

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF THE COMMONWEALTH
OF PENNSYLVANIA'S MEDICAID
BEHAVIORAL *HEALTHCHOICES*
PROGRAM**

**STATE FISCAL YEARS ENDING
JUNE 30, 2001 AND JUNE 30, 2002**



**NOVEMBER 2003
A-03-03-00200**

Office of Inspector General

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Memorandum

Date NOV 26 2003

From Regional Inspector General for Audit Services

Subject Review of the Commonwealth of Pennsylvania's Medicaid Behavioral *HealthChoices* Program for State Fiscal Years Ending June 30, 2001 and June 30 2002 (A-03-03-00200)

To Sonia A. Madison
Regional Administrator
Centers for Medicare & Medicaid Services

This final report provides the results of our **REVIEW OF THE COMMONWEALTH OF PENNSYLVANIA'S MEDICAID BEHAVIORAL *HEALTHCHOICES* PROGRAM FOR STATE FISCAL YEARS ENDING JUNE 30, 2001 AND JUNE 30, 2002**. The *HealthChoices* program began in February 1997 under a waiver granted by the Centers for Medicare & Medicaid Services (CMS) under section 1915(b) of the Social Security Act. The program has two components, physical health and behavioral health and is administered by Pennsylvania's Department of Public Welfare (DPW). Our objectives were to determine: (1) to what extent intergovernmental transfers or other financing mechanisms are used to maximize Federal Medicaid reimbursement, (2) if the contract procurement process conforms to Federal regulations and (3) if the profits¹ (or losses) incurred by counties in administering this program are unreasonable.

We reviewed county-specific revenue and expense records for State fiscal years (SFY) 2001 and 2002.² We reconciled this information with the amounts Pennsylvania claimed on the *Medicaid Program Expenditures Report* (Form CMS-64). We also reviewed applicable criteria that included the *HealthChoices* waiver, Pennsylvania's Medicaid State plan, Federal statutes and regulations, and implementing policies and guidelines.

- There was no evidence of intergovernmental transfers or any other questionable funding mechanisms in the behavioral *HealthChoices* program.
- Federal bid procurement regulations were not violated since the CMS approved *HealthChoices* waiver allows Pennsylvania counties the right of first opportunity to provide behavioral health services without a competitive bid process.

¹ For this review, we refer to the differences between county revenue (capitation payments and investment income) and expenses (medical and administrative costs) as profit or loss while the State may refer to this difference as reinvestment funds.

² Pennsylvania's SFY 2001 ended on June 30, 2001, SFY 2002 ended on June 30, 2002.

- In 2001, 15 counties sustained an aggregate loss of 2.13 percent. The following year, 25 counties realized an aggregate profit of 5.51 percent. These are not unreasonable amounts.

Three of 15 counties in 2001 realized profits in excess of 10 percent. The following year, 8 of 25 counties also made in excess of 10 percent profit. In each year, the county-high profit was 38 percent. We recommend that CMS:

- (1) Require Pennsylvania to report county-specific profits and/or losses into its base year administrative costs, and
- (2) Compare proposed rates to base year rates to assure that they are reasonable.

In our draft report, we recommended that CMS modify the waiver to include county-specific profit limits and a provision that allows CMS to offset, on Form CMS-64, the Federal share of those profits in excess of established limits. In its response, the CMS regional office stated that county-specific limits: (1) cannot be implemented since there is no regulatory authority to do so, (2) are arbitrary and not appropriate for Medicaid managed care, and (3) would have no impact on the methodology for calculating capitation rates. CMS also stated that its recently developed checklist to evaluate capitation rate requests should address our concerns. Item number AA.3.2 of the checklist, *Administrative cost allowance calculations (Mandatory)*, set a “rule of thumb” of no more than 15 percent of per-member-per-month (PMPM) capitation payments for administrative costs. Administrative costs include, but are not limited to, marketing, claims processing, medical management, staff overhead, and profit. States were to justify administrative costs in excess of 15 percent prior to CMS approval.

Pennsylvania also disagreed with our recommendation to limit profits. It noted that the current capitation rate development process for 2002 and 2003 resulted in rate reductions in three counties between 4 percent and 7 percent. One of these counties was cited in our report. Pennsylvania believes that the use of encounter data for rate setting will eliminate fluctuations in profits and losses.

