DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

November 15, 2010

TO: Mary Wakefield, Ph.D., R.N.
Administrator
Health Resources and Services Administration

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Ryan White Title II Funding in Pennsylvania (A-03-08-00552)

Attached, for your information, is an advance copy of our final report on Ryan White Title II funding in Pennsylvania. We will issue this report to the Pennsylvania Department of Public Welfare within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Lori S. Pilcher, Assistant Inspector General for Grants, Internal Activities, and Information Technology Audits, at (202) 619-1175 or through email at Lori.Pilcher@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-08-00552.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

November 17, 2010

Report Number: A-03-08-00552

Mr. Theodore Dallas
Executive Deputy Secretary
Pennsylvania Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105

Dear Mr. Dallas:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Ryan White Title II Funding in Pennsylvania*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (215) 861-4470, or contact Leonard Piccari, Audit Manager, at (215) 861-4493 or through email at Leonard.Piccari@oig.hhs.gov. Please refer to report number A-03-08-00552 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Sandy Seaton
Health Resources and Services Administration
Office of Federal Assistance Management/Division of Financial Integrity
Room 11A-55, Parklawn Building
Rockville, MD 20857

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RYAN WHITE TITLE II FUNDING IN PENNSYLVANIA

Daniel R. Levinson
Inspector General

November 2010
A-03-08-00552

Office of Inspector General

http://oig.hhs.gov

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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, P.L. No. 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 & Human Services, the Health Resources and Services Administration administers the CARE Act.

Title II of the CARE Act (42 U.S.C. §§ 300ff-21 through 300ff-38) 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. Title II grant funds may be used only for individuals determined to meet medical and financial eligibility requirements. Additionally, 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.

In Pennsylvania, the Department of Public Welfare, Office of Medical Assistance Programs (State agency), administers the ADAP. The majority of Pennsylvania's Title II program funds are designated for drugs to treat HIV/AIDS patients through its ADAP. For grant years 2004 through 2006, the State agency claimed ADAP expenditures totaling $104,278,085 for drugs to treat clients with HIV/AIDS.

Pursuant to the Pennsylvania Code (6 Pa. Code chapter 22), the Pennsylvania Department of Aging separately operates the Pharmaceutical Assistance Contract for the Elderly (PACE) program, which assists low-income Pennsylvania residents aged 65 or older with prescription drug payments.

OBJECTIVES

Our objectives were to determine whether the State agency:

- used Title II funds only for eligible clients and
- 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 State agency did not always comply with the Title II requirements that funds be used only for eligible clients and only for drugs that are not eligible for coverage by other Federal, State, or private health insurance plans.

- Based on our review of 133 sampled payments for clients under the age of 65, we determined that 121 payments were allowable; however, 12 payments were unallowable because the clients either were ineligible or had private health insurance that would have covered the drugs.

- Based on our review of all 3,615 payments for clients aged 65 or older, we determined that 439 payments were allowable; however, 3,176 payments were unallowable because the clients were enrolled in the State's PACE program, which would have covered the drugs.

The State agency claimed at least $3,218,748 ($2,162,998 Federal share) that was unallowable: at least $2,676,839 ($1,798,835 Federal share) in estimated unallowable payments based on our sample of payments made for clients under the age of 65 and $541,909 ($364,163 Federal share) for payments made for clients aged 65 or older.

These errors occurred because the State agency did not review and validate information on some client applications and because the State agency considered the PACE program, rather than the Title II program, to be the payer of last resort.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,162,998 to the Federal Government for payments improperly claimed to Title II,

- review clients identified by this review as ineligible or having other health insurance to determine whether additional Title II payments made outside the audit period were improper,

- review and validate information provided by clients on their ADAP applications before admitting clients to the program, and

- ensure that the ADAP is considered the payer of last resort for clients who are enrolled in both the ADAP and the PACE program.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency generally agreed with our findings and outlined its actions to address our recommendations. However, the State agency did not agree with our finding related to one ineligible client. Under separate cover, the State agency provided documentation of a medical diagnosis for that client.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Our review of the State agency's additional documentation determined that the client was eligible for Title II funding based on the medical diagnosis. Therefore, we revised our findings to remove the three payments associated with this client and adjusted the recommended refund accordingly.

