Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

KEYSTONE FIRST SHOULD IMPROVE ITS PROCEDURES FOR REVIEWING SERVICE REQUESTS THAT REQUIRE PRIOR AUTHORIZATION

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Inspector General

December 2022
A-03-20-00201

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

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

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.

Report in Brief
Date: December 2022
Report No. A-03-20-00201

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization

Why OIG Did This Audit

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid beneficiaries. The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid managed care organization (MCO) industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight.

Our objective was to determine whether Keystone First HealthChoices complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required prior authorization.

How OIG Did This Audit

During 2018 and 2019, Keystone First denied 136,022 physical health service requests that required a prior authorization. Our audit covered 2,482 denied pediatric skilled nursing requests and 1,702 dental, radiology, pharmacy, and medical denials overturned by Keystone First during the appeals process. We selected and reviewed a judgmental sample of 100 denied service requests that required a prior authorization to determine whether they complied with Federal and State requirements.

What OIG Found

Keystone First did not comply with Federal and State requirements when denying 76 of the sampled denied service requests. Specifically, Keystone First should not have denied the overnight care portion of 10 denied sampled pediatric skilled nursing service requests on the basis that it had not received work or school verification documentation for the caregiver. For 72 denied service requests, Keystone First's denial letter, based on Pennsylvania's required form, did not inform beneficiaries of their right to request a State fair hearing after exhausting the MCO's appeals process.

Denying overnight care that should be approved could place the health and safety of the beneficiary at risk. If beneficiaries do not receive information about their right to request a State fair hearing, they may not have the information needed to enable them to understand the totality of the appeals process and their rights and options within that process.

What OIG Recommends and Keystone First and State Agency Comments

We recommend that Keystone First coordinate with Pennsylvania to: (1) update Keystone First's administrative process to require that medical directors assess whether overnight care requests meet the medical necessity requirement, even if some documentation is missing; (2) review all pediatric skilled nursing service requests for which overnight care was completely denied and determine whether overnight care requests meet the medical necessity requirement; and (3) implement a revised initial denial notice to explain that a beneficiary has the right to request a State fair hearing after exhausting the MCO's appeals process. We also recommend that Pennsylvania revise its denial notice template. The full recommendations are in the report.

In written comments on our draft report, Keystone First stated that it concurred with the intent of all three recommendations addressed to it. Pennsylvania also concurred with the recommendation addressed to it and concurred with the first and third recommendations addressed to Keystone First but did not concur with the second recommendation due, in part, to a COVID-19 waiver. Both Keystone First and Pennsylvania described corrective actions that they have taken and plan to take in response to our recommendations. We believe that any new requests for pediatric skilled nursing services not covered by the COVID-19 waiver should be reviewed.

The full report can be found at https://oig.hhs.gov/oas/reports/region3/32000201.asp.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid beneficiaries. Medicaid managed care organizations (MCOs) provide Medicaid beneficiaries with coverage for a variety of health care services through a network of contracted health care providers. Specifically, MCOs may cover medical (inpatient, outpatient, and laboratory), radiology, dental, and pharmacy services.

The Senate Special Committee on Aging requested that OIG conduct a review of the Medicaid MCO industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight. Specifically, these articles identified concerns related to patient neglect due to MCO denials of requests for medically necessary services and lack of oversight by the Centers for Medicare & Medicaid Services (CMS).[1] This report is the first in a series of OIG reports to examine Medicaid MCO denials.

We selected Keystone First HealthChoices (Keystone First) for audit because it had the highest number of denied services of any Medicaid MCO in Pennsylvania during calendar years 2018 and 2019 (audit period).

OBJECTIVE

Our objective was to determine whether Keystone First complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required prior authorization.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a

[1] *Des Moines Register*, "Care Denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals," Jan. 16, 2018; *Dallas Morning News*, "As patients suffer, companies rack up profits," June 3, 2018; *Los Angeles Times*, "Coverage denied: Medicaid patients suffer as layers of private companies profit," Dec. 19, 2018; and the Pennsylvania Health Law Project, *Health Law News*, "Alert: Consumers Face Barriers Challenging Service Denials by Keystone First and AmeriHealth Caritas," Feb. 28, 2020.

CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid beneficiaries. States contract with MCOs to make services available to enrolled Medicaid beneficiaries. Under a risk-based managed care plan, State Medicaid agencies pay MCOs a capitation payment—a fixed amount per beneficiary per month—for each enrolled beneficiary. The State Medicaid agency makes the payment regardless of whether the beneficiary receives services during the period covered by the payment.

The contractual risk-based arrangements between State Medicaid agencies and MCOs shift financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO. If an MCO spends more on covered services than it receives in capitation payments, the MCO absorbs the loss; if it spends less, it keeps the gain. This financial risk gives MCOs a potential incentive to limit what they pay their network providers either by improperly denying beneficiaries' access to covered services or by constraining their payments to providers, or both.

The State Medicaid agency is responsible for monitoring its Medicaid managed care program. The State's monitoring system must address all aspects of the managed care program, including the performance of each MCO's administration and management, appeal and grievance systems, and claims management (42 CFR §§ 438.66(a) and (b)). Each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary (42 CFR § 438.210(a)(3)(ii)).

