Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PENNSYLVANIA MEDICAID MANAGED CARE PROGRAM POTENTIAL SAVINGS WITH MINIMUM MEDICAL LOSS RATIO

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Office of Inspector General

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Report in Brief
Date: July 2017
Report No. A-03-15-00203

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

Review of Pennsylvania Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio

Why OIG Did This Review

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to spend a fixed percentage of premium dollars to provide medical services and health quality improvement activities. This percentage is known as a medical loss ratio (MLR). This report is part of a series of OIG reviews conducted to determine whether the Medicaid program could have achieved savings if States had required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Our objective was to determine the potential Medicaid program savings if Pennsylvania (1) required its Medicaid managed care contracts and grants to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances if that MLR standard was not met.

How OIG Did This Review

We reviewed 2014 cost and premium revenue data for 27 contracts and grants with 15 Pennsylvania Medicaid MCOs. We determined the MLR for the same period for each contract and grant and for each rating category within these contracts and grants. We also determined the amount the MCOs would have had to return if Pennsylvania required MCOs to meet MLR standards similar to those for private insurers and Medicare Advantage plans.

What OIG Found

We determined that Pennsylvania's Medicaid managed care program, known as HealthChoices, could have saved between $8 million ($4.3 million Federal share) on a contract and grant basis and $81.4 million ($42.3 million Federal share) on a rating category basis in 2014 if Pennsylvania (1) required its MCOs to meet a minimum MLR standard similar to the Federal standards for certain private insurers and Medicare Advantage plans and (2) required remittances when MCOs did not meet the MLR standard. Because States have the flexibility to choose to calculate MLRs and remittances either on a contract basis or a rating category basis, we calculated MLRs and remittances using both methods.

Of the 27 contracts and grants that we reviewed, we calculated that 6 had MLRs that were less than 85 percent (the minimum MLR standard for large private insurers) during 2014. Pennsylvania through its actuary must certify the final capitation rate paid per rate cell under each risk contract and document the underlying data assumptions and methodologies supporting that specific capitation rate. Each of the 27 contracts included 7 rating categories for a total of 189 rate cells. Pennsylvania calculates a capitation rate for each of the 189 rate cells. Of the 189 rate cells that we reviewed, 57 had MLRs that were less than 85 percent during 2014. After our review but before the issuance of our report, the Centers for Medicare & Medicaid Services (CMS) published a final rule requiring Medicaid MCOs to achieve a minimum MLR for rate setting purposes.

What OIG Recommends and Pennsylvania Comments

We recommend that Pennsylvania (1) incorporate into its contracts and grants with Medicaid MCOs the MLR standards adopted in the CMS final rule and (2) consider implementing into its Medicaid MCO contracts and grants a remittance requirement if appropriate. In written comments on our draft report, Pennsylvania agreed with our recommendations. Pennsylvania stated that it incorporated the CMS MLR reporting requirements into its grant agreements beginning in 2017 for its physical health MCOs and into behavioral health managed plan agreements effective July 1, 2017. Pennsylvania will incorporate a remittance requirement consistent with the CMS final rule beginning with its 2018 grant agreements for its physical health MCOs but will not incorporate a remittance requirement for its behavioral health managed care plans because its current reinvestment sharing arrangement with behavioral health MCOs captures and returns excess profits.

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INTRODUCTION

WHY WE DID THIS REVIEW

A medical loss ratio (MLR) is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement activities for its members. This report is part of a series of Office of Inspector General reviews[1] conducted to determine whether the Medicaid program could have achieved savings if States had required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet Federal minimum MLR standards.[2] Medicare Advantage plans and Medicare Part D sponsors are required to pay remittances to the Centers for Medicare & Medicaid Services (CMS) if their MLR falls below 85 percent. Private health insurers, subject to the ACA's MLR standard, must provide rebates to their enrollees if their MLR falls below the appropriate percentage, which is set at either 80 or 85 percent. At the time of our review, CMS did not require States to have a minimum MLR standard for Medicaid MCOs. After our review but before the issuance of our report, CMS published a final rule requiring states to set capitation rates that target a minimum MLR for Medicaid MCOs. The MLR formula required by the final rule is similar to the MLR requirements for most private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. In the final rule, CMS encourages States to adopt provisions that require Medicaid MCOs to pay remittances when they do not meet the MLR standard. Several States have already awarded contracts to Medicaid MCOs with MLR standards similar to those for private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. Some of these contracts require MCOs to issue remittances to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.

The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program.

At the time of our review, Pennsylvania's Medicaid (HealthChoices) physical health managed care grants did not limit the amount of premium revenue that MCOs could use for administrative costs or keep as profits.

OBJECTIVE

Our objective was to determine the potential Medicaid program savings if the Pennsylvania Department of Human Services (State agency) (1) required its Medicaid managed care contracts and grants to meet a minimum MLR standard similar to the Federal standards for certain

[1] See Appendix A for related Office of Inspector General reports.

[2] Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), and amending provisions of the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the ACA.

private health insurers and Medicare Advantage plans and (2) required remittances if that MLR standard was not met.

BACKGROUND

The Medicaid Program

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources (Title XIX of the Social Security Act). The Federal and State Governments jointly fund and administer the program. CMS administers the program at the Federal level. In Pennsylvania, the State agency administers the Medicaid program.

Minimum Medical Loss Ratio for Medicaid Managed Care Organizations

On May 6, 2016, CMS published a final rule that requires Medicaid MCOs to achieve a minimum MLR of at least 85 percent.[3] CMS implemented an MLR calculation for Medicaid MCOs similar to the Federal standards for most private health insurers, Medicare Advantage Plans, and Medicare Part D sponsors. The MLR calculation for Medicaid MCOs includes some variations to account for differences in the Medicaid program and population; these variations include provisions for long-term services and supports or other services specific to Medicaid and covered under the State plan. Under the final rule, States are required to use the 85-percent MLR as they develop capitation rates, and an MLR is one tool that can be used to assess whether capitation rates are appropriately set. Appropriately set capitation rates help to ensure adequate payments are made to provide services to beneficiaries rather than for administrative expenses. MCOs are required to calculate and report their MLR to the State Medicaid agencies, and States have the flexibility to choose whether MLRs will be calculated on a contract basis or a specific population basis.[4] CMS did not require Medicaid State agencies to implement remittances for MCOs that fail to meet MLR standards. However, CMS provided States the flexibility to require remittances from MCOs and encouraged States to implement contract provisions for remittances when the minimum MLR standard is not met.

