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

Washington, D.C. 20201

May 4, 2010

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

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of Ryan White Title II Funding in Florida (A-04-08-06002)

Attached is an advance copy of our final report on Ryan White Title II funding in Florida. We will issue this report to the Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS (the State agency), within 5 business days.

Title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 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. Additionally, Title II grant funds may be used only for individuals determined to meet medical and financial eligibility requirements.

Our objectives were to determine, for grant years 2003–2005, whether the State agency (1) 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 and (2) used the Title II funds only for clients whose files contained the documentation needed to determine eligibility for the ADAP.

The State agency (1) did not always 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 and (2) did not always use the Title II funds for clients whose files contained the documentation needed to determine eligibility for the ADAP. Based on our sample results, we estimated that the State agency claimed $4,400,613 in unallowable Federal funding for grant years 2003–2005. This overpayment occurred because the State agency did not always follow its procedures for billing HIV/AIDS drugs to the insurance plans with primary payment responsibility and for documenting clients' eligibility for ADAP funds.

We recommend that the State agency:

- refund $4,400,613 to the Federal Government;
- follow its procedures for billing HIV/AIDS drugs to the Federal, State, or private health insurance plans with primary payment responsibility; and
- follow its procedures for documenting clients' eligibility for ADAP funds.

In written comments on our draft report, the State agency said that refunding almost $4.5 million would have a devastating effect on ADAP clients. The State agency did not directly address our second and third recommendations. The State agency did not provide any additional information that would cause us to modify our findings or recommendations.

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 Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-08-06002.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

May 11, 2010

Report Number: A-04-08-06002

Ana M. Viamonte Ros, M.D., M.P.H.
Surgeon General and Secretary
Florida Department of Health
4052 Bald Cypress Way, Mail Bin #A-00
Tallahassee, Florida 32399

Dear Dr. Viamonte Ros:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Ryan White Title II Funding in Florida." 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, or contact Denise Novak, Audit Manager, at (305) 536-5309, extension 10, or through email at Denise.Novak@oig.hhs.gov. Please refer to report number A-04-08-06002 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Team Leader, Compliance Team, OFAM/DFI
Health Resources and Services Administration
Parklawn Building, Room 11A-55
5600 Fishers Lane
Rockville, Maryland 20857

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RYAN WHITE TITLE II FUNDING IN FLORIDA

Daniel R. Levinson
Inspector General

May 2010
A-04-08-06002

Office of Inspector General

http://oig.hhs.gov

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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 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. Additionally, Title II grant funds may be used only for individuals determined to meet medical and financial eligibility requirements.

During our audit period (grant years 2003–2005), the Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS (the State agency), claimed Title II drug expenditures totaling $214,126,688.

OBJECTIVES

Our objectives were to determine, for grant years 2003–2005, whether the State agency:

- 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 and

- used the Title II funds only for clients whose files contained the documentation needed to determine eligibility for the ADAP.

SUMMARY OF FINDINGS

The State agency (1) did not always 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 and (2) did not always use the Title II funds for clients whose files contained the documentation needed to determine eligibility for the ADAP. Of the 100 prescriptions in our sample, 86 were correctly claimed to the Title II program for eligible clients without other health care coverage for HIV/AIDS drugs. However, of the 14 remaining prescriptions, 5 were incorrectly claimed for clients who had other health insurance that would have covered the drugs, and 9 were incorrectly claimed for clients whose ADAP eligibility was not adequately documented. Because we did not contact private insurers to determine whether

ADAP clients had private health insurance, we would not have identified any instances in which ADAP clients had such coverage but had not informed the State agency.

Based on our sample results, we estimated that the State agency claimed $4,400,613 in unallowable Federal funding for grant years 2003–2005. This overpayment occurred because the State agency did not always follow its procedures for billing HIV/AIDS drugs to the insurance plans with primary payment responsibility and for documenting clients' eligibility for ADAP funds.

RECOMMENDATIONS

We recommend that the State agency:

- refund $4,400,613 to the Federal Government;
- follow its procedures for billing HIV/AIDS drugs to the Federal, State, or private health insurance plans with primary payment responsibility; and
- follow its procedures for documenting clients' eligibility for ADAP funds.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that refunding almost $4.5 million would have a devastating effect on ADAP clients. The State agency did not directly address our second and third recommendations. The State agency's comments, except for personally identifiable information, are included as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

The State agency did not provide any additional information that would cause us to modify our findings or recommendations.