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INTRODUCTION

BACKGROUND

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, P.L. No. 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 & Human Services, the Health Resources and Services Administration (HRSA) administers the CARE Act.

Title II Grant Funds

Title II of the CARE Act (42 U.S.C. §§ 300ff-21 through 300ff-38) 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 Pennsylvania, the Department of Public Welfare, Office of Medical Assistance Programs (State agency), administers its ADAP as part of the Special Pharmaceutical Benefits Program. The majority of Pennsylvania's Title II program funds are designated for drugs to treat HIV/AIDS patients through its ADAP. For example, ADAP expenditures for the grant year ended March 31, 2006, accounted for about 70 percent of Title II expenditures.

Program Eligibility Requirements

Pursuant to 42 U.S.C. § 300ff-26(b), to be eligible to receive assistance from a State under Title II of the CARE Act, an individual must "(1) have a medical diagnosis of HIV disease; and (2) be a low-income individual, as defined by the State." According to HRSA's *ADAP Manual*, section II, chapter I (2003), States are responsible for determining whether patients meet the medical and financial eligibility requirements for enrollment in the ADAP. During our audit period, Commonwealth of Pennsylvania Medical Assistance Bulletin No. 02-95-02 (Pennsylvania Bulletin), effective January 5, 1995, required that an applicant have a medical need for HIV/AIDS drugs as prescribed by a physician and defined a low-income individual as an applicant whose household income was not expected to exceed $30,000 plus $2,480 for each additional family member.

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, 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 (and included in section IV of HRSA's *CARE Act Title II Manual* (2003)), 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 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."

Pharmaceutical Assistance Contract for the Elderly Program Requirements

Pursuant to the Pennsylvania Code (6 Pa. Code chapter 22), the Pennsylvania Department of Aging operates the Pharmaceutical Assistance Contract for the Elderly (PACE) program, which assists the elderly with prescription drug payments. To be eligible for the PACE program, an individual must be a Pennsylvania resident aged 65 or older and must have a total income for the preceding calendar year of $11,999 or less for a single person or $14,999 or less for a married couple living together. The Pennsylvania Department of Aging considers the PACE program to be the payer of last resort.

Financial Reporting Requirement

Pursuant to 45 CFR § 92.41(b), grantees are required to use Standard Form 269, Financial Status Report, to report the status of grant funds. HRSA uses these reports to monitor cash advances to grantees and to obtain disbursement or outlay information for each grant. The Financial Status Report, which is an accounting of expenditures under the grant, is due within 90 days after the grant year.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether the State agency:

- used Title II funds only for eligible clients and

[1] During our audit period, the Ryan White HIV/AIDS Treatment Modernization Act of 2006, §§ 204(c)(1)(A) and (c)(3), P.L. No. 109-415 (Dec. 19, 2006), redesignated this provision as 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.

- 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, 2004, through March 31, 2007 (grant years 2004 through 2006). On its Financial Status Reports for that period, the State agency claimed ADAP expenditures totaling $104,278,085 for drugs to treat HIV/AIDS that were dispensed at pharmacies throughout Pennsylvania. This amount was net of drug manufacturer rebates and third-party liability payments (discounts) received by the State agency. These discounts could not be attributed to specific claims.

We did not assess the State agency's overall internal controls for administering Title II funds. Rather, we limited our review to gaining an understanding of those controls related to claiming HIV/AIDS drug costs.

