



September 22, 2011

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

**FROM:** /Daniel R. Levinson/  
Inspector General

**SUBJECT:** Review of Ryan White Part B Funding and the Payer-of-Last-Resort Requirement  
(A-05-10-00088)

The attached final report provides the results of our review of Ryan White Part B funding and the payer-of-last-resort requirement.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (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 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](mailto:Lori.Pilcher@oig.hhs.gov). We look forward to receiving your final management decision within 6 months. Please refer to report number A-05-10-00088 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF RYAN WHITE  
PART B FUNDING AND THE  
PAYER-OF-LAST-RESORT  
REQUIREMENT**



Daniel R. Levinson  
Inspector General

September 2011  
A-05-10-00088

# *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 (HRSA) administers the CARE Act.

Title II (Part B) of the CARE Act (42 U.S.C. §§ 300ff-21–300ff-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. Part B 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.

### **OBJECTIVES**

Our objectives were to (1) summarize the results of prior audits that determined whether certain States complied with the Part B payer-of-last-resort requirement and whether the States used the Part B funds only for eligible clients and to (2) determine whether HRSA could improve its oversight to ensure that States comply with payer-of-last-resort and eligibility requirements.

### **SUMMARY OF FINDINGS**

Five of the nine States reviewed claimed costs for prescriptions dispensed to individuals who had other health insurance that would have covered the drugs, and two States claimed costs for prescriptions dispensed to clients for whom the respective States did not maintain adequate documentation of ADAP eligibility. The States claimed unallowable costs totaling \$33.4 million because they did not have adequate controls to ensure compliance with the Part B payer-of-last-resort requirement or did not follow their eligibility procedures.

HRSA could improve its oversight to ensure that States comply with payer-of-last-resort and eligibility requirements. We identified best practices in two States that HRSA could use to help States improve compliance with the statutory requirement that Ryan White funds not be used when private health insurance can reasonably be expected to pay for an item or service.

Because HRSA has provided inconsistent guidance on eligibility recertifications, States vary widely in how frequently and to what extent they recertify client eligibility.

## **RECOMMENDATIONS**

We recommend that HRSA:

- require States to work with their State Medicaid agencies to identify Ryan White clients who obtain Medicaid coverage during the period of their Part B coverage;
- require States to process retroactive Medicaid claims for individuals eligible for Medicaid at the time Ryan White funds were used to pay their claims and credit the Ryan White program for any Medicaid payment; and
- ensure that funds are not used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance by specifically:
  - providing technical assistance to States on best practices for implementing the statutory payer-of-last-resort mandate regarding private insurance, such as contracting with an outside vendor to perform data matches to identify clients with private health insurance and initiate recovery actions, and
  - requiring that ADAP recertifications be performed consistently and uniformly across States and not be limited to comparing ADAP eligibility with Medicaid eligibility files.

## **HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS**

In written comments on our draft report, HRSA concurred with our recommendations. HRSA's comments are included in their entirety as Appendix B.

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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.

### **Part B Grant Funds**

Title II (Part B) of the CARE Act (42 U.S.C. §§ 300ff-21–300ff-38) provides grants to States and territories to fund the purchase of medications through AIDS Drug Assistance Programs (ADAP) and other HIV/AIDS health care and support services, such as outpatient care, home and hospice care, and case management. Part B 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.

### **Office of Inspector General Reviews of Ryan White Title II Funding**

We conducted nine reviews to determine whether State and territory agencies (States) complied with the Part B payer-of-last-resort requirement and whether the States used the Part B funds only for eligible clients. (See Appendix A for a list of our reviews and review periods.)

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

### **Objectives**

Our objectives were to (1) summarize the results of prior audits that determined whether certain States complied with the Part B payer-of-last-resort requirement and whether the States used the Part B funds only for eligible clients and to (2) determine whether HRSA could improve its oversight to ensure that States comply with payer-of-last-resort and eligibility requirements.