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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 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 Florida, the Department of Health, Division of Disease Control, Bureau of HIV/AIDS (the State agency), administers the Title II program. The majority of Florida's 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 90 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]

[1]Subsequent to 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 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)."

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." Furthermore, in situations in which a client is eligible under ADAP but later becomes retroactively eligible for Medicaid, HRSA's "ADAP Manual," section II, chapter 3, page 3 (2003), provides that the State "should back-bill Medicaid for ADAP funds expended during the retroactive coverage period."

Program Eligibility Requirements

Pursuant to section 2616(b) of the Public Health Service Act (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." State agencies usually define financial eligibility as a percentage of the Federal poverty level. According to HRSA's "ADAP Manual," section II, chapter 1, page 6 (2003), States are responsible for determining whether patients meet the medical and financial eligibility requirements for enrollment in the ADAP. Florida's "AIDS Drug Assistance Program Manual" (2003) (the Florida Manual) states that ADAP medications may not be dispensed to patients until the State confirms and documents that the patients meet medical and financial eligibility requirements.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine, for grant years 2003–2005, whether the State agency:

- 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 and

- used the Title II funds only for clients whose files contained the documentation needed to determine eligibility for the ADAP.

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 State agency claimed ADAP expenditures totaling $214,126,688 for HIV/AIDS drugs.

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

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 significant controls related to the administration of the ADAP. Because of concerns about protecting program clients' personally identifiable information, we did not contact private health insurance companies to determine whether clients had private health insurance coverage.

We conducted our fieldwork at the State agency in Tallahassee, Florida, and at 21 of the 67 county health department offices located throughout Florida from May through November 2008.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed documentation provided by the State agency for grant years 2003–2005, 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 program);
- 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;
- reviewed the State agency's procedures for accounting for and dispensing drugs to Title II clients;
- used the State agency database to identify clients enrolled in Florida's ADAP;
- identified from the State agency's database a sampling frame of 86,621 HIV/AIDS prescriptions written during the period April 1, 2003, through March 31, 2006;
- selected a simple random sample of 100 prescriptions from the sampling frame and, for the sampled prescriptions:
    - identified the cost of the drugs dispensed using the State agency's drug prices by national drug code (NDC)[3] for each of the grant years reviewed;
    - compared the clients for whom the prescriptions were written against Florida's Medicaid Statistical Information System files to determine whether these clients had Medicaid drug benefits;

[3]The NDC is a unique 10-digit, 3-segment number assigned by the Food and Drug Administration to each drug and device that has been submitted as part of the listing process required by section 510 of the Federal Food, Drug, and Cosmetic Act. The NDC identifies the drug labeler (manufacturer or distributor), product, and trade package size.

- visited county health department offices to obtain client files; and

- reviewed the clients' files to determine whether (1) the clients picked up the sampled prescriptions; (2) the files contained the documentation needed to determine eligibility for the ADAP, including but not limited to laboratory results to document medical eligibility and the State agency's "ADAP Eligibility Determination and Enrollment Form" to document financial and program eligibility; and (3) the clients were enrolled in other government or private health insurance plans; and

- estimated, based on the sample results, the total unallowable Federal funding.

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

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.

FINDINGS AND RECOMMENDATIONS

The State agency (1) did not always 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 and (2) did not always use the Title II funds for clients whose files contained the documentation needed to determine eligibility for the ADAP. Of the 100 prescriptions in our sample, 86 were correctly claimed to the Title II program for eligible clients without other health care coverage for HIV/AIDS drugs. However, of the 14 remaining prescriptions, 5 were incorrectly claimed for clients who had other health insurance that would have covered the drugs, and 9 were incorrectly claimed for clients whose ADAP eligibility was not adequately documented. Because we did not contact private insurers to determine whether ADAP clients had private health insurance, we would not have identified any instances in which ADAP clients had such coverage but had not informed the State agency.

Based on our sample results, we estimated that the State agency claimed $4,400,613 in unallowable Federal funding for grant years 2003–2005. This overpayment occurred because the State agency did not always follow its procedures for billing HIV/AIDS drugs to the insurance plans with primary payment responsibility and for documenting clients' eligibility for ADAP funds.