We conducted our fieldwork at the State agency in Harrisburg, Pennsylvania, from April 2008 through June 2009.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- reviewed documentation provided by the State agency, including Title II grant applications, notices of grant award, Financial Status Reports and supporting accounting records, and the ADAP drug formulary (a list of drugs authorized for purchase by the ADAP);

- held discussions with State agency officials to identify policies, procedures, and guidance for billing HIV/AIDS drugs to other Federal or State programs and private health insurance plans;

- analyzed the State agency's procedures for accounting for and dispensing drugs to Title II clients;

- verified the completeness of the State agency's ADAP paid invoice database by judgmentally selecting 10 client case folders and matching the client information and Title II payment dates and amounts to the database;

- determined whether the drug payments from the State agency's ADAP paid invoice database matched the drug expenditures on the Financial Status Reports;

- identified from the State agency's ADAP paid invoice database a total of 3,615 drug payments that the State agency made to pharmacies for clients who were at least 65 years old and removed the payments from the population;

- provided the list of 3,615 payments for clients who were at least 65 years old to the Pennsylvania Department of Aging for comparison with the enrollee database for the State's PACE program and identified any Title II payments made while the clients were enrolled in the PACE program;

- identified from the State agency's remaining ADAP paid invoice database a sampling frame of 277,589 drug payments made to pharmacies totaling $137,466,721 (not reflecting discounts) that were greater than $100 each;

- selected a stratified random sample of 133 payments: all 33 payments greater than $4,000 each and 100 payments greater than $100 and less than or equal to $4,000 each (Appendix A);

- reviewed, for the 133 sampled payments:

    - State agency client case folders to verify client eligibility and to determine whether the clients were enrolled in private health insurance plans and

    - Federal Medicaid records to determine whether the clients were enrolled in Medicaid;

- provided the State agency with a listing of 42 clients, accounting for 47 payments in our sample, whose case folders indicated that they had private health insurance and requested that the State agency determine whether the clients had insurance that would have covered the drugs associated with these payments;

- estimated, based on the sample results, the unallowable Federal funding claimed for the sampling frame (Appendix B); and

- calculated a discount per dollar claimed[3] of 27.71 cents and applied it to the estimated unallowable Federal funding claimed.

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 objectives.

[3] To calculate the discount per dollar claimed, we divided the value of discounts paid to the State by the value of the ADAP paid drug invoice database.

FINDINGS AND RECOMMENDATIONS

The State agency did not always comply with the Title II requirements that funds be used only for eligible clients and only for drugs that are not eligible for coverage by other Federal, State, or private health insurance plans.

- Based on our review of 133 sampled payments for clients under the age of 65, we determined that 121 payments were allowable; however, 12 payments were unallowable because the clients either were ineligible or had private health insurance that would have covered the drugs.

- Based on our review of all 3,615 payments for clients aged 65 or older, we determined that 439 payments were allowable;[4] however, 3,176 payments were unallowable because the clients were enrolled in the State's PACE program, which would have covered the drugs.

The State agency claimed at least $3,218,748 ($2,162,998 Federal share) that was unallowable: at least $2,676,839 ($1,798,835 Federal share) in estimated unallowable payments based on our sample of payments made for clients under the age of 65 and $541,909 ($364,163 Federal share) for payments made for clients aged 65 or older.

These errors occurred because the State agency did not review and validate information on some client applications and because the State agency considered the PACE program, rather than the Title II program, to be the payer of last resort.

PAYMENTS FOR CLIENTS WHO WERE INELIGIBLE OR HAD PRIVATE HEALTH INSURANCE

Of the 12 unallowable sampled payments for clients under the age of 65, 5 payments were for clients who did not meet Title II eligibility requirements: 2 payments for clients who did not meet medical requirements and 3 payments for clients who did not meet income requirements. The seven remaining unallowable payments were for clients who had private health insurance that would have covered the drugs.

Eligibility Requirements Not Met

Medical Diagnosis

Pursuant to 42 U.S.C. § 300ff-26(b), to be eligible to receive assistance from a State under Title II of the CARE Act, an individual must have a medical diagnosis of HIV disease. The Pennsylvania Bulletin requires that the applicant have a medical need for HIV/AIDS drugs as prescribed by a physician.

The State agency incorrectly claimed to Title II two payments for two clients whose case folders did not contain supporting documentation of a medical diagnosis of HIV/AIDS or a prescription

[4] We did not independently review the Title II eligibility of clients associated with these payments.

by a physician for drugs to treat HIV/AIDS. The State agency had approved the clients' applications without evidence of a diagnosis of HIV/AIDS.