Pennsylvania's Medicaid Managed Care Program

The HealthChoices managed care program has two components: physical health and behavioral health. The State agency awards grants directly to MCOs for physical health services, such as hospital and physician services. For behavioral health services, such as mental health services or drug and alcohol abuse services, the State agency contracts with 34 risk-bearing entities: 32 county governments[5] and 2 private-sector behavioral health MCOs.

[3] 81 Fed. Reg. 27498 (May 6, 2016). Medicaid MCOs must calculate MLRs effective July 1, 2017, and States must set capitation rates that would reasonably allow MCOs to achieve a minimum MLR of at least 85 percent effective July 1, 2019.

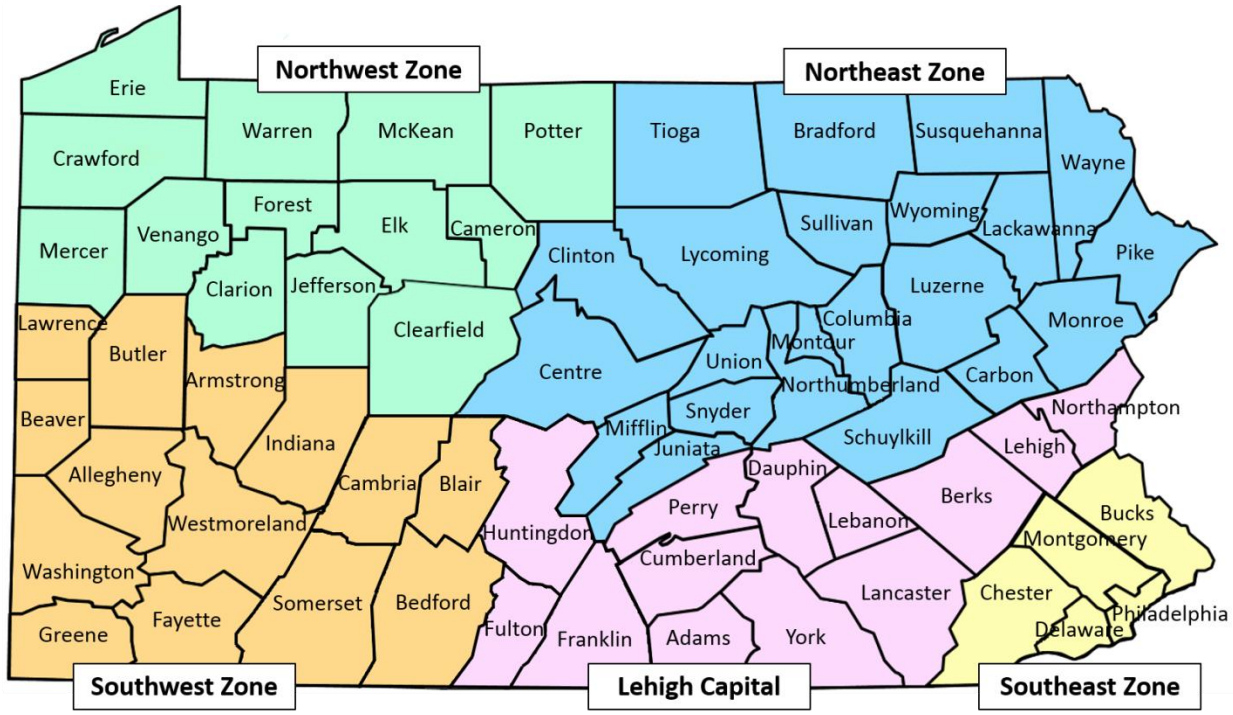
[4] 81 Fed. Reg. 27498, 27531(May 6, 2016) and 42 CFR § 438.8(i).

[5] Some counties grouped together and entered into joint contracts with the State agency.

The county government entities act as MCOs and subcontract with private sector behavioral health MCOs to provide eligible people with behavioral health services. In December 2014, 1,678,954 Medicaid beneficiaries in Pennsylvania were enrolled in Medicaid managed care plans.

The HealthChoices physical health grants[6] are based on five geographic zones comprised of designated counties. Capitation rates are independently developed for each MCO and each rating category in each zone. Thus the State pays different capitation rates to different MCOs for the same rating categories in the same zones. The figure provides a map of the Pennsylvania HealthChoices physical health zones.

Figure: Pennsylvania HealthChoices Physical Health Zones



Behavioral health contracts are awarded to individual counties or to a group of adjoining counties. Capitation rates differ because they are set based on historical encounter data for each geographic area.

Appendix B contains a detailed description of the HealthChoices managed care rating categories, and Appendix C contains the MLR standards for Medicaid MCOs.

The State agency pays each of the Medicaid MCOs a monthly capitation payment for each enrolled beneficiary. The capitation payment is determined by rating categories. The rating categories are based on the beneficiaries' county of residence and category of aid status

[6] Physical health grants in Pennsylvania are subject to the same Federal rules as MCO contracts.

according to the State agency or Social Security Administration. The MCOs must provide all contracted services to their members and also provide the administrative and quality structure for those services within that fixed amount. If enrollees' care costs less than the fees, the MCOs make money; if it costs more, they lose money.

During calendar year (CY) 2014, the State agency claimed CMS Medicaid reimbursement totaling $11,937,636,708 ($6,389,023,580 Federal share) for payments the State agency made to MCOs. Of this amount, payments made to the 9 physical health HealthChoices MCOs and 34 behavioral health HealthChoices MCOs totaled $9,018,610,568 ($4,826,760,376 Federal share) and $2,919,026,140 ($1,562,262,790 Federal share), respectively.