IMPROPER TITLE II CLAIMS FOR PRESCRIPTION DRUGS

Other Health Insurance Coverage Available

The payer-of-last-resort requirement set forth in section 2617(b)(6)(F) of the Public Health Service Act 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 State agency claimed Title II funding for five sampled prescriptions dispensed to individuals who had other health insurance that would have covered the drugs and that had primary payment responsibility for the prescriptions. The five prescriptions, which totaled $2,876, were for clients covered by the State Medicaid program at the time the prescriptions were written.

Client Eligibility Not Documented

Pursuant to section 2616(b) of the Public Health Service Act, 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." The Florida Manual specifies how the State will implement these requirements. Regarding documentation of medical eligibility, the Florida Manual (page 15) requires that a patient provide "[a] laboratory test documenting confirmed HIV infection," and it lists specific laboratory tests that will be accepted. Regarding documentation of financial eligibility, the Florida Manual (page 6) requires the patient to document income for all household members at the first enrollment and every reenrollment. The Florida Manual includes descriptions of acceptable documentation of income, as well as descriptions of the necessary documentation that individuals who claim they have no income must produce.

Contrary to these requirements, the State agency claimed Title II funding for nine sampled prescriptions dispensed to nine clients for whom the State agency did not maintain adequate documentation of ADAP eligibility. Specifically, in three of the nine cases, the State agency could not provide the associated client files. In the six remaining cases, the State agency provided some evidence of the eligibility determination process, such as laboratory results documenting an HIV/AIDS diagnosis and disease progression or tests of income eligibility. However, the documentation provided was not sufficient to demonstrate that the individuals met both eligibility criteria. These nine prescriptions totaled $6,624.

Unallowable Federal Funding

Based on our sample results, we estimated that the State agency claimed $4,400,613 in unallowable Federal funding for grant years 2003–2005.

The State agency claimed the unallowable funding because it did not always follow its procedures for billing HIV/AIDS drugs to other insurance plans that would have covered the drugs and did not always follow its procedures for documenting clients' eligibility for ADAP funds.

RECOMMENDATIONS

We recommend that the State agency:

- refund $4,400,613 to the Federal Government;
- follow its procedures for billing HIV/AIDS drugs to the Federal, State, or private health insurance plans with primary payment responsibility; and
- follow its procedures for documenting clients' eligibility for ADAP funds.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with most of our findings and said that refunding almost $4.5 million would have a devastating effect on ADAP clients in Florida. The State agency did not directly address our second and third recommendations. The State agency also provided information on each of the 14 sampled prescriptions that we questioned. The State agency's comments, except for personally identifiable information, are included as Appendix C.

The information and accompanying documentation that the State agency provided was the same as that provided during our audit. The State agency did not provide any additional information that would cause us to modify our findings or recommendations.

The State agency's specific comments and our responses are summarized below.

Other Health Insurance Coverage Available

State Agency Comments

The State agency agreed that one client had Medicaid coverage and that Title II funds should not have been used for a prescription delivered during our audit period. However, the State agency stated that the four other clients included in our finding did not have Medicaid coverage when it performed ADAP eligibility screening.

The State agency noted that the screening process requires clients to be checked for Medicaid coverage upon enrollment and reenrollment in the ADAP program and that it relied on clients and case managers for information on Medicaid coverage changes. Although the State agency did not have the capability to share real-time information with the State Medicaid office during our audit period, the State agency said that it had established a data-sharing agreement with the Medicaid office and could now cross-match clients to determine whether a client has Medicaid coverage at the time of the prescription.

Office of Inspector General Response

During our review, we determined that clients had Medicaid drug coverage when five sampled prescriptions were written. In response to the State agency's comments, we clarified our finding to emphasize that these clients were covered by the State Medicaid program at the time the prescriptions were written. We note that one of these clients was covered by Medicaid not only at the time the prescription was written but also at the time of enrollment in the ADAP program.

