

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE CORE MEDICAL SERVICES
REQUIREMENT IN THE RYAN
WHITE PROGRAM**



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OBJECTIVE

1. To determine the extent to which Ryan White grantees expended grant funds on core medical services, as required.
2. To describe effects of the core medical services requirement on grantee operations.
3. To assess the Health Resources and Services Administration's (HRSA) guidance on and project officers' oversight of the core medical services requirement.

BACKGROUND

Enacted in 1990, the Ryan White CARE Act (the Act), as amended, established the Ryan White program to provide funding to grantees to develop, organize, coordinate, and operate effective and cost-efficient health care and support services for people with HIV and AIDS. Administered by HRSA, the Ryan White program had a budget of \$2.1 billion in 2008.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 changed how Ryan White funds may be used, emphasizing life-saving and life-extending services for people living with HIV/AIDS. A key change made by this law provided more funds for direct health care services for Ryan White clients and established a requirement that certain grantees spend at least 75 percent of awarded grant funds on core medical services unless they receive waivers of this requirement. The requirement went into effect in 2007. Section 703 of the law repealed the entire Ryan White program effective October 1, 2009, unless it is again reauthorized. In late 2009, Congress was holding hearings on reauthorization of the program.

Ryan White grantees must submit financial and performance reports throughout the grant period, and each grantee is assigned a HRSA project officer to oversee and assist with the proper use of grant funds.

This evaluation is based on grantee interviews, grantee expenditure and allocation information, project officer interviews, and a review of HRSA guidance.

FINDINGS

Almost all grantees complied with the core medical services requirement; grantee expenditures for core medical services changed little from 2006 to 2007.

Ninety-six percent of Part A grantees complied with the requirement in 2007, and 98 percent allocated their grant funds in compliance with the requirement in 2008. All Part B and Part C grantees were in compliance with the requirement based on 2007 expenditure and 2008 allocation reports. Even though grantee expenditures on core medical services changed little from 2006 to 2007, 55 of the 92 grantees responding to the question reported that they could better serve the goals of their programs and meet the needs of their clients if more flexibility were built into the requirement (e.g., more local control over funding, options to adjust the percentage spent on core medical services). Additionally, 71 of the 121 grantees that responded to the question provided suggestions for Congress to consider during the next reauthorization.

The core medical services requirement affected support services and administrative processes for some grantees.

When compared to Part B and C grantees, a higher percentage of Part A grantees reported that the core medical services requirement had a significant effect on support services provided to their clients. When asked, 14 percent of all grantees reported that the core medical services requirement increased their administrative burden.

HRSA guidance was helpful, but project officer turnover created program management difficulties.

Of the 81 percent of grantees that received guidance from HRSA, 95 percent found HRSA guidance helpful. However, 71 percent of grantees reported experiencing project officer turnover in recent years that created program management difficulties. Further, OIG found that issues with project officer oversight continue to cause vulnerabilities within the Ryan White program.

CONCLUSION

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 emphasized providing funds for direct health care services for people living with HIV/AIDS by establishing a requirement that certain grantees spend at least 75 percent of their grant funds on core medical services. OIG found that, overall, those grantees complied with the core medical services requirement in 2007 and allocated their funds in compliance with the requirement in 2008. There was little change in

grantee spending on core medical services after the requirement went into effect. However, some grantees reported that the core medical services requirement affected their delivery of support services and increased their administrative burden. Further, when asked, just over half of the grantees we interviewed would welcome the opportunity to provide input as Congress considers reauthorization of the Ryan White program in 2009. Lastly, while over 90 percent of grantees found HRSA guidance helpful, OIG found that project officer oversight continues to be a vulnerability in the Ryan White program.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HRSA concurred with our findings. Regarding the finding pertaining to turnover among project officers affecting oversight of grantees, HRSA further commented that it has lost a number of experienced project officers in recent years, and is currently hiring new staff. HRSA also noted that in response to the complex requirements mandated by the Act, impending reauthorization of the Act, and the influx of new project officers, it will be intensifying training in the coming weeks. We did not make any changes in response to HRSA's comments.



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BACKGROUND

Enacted in 1990, the Ryan White CARE Act (the Act), as amended, established the Ryan White grant program to provide funding to develop, organize, coordinate, and operate effective and cost-efficient health care and support services to people with HIV and AIDS. Administered by HRSA, the Ryan White program is the largest federally funded program dedicated to providing services to people with HIV/AIDS, with funding of \$2.1 billion in 2008.¹ The Ryan White program serves nearly half a million people annually.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006, the most recent reauthorization of the Ryan White program, changed how Ryan White funds may be used, emphasizing life-saving and life-extending services for people living with HIV/AIDS. A key change made by this law established a requirement that certain grantees spend at least 75 percent of awarded grant funds on core medical services unless they receive waivers of this requirement.² Examples of core medical services include outpatient health services, home health care, mental health services, and medications. Section 703 of the law repealed the entire Ryan White program effective October 1, 2009, unless it is again reauthorized.³ In late 2009, Congress was holding hearings on reauthorization of the program.

¹ HIV/AIDS Policy Fact Sheet, "The Ryan White Program." The Henry J. Kaiser Family Foundation, June 2008. Available online at <http://hab.hrsa.gov/reports/funding.htm>. Accessed on June 30, 2009.

² The 2006 reauthorization also renamed various Titles of the Act: Title I became Part A, Title II became Part B, and Title III became Part C.

³ Ryan White HIV/AIDS Treatment Modernization Act of 2006, P.L. No. 109-415 (Dec. 19, 2006).