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 27 contracts and grants (21 physical health grants and 6 behavioral health contracts[7]) with 15 Pennsylvania Medicaid MCOs (9 physical health and 6 behavioral health). During this period, the total amount of Medicaid premium revenue earned by these MCOs was $9,293,241,511. We determined the MLR for the same period for each contract and grant we reviewed and for each rating category within these contracts and grants. We also determined the amount the MCOs would have had to return to the State agency if the State agency had required the MCOs to meet MLR standards similar to those for private insurers and Medicare Advantage plans. We used the MLR formula applicable to private health insurers and Medicare Advantage plans.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix D contains the details of our audit scope and methodology.

FINDINGS

We determined that the HealthChoices program could have saved between $8,027,156 ($4,296,134 Federal share) on a contract and grant basis and $81,414,267 ($42,285,045 Federal share) on a rating category basis in CY 2014 if the State agency (1) required its MCOs to meet a minimum MLR standard similar to the Federal standards for certain private insurers and Medicare Advantage plans and (2) required remittances when MCOs did not meet the MLR standard. Because States have the flexibility to choose to calculate MLRs and remittances either based on contracts and grants or based on rating categories, we calculated MLRs and remittances using both methods.

[7] We reviewed the contracts and grants for which the State agency either did not calculate an MLR or calculated an MLR that was below 85 percent.

Specifically, of the 27 contracts and grants that we reviewed, we calculated that 6 had MLRs that were less than 85 percent (the minimum MLR standard for large private insurers) during CY 2014. Pennsylvania through its actuary must certify the final capitation rate paid per rate cell under each risk contract and document the underlying data assumptions and methodologies supporting that specific capitation rate.[8] Each of the 27 contracts included 7 rating categories for a total of 189 rate cells. The State agency calculates a capitation rate for each of the 189 rate cells. Of the 189 rate cells that we reviewed, 57 had MLRs that were less than 85 percent during CY 2014. At the time of our review, Pennsylvania's HealthChoices physical health managed care grants did not limit the amount MCOs could charge for administrative costs or profits.

SOME MANAGED CARE ORGANIZATIONS HAD A MEDICAL LOSS RATIO OF LESS THAN 85 PERCENT

We determined that 6 MCO contracts and grants and 57 rating categories had MLRs that were less than 85 percent during CY 2014. Because States have the flexibility to choose to calculate remittances either based on contracts and grants or based on rating categories, we calculated remittances using both methods.

We calculated that the Medicaid program could have saved between $8,027,156 ($4,296,134 Federal share) on a contract and grant basis or $81,414,267 ($42,285,045 Federal share) on a rating category basis in CY 2014 if the State agency had required its MCOs to meet MLR standards for private insurers and Medicare Advantage plans and had required the MCOs to issue remittances to the State agency when they did not meet the standards. These standards, with the exception of the one requiring the issuance of remittances, have since been established for Medicaid MCOs in the CMS final rule.[9]

Medical Loss Ratio Calculated on a Contract/Grant Basis

Of the 27 contracts and grants that we reviewed, 6 had MLRs that were less than 85 percent during CY 2014. We calculated that the Medicaid program could have saved $8,027,156 ($4,296,134 Federal share) during CY 2014 on a contract and grant basis if the MLR requirement had been in effect.

Appendix E contains the results of our calculation of the MLR for the selected contracts and grants using the formula applicable to private health insurers and Medicare Advantage plans. Appendix E also includes the results of our calculation of potential remittances if the plans did not meet an 85-percent minimum MLR standard, and potential Medicaid program savings if the State agency had required its Medicaid MCOs to meet an 85-percent minimum MLR standard and issue remittances to the State agency if the standards were not met.

[8] 81 Fed. Reg. 27498, 27861, and 27862 (May 6, 2016) and 42 CFR § 438.7(6)(c).

[9] The standards give States some flexibility in implementing the MLR requirements; this may affect application of the formula.

Medical Loss Ratio Calculated on a Rating Category Basis

Of the 189 rate cells that we reviewed, 57 had MLRs that were less than 85 percent during CY 2014. Each of the contracts and grants required the MCOs to report financial information based on seven different rating categories, each of which had separately calculated capitation rates that were developed using those rating categories. We determined that the Medicaid program could have saved $81,414,267 ($42,285,045 Federal share) on a rating category basis if the MLR requirement had been in effect.

Appendix F contains the results of our calculation of the MLRs on a rating category basis, using the formula applicable to private health insurers and Medicare Advantage plans. Appendix F also includes the results of our calculation of remittances if the plans had not met an 85-percent minimum MLR standard and potential Medicaid program savings if the State agency had required its MCOs to meet an 85-percent minimum MLR standard and issue remittances to the State agency if the standards were not met.

RECOMMENDATIONS

We recommend that the State agency:

- incorporate into its contracts and grants with Medicaid MCOs the MLR standards adopted in the CMS final rule and

- consider implementing into its Medicaid MCO contracts and grants a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our recommendations. It stated that it incorporated the CMS MLR reporting requirements into its grant agreements beginning in 2017 for its physical health MCOs and into behavioral health managed plan agreements effective July 1, 2017. The State agency will incorporate a remittance requirement consistent with the CMS final rule beginning with its 2018 grant agreements for its physical health MCOs but it will not incorporate a remittance requirement for its behavioral health managed care plans. The State agency said that its current reinvestment sharing arrangement with behavioral health managed care plans already captures and returns to the State agency and CMS any excess profits.

The State agency stated that in the future it will calculate one MLR for each physical health MCO grant. If this had been in effect at the time of our review, we determined that a remittance of $8,027,156 ($4,296,134 Federal share) would have been due to the State agency.

The State agency questioned five MLR calculations for its physical health MCOs. We agreed with four of their calculations and made the appropriate changes in Appendixes E and F. These changes had no effect on our calculations of potential savings. We did not change the fifth MLR calculation because the State agency excluded a component, the Philadelphia gross receipts tax, from its calculation. We have verified that our original calculation was correct.

