fund necessary administrative services, such as data tracking and program management, and another commented that clinical staff must now perform administrative duties. However, 19 grantees reported that the administrative expense cap has had positive effects on their programs, while not necessarily changing their services. These survey respondents reported that the administrative expense cap has led them to review how they spend their Part D funds or take steps to save money or change staff roles.

Some grantees reported that they were unable to pay for all of their Part D programs' administrative expenses with their Part D grants because of the administrative expense cap. Almost all grantees charged administrative expenses to their Part D grants (82 of the 83 survey respondents). However, about half (41 of the 83) of the grantees that responded to the survey reported that not all of their administrative expenses for the Part D program were covered by the 10 percent allowance. Grantees that needed additional funding to cover their Part D administrative expenses reported using money from their organizations' general operating budgets (26 of the 41 grantees), funds from other government grants (17 of the 41), and in-

²⁰The remaining 12 grantees described actions that did not affect client services.

kind donations (14 of the 41). HRSA officials told us that Part D funding is not intended to cover all of a program's expenses and that the agency encourages Part D grantees to seek other sources of funding to pay for any administrative expenses that are not covered by the 10 percent allowance.

Part D Grantees Report Planned Administrative Expenses and Indirect Costs

Part D grantees report their planned administrative expenses and indirect costs in their grant applications, budget revisions, and other documents they submit to HRSA. HRSA officials review that information to ensure that grantees adhere to their spending plans. Starting in fiscal year 2009, Part D grantees will complete standardized budget forms that will provide information to HRSA on the grantees' final spending on administrative expenses and indirect costs. Documents submitted to HRSA by grantees indicated that grantees complied with the administrative expense cap. However, responses to our survey indicate that the amount grantees spent on the types of items that would generally be covered by the administrative expense cap if a grantee did not have an approved indirect cost rate was up to 36 percent of their grants in fiscal year 2007, with grantees with approved indirect cost rates spending more on those expenses.

Part D Grantees Report Planned Administrative Expenses and Indirect Costs to HRSA but Will Provide Additional Information in Fiscal Year 2009

Part D grantees report planned administrative expenses and indirect costs to HRSA in their grant applications, which the agency uses to oversee grantees' compliance with the Part D program. Part D grantees submit grant applications to HRSA that include planned expenses in line-item budgets and budget justifications. Grantees are required to include in the grant applications explanations of how they plan to spend their Part D grant funds. They do this using line-item budgets, in which each expense is shown on one line. They also provide budget justifications, which are narratives of how the grantee plans to spend its grant money. These budgets and justifications show a range of expenses, such as the grantee's estimated expenses for medical services and support services, as well as the grantee's estimated indirect costs and—starting in fiscal year 2007, the first year of the administrative expense cap—administrative expenses for the year.

HRSA uses the budget information grantees submit to oversee their spending. Grantees must report to HRSA any changes to the budgets they submitted in their grant applications and HRSA must review and approve

those changes before a grantee can change how it spends its Part D grant funds. HRSA also receives the annual audits of Part D grantees conducted under the Single Audit Act.²¹ Among other things, these audits examine grantees' Part D spending, which may include whether the grantees comply with the administrative expense cap. HRSA officials reported that the project officers and other HRSA staff review all of the grantees' budget information to ensure that the grantees are meeting the obligations of the Part D program.

Starting in fiscal year 2009, HRSA will require Part D grantees to report more detailed information, including administrative expenses, at the beginning and end of each fiscal year. HRSA officials stated that, starting in fiscal year 2009, Part D grantees will be required to complete forms at both the beginning (planned allocation report) and end (final expenditure report) of the fiscal year.²² In the planned allocation reports, grantees will be required to report their expected administrative expenses and indirect costs at the beginning of the fiscal year. In the final expenditure reports, grantees will be required to report the actual administrative expenses and indirect costs they incurred by the end of the fiscal year. Both reports note that administrative expenses cannot exceed 10 percent of the Part D grant award. The reports will also require grantees to provide detailed information about the services they provide with their Part D funding. The reports include a list of possible Part D medical and support services—such as outpatient services, mental health services, case management, and child care—and the grantees will be required to note what amount, if any, they spent on each of those. The reports also state that HRSA will use the information from the allocation and expenditure reports to prepare an annual report to Congress on the use of Part D funds.²³

²¹According to a HRSA official, 47 of the 90 Part D grantees receive grants of less than \$500,000 from the Part D program and therefore may not meet the threshold to require a Single Audit Act audit. However, if those grantees expend additional federal funds that, combined with the Part D grants, total more than \$500,000 then they must submit to a single audit.

