DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

June 22, 2009

Report Number: A-06-08-00022

Ms. Janna Zumbrun
TB/HIV/STD Unit Manager, MC 7909
Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3199

Dear Ms. Zumbrun:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of the Texas Department of State Health Services' Compliance with the Ryan White CARE Act Payer-of-Last-Resort Requirement for the Period April 1, 2003 Through March 31, 2006." We will forward a copy of this report to the HHS action official noted below.

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 direct them to the HHS action official. Please refer to report number A-06-08-00022 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

cc:
Ms. Michelle Esquivel, CPA
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES' COMPLIANCE WITH THE RYAN WHITE CARE ACT PAYER-OF-LAST-RESORT REQUIREMENT FOR THE PERIOD APRIL 1, 2003 THROUGH MARCH 31, 2006

Daniel R. Levinson
Inspector General

June 2009
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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, 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 Texas Department of State Health Services (the State agency) claimed Federal Title II drug expenditures totaling $157,919,450.

OBJECTIVE

Our objective was 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.

SUMMARY OF FINDING

The State agency appeared to have 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. However, because we did not contact private insurers to determine whether ADAP clients had private insurance coverage, we would not have identified any instances in which ADAP clients had such coverage but had not informed the State agency. This report contains no recommendations.

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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 Texas, the Department of State Health Services (the State agency) administers the Title II program. During the period April 1, 2003, through March 31, 2006, the State agency claimed Federal Title II drug expenditures totaling $157,919,450.

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 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)."

[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 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.

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 Federal ADAP expenditures totaling $157,919,450[3] for HIV/AIDS drugs dispensed.

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 claiming HIV/AIDS prescription drug costs. Because of concerns about protecting program clients' personally identifiable information, we did not contact private health insurance companies to confirm health insurance coverage. We conducted our fieldwork at the State agency's offices in Austin, Texas from January 2008 through December 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed documentation provided by the State agency for grant years 2003–2005, including Title II grant applications, 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 State agency officials, public health clinic officials and an ADAP participating pharmacist to identify policies, procedures, and guidance used to identify other insurance coverage for ADAP clients;
- identified a sampling frame of 724,700 prescriptions totaling $225,851,667;

[3]Title II of the CARE Act, section 2617(d)(1), indicates that States must also contribute funds. Texas paid a total of $230,787,848 for prescription drugs dispensed to ADAP clients for grant years 2003–2005.

- analyzed and discussed the State agency's procedures for accounting for and dispensing prescription drugs to ADAP clients;

- selected a stratified random sample of 120 prescriptions from the sampling frame of 724,700 prescriptions and

    - contacted the Texas Workforce Commission to verify the employer-reported income of ADAP clients who received the sampled prescriptions,

    - contacted Texas Medicaid officials to determine whether clients were enrolled in Medicaid and whether Medicaid would have covered the prescription,

    - reviewed the State agency's files to determine whether clients were enrolled in other health insurance plans,

    - reviewed the State agency's drug formulary pricing schedules and drug database to identify the cost of dispensed drugs; and

- reviewed State agency data to determine whether there was evidence that ADAP clients were enrolled in Medicaid and private health insurance plans.

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 finding and conclusions based on our audit objective.

RESULTS OF REVIEW

The State agency appeared to have 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. However, because we did not contact private insurers to determine whether ADAP clients had private insurance coverage, we would not have identified any instances in which ADAP clients had such coverage but had not informed the State agency. This report contains no recommendations.