### **Scope**

Our nine prior reviews covered various periods from April 1, 2002, through March 31, 2007. We conducted fieldwork at the respective States and HRSA offices in Rockville, Maryland.

### **Methodology**

To accomplish our objectives, we analyzed the findings and recommendations from our prior audits, reviewed Federal requirements and HRSA policies on program oversight, and discussed

compliance with payer-of-last-resort and eligibility requirements with HRSA officials. We also performed additional work to determine if any of the nine States had implemented a 6-month recertification process.

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**

Five of the nine States reviewed claimed costs for prescriptions dispensed to individuals who had other health insurance that would have covered the drugs, and two States claimed costs for prescriptions dispensed to clients for whom the respective States did not maintain adequate documentation of ADAP eligibility. The States claimed unallowable costs totaling \$33.4 million<sup>1</sup> because they did not have adequate controls to ensure compliance with the Part B payer-of-last-resort requirement or did not follow their eligibility procedures.

HRSA could improve its oversight to ensure that States comply with payer-of-last-resort and eligibility requirements. We identified best practices in two States that HRSA could use to help States improve compliance with the statutory requirement that Ryan White funds not be used when private health insurance can reasonably be expected to pay for an item or service.

Because HRSA has provided inconsistent guidance on eligibility recertifications, States vary widely in how frequently and to what extent they recertify client eligibility.

## **NONCOMPLIANCE WITH PART B REQUIREMENTS**

### **Payer-of-Last-Resort Requirement Not Met**

Part B 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. 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

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<sup>1</sup> The estimated unallowable costs for Florida and Pennsylvania are based on sample results for clients who had other insurance or were ADAP ineligible. The specific dollar amounts associated with either the payer-of-last-resort requirement or ADAP eligibility were not determinable.

health benefits program; or (ii) by an entity that provides health services on a prepaid basis.<sup>2</sup>

In addition, HRSA Program Policy No. 97-02, issued February 1, 1997, and reissued as DSS<sup>3</sup> 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 Part B 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."

Florida, Illinois, New Jersey, Pennsylvania, and Puerto Rico claimed unallowable costs for prescriptions dispensed to individuals who had other health insurance (Medicaid and other public or private health insurance plans) that would have covered the drugs. The other health insurance plans had primary payment responsibility for these prescriptions.

States did not bill Medicaid or other insurance plans because they did not have adequate procedures for identifying when to bill other insurance plans that would have covered the drugs. At least one State had not developed procedures to bill covered drugs to other insurance plans. Another State's procedures did not identify beneficiaries who received similar services covered by Medicaid. In addition, three States failed to retroactively bill the State Medicaid agencies for ADAP drug costs incurred since the dates of the individuals' Medicaid applications.

### **AIDS Drug Assistance Programs Eligibility**

Pursuant to 42 U.S.C. § 300ff-26(b)), to be eligible to receive assistance from a State under Part B 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."<sup>4</sup> 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.

Florida and Pennsylvania claimed unallowable costs for Part B funding for prescriptions dispensed to clients for whom the States did not follow their eligibility procedures. Pennsylvania claimed costs for individuals who did not meet the income eligibility requirement. Both Florida and Pennsylvania failed to maintain adequate documentation of ADAP eligibility. In both

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<sup>2</sup> The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (2006 Amendments), §§ 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)."

<sup>3</sup> DSS is the Division of Service Systems, a component of HRSA's HIV/AIDS Bureau.

<sup>4</sup> The 2006 Amendments struck out "HIV disease" wherever it appeared and inserted "HIV/AIDS."

States, some case folders did not contain documentation of an HIV/AIDS diagnosis. In Florida, some files lacked documentation of income eligibility.