The State agency's comments are included as Appendix G.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of Wisconsin Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	A-05-15-00040	6/6/2017
Review of California Medicaid Managed-Care Program Potential Savings With Minimum Medical Loss Ratio	A-09-15-02025	1/13/2017
Review of South Carolina's Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	A-04-16-06191	12/21/2016
Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	A-01-15-00505	11/30/2016
The Medicaid Program Could Have Achieved Savings if Oregon Had Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act	A-09-15-02033	4/12/2016
The Medicaid Program Could Have Achieved Savings if New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act	A-02-13-01036	10/20/2015

APPENDIX B: HEALTHCHOICES MANAGED CARE RATING CATEGORIES

PHYSICAL HEALTH PROGRAM

Under its HealthChoices program, the State agency enters into grant agreements with MCOs to provide a complete package of physical health benefits to Medicaid consumers. In CY 2014, the State agency entered into 21 grant agreements with 9 physical health MCOs to provide physical health and certain behavioral health Medicaid benefits to enrolled Medicaid recipients residing in various zones. The behavioral health benefits primarily related to behavior-related pharmaceutical coverage. The State agency groups Pennsylvania's 67 counties into 5 zones and awards grants to 3 to 5 MCOs within each of those zones to ensure that beneficiaries have multiple MCOs from which to choose.

MCOs are paid a fixed per-member per-month base capitation rate according to the beneficiary's county of residence and category of aid status. Table 1 below shows the different physical health categories of aid. Capitation rates are independently developed for each MCO and each rating category in each zone. Thus Pennsylvania pays different capitation rates to different MCOs for the same rating categories in the same zones. MCOs also receive a fixed payment per live birth delivery. Pennsylvania makes maternity care payments that cover delivery regardless of the mother's category of aid.

Table 1: HealthChoices Physical Health Categories of Aid

Rating Categories	Category of Aid
A	TANF-HB-MAGI[10] Ages 19+ Years
B	TANF-HB-MAGI 0-18 Years
C	SSI-HH[11]-With Medicare
D	SSI-HH-Without Medicare Other Disabled
E	BCCPT[12]
F	Category Needy State Only[13]
G	Medically Needy State Only[14]

[10] Temporary Assistance for Needy Families-Healthy Beginnings-Modified Adjusted Gross Income (TANF-HB-MAGI) enrollees include low-income families, children, pregnant women, and childless adults without disabilities that qualify them for Supplemental Security Income (SSI).

[11] SSI-Healthy Horizons (HH) enrollees include low-income individuals who are disabled, blind, or at least 65 years old.

[12] Breast and Cervical Cancer Prevention and Treatment (BCCPT) enrollees include uninsured women under 65 years old requiring treatment for breast or cervical cancer or for a precancerous condition of the breast or cervix.

[13] Category Needy State Only enrollees include low-income adults who have disabilities that preclude employment, who are caring for children under 13 years old or for a disabled individual, who are undergoing drug and alcohol treatment, or who are domestic violence victims. Enrollees in this category of aid do not qualify for Medicaid but do qualify for State-funded assistance.

[14] Medically Needy State Only enrollees include low-income adults with high medical expenses who do not qualify for Medicaid but do qualify for State-funded assistance.

Under their respective capitated payment agreements with the State agency, physical health MCOs provide a comprehensive set of healthcare services to covered enrollees. The benefits packages include:

- hospital inpatient, ambulatory surgical center, ambulance, and emergency room services;
- hospice, home health care, and renal dialysis center services;
- early and periodic screening, diagnostic screening, and treatment screens and services;
- physician, chiropractor, podiatrist, therapy, dental, and vision services;
- laboratory, radiology, pharmacy, and family planning services;
- Federally Qualified Health Center and Rural Health Clinic services; and
- durable medical equipment and medical supplies.[15]

BEHAVIORAL HEALTH PROGRAM

The State agency contracts with county governments or private sector behavioral health MCOs to provide a complete package of behavioral health benefits to Medicaid beneficiaries under the State agency's HealthChoices program. Table 2 on the following page shows the behavioral health categories of aid. In 2014, the State agency entered into 34 contracts with counties or behavioral health MCOs to provide behavioral health services to Medicaid beneficiaries.[16] Many counties entered into subcontract arrangements with one of four private sector behavioral health MCOs, but these counties continued to be responsible for contract compliance. Behavioral health MCOs receive fixed, monthly per-member per-month capitation payments based on recipients' category of aid; the MCOs also bear the risk that the cost of health care services may exceed the capitation amounts received.

[15] Individual plans may also offer additional services such as a membership in the Weight Watchers program, acupuncture, gym memberships, and additional eye care and dental benefits.

[16] Some counties grouped together and entered into joint contracts with the State agency.

Table 2: HealthChoices Behavioral Health Categories of Aid

Rating Categories	Category of Aid
A	TANF-HB-MAGI Adult
B	TANF-HB-MAGI Child
C	SSI-HH-With Medicare
F	Category Needy State Only
G	Medically Needy State Only
H	SSI-HH-Without Medicare Child
I	SSI-HH-Without Medicare Adult

Behavioral health benefit packages include inpatient and outpatient psychiatric services; inpatient, outpatient, and non-hospital drug and alcohol services; behavioral health rehabilitation services; accredited and non-accredited residential treatment facility services; and community support and ancillary services.

APPENDIX C: THE MEDICAL LOSS RATIO STANDARDS FOR MEDICAID MANAGED CARE ORGANIZATIONS

CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to calculate, report, and use an MLR to develop capitation rates. The final rule requires that the capitation rates for MCOs be set so as to achieve a minimum MLR of at least 85 percent.[17] The MLR calculation for Medicaid MCOs is similar to the Federal standards for most private health insurers, Medicare Advantage Plans,[18] and Medicare Part D sponsors.[19]

The MLR is the sum of an MCO's incurred claims, expenditures for activities that improve health care quality, and possibly limited expenditures for fraud prevention activities[20] divided by premium revenue adjusted for Federal or State taxes and licensing or regulatory fees and accounting for net adjustments for risk corridors or risk adjustment. According to CMS, the calculation is the same general calculation as the one established in 45 CFR § 158.221 for private insurers, with differences as to what is included in the numerator and the denominator to account for differences in the Medicaid program and population.