I N T R O D U C T I O N

The Act is divided into six parts, and the core medical services requirement applies to funds provided under Parts A, B, and C; the majority of Ryan White grant funds are allocated to these three parts. Grants and grantees are referred to based on the part of the Act under which their grants are awarded; for example, an organization receiving a grant under Part A of the Act would be referred to as a Part A grantee. Part A grants are awarded to metropolitan areas for HIV-related services. Part B base grants, along with supplemental funds, are awarded to States and Territories to improve the quality, availability, and organization of health care and support services.⁴ Finally, Part C Early Intervention Services (EIS) grants are made to public and private nonprofit organizations to fund comprehensive primary health care in an outpatient setting for people living with HIV.⁵

Core Medical Services Requirement

The 2006 reauthorization of the Act established a requirement that Parts A, B, and C grantees spend at least 75 percent of their funds, after deducting funds for administration and quality management services, on core medical services (hereinafter referred to as the requirement).⁶ Grantees may seek waivers of the requirement under circumstances specified by statute.

⁴ Many of the supplemental funds associated with Part B grants are earmarked for the AIDS Drug Assistance Program (ADAP). ADAP provides medications for the treatment of HIV. States may also use ADAP program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. HRSA, “Part B: Grants to States and Territories.” Available online at <http://www.hab.hrsa.gov/treatmentmodernization/partb.htm#ADAP>. Accessed on July 14, 2009.

⁵ Part C includes two categories of grants: EIS grants, which fund comprehensive primary health care in an outpatient setting; and Planning and Capacity Development grants, which support organizations in planning for service delivery and in building capacity to provide services.

⁶ Sections 2604(c), 2612(b), 2620(e), and 2651(c) of the Act (42 U.S.C. §§ 300ff-14(c), 300ff-22(b), 300ff-29a(e), and 300ff-51(c)).

I N T R O D U C T I O N

The requirement applies to the formula funding, most supplemental funding,⁷ and Minority AIDS Initiative (MAI) funding received by Parts A, B, and C grantees.⁸ The requirement also applies to most funding awarded under Part C, including MAI grants.⁹

The core medical services specified in the Act are:

- outpatient and ambulatory health services;
- pharmaceutical assistance, including medications provided through ADAP;
- oral health care;
- early intervention services;
- health insurance premium and cost-sharing assistance for low-income individuals;
- home health care;
- medical nutrition therapy;
- hospice services;
- home and community-based health services;
- mental health services;
- outpatient substance abuse care; and
- medical case management, including treatment adherence services.¹⁰

⁷ The core medical services requirement does not apply to the supplemental grants awarded under Part B for Emerging Communities. Section 2621 of the Act (42 U.S.C. § 300ff-30a); “HRSA HIV Care Grant Program Part B Program Guidance, FY 2008,” p. 38 (November 30, 2007).

⁸ HRSA awards MAI grants to Parts A, B, C, D, and F grantees through a competitive process. The goal of these grants is to reduce HIV-related health disparities among minority populations. Section 2693 of the Act (42 U.S.C. § 300ff-121). When a Part A, B, or C grantee receives MAI funding, the requirement applies to the total combined award. HRSA Announcement No. 07-135, Part A Minority AIDS Initiative Grant Program, “Application Guidance for New Competing Discretionary Grants, 2007.” HRSA Announcement No. HRSA 5-H3M-08-001, Part A Minority AIDS Initiative Grant Program, “Non-Competing Continuation Discretionary Grants, 2008.” HRSA Announcement No. 07-136, Part B Minority AIDS Initiative Grant Program, “Application Guidance for New Competing Discretionary Grants, 2007.” HRSA Announcement No. HRSA 5-G24-08-001, Part B Minority AIDS Initiative Grant Program, “Non-Competing Continuation Discretionary Grants, 2008.”

⁹ Only Part C EIS grantees are subject to the core medical services requirement. Hereinafter, we refer to Part C EIS grantees as simply Part C grantees. HRSA Announcement No. 5-H76-07-002, “Ryan White Title III: Categorical Grant Program for Outpatient EIS, Non-Competing Continuation Application, 2007.” HRSA Announcement No. 5-H76-08-001, “Ryan White Part C (Title III): Categorical Grant Program for Outpatient EIS, Non-Competing Continuation Application, 2008.”

¹⁰ Sections 2604(c)(3), 2612(b)(3), 2620(e), and 2651(c)(3) (42 U.S.C. §§ 300ff-14(c)(3), 300ff-22(b)(3), 300ff-29a(e), and 300ff-51(c)(3)).

Grantees may spend up to 25 percent of their Ryan White grant funds on support services needed for individuals with HIV/AIDS to achieve their desired medical outcomes (e.g., outreach, medical transportation, linguistic services, respite care, and referrals for health care and support services).

Grantees may apply on an annual basis for waivers, which allow them to spend less than 75 percent of their Ryan White grant funds on core medical services. To qualify for a waiver, there must be no ADAP waiting list in the grantee's State and core medical services must be available to all individuals identified and eligible to receive services under the Act.¹¹ Grantees applying for waivers in grant years 2007 and 2008 self-certified that they met these requirements.¹²

According to HRSA, 5 of the 56 Part A grantees and 3 of the 59 Part B grantees received waivers of the requirement for the 2007 funding cycle. For the 2008 funding cycle, 5 of the 56 Part A grantees were granted waivers, 3 of which also received waivers in 2007. No Part C grantees have applied for waivers. To date, HRSA has approved all requests for waivers.

