DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

February 6, 2009

Report Number: A-05-08-00052

Alan D. Biggerstaff
Deputy Director
Illinois Department of Public Health
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761-0001

Dear Mr. Biggerstaff:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of the Illinois Department of Public Health's Compliance with the Ryan White CARE Act Payer-of-Last-Resort Requirement." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mike Barton, Audit Manager, at (614) 469-2543 or through e-mail at Mike.Barton@oig.hhs.gov. Please refer to report number A-05-08-00052 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Rebecca Spitzgo
Associate Administrator
Office of Federal Assistance Management
Health Resources and Services Administration
5600 Fishers Lane
Parklawn Building, Room 13-103
Rockville, Maryland 20857-0001

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH'S COMPLIANCE WITH THE RYAN WHITE CARE ACT PAYER-OF-LAST-RESORT REQUIREMENT

Daniel R. Levinson
Inspector General

February 2009
A-05-08-00052

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Public Law 101-381, funds health care and support services for people who have HIV/AIDS and who have no health insurance or are underinsured. As the Federal Government's largest source of funding specifically for people with HIV/AIDS, the CARE Act assists more than 500,000 individuals each year. Within the U.S. Department of Health and Human Services, the Health Resources and Services Administration administers the CARE Act.

Title II of the CARE Act, sections 2611-2631 of the Public Health Service Act, provides grants to States and territories to fund the purchase of medications through AIDS Drug Assistance Programs (ADAP) and other health care and support services. Pursuant to 42 U.S.C. § 300ff-27(b)(6)(F), these grant funds may not be used to pay for items or services that are eligible for coverage by other Federal, State, or private health insurance. This provision is commonly referred to as the "payer of last resort" requirement.

During our audit period (grant years 2003–2005), the Illinois Department of Public Health (the Department) claimed Title II drug expenditures totaling $81,915,290.

OBJECTIVE

Our objective was to determine, for grant years 2003-2005, whether the Department complied with the Title II payer-of-last-resort requirement that funds not be used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance.

SUMMARY OF FINDINGS

The Department did not fully comply with the Title II payer-of-last-resort requirement that funds not be used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance. Of the 100 prescriptions that we sampled, 97 were correctly claimed to the Title II program for patients without other health care coverage for HIV/AIDS drugs. However, the remaining three prescriptions were incorrectly claimed to the Title II program for patients who had other health insurance that would have covered the drugs. As a result, the Department claimed $808 in unallowable Federal funding for grant years 2003–2005.

The overpayments occurred because the Department's procedures did not identify beneficiaries who received similar services paid for by Medicaid and did not identify beneficiaries who became Medicaid-eligible retroactive to the time that the prescriptions were filled. Consequently, the beneficiaries were eligible for drug coverage under the Illinois Medicaid program and therefore, the Department's Title II program should not have paid for the prescriptions.

RECOMMENDATIONS

We recommend that the Department:

- refund $808 to the Federal Government and

- consider implementing additional procedures to prevent beneficiaries from filling prescriptions within the Medicaid program and the ADAP and to identify beneficiaries who become retroactively eligible for the Medicaid program to ensure the ADAP program only pays for drug costs associated with patients that are not eligible for HIV/AIDS drug coverage by other Federal, State, or private health insurance plans.

DEPARTMENT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, the Department did not specifically address our first recommendation, but indicated that it will work with the Illinois Medicaid Agency to implement procedures to identify retroactive eligibility claims and return credit for any claims identified as payable by Medicaid. The Department's comments are included in their entirety as Appendix C.

We continue to recommend that the Department refund $808 to the Federal government.

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INTRODUCTION

BACKGROUND

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, Public Law 101-381, funds health care and support services for people who have HIV/AIDS and who have no health insurance or are underinsured. As the Federal Government's largest source of funding specifically for people with HIV/AIDS, the CARE Act assists more than 500,000 individuals each year. Within the U.S. Department of Health and Human Services, the Health Resources and Services Administration (HRSA) administers the CARE Act.

Title II Grant Funds

Title II of the CARE Act, sections 2611-2631 of the Public Health Service Act, provides grants to States and territories to fund the purchase of medications through AIDS Drug Assistance Programs (ADAP) and other HIV/AIDS health and support services, such as outpatient care, home and hospice care, and case management.

In Illinois, the Department of Public Health (the Department) administers the Title II program. The majority of Illinois' Title II program funds are designated for drugs to treat HIV/AIDS through the ADAP. For example, ADAP expenditures for the grant year ended March 31, 2005, accounted for about 77 percent of Title II expenditures.