²²Grantees already must also include with their Part D grant application an SF-424A and submit to HRSA within 90 days of the end of the grant period an SF-269. 45 C.F.R. § 74.52. These are governmentwide standard forms developed by OMB that allow entities to submit standardized data sets to the federal government.

²³These new reports are similar to ones required of CARE Act Part A and B grantees that result in annual allocation and expenditure reports.

Grantees Reported Complying with the Administrative Expense Cap

Grantees reported to HRSA that they spent 10 percent or less of their Part D grants on administrative expenses, but those with approved indirect cost rates were able to spend more on the types of expenses that could otherwise be considered administrative expenses. In the fiscal year 2007 grant applications, grantees reported administrative expense estimates that ranged from 0 to the maximum allowed 10 percent. However, 60 of the 83 grantees reported in our survey that they had federally approved indirect cost rates²⁴ and that, with these rates, they charged to their Part D grants an average of 10 percent for indirect costs in addition to the 10 percent allowed for administrative expenses. In our survey, the highest rate grantees reported charging to the Part D grant was 26 percent, although the maximum approved indirect cost rate was 66 percent.²⁵ Taking into account the maximum approved indirect cost rate in our survey, as well as the 10 percent that all grantees are allowed for administrative expenses, some grantees could use as much as 76 percent of their Part D grants to pay for items that could qualify as indirect costs or administrative expenses, such as rent, utilities, and photocopying.²⁶ In our survey, while most of the grantees reported using their full rate for the Part D program (46 of the 60), the highest reported combined percentage of a Part D grant spent on administrative expenses and indirect costs was 36 percent. The primary reason grantees reported for not charging their full indirect cost rate was because they chose to use a greater portion of their grant award to pay for medical and support services for clients, rather than for indirect costs.

²⁴Over 90 percent of the grantees that are universities/colleges (17 of the 18) and university/college hospitals/medical centers (10 of the 11) reported having approved indirect cost rates. CBOs were least likely to have indirect cost rates, with 52 percent of such grantees (14 of the 27) reporting having an approved rate. Grantees that are government entities reported the lowest average indirect cost rate of around 15 percent, while those that are hospital/medical centers reported the highest average indirect cost rate of 33 percent and included the institution with the highest rate, at 66 percent.

²⁵In our survey, grantees reported that their approved indirect cost rates ranged from 5 to 66 percent, with an average of around 22 percent.

²⁶Grantees with indirect cost rates can pay for expenses such as rent and utilities as indirect costs and pay for other items, such as administrative personnel and office supplies, as administrative expenses under Part D. Grantees without indirect cost rates may only charge such expenses as administrative expenses.

HRSA Took Multiple Steps to Implement the Administrative Expense Cap, but Grantees' Experiences Implementing the Cap Varied

To implement the fiscal year 2007 administrative expense cap, HRSA reported revising its grant application guidance, approving grants with the condition that the grantee comply with the cap, and developing training for both its staff and grantees to implement the administrative expense cap. While 33 of the 83 grantees reported that the new guidance was helpful, others suggested that their project officers could have been more helpful in assisting them to meet the new administrative expense cap and some grantees expressed interest in receiving additional guidance.

HRSA Took Multiple Steps to Implement the Administrative Expense Cap

To implement the administrative expense cap, HRSA revised and issued new written grant application guidance, approved grants with the condition that the grantee comply with the cap, and developed training for both its staff and grantees.