HRSA Grantee Oversight

HRSA requires Ryan White grantees to submit reports throughout the grant period, including performance reports and financial reports at the end of each annual grant period.¹³ HRSA also requires grantees to submit a number of standardized reports annually on clients, services provided, and expenditures. These reports are important for determining grantees' compliance with the requirement.¹⁴

HRSA project officers have primary responsibility for overseeing grantees. Each grantee is assigned a project officer to oversee and assist with the proper use of grant funds. Project officers use grantees'

¹¹ Sections 2604(c)(2), 2612(b)(2), 2620(e), and 2651(c)(2) (42 U.S.C. §§ 300ff-14(c)(2), 300ff-22(b)(2)), 300ff-29a(e), and 300ff-51(c)(2)). Some States have more people needing medications than their ADAP funding can provide for; these States have had to institute waiting lists of people needing medications.

¹² FY 2007 Interim Waiver Eligibility Guidance; 72 Fed. Reg. 66181 (November 27, 2007); 73 Fed. Reg. 33097 (June 22, 2008).

¹³ Requirements for grantees to submit performance and financial reports are found at 45 CFR §§ 92.40(b)(1) and 92.41(b)(3) (for governmental grantees) and 45 CFR §§ 74.51(b) and 74.52 (for nongovernmental grantees).

¹⁴ Grantees receiving ADAP funds must submit the quarterly ADAP report; MAI funds are included on the allocation and expenditure reports.

performance and financial reports to determine compliance with spending requirements. Project officers also give feedback in response to grantees' reports, including acknowledging receipt of the documents, providing clarifying information, and asking grantees to make any necessary budget revisions.

Previous Office of Inspector General Work

A previous Office of Inspector General (OIG) report found that 53 percent of Titles I and II (now known as Parts A and B) Ryan White expenditures in 1992 were for medical services and pharmaceuticals.¹⁵ In 2004, an OIG report found that project officers were not adequately monitoring the Ryan White grantees studied and that HRSA provided little support to its project officers.¹⁶ OIG made recommendations to improve the monitoring of Ryan White grantees, including: specifying and enforcing standards and guidelines for how project officers should monitor grantees; addressing ongoing training for project officers; standardizing a corrective action process and addressing grantee issues more formally; increasing frequency and comprehensiveness of site visits; and improving project officer continuity. HRSA agreed to make changes in its monitoring of grantees in response to those recommendations.

In May 2008, HRSA informed OIG that it had taken a variety of steps to implement the recommendations. These steps included enhancing training for project officers, developing a site visit protocol for onsite monitoring, and increasing the number of grantee site visits. Additionally, HRSA reported that it has consolidated its grants management offices, relocated all Title II (Part B) monitoring responsibilities from regional offices to headquarters, and redefined the Office of Field Operations as the Office of Performance Review.¹⁷

METHODOLOGY

We limited our grantee population for this study to grantees located in the 50 States, the District of Columbia, and Puerto Rico. This

¹⁵ "The Ryan White Care Act: Fiscal Year (FY) 1992 Title I and Title II Expenditures," OEI-05-93-00331, April 1994.

¹⁶ "Monitoring of Ryan White CARE Act Title I and Title II Grantees," OEI-02-01-00640, March 2004.

¹⁷ "Compendium of Unimplemented Office of Inspector General Recommendations," Department of Health and Human Services OIG, May 2009, p. 87.

population included all 56 Part A grantees, 52 of 59 Part B grantees, and 361 of the 363 Part C grantees. Our sample consisted of all 56 Part A grantees, all 52 Part B grantees, and a simple random sample of 90 of 361 Part C grantees. This study also included all HRSA-identified project officers responsible for working with the Ryan White Parts A, B, and C grantees. We requested responses to a structured interview guide from all Part A, all Part B, and sampled Part C grant officials through in-person interviews, telephone interviews, or email. For all grantees included in this study, we requested, in writing, the grantees' expenditures for FYs 2006 and 2007 and their allocated expenditures for FY 2008.¹⁸ We also sent an electronic structured survey to all HRSA-identified project officers. Additionally, we reviewed HRSA-developed guidance documents.

Grantee Interviews

We requested responses to a structured interview guide from all Part A, all Part B, and sampled Part C grant officials responsible for administering each of the Ryan White grants. In their responses, grantees provided us with information regarding their experiences with the core medical services requirement and any changes in operations resulting from the requirement. Grantee responses also provided information regarding why they did or did not apply for waivers and about their guidance and oversight experiences with HRSA. Grantee response rates were 98 percent for Part A grantees (55/56), 85 percent for Part B grantees (44/52), and 80 percent for Part C grantees (72/90).

Grantee Expenditure and Allocation Report Review

We requested that all Part A, all Part B, and sampled Part C grant officials complete a form to provide us with Ryan White grant expenditures for 2006 and 2007 and allocated expenditures for 2008.¹⁹ We analyzed the information provided to determine whether each grantee complied with the requirement in 2007 and whether each allocated at least 75 percent of its 2008 funds to core medical services,

¹⁸ We requested information on grantees' total Ryan White funds, including their Parts A, B, and C base grants and any supplemental funding, such as ADAP or MAI funding they received in each year.

¹⁹ The grant year for Part A and Part C funds is March 1 to February 28; for Part B funds, April 1 to March 31; and for Part F funds, August 1 to July 31. We requested that grantees provide expenditures and allocations for the 2006, 2007, and 2008 grant years for Parts A, B, and C grants.

after deducting funds for administration and quality management.²⁰ We also analyzed the information provided to determine whether and how grantee expenditures on core medical and support services changed from 2006, prior to the implementation of the requirement, to 2007 and 2008. Rates of response to our request for grantee expenditures in 2006 and 2007 and allocated expenditures in 2008 varied among Part A, Part B, and Part C grantees; see Table 1.