Payer-of-Last-Resort Requirement

Title II of the CARE Act stipulates that grant funds not be used to pay for items or services that are eligible for coverage by other Federal, State, or private health insurance. This provision is commonly referred to as the "payer of last resort" requirement. Specifically, section 2617(b)(6)(F) of the Public Health Service Act (42 U.S.C. § 300ff-27(b)(6)(F)) states:

> [T]he State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service –
>
> (i) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or
>
> (ii) by an entity that provides health services on a prepaid basis.[1]

In addition, HRSA Program Policy No. 97-02, issued February 1, 1997, and reissued as DSS[2] Program Policy Guidance No. 2 on June 1, 2000, reiterates the statutory requirement that "funds received . . . will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made . . ." by sources other than

[1]Subsequent to the audit period in question, The Ryan White HIV/AIDS Treatment Modernization Act of 2006, §§ 204(c)(1)(A) and (c)(3), Pub. Law No. 109-415 (December 19, 2006), redesignated this provision as section 2617(b)(7)(F) (42 U.S.C. § 300ff-27(b)(7)(F)) and amended subparagraph (ii) to prohibit the State from using these grant funds for any item or service that should be paid for "by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Service)."

[2]DSS is the Division of Service Systems, a component of HRSA's HIV/AIDS Bureau.

Title II funds. The guidance then provides: "At the individual client level, this means that grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of CARE Act funds whenever possible."

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine, for grant years 2003–2005, whether the Department complied with the Title II payer-of-last-resort requirement that funds not be used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance.

Scope

Our review covered the period April 1, 2003, through March 31, 2006 (grant years 2003–2005). On its financial status reports for that period, the Department claimed ADAP expenditures totaling $81,915,290 for HIV/AIDS drugs dispensed by mail order through the contracted pharmacy.

We did not assess the Department's overall internal controls for administering Title II funds. Rather, we limited our review to gaining an understanding of those significant controls related to the claiming of HIV/AIDS drug costs. Due to concerns regarding the protection of program participant's personally identifiable identification, we did not contact private health insurance companies to confirm health insurance coverage. We conducted our fieldwork at the Department's offices in Springfield, Illinois.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed documentation provided by the Department for grant years 2003–2005, including notice of grant awards, financial status reports and supporting accounting records, and the ADAP drug formulary (a list of drugs authorized for purchase by the program);
- held discussions with Department officials to identify policies, procedures, and guidance used to identify other insurance coverage and for billing HIV/AIDS drugs to other Federal or State programs and private insurance plans;
- analyzed the Department's procedures for accounting for and dispensing drugs to Title II patients;
- identified a population of 351,343 HIV/AIDS prescriptions for which claims totaled $100,742,778 (which includes both Federal and State funded ADAP drugs);

- selected a simple random sample of 100 prescriptions from the population of 351,343 prescriptions and, for the sampled prescriptions:
    - identified patients enrolled in the Illinois Medicaid plan by using the State's Medicaid-eligibility database,
    - identified patients enrolled in private health insurance plans by using the Department's files,
    - confirmed other insurance drug coverage and the amount of that coverage with officials of the Department's contracted pharmacy, and
    - identified the cost of dispensed drugs by using the Department's payment invoices, and
- reviewed the contracted pharmacy's documentation of the inventory tracking process, dispensing procedures, accounting for adjustments, and verified information on a limited number of sampled prescriptions.

Appendix A contains details on our sample design and methodology, and Appendix B contains our sample results.

We conducted this performance audit 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 objective.

FINDINGS AND RECOMMENDATIONS

The Department did not fully comply with the Title II payer-of-last-resort requirement that funds not be used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance. Of the 100 prescriptions that we sampled, 97 were correctly claimed to the Title II program for patients without other health care coverage for HIV/AIDS drugs. However, the remaining three prescriptions were incorrectly claimed to the Title II program for patients who had other health insurance that would have covered the drugs. As a result, the Department of Public Health claimed $808 in unallowable Federal funding for grant years 2003–2005.

The overpayments occurred because the Department's procedures did not identify beneficiaries who received similar services paid for by Medicaid and did not identify beneficiaries who became Medicaid-eligible retroactive to the time that the prescriptions were filled. Consequently, the beneficiaries were eligible for drug coverage under the Medicaid program and therefore, the Department's Title II program should not have paid for the prescriptions.

IMPROPER TITLE II CLAIMS FOR PRESCRIPTION DRUGS

The payer-of-last-resort requirement set forth in 42 U.S.C. § 300ff-27(b)(6)(F) provides that Title II funds may not be used to pay for items or services that are eligible for coverage under other Federal, State, or private health insurance.

Contrary to the payer-of-last-resort requirement, the Department claimed Title II funding for three sampled prescriptions dispensed to individuals who had other health insurance that would have covered the drugs. Specifically, the Illinois Medicaid program had primary payment responsibility for the three prescriptions. The Federal share of the amount claimed for the three prescriptions totaled $808. Details regarding the three prescriptions follow:

- For one prescription, the beneficiary obtained the prescribed drugs from a retail pharmacy, which received reimbursement from the Illinois Medicaid program. During this same service period, the beneficiary received the prescribed drugs from the ADAP-contracted pharmacy, which submitted a claim to the Illinois Medicaid program for reimbursement. The claim was denied because the Medicaid program had already paid for the prescription.