Pennsylvania's Medicaid Managed Care Program

The Pennsylvania Department of Human Services, Office of Medical Assistance Programs (State agency) oversees the physical health portion of Pennsylvania's medical assistance managed care program, known as HealthChoices. Under HealthChoices, the State agency provides physical health services through physical health MCOs; other managed care programs operated by the Pennsylvania Department of Human Services include behavioral health services provided through behavioral health MCOs and long-term services and supports provided through long-term services and supports MCOs.

Between January 1, 2018, and December 31, 2019, Pennsylvania had contractual agreements with eight physical health MCOs, five behavioral health MCOs, and three long-term services and supports MCOs (that cover dual-eligible (Medicare and Medicaid) beneficiaries) to ensure that all services covered under the various managed care programs were available and accessible to MCO enrollees. During 2019, the State agency's payments to the eight physical health MCOs totaled $13.4 billion.

State regulations at 55 Pa. Code section 1101.21 specify that to be considered medically necessary, a service, item, procedure, or level of care must be: (1) compensable under the Medical Assistance Program; (2) necessary to the proper treatment or management of an illness, injury, or disability; and (3) prescribed, provided, or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice. In addition, a service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that: (1) will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability; (2) will, or is reasonably expected to, reduce the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (3) will assist the beneficiary to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the beneficiary and the functional capacities appropriate for recipients of the same age (55 Pa. Code § 1101.21a).[2]

The scope of benefits for which beneficiaries are eligible differs according to beneficiaries' categories of assistance, as stated in 55 Pa. Code section 1101.31. Beneficiaries under 21 years of age are eligible for all medically necessary services.

To help facilitate the State agency's monitoring efforts, MCOs provide the State agency with a monthly list of all denied service requests. The State agency randomly selects and reviews some of these denied service requests to verify that the denials meet standards identified in agreements between the MCOs and the State agency.

Keystone First HealthChoices

Keystone First, headquartered in Philadelphia, is Pennsylvania's largest HealthChoices physical health MCO. During 2019, Keystone First served more than 400,000 Medicaid beneficiaries in the 5-county Greater Philadelphia area and received approximately $2.9 billion in gross revenues from the State agency to cover these beneficiaries.[3]

Keystone First provides general direction, policy development, and support for its network providers, which include hospitals, urgent care clinics, and other types of facilities. These providers deliver covered physical health services to beneficiaries.

Keystone First's Prior Authorization Process

To be covered by Keystone First's Medicaid MCO plan, health care services must be medically necessary as defined in Keystone First's Shift Care Prior Authorization Policy and the HealthChoices Agreement between the State and Keystone First. Keystone First's *Member*

[2] Under the HealthChoices Agreement, a service is considered medically necessary if it is compensable under the Medical Assistance Program and meets any one of the standards under 55 Pa. Code § 1101.21a.

[3] The Greater Philadelphia area consists of Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

Handbook provides a list of covered services that have limits or require prior authorization.[4] If a service is needed beyond the limits listed in Keystone First's plan, the health care provider can request an exception. In addition, health care services requiring prior authorization must be approved by Keystone First before the health care services are provided.

Keystone First's Medicaid managed care prior authorization process begins when a beneficiary's primary care physician (PCP) or other health care provider submits a request for health care services documenting that the service or medicine is medically necessary. Health care providers usually provide this information in a Letter of Medical Necessity, which usually includes the beneficiary's diagnosis, level of care requested (including a description of specific care needs), plan of care, goals of the treatment plan, and length of time requested for the requested services.

Keystone First's nurses and pharmacists use clinical guidelines approved by the State Medicaid agency to review prior authorization requests. If a request is approved, Keystone First notifies the provider; if a request cannot be approved by a Keystone First nurse or pharmacist, a Keystone First medical director reviews the request. If a request is denied after a Keystone First medical director's review, Keystone First sends a letter to the beneficiary and the provider explaining the reason for the denial.[5] If beneficiaries or providers disagree with Keystone First's decision, they may file an appeal (grievance or complaint)[6] with Keystone First. After exhausting Keystone First's appeals process, they may request a State fair hearing from Pennsylvania's Department of Human Services' Bureau of Hearings and Appeals.[7]

---

[4] Any request that exceeds the limits identified on the Medical Assistance Fee Schedule set forth by the Pennsylvania Department of Human Services would require a prior authorization. For example, therapy services (including outpatient physical, occupational, and speech therapy services) are limited to 24 combined visits in a calendar year.

[5] According to Exhibit N of the State agency's HealthChoices agreement with MCOs, a written notice of denial must be issued to the beneficiary for the following: (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial of a requested service because it is not a covered service for the beneficiary; and (4) the denial of a requested service but approval of an alternative service.

[6] According to the Keystone First *Provider Manual*, an appeal is a written request from a health care provider for the reversal of a denial by Keystone First. The *Provider Manual* and Exhibit GG of the State agency's agreement with MCOs define a grievance as a request to have Keystone First reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance is not the same as a complaint. The *Provider Manual* and Exhibit GG of the State agency's agreement with MCOs generally define a complaint as a dispute or objection regarding a network provider or the coverage, operations, or management policies of the MCO if the dispute or objection has not been resolved by the MCO and has been filed with the MCO or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department. Grievances and complaints are filed using the same form, which starts the appeals process. Appeals due to grievances and complaints follow similar processes.