Table 1: Percentage of Grantees Responding to Requests for Expenditure and Allocation Information

Grantee Type	Expenditure Information		Allocation Information
	2006	2007	2008
Part A	89.9	98.2	98.2
Part B	86.5	86.5	86.5
Part C	78.9	81.1	78.9

Source: OIG analysis of grantee expenditure and allocation information.

HRSA Project Officer Interviews and HRSA Guidance Review

We reviewed HRSA-developed guidance regarding Ryan White grant requirements. We also requested responses to a structured interview guide from all 42 HRSA Ryan White project officers for Parts A, B, and C grants in early 2009. The interviews included questions about the training and guidance project officers received, project officers’ interactions with grantees, project officers’ oversight of grantees, implementation of the requirement, and waivers of the requirement. The project officer interview response rate was 100 percent.

Limitations

This evaluation did not assess the accuracy of expenditure and allocation information provided by grant officials. We also did not determine grantees’ compliance with HRSA’s policies and practices used to oversee grantees.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” approved by the Council of the Inspectors General on Integrity and Efficiency.

²⁰ Because data collection occurred during FY 2008, final expenditure reports were not yet available.

► FINDINGS

Almost all grantees complied with the core medical services requirement; grantee expenditures for core medical services changed little from 2006 to 2007

Overall, Parts A, B, and C grantees collectively spent an average of 93 percent of their Ryan White grant funds on core medical services in 2007. Part A

grantees' average spending on core medical services in 2007 and their allocated expenditures in 2008 were 82 percent. Part B and Part C grantees each had average spending on core medical services in 2007 of 94 and 95 percent, respectively; their allocated expenditures for core medical services in 2008 were both 94 percent. The five Part A and three Part B grantees that received waivers of the requirement spent between 54 and 99 percent of their grant funds on core medical services. Point estimates and confidence intervals for selected statistics are presented in Appendix A. Appendix B shows that the proportion of funds devoted to core medical service categories changed little from 2006 to 2008.

Overall, Parts A, B, and C grantees complied with the core medical services requirement in 2007 and 2008

Ninety-six percent of Part A grantees complied with the requirement in 2007, and 98 percent allocated their grant funds in compliance with the requirement in 2008. The two grantees that did not have waivers and spent less than 75 percent on core medical services in 2007 spent 71.0 and 73.9 percent, respectively.²¹ At the time of our review, only one grantee expected to spend less than 75 percent of its grant funds on core medical services in 2008.²² All Part B and Part C grantees were in compliance with the requirement based on 2007 expenditure reports and 2008 allocation reports.²³

²¹ These grantees reported that difficulties with midyear implementation and budget changes contributed to their noncompliance with the requirement. HRSA project officers reported that they anticipated that these two grantees would comply with the requirement in 2008.

²² One Part A grantee allocated only 69.0 percent of its grant funds to the core medical services in 2008. However, at the time of our data collection, 2008 final expenditure reports were not due. Therefore, we cannot report how grantees actually spent their funds in 2008.

²³ While all 71 responding Part C grantees were in compliance with the core medical services requirement, we estimate with 95-percent statistical confidence that between 94.1 and 100 percent of all Part C grantees were in compliance in 2007 and between 95.9 and 100 percent of all Part C grantees were in compliance in 2008.

Parts A, B, and C grantees' expenditures for core medical services changed little from 2006 to 2007

Our analysis of grantees' 2006 expenditures showed that they were already spending a high proportion of their grant funds on core medical services prior to implementation of the requirement. From 2006 to 2007, Part A grantees' average spending on core medical services changed from 74 percent to 82 percent, Part B grantees' average spending changed from 95 percent to 94 percent, and Part C grantees' average spending remained at 95 percent.²⁴

Even though there was little change in grantee spending on core medical services, 55 of the 92 grantees that responded to the question reported that they could better serve the goals of their program and meet the needs of their clients if more flexibility were built into the requirement (e.g., more local control over funding, options to adjust the percentage spent on core medical services). Further, when asked, 71 of the 121 grantees that responded to the question provided suggestions for Congress to consider during the next reauthorization.²⁵

The most common suggestions included: expanding the definitions of the core medical service categories to include case management, inpatient substance abuse treatment, and transportation; and seeking provider and consumer input during the next reauthorization. One grantee stated, "The distribution of funds formula should be reconsidered, including those [living] with HIV as well as those [diagnosed] with AIDS, as the trend of the epidemic is that people with HIV are surviving and improving." Another grantee offered that "... during [the] last reauthorization, there was very little chance for communities and consumers to provide input. [We] encourage Congress to provide more opportunities for input from people who use and run the program."

²⁴ These estimates are based on grantee-reported expenditure information.

²⁵ Because of the low rates of response to these interview questions, we could not project the number of grantees in the population that reported that they could better serve the goals of their programs and meet the needs of their clients if more flexibility were built into the requirement or that provided suggestions for Congress to consider during the next reauthorization.

The core medical services requirement affected support services and administrative processes for some grantees

The circumstances of individual grantees and their clients’ needs played a role in the degree to which

the requirement affected their programs. Part A grantees reported that the requirement had a significant effect on the provision of support services to their clients more often than Part B or C grantees. Although Parts A, B, and C grantees rated implementing the requirement as easy, they also indicated that the requirement and other changes established in the reauthorization created additional burdens on administrative practices.

The core medical services requirement affected the delivery of support services for 27 percent of Part A grantees, 7 percent of Part B grantees, and 1 percent of Part C grantees

Twenty-seven percent of Part A grantees reported that the requirement had a significant effect on support services provided to their clients, compared to only 7 percent of Part B and 1 percent of Part C grantees. Because the requirement imposed a minimum percentage for spending on core medical services and a maximum percentage for spending on support services, grantees that devoted a greater percentage of their funds to support services either made greater changes to how they spent their grant funds and the services they provided to clients or sought waivers of the core medical services requirement.