The formula for calculating the MLR under the final rule is:

(Incurred Claims + Expenditures for Activities that Improve Health Care Quality[21]) ÷
(Premium Revenue[22] − Taxes − Licensing and Other Regulatory Fees)

The CMS final rule proposes that States may impose a remittance requirement in accordance with State requirements if an MCO fails to meet the minimum MLR. While the final rule does not require States to collect remittances from MCOs, CMS encourages States to implement

[17] 81 Fed. Reg. 27498, 27858 (May 6, 2016).

[18] 42 CFR part 422.

[19] 42 CFR part 423.

[20] CMS noted in the final rule that it was premature to adopt a standard for incorporating fraud prevention activities in the MLR for Medicaid because these expenses are not included in the current regulations on the MLR in the private insurance market. CMS further stated that fraud prevention activities should be aligned across programs. Therefore, the final rule stated that regulations related to incorporating fraud prevention activities in the MLR calculation will specify that MCO expenditures on activities related to fraud prevention as adopted for the private insurance market at 45 CFR part 158 would be incorporated into the Medicaid MLR calculation in the event the private insurance market MLR regulations are amended.

[21] The definition of activities that improve health care quality encompasses activities related to service coordination and case management as well as activities supporting States' goals for community integration of individuals with more complex needs, such as individuals using long-term services and supports.

[22] Payments by States to MCOs for one-time, specific life events of enrollees—events that do not receive separate payments in the private market or Medicare Advantage—would be included as premium revenue. Typical examples of these include maternity "kick-payments," where payments to MCOs are made at the time of delivery to offset the cost of prenatal, postnatal, and labor and delivery costs for an enrollee.

these types of financial contract provisions. Section 1.B.1.c.(3) of the final rule addresses the treatment of any Federal share of such remittances.[23]

[23] 81 Fed. Reg. 27498, 27532 (May 6, 2016).

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts recorded on the MCOs' general ledgers for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees for 27 contracts and grants (21 physical health grants and 6 behavioral health contracts) for CY 2014.[24] During this period, the total amount of Medicaid premium revenue earned by these contracts and grants was $9,293,241,511.

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to nine physical health HealthChoices MCOs and six behavioral health HealthChoices MCOs totaling $9,018,610,568 ($4,826,760,376 Federal share) and $274,630,943($146,982,481 Federal share), respectively.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Pennsylvania Provider Reimbursement and Operations Management Information System (PROMISe)[25] file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the PROMISe to the State's claim for reimbursement in the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

We did not review the overall internal control structure of the State agency or the Pennsylvania HealthChoices program. Rather, we reviewed only those controls related to our objective. We did not verify the accuracy of all cost and premium revenue information provided by the MCOs.

We performed fieldwork from August 2015 through August 2016 at the State agency's office in Harrisburg, Pennsylvania, at MCO offices throughout Pennsylvania, and at one MCO office in Hartford, Connecticut.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS officials to obtain information regarding the Pennsylvania HealthChoices managed care program;

[24] MCOs are required to file a statement of financial condition, including a balance sheet, a summary of receipts and disbursements, an income statement, and an analysis of utilization of all services covered by the MCO for each contract agreement.

[25] Pennsylvania's Medicaid Management Information System.

- held discussions with State agency officials to gain an understanding of the State agency's policies and procedures for overseeing and administering its Medicaid managed care program;

- reconciled Medicaid managed care payments included on Form CMS-64 to the State's PROMISe for the quarter ended September 30, 2014;

- obtained from the State agency a summary of capitated payments made to MCOs that contracted with the State agency during CY 2014;

- obtained from the State agency audited financial statements and financial reports for all Medicaid MCO plan contracts and grants;

- selected for review 27 MCO contracts and grants (all 21 physical health grants and 6 of the 34 behavioral health contracts) and:

    - obtained from the MCOs total amounts recorded on their plans' general ledgers for cost and premium revenue;[26]

    - obtained from the MCOs supporting documentation (e.g., general ledger account summaries and actuarial estimates and opinions) for the cost and premium revenue elements and an explanation of how these amounts were derived;

    - verified a judgmental sample of incurred medical expenses;[27]

    - verified earned premium revenue;[28]

    - used the financial data obtained from the MCOs to compute the MLR for each rating category, using the formula applicable to private health insurers and Medicare Advantage plans; and

    - used the financial data obtained from the MCOs to compute the MLR for each contract and grant and for each rating category, using the formula applicable to private health insurers and Medicare Advantage plans;

[26] Specifically, we obtained the total amounts reported on the plans' general ledgers for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees.

[27] We selected and verified certain medical expenses incurred by each MCO. For medical expenses incurred and paid, we obtained detailed underlying support, such as the claims data summary. For medical expenses incurred but not reported, we obtained a description of the actuarial methodology used to determine the actuarial estimates.

[28] We obtained total capitated payments made by the State agency for each contract and grant and for each rating category and compared those amounts with the contracts and grants' earned premium revenue.

- calculated the remittance[29] that would have been issued to the State agency and determined the potential Medicaid program savings if the State agency had required the MCO contracts and grants to meet a minimum MLR standard and issue a remittance to the State agency if the standard was not met; and

- discussed our audit results with 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.

[29] The ACA-established formula for calculating the remittance is (premium revenue − taxes − licensing and regulatory fees) × (the applicable MLR standard − the insurer's calculated MLR).

APPENDIX E: MEDICAL LOSS RATIOS FOR HEALTHCHOICES CONTRACTS/GRANTS AND POTENTIAL PROGRAM SAVINGS ON A CONTRACT/GRANT BASIS

MCO	Contract Rating Zone[30]	MLR[31]	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[32]
PHMCO-1	SE	94.1%	-	-
PHMCO-1	SW	92.3%	-	-
PHMCO-1	LC	88.2%	-	-
PHMCO-2	SE	90.8%	-	-
PHMCO-3	SE	90.4%	-	-
PHMCO-4	LC	91%	-	-
PHMCO-4	NW	95.2%	-	-
PHMCO-4	NE	97.8%	-	-
PHMCO-5	SE	99.1%	-	-
PHMCO-6	SE	95.2%	-	-
PHMCO-6	SW	76.3%	$4,609,016	$2,466,745
PHMCO-6	LC	101%	-	-
PHMCO-6	NW	83.7%	974,092	521,334
PHMCO-6	NE	88.6%	-	-
PHMCO-7	SW	96%	-	-
PHMCO-7	LC	95.6%	-	-
PHMCO-7	NW	99%	-	-
PHMCO-8	SW	88.7%	-	-
PHMCO-8	LC	92.3%	-	-
PHMCO-8	NW	91.9%	-	-
PHMCO-9	NE	97.4%	-	-
Subtotal			**$5,583,108**	**$2,988,079**

[30] The State agency uses zones (a group of counties) to award managed care grants. See the Figure on page 3.