HRSA Revised the Part D Grant Guidance to Reflect the Administrative Expense Cap

To implement the administrative expense cap, HRSA revised its Part D grant application guidance. In 2007, the first year of the administrative expense cap, HRSA issued grant guidance for Part D grantees that included guidance on how to define and calculate administrative expenses. Prior to RWTMA, there was no cap on Part D grantees' administrative expenses so there was no guidance on administrative expenses specific to Part D grantees. The fiscal year 2007 grant application guidance stated that "a grantee may not use more than 10 percent of amounts received under a grant award under Part D for administrative expenses." That guidance also defined administrative expenses as the CARE Act does as "funds that are to be used by grantees for grant management and monitoring activities, including costs related to any staff or activity unrelated to services and indirect costs."

HRSA included additional revisions related to the administrative expense cap in the fiscal year 2008 grant application guidance and plans to provide grantees with further guidance in the fiscal year 2009 application. In fiscal year 2008, HRSA added the following sentences to its definition of administrative expenses in its Part D grant application guidance: "Administrative costs also include rent, utilities and telephone services, as well as other costs not directly related to patient care. Administrative expenses are separate from those of indirect costs." HRSA officials reported that the fiscal year 2009 grant guidance will be further revised to

include more detail about how grantees should categorize their expenses, including administrative expenses. HRSA officials stated that the fiscal year 2009 grant guidance will be available to grantees in January 2009.

In addition to the revised grant application guidance, HRSA issued a letter to all Part D grantees in May 2008 clarifying the definition of administrative expenses that appeared in the fiscal year 2008 guidance. The letter stated that the following are administrative expenses that are subject to the administrative expense cap: routine grant administration and monitoring activities, contracts for services awarded as part of the grant, and “costs which could qualify as either indirect or direct costs but are charged as direct costs,” such as rent, utilities, and telecommunications. The letter also described activities that are not subject to the administrative expense cap, such as indirect costs.

HRSA Conditionally Approved Fiscal Year 2007 Part D Grants to Ensure Compliance with the Administrative Expense Cap

HRSA officials reported that they placed conditions²⁷ on all fiscal year 2007 Part D grant awards to ensure that all grantees met certain new requirements mandated in RWTMA, including the administrative expense cap, in order to avoid having their grant funds restricted. Some grantees reported that HRSA’s conditions required them to revise multiple documents, such as their budgets and work plans, in order to comply with the Part D program requirements. HRSA officials reported that, before they awarded the fiscal year 2008 grants, they had removed the conditions on all fiscal year 2007 Part D grant awards because the grantees had met all of the necessary requirements for the Part D grant awards, including the administrative expense cap. The amount of time grantees reported having conditions on their awards varied. In their survey responses, grantees reported that it took from over 2 weeks to almost 11 months to have the conditions removed.

HRSA Trained Project Officers and Grantees about the Administrative Expense Cap

Following the enactment of RWTMA, HRSA provided its project officers and grantees with training on the changes resulting from the law. The training for project officers included briefing slides, a handout highlighting changes due to RWTMA, the creation of a model budget form, and additional guidance for responding to grantee questions about the administrative expense cap. The eight project officers we interviewed

²⁷HRSA places conditions on a grant award when the agency decides to only conditionally approve a grantee’s application. To remove the condition, a grantee must submit revised or additional information to HRSA, such as a revised budget. Failure to submit this information could result in HRSA restricting the grantee’s funds or denying the grantee future funding.

reported receiving the training, consistently defining administrative expenses as they are defined by HRSA, and rarely requiring their supervisors to provide additional guidance to their grantees on administrative expenses. In addition to training the project officers, HRSA provided training for grantees. HRSA officials reported conducting multiple telephone and Internet technical assistance training sessions with grantees.

Grantees' Experiences with the HRSA Guidance Implementing the Administrative Expense Cap Varied

In our survey, grantees reported both positive and negative reviews of the guidance HRSA provided related to the administrative expense cap. In addition, some grantees indicated the need for additional guidance from HRSA on the administrative expense cap.

Grantees Reported Both Positive and Negative Reactions to HRSA's Grant Guidance

Grantees reported receiving various types of guidance from HRSA on the administrative expense cap. In addition to the grant application guidance that is included in the grant application that all grantees must complete, grantees that responded to our survey reported receiving verbal (63 of 83) and written (43 of 83) guidance from their project officers on the administrative expense cap. Fewer reported receiving technical assistance (6 of 83) and verbal (13 of 83) and written (19 of 83) guidance from other HRSA officials.