One Part A grantee reported that the limitations placed on how Ryan White funds could be spent reduced funding for transportation in their rural area and caused clients difficulty in obtaining services, saying, “Many support services are just as important as core [medical services] in some ways. How can [a client] go to work when going to the doctor takes all day on the bus?” Another grantee noted the lack of funds for food assistance, saying, “Food is critical to [the] success of medications; sometimes food banks don’t have food that patients can eat or that will help them absorb their medications.” Finally, one grantee reported that as a result of their own evaluation, they “found that these [support] services were absolutely critical as part of health outcomes, which put a lot more pressure on the county to provide [support] services.”

The core medical services requirement increased the administrative burden for 14 percent of all grantees

When we asked grantees to rate the degree of difficulty they experienced with implementing the requirement on a 5-point scale, where 1 indicated easiest and 5 indicated most difficult, the most common rating was 1 (see Appendix C for further information on grantees’ ratings). However, when we asked grantees whether the requirement affected their administrative practices, 14 percent reported that it increased their administrative burden. Examples of changes made to administrative practices included: modifying program policies and practices, changing strategic planning practices, allocating and budgeting funds, reporting and tracking program expenditures, renegotiating contracts with providers, and identifying additional community resources.

Other changes established by the reauthorization also affected grantees’ administrative practices. For example, prior to the reauthorization, MAI funds were applied for and disbursed in conjunction with Parts A, B, and/or C grant funds; now these funds are applied for and disbursed separately.²⁶ Grantees reported that these activities lessened their focus on service delivery to clients. As one grantee stated, “We spend so much time on reporting and completing grant applications that it leaves little time to think about service delivery.”

HRSA guidance was helpful, but project officer turnover created program management difficulties

Eighty-one percent of Ryan White grantees reported receiving guidance from HRSA on the requirement, and 95 percent of

grantees that received guidance indicated that they found the guidance helpful. However, grantees also reported that the turnover in and limited experience of Ryan White project officers contributed to inconsistent grantee oversight. Grantee and project officer responses about the difficulties caused by turnover indicate that consistent grantee monitoring by project officers continues to be a vulnerability

²⁶ In a Government Accountability Office report on the implementation of the requirements of the Act for MAI grants, HRSA officials said that they changed the MAI FY for 2007 so that HRSA could complete the new guidance necessitated by the changes made by the Act. The FY for MAI funding is from August 1 to July 31. “Ryan White Care Act: Implementation of the New Minority AIDS Initiative Provisions,” GAO-09-315, March 2009, p. 19.

within the Ryan White program, as previously identified in a 2004 OIG report.²⁷

Eighty-one percent of grantees reported receiving guidance on the core medical services requirement

According to grantees, HRSA provides guidance through written materials, conference calls, and electronic mail, as well as in-person meetings and telephone conversations with project officers. Of the grantees that received guidance from HRSA, 95 percent found it helpful. However, 21 percent of all grantees reported that some of the core medical services' definitions were unclear. Specifically, grantees reported that the definitions of medical case management, transportation, and early intervention services were unclear. Thirty-eight percent of project officers confirmed that grantees seek additional information and clarification on service definitions.

Turnover affects project officer oversight of grantees

At the time of our review, 71 percent of grantees reported experiencing project officer turnover in recent years. Of these, 62 percent reported that project officer turnover created program management difficulties. Twenty-eight percent of the grantees that reported turnover said that they have to repeatedly train project officers on both the Ryan White program and the individual grantees' unique organizations and processes. Further, 26 percent of these grantees reported experiencing varying project officer expectations, and 23 percent of grantees reported a lack of consistency in project officer interactions. Grantees offered the following comments about project officer turnover and oversight:

- “In my 10 years, we have had eight project officers. Continuity is an issue. We [the grantee] have to retrain them.”
- “We have had three different project officers in the past year. Each has had different expectations and . . . differing methods to monitor [the] program.”
- “[Project officer] turnover has occurred without notification, and sometimes submissions [reports] appear to have been lost in the shuffle.”

²⁷ “Monitoring of Ryan White CARE Act Title I and Title II Grantees,” OEI-02-01-00640, March 2004.

F I N D I N G S

- “Our new project officer has to consult with others constantly and never makes decisions on her own. She is not familiar with the program . . . her relative inexperience creates a lot of trouble.”

Project officers generally agreed with the grantees’ assessments of high turnover within their ranks, explaining that HRSA has experienced staffing shortages in the past few years. As HRSA project officers turn over, grantees are reassigned among the available staff. Project officers noted problems resulting from turnover similar to those that grantees reported, including difficulties establishing relationships with grantees, inconsistent project officer expectations of grantees, and differing project officer approaches for grant oversight. Of the forty-two project officers we interviewed, 21 reported that the frequent reassignment of grantees affected their ability to effectively oversee their grantees. Twenty-one project officers reported having no Ryan White experience prior to becoming Ryan White project officers, and 31 reported having no prior project officer experience. Further, 19 project officers also reported that they came to their positions with limited prior experience and had only recently joined HRSA.

► C O N C L U S I O N

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 emphasized providing funds for direct health care services for people living with HIV/AIDS by establishing a requirement that certain grantees spend at least 75 percent of their grant funds on core medical services. OIG found that, overall, those grantees complied with the core medical services requirement in 2007 and allocated their funds in compliance with the requirement in 2008. Our analysis of grantees' 2006 expenditures showed that most grantees were already spending a high proportion of their grant funds on core medical services in 2006, prior to the implementation of the requirement. Therefore, there was little change in grantee spending on core medical services since the requirement went into effect.