On July 22, 2003, 2 months after our draft report was issued, CMS amended its checklist and removed the 15 percent “rule of thumb.” Administrative costs are now limited to only those costs directly related to the provision of State plan approved services to Medicaid-eligible members. No specific limit is noted. It simply states, “*CMS does not have established standards for risk and profit levels but does allow **reasonable** (emphasis added) amounts for risk and profit to be included in capitated rates.*” This change prompted further analysis of administrative costs (including profits) by the Office of Inspector General (OIG). Aggregate rates for administrative costs, including profits, appear to be reasonable. However, some individual county rates do not appear reasonable. Proposed capitation rates for calendar year 2003 were incomplete since the base-year data did not include county-specific profits or losses. Therefore, we modified our recommendations. We also made changes in the report to reflect CMS and DPW comments. We included the comments, in their entirety, in Appendix A and Appendix B. CMS’s and Pennsylvania’s comments and OIG response are summarized in the report.

BACKGROUND

In 1965, Medicaid was established as a jointly funded Federal and State program providing medical assistance to qualified low-income people. At the Federal level, the program is administered by CMS, an agency within the Department of Health and Human Services. Within a broad legal framework, each State designs and administers its own Medicaid program. Each State prepares a State plan that defines how a state will operate its Medicaid program and is required to submit that plan for CMS approval. In Pennsylvania, DPW is the State Medicaid agency.

The Federal government and States share in the cost of the Medicaid program based on the applicable Federal medical assistance percentage. This share ranges from 50 percent to 83 percent, depending upon each State's relative per capita income. The rate in Pennsylvania is approximately 54 percent. The Federal payment for its share of medical cost is referred to as Federal financial participation (FFP). States report medical assistance expenditures quarterly to CMS on Form CMS-64.

In February 1997, DPW initiated the *HealthChoices* program that required medical assistance beneficiaries to enroll in managed care plans. The program was approved by CMS under a waiver granted under §1915(b) of the Social Security Act. The program has two components, physical health and behavioral health. DPW contracts directly with managed care organizations for physical health services and with counties that coordinate behavioral health services. DPW does not enroll all medical assistance beneficiaries in *HealthChoices*. Among those beneficiaries excluded are those who:

- Reside in a nursing home for more than 30 consecutive days,
- Reside in a juvenile detention center for more than 35 consecutive days,
- Are admitted to a State facility other than a public intermediate care facility for the mentally retarded, and/or
- Are ventilator-dependent and hospitalized for more than 30 consecutive days.

In addition, newly eligible medical assistance beneficiaries have 4 to 6 weeks from the time eligibility is confirmed until enrollment in the *HealthChoices* program. Beneficiaries not in *HealthChoices* are covered under Pennsylvania's fee-for-service Medicaid program. The 67 Pennsylvania counties are organized into six *HealthChoices* zones.

- The *Southeast* zone, consisting of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, initiated the program on February 1, 1997 and is the largest region in terms of membership.
- The *Southwest* zone includes Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland counties. This zone began serving voluntary enrollees on January 1, 1999. By July 1, 1999 enrollment was mandatory. This zone has the second largest membership. Future expansion is planned to Bedford, Blair, Cambria, and Somerset counties.

- The *Lehigh/Capital* zone initiated voluntary enrollment in October 2001 with mandatory enrollment effective by April 2002. This zone, with the third largest membership, serves Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York counties.
- The remaining counties that comprise the *Northeast, Northwest, and Central* zones are targeted for conversion to *HealthChoices* after January 2004.

Behavioral health services include mental health and drug and alcohol treatment. Mental health services include inpatient and outpatient psychiatric services; partial hospitalization; residential treatment and behavioral health rehabilitation services for children; and crisis intervention, family-based, and resource coordination services. Drug and alcohol services include inpatient, non-hospital, and outpatient drug and alcohol detoxification, drug and alcohol rehabilitation, and methadone maintenance.