Income in Excess of the State Agency Limit

Pursuant to 42 U.S.C. § 300ff-26(b), only low-income individuals, as defined by the State, are eligible to receive assistance under Title II of the CARE Act. The Pennsylvania Bulletin defined a low-income individual as an applicant whose household income was not expected to exceed $30,000 plus $2,480 for each additional family member.

The State agency incorrectly claimed to Title II three payments for three clients who did not meet income eligibility requirements. The State agency approved the clients' applications even though the clients' income exceeded the State limit or after the State agency had incorrectly calculated their income.

Covered by Private Health Insurance

Pursuant to 42 U.S.C. § 300ff-27(b)(6)(F), grants provided to States and territories to fund the purchase of medications through the ADAP and to fund other health care and support services may not be used to pay for items or services that are eligible for coverage by other Federal, State, or private health insurance.

The State agency incorrectly claimed to Title II seven payments for five clients who had private health insurance that had primary payment responsibility and that would have paid for the drugs. The State agency's case folders for 42 clients in our sample indicated that the clients had private health insurance. At our request, the State agency contacted the private insurance companies and found that 5 of the 42 clients had insurance that would have covered the drugs paid by Title II. The State agency had approved the clients' applications without determining whether the clients' private health insurance would cover any of the ADAP formulary drugs.

Estimate of Unallowable Payments

Based on these sample results, we estimated that the State agency claimed at least $2,676,839 ($1,798,835 Federal share) in unallowable Title II expenditures for clients who were ineligible or had other health insurance. (See Appendix B for details on our sample results and estimates.)

PAYMENTS FOR CLIENTS WHO WERE ENROLLED IN THE PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY PROGRAM

Pursuant to 42 U.S.C. § 300ff-27(b)(6)(F), grants provided to States and territories to fund the purchase of medications through the ADAP and to fund other health care and support services may not be used to pay for items or services that are eligible for coverage by other Federal, State, or private health insurance.

The State agency incorrectly claimed to Title II 3,176 payments for 36 clients aged 65 or older who were enrolled in the PACE program. The PACE program would have covered the drugs.

The State agency claimed these payments because Pennsylvania officials considered the PACE program the payer of last resort. In total, the State agency improperly claimed $541,909 ($364,163 Federal share) in unallowable Title II expenditures payable by the PACE program.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,162,998 to the Federal Government for payments improperly claimed to Title II,
- review clients identified by this review as ineligible or having other health insurance to determine whether additional Title II payments made outside the audit period were improper,
- review and validate information provided by clients on their ADAP applications before admitting clients to the program, and
- ensure that the ADAP is considered the payer of last resort for clients who are enrolled in both the ADAP and the PACE program.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency generally agreed with our findings and outlined its actions to address our recommendations. However, the State agency did not agree with our finding related to one ineligible client. Under separate cover, the State agency provided documentation of a medical diagnosis for that client.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

Our review of the State agency's additional documentation determined that the client was eligible for Title II funding based on the medical diagnosis. Therefore, we revised our findings to remove the three payments associated with this client and adjusted the recommended refund accordingly.

APPENDIXES

APPENDIX A: SAMPLE METHODOLOGY

POPULATION

The population consisted of State and federally funded payments for AIDS Drug Assistance Program (ADAP) drugs dispensed to HIV/AIDS patients and claimed from April 1, 2004, through March 31, 2007.

SAMPLING FRAME

The sampling frame consisted of 277,589 drug payments totaling $137,466,721 (not reflecting discounts) that were greater than $100 each.

SAMPLE UNIT

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

SAMPLE DESIGN

We used a stratified random sample. Stratum 1 consisted of 277,556 payments of $100.01 to $4,000 each. Stratum 2 consisted of all 33 payments greater than $4,000.

SAMPLE SIZE

We selected 133 payments: 100 payments from stratum 1 and all 33 payments from stratum 2.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers for stratum 1, we selected the corresponding frame items. For stratum 2, we selected all 33 payments.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of unallowable payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Payments	Value of Unallowable Payments (Federal Share)
1	277,556	$137,358,825	100	$36,080	8	$2,728
2	33	107,896	33	107,896	4	11,140
Total	277,589	$137,466,721	**133**	**$143,976**	**12**	**$13,868**

Total Estimated Value of Unallowable Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$7,583,514
Lower limit	2,488,360[1]
Upper limit	12,678,667

[1] We calculated the $1,798,835 that we are questioning by applying a 27.71-cent discount per dollar claimed to the lower limit of our estimate ($2,488,360 × [$1.00 − $0.2771] = $1,798,835).