The payer-of-last-resort requirement set forth in section 2617(b)(6)(F) of the Public Health Service Act stipulates that Title II funds are not to be used to pay for items or services that are eligible for coverage by Medicaid. The overpayments for the four disputed prescriptions occurred because the State agency's procedures did not identify clients who became eligible for Medicaid after the individual was enrolled in the Title II program but before the prescription was filled. Because the individuals were eligible for drug coverage under the Medicaid program, the State agency's Title II program should not have paid for the prescriptions. In addition, HRSA's "ADAP Manual," section II, chapter 3, page 3 (2003), requires that a State's ADAP agency "back-bill" Medicaid for Title II funds expended once a client receives retroactive Medicaid eligibility. Therefore, the State agency should retroactively bill Medicaid because the clients were Medicaid eligible at the time the prescriptions were written.

Client Eligibility Not Documented

State Agency Comments

In most cases, the State agency disagreed with our finding that it did not provide sufficient information to document the ADAP eligibility of its clients. The State agency also noted that three ADAP client files were missing and said that those files were damaged during a hurricane.

Office of Inspector General Response

The State agency did not provide new information to substantiate the ADAP eligibility of its clients. In some cases, the State agency's information did not pertain to the period related to the prescriptions in our sample. In other cases, the information was not sufficient to demonstrate compliance with the eligibility requirements of the Florida Manual (page 6) because it lacked income eligibility documentation for the clients or for the clients' household members. In addition, county officials informed us that the files damaged by the hurricane should have been identified by a prefix on the ADAP prescriptions. However, none of the sampled prescriptions that we questioned had the prefix corresponding to the facility damaged by the hurricane. Accordingly, we maintain that the State agency's documentation was not sufficient to demonstrate that nine clients met both HIV diagnosis and income eligibility criteria as required by section 2616(b) of the Public Health Service Act.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

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

SAMPLING FRAME

The sampling frame was a database containing 86,621 prescriptions for federally funded ADAP drugs dispensed from April 1, 2003, through March 31, 2006, to HIV/AIDS patients in Florida. During this period, the State agency claimed ADAP expenditures totaling $214,126,688.

SAMPLE UNIT

The sample unit was a federally funded prescription.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 prescriptions.

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 sequentially numbered the drug prescriptions in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items. We then created a list of sample items.

[1]We assumed that all drugs prescribed to an individual client with the same prescription date constituted one prescription. We did not count drug refills as additional prescriptions. If a prescription containing refills was considered improper, only the original prescription was counted as an error.

CHARACTERISTICS TO BE MEASURED

We considered a sample item improper if the client had other Federal, State, or private health insurance that covered the dispensed drug or if the program documentation to support client eligibility was inadequate.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the total unallowable Federal reimbursement for drugs.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Sample Size	Value of Sample	Number of Unallowable Prescriptions in Sample	Value of Unallowable Prescriptions in Sample
100	$64,968	14	$9,500

Estimated Value of Unallowable Prescriptions for Grant Years 2003–2005

Limits Calculated for a 90-Percent Confidence Interval

Point estimate	$8,229,160
Lower limit	$4,400,613
Upper limit	$12,057,706

FLORIDA DEPARTMENT OF HEALTH

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

August 27, 2009

Mr. Peter J. Barbera
Regional Inspector General
For Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Dear Mr. Barbera:

Dr. Viamonte Ros, Surgeon General and Secretary of the Florida Department of Health (DOH), has received the draft report from the U.S. Department of Health and Human Services, Office of Inspector General (OIG) on report number A-04-08-06002. As Chief of the DOH Bureau of HIV/AIDS, Dr. Viamonte Ros has asked me to respond on her behalf.

We thank you for the opportunity to provide feedback on the validity of the facts contained in the report and the reasonableness of the recommendations. Staffs in the DOH Bureau of HIV/AIDS have carefully reviewed the details of the report and strongly disagree with the interpretation of the findings and the recommendation that the state repay $4,400,613 to the Federal Government.

As noted on page three (3) of your draft report, from 2003-2006, the ADAP received over 86,000 prescriptions. These prescriptions served, on average, 12,000 plus clients each year. Each client was screened for program eligibility prior to receiving services from the ADAP program. To be eligible for the ADAP, patients are screened for the following:

• Documentation of HIV Status	• Medicaid and other insurance
• CD4 and Viral Load Tests results	• Documentation of Inadequate Insurance (for waivers)
• Income and assets documentation	• Prescription for a medication on the ADAP formulary

It is without doubt that the state has exercised reasonable, if not exceptional, care to ensure that clients who are in need of treatment from the ADAP are screened for eligibility using established policy and procedures. The bureau strives to maintain policy compliance through staff trainings, monitoring, education, legislative updates and requirements, policy changes, and access to technical assistance. Page 22 of the 2003 ADAP Policy Manual clearly outlines the documentation required in each client's file. Headquarters staffs provide trainings for ADAP staff as well as copies of the latest policy manuals. Headquarters staffs also conduct monitoring and have developed forms to assist ADAP workers in obtaining proper

Office of Inspector General Note: We have redacted personally identifiable information from this Appendix.

documentation. The 2003 ADAP Policy Manual (see pages 11-14) outlines specific guidelines related to insurance and Medicaid.