Each month, Pennsylvania pays *HealthChoices* counties a capitation payment for behavioral health services for enrolled members. Most counties then sub-contract for service delivery. Others contract with management organizations that coordinate service delivery. Pennsylvania administers *HealthChoices* for one county. The *HealthChoices* program allows counties opportunities to use profits resulting from “management efficiencies to create reinvestment opportunities.” Counties receive State approval to reinvest any profits and must provide additional in-plan behavioral health services.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to determine: (1) to what extent intergovernmental transfers or other financing mechanisms are used to maximize Federal Medicaid reimbursement, (2) if the contract procurement process conforms to Federal regulations and (3) if the profits (or losses) incurred by counties in administering this program are reasonable. For this review, we refer to the differences between county revenue and expenses as profit or loss while the State may refer to this difference as reinvestment funds. We did not validate the county’s use of these funds. We reviewed county-specific revenue and expense records for State fiscal years 2001 and 2002 and proposed capitation rates for calendar year 2003. We reconciled county reported capitation payments with the amounts Pennsylvania claimed on Form CMS-64. We also reviewed the *HealthChoices* waiver, Pennsylvania’s Medicaid State plan, Federal statutes and regulations, and CMS’s implementing policies and guidelines.

Our review of internal controls was limited to validating the State’s capitation payments to counties and reconciling those payments with payments reported on Form CMS-64. Our fieldwork was performed at DPW in Harrisburg, Pennsylvania during November and December 2002. We performed our review in accordance with generally accepted government auditing standards.

FINDINGS

HEALTHCHOICES IS FUNDED PROPERLY

We found no evidence of intergovernmental transfers or any other questionable funding mechanisms in the behavioral *HealthChoices* program. In 2001, Pennsylvania made \$721.5 million in *HealthChoices* capitation payments to 15 counties. The following year, these payments increased to \$944.0 million to 25 counties.³ In 2002, *HealthChoices* expanded to the 10 county Lehigh/Capital zone.

Pennsylvania computed capitation payments to counties by multiplying a per-member-per-month rate by the total member months. A member month equals the percentage of days a beneficiary was enrolled in a given month. If a member was enrolled on any day other than the first day, the capitation payments were prorated. For example, if a beneficiary was enrolled on the 15th of the month, the payments were prorated for one-half month. The following table summarizes the capitation payments claimed during our review:

CATEGORY	SFY 2001	SFY 2002
Average Member Months	733,451	834,838
Average PMPM	\$81.97	\$94.23
Medical Services PMPM	\$75.43	\$83.77
Administration PMPM	\$6.54	\$10.46
Capitation Payments to Counties	\$721.5M	\$944.0M
Federal Share	\$358.4M	\$462.8M
State Share	\$363.1M	\$481.2M

HEALTHCHOICES DOES NOT VIOLATE FEDERAL BID PROCUREMENT REGULATIONS

Under provisions set forth in the Office of Management and Budget Circular A-87, *Cost Principals for State, Local, and Indian Tribal Governments*, Pennsylvania could only claim Federal matching funds for the actual *HealthChoices* expenditures incurred by the counties, not the capitation payments made by the State if the State's contracts with the counties were not consistent with the Federal procurement regulations.⁴ However, the *HealthChoices* waiver allowed Pennsylvania counties the right of first opportunity to provide behavioral health services. Commercial bids, submitted through a request-for-proposal were not reviewed if a county chose to participate and met certain criteria. Therefore, compliance with

³ Pennsylvania claimed \$667.7 million on Form CMS-64 for 2001 capitation payments and \$850.2 million for 2002. Two factors account for the difference between the paid and claimed amounts. First, there were two groups of beneficiaries that received benefits under State-only programs and were not eligible for Federal matching funds. Second, there were disparities between payment and reporting times.

⁴ Code of Federal Regulations: Title 45--Public Welfare, Subtitle A--Department of Health and Human Services, Part 74—*Uniform Administrative Requirements for Awards and Sub-awards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations; and Certain Grants and Agreements with States, Local Governments and Indian Tribal Governments*

Federal bid procurement regulations was not at issue. If a county was unable to meet the State’s standards for participation or chose not to provide services, the State contracted directly with a private managed care organization. This arrangement was in effect for one county.

AGGREGATE COUNTY PROFITS/LOSSES ARE INSIGNIFICANT. HOWEVER, SOME INDIVIDUAL COUNTY PROFITS APPEAR UNREASONABLE

In 2001, 15 counties sustained an aggregate loss of 2.13 percent. The following year, 25 counties realized an aggregate profit of 5.51 percent. The county income includes both capitation and investment income, while expenses include both medical and administrative costs. We believe these profits are reasonable. Currently, there is nothing in the waiver, nor are there Federal regulations, that limit county-specific profits. Some county-specific profits exceeded 10 percent. We believe this may be unreasonable.