APPENDIX C: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA

AUG 0 3 2010

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region III
150 South Independence Mall West, Suite 316
Philadelphia Pennsylvania 19106-3499

Dear Mr. Virbitsky:

Thank you for your July 17 letter that transmitted the draft report titled "Review of Ryan White Title II Funding in Pennsylvania" for the period April 1, 2004 through March 31, 2007.

This audit focused on the funding utilized under the Ryan White grant for the payment of HIV/AIDS medications. The Ryan White grant requires that this funding be used as a payer of last resort. The OIG selected a sample of the 3,748 transactions, which resulted in 557 allowable payments and 3,191 payments that were disallowed due to ineligibility of the client, availability of third party insurance for prescription drugs, or the client was eligible for Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) program.

Office of Inspector General (OIG) Recommendation: We recommend that the State agency refund $2,169,134 to the Federal Government for payments improperly claimed to Title II.

Department of Public Welfare (DPW) Response: The DPW will work with the Federal Government to determine improperly claimed Title II expenditures.

OIG Recommendation: We recommend that the State agency review clients identified by this review as ineligible or having other health insurance to determine whether additional Title II payments made outside the audit period were improper.

DPW Response: The DPW has reviewed the 15 sampled payments identified as ineligible or having other health insurance. Based on this review the following results were determined. eight payments were for eligible clients with no exceptions and therefore eligible under grant requirements; three payments were for clients that did not meet income eligibility requirements; and four payments were for client's files that did not contain supporting documentation related to the client's medical diagnosis.

The Special Pharmacy Benefits Program (SPBP) has made enrollment modifications for the special pharmacy program for fiscal years subsequent to the grant years tested in this audit. For example, the SPBP revised the enrollment application to include a "Clinicians" attestation requirement. An annual recertification of special pharmacy clients was initiated to verify and capture changes in income, third party payer information and/or residency to ensure clients remain eligible for the program.

The DPW also reviewed the seven payments noted as having private third party health insurance. The SPBP has a policy in place to make recoveries from third party providers which would have covered the medications. The DPW requested to have the Pennsylvania Department of Aging's claims processing vendor forward the SPBP paid claims history data to its third party recovery contractor to ensure appropriate payments were made for all SPBP claims submitted during the time period of January 2003 through May 2008. Third party insurance was validated for each of these claims. Additionally, as a quality management effort, the DPW requested that all SPBP claims beginning with June 2008 be reviewed against third party insurers on an ongoing basis.

OIG Recommendation: We recommend that the State agency review and validate information provided by clients on their AIDS Drug Assistance Program (ADAP) applications before admitting clients to the program.

DPW Response: The SPBP continues to perform monthly MA data matches to ensure SPBP cardholders who become MA eligible are cancelled from the special pharmacy program. The SPBP has further expanded its processes to capture and collect third party payer information through the PDA's claims processing vendor to include monthly insurance matches with other third party carriers. During 2009, the SPBP staff developed a procedure manual outlining Pennsylvania's eligibility requirements and implemented a peer review process.

OIG Recommendation: We recommend that the State agency ensure that the ADAP is considered the payer of last resort for clients who are enrolled in both the ADAP and the PACE program.

DPW Response: Beginning January 2009, the DPW and the DPA have changed the hierarchy in the claims processing to ensure that SPBP is the payer of last resort for clients enrolled in both the SPBP and the PACE programs. The PACE program has agreed to refund $364,163 to the Federal Government for the 3,178 questioned cases noted within the audit report.

Thank you for the opportunity to respond to this report. If you need any further information, please contact Maranatha Earling, Audit Resolution Section, at (717) 772-4911, or via e-mail at mearling@state.pa.us.

Sincerely,

Michael Stauffer
Acting Deputy Secretary of Administration