PERFORMANCE AUDIT REPORT

UPMC Health Plan

Community HealthChoices Contract with the Pennsylvania Department of Human Services

March 2025

Commonwealth of Pennsylvania
Department of the Auditor General

Timothy L. DeFoor • Auditor General

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TIMOTHY L. DEFOOR
AUDITOR GENERAL

February 25, 2025

Mr. Brendan Harris, President of UPMC *for You* and State Programs
UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Dear Mr. Harris:

This report contains the results of the Department of the Auditor General's performance audit of the UPMC Health Plan (UPMC) regarding the Community HealthChoices (CHC) contract with the Pennsylvania Department of Human Services (DHS).

Our performance audit covered the period January 1, 2022, through December 31, 2022, and included the audit objective to determine whether UPMC provided accurate and timely CHC program participant eligibility information to DHS to ensure accurate capitation rates paid to UPMC. The audit was conducted pursuant to Sections 402 and 403 of The Fiscal Code (Code)[1] and in accordance with the Code's Article XVII-B. 2021-2022 Budget Implementation provision,[2] and Article XVII-F.1. 2022-2023 Budget Implementation provision.[3]

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 objective.[4] We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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[1] 72 P.S. §§ 402 and 403.
[2] 72 P.S. § 1715-B (Act 24 of 2021, effective July 1, 2021).
[3] 72 P.S. § 1715-F.1(1) (Act 54 of 2022, retroactively applicable to July 1, 2022).
[4] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021.

Our methodology to satisfy this audit objective, along with our evaluation of management's internal controls significant to this audit objective, is included in *Appendix A* of this report. This report presents 2 findings and 17 recommendations, 11 of the 17 recommendations are directed to UPMC and 6 of the 17 recommendations are directed to DHS.

As discussed in ***Finding 1**,* we found UPMC failed to adequately perform all required participant assessments, did not require supervisor approval of assessments, and did not notify DHS and County Assistance Offices, through the required methods, of events and changes to CHC program participants' program eligibility status. UPMC is not required to perform annual assessments on participants that are ineligible for nursing facility care. As a result, due to this lack of required contact, there were two participants that UPMC was not aware had died, however, were still enrolled with UPMC for 16 months and 18 months, respectively.

In ***Finding 2***, we noted that as a result of UPMC not consistently providing CHC participant eligibility information to DHS, incorrect capitation payments were made by DHS to UPMC for 8 of 66 participants selected for review. The incorrect capitation payments totaled $357,048 of which $120,977 could not be recovered due to payment recovery restrictions included in the 2022 CHC Agreement. We also found that UPMC's reconciliation of participant eligibility to capitation payments received from DHS appeared to be focused on issues that only resulted in underpayments to UPMC. Finally, we found that UPMC does not perform outreach to participants aged 65 or older that are not enrolled in Medicare. We identified 3 of 66 selected participants who were over age 65 during the audit period but were not enrolled in Medicare. Enrollment in Medicare for these participants could result in savings to DHS and the Commonwealth.

In closing, we thank UPMC for its cooperation and assistance during the audit. UPMC management agreed with ***Finding 1*** and is in general agreement with ***Finding 2**.* UPMC agreed with the recommendations in ***Finding 2***; however, they disagreed that it was their responsibility to implement recommendations regarding the review of the Social Security Administration Death Master File, performing Medicare eligibility outreach, and conducting annual outreach to participants not eligible for nursing facility care. We conclude on UPMC's responses in the *Auditor's Conclusion to UPMC Health Plan's Response* section later in this report. In addition to the recommendations made to UPMC, ***Findings 1 and 2*** include six recommendations directed to DHS for which we strongly urge DHS consider and implement to improve the efficiency of operations within the CHC program.

We reserve the right to follow up at an appropriate time to determine whether and to what extent our recommendations have been implemented.

Sincerely,

Gordon R. Denlinger, CPA
Deputy Auditor General for Audits

A Performance Audit

UPMC Health Plan
Community HealthChoices contract with the Pennsylvania Department of Human Services

TABLE OF CONTENTS

Executive Summary 1

Introduction and Background 3

Finding One: UPMC failed to adequately perform all required participant assessments and did not notify DHS of changes to participants' program eligibility status 12

Recommendations 21

Finding Two: UPMC did not consistently provide CHC participant eligibility information to DHS, which resulted in incorrect capitation payments. Additional procedures are needed by UPMC in its capitation payment reconciliation process and Medicare eligibility outreach to participants 22

Recommendations 31

UPMC Health Plan's Response and Auditor's Conclusion 33

Appendix A – *Objectives, Scope, Methodology, and Data Reliability* 43

Appendix B – *UPMC Community HealthChoices Program Enrollment* 55

Appendix C – *UPMC Participants Test Selection* 57

Appendix D – *Distribution List* 58

A Performance Audit

UPMC Health Plan
Community HealthChoices contract with the Pennsylvania Department of Human Services

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Executive Summary

This report presents the results of our performance audit of the UPMC Health Plan (UPMC) regarding the Community HealthChoices (CHC) contract with the Pennsylvania Department of Human Services (DHS). Our performance audit objective was to determine whether UPMC provided accurate and timely CHC program participant eligibility information to DHS to ensure accurate capitation rates paid to UPMC. The audit period was January 1, 2022, through December 31, 2022.

Our audit results are contained in 2 findings with 17 recommendations; 11 of the 17 recommendations are directed to UPMC and 6 of the 17 recommendations are directed to DHS. UPMC management is in agreement with ***Finding 1*** and in general agreement with ***Finding 2***. UPMC stated that it has already begun to implement or will consider implementing the majority of recommendations to strengthen its operations. Although they agreed with the recommendations made in ***Finding 2***, they disagreed that it is their responsibility to implement some of the recommendations. For further detail, *see Auditor's Conclusion to UPMC Health Plan's Response* section of this report.

Finding 1 – UPMC failed to adequately perform all required participant assessments and did not notify DHS of changes to participants' program eligibility status.

UPMC must provide accurate and timely CHC program participant (individuals enrolled in the CHC program and referred to in the report as a participant) eligibility information to DHS to ensure accurate capitation rates are paid to UPMC. As part of our audit procedures, we reviewed documents that support UPMC's processes for enrolling participants in its CHC program and assessments performed during the period January 1, 2022, through December 31, 2022 (audit period) for 66 participants selected for review.

We found that UPMC either did not perform or not timely perform assessments of participants as required by the 2022 CHC Agreement. We found UPMC failed to adequately perform all required participant assessments and did not notify DHS, through the required methods, of changes to CHC program participants' program eligibility status. As a result, as discussed in detail in ***Finding 2***, DHS made capitation payments to UPMC for ineligible services for participants. If UPMC had notified DHS of the participants' change in status in a timely manner, DHS may have been able to prevent the significant capitation payments made to UPMC in error.

Additionally, we determined that UPMC is not required to make regular contact with participants that are classified as ineligible for nursing facility care. As a result, due to the lack of required contact, there were two participants that UPMC was not aware had died, however, were still enrolled with UPMC for 16 months and 18 months, respectively.

We offer six recommendations to UPMC and two recommendations to DHS to remedy the inconsistencies and other issues identified by our audit work.

Finding 2 – UPMC did not consistently provide CHC participant eligibility information to DHS, which resulted in incorrect capitation payments. Additional procedures are needed by UPMC in its capitation payment reconciliation process and Medicare eligibility outreach to participants.

Based on results of audit procedures performed for the 66 participants selected for review, DHS made incorrect capitation payments for 8 of the 66 participants totaling $357,048. Of this amount, DHS was unable to recover $120,977 due to payment recovery restrictions included in the 2022 CHC Agreement. The incorrect payments were made to UPMC based on incorrect eligibility information. The incorrect eligibility information included participants that were deceased, incarcerated, or had requested to be removed from UPMC's services, but remained enrolled in UPMC's CHC program.

Additionally, we determined that UPMC's reconciliations of participant eligibility to capitation payments received from DHS appears to be focused on issues that only resulted in underpayments to UPMC. Although UPMC management stated that there is a smaller number of instances where overpayments occur, it is equally important for UPMC to follow up on those discrepancies as well.