[7] Beneficiaries or providers may request (in writing) a State fair hearing if they disagree with MCO decisions regarding an appeal (grievance or complaint) of denied service requests.

HOW WE CONDUCTED THIS AUDIT

During our audit period, Keystone First denied 136,022 physical health service requests that required a prior authorization. Our audit covered the 2,482 pediatric skilled nursing requests denied during our audit period and the 1,702 dental, radiology, pharmacy, and medical denials overturned by Keystone First through the appeals process during our audit period.

We selected and reviewed a judgmental sample of 100 denied service requests that required a prior authorization to determine whether they complied with Federal and State requirements. Specifically, we selected for review 50 denied pediatric skilled nursing requests because of the vulnerability of the pediatric population and due to concerns raised in the *Dallas Morning News* article.[8] (See footnote 1.) We also selected a combined total of 50 dental, radiology, pharmacy, and medical denied service requests overturned by Keystone First during the appeals process because Keystone First had the highest number of service requests overturned compared to other MCOs.[9] We reviewed these denied service requests to determine whether they were denied in accordance with Federal requirements.

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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains details regarding types of denied service requests, and Appendix C contains Federal and State requirements for Medicaid MCO services that require a prior authorization.

FINDINGS

Keystone First complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required prior authorization for 24 of the 100 denied service requests in our sample. However, it did not comply with Federal requirements when it denied the remaining 76 sampled denied service requests.[10] Specifically, Keystone First should not have denied the overnight care portion of 10 denied sampled pediatric skilled nursing service requests on the basis that it had not received work or school verification documentation for the caregiver. Keystone First should have approved the overnight care portion of the requests because overnight care is not dependent on caregiver work or school verification. In addition, for 72 sampled denied service requests, Keystone

[8] We selected two requests from each of the 24 months of our audit period plus two additional requests.

[9] We did not submit these requests for medical review; instead, we looked at the administrative process that Keystone First used to determine whether the services requested were medically necessary. We selected two requests from each of the 24 months of our audit period plus two additional requests.

[10] Seven of the denied service requests did not comply with more than one requirement.

First's denial letter informed beneficiaries that they could appeal the denial using the MCO's appeals process but did not inform them of their right to request a State fair hearing after exhausting the MCO's appeals process.

Denying overnight pediatric skilled nursing services that should be approved could place the health and safety of the beneficiary at risk because the beneficiary may not receive medically necessary overnight care. If beneficiaries do not receive information about their right to request a State fair hearing, they may not have the information needed to enable them to understand the totality of the appeals process and their rights and options within that process.

KEYSTONE FIRST COMPLETELY DENIED PEDIATRIC SKILLED NURSING SERVICE REQUESTS THAT SHOULD HAVE BEEN PARTIALLY APPROVED

Federal and State Requirements

According to 42 CFR sections 438.210(b)(2)(i) and (ii), to process requests for initial or continuing authorization of services, each contract must require that the MCO have mechanisms in place to ensure consistent application of review criteria for authorization decisions. Further, 42 CFR section 438.210(b)(3) states that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (referred to as "approved other than requested") must be made by an individual with appropriate expertise in addressing the beneficiary's medical, behavioral health, or long-term services and supports needs.

Under the MCO contract provision at section V.A.2 of the 2018 and 2019 HealthChoices Agreements, MCOs may not deny a request for medically necessary in-home nursing services, home health aide services, or personal care services for a beneficiary under 21 years of age on the basis that a live-in caregiver can perform the task unless there is a determination that the live-in caregiver is actually able and available to provide the needed level or extent of care. This determination must consider the caregiver's work schedule and other responsibilities, including other responsibilities in the home.

Keystone First Denied Overnight Care Requests Without Determining Whether the Caregiver Was Able and Available To Provide Care

Of the 50 pediatric skilled nursing service request denials in our sample, 10 were completely denied when they should have been partially allowed. In these cases, the PCP specifically requested at least 8 hours of overnight skilled nursing care so that the beneficiary's primary caregiver could rest. In addition, the PCP requested other hours, such as daytime hours,

flexible hours,[11] and medical day care hours.[12] For these 10 denied pediatric skilled nursing service requests, the requested overnight hours should have been allowed.

According to Keystone First's Shift Care Prior Authorization Policy, all requests for pediatric skilled nursing services must be accompanied by a Letter of Medical Necessity from the beneficiary's treating physician indicating the beneficiary's medical needs. Specifically, the letter should include the beneficiary's diagnosis, level of care being requested (including a description of specific care needs), plan of care, goals of the treatment plan, and requested duration of the services. Pediatric skilled nursing services may be provided to a beneficiary in the home and in settings outside of the beneficiary's home, but the letter must specify the setting or settings.

Keystone First indicated that the 10 pediatric skilled nursing service requests were completely denied on the grounds that Keystone First was unable to determine the medical necessity of the requested services because it did not receive verification of the caregiver's work or school schedule. If overnight pediatric skilled nursing services that are medically necessary are improperly denied, it could place the health and safety of the beneficiary at risk because the caregiver may be unable or unavailable to provide needed medical care. See below for examples of pediatric skilled nursing service requests denied by Keystone First.