[31] We rounded insurers' MLRs in accordance with Federal regulations (45 CFR § 158.221 and 42 CFR §§ 422.2400-2480).

[32] The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (section 1903(d)(3)(A) of the Social Security Act). To determine the Federal share for managed care contracts, we multiplied the Medicaid potential program savings by the Pennsylvania Federal medical assistance percentage (FMAP) of 53.52 percent.

MCO	Contract Rating Zone	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings
BHMCO-1		88.6%	-	-
BHMCO-2		86.5%	-	-
BHMCO-3		79%	$1,497,079	$801,237
BHMCO-4		82.5%	585,281	313,242
BHMCO-5		84.1%	244,562	130,890
BHMCO-6		83.1%	117,126	62,686
Subtotal			**$2,444,048**	**$1,308,055**
Total			**$8,027,156**	**$4,296,134**

APPENDIX F: MEDICAL LOSS RATIOS FOR HEALTHCHOICES CONTRACTS/GRANTS AND POTENTIAL PROGRAM SAVINGS ON A RATING CATEGORY BASIS

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
PHMCO-1	SE	A	94%	-	-
PHMCO-1	SE	B	91.2%	-	-
PHMCO-1	SE	C	50.5%	$516,966	$276,680
PHMCO-1	SE	D	96.7%	-	-
PHMCO-1	SE	E	114.6%	-	-
PHMCO-1	SE	F	87.2%	-	-
PHMCO-1	SE	G	73.2%	222,768	*
PHMCO-1	SW	A	89.3%	-	-
PHMCO-1	SW	B	95.9%	-	-
PHMCO-1	SW	C	58.3%	275,017	147,189
PHMCO-1	SW	D	95.2%	-	-
PHMCO-1	SW	E	105.7%	-	-
PHMCO-1	SW	F	83.2%	172,478	*
PHMCO-1	SW	G	93.2%	-	-
PHMCO-1	LC	A	81.5%	1,451,909	777,061
PHMCO-1	LC	B	91.3%	-	-
PHMCO-1	LC	C	59%	288,684	154,504
PHMCO-1	LC	D	88.9%	-	-
PHMCO-1	LC	E	68%	152,387	81,557
PHMCO-1	LC	F	89.5%	-	-
PHMCO-1	LC	G	132.7%	-	-
PHMCO-2	SE	A	92.3%	-	-
PHMCO-2	SE	B	91.7%	-	-
PHMCO-2	SE	C	90.6%	-	-
PHMCO-2	SE	D	93%	-	-
PHMCO-2	SE	E	87.6%	-	-
PHMCO-2	SE	F	91.4%	-	-
PHMCO-2	SE	G	89.1%	-	-
PHMCO-3	SE	A	92.5%	-	-
PHMCO-3	SE	B	91.9%	-	-
PHMCO-3	SE	C	61.2%	1,690,160	904,573
PHMCO-3	SE	D	91.8%	-	-

[33] The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (section 1903(d)(3)(A) of the Social Security Act). To determine the Federal share for managed care contracts, we multiplied the Medicaid potential program savings by the Pennsylvania FMAP of 53.52 percent.

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
PHMCO-3	SE	E	128.1%	-	-
PHMCO-3	SE	F	127.8%	-	-
PHMCO-3	SE	G	138.8%	-	-
PHMCO-4	LC	A	83.6%	1,623,588	868,944
PHMCO-4	LC	B	85.7%	-	-
PHMCO-4	LC	C	61.2%	480,520	257,174
PHMCO-4	LC	D	94.2%	-	-
PHMCO-4	LC	E	119.9%	-	-
PHMCO-4	LC	F	112.9%	-	-
PHMCO-4	LC	G	117.5%	-	-
PHMCO-4	NW	A	90.1%	-	-
PHMCO-4	NW	B	80.5%	550,370	294,558
PHMCO-4	NW	C	54.4%	47,455	25,398
PHMCO-4	NW	D	103.8%	-	-
PHMCO-4	NW	E	119.4%	-	-
PHMCO-4	NW	F	112.3%	-	-
PHMCO-4	NW	G	72.3%	8,691	*
PHMCO-4	NE	A	94.2%	-	-
PHMCO-4	NE	B	90.1%	-	-
PHMCO-4	NE	C	60.4%	330,274	176,762
PHMCO-4	NE	D	100.4%	-	-
PHMCO-4	NE	E	76.5%	55,752	29,839
PHMCO-4	NE	F	143.3%	-	-
PHMCO-4	NE	G	243.7%	-	-
PHMCO-5	SE	A	87.8%	-	-
PHMCO-5	SE	B	88.8%	-	-
PHMCO-5	SE	C	44.4%	211,723	113,314
PHMCO-5	SE	D	104.6%	-	-
PHMCO-5	SE	E	226.9%	-	-
PHMCO-5	SE	F	123.3%	-	-
PHMCO-5	SE	G	167.7%	-	-
PHMCO-6	SE	A	115.5%	-	-
PHMCO-6	SE	B	83.5%	1,086,556	581,525
PHMCO-6	SE	C	705.5%	-	-
PHMCO-6	SE	D	90.9%	-	-
PHMCO-6	SE	E	121.4%	-	-
PHMCO-6	SE	F	77.9%	1,272,948	*
PHMCO-6	SE	G	93.4%	-	-
PHMCO-6	SW	A	70.9%	1,440,160	770,774