Despite the small amount of change in spending, a higher percentage of Part A grantees reported being affected by the core medical services requirement in the delivery of support services, compared to Part B and Part C grantees. Additionally, 14 percent of all grantees reported that since implementation of the requirement, they have experienced an increase in their administrative burden. Further, when asked, just over half of the grantees we interviewed would welcome the opportunity to provide input as Congress considers reauthorization of the Ryan White program in 2009. Lastly, while 95 percent of the grantees who received guidance from HRSA found it helpful, grantee and project officer responses about the difficulties caused by turnover indicate that project officer oversight continues to be a vulnerability in the Ryan White program.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

HRSA concurred with our findings. Regarding the finding pertaining to turnover among project officers affecting oversight of grantees, HRSA further commented that it has lost a number of experienced project officers in recent years, and is currently hiring new staff. HRSA also noted that in response to the complex requirements mandated by the Act, impending reauthorization of the Act, and the influx of new project officers, it will be intensifying training in the coming weeks. We did not make any changes in response to HRSA's comments. For the full text of HRSA's comments, see Appendix D.

► A P P E N D I X ~ A

Point Estimates and Confidence Intervals

Statistic Description	Grantee Type	Sample Size	Point Estimate	95% Confidence Interval*
Estimates from expenditure and allocation reports				
Average percentage of grantee funds expended on core medical services in 2007	All	171	92.9	92.0–93.7
	A	55	81.7	-
	B	45	93.5	-
	C	71	94.9	93.8–96.1
Average percentage of grantee funds allocated for core medical services in 2008	All	169	93.3	92.5–94.2
	A	53	81.5	-
	B	45	93.9	-
	C	71	95.4	94.3–96.5
Grantees in compliance with the core medical services requirement in 2007	A	55	96.4	-
	B	45	100.0	-
	C	71	100.0	94.9–100.0
Grantees in compliance with the core medical services requirement in 2008	A	53	98.1	-
	B	45	100.0	-
	C	71	100.0	94.9–100.0
Average percentage of grantee funds expended on core medical services in 2006	A	50	74.3	-
	B	45	95.0	-
	C	70	94.8	93.4–96.1
Estimates from interview responses				
Percentage of grantees reporting significant effects on service delivery	A	49	26.5	-
	B	43	7.0	-
	C	71	1.4	0.0–3.8
Percentage of grantees reporting significant effects on administrative processes	All	172	13.5	8.9–18.2
	A	47	19.1	-
	B	42	28.6	-
	C	83	10.8	5.0–16.7

* Statistics presented for Parts A and B grantees are descriptive population statistics and therefore have no confidence interval.

Point Estimates and Confidence Intervals (continued)

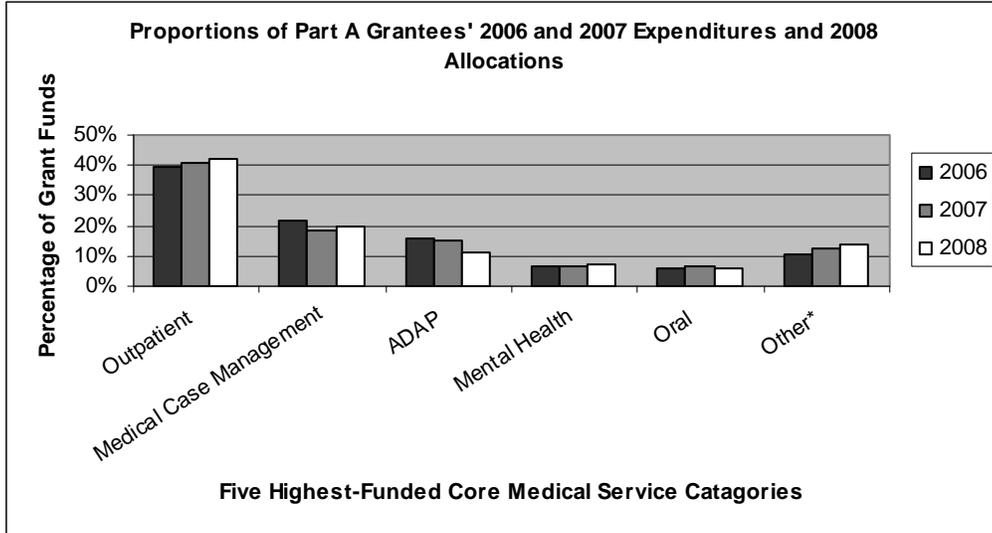
Statistic Description	Grantee Type	Sample Size	Point Estimate	95% Confidence Interval*
Percentage of grantees reporting receiving guidance on the core medical services requirement	All	171	80.9	74.7–87.0
Percentage of grantees that received guidance reporting finding the guidance helpful	All	141	94.8	91.6–97.9
Percentage of grantees reporting that the core medical service definitions are unclear	All	171	21.4	15.4–27.4
Percentage of grantees reporting project officer turnover	All	170	70.5	64.2–76.9
Percentage of grantees with project officer turnover reporting that turnover created difficulties	All	96	61.7	51.9–71.5
Percentage of grantees with project officer turnover reporting that turnover resulted in need to help project officer understand program	All	96	28.0	19.1–36.8
Percentage of grantees with project officer turnover reporting that turnover resulted in experiencing varying project officer expectations	All	96	26.3	17.5–35.2
Percentage of grantees with project officer turnover reporting that turnover resulted in lack of consistency in project officer interactions	All	96	23.4	15.3–31.5

* Statistics presented for Parts A and B grantees are descriptive population statistics and therefore have no confidence interval.