Finally, our audit found UPMC does not perform Medicare eligibility outreach for participants aged 65 or older that may be eligible but are not enrolled in Medicare. Since the capitation rates paid to UPMC are higher for participants that are not enrolled in Medicare, outreach could result in participants enrolling in Medicare, which could result in subsequent savings to DHS and the Commonwealth. We identified 3 of the 66 selected participants who were over the age of 65 but not enrolled in Medicare. We determined that if the three participants had been enrolled in Medicare during the audit period, the capitation payments made by DHS to UPMC would have been reduced by $48,287.

We offer five recommendations to UPMC and four recommendations to DHS to remedy the inconsistencies and other issues identified by our audit work.

A Performance Audit

UPMC Health Plan
Community HealthChoices contract with the Pennsylvania Department of Human Services

Introduction and Background

This report by the Department of the Auditor General presents the results of our performance audit of UPMC Health Plan (UPMC) with regard to its **Community HealthChoices** (CHC) contract with the Pennsylvania Department of Human Services (DHS). This audit was conducted under the authority of Sections 402 and 403 of The Fiscal Code (Code),[5] and in accordance with the Code's Article XVII-B. 2021-2022 Budget Implementation provision,[6] and Article XVII-F.1. 2022-2023 Budget Implementation provision,[7] as well as in accordance with generally accepted *Government Auditing Standards* (GAS) issued by the Comptroller General of the United States.[8]

Our performance audit consisted of one objective and included the audit period of January 1, 2022, through December 31, 2022. The objective was to determine whether UPMC provided accurate and timely CHC program participant (individuals enrolled in the CHC program and referred to in the report as a participant) eligibility information to DHS to ensure accurate capitation rates were paid to UPMC.

Appendix A of this audit report provides a detailed description of the audit objective, scope, methodology, data reliability, and evaluation of management's internal controls related to the audit objective.

In the sections that follow, we present relevant background information about CHC and UPMC as a managed care organization (MCO) in the CHC program.

Community HealthChoices

DHS' Office of Medical Assistance Programs (OMAP) administers the joint state/federal Medical Assistance (Medicaid) program that purchases health care for over 2.8 million income-eligible Pennsylvania residents. Local County Assistance Offices (CAO) determine eligibility for Medicaid, and individuals deemed eligible are asked to enroll in a managed care plan. OMAP contracts with MCOs to deliver Medicaid services under the HealthChoices Program.[9]

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[5] 72 P.S. §§ 402 and 403.
[6] 72 P.S. § 1715-B (Act 24 of 2021, effective July 1, 2021).
[7] 72 P.S. § 1715-F.1(1) (Act 54 of 2022, retroactively applicable to July 1, 2022).
[8] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021.
[9] https://home.myodp.org/wp-content/uploads/2023/03/EPSDT-ODP-10-10-19-KB.pdf#:~:text=Medical%20Assistance%20purchases%20services%20through%20contracts%20with%20managed-care,care%20organizations%20is%20called%20the%20HealthChoices%20Program%20%28HC%29 (accessed October 2, 2024).

The HealthChoices Program is divided into three interrelated segments: 1) Physical, 2) Behavioral, and 3) Community.[10] Our audit focused on the Community segment, or CHC. CHC is administered by the DHS Office of Long-Term Living (OLTL) and covers physical health services, home and community-based services, and nursing facility services for participants.[11] CHC is DHS' Medicaid program that allows MCOs to coordinate medical care and long-term services and supports (LTSS)[12] for individuals who qualify for Medicaid and also qualify for Medicare or require a nursing facility level of care.[13]

The CHC program serves people in communities to give them the opportunity to work, spend time with their families, and experience an overall better quality of life. CHC was developed to enhance access to and improve coordination of medical care and create a long-term support system in which people have choice, control, and access to a full array of quality services that provide independence, health, and quality of life. LTSS helps eligible individuals to perform daily activities in their homes, such as bathing, dressing, preparing meals, and administering medications.[14]

Individuals are eligible for CHC if they are 21 years old or older, live in Pennsylvania, and are Dual Eligible (eligible for both Medicare and Medicaid and referred to in the report as Dual) or eligible for Medicaid and qualify for LTSS because they need the level of care provided by a nursing facility.[15] Eligible individuals enroll in CHC through an Independent Enrollment Broker (IEB).[16] The IEB is contracted to facilitate the enrollment process for individuals seeking home and community-based services (HCBS) and supports, as well as LTSS.[17] MCOs develop outreach materials, such as pamphlets and brochures, to be used by the IEB to assist CHC-eligible individuals in selecting an MCO.

Individuals eligible for CHC may choose which MCO to use to coordinate their services and may switch to a different MCO at any time. During the fiscal year ended June 30, 2022, there

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[10] https://www.pa.gov/en/agencies/dhs/resources/medicaid.html (accessed October 2, 2024).
[11] https://www.pa.gov/content/dam/copapwp-pagov/en/budget/documents/publications-and-reports/commonwealthbudget/past-budgets-to-2021-22/2022-23-budget-documents/budget%20book%202022-23.pdf (accessed January 22, 2025).
[12] A representative from the local Area Agency on Aging or Aging Well assesses individual's needs and determine eligibility for LTSS. https://chc.upmchealthplan.com/en/learn/learn/eligibility/ (accessed October 1, 2024).
[13] https://chc.upmchealthplan.com/en/learn/ (accessed October 1, 2024).
[14] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/CHC%20Fact%20Sheet.pdf (accessed October 1, 2024).
[15] https://chc.upmchealthplan.com/en/learn/learn/eligibility/ (accessed October 1, 2024).
[16] https://chc.upmchealthplan.com/en/learn/learn/how-to-enroll/ (accessed October 1, 2024).
[17] https://paieb.com/en (accessed October 2, 2024).

were four MCOs in the CHC program.[18] Our audit focused on UPMC which is one of four MCOs.

CHC serves more than 450,000 individuals.[19] Approximately 94 percent of CHC Participants are Dual Eligible. Both Medicare and Medicaid cover physical health services, such as doctors' visits, hospital stays, lab tests, and pharmaceuticals. Medicaid is the payer of last resort. Once a participant's Medicare and any other health insurance coverage has/have paid or denied a claim, Medicaid should be billed for the remainder of the claim.[20]

CHC was phased in across Pennsylvania over a three-year period starting January 1, 2018, and operates statewide in five geographic zones: 1. Southwest (Phase 1), 2. Southeast (Phase 2), 3. Northwest (Phase 3), 4. Northeast (Phase 3), and 5. Lehigh/Capital (Phase 3).[21]

The Commonwealth reported CHC program expenditures of $4.62 billion and $5.04 billion for the fiscal years ended June 30, 2022, and June 30, 2023, respectively.[22]

CHC MCOs receive capitation payments by the fifteenth of each month for each enrolled participant based on a daily per diem rate and the number of days the participant was enrolled during the prior month. The daily per diem rate depends on the participant's rate cell and the region in which they reside.[23] A participant's rate cell[24] is dependent upon the following:

[18] The four MCOs were: 1) AmeriHealth Caritas Pennsylvania CHC, 2) PA Health & Wellness, 3) UPMC CHC, and 4) Keystone First CHC. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/hc-landing/documents/CY24_ENC_PA_CHC_Databook.pdf (accessed October 8, 2024).

[19] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/budget-information/2022-23-DHS-Blue-Book.pdf (accessed October 18, 2024).

[20] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/Coordination-of-Medicare.pdf (accessed September 18, 2024).

[21] https://www.pa.gov/en/agencies/dhs/resources/medicaid/chc.html#:~:text=Community%20HealthChoices%20(CHC)%20is%20a%20Medicaid%20program%20that%20coordinates%20health (accessed October 2, 2024).

[22] https://www.budget.pa.gov/Publications%20and%20Reports/AnnualFinancialReport/Documents/2022-gf-budgetary-comp-schedule.pdf (accessed October 8, 2024) and https://www.budget.pa.gov/Publications%20and%20Reports/AnnualFinancialReport/Documents/2023-gf-budgetary-comp-schedule.pdf (accessed October 8, 2024).

[23] 2022 CHC Agreement, Appendix 3(d) Overview of Methodologies for Rate Setting, (f) Participant Enrollment Mix Adjustment.

[24] A "rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment. Characteristics may include age, gender, eligibility category, and region or geographic area." *See* 42 CFR Part 438.2.

- Level of nursing facility[25] clinical care needs
  - **Nursing Facility Clinically Eligible (NFCE)** – clinical needs that require the level of care provided in a nursing facility[26]
  - **Nursing Facility Ineligible (NFI)** – clinical needs that do not require the level of care provided in a nursing facility
- Enrollment in Medicare or only Medicaid
  - **Dual** – Enrolled in Medicaid and Medicare
  - **Non-Dual** – Enrolled in Medicaid only
- Age
  - 21-59 years old
  - 60 years or older

For capitation payment purposes, the previously described five geographic zones are further broken down into seven regions:[27]

- Northwest[28]
- Northeast[29]
- Lehigh/Capital[30]
- Southwest[31]
- Southwest – Allegheny County
- Southeast[32]
- Southeast – Philadelphia County

Capitation payments are made to an MCO for each participant to provide coverage of all covered services and are paid whether or not the participant receives services during the period covered

[25] According to DHS' 2022 CHC Agreement, a nursing facility is a general, county, or hospital-based nursing facility, which is licensed by the Pennsylvania Department of Health and enrolled in the Medical Assistance Program.
[26] Although eligible for nursing facility level care, participants can receive that care in their own home instead of a nursing facility.
[27] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/hc-landing/documents/CY24_ENC_PA_CHC_Databook.pdf (accessed October 8, 2024).
[28] Counties include Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren.
[29] Counties include Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming.
[30] Counties include Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York.
[31] Counties include Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland.
[32] Counties include Bucks, Chester, Delaware, and Montgomery.

by the payment.[33] DHS will make a monthly payment for each participant enrolled for the first day in the month the participant is enrolled and for each subsequent day, through and including the last day of the month.[34] A capitation payment is not made for a participant month if the participant's eligibility ends prior to the first of the month.[35]

DHS will recover capitation payments made for participants who were later determined to be ineligible for managed care up to 12 months after the service month for which payment was made. Capitation payments made for deceased participants will be recovered up to 21 months after the service month in which the date of death occurred.[36] MCOs are required to report to DHS within 60 calendar days when capitation payments or other payments in excess of the amounts specified in the CHC Agreement are identified.[37] *See **Finding 2*** in this report for discussion on issues noted during our review.

UPMC Managed Care Program – Community HealthChoices

UPMC was one of the four CHC MCO providers during the calendar year 2022. The number of CHC participants enrolled in the UPMC CHC program increased by almost 5,500 participants from 134,166 on January 1, 2022, to 139,657 on December 31, 2022. Detailed enrollment information is included in a table in *Appendix B* of this report. During the calendar year 2022, DHS made CHC capitation payments to UPMC totaling $357,127,667.[38]

Once a CHC participant has selected UPMC as its MCO, DHS notifies UPMC through the 834 Eligibility File.[39] Either the IEB or the prior MCO (if the participant is transitioning between MCOs) will provide UPMC with the participant's information, which includes items such as medical records, Person-Centered Service Plan (PCSP), and the rate cell the participant has been identified in, either NFCE or NFI.

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[33] 2022 CHC Agreement, Section II: Definitions, Capitation Payment.
[34] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2(ii) Capitation Payments.
[35] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2(iii) Capitation Payments.
[36] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2(vii) Capitation Payments.
[37] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2(viii) Capitation Payments.
[38] Payment amounts obtained from the CAP Medicaid Payment file obtained via the DHS DocuShare site. This data was determined to be sufficiently reliable, as described in *Appendix A Objectives, Scope, Methodology, and Data Reliability*.
[39] DHS provides both a Daily and a Monthly 834 Eligibility File to UPMC. The 834 files are generated from DHS' Provider Reimbursement and Operations Management Information System (PROMISe) and contain information such as Medicaid eligibility period, CHC coverage, and demographic information for each of the participants.

UPMC must provide participant orientation within 30 days of the new participant's start date with UPMC.[40] A UPMC service coordinator then creates a care management plan that identifies and addresses how a participant's physical, cognitive, and behavioral healthcare will be managed.[41] This plan must also address how the participant's Medicare coverage will be coordinated.[42]

The sections that follow describe, in detail, the following processes related to our audit objective that occur once a participant selects and enrolls in UPMC's CHC program:

- Participant Assessments Performed
- Notification of Change in Participants Status
- CHC Eligibility and Capitation Payment Reconciliation

Participant Assessments Performed

The following types of assessments are conducted on participants by UPMC service coordinators:

- Comprehensive Needs Assessment[43]
- Comprehensive Needs Reassessment
- Trigger Event Assessment
- Requested Assessment

Comprehensive Needs Assessment

UPMC must conduct a Comprehensive Needs Assessment (assessment) for new NFCE participants, depending on the services they are receiving, no later than five to fifteen business days from their start date. UPMC is also required to screen new NFI participants for need within 90 days of their start date.[44] DHS allows UPMC to utilize a Health Risk Assessment (HRA) as

[40] 2022 CHC Agreement, Section V: Program Requirements, O: Participant Enrollment, Disenrollment, Outreach, and Communications, 14. New Participant Orientation.
[41] The 2022 CHC Agreement requires a service coordinator to be either 1) a registered nurse; 2) have a Bachelor's degree in Social Work, Psychology, or other related fields with practicum experience; or 3) have at least three or more years of experience in a social service or a healthcare related setting.
[42] 2022 CHC Agreement, Section V: Program Requirements, H: Care Management Plans.
[43] An assessment is performed on the participant to evaluate their overall health and needs such as caregiving, support services, and housing. A reassessment is the assessment that is subsequently performed on a participant on an annual basis.
[44] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.

the tool to screen NFI participants for need. UPMC mails an HRA to new NFI participants within 30 to 45 days after their start date. The HRA includes questions for the participant such as current living situation, physical and mental health status and needs, and assistance being received.

Comprehensive Needs Reassessment

Comprehensive Needs Reassessments (reassessments) of NFCE participants must be conducted at least once a year within 365 days of the most recent assessment. Unless a trigger event (described in detail in a later section) occurs, a reassessment cannot be conducted more than 60 days prior to the one-year mark of the last assessment date.[45]

Reassessments are not required for NFI participants, but they can request an assessment at any time if they believe their health status has changed to the point where they feel they need HCBS in order to continue living safely in the community.

Through the participant's assessment and reassessment, which are conducted by service coordinators, UPMC assesses the participant's physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. If during an assessment or reassessment, UPMC determines a participant who has not been determined NFCE has a need for LTSS, then the participant should be referred for a clinical eligibility determination.[46] UPMC staff document the results of assessments and reassessments on a InterRAI Assessment form. UPMC transmits information from the forms daily to DHS which is then used to determine if eligibility may have changed and if an assessment is needed by a physician to make a final determination.

Trigger Event Assessment

Trigger events are significant healthcare events that include, but are not limited to, a hospital admission or discharge, transition between healthcare settings, a change in functional status, caregiver, home setting or environment, a diagnosis that is not temporary, or if requested by the participant, caregiver, or DHS.[47] If a trigger event occurs, UPMC must complete a reassessment as expeditiously as possible, but in no case more than 14 days after the occurrence of the trigger event.[48]

[45] Ibid.
[46] Ibid.
[47] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.
[48] Ibid.

Requested Assessment

An assessment is performed if requested by the participant or a participant's designee or family member. Assessments must be conducted no later than 15 days from the date of the request.[49]

Notification of Change in Participant Status

Pursuant to the CHC Agreement between DHS and UPMC, there are two notification processes that were reviewed during the audit, the Weekly Enrollment/Disenrollment/Alert file and the CAO Notification Form.

UPMC must report the following to DHS' Medicaid Management Information System (MMIS) on the Weekly Enrollment/Disenrollment/Alert file: a pregnancy or a death (not already reported in DHS' client information system (eCIS)) and returned mail alerts.[50] UPMC may first learn of these events, for example, through its contact with the participant, the participant's family, or the participant's care provider. Once this information is obtained, UPMC staff can check the participant's information in eCIS and if the event is not already reported, UPMC must report the information to DHS.

UPMC must also report a participant's change in status to the appropriate CAO using the CAO Notification Form within 10 business days of the change becoming known.[51] These changes include phone number, address, pregnancy, death, and family addition/deletion. Along with this notification, UPMC must provide a detailed explanation on the form of how this information was verified.[52]

CHC Eligibility and Capitation Payment Reconciliation

UPMC is required to reconcile the eligibility information in the monthly and daily 834 Eligibility Files (834 file) and capitation payments in the monthly 820 Capitation Payment File (820 file), which are provided by DHS, to its internal participant data and notify DHS within 30 business days of any discrepancies found in the files.[53] Additionally, UPMC is required to report to DHS

[49] Ibid.
[50] 2022 CHC Agreement Section V: Program Requirements, O: Participant Enrollment, Disenrollment, Outreach, and Communications, 10. Change in Participant Status.
[51] Ibid.
[52] Ibid.
[53] 2022 CHC Agreement Section V: Program Requirements: 1) O. Participant Enrollment, Disenrollment, Outreach, and Communications, 11. Participant Files, a. Monthly File and 2) X. Administration, 6.x. Management Information Systems.

within 60 calendar days any capitation payments or other payments in excess of amounts specified in the CHC Agreement.[54]

UPMC pulls data after the 15th of each month and runs a query through their system that allows for comparison of the DHS files by participant to identify discrepancies. The reconciliation process, performed by its insurance revenue section staff, also includes a comparison of UPMC's receivable schedule for expected capitation payments based on participant classifications in the 834 reports. Discrepancies are researched using the eCIS where the CHC plans and coverage dates are verified. UPMC has 60 days to perform a reconciliation and forward unresolved discrepancies to the OLTL which is responsible for determining if corrective actions are needed.[55]

[54] 2022 CHC Agreement, Section VII: Financial Requirements, B.2.viii Capitation Payments.
[55] 2022 CHC Agreement, Section V: Program Requirements, X. Administration, 6 (x) Management Information Systems, indicates that UPMC must perform a reconciliation and forward unresolved discrepancies to the OLTL, which is responsible for the determination of corrective actions if needed within 30 days; however DHS has requested a two to three month delay in the reconciliation of the 820 payment files to the 834 eligibility files in order to address the timing issues and this is reflected in the 2023 CHC Agreement.

Finding 1 – UPMC failed to adequately perform all required participant assessments and did not notify DHS of changes to participants' program eligibility status.

The performance audit objective of the UPMC Health Plan (UPMC) regarding the Community HealthChoices (CHC) contract with the Pennsylvania Department of Human Services (DHS) was to determine whether UPMC provided accurate and timely CHC program participant (individuals enrolled in the CHC program and referred to in the report as a participant) eligibility information to DHS to ensure accurate capitation rates[56] were paid to UPMC. Our audit procedures included reviewing UPMC processes for: (1) enrolling participants in its CHC program; (2) performing timely assessments[57] on the participants; (3) updating DHS on the status of participants that affect capitation rates; and (4) reconciliations performed by UPMC comparing capitation payments received to participant eligibility information.[58] *See **Finding 2*** for details regarding capitation payments and reconciliations.

The results of our audit procedures performed, described in later sections of the finding, include UPMC failing to perform and failing to timely perform required assessments of participants as well as UPMC not notifying or not timely notifying DHS of changes in participants' status, such as death.

As part of our audit procedures, we obtained capitation payment data for the 156,732 transactions associated with the 156,267 participants for which UPMC received payments during our audit period of January 1, 2022, through December 31, 2022, (referred to in this finding as the "audit year").[59] We judgmentally selected 66 of these participants from four categories of participants enrolled in UPMC CHC during the audit year.[60] The four categories, and the number selected from each, include: (1) 10 participants newly enrolled in the UPMC CHC program (**New**); (2) 30 participants whose rate cell/classification[61] remained the same (**No Changes**); (3)

[56] Capitation rates are the set amounts paid monthly by DHS to UPMC for each participant based upon the criteria, as described in the *Introduction and Background*, the participant's rate cell/classification and region. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/CHC%20Overview.pdf (accessed November 1, 2024).
[57] *See Introduction and Background* for detail on types of assessments performed.
[58] *See Appendix A Objectives, Scope, Methodology, and Data Reliability* for more detail regarding our audit procedures.
[59] The number of participants is greater than the totals reported in the *Introduction and Background* due to those amounts only reflecting one specific date during the audit year rather than the total number of participants enrolled with UPMC over the course of the full calendar year.
[60] *See Appendix A Objectives, Scope, Methodology, and Data Reliability* for more detail regarding the four categories and our participant test selection process.
[61] As described in detail in the *Introduction and Background*, rate cells/classification are dependent upon the participant's level of nursing facility clinical care needs, enrollment in Medicare or only Medicaid, and age.

16 participants whose rate cell/classification changed (**With Changes**); and (4) 10 participants who were disenrolled from the UPMC CHC program (**Dropped**).[62]

Results of our audit procedures performed on the 66 participants are described in the following sections of the finding:

- Assessments of participants were either not performed or not timely performed.
- DHS was either not notified or not timely notified of changes in participants' status.

Assessments of Participants Were Either Not Performed or Not Timely Performed

As described in the *Introduction and Background*, various types of assessments are performed on participants by UPMC service coordinators, and the results are documented on an InterRAI Assessment form and in service coordinator notes. UPMC management stated service coordinators' work is monitored by supervisors.[63] UPMC management further explained that service coordinators and staff use a care management information system to track deadlines for assessments and reassessments. The care management information system generates notifications to service coordinators regarding the necessity of: (1) Comprehensive Needs Assessment for newly enrolled participants, and (2) Reassessments, performed annually, of participants.

Regarding Reassessments, service coordinators are notified approximately 60 days prior to the annual deadline. This allows time for the service coordinator to schedule and perform the reassessment. When service coordinators are unable to perform the reassessments within the required 365 days, it will be considered overdue but allowable with a reasonable justification.

UPMC management stated service coordinator supervisors review the care management information system daily to ensure service coordinators are performing the assessments and reassessments. UPMC management confirmed supervisors are not required to review or approve the completed InterRAI Assessment forms. As discussed below, implementing an approval process may help to ensure the assessments and reassessments are performed as required.

[62] *See Appendix C* for information regarding the breakdown of the number of participants selected, by rate cell/classification and category, as well as the population of transactions from which the participants were selected.
[63] The 2022 CHC Agreement requires service coordinator supervisors to either: 1) be a registered nurse; or 2) have a master's degree in social work or in a human services or healthcare field and three years of relevant experience with a commitment to obtain either a Pennsylvania social work or mental health professional license within one year of hire.

The types of assessments, including reassessments, reviewed during our audit and discussed in detail in the sections that follow include:

- Comprehensive Needs Assessment
- Comprehensive Needs Reassessment
- Trigger Event Assessment
- Requested Assessment

Comprehensive Needs Assessment

Comprehensive Needs Assessments, or initial assessments, are performed on Nursing Facility Clinically Eligible (NFCE)[64] participants that are new to the UPMC CHC program. As reported previously, 10 of the 66 participants selected for review were new to UPMC CHC in the audit year; however, only six were classified as NFCE. Audit procedures performed on supporting documentation pertaining to the six NFCE participants found that assessments were performed on five of the six participants within the required timeframe of no later than 5 to 15 business days (dependent upon classification) from the individual's start date with UPMC.[65] The remaining participant was in a long-term care/nursing facility and the assessment did not occur until 144 business days after the individual's start date. UPMC management stated the delay in conducting the initial visit was the result of an untimely assignment of the task to the nursing facility service coordinator. UPMC management stated that since the audit year, UPMC implemented and DHS approved monitoring and reporting procedures for assessments performed on participants in nursing facilities. However, we did not perform procedures on nursing facility assessments performed after the audit year, and therefore, cannot comment on the effectiveness of these procedures.

The remaining four new participants were classified as Nursing Facility Ineligible (NFI).[66] UPMC management stated, and DHS management confirmed, that initial assessments are not required to be performed by service coordinators on NFI participants. In lieu of an assessment, UPMC mails a Health Risk Assessment (HRA) to NFI participants. UPMC records indicate all four participants were timely sent an HRA; however, only one returned the completed HRA to UPMC. The choice of returning the HRA is at the discretion of the participant, and UPMC is currently not required to follow-up with the participant to confirm receipt or intent to return the completed document to UPMC. Upon inquiry regarding UPMC's practice, DHS management stated that ideally UPMC should follow-up, but there is no current requirement to do so. DHS

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[64] A NFCE participant has clinical needs that require the level of care provided in a nursing facility. However, a participant can receive that care in their own home or a nursing facility.
[65] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.
[66] A NFI participant's clinical needs do not require the level of care provided in a nursing facility.

management further stated that follow up is something that it could potentially add as a requirement in the next CHC Agreement.

Reassessments

Annual reassessments are required for NFCE participants;[67] however, reassessments are not required for NFI participants. Issues that resulted from this lack of requirement for NFI participants are discussed below. Of the 66 participants selected for review, as of December 31, 2022, 44 participants were classified as NFCE and 22 participants as NFI.[68]

The results from our audit procedures performed on supporting documentation for the 44 NFCE participants found 38 reassessments were either performed timely or were not required due to the participant passing away prior to the date of the required reassessment. The issues with the remaining six reassessments are described below:

- **One participant** did not have a reassessment performed as required. UPMC management stated the participant moved into a nursing facility however no reassessment was done at that time. The service coordinator notes indicated that the service coordinator attempted to do an assessment on two later dates but neither took place due to the participant being hospitalized.

- **Two reassessments** were performed, but not within the required 365 days. UPMC management stated there were no notes on file to indicate why one of the reassessments was not completed until day 395 (30 days late). For the second participant, UPMC was unable to locate any service coordinator notes and therefore unable to comment as to why it was not completed until day 376 (11 days late).

- **Three participants** died prior to the audit year and, therefore, no reassessments were performed. UPMC management stated one participant was deceased prior to being enrolled with UPMC in January 2019 and the other two participants died in April 2020 and September 2021, respectively, and therefore no reassessments would have occurred. The issue with capitation payments made to UPMC while the three deceased participants remained enrolled in the UPMC CHC program for a lengthy period of time is discussed in further detail in ***Finding 2***.

[67] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.
[68] Although a participant's classification may have changed between NFCE and NFI during the audit year, our review covered the 44 participants that were NFCE as of December 31, 2022, the last day of the audit period.

Regarding the 22 NFI participants, UPMC is not required to assign a service coordinator to NFI participants, nor are they required to perform annual reassessments. DHS management stated NFI participants receive a physical health benefit package which functions as their health insurance. NFI participants can request an assessment at any time if they believe their health status has changed to the point where they feel additional services are needed.

As a result of UPMC not being required to contact NFI participants, UPMC was unaware that two participants had died and remained enrolled with UPMC for 16 months and 18 months, respectively. If, at a minimum, annual contact was required for NFI participants as it is for NFCE participants, UPMC would have been aware of the death of the participants in a timelier manner. The issue of capitation payments made to UPMC while the deceased NFI participants remaining enrolled with UPMC is discussed in further detail in ***Finding 2***.

Trigger Assessment

As part of our audit procedures, we reviewed the available service coordinator notes for the 66 participants we selected to review to determine if any trigger events (described in the *Introduction and Background*) happened that required an assessment to occur.[69] The results from our audit procedures performed on supporting documentation found that for 46 participants, a trigger assessment was not performed. We found the lack of a trigger assessment was due to: (1) no trigger event occurred; (2) the participant was classified as NFI, (no service coordinator notes are required to determine if a trigger event occurred); or (3) the participant died prior to January 1, 2022, or prior to the scheduled trigger assessment.

Regarding the remaining 20 participants, we found the following:

- **1 participant's** service coordinator notes were not provided to us to review. UPMC management was unable to find the service coordinator notes for the period January 1, 2022, through August 18, 2022. Therefore, we were unable to determine if a trigger event occurred during this period.

- **19 participants** had a total of 30 trigger events that occurred during the audit year. UPMC management provided documentation to support that trigger assessments were performed or that the participant refused the assessment for 29 of the 30 events. The service notes for the one remaining participant indicated that a trigger assessment was scheduled but UPMC did not have any record that the assessment was performed, nor was there documentation as to why it was not performed.

[69] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.

Requested Assessments

An assessment is performed if requested by the participant or a participant's designee or family member.[70] As part of our audit procedures, we reviewed the service coordinator notes available for the 66 participants selected for review to determine if any assessments were requested. The results from our audit procedures performed found three participants' assessments were either conducted timely or cancelled by the participant and 61 participants fell into one of the following categories: (1) had no request for assessments listed in the service coordinator notes; (2) were NFI participants with no service coordinator notes maintained; or (3) the participant died prior to January 1, 2022. The issues found with the remaining two participants are described below:

- UPMC management was unable to find, and therefore did not provide, service coordinator notes for a portion of the audit year to review to determine if an assessment was requested.[71] UPMC management stated that for one participant, it was likely due to a lack of proper documentation by the assigned service coordinator of any participant follow up that may have occurred during the time period in question. For the second participant, management stated the annual assessment (which is different from a requested assessment) was performed and check-in calls were made, however, the service coordinator did not generate corresponding notes for these interactions. Due to the lack of service coordinator notes, we were unable to determine if during those time periods a request for an assessment was made for the two participants.

According to UPMC management, information from the various assessments performed, as described above, is forwarded to DHS daily to be used to determine if participant eligibility has changed and if an assessment is needed by a physician to make a final determination. Assessments are necessary to help ensure participants are receiving services that meet their needs. Therefore, it is critical that all assessments are performed accurately and timely. Without supervisory review or approval, there is a risk that assessments are not being completed accurately and that DHS will not receive information needed regarding participant needs and eligibility. The same risk exists with those assessments that were either not completed or not completed timely.

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[70] 2022 CHC Agreement, Section V: Program Requirements, E: Comprehensive Needs Assessments and Reassessments.

[71] The number of participants with service coordinator notes missing for a portion of the audit year is reported as two participants regarding requested assessments, but only one participant is reported in the Trigger Assessment section due to the fact that one of the participants who was missing service coordinator notes for a portion of the audit year had a trigger event listed in the service coordinator notes that were available for a portion of the audit year. Therefore, that participant is accounted for in the total of 19 participants with trigger events during the audit year.

Additionally, as a result of no contact required with NFI participants, circumstances such as the death or incarceration of the participant can go undetected by UPMC. This results in DHS making incorrect capitation payments to UPMC for participants who are no longer eligible. We describe such situations in detail in ***Finding* 2**. We acknowledge that DHS has procedures in place to contact participants (or family members in the case of a participant death). However, requiring Managed Care Organizations (MCOs), such as UPMC to make initial and then at least annual contact with the participant adds another review layer to ensure a participant's change in circumstances is identified timely.[72]

DHS Was Either Not Notified or Not Timely Notified of Changes in Participants' Status

Pursuant to the CHC Agreement between DHS and UPMC, there are two required notification processes and documentation that were reviewed during the audit: (1) the Weekly Enrollment/Disenrollment/Alert file (Alert file), and (2) the CAO Notification Form.[73] As part of our audit procedures, we reviewed the available service coordinator notes and other participant documents maintained to determine if any of the 66 participants selected for review encountered circumstances outlined in the CHC Agreement that would require UPMC to notify DHS through either the Alert file or a CAO Notification Form. Results of our audit procedures are described below.

Alert File

Of the documentation we reviewed for the 66 participants selected, we found one event was reported timely on the Alert file and 60 participants either did not have a reportable event that occurred in the audit year (or DHS was made aware of the event first and notified UPMC) or were classified as NFI and no service coordinator notes were maintained to determine if a reportable event occurred. The issues of the remaining five participants are described below:

- **Two participants** did not have service coordinator notes for a portion of the audit year. Therefore, as previously reported, we were unable to determine if reportable events occurred.

- **One participant's death** was not reported on the Alert file. UPMC management stated they were unable to reach the participant after trying to make contact. UPMC did not communicate this information via the Alert file but did send a 1768 Form to the appropriate CAO. The 1768 Form is a DHS Home and Community Based Services

[72] *See Introduction and Background* for detail on Managed Care Organizations.
[73] *See Introduction and Background* for explanation of Alert file and CAO Notification Form.

(HCBS) Eligibility/Ineligibility/Change Form that DHS also requires UPMC to transmit to the CAO if a participant dies.[74] However, upon inquiry, DHS management stated the 1768 Form is used specifically for changes related to eligibility for Waiver services and should not be utilized in lieu of the documents required pursuant to the CHC Agreement, such as the Alert file and the CAO Notification Form. As noted in the *Introduction and Background*, events including "returned mail alerts" should be reported on the Alert file. Therefore, when UPMC was unable to contact the participant, they should have notified DHS via the Alert file.

- **One participant's records** did not include any notation regarding the reporting of the participant's death on the Alert file. Management stated that the note on file indicating the date of death does not include details regarding how UPMC was made aware of the participant's death. Therefore, we are unable to determine if UPMC was notified first and as a result, required to report the death on the Alert file or if they were notified of the death by DHS, and therefore, not required to report the death on the Alert file.

- **One participant's death** was not timely reported on the Alert file. UPMC management stated they were made aware of the participant's death on April 13, 2020, and a system task to make the necessary notifications was generated. However, due to an internal error, the task was closed before an alert to DHS was generated. During a subsequent internal review, the error was discovered, and the participant's date of death was sent on the January 25, 2022, Alert file, after a delay of 21 months.

CAO Notification Form

Of the documentation we reviewed for the 66 participants selected, we found two participants' change in status were reported timely on a CAO Notification Form and 59 participants either did not have a reportable event that occurred in the audit year (or DHS was made aware first of the event and notified UPMC) or were classified as NFI and no service coordinator notes were maintained to review to determine if a reportable event occurred. The issues with the remaining five participants are described below:

- **Two participants** did not have service coordinator notes for a portion of the audit year. Therefore, as previously reported, we were unable to determine if reportable events occurred.

[74] DHS CHC Operations Memorandum #2019-05, *Circumstances When CHC-Managed Care Organizations (MCO) Must Transmit the Home and Community-Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768)*, dated November 20, 2019.

- **Two participants** had CAO Notification Forms sent to the CAO regarding their deaths, but not within the required 10 business days. Instead, we found UPMC sent the forms 492 and 725 business days after being notified of the participants' deaths. The following describes the responses from UPMC management when we inquired regarding the delays:

    - **492 business days** – As previously noted, UPMC management stated that due to an internal error, the task to generate a death notification to be submitted to the CAO was closed before it could be properly communicated. An Alert was sent to DHS on January 27, 2022, and when that did not result in the termination of the participant from the UPMC CHC program, UPMC sent the CAO Notification Form on March 2, 2022.

    - **725 business days** – UPMC management stated the service coordinator was informed during the initial outreach to the participant when first enrolled in January 2019 that the participant died on November 27, 2018. The service coordinator notified their supervisor and began to end all of the participant's services in the service plan. However, the CAO Notification Form notifying the CAO of the date of death was not sent until November 10, 2021, when UPMC's Finance Department noted the discrepancy. The issue of the enrollment of a deceased individual and capitation payments made to UPMC is further discussed in ***Finding 2***.

- One participant's service coordinator notes did not indicate how UPMC was notified of the participant's death. Therefore, we were unable to determine if UPMC was required to send a CAO Notification Form.

Conclusion

The need for UPMC to comply with the CHC Agreement requirements of timely notifying DHS, utilizing the Alert file or the CAO Notification Form, is critical to timely determine the participant's eligibility in the CHC program and to make accurate capitation payments to UPMC. As discussed in ***Finding 2***, DHS made capitation payments to UPMC for ineligible services for participants. If UPMC had notified DHS in a timely manner of the participants' change in status, such action may have prevented the capitation payments incorrectly made to UPMC.

Recommendations for Finding 1

We recommend that UPMC management:

1. Ensure service coordinator supervisors are monitoring to ensure all service coordinators are conducting timely assessments and reassessments of participants.

2. Require service coordinator supervisors to review and approve all InterRAI Assessment documents.

3. Reinforce to service coordinators that notes need to be maintained for all contact and attempted contact with participants.

4. Reinforce to service coordinators the need to document when and from whom status change information was provided.

5. Ensure all changes to a participant's status are documented and timely forwarded to the appropriate CAO on a CAO Notification Form, when required by the CHC Agreement.

6. Ensure DHS is timely notified of all events in the Weekly Enrollment/Disenrollment/Alert file, when required by the CHC Agreement.

We recommend that DHS management:

1. Amend future CHC Agreements with MCOs, such as UPMC, to require follow-up be performed when a participant does not return a completed Health Risk Assessment to the MCO.

2. Require MCOs, such as UPMC, to make at least annual contact with NFI participants.

Finding 2 – UPMC did not consistently provide CHC participant eligibility information to DHS, which resulted in incorrect capitation payments. Additional procedures are needed by UPMC in its capitation payment reconciliation process and Medicare eligibility outreach to participants.

In this finding, we discuss the incorrect capitation payments made by the Pennsylvania Department of Human Services (DHS) to UPMC Health Plan (UPMC) for individuals (referred to in this finding as "participants") enrolled in its Community HealthChoices (CHC) program. Accurate participant eligibility at DHS is essential for ensuring correct capitation payments,[75] and UPMC is responsible for providing timely updates to DHS to maintain the accuracy of these payments. However, as discussed in detail in ***Finding 1***, UPMC's failure to adequately and timely perform various participant assessments and notify DHS of participant status changes directly contributed to the incorrect capitation payments discussed in this finding.

We also determined that UPMC staff should perform additional procedures when investigating discrepancies in eligibility and capitation payments. Finally, UPMC should conduct outreach to participants who are eligible but not enrolled in Medicare. This outreach could result in some applicants enrolling in Medicare, which in turn could result in subsequent savings to DHS and the Commonwealth.

As part of our audit procedures, we obtained capitation payment transactions from UPMC for each of the 66 participants judgmentally selected for review for our audit period of January 1, 2022, through December 31, 2022.[76] The capitation payment amounts were compared for accuracy to the agreed upon capitation rates in the applicable CHC Agreement.[77] Additionally, we obtained reconciliations performed by UPMC staff to compare participants' eligibility information to the capitation payments made by DHS to UPMC.

[75] As described in the *Introduction and Background*, UPMC is paid monthly capitation payments for participants enrolled in its CHC program. The payments are dependent upon the rate cell assigned to the participant and the region in which they reside. The rate cell assigned to each participant is dependent upon the participant's eligibility information maintained by DHS.
[76] *See Finding 1* for details regarding the 66 participants selected and *Appendix A Objectives, Scope, Methodology, and Data Reliability* for more detail regarding our participant test selection process.
[77] 2022 Community HealthChoices Agreement between DHS and UPMC as the CHC Managed Care Organization. The term of the agreement is January 1, 2018, and has an initial term of five years with the option to extend the agreement for an additional two-year period. Capitation rates are updated each year of the agreement.

The results of our audit procedures performed for the 66 participants are described in the following sections of this finding:

- Capitation payments were made to UPMC based on incorrect eligibility information.
- UPMC's reconciliation of participant eligibility to capitation payments received from DHS appeared to be focused on issues that only resulted in underpayments to UPMC.
- UPMC does not perform Medicare eligibility outreach for Non-Dual participants aged 65 or older.

Capitation Payments Were Made to UPMC Based on Incorrect Eligibility Information

As shown in the table below, the results of our audit procedures found DHS made capitation payments totaling $357,048 to UPMC based on incorrect eligibility information for 8 of the 66 participants selected for review. However, due to payment recovery restrictions included in the CHC Agreement, DHS was unable to recover $120,977 of the payments. The capitation payments made to UPMC were for participants that were deceased, incarcerated, or had chosen to no longer have UPMC as their Managed Care Organization (MCO) in the CHC program. These payment amounts are detailed in the table below.

Capitation Payments Made by DHS to UPMC Based on Incorrect Eligibility Information and Amounts Recovered by DHS

Reason for Incorrect Capitation Payment by Participant	Amount DHS Paid UPMC[a/]	Amount Recovered by DHS	Amount DHS Was Unable to Recover from UPMC
Deceased Participants			
1	$226,227	$121,341	**$104,886**
2	$119,097	$103,908	**$15,189**
3	$2,672	$2,672	$0
4	$1,898	$1,898	$0
Incarcerated Participants			
1	$2,640	$1,738	**$902**
2	$1,343	$1,343	$0
3	$1,132	$1,132	$0
Participant Disenrolled from UPMC			
1	$2,039	$2,039	$0
Total	**$357,048**	**$236,071**	**$120,977**

[a/] - Amounts DHS paid UPMC during the audit period were obtained from UPMC management. Amounts paid to UPMC that were not paid during the audit period were obtained from capitation payment files DHS provided to the Department of the Auditor General for use in performing the annual Single Audit of the Commonwealth of Pennsylvania. The purpose of the Single Audit is to provide assurance to the federal government about the management and use of federal funds by the state. The Single Audit includes examination of an entity's financial records, financial statements, federal award transactions and expenditures, operations management, internal controls, and federal assistance received during the period subject to audit.

Source: Produced by staff of the Department of the Auditor General based on payment information provided by DHS and validated with payment information obtained from UPMC management, for the audit period.

The following sections describe in detail the issues found with each of the eight participants noted in the above table.

Deceased Participants

UPMC received capitation payments for the following four deceased participants:

- **Participant 1**: The participant died on November 27, 2018, but was enrolled in the UPMC CHC program on January 1, 2019, over one month after the date of death (DOD). We inquired of DHS management as to why/how a deceased individual was able to be enrolled. DHS management stated the information received from the Social Security Administration (SSA) showed the participant as active and therefore the County Assistance Office (CAO) enrolled the participant.[78] As noted in ***Finding 1***, UPMC management stated they were informed of the participant's death in January 2019 during their initial outreach; however, UPMC did not notify DHS of the DOD until November 10, 2021, when UPMC's Finance Department noted the discrepancy. At that time, UPMC communicated this change through a CAO Notification Form.[79] DHS did not disenroll the participant from UPMC until August 31, 2022. As a result, DHS made capitation payments to UPMC for the 43 months from January 2019 through July 2022, totaling $226,227. However, due to a 21-month recovery restriction in the CHC Agreement regarding deceased participants, DHS was only able to recover $121,341 for the months of November 2020 through July 2022.[80] DHS was unable to recover the payments for the remaining 22 months prior to November 2020, totaling $104,886. Since UPMC was

[78] DHS management stated it receives information from SSA in a nightly exchange when changes are reported.
[79] As described in the *Introduction and Background*, UPMC must report a participant's change in status (including death) to the appropriate CAO using the CAO Notification Form within 10 business days of the change becoming known. UPMC must also provide a detailed explanation on the form of how this information was verified. 2022 CHC Agreement Section V: Program Requirements, O: Participant Enrollment, Disenrollment, Outreach, and Communications, 10. Change in Participant Status.
[80] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2(vii) Capitation Payments.

aware of the participant's death, it should have noted the discrepancy when performing the required reconciliation of monthly capitation payments received[81] with its internal membership information and reported the discrepancy to DHS within the required 30 days.[82] Issues regarding UPMC's reconciliation process are discussed in a later section of this finding.

- **Participant 2**: The participant died on April 11, 2020; however, the participant was not disenrolled from UPMC until March 31, 2022. Although UPMC was timely notified of the participant's DOD on April 13, 2020, according to UPMC management, due to an internal error, UPMC did not send an Alert to DHS until January 25, 2022. DHS disenrolled the participant from UPMC on March 31, 2022.[83] As noted in the prior bullet, although UPMC is required to reconcile monthly capitation payments received with its internal membership information and report any discrepancies to DHS within 30 days, UPMC did not notify DHS of the discrepancy in subsequent months when UPMC continued to be paid for the deceased participant. During the 24 months (April 2020 through March 2022), UPMC received capitation payments totaling $119,097 for the deceased participant. In April 2022, DHS recovered $103,908 for the last 19 months of payments made to UPMC. The CHC Agreement between DHS and UPMC allows for the recovery of payments made for deceased participants for up to 21 months after the month in which the DOD occurred. Therefore, DHS could not recover the first payment, for May 2020, totaling $5,118 due to it being past 21 months. However, the two payments for June and July 2020, totaling $10,071, were also not recovered even though they were within the 21-month rule. Upon inquiry, DHS management stated that during the audit period, DHS was only going back 18 months to recover payments made for deceased participants. It was not until the end of 2023 that they started to go back 21 months.[84]

- **Participant 3**: The participant died on September 16, 2020; however, the participant was not disenrolled from UPMC until March 31, 2022. As noted in ***Finding 1***, UPMC is not required to contact Nursing Facility Ineligible (NFI) participants. As a result, UPMC was unaware the participant died until DHS notified them on March 22, 2022. Upon inquiry, DHS management stated the DOD information was received from the SSA Death Master File (DMF);[85] however, the information was cleared and therefore the CAO was not

[81] DHS provides monthly capitation payment information to UPMC in an 820 Capitation Payment File.
[82] 2022 CHC Agreement Section V: Program Requirements, X. Administration, 6.x. Management Information Systems.
[83] DHS management stated CAOs have 90 days to process the closure after receiving confirmation of a participant's DOD.
[84] Although DHS management stated they did not begin to recover 21 months of payment until the end of 2023, we note that for the participant described in the prior bullet, DHS did recover 21 months of payments in 2022.
[85] The DMF is a file extracted from the SSA database of Social Security number holders that contains the death reports that SSA collects to administer its programs. https://www.ssab.gov/research/social-security-and-the-death-master-file/ (accessed November 20, 2024).

notified to investigate. The CAO was notified on March 17, 2022, by Medicare, of the participant's DOD and the participant was then disenrolled. UPMC received payments for October 2020 through February 2022, totaling $2,672. DHS recovered the full amount in April 2022; however, this was a delay of 19 months after the participant's DOD.

- **Participant 4**: The participant died on March 27, 2021, but was not disenrolled from UPMC until July 31, 2022. The participant was NFI and as a result, UPMC was unaware the participant passed away until DHS notified them on July 20, 2022. Upon inquiry, DHS management stated the participant was not removed from the CHC program timely due to the CAO failing to close the case when the DOD information was received. Therefore, UPMC received payments for April 2021 through June 2022 totaling $1,898. DHS recovered the full amount in August 2022; however, this was a delay of 17 months after the participant's DOD.

The CHC Agreement allows DHS to recover payments made for deceased participants up to 21 months after the month in which the DOD occurred. We inquired as to why this limit was placed in the CHC Agreement and DHS management stated that prior to the 2022 CHC Agreement, the recovery timeframe was 18 months. In the 2022 CHC Agreement, the timeframe was increased to 21 months. However, DHS management could not provide a rationale for why the arbitrary timeframe of 21 months was selected, especially since the Centers for Medicare and Medicaid Services[86] removed the requirement to complete prior period adjustments within two years on July 1, 2017. DHS management further stated they intend to remove the 21-month timeframe restriction from future Agreements.

As reported above, deceased participants are not consistently and timely identified by DHS during its review of the DMF. The CHC Agreement does not require UPMC to perform a review of the DMF to determine if any of the participants enrolled in its CHC program are deceased. However, if UPMC performed monthly/regular reviews of the DMF, it would increase the chance that deceased participants, in particular those that are NFI that UPMC does not make regular contact with, would be timely identified. This would assist in the process to ensure timely removal of deceased participants from the CHC Program; therefore, decreasing the amount DHS would have to recover from UPMC. UPMC management stated it is likely that it has sufficient information to check, or have a vendor check, participants against the DMF. Upon inquiry, DHS management did not respond as to whether there are any potential issues that would preclude UPMC from performing checks against the DMF.

[86] CMS is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.

Incarcerated Participants

The three participants UPMC received capitation payments for while they were incarcerated were all NFI participants. As previously noted, UPMC is not required to contact NFI participants after an attempt is made upon initial enrollment. Therefore, UPMC was unaware that they had been incarcerated and should have been disenrolled. The following provides details for each of the three incarcerated participants:

- **Participant 1**: The participant was incarcerated from April 21, 2021, through November 20, 2022, but was not disenrolled from UPMC. DHS management stated the incarceration information was received, and the CAO attempted to act timely to close case; however, an IT error was received when processing the closure. The error created an issue where the case was opened in an incorrect category and the CAO missed the erroneous opening.[87] Therefore, DHS continued to pay UPMC a total of $2,640 in capitation payments for this time period. DHS learned of the participant's incarceration in November 2022 and subsequently recovered $1,738 from UPMC. DHS was unable to recover the remaining $902 due to the terms of the CHC Agreement, which limits DHS to only recover payments made for participants who were later determined to be ineligible for up to 12 months after the service month for which payment was made.[88] Upon inquiry, DHS management stated the CHC Agreement includes the 12-month limit because the language in the initial CHC Agreement was based on requirements DHS had placed in similar agreements. Management further stated they plan to determine if there is anything to prohibit them from removing the limitation in the next CHC Agreement.

- **Participant 2**: The participant was enrolled with UPMC on November 15, 2021, and then incarcerated on November 25, 2021; however, DHS did not notify UPMC of the incarceration until September 26, 2022. Upon enrollment as an NFI participant, UPMC sent a Health Risk Assessment (which according to UPMC, was not returned), but made no other attempts to contact the participant. Therefore, the participant remained enrolled in the CHC program, and UPMC received capitation payments for 10 months (December 2021 through September 2022), totaling $1,343. DHS did not begin to recover the full amount of the overpayments until November 2022, a full year after the participant was incarcerated. Upon inquiry, DHS management stated they received the incarceration information January 6, 2022; however, the information was not sent to the CAO for follow-up until DHS received incarceration information from SSA.

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[87] DHS receives incarceration information daily from county jails and State Correctional Institutions.
[88] 2022 CHC Agreement, Section VII: Financial Requirements, B. Department Capitation Payments, 2 (vii) Capitation Payments.

- **Participant 3**: The participant was incarcerated twice in 2021, during February through March, and August through November, while also enrolled with UPMC. Although, according to UPMC management, DHS notified UPMC in July 2021 of the incarceration, it continued to pay UPMC through November 2021. In March 2022, 14 months after the participant was originally incarcerated, DHS recovered the entire $1,132 paid to UPMC during the time periods the participant was incarcerated. Upon inquiry, DHS provided no further explanation regarding why it continued to pay UPMC after being notified of the participant's incarceration.

Participant Disenrolled from UPMC

- **Participant 1**: The participant chose to change their MCO and disenrolled from UPMC on October 31, 2021. However, DHS incorrectly continued to make capitation payments to UPMC through October 2022, totaling $2,039. DHS recovered this full amount in December 2022, a delay of 14 months after the participant disenrolled from UPMC. UPMC management stated they were unaware the participant had disenrolled until DHS recovered the payments in December 2022. Upon inquiry, DHS provided no further explanation regarding the payments made to UPMC after the participant chose to change their MCO.

UPMC's Reconciliation of Participant Eligibility to Capitation Payments Received from DHS Appeared to be Focused on Issues that Only Resulted in Underpayments to UPMC

DHS provides Daily and Monthly 834 Eligibility Files to UPMC that contain participant information and eligibility changes.[89] DHS makes capitation payments to UPMC by the 15th day of each month for each participant based on a participant's eligibility status and the number of days the participant was enrolled with UPMC in the prior month.[90] Capitation payment information is provided to UPMC in an 820 Capitation Payment File. As previously reported, UPMC is required to reconcile the 820 Capitation Payment File with its internal membership information and report any discrepancies to DHS within 30 days.[91] UPMC must also notify DHS

[89] 2022 CHC Agreement Exhibit K, CHC-MCO Participant Coverage Document, Section B. Participant Files/Coverage Dates/Eligibility.
[90] 2022 CHC Agreement Section VII: Financial Requirements, B. Department Capitation Payments, 2.vi. Capitation Payments.
[91] 2022 CHC Agreement Section V: Program Requirements, X. Administration, 6.x. Management Information Systems.

within 60 calendar days for any capitation payment in excess of amounts specified in the CHC Agreement.[92]

Although the CHC Agreement includes timelines and requires UPMC to notify DHS if it identifies the above noted discrepancies, UPMC management stated that based on a request from DHS, UPMC waits two or three months before conducting their review for discrepancies. Upon inquiry, DHS management confirmed that they requested the delay to allow them time to review their reports and to identify and correct discrepancies in an effort to reduce the number of discrepancies identified by UPMC, but such delay results in negating the time requirements outlined in the CHC Agreement.

Due in part to this request for a delay in reconciliations there were only three discrepancies forwarded to DHS from UPMC during the audit period. The discrepancies, which were identified when UPMC reconciled the 834 Eligibility File to the 820 Capitation Payment File, covered the months of December 2021, through June 2022. UPMC management stated that due to the delay requested by DHS, all the discrepancies identified during their initial review of files for July 2022, through December 2022, were subsequently corrected by DHS. Therefore, UPMC did not submit any discrepancies for DHS to review for this time period.

Our review of the reconciliation documents[93] provided by UPMC found that although UPMC's reconciliation process identifies eligibility discrepancies resulting in both over payments[94] and under payments[95] made to UPMC by DHS, it appeared that UPMC staff only investigated eligibility issues that resulted in an underpayment to UPMC. UPMC management stated that although there are cases where eligibility discrepancies result in an overpayment, this is a smaller ratio of the total discrepancies. Since UPMC has limited staff to perform the investigations, UPMC management stated that it tends to focus on the NFCE participants that are listed as NFI since those participants have more need for UPMC services. Although NFCE participants do require more services than NFI participants, it is equally important for UPMC to follow up on all discrepancies that lead to overpayments made to UPMC. As reported in the above sections, overpayments have resulted in $357,048 in overpayments to UPMC for 8 of the 66 participants that we selected for review during the audit period. Additionally, $120,977 was unable to be recovered by DHS due to the timeline restrictions in the 2022 CHC Agreement.

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[92] 2022 CHC Agreement Section VII: Financial Requirements, B. Department Capitation Payments, 2. viii. Capitation Payments.

[93] Documents included the results of analysis performed to identify differences between participants' eligibility status and the capitation payments made to UPMC.

[94] An overpayment can occur if a NFI participant is listed incorrectly in DHS' records as NFCE eligible since capitation payments are higher for a NFCE participant than they are for a NFI participant.

[95] An underpayment can occur if a NFCE participant is listed incorrectly in DHS' records as NFI eligible since capitation payments are lower for a NFI participant than they are for a NFCE participant.

UPMC Does Not Perform Medicare Eligibility Outreach for Non-Dual Participants Aged 65 or Older

As described in the *Introduction and Background,* participants enrolled in both Medicare and Medicaid are referred to as Dual and those that are only enrolled in Medicaid are referred to as Non-Dual.[96] Generally, individuals become eligible for Medicare when they become 65.[97] Pursuant to the CHC Agreement, a higher daily capitation rate is paid for Non-Dual participants than Dual participants. Analysis performed on the 66 participants selected for review found that during the audit period, there were three Non-Dual participants over age 65 that were, based on age, eligible for Medicare benefits.[98] DHS management stated enrollment in Medicare is not a CHC program requirement. However, if the participants were enrolled in Medicare, DHS would pay UPMC a lower daily rate, resulting in a cost savings.

UPMC management stated, and DHS management confirmed, that UPMC is not currently required and therefore does not perform outreach regarding Medicare eligibility for Non-Dual participants aged 65 or older. Although UPMC is not currently required under the CHC Agreement to perform this type of outreach, contracting with UPMC to coordinate enrollment of eligible participants in Medicare would provide financial benefits to DHS and the Commonwealth.

We performed audit procedures for the three Non-Dual participants over age 65 during the audit period to determine the difference in capitation payments if the participants had been enrolled in Medicare. We determined that the daily rate difference DHS paid UPMC as a result of the participants' Non-Dual status was an additional $79 per day for two of the participants and $86 per day for the third participant. Our audit procedures also included determining what the total payments to UPMC would have been during the audit period if outreach had been performed to the three participants and if they had successfully been enrolled in Medicare. We determined that for the three Non-Dual participants, UPMC received $177,059 in capitation payments during the audit period. If the same three participants had been enrolled in Medicare and classified as Dual, UPMC would have only been paid $128,772, a difference of $48,287.

According to data obtained from DHS, as of December 31, 2022, approximately 3,500 participants were classified as Non-Dual and age 60 or older. We did not have birthdates for these individuals to determine how many were age 65 or older, but UPMC does have this information and can determine which participants are potentially eligible for Medicare. Analysis

[96] For Dual participants, Medicare is the primary payer for services covered by Medicare. CHC Coordination With Medicare. https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/Coordination%20of%20Medicare.pdf (accessed September 18, 2024).
[97] Individuals may be eligible for Medicare earlier due to a disability. https://www.medicare.gov/basics/get-started-with-medicare (accessed November 19, 2024).
[98] The three participants were age 67, 73, and 76 during the audit period.

to determine which Non-Dual participants are age 65 or older and subsequent outreach could result in