Examples of Denied Pediatric Skilled Nursing Service Requests

Examples

1: A beneficiary was diagnosed with cystic fibrosis with pulmonary and gastrointestinal manifestations complicated by Down syndrome, chronic respiratory failure, dysphagia, gastroesophageal reflux disease, pancreatic insufficiency, and chronic rhinitis. The beneficiary required gastrostomy tube feeding and enzymes several times a day. The PCP requested 6 months of skilled nursing services for 10 hours a day, 5 days a week, on both school and non-school days while the caregivers worked, and an additional 56–66 hours of overnight care to allow the caregivers to sleep.

2: A beneficiary was diagnosed with multiple conditions, including encephalitis, hyper immunodeficiency, autoimmune hemolytic anemia, vasculitis, stroke, spastic quadriplegia, scoliosis, obstructive sleep apnea, seizure disorder, feeding disorder, gastrostomy tube placement, pneumonia, and asthma. The beneficiary had a single caregiver, and the beneficiary's

[11] Flexible hours are utilized for other responsibilities, such as household duties or attending appointments.

[12] Medical day care is for children with special medical needs who require skilled care. Each medical day care defines the type of care and the ages that are eligible to attend. Most have a medical director, a program manager, pediatric nurses, nursing assistants, therapists (including physical, occupational, and speech), social workers, teachers, a nutritionist, and pharmacists for consultation with the staff and parents.

overnight care included respiratory treatments, chest physiotherapy, oropharyngeal suctioning and repositioning the beneficiary's head frequently to maintain the beneficiary's airway, continuous feeds via gastrostomy tube, medication administration, and blood pressure monitoring. The PCP requested 6 months of home skilled nursing services for 9 hours a day, 5 days a week on school days plus 8 hours a day, 7 days a week of overnight care for parental sleep.

3: A beneficiary was diagnosed with multiple conditions, including microcephaly, cerebral palsy, profound mental retardation, history of hearing loss, and constipation. The beneficiary, who was non-ambulatory and non-verbal, was dependent on a caregiver for all daily activities, including bathing, feeding, dressing, and transferring from bed to wheelchair. The PCP requested 6 months of skilled nursing services for 16 hours a day, 7 days per week when the caregiver was at work and to allow the caregiver to sleep.

4: A beneficiary was diagnosed with multiple conditions, including global developmental delay, gastrostomy tube dependency, restrictive lung disease, asthma, bilateral club feet, conductive hearing loss, delayed gastric emptying, gastroesophageal reflux, and visual impairment. The PCP requested 6 months of skilled nursing services for 9 hours a day at home, 5 days a week at school, and 8 hours a night, 7 nights a week to allow the caregiver to sleep.

Overnight Care Should Have Been Approved

Keystone First completely denied these service requests because its medical director was unable to determine the medical necessity of the requested services due to a lack of information. Specifically, in each case, Keystone First did not have verification of the caregiver's current work or school schedule. Keystone First did not challenge any other aspect of the medical necessity of these requests. Keystone First should have approved the overnight care portion of the requests because overnight care is not dependent on a caregiver's work or school schedule.

These errors occurred because some Keystone First medical directors completely denied pediatric skilled nursing service requests for cases in which caregiver work verification documentation was missing instead of making a partial approval (approved other than requested) and specifically approving the overnight care hours when medically necessary. Even though the caregivers' work verification documentation was missing, Keystone First should not have denied the overnight care portion of 10 denied sampled pediatric skilled nursing service requests on the basis that it had not received work or school verification documentation for the caregiver. Keystone First should have been able to approve the request for overnight care based on the rest of the documentation provided, which included the plan of care, nurse's notes, and the summary of the beneficiary's overall medical conditions, needed care,

medications, physicians, and social assessment. Also, there was no indication in the case notes or other documentation to show that Keystone First made a determination that the caregiver was able and available to provide overnight care as required by the HealthChoices Agreement.

Keystone First's medical directors who made the denial decisions stated that they did not question the medical necessity of the care needed, but their practice was to deny the entire service request if any documentation, such as work or school verification, was missing. Keystone First officials agreed that Keystone First should have approved the overnight hours and stated that they will update Keystone First's *Medical Director Training Manual* and *Clinical Care Reviewer Reference Guide* for pediatric skilled nursing service requests.

THE DENIAL NOTICE USED BY KEYSTONE FIRST DID NOT INFORM BENEFICIARIES OF THEIR RIGHT TO REQUEST A STATE FAIR HEARING

Federal Requirements

Federal requirements at 42 CFR section 438.404(b)(3) state that denial notices must explain the beneficiary's right to request an appeal of the MCO's denial and include information on exhausting the MCO's one level of appeal described at 42 CFR section 438.402(b) and the beneficiary's right to request a State fair hearing consistent with 42 CFR section 438.402(c). Also, Federal requirements at 42 CFR section 438.404(b) state that denial notices must explain the circumstances under which an appeals process can be expedited and how to request it be expedited; the beneficiary's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the beneficiary may be required to pay the costs of denied services under appeal.