Source: Office of Inspector General analysis of grantee survey responses, expenditure reports, and allocation reports, 2009.

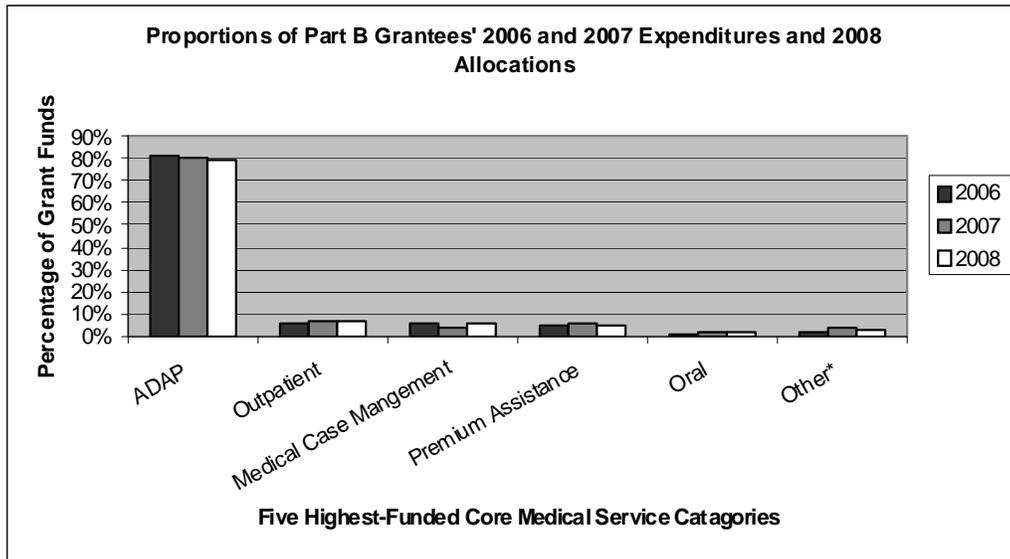
▶ **A P P E N D I X ~ B**

Five Highest-Funded Core Medical Service Categories by Grantee Type



* "Other" includes early intervention services, premium assistance, home health, nutrition, hospice, home- and community-based services, and substance abuse.

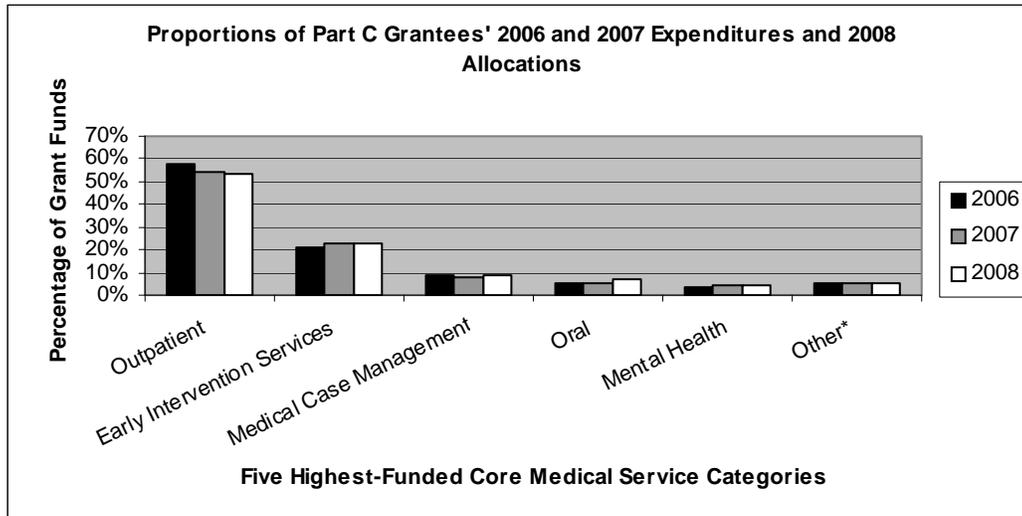
Source: Office of Inspector General (OIG) analysis of Part A Ryan White grantees' expenditures and allocations.



* "Other" includes substance abuse, home health, nutrition, hospice, home- and community-based services, early intervention services, and mental health.

Source: OIG analysis of Part B Ryan White grantees' expenditures and allocations.

Five Highest-Funded Core Medical Service Categories by Grantee Type
(continued)



* "Other" includes ADAP, premium assistance, home health, nutrition, hospice, home- and community-based services, and substance abuse.

Source: OIG analysis of Part C Ryan White grantees' expenditures and allocations.

Point Estimates and Confidence Intervals Relating to Part C Grantees' Expenditures and Allocations