The OIG Office asserts that it "considered a sample [AKA client's record] improper if the client had other Federal, State, or private health insurance. . .", the ***State is in agreement with the statement***. The ADAP policy requires that clients be checked for Medicaid upon enrollment and re-enrollment. Of the cases in question, it is clear that the policy was consistently applied as it relates to the payer of last resort. Four of the 14 clients were closed to the system because of insurance, either during the period of re-enrollment or upon notification of status change. Again, this practice is consistent with ADAP policy and procedures.

Four of the fourteen files from the Broward County Health Department were missing documentation. As explained by the Broward County staff, during one of the hurricane events, boxes and files were damaged. As you know, hurricanes are very much a reality and a way of life for this state. In spite of this misfortune, Broward County was able to produce one of the four files cited. For the remaining three files, we provided a copy of the clients' diagnoses from the HIV/AIDS Reporting System (HARS), along with Medicaid screen shots submitted by the Broward pharmacist. This information showed that during the period in question, the identified clients were not eligible for Medicaid and were HIV positive—a likely probability that they were eligible for ADAP.

Attached you will find a response to each record the OIG labeled as "non-sufficient," along with accompanying documentation. The bureau provided this information previously in accordance with the original request. Our records show that in each instance, with the exception of one file, during the time of eligibility screening, the clients in question did not have other payer sources.

Since 2005, the bureau has continued to improve its practices by standardizing eligibility requirements statewide for HIV Patient Care Services through Rule 64D-4. The ADAP has implemented routine visits to the local county health departments to provide monitoring, quality assurance and technical assistance. The bureau holds quarterly statewide conference calls to provide updates and policy changes and to reinforce program requirements. In addition, the bureau holds bi-annual training conferences for persons administering ADAP and/or making referrals. Each quarter, new ADAP workers are trained on eligibility, with a special emphasis on payer of last resort. Although we are unable to have real-time information from the Agency for Health Care Administration (AHCA) Medicaid Office, the bureau has established a data-sharing agreement with AHCA to cross-match clients.

The bureau has also implemented automated controls in the ADAP database. These controls ensure that persons whose eligibility has expired are re-enrolled or their case is closed. The bureau continues to monitor the number of clients that remain active after the end of their eligibility period and takes the appropriate steps to re-enroll or close cases.

We are extremely proud of Florida's HIV/AIDS patient care programs, particularly the ADAP. We are confident that we have implemented and exercised reasonable and appropriate measures to ensure compliance from each of the 67 counties which administer the program. To require a payback from the department undermines the spirit and intent of the Ryan White Treatment and Modernization Act. We serve a population that is vulnerable, disenfranchised, stigmatized and lacking insurance or other means to pay for drugs and/or medical service. One of the essential duties of our program is to provide life-saving HIV care to the poorest and

sickest of our citizens. We are committed to doing so in a manner that is both dignified and cost effective. On a daily basis, our ADAP workers make decisions that impact whether a client will live or die. As an extremely sad example, in one of the "samples" you cited as "not adequately documented," our records show that the client did not, in fact, have Medicaid. Four months after enrolling in ADAP, the client died. It is vitally important that whatever role we play in ensuring the success of the Ryan White CARE Act, whether that role is implementing the very complex provisions of the grant or auditing compliance with those provisions, we not lose site of the fact that the "samples" or "random numbers" are actually people in crisis with nowhere else to turn. The recommendation that Florida return almost $4.5 million would have a devastating impact on 450 of these people.

Thank you again for the opportunity to comment on the report. We will continue to ensure that decisions to enroll clients in ADAP are based on sound policy, consistent procedures, HRSA guidance and the best information available at the time of eligibility screening.

If you need additional information or if I can answer any questions, please contact me at (850) 245-4477.