Some grantees reported that HRSA's guidance was helpful when implementing the administrative expense cap. Specifically, 33 of 83 grantees reported that the guidance on administrative expenses was very or somewhat helpful.²⁸ In written comments on the survey, grantees that reported that HRSA's guidance was helpful commented that the guidance made clear how to categorize expenses, their project officers could answer any questions, and what was required of the grantees to comply with the cap was clear. We also heard similar comments during our interviews. For example, one grantee reported that its project officer provided specific advice and was very helpful and explicit, speaking with the grantee daily when necessary. Another grantee stated that its project officer was "knowledgeable and helpful."

²⁸Universities/colleges had the highest percentage of grantees reporting that the guidance was helpful compared to other types of organizations, with 11 of the 18 reporting that the guidance was very or somewhat helpful. Twenty grantees reported that they were either neutral on the guidance or had no basis to judge the guidance.

Some grantees, however, reported that HRSA’s guidance was not helpful when implementing the administrative expense cap. Thirty of the 83 survey respondents reported that they found the guidance not at all helpful or somewhat unhelpful. In written comments on the survey, grantees that reported that HRSA’s guidance was unhelpful commented that the guidance did not provide clear definitions of allowable expenses and that the guidance was unclear or poorly written. Twelve of the 30 commented that they had received conflicting guidance from HRSA. Five of the grantees commented that the project officers could not answer questions or provide explanations regarding the grant application guidance or that the project officers provided different information to different grantees. A poll of the group interview participants showed that none thought that either the formal guidance or the informal guidance, such as guidance from project officers, was adequate.

Some Grantees Indicated a Need for Additional Guidance on the Administrative Expense Cap, and HRSA Officials Reported Revising the Guidance in Response to Feedback

Some grantees reported seeking more detailed guidance about what should be considered an administrative expense. For example, during the group interviews, an official from one grantee stated that she would like to receive a list of approved administrative expenses from HRSA. In an interview with an official of a grantee, the official reported that there are “several gray areas” between what is considered an administrative expense and an indirect cost and HRSA had provided few definitions of those expenses. In addition, 16 of the 83 survey respondents sought guidance from sources other than HRSA on administrative expenses and the cap, such as from the AIDS Alliance for Children, Youth & Families.

HRSA officials reported that the agency has received feedback from grantees about the grant application guidance and has worked to improve the guidance each year. These officials explained that the agency’s latitude is somewhat limited when revising the grant guidance. One official explained that the agency does not have complete control over the Part D guidance because all HRSA grant applications and guidance must follow a standard template. Moreover, one official stated that grantees often do not carefully read the guidance. Officials stated that in response to questions about the grant application guidance, project officers will often refer grantees back to the grant application guidance and might not provide additional clarification to ensure fairness in the application process by not providing existing grantees with information unavailable to new applicants.

Agency Comments

HHS provided technical comments on a draft of the report, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and the Administrator of HRSA. This report also is available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me on (202) 512-7114 or crossem@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

A handwritten signature in black ink that reads "Marcia Crosse". The signature is written in a cursive style with a long horizontal line extending to the right.

Marcia Crosse
Director, Health Care

Appendix I: Scope and Methodology

We examined the administrative expense cap, which took effect in fiscal year 2007, placed on grants for family-centered medical and support services for women, infants, children, and youth with HIV/AIDS and their families (Part D grants) under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act).¹ Specifically, we examined (1) the services that Part D grantees provide and what effect, if any, the administrative expense cap has had on those services and on grantee programs; (2) how Part D grantees report on administrative expenses, indirect costs, and compliance with the administrative expense cap; and (3) how the Department of Health and Human Services' Health Resources and Services Administration (HRSA) implemented the Part D administrative expense cap and grantees' views on that implementation.

To determine what services Part D grantees provide and what effect the administrative expense cap has had on those services; how Part D grantees report on administrative expenses, indirect costs, and compliance with the administrative expense cap; and how HRSA has implemented the Part D administrative expense cap, we analyzed data from our Web-based survey sent to all 90 Part D grantees. We obtained the e-mail addresses and the names of grantee contacts from HRSA. The survey contained questions on grantees' services and clients, administrative expenses and indirect costs, and HRSA's implementation of the administrative expense cap. The questions focused on changes that occurred in fiscal year 2007, the first year the administrative expense cap was in effect. Fiscal year 2007 was the only full year of information we were able to obtain from grantees. Because the Part D grants are generally awarded in August of each year—the beginning of what HRSA officials refer to as the budget year—a full year of information was not available for fiscal year 2008. Of the 90 Part D grantees, 83 completed the survey for a 92 percent response rate (see table 2).