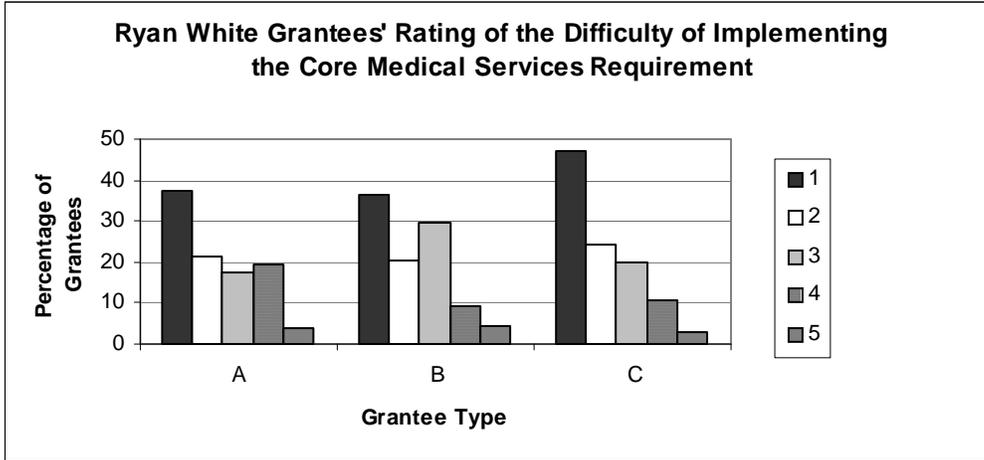
Statistic Description	Fiscal Year	Sample Size	Point Estimate	95% Confidence Interval
Part C grantees' expenditures on outpatient services	2006	72	57.6	47.6–67.6
	2007	71	54.5	47.0–62.1
	2008	73	52.9	45.6–60.3
Part C grantees' expenditures on early intervention services	2006	72	21.3	13.8–28.7
	2007	71	22.8	14.9–30.6
	2008	73	22.4	14.7–30.2
Part C grantees' expenditures on medical case management	2006	72	9.0	6.6–11.4
	2007	71	7.9	5.6–10.1
	2008	73	8.5	6.4–10.6
Part C grantees' expenditures on oral health services	2006	72	5.5	3.4–7.6
	2007	71	5.6	3.6–7.6
	2008	73	6.7	4.3–9.1
Part C grantees' expenditures on mental health services	2006	72	3.5	2.5–4.6
	2007	71	4.1	2.9–5.2
	2008	73	4.5	3.0–6.0
Part C grantees' expenditures on all other core medical services	2006	72	5.6	3.9–7.3
	2007	71	5.2	3.7–6.7
	2008	73	4.9	3.5–6.4

Source: OIG analysis of Part C Ryan White grantees' expenditures and allocations, 2009.

➤ A P P E N D I X ~ C

Grantee Ratings of the Difficulty of Implementing the Core Medical Services Requirement

We asked grantees to rate the difficulty they experienced in implementing the core medical services requirement on a scale from 1 to 5, with 1 being the easiest and 5 being the most difficult. The chart below illustrates how each type of grantee responded.



Source: Office of Inspector General (OIG) analysis of grantee responses, 2009.

Point Estimates and Confidence Intervals Relating to Part C Grantees' Ratings of Difficulty

Statistic Description	Grantee Type	Sample Size	Point Estimate	95% Confidence Interval
Percentages of grantees rating the difficulty of implementing the core medical services requirement (1=easy through 5=difficult)	A	51	1 - 37.3	-
			2 - 21.6	
			3 - 17.6	
			4 - 19.6	
			5 - 3.9	
	B	44	1 - 36.4	-
			2 - 20.5	
			3 - 29.5	
			4 - 9.1	
C	70	1 - 47.1	36.9-57.4	
		2 - 24.3	15.4-33.1	
		3 - 18.6	10.6-26.6	
		4 - 8.6	2.8-14.3	
		5 - 1.4	0.0-3.9	

Source: OIG analysis of grantee survey responses, 2009.

▶ A P P E N D I X ~ D

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services
Administration

Rockville, MD 20857

OCT 7 2009

TO: Inspector General
FROM: Administrator
SUBJECT: OIG Draft Report: "The Core Medical Services Requirement in the Ryan White Program" (OEI-07-08-00240)

This is in response to the OIG's request for comments on the draft report, "The CORE Medical Services Requirement in the Ryan White Program" (OEI-07-08-00240). Attached are the Health Resources and Services Administration's comments. If you have any questions, please contact Patricia A. Reese in HRSA's Office of Federal Assistance Management at (301) 443-0270.

/s/

Mary K. Wakefield, Ph.D., R.N.

Attachment

**Health Resources and Services Administration's Comments on the OIG Draft Report -
"The Core Medical Services Requirement in the Ryan White Program"
(OIG-07-08-00240)**

The Health Resources and Services Administration has reviewed the OIG's draft report and has the following comments.

GENERAL COMMENTS

In general, the Executive Summary, Introduction, Methodology and Findings sections of the report are clear and technically accurate. HRSA has comments with respect to the following specific findings:

P. 8 OIG Finding:

Almost all grantees complied with the core medical services requirements; grantee expenditures on core medical services changed little from 2006-2007.

HRSA Response:

HRSA concurs with this finding.

P. 10 OIG Finding:

The core medical service requirement affected support services and administrative processes for some grantees.

HRSA Response:

HRSA concurs with this finding.

P. 11 OIG Finding:

HRSA guidance was helpful, but project officer turnover created program management difficulties.

HRSA Response:

HRSA concurs with this finding. HRSA has lost a number of experienced project officers in recent years. However, we are now in the process of hiring new staff to fill this void.

P. 11 OIG Finding:**HRSA guidance was helpful, but project officer turnover created program management difficulties – subheading:**

- o **Turnover affects project officer oversight of grantees:**

HRSA Response:

To respond to these challenges HRSA implemented intensive training for staff and grantees. Training was provided at the Bureau, Division, Branch, and individual project officer level. The training of project officers is an ongoing process in HRSA. It is important to note, however, that the RWTMA of 2006 is an extremely complex statute with multiple programs, mandates and requirements. The reauthorized law added layers of complexity to project officers' grant monitoring and technical assistance responsibilities. Because HRSA is hiring new project officers and the Ryan White statute is again being reauthorized, project officer training will be intensified in the coming weeks.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Michala Walker served as the lead analyst for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Rae Hutchison, Amber Meurs, Dennis Tharp, and Deborah Walden; central office staff who contributed include Talisha Searcy and Kevin Farber.