County profits/losses ranged from a 7.98 percent loss to a 37.69 percent profit. The following year the range went from a 12.47 percent loss to a 38.05 percent profit. Three of 15 counties in 2001 realized profits in excess of 10 percent. The following year, 8 of 25 counties also made in excess of 10 percent profit. Two of the three counties with profits in excess of 10 percent in 2001 also exceeded 10 percent profits in the following year. One county made a profit of 38 percent in 2001. The following year, this county realized a profit of almost 20 percent. For this county, we believe the State should have adjusted the capitation payments for 2002 to factor the prior year’s gain since these profits help counties generate “reinvestment” opportunities in behavioral health services. We did not validate the county’s use of these funds.

CONCLUSION AND RECOMMENDATIONS

We found no evidence of intergovernmental transfers or any other questionable funding mechanisms in the behavioral *HealthChoices* program, nor did the State violate any Federal bid procurement regulations. We also found that aggregate county profits/losses were insignificant (-2.13 percent in 2001 and 5.51 percent in 2002). However, three of 15 counties in 2001 realized profits in excess of 10 percent. The following year, eight of 25 counties also made in excess of 10 percent profit. In each year, the county-high profit was 38 percent. Currently, there is nothing in regulations or the waiver that limits county-specific profits. We initially recommended that CMS modify the waiver to include a county-specific profit limit, and a provision that allows CMS to offset, on Form CMS-64, the Federal share of those profits in excess of established limits. However, because of significant changes in CMS guidelines and additional data we developed since we issued the draft report, we revised the recommendation to better address the condition at hand. Therefore, we now recommend that CMS:

- (1) Require Pennsylvania to report county-specific profits and/or losses into its base year administrative costs, and
- (2) Compare proposed rates to base year rates to assure that they are reasonable.

CMS AND DPW COMMENTS AND OIG RESPONSE

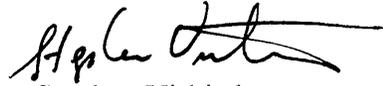
In its response (Appendix A) the CMS regional office did not concur with our recommendations. CMS noted that the capitation rates paid to counties during our review period were developed with the assistance of consulting actuaries and complied with the Federal regulations in effect at that time. Those regulations set an upper payment limit for capitation payments to what the costs would have been on a fee-for-service basis. The CMS regional office believed that county-specific limits: (1) cannot be implemented since there is no regulatory authority to do so, (2) are arbitrary and not appropriate for Medicaid managed care, and (3) would have no impact on the methodology for calculating capitation rates.

In its response (Appendix B) Pennsylvania also disagreed with our initial recommendation concerning profit limits. It stressed that the capitation rate-setting process, through the use of encounter data, should eliminate fluctuations in profits and losses. For 2002 and 2003, it noted reductions in rates for three counties between 4 percent and 7 percent. One of these counties was cited in our report. The State also noted that some counties that had realized profits subsequently experienced losses, primarily due to increased utilization of children's services.

Federal regulations (42 CFR §438.6(c)), effective August 13, 2002, require States to develop actuarially sound capitation rates based on costs and utilization of Medicaid State plan services and populations. CMS prepared a review checklist for use by CMS regional offices to approve all rate requests. Item number AA.3.2 of this checklist, *Administrative cost allowance calculations (Mandatory)*, recommended, as a "rule of thumb," that contractors limit administrative costs to 15 percent of medical services costs. Administrative costs include, but are not limited to, marketing, claims processing, medical management, staff overhead, and profit.

On July 22, 2003, CMS amended the rate-setting checklist to remove the 15 percent guideline and replace it with a **reasonable** (emphasis added) standard. CMS now limits administrative costs to only those directly related to the provision of the State plan approved services to Medicaid-eligible members. No specific limit is noted. As a result of these changes, we

reviewed the 2003 proposed administrative cost rates and found that Pennsylvania’s base year data (used to develop the proposed rates) did not include profits (or losses). Without the inclusion of profits, CMS cannot properly perform its oversight function in terms of determining a reasonable administrative rate and if a county is realizing excess profits. These profits go to “reinvestment opportunities” to fund behavioral health programs. However, we do not believe that the *HealthChoices* program was intended to allow the Federal government to share in a capitation payment that ensures sufficient “reinvestment opportunities” for services that may or may not be state plan approved.