## **NEED FOR IMPROVED OVERSIGHT**

### **Best Practices Regarding Identification of Other Insurance**

States are required to ensure that Ryan White grant funds are not used when an individual has insurance that can reasonably be expected to pay for the item or service. We identified practices in two States that HRSA could use in its outreach efforts to help States improve compliance with the payer-of-last-resort requirement. In response to our audit, Pennsylvania contacted private insurance companies and found that the clients' private insurance would have covered the drugs paid by Part B. In addition, New Jersey contracted with an outside vendor to perform data matches to identify clients with private health insurance. The contractor reviewed for third-party liability by matching ADAP clients against a database that included government plans, commercial insurance, casualty insurance, and other third-party payers and initiated actions to recover payments made for ADAP clients who had other health insurance coverage.

### **Inconsistent Application of Recertification Criteria**

HRSA's *ADAP Manual*, section V.1 (2003) and DSS Program Policy Guidance No. 6 (June 1, 2000) (included in section IV of HRSA's *Care Act Title II Manual* (2003)) both state that "[e]very State should establish and implement procedures for ADAP client re-certification on a periodic basis ...." HRSA informed us that each Ryan White Part B grant states that grantees must implement an ADAP recertification process, at a minimum, every 6 months to ensure that the program serves only eligible clients. A fact sheet issued by HRSA in August 2008 describes in general terms the Ryan White HIV/AIDS program and states: "All States and Territories are required to implement an ADAP recertification process every 6 months to ensure that only eligible clients are served." However, a HRSA official noted that recertification every 6 months may not be feasible because of resource limitations. Additionally, this official stated that HRSA has informed some States that the recertification requirement will be satisfied if the State compares the ADAP client file with State Medicaid eligibility files.

Based on our limited review of State policies and regulations, we found that three States currently require recertifications every 6 months; however, others require annual recertifications, and one State requires recertifications only once every 3 years. Additionally, in place of a 6-month recertification, two other States match client eligibility with Medicaid eligibility files at least monthly.

## **RECOMMENDATIONS**

We recommend that HRSA:

- require States to work with their State Medicaid agencies to identify Ryan White clients who obtain Medicaid coverage during the period of their Part B coverage;

- require States to process retroactive Medicaid claims for individuals eligible for Medicaid at the time Ryan White funds were used to pay their claims and credit the Ryan White program for any Medicaid payment; and
- ensure that funds are not used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance by specifically:
  - providing technical assistance to States on best practices for implementing the statutory payer-of-last-resort mandate regarding private insurance, such as contracting with an outside vendor to perform data matches to identify clients with private health insurance and initiate recovery actions, and
  - developing and enforcing guidance to help ensure that ADAP recertifications are performed consistently and uniformly across States and are not limited to comparing ADAP eligibility with Medicaid eligibility files.

#### **HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS**

In written comments on our draft report, HRSA concurred with our recommendations. HRSA's comments are included in their entirety as Appendix B.

# **APPENDIXES**

**APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REVIEWS**

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<b>State or Territory</b>	<b>Review Number</b>	<b>Review Period</b>	<b>Costs That Did Not Meet Payer-of-Last-Resort and/or Eligibility Requirements</b>
California	A-09-09-00037	April 1, 2003, to June 30, 2006	\$0
Florida	A-04-08-06002	April 1, 2003, to March 31, 2006	4,400,613
Illinois	A-05-08-00052	April 1, 2003, to March 31, 2006	808
Maryland	A-03-08-00551	April 1, 2003, to March 31, 2006	0
New Jersey	A-02-08-02007	April 1, 2003, to March 31, 2006	2,498,819
New York	A-02-08-02006	April 1, 2003, to March 31, 2006	0
Pennsylvania	A-03-08-00552	April 1, 2004, to March 31, 2007	2,162,998
Puerto Rico	A-02-06-02000	April 1, 2002, to March 31, 2005	24,340,789
Texas	A-06-08-00022	April 1, 2003, to March 31, 2006	0
<b>Total</b>			<b>\$33,404,027</b>

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## APPENDIX B: HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services  
Administration

Rockville, MD 20857

June 1, 2011

TO: Inspector General

FROM: Administrator

SUBJECT: OIG Draft Report: "Review of Ryan White Part B Funding and the Payer-of-Last-Resort Requirement" (A-05-10-00088)

Attached is the Health Resources and Services Administration's (HRSA) response to the OIG's draft report, "Review of Ryan White Part B Funding and the Payer-of-Last-Resort Requirement" (A-05-10-00088). If you have any questions, please contact Sherry Angwafo in HRSA's Office of Federal Assistance Management at (301) 443-9547.