- For two prescriptions, two beneficiaries were not Medicaid-eligible at the time they obtained the prescribed drugs from the ADAP-contracted pharmacy. However, the beneficiaries applied for Medicaid eligibility in the first or second month after obtaining the drugs and became retroactively eligible for drug coverage under the Illinois Medicaid program.

The overpayments occurred because the Department's procedures did not identify beneficiaries who received similar services paid for by Medicaid and did not identify beneficiaries who became Medicaid-eligible retroactive to the time that the prescription was filled. Consequently, the beneficiaries were eligible for drug coverage under the Medicaid program and therefore, the Department's Title II program should not have paid for the prescriptions.

RECOMMENDATIONS

We recommend that the Department:

- refund $808 to the Federal Government and

- consider additional procedures to prevent beneficiaries from filling prescriptions within the Medicaid program and the ADAP and to identify beneficiaries who become retroactively eligible for the Medicaid program to ensure the ADAP program only pays for drug costs associated with patients that are not eligible for HIV/AIDS drug coverage by other Federal, State, or private health insurance plans.

DEPARTMENT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to our draft report, the Department did not specifically address our first recommendation, but indicated that it will work with the Illinois Medicaid Agency to implement

procedures to identify retroactive eligibility claims and return credit for any claims identified as payable by Medicaid. The Department's comments are included in their entirety as Appendix C.

We continue to recommend that the Department refund $808 to the Federal government.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of all Federal and State funded prescriptions for AIDS Drug Assistance Program (ADAP) drugs dispensed to HIV/AIDS patients and claimed from April 1, 2003, through March 31, 2006.

SAMPLING FRAME

The sampling frame consisted of 351,343 prescriptions for Federal and State funded ADAP drugs with claimed expenditures totaling $100,742,778 for the period April 1, 2003, through March 31, 2006.

SAMPLE UNIT

The sample unit was a prescription for ADAP drugs dispensed to an HIV/AIDS patient.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 prescriptions.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical software. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the prescriptions in our sampling frame, including prescriptions for drugs listed in both the ADAP-funded and the State-funded formularies (mixed prescriptions). After generating 100 random numbers, we selected the corresponding frame items and created a list of sample items.

CHARACTERISTICS TO BE MEASURED

We considered a sample item improper if the patient had other Federal, State, or private health insurance that covered the dispensed drugs. The amount of the improper payment was the amount that the other health plan would have paid.

Drugs purchased with State-only funds that appeared on a prescription were not counted as errors.

APPENDIX B

SAMPLE RESULTS

Number of Prescriptions in Frame	Value of Frame	Sample Size	Value of Sampled Prescriptions	Number of Improper Payments	Value of Improper Payments (Federal Share)
351,343	$100,742,778	100	$27,206	3	$808

Illinois Department of
PUBLIC HEALTH

Rod R. Blagojevich, Governor
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

January 21, 2009

Mr. Marc Gustafson
Department of Health and Human Services
Office of Audit Services
233 North Michigan Avenue
Chicago, Illinois 60601

Dear Mr. Gustafson:

This letter is in response to the draft audit report number A-05-05-0052, entitled "Review of the Illinois Department of Public Health's Compliance with the Ryan White CARE Act Payer-of-Last-Resort Requirement".

The findings were reviewed and discussed with the AIDS Drug Assistance Program (ADAP) Administrator. As stated in the report, two claims were the result of retroactive eligibility for Medicaid benefits. On the date that the prescription was filled, the client was not eligible for Medicaid. However, the client became eligible three months later with benefits extending retroactively back six months, which included the date of the fill.

To identify retroactive Medicaid eligibility for over 5,000 clients each month is not feasible using the current client by client system. Therefore, the Department will be seeking an agreement with the Illinois Healthcare and Family Service, the state Medicaid agency, to allow a tape match no less than every six (6) months to identify these retroactive eligibility claims. The Department will request a Medicaid back-bill by the dispensing pharmacy and return credit for any claims identified as payable by Medicaid.

The third prescription fill identified as incorrectly claimed to the Title II Program was rejected by Medicaid as "refill to soon". Due to timeframe required for the Medicaid eligibility check, prescription processing and shipment, the Department does not see a possible remedy for avoiding this type of incorrect claim which Medicaid rejected. A duplicate prescription was filled at a retail pharmacy by the client upon receipt of the Medicaid card. The Medicaid database was updated after the eligibility check and approval for processing and claim paid by Title II Program was scheduled.

The Department will seek to reduce, if not eliminate, incorrect claims to the Title II Program, now known as Ryan White Part-B.

Sincerely,

Alan Biggerstaff, Deputy Director
Office of Health Protection

cc: Joe Ramos, Chief, Division of Infectious Diseases
Mildred Williamson, HIV / AIDS Section Chief