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky

APPENDICES



Memorandum

Centers for Medicare & Medicaid Services

Region III

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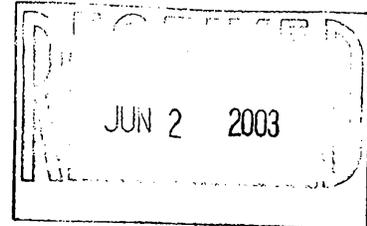
Philadelphia, PA 19106-3499

Date: MAY 30 2003

To: Regional Inspector General for Audit Services

From: Regional Administrator

Subject: Draft Office of Inspector General Audit Report, "Review of the Commonwealth of Pennsylvania's Medicaid Behavioral HealthChoices Program for State Fiscal Years Ending June 30, 2001 and June 30, 2002" (A-03-03-00200)



I am writing to respond to your request for comments on the subject report. The report did not cite any deficiencies where the State's waiver was out of compliance with Federal guidelines and requirements. However, specific recommendations were made to modify the waiver. The report recommended that CMS impose county specific profit limits and disallow the Federal share of profits in excess of such limits. The report concluded that without criteria limiting county-specific profit levels, the methodology for computing capitation rates may not be reasonable.

The overall audit report findings that the HealthChoices waiver is operating in compliance with Federal requirements is consistent with our monitoring of the waiver. CMS renewed the waiver on April 17, 2002. Documentation provided by the state in support of its waiver renewal application demonstrated that the waiver was cost effective and resulted in program savings to both the Federal and State governments while maintaining Medicaid recipient access to quality services. In addition, the capitation rates paid to the counties that administer the behavioral health component of the waiver were reviewed and approved by this office. The rates were prepared by the State with the assistance of consulting actuaries. The State demonstrated to our satisfaction that the rates were actuarially sound and did not exceed the Federal Upper Payment Limit (UPL) which was the regulation applicable to such rates at the time.

Although both the waiver and the capitation rates meet Federal requirements, you are recommending that, through the waiver, limits be placed on county profits to insure that the methodology for computing capitation rates is reasonable. We do not concur with your recommendation for several reasons:

- The imposition of such limits on managed care organization (MCO) and prepaid inpatient health plan (PIHP) risk based contracts may require additional legislative and regulatory authority that does not exist at this time.
- CMS believes that limiting profits arbitrarily is inappropriate in Medicaid managed care and placing limits on county profits will not impact on the methodology for calculating capitation rates.
- CMS has recently implemented initiatives addressing the development of capitation rates and waiver cost effectiveness. These initiatives should address your areas of concern.

CMS does not currently have the regulatory authority to limit profits within specific managed care programs. Medicaid managed care waiver programs and demonstrations are intended to provide better access and care for beneficiaries and produce cost savings at the program level or are budget neutral. Limiting profits to MCOs or PIHPs that participate in these programs would not impact those goals except in potentially lowering the number of organizations willing to participate in these programs. On the other hand, counties providing additional services with those profits does help to meet the objective of providing better access and care for the beneficiaries. The development of capitation rates is a complicated process that includes many variables including baseline assumptions and data that drive the resulting rates. Limiting profits would not be an effective strategy for ensuring “reasonable rates”.

CMS published regulations effective August 13, 2002 that establish new requirements for the development and use of actuarially sound rates for risk contracts. The regulations at 42 CFR 438.6(c) specifically require that States meet certain criteria in the methodology used in developing their rates. Among these are the requirements that rates are developed using only costs and utilization based on Medicaid State Plan Services and State Plan populations. Risk corridor arrangements are also discussed within the regulation and specify the requirements for profit/(loss) arrangements similar to the concepts addressed in your report, i.e. Federal and State participation in excess profits and losses as part of a contract. The regulation further requires that qualified actuaries must certify such rates as meeting practice standards and requires states to submit specific documentation to CMS to support that the certification and demonstrate the impact of the rates on proposed expenditures. CMS believes that something more than “reasonable” rates must be required and that this regulation will be an effective way to ensure the development of actuarially sound rates.