Keystone First's Denial Notice Did Not Inform Beneficiaries of Their Right To Request a State Fair Hearing

For 72 of the 100 denied service requests in our sample, the initial denial notice informed beneficiaries that they could appeal the denial decision to Keystone First but did not inform beneficiaries that they had the right to request a State fair hearing. Keystone First stated that it issued these denial notices using the State agency's denial notice template, which Keystone First was required to use under the HealthChoices Agreement. In 2018, the State agency removed from its denial notice template a section explaining the process of appealing to the State to request a State fair hearing. Keystone First sent the initial denial notices for these 72 denied service requests after the State agency changed its template. The remaining 28 denial notices, which did inform beneficiaries of their right to request a State fair hearing, were sent before the template change.

The State agency required MCOs to implement the revised template by July 1, 2018. When we asked the State agency why it removed this information from the denial notice template, the State agency responded that the 2016 Medicaid Managed Care Final Rule changed the timeline under 42 CFR section 438.408(f) for when a beneficiary could request a State fair

hearing.[13] Before this final rule, a beneficiary could concurrently request both a grievance from the MCO and a State fair hearing. The final rule specified that the beneficiary must first go through the MCO's appeals process before requesting a State fair hearing.

According to the State agency, this change at the Federal level necessitated the change to the State agency's denial notice template. However, the final rule required the denial notice to include information on exhausting the MCO's appeals process and on the beneficiary's right to request a State fair hearing. Regardless of the timeline for when a beneficiary may request a State fair hearing, the denial notice should still include information regarding the beneficiary's right to request such a hearing.

Providing beneficiaries with this information ensures that the appeal process is transparent to beneficiaries. Without this information, beneficiaries may not understand their rights and options within that process.

RECOMMENDATIONS

We recommend that Keystone First HealthChoices coordinate with the Pennsylvania Department of Human Services, Office of Medical Assistance Program, to:

- update Keystone First's administrative process to require that medical directors assess whether overnight care requests meet the medical necessity requirement based on the documentation Keystone First has received even if some documentation, such as the caregiver's work verification documentation, is missing;

- review all pediatric skilled nursing service requests for which overnight care was completely denied and determine whether the overnight care requests meet the medical necessity requirement regardless of whether the caregiver provided work or school verification documentation; and

- implement a revised initial denial notice to explain that a beneficiary has the right to request a State fair hearing after exhausting the MCO's appeals process.

We recommend that the Pennsylvania Department of Human Services, Office of Medical Assistance Program, revise the initial denial notice template referenced under Exhibit N in the HealthChoices Agreement to include information regarding the beneficiary's right to request a State fair hearing after exhausting the MCO's appeals process.

KEYSTONE FIRST AND STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Keystone First stated that it concurred with the intent of all three recommendations addressed to it, and the State agency also provided written

[13] The 2016 Medicaid Managed Care Final Rule can be found at 81 Fed. Reg. 27498 (May 6, 2016).

comments and concurred with the recommendation addressed to it. Although our other three recommendations were addressed to Keystone First, the State agency concurred with the first and third recommendations but did not concur with the second recommendation. In their comments, Keystone First and the State agency both outlined the corrective actions that they have taken and plan to take in response to the recommendations.

With regard to our first recommendation to Keystone First, Keystone First stated that it has retrained its medical directors and clinical care reviewers to ensure that all overnight care requests are properly reviewed. It has also updated its *Medical Director Training Manual* and *Clinical Care Reviewer Reference Guide*, effective October 2022. The State agency stated that it will ensure that the *Medical Director Training Manual* and *Clinical Care Reviewer Reference Guide* are updated appropriately and will work with Keystone First to ensure that Keystone First's medical directors and clinical care reviewers have received proper training on the information included in the training manual and reference guide.

With regard to our second recommendation to Keystone First, Keystone First stated that it was informed that the Pennsylvania Department of Human Services intends to conduct periodic reviews of pediatric shift care service request denials in 2023. Keystone First stated that it "is committed to a quality review and improvement process and looks forward to coordinating with [the Pennsylvania Department of Human Services] on the additional case reviews." However, the State agency did not concur with this recommendation because, according to the State agency, beneficiaries' conditions may have changed, beneficiaries may no longer be members of Keystone First, and there has been a COVID-19 waiver in place regarding prior authorization of pediatric skilled nursing requests since 2020. Although the State agency did not concur with this recommendation, it stated that it will work with Keystone First to review a sample of pediatric skilled nursing service denials periodically once the Pennsylvania Department of Human Services reinstates the prior authorization requirements for pediatric skilled nursing services. The State agency stated that this review will aim to ensure that denials are made appropriately and that medically necessary services for overnight hours are not denied due to missing work or school verification.

In response to our third recommendation, Keystone First stated that it will implement the new denial templates in accordance with the State agency's required timeline. In response to our recommendation to the State agency, the State agency revised its initial denial templates to include that the beneficiary has the option to request a State fair hearing once the MCO's internal process is complete. The State agency sent the revised templates to the MCOs on September 6, 2022, in preparation for implementation by January 1, 2023.

Both Keystone First and the State agency also provided technical comments, which we addressed as appropriate. Keystone First's comments, excluding the technical comments, are included in their entirety as Appendix D. The State agency's comments are included in their entirety as Appendix E.