¹Pub. L. No. 101-381, 104 Stat. 576 (codified as amended at 42 U.S.C. §§ 300ff through 300ff-121). Unless otherwise indicated, references to the CARE Act are to current law.

Table 2: Types of Organizations That Responded to the Survey

Organization type	Number responding
Community-based organization	27
Government entity	13
Hospital/medical center	14
University/college hospital/medical center	18
University/college	11
Total	83

Source: GAO analysis of survey data.

Note: Eighty-three of the 90 Part D grantees responded to our survey.

During the development of our survey, we pretested it with three Part D grantees from New York, Washington, D.C., and Maryland. We opened the survey on May 14, 2008. During the course of the survey, we sent two follow-up e-mails to each nonrespondent and then made telephone follow-up calls to remaining nonrespondents to address any problems they had and to encourage them to complete the survey. We closed the survey on July 10, 2008. Because this survey was conducted with all of the Part D grantees, it is not subject to sampling error. However, the practical difficulties of conducting any survey may introduce other errors. For example, difficulties in interpreting a particular question or sources of information available to respondents can introduce unwanted variability or bias into the survey results. We took steps to minimize such nonsampling errors in developing the questionnaire and collecting and analyzing the data. While the response rate of 92 percent is high, if those not responding differed materially from those responding on any particular question we analyzed, our analysis may not accurately represent the group surveyed. Our results therefore best represent only those responding to our survey. However, given our analysis of the nonresponders, we determined that we could generalize our findings to all Part D grantees.

To obtain information on grantees' fiscal year 2007 spending, including administrative expenses and indirect costs, we reviewed the grantees' 2007 Part D grant applications that contain their proposed budgets. Because the Part D grant applications did not contain standardized spending information that met our reporting objectives, we also included questions in the survey on grantees' fiscal year 2007 Part D spending.

To gain further information on Part D grantees and the administrative expense cap, we visited two Part D grantees and one Part D subgrantee in the Washington, D.C., metropolitan area and conducted telephone interviews with officials from six Part D grantees. We selected the grantees for visits and interviews through a nongeneralizable sample based on their size, location, and organizational structure. We also conducted two group interviews held at the AIDS Alliance for Children, Youth & Families conference in May 2008. The 18 grantees that participated were self-selected volunteers representing universities, hospitals, community-based organizations, and government entities.

To determine how HRSA has implemented the Part D administrative expense cap, we interviewed HRSA officials and reviewed relevant documents. We interviewed HRSA officials responsible for overseeing the Part D program. We also conducted one-on-one interviews with 8 of the approximately 30 project officers who oversee at least one Part D grant.² These project officers write program guidance that defines the grant program objectives, monitor grantees' performance, and evaluate grantee achievements. We selected the 8 project officers based on unbiased selection criteria by project officers' service areas. We excluded project officers who were hired in 2008 because those officers did not oversee grantees during the entire first year of the administrative expense cap. Finally, we reviewed HRSA's technical assistance tools and training provided to grantee staff and project officers, including fiscal years 2007 and 2008 grant application guidance, and reviewed Part D fiscal year 2007 grant applications. We did not consider how HRSA's treatment of administrative expenses differed from other programs.

We conducted this performance audit from January 2008 through November 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, 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 audit objectives.

²During the course of our audit work, because some project officers resigned or were reassigned, the number of project officers overseeing at least one Part D grant fluctuated between 25 and 34.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Marcia Crosse, (202) 512-7114 or crossem@gao.gov

Acknowledgments

In addition to the contact named above, Tom Conahan, Assistant Director; Stefanie A. Bzdusek; Shaunessye Curry; Kelly L. DeMots; Cathy Hamann; Christopher Howard; Martha Kelly; and Eden Savino made key contributions to this report.

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