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
PHMCO-6	SW	B	66.8%	2,229,477	1,193,216
PHMCO-6	SW	C	44.9%	164,989	88,302
PHMCO-6	SW	D	83.8%	284,440	152,232
PHMCO-6	SW	E	140.5%	-	-
PHMCO-6	SW	F	77.7%	470,715	*
PHMCO-6	SW	G	61.1%	107,089	*
PHMCO-6	LC	A	91.4%	-	-
PHMCO-6	LC	B	98.9%	-	-
PHMCO-6	LC	C	721.8%	-	-
PHMCO-6	LC	D	99.2%	-	-
PHMCO-6	LC	E	99.2%	-	-
PHMCO-6	LC	F	100.3%	-	-
PHMCO-6	LC	G	103.5%	-	-
PHMCO-6	NW	A	85%	-	-
PHMCO-6	NW	B	64%	3,454,423	1,848,807
PHMCO-6	NW	C	81.7%	10,681	5,716
PHMCO-6	NW	D	88.6%	-	-
PHMCO-6	NW	E	25%	133,359	71,374
PHMCO-6	NW	F	113.1%		-
PHMCO-6	NW	G	217.7%		-
PHMCO-6	NE	A	81.9%	755,246	404,208
PHMCO-6	NE	B	70.5%	4,829,356	2,584,671
PHMCO-6	NE	C	48.8%	222,578	119,124
PHMCO-6	NE	D	99.7%	-	-
PHMCO-6	NE	E	82.9%	10,284	5,504
PHMCO-6	NE	F	99.5%	-	-
PHMCO-6	NE	G	121.6%	-	-
PHMCO-7	SW	A	98.2%	-	-
PHMCO-7	SW	B	87.3%	-	-
PHMCO-7	SW	C	121.5%	-	-
PHMCO-7	SW	D	93.2%	-	-
PHMCO-7	SW	E	84.2%	15,182	8,126
PHMCO-7	SW	F	554.9%	-	-
PHMCO-7	SW	G	319.8%	-	-
PHMCO-7	LC	A	84.1%	1,138,863	609,519
PHMCO-7	LC	B	92.8%	-	-
PHMCO-7	LC	C	167.3%	-	-
PHMCO-7	LC	D	94%	-	-
PHMCO-7	LC	E	99.9%	-	-

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
PHMCO-7	LC	F	518.8%	-	-
PHMCO-7	LC	G	443.1%	-	-
PHMCO-7	NW	A	92.5%	-	-
PHMCO-7	NW	B	92.4%	-	-
PHMCO-7	NW	C	139.2%	-	-
PHMCO-7	NW	D	98%	-	-
PHMCO-7	NW	E	81.3%	$8,220	$4,399
PHMCO-7	NW	F	496.7%	-	-
PHMCO-7	NW	G	588.3%	-	-
PHMCO-8	SW	A	102.8%	-	-
PHMCO-8	SW	B	73.6%	27,188,342	14,551,201
PHMCO-8	SW	C	32.4%	1,769,834	947,215
PHMCO-8	SW	D	86.5%	-	-
PHMCO-8	SW	E	90.9%	-	-
PHMCO-8	SW	F	285.7%	-	-
PHMCO-8	SW	G	746.3%	-	-
PHMCO-8	LC	A	111.8%	-	-
PHMCO-8	LC	B	66.3%	4,796,166	2,566,908
PHMCO-8	LC	C	31.4%	293,241	156,942
PHMCO-8	LC	D	95%	-	-
PHMCO-8	LC	E	146.9%	-	-
PHMCO-8	LC	F	190.3%	-	-
PHMCO-8	LC	G	294.3%	-	-
PHMCO-8	NW	A	109.6%	-	-
PHMCO-8	NW	B	74%	10,307,549	5,516,600
PHMCO-8	NW	C	44.5%	420,006	224,787
PHMCO-8	NW	D	92.7%	-	-
PHMCO-8	NW	E	126.4%	-	-
PHMCO-8	NW	F	253.5%	-	-
PHMCO-8	NW	G	251.5%	-	-
PHMCO-9	NE	A	96.3%	-	-
PHMCO-9	NE	B	88.3%	-	-
PHMCO-9	NE	C	126.9%	-	-
PHMCO-9	NE	D	100.3%	-	-
PHMCO-9	NE	E	69.1%	615,330	329,325
PHMCO-9	NE	F	123.5%	-	-
PHMCO-9	NE	G	172.7%	-	-
Subtotal				**71,103,776**	**36,848,028**
BHMCO-1		A	95%	-	-

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
BHMCO-1		B	82.2%	$471,364	$252,274
BHMCO-1		C	90.6%	-	-
BHMCO-1		F	105.9%	-	-
BHMCO-1		G	113.8%	-	-
BHMCO-1		H	80.2%	1,150,808	615,912
BHMCO-1		I	93.8%	-	-
BHMCO-2		A	90.7%	-	-
BHMCO-2		B	80.4%	1,160,368	621,029
BHMCO-2		C	99.4%	-	-
BHMCO-2		F	103%	-	-
BHMCO-2		G	60%	54,296	*
BHMCO-2		H	80.3%	1,430,471	765,588
BHMCO-2		I	89.8%	-	-
BHMCO-3		A	104.7%	-	-
BHMCO-3		B	70.8%	1,146,620	613,671
BHMCO-3		C	117.2%	-	-
BHMCO-3		F	94.5%	-	-
BHMCO-3		G	137%	-	-
BHMCO-3		H	74.4%	1,225,027	655,635
BHMCO-3		I	95.6%	-	-
BHMCO-4		A	85%	-	-
BHMCO-4		B	75.3%	724,316	387,654
BHMCO-4		C	96.7%	-	-
BHMCO-4		F	74.8%	93,973	*
BHMCO-4		G	53.2%	3,374	*
BHMCO-4		H	85.7%	-	-
BHMCO-4		I	84.6%	13,809	7,391
BHMCO-5		A	106.9%	-	-
BHMCO-5		B	84.4%	38,943	20,842
BHMCO-5		C	79.6%	118,696	63,526
BHMCO-5		F	135.7%	-	-
BHMCO-5		G	151.9%	-	-
BHMCO-5		H	73.1%	1,456,856	779,710
BHMCO-5		I	78.6%	243,854	130,511
BHMCO-6		A	87.7%	-	-
BHMCO-6		B	98.9%	-	-
BHMCO-6		C	86%	-	-
BHMCO-6		F	168.1%	-	-
BHMCO-6		G	688.7%	-	-

MCO	Contract Rating Zone	Rating Category	MLR	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings[33]
BHMCO-6		H	51.3%	$977,716	$523,274
BHMCO-6		I	122.2%	-	-
Subtotal				**10,310,491**	**5,437,017**
Total				**$81,414,267**	**$42,285,045**

* A rating category that does not receive Federal matching funds under traditional Medicaid.

APPENDIX G: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

MAY - 4 2017

Mr. Jason Jelen
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, Pennsylvania 19106

Dear Mr. Jelen:

Thank you for providing the draft report number A-03-15-00203 entitled, "Review of Pennsylvania Medicaid Managed Care Program Potential Savings with Minimum Medical Loss Ratio". Below are our specific comments to the finding and each recommendation included in the draft report. We have separated our comments between the Physical Health (DHS, Office of Medical Assistance Programs) and the Behavioral Health (DHS, Office of Mental Health and Substance Abuse Services) components of Medicaid Managed Care. We request that you consider our comments and incorporate those points into the final report.

Finding:

Some Managed Care Organizations had a Medical Loss Ratio of Less Than 85 Percent:

Medical Loss Ratio Calculated on a Contract/Grant Basis:

Department of Human Services (DHS) Response:

Physical Health – DHS noted that Appendix E of the draft report contains two incorrect MLRs. PHMCO-3 SE is noted as 90.4%, but should be 92.9% and PHMCO-6 SE is noted as 87.0%, but should be 95.2%.

DHS currently has a separate agreement with each MCO for each zone in which they operate. For example, PHMCO-5 and PHMCO-6 had two agreements that had MLRs under 85%, three of their six agreements had high MLRs (101.0%, 99.1%, and 95.2%), and overall, their MLR was approximately 93%. DHS reviews results across all agreements with an MCO. In the future, DHS will have one agreement per MCO that includes all zones in which the MCO participates. If DHS had recovered in the two zones with MLRs under 85%, the effective overall MLR would have been 94%, which is not a sustainable MLR. DHS may have needed to adjust rates in the high MLR zones. Also, PHMCO-6 was in a new zone with expansion counties. They reported conservative results in 2012 and 2013, then released reserves in 2014, contributing to the low MLR. If MLR had been in place the reporting may have been different.

Deputy Secretary for Administration
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Behavioral Health – DHS is unable to confirm the membership amounts listed for the HealthChoices Behavioral Health (HC-BH) program, nor were we able to reconcile the revenue paid amounts utilized in the calculations. Therefore, we are unable to concur with the amount of potential savings listed in the draft report.

In addition, there is an incorrect statement in the last sentence of the second paragraph of the finding regarding the HC-BH program not placing limits on administrative costs or profits. The HC-BH program has a profit limitation in place that is called Reinvestment Sharing Arrangement.

Medical Loss Ratio Calculated on a Rating Category Basis:

DHS Response:

Physical Health – DHS noted that Appendix F of the draft report contains three incorrect MLRs. PHMCO-8 NW E is noted as 92.7%, but should be 126.4%, PHMCO-8 NW F is noted as 126.4%, but should be 253.5%, and PHMCO-8 NW G is noted as 253.5%, but should be 251.5%.

On the rating category basis, 24 of the 41 Physical Health MCOs that were under 85% MLRs were in three very low membership rate cells – Duals under 21, Breast and Cervical Cancer (BCC), and Medically Needy Only (MNO) (State). Duals under 21 averaged 386 members per month per plan, BCC averaged 184 members per month per plan, and MNO averaged 929 members per month per plan. Of the 147 rating category zone MCO combinations, 41 were under 85%; however 74 were over 93%, and of these, 53 were over 100%, of which 16 were between 200% and 750%.

Behavioral Health – The value of the HC-BH programs range from very small ($5M annual capitation revenue) to very large ($750M annual capitation revenue). The MLR threshold becomes more difficult to meet in the smaller contracts, especially without the benefit of the credibility adjustment permitted in certain cases, as described in the CMS Final Rule at Section 438.8(h). According to DHS' analysis, all but two of the then 32 HC-BH contractors met or exceeded the 85% threshold.

Very small contracts in the HC-BH program equates to very small numbers of members within a rating category. As such, rating categories with small membership are subject to outliers, which could result in an individual rating category MLR falling below the 85% threshold. The HC-BH agreements have both risk corridors and reinvestment sharing arrangements that help to equalize both profits and losses within a rating category and across the individual contracts. Calculating the MLR on a rating category basis could result in unintended losses for the smaller plans.

Office of Inspector General Recommendations: We recommend that the State agency:

- Incorporate into its contracts and grants with Medicaid MCOs the MLR standards adopted in the CMS final rule, and
- Consider implementing into its Medicaid MCO contracts and grants a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

DHS Response: Overall, DHS agrees with the recommendations included in the draft report, as listed above.

Physical Health – DHS has incorporated into its 2017 grant agreements an MLR reporting requirement consistent with the CMS final rule, and will incorporate into its 2018 grant agreements both an MLR reporting requirement and remittance requirement consistent with the CMS final rule.

Behavioral Health – a DHS has incorporated the MLR requirements into its HC-BH program agreements effective July 1, 2017, and has conducted training with the HC-BH plans on reporting aspects of the MLR requirement. DHS has not incorporated a remittance requirement into its HC-BH program agreements at this time. The existing Reinvestment Sharing arrangements already capture and return to DHS and CMS any excess profits derived on an annual basis.

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

Sincerely,

Jay Bausch
Deputy Secretary for Administration

c: Mr. William R. Grayson, Office of Inspector General
Mr. Robert Baiocco, Office of Inspector General
Mr. Charles Hubbs, Office of Inspector General
Mr. Frederick Kalibbala, Office of Inspector General
Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section