We appreciate the corrective actions Keystone First and the State agency have taken and plan to take to address our recommendations, and we note that the State agency revising its denial

template will ensure that beneficiaries at all eight physical health MCOs will be aware of their rights regarding a State fair hearing. In response to the State agency's comments pertaining to pediatric skilled nursing, we believe that any new requests for pediatric skilled nursing services that were not covered by the COVID-19 waiver, were denied, and were subject to prior authorization should be included in the 2023 joint review to be conducted by the State agency and Keystone First.[14]

OTHER MATTERS

For one sampled denied pediatric skilled service request, Keystone First sent a letter to the beneficiary requesting additional information; however, the address, which the beneficiary's caregiver verified, was for a homeless shelter. Keystone First could not be assured that the beneficiary received the letter. When verifying the beneficiary's address, Keystone First did not identify that the address was a homeless shelter and did not take additional steps to ensure that the beneficiary received the letter requesting additional information. Keystone First denied the requested pediatric skilled nursing service request because it did not receive the additional information it requested. If pediatric skilled nursing services that are medically necessary are denied due to a lack of information, it could jeopardize the beneficiary's health.

When we informed Keystone First of this situation, Keystone First stated that this beneficiary was a transfer from another MCO and that the information Keystone First receives upon transfer currently does not identify whether a beneficiary is housing insecure. Keystone First stated that it will develop processes to ensure that information it receives upon a beneficiary's transfer identifies whether the beneficiary is housing insecure. In addition, when Keystone First is verifying a beneficiary's home address during initial and subsequent enrollment verification, it will also confirm that the address is the beneficiary's mailing address and inform the beneficiary's caregiver that important benefit correspondence that may require a response will be sent to that address. Additionally, Keystone First stated that it will remind the caregiver of the importance of keeping the MCO informed of any change in mailing address.

[14] Prior authorization requirements were reinstated for certain services effective July 1, 2021. Prior authorization requirements for shift care services, which include overnight care, have not yet been reinstated as of October 2022.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During our audit period (January 1, 2018, through December 31, 2019), Keystone First denied 136,022 physical health service requests that required a prior authorization. Our audit covered 2,482 denied pediatric skilled nursing requests and 1,702 denials overturned by Keystone First during the appeals process. In 2019, Keystone First received approximately $2.9 billion in gross revenues from the State agency to cover physical health Medicaid beneficiaries in the Greater Philadelphia area. We reviewed a judgmental sample of 100 denied service requests that required a prior authorization. Specifically, we reviewed 50 denied pediatric skilled nursing service requests and a combined total of 50 dental, radiology, pharmacy, and medical denied service requests overturned by Keystone First during the appeals process.

We reviewed the design, implementation, and operating effectiveness of Keystone First's internal controls related to our objective. We obtained an understanding of the laws and regulations relevant to Keystone First and the State agency's monitoring process to ensure that Keystone First complied with requirements for services that required a prior authorization. We reviewed Keystone First's 2018 and 2019 reviews of the call center and Utilization Management activities that it used to ensure that Keystone First complied with recognized standards set forth by the National Committee for Quality Assurance and Federal and State regulations.

We conducted our audit work from August 2020 to August 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and the HealthChoices Agreements;
- interviewed State agency officials to gain an understanding of the State agency's oversight of the denial process;
- obtained and reviewed Keystone First's policies and procedures covering its approval process for service requests that require a prior authorization;
- reviewed program requirements, including guidelines for reviewing requested services;
- interviewed Keystone First staff to understand Keystone First's policies and procedures for processing service requests that require a prior authorization and Keystone First's processes, training, and monitoring activities;
- obtained documentation related to the prior authorization requests, such as the denial logs (database), Keystone First's *Provider Manual*, and any improvement plans;

- judgmentally selected a sample of 100 denied service requests (50 pediatric skilled nursing service requests and 50 denials overturned by Keystone First during its appeals process) and determined whether those denials complied with Federal and State requirements;

- reviewed denial letters to ensure that they were sent to the beneficiary and provider in the required timeframe and included the correct content and details in language that is easily understood;

- reviewed the MCO's Medicaid Benefit Package to determine whether the denials were for covered services;

- reviewed the qualifications of Keystone First's medical directors (qualified medical professionals with appropriate expertise), who authorized service request decisions;

- reviewed the administrative process that Keystone First used to determine whether the services requested were medically necessary, including the Letters of Medical Necessity submitted by treating physicians and other supporting documentation for those services that were denied and appealed; and

- discussed the results of our audit with Keystone First and State agency officials.

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.

APPENDIX B: TYPES OF DENIED SERVICE REQUESTS

Category	Examples of Types of Services Denied	Number of Denied Requests	Percentage of All Denied Requests	Number of Denied Requests Sampled
Dental	Crowns, braces	34,140	25%	6
Radiology	Imaging (MRIs and CTs)	23,993	18%	14
Pharmacy	Non-formulary, Non-preferred, and opioid	61,820	45%	20
Medical	Skilled nursing, home health aide, durable medical equipment, inpatient, and outpatient	16,069	12%	60
Totals		**136,022**	**100%**	**100**

APPENDIX C: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Notice of Adverse Benefit Determination, 42 CFR § 438.210(c)

> Each contract [between a State and an MCO] must provide for the MCO . . . to notify the requesting provider, and give the enrollee written notice of any decision by the MCO . . . to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs . . . the enrollee's notice must meet the requirements of § 438.404.