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

Attachment

**Health Resources and Services Administration's Comments on the OIG Draft Report – "Review of the Ryan White Part B Funding and the Payer-of-Last-Resort Requirement" (A-05-10-00088)**

The Health Resources and Services Administration (HRSA) appreciates the opportunity to respond to the above subject draft report. HRSA's comments regarding the Office of Inspector General's (OIG) findings and recommendations are as follows:

**Page 2: OIG FINDINGS AND RECOMMENDATIONS:**

**First paragraph:**

Five of nine States reviewed claimed costs for prescriptions dispensed to individuals who had other health insurance that would have covered the drugs, and two States claimed costs for prescriptions dispensed to clients for whom the respective States did not maintain adequate documentation of ADAP eligibility. The States claimed unallowable costs totaling \$33.4 million because they did not have adequate controls to ensure compliance with the Part B payer-of-last resort requirement or did not follow their eligibility procedures.

**HRSA Response:**

Ryan White Part B Grantees were made aware of the legislative Payer-of-Last-Resort requirement using several methods: 1) the annual Ryan White Part B Grant Application, 2) the conditions of grant award which accompany the Notice of Grant Award (NGA), and 3) Assurances and Certifications that must be signed by the Chief Elected Official or designee of each state Part B Program. The language in the Assurances and Certifications is as follows: Grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service

- under any state compensation program, insurance policy, federal or state health benefits program, or
- 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 Services).

Appropriate monitoring systems include controls to ensure compliance and prevent unallowable costs and improper payments. In addition, monitoring systems are to include policies that define client eligibility based on proof of HIV status and income level. The definitions for allowable program activities and allowable program costs are available to grantees. Each Ryan White Part B Grantee is responsible for the development of appropriate monitoring systems at both the state and local levels.

**Second Paragraph:**

HRSA could improve its oversight to ensure that States comply with the payer-of-last-resort and eligibility requirements. We identified best practices in two States that HRSA could use to help States improve compliance with the statutory requirement that Ryan White funds not be used when private health insurance can reasonably be expected to pay for an item or service.

**HRSA Response:**

When it is determined that HRSA grantees or sub-grantees have misused or mismanaged federal funds, the grantees are required to submit a corrective action plan to HRSA's grants management officials stating how and when the instance of mismanagement or misuse will be corrected. Sometimes, this corrective action plan is part of the A-133 audit. The submission and completion of the corrective action plan may also become a condition of the grant award. Failure to comply with this condition could result in delay or denial of the payment of grant funds. Situations of misuse and mismanagement of grant funds can result in actions to collect mismanaged funds. The integration of the financial assessments into the Electronic Handbooks has provided HRSA with the capability to electronically monitor grantees' responses to conditions placed on grant awards.

When grant funds are misused, for example, to pay for a service that is not allowed under any federal grant program, project officers are typically the first to learn about it through their grant monitoring activities or during site visits. Consequently, the project officer then works closely with the grantee staff (and planning council/planning body, as appropriate) to prevent such misuse of funds in the future, while HRSA's grants management officials work with the grantee to recover the funding.

**Third paragraph:**

Because HRSA has provided inconsistent guidance on eligibility recertifications, States vary widely in how frequently and to what extent they recertify client eligibility.

**HRSA Response:**

Since these OIG audits occurred, HRSA has provided additional guidance on eligibility recertification and established timeframes for states to recertify clients. These requirements are included in the Annual Ryan White Part B Application Guidance, and are also part of the program terms and conditions, which accompany the Notice of Grant Award for Part B/AIDS Drug Assistance Program (ADAP).