CMS has also developed tools to aid Regional Offices in the evaluation and approval of risk contracts and the evaluation and monitoring of 1915(b) waiver programs. CMS has prepared a comprehensive rate review checklist for use by the CMS regional offices that must approve all rate requests.

CMS has also established a new process for states to document the cost effectiveness of their waiver programs as part of the waiver application and renewal process. This new process requires States to identify State Plan services, populations and costs under the waiver prospectively and to demonstrate that their actual expenditures for

the waiver program are within approved waiver projections. All services will be limited to a growth rate applied to cost developed in an actuarially sound process. CMS believes that this new waiver application and review process and the rate regulations are appropriate means of developing actuarially sound rates.

I appreciate the opportunity to comment on the draft audit report. I will be glad to answer any questions you may have about these comments.


Sonja A. Madison



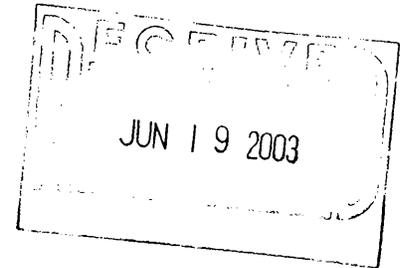
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JUN 17 2003

Michael Stauffer
Deputy Secretary for Administration

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Mr. Steven Virbitsky, Regional Inspector
General for Audit Services
Office of Audit Services
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Department of Health & Human Services
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Dear Mr. Virbitsky:

Thank you for your May 20, 2003, letter in which you transmitted the draft report entitled "Review of the Commonwealth of Pennsylvania's Medicaid Behavioral Health Choices Program for State Fiscal Years Ending June 30, 2001 and June 30, 2002." Following is the Department of Public Welfare's (DPW) formal response to the report.

In the Background Section of the report, the DPW would like to clarify the following: Mental health services include inpatient and outpatient psychiatric services; partial hospitalization; residential treatment and behavioral health rehabilitation services for children; and crisis intervention, family-based and resource coordination services. Drug and alcohol (D&A) services include inpatient, nonhospital D&A, and outpatient services.

With respect to the report findings, the DPW agrees that there is no use of intergovernmental transfers (IGTs) in the HealthChoices Behavioral Health Program, and no procurement regulations have been violated in providing counties with the right of first opportunity. In fact, as noted in the report, the procurement process has been approved by the Centers for Medicaid and Medicare Services (CMS), and also comports with the Commonwealth's procurement processes. The DPW, however, does take issue with the characterization of IGTs as being a "questionable funding mechanism." As you know from prior reviews, the Commonwealth has utilized IGTs in other contexts that are authorized under federal law and that have been approved for the Commonwealth pursuant to the Medical Assistance State Plan.

Regarding the third finding that describes profits and losses for the two different state fiscal years, the DPW recognizes that some counties experienced reinvestment funds in excess of ten percent of revenue in the period under review. Some of those same counties have since experienced losses, primarily due to increased utilization of children's services. During the 2001 and 2002 rate development process, the DPW was in the midst of settling

Mr. Steven Virbitsky

- 2 -

litigation around children's services. The data used in the rate development demonstrated increased demand for these services. Not all of the counties' service delivery systems had expanded to the degree assumed in the rate development. Those counties accrued reinvestment funds on those rates.

The DPW disagrees with the recommendation that the CMS be required to place a limit on profits/reinvestment opportunities. Should this recommendation go forward, the DPW would request that the CMS also consider a limit on losses as well. When the DPW determines that expenditures are less than anticipated, an investigation occurs and corrective action is required by the county. To the extent that rates require adjustment, that action is also taken. Capitation rates were reduced in three counties by between four percent and seven percent in the 2002 and 2003 rate development processes. One of the counties that had seen a high level of reinvestment accrual, and is referenced in this report, has received rate cuts three years in a row. As the DPW focuses more on using encounter data for rate setting, the DPW expects the fluctuations in profits/losses to dissipate and expenses to exhibit more stable trends.

Thank you for the opportunity to respond to this draft report. Please contact Linda Swick, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7218 if you have any questions or require additional information.

Sincerely,



Michael Stauffer

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, *Regional Inspector General for Audit Services*. Other principal Office of Audit Services staff who contributed include:

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Lisa Ferraro, *Auditor-in-Charge*
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