Timeframe for Standard Authorization Decisions, 42 CFR § 438.210(d)(1)

> For standard authorization decisions, [the MCO must] provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if –
>
> (i) the enrollee, or the provider, requests an extension; or
>
> (ii) the MCO . . . justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

Prior Authorization of Outpatient Drugs, 42 CFR § 438.210(d)(3)

> For all covered outpatient drug authorization decisions, [the MCO must] provide notice as described in section 1927(d)(5)(A) of the Act.

Content of Notice [of Adverse Benefit Determination], 42 CFR § 438.404(b)

> The notice must explain the following:
>
> (1) The adverse benefit determination the MCO . . . has made or intends to make.
>
> (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. . . .
>
> (3) The enrollee's right to request an appeal of the MCO's . . . adverse benefit determination, including information on exhausting the MCO's . . . one

level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c).

(5) The circumstances under which an appeals process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

Authorization of Services, 42 CFR § 438.210(b)(3)

For the processing of requests for initial and continuing authorizations of services, each contract must require . . .

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Language and Format, 42 CFR § 438.10(d)(6)(i)

This section states that the State must provide, and require MCOs to provide, all written materials for potential enrollees and enrollees using easily understood language and formatting.

Coverage of Services, 42 CFR § 438.210(a)(3)(ii)

This section states that each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

STATE REQUIREMENTS

Timeframes for Utilization Review, 28 Pa. Code § 9.753(b)[15]

A prospective [utilization review] decision shall be communicated to the plan, enrollee and health care provider within 2 business days of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and the health care provider written or electronic

[15] A utilization review is performed by a utilization review entity or MCO to determine the medical necessity and appropriateness of health care services prescribed, provided, or proposed to be provided to an enrollee (28 Pa. Code § 9.602).

confirmation of the decision within 2 business days of communicating the decision.

Time Frames for Standard Notice of Decisions, HealthChoices Agreement V.B.2.c

If the requested information is not received within fourteen (14) days, the [physical health] MCO must make a decision to approve or deny the service based upon the available information and notify the Member orally within two (2) Business Days after the additional information was to have been received. The [physical health] MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two (2) Business Days after the decision is made.

Time Frame for Outpatient Drug Services, HealthChoices Agreement Exhibit BBB.4.a(i)

The [physical health] MCO may require Prior Authorization (includes step therapy) as a condition of coverage or payment for a Covered Outpatient Drug provided that: (i) The [physical health] MCO provides a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request.

Prior Authorization Guidelines for Participating Managed Care Organization, HealthChoices Agreement Exhibit H.B.2(e)

Medically Necessary Requirements: The [physical health] MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the [Request for Proposal], the HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines:

(1) That the prescriber did not make a good faith effort to submit a complete request, or

(2) That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

APPENDIX D: KEYSTONE FIRST COMMENTS

Keystone First
200 Stevens Drive
Philadelphia, PA 19113

Report A-03-20-00201

October 21, 2022

Nicole Freda
Regional Inspector General for Audit Services
Office of Audit Services, Region III
Strawbridge Building
801 Market Street, Suite 8500
Philadelphia, PA 19107

Dear Regional Inspector General Freda,

Thank you for the opportunity to review and comment on the draft report, Report A-03-20-00201 (Report). Keystone First appreciates the courtesy and diligence of the Office of Inspector General (OIG) in connection with its audit. Keystone First is committed to our mission of helping people get care, stay well and build healthy communities, and our associates work hard every day to promote access to quality and timely services for our members. To that end, Keystone First provides the following information regarding OIG's findings and concurs with the intent of OIG's recommendations that it: (1) update certain administrative processes related to overnight pediatric shift care (skilled nursing) service requests; (2) review overnight pediatric shift care service requests; and (3) revise the initial denial notice.

First, OIG found that in some of the cases OIG reviewed related to pediatric shift care, for a limited period of time, a few Medical Directors at Keystone First completely denied some overnight shift care requests when the requests should have been partially approved. Notably, Keystone First found this issue at the time it occurred and effectively fixed it, which shows the integrity of Keystone First's quality and improvement efforts. Specifically, Keystone First self-identified the issue, proactively retrained its Medical Directors and Clinical Care Reviewers to ensure that all overnight care requests were properly reviewed, and re-reviewed the cases thereafter. Since these steps were taken, no further instances of this issue have been identified and, no member harm was identified at the time of the issue, and again during OIG's review.

Moreover, after conversations with OIG, Keystone First made updates to its Medical Director Training Manual and Clinical Care Reviewer reference guide to further buttress the re-training. Accordingly, Keystone First has already taken the actions recommended by OIG to (1) update certain administrative processes related to overnight pediatric shift care service requests. As to recommendation (2) review overnight pediatric shift care service requests, Keystone First recently was informed by the Pennsylvania Department of Human Services ("PA DHS") that, in response to OIG's recommendations, PA DHS intends to commence periodic reviews of pediatric shift care service request denials in 2023. Keystone First is committed to a quality review and improvement process and looks forward to coordinating with DHS on the additional case reviews.

Second, OIG found 72 initial denial letters to be in non-compliance with federal regulations because the letters did not inform members of the right to a state fair hearing at the time of the initial denial (the right to a state fair hearing is presented to the member in a later notice). As OIG notes, the appeals language in the initial denial letter that OIG found deficient is specific language that Keystone First (and all the other Medicaid MCOs) was required by the state to use. As to recommendation (3) revise the initial denial notice, PA DHS has

changed the required initial denial letter language to include language about the right to request a state fair hearing, and Keystone First will implement the new form per the state required timeline.