Sincerely,

Thomas Liberti

Thomas Liberti, Chief
Bureau of HIV/AIDS

Enclosure
TL/sr

CIN A-04-08-06002
Audit of Ryan White, Title II, AIDS Drug Assistance Program (ADAP)
Payer of Last Resort Audit in Florida

ADAP FINAL RESPONSE

OIG Summary of Audit Findings

A= Lack of documentation. The State could not provide an ADAP record for the date of the sampled Rx
B= Lack of eligibility documentation. No evidence that the eligibility process was completed
C= Other insurance – Medicaid MS. Ryan White should not have been the "Primary Payer"
D= Other Insurance – Medicaid MW-A. Ryan White should have been the "Primary Payer"
E + A= Other Insurance – Blue Cross Blue Shield and lack of documentation – no ADAP file

SAMPLE NUMBER: 95
SSN LAST 4 DIGITS: [redacted]
County: Duval/Clay CHD
Findings: E + A

Sample Rx Date: 08/01/2003
Enrollment date: 02/06/2003

Rx pickup date: 08/07/2003

Notes: According to OIG findings, records could not be found. After reviewing records provided by Clay County Health Department, We were able to find proof of HIV positivity but could not find proof of income. In addition OIG has found that client had Blue Cross/Blue Shield coverage effective 07/15/02. At that time, ADAP program policy required that client should be checked for insurance upon enrollment and re-enrollment and relied on the client and case manager for information of his/her insurance status change. Client was found as not having insurance during enrollment done on 02/06/2003 and once ADAP program was notified, record was closed out on 12/04/2003.

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SAMPLE NUMBER: 11
SSN LAST 4 DIGITS: [redacted]
County: Miami-Dade
Findings: A

Sample Rx Date: 05/12/2003
Enrollment date: 05/12/2003

Notes: According to OIG findings, records could not be found. Enclosed please find proof of HIV positivity and income. Please note that although client had access to food stamp, he was not qualified for Medicaid.

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SAMPLE NUMBER: 92
SSN LAST 4 DIGITS: [redacted]
County: Miami-Dade
Findings: A

Sample Rx Date: 01/20/2005
Enrollment date: 07/19/2004

Rx pickup date: 01/26/2005

Notes: According to OIG findings, records could not be found. Patient was served at South Shore Hospital, which has ceased operation since 2004. Senior attorney from Miami-Dade County Health Department, Office of HIV/AIDS, may issue a subpoena in order to obtain client's file. However, the process will exceed the deadline established by the OIG office. Enclosed please find email from senior attorney [redacted]

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SAMPLE NUMBER: 12
SSN LAST 4 DIGITS: [redacted]
County: Broward
Findings: A

Sample Rx Date: 07/24/2003
Enrollment date: 06/26/2003

Rx pickup date: 07/28/2003

Notes: According to OIG findings, records could not be found. Although ADAP was not able to locate supporting documentation, according to email from [redacted], Broward County Health Department, Office of HIV/AIDS, client has never been eligible for Medicaid. Enclosed please find letter from [redacted] and a snapshot from Medicaid system from 01/29/2009 showing that client has never been determined eligible for Medicaid.

****

SAMPLE NUMBER: 44
SSN LAST 4 DIGITS: [redacted]
County: Broward
Findings: B

Sample Rx Date: 10/01/2003
Rx pickup date: 10/09/2003 & 12/08/2003
Enrollment date: 10/01/2003

Notes: According to OIG findings, records could not be found. Although ADAP was not able to locate supporting documentation, according to the same email as above from [redacted] client has never been eligible for Medicaid. Enclosed please find a snapshot from Medicaid system from 01/29/2009 showing that client has never been determined eligible for Medicaid.

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SAMPLE NUMBER: 65
SSN LAST 4 DIGITS: [redacted]
County: Broward
Findings: B

Sample Rx Date: 11/17/2003
Rx pickup date: 11/17/2003
Enrollment date: 04/24/2003 & 12/01/2003

Notes: According to OIG findings, client's eligibility information could not be found. Broward County Health Department was able to find documents. Enclosed please find proof of HIV positivity and income.