On April 1, 2011, the HIV/AIDS Bureau (HAB) released the *National Monitoring Standards* for Part A and Part B Grantees. *The National Monitoring Standards* are a compilation of the minimum requirements for program and fiscal monitoring, and include Title XXVI of the Public Health Service Act, 42 U.S.C. Section 300ff-11 et seq., also

known as the Ryan White HIV/AIDS Program legislation; the Code of Federal Regulations; Federal, Department of Health and Human Services (HHS); and the Public Health Service Grant Management policies (such as, the Office of Management and Budget Circulars, and the HHS Grants Policy Manuals); HRSA/HAB policies and guidelines; Part A and B Program Guidance Documents, Notices of Grant Award and Conditions of Award (which accompany the annual grant awards), OIG reports and recommendations, Manuals and Guides issued by HRSA (such as the Part A and B Manuals).

States are required to recertify for ADAP eligibility every 6 months. The recertification processes are to include verification of income and the existence of other payer sources. These requirements are detailed in the National Monitoring Standards.

**OIG Recommendations to HRSA:**

Require States to work with their State Medicaid agencies to identify Ryan White clients who obtain Medicaid coverage during the period of their Part B coverage.

Require States to process retroactive Medicaid claims for individuals eligible for Medicaid at the time Ryan White funds were used to pay their claims and credit the Ryan White program for any Medicaid payment.

**HRSA Response:**

HRSA concurs with these recommendations and already requires states to work with Medicaid agencies and develop systems for "back-billing" of Medicaid for clients who obtain coverage during their initial Ryan White HIV/AIDS Program coverage period.

Currently HRSA is enforcing the Payer-of-Last-Resort requirement through its existing monitoring systems. Plans are currently being developed to highlight, by the use of webinars, technical assistance and conference presentations, state programs that created effective collaborations with Medicaid programs. HRSA will make the Payer-of-Last-Resort and its models of Medicaid collaboration a focal point of key sessions at the 2012 Ryan White HIV/AIDS Program All Grantees Meeting.

**OIG Recommendation to HRSA:**

Ensure that funds are not used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance by specifically:

- providing technical assistance to States on best practices for implementing the statutory payer-of-last-resort mandate regarding private insurance, such as contracting with an outside vendor to perform data matches to identify clients with private health insurance and initiate recovery actions, and

- developing and enforcing guidance to help ensure that ADAP recertifications are performed consistently and uniformly across States and are not limited to comparing ADAP eligibility with Medicaid eligibility files.

**HRSA Response:**

HRSA concurs with this recommendation and will continue its efforts to provide technical assistance and guidance to states regarding Payer-of-Last-Resort. Technical assistance is provided through a variety of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, reverse site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development of products and training curricula in hard copy or web-based, email list serves and other means of regular communications and information dissemination. HRSA has a technical assistance cooperative agreement in the area of fiscal management; this agreement provides a nationwide approach for multifaceted information dissemination and direct provision of training and technical assistance that will also include methods for implementing the statutory Payer-of-Last-Resort requirement.

On July 8, 2011, HRSA released a \$40 million funding opportunity for disbursement of ADAP funds to states that have established and reported waiting lists. As a condition of the grant award, states will be required to use the funds to address current ADAP waiting lists and cost-containment strategies, such as: modifying drug purchasing and distribution methods; utilizing health insurance purchasing options; improving coordination with Medicaid and Medicare Part D; instituting or improving client eligibility recertification to assure Ryan White HIV/AIDS Program funds are used as the Payer-of-Last-Resort; implementing co-pays on a sliding fee scale basis; modifying the ADAP formulary; and, modifying ADAP income eligibility requirements. As described above, on April 1, 2011, HAB released the *National Monitoring Standards* for Part A and Part B Grantees.