Finally, with respect to the Other Matters, Keystone First is in agreement with OIG that processes need to be in place to ensure that members with housing insecurity issues receive critical information related to their health care services. Members are permitted to receive their mail at many homeless shelters and Keystone First will continue to send mail to homeless shelters when requested. In regard to the referenced case, as the report notes, Keystone First verified the mailing address with the mother (caregiver) via telephone, Keystone First was not aware that the verified address was a homeless shelter, and the mother did not disclose that information. The letter was sent to the address that the mother verified. Additionally, our care manager called the mother via phone, verbally provided all of the additional information that was needed for the medical necessity review, and the mother verbalized understanding of the information that was needed. Accordingly, the caregiver received the critical information needed for the member.

In sum, Keystone First has already implemented the first recommendation and looks forward to working with PA DHS to implement the second and third OIG recommendations. We appreciate the commitment OIG shares to promote the health of our HealthChoices members.

Sincerely,

Joanne McFall

Joanne McFall
Market President
Keystone First

APPENDIX E: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

October 7, 2022

Ms. Nicole Freda
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
801 Market Street, Suite 8500
Philadelphia, Pennsylvania 19107-3134

Dear Ms. Freda:

The Department of Human Services (DHS) has received the draft report number A-03-20-00201 titled "Keystone Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization." The objective of this audit was to determine whether Keystone complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required prior authorization.

DHS noted that the draft report referenced Keystone First Community HealthChoices throughout the report. Keystone First Community HealthChoices is a long-term services and supports managed care program, while Keystone First HealthChoices provides physical health services. We believe the Office of Inspector General (OIG) has erroneously referenced Keystone First Community HealthChoices. The findings discussed in the draft audit report and our response are applicable to Keystone First HealthChoices. We request that OIG change this throughout the audit report.

OIG Recommendation 1: We recommend that Keystone First HealthChoices coordinate with the Pennsylvania Department of Human Services, Office of Medical Assistance Programs, to update Keystone's administrative process to require that medical directors assess whether overnight care requests meet the medical necessity requirement based on the documentation Keystone has received even if some documentation, such as the caregiver's work verification documentation, is missing.

DHS Response: DHS concurs with this recommendation. DHS reached out to Keystone First for a copy of their updated Medical Director Training Manual and Clinical Care Reviewer Reference Guide for pediatric skilled nursing service requests to ensure

Deputy Secretary for Administration
P.O. Box 2675 | Harrisburg, PA 17105 | 717.787.3422 | F 717.772.2490 | www.dhs.pa.gov

this information was added. We also will be working with Keystone First to ensure their medical directors and clinical care reviewers have received and been trained on the information included in the training manual and reference guide.

OIG Recommendation 2: We recommend that Keystone First HealthChoices coordinate with the Pennsylvania Department of Human Services, Office of Medical Assistance Programs, to review all pediatric skilled nursing service requests for which overnight care was completely denied and determine whether the overnight care requests meet the medical necessity requirement regardless of whether the caregiver provided work or school verification documentation.

DHS Response: DHS does not concur with this recommendation. The denials reviewed for this audit were from 2018 and 2019. Beneficiaries' conditions may have changed since that time. In addition, beneficiaries may no longer be a member of Keystone First. For 2020 until present, DHS waived prior authorization of pediatric skilled nursing requests. Once DHS reinstates prior authorization of pediatric skilled nursing services, we will work with Keystone First to review a sample of pediatric skilled nursing service denials periodically to ensure that denials are made appropriately and that medically necessary services for overnight hours are not denied due to missing work or school verification.

OIG Recommendation 3: We recommend that Keystone First HealthChoices coordinate with the Pennsylvania Department of Human Services, Office of Medical Assistance Programs, to revise its initial denial notice to explain that a beneficiary has the right to request a State fair hearing after exhausting the MCO's appeals process.

DHS Response: DHS concurs with this recommendation. All MCOs are required to use the denial templates issued by DHS. We have revised the initial denial templates to include the option to request a Fair Hearing once the MCO's internal process has been completed. The revised templates were sent to the MCOs on September 6, 2022, in preparation for implementation by January 1, 2023.

OIG Recommendation 4: We recommend that the Pennsylvania Department of Human Services, Office of Medical Assistance Programs, revise the initial denial notice template referenced under Exhibit N in the HealthChoices Agreement to include information regarding the beneficiary's right to request a State fair hearing after exhausting the MCO's appeals process.

DHS Response: DHS concurs with this recommendation. DHS has revised its initial denial templates to include the option to request a Fair Hearing once the MCO's internal process has been completed. The revised templates were sent to the MCOs on September 6, 2022, in preparation for implementation by January 1, 2023.

.

Thank you for the opportunity to respond to this draft audit report. If you have any questions or concerns regarding this response, please contact Mr. David R. Bryan, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7217 or via email at davbryan@pa.gov.

Sincerely,

Carolyn K. Ellison

Carolyn K. Ellison
Deputy Secretary for Administration

c: Mr. Charles Hubbs, Assistant Regional Inspector General for Audit Services
Mr. David R. Bryan, Bureau of Financial Operations, Audit Resolution Section