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SAMPLE NUMBER: 23
SSN LAST 4 DIGITS: [redacted]
County: Broward
Findings: B

Sample Rx Date: 05/02/2003
Rx pickup date: 05/06/2003 & 05/27/2003
Enrollment date: 05/23/2003

Notes: According to OIG findings, records could not be found. Although ADAP was not able to locate supporting documentation, according to the same email from sample 12, client has never been eligible for Medicaid. Enclosed please find a snapshot from Medicaid system from 01/29/2009 showing that client has never been determined eligible for Medicaid.

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SAMPLE NUMBER: 4
SSN LAST 4 DIGITS: [redacted]
County: Miami-Dade
Findings: B

Sample Rx Date: 01/06/2005
Enrollment date: 11/09/2004

Rx pickup date: 01/11/2005

Notes: According to OIG findings, records could not be found. Enclosed please find proof of HIV positivity and income.

****

SAMPLE NUMBER: 55
SSN LAST 4 DIGITS: [redacted]
County: Miami-Dade
Findings: B

Sample Rx Date: 05/07/2004
Enrollment date: 11/16/2004

Rx pickup date: 05/07/2004

Notes: According to OIG findings, records could not be found. Miami-Dade office was able to find documents. Enclosed please find proof of HIV positivity and income.

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SAMPLE NUMBER: 3
SSN LAST 4 DIGITS: [redacted]
County: Broward
Findings: C

Sample Rx Date: 04/07/2003
Enrollment date: 03/21/2003

Rx pickup date: 03/21/2003 & 04/07/2003
Rx entry date: 06/19/2003

Notes: According to OIG findings, client had Medicaid coverage when prescription was filled. However, at the time of enrollment, 03/21/2003, client did not have access to Medicaid as coverage became effective on 04/01/2003. ADAP program policy required that client should be checked for Medicaid upon enrollment and re-enrollment and relied on the client and case manager for information of his/her Medicaid status change. In addition, ADAP did not have the ability to share data as we do now.

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SAMPLE NUMBER: 63
SSN LAST 4 DIGITS: [redacted]
County: Marion
Findings: C

Sample Rx Date: 04/20/2005
Enrollment date: 04/21/2005

Rx pickup date: 05/04/2005

Notes: According to OIG findings, client had Medicaid coverage when prescription was filled. However, at the time of enrollment, 04/21/2005, client did not inform of his Medicaid status, which could have been the case due to mailing timing as client's coverage became effective on 04/01/2005. Once ADAP program was informed by the client of his status, record was closed out on 06/21/2005.

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SAMPLE NUMBER: 86
SSN LAST 4 DIGITS: [redacted]
County: Alachua
Findings: C

Sample Rx Date: 05/24/2004
Enrollment date: 05/26/2004

Rx pickup date: 06/14/2004

Notes: According to OIG, client had Medicaid coverage between April 1, 2004 and June 30, 2004 and RW funds should not have been used for prescription delivered on 06/14/2004. According to notes from ADAP Contact, client should have been closed.

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SAMPLE NUMBER: 91
SSN LAST 4 DIGITS: [redacted]
County: Palm Beach
Findings: C

Sample Rx Date: 01/16/2006
Enrollment date: 12/13/2005

Rx pickup date:

Notes: According to OIG findings, client had Medicaid coverage when prescription was filled. However, at the time of enrollment, 12/13/2005, client did not have access to Medicaid as coverage became effective on 01/01/2006. Once ADAP program was informed by the client of his Medicaid status change, record was closed out on 04/04/2006. ADAP policy required that client should be checked for Medicaid upon enrollment and re-enrollment and relied on the client and case manager for information of his/her Medicaid status change. In addition, ADAP did not have the ability to share data as we do now.

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SAMPLE NUMBER: 31
SSN LAST 4 DIGITS: [redacted]
County: Pasco
Findings: D

Sample Rx Date: 12/08/2004
Enrollment date: 09/09/2004
Closure date: 02/02/2005
Reason for Closure: Medicaid

Rx pickup date: 01/31/2005

Notes: According to OIG, client had Medicaid coverage when prescription was filled. However, at the time of enrollment, client did not have access to Medicaid as coverage became effective on 10/01/2004. Once ADAP program was informed by the client of his Medicaid status change, record /was closed out of ADAP on 02/02/2005. ADAP policy required that client should be checked for Medicaid upon enrollment and re-enrollment and relied on the client and case manager for information of his/her Medicaid status change. In addition, ADAP did not have the ability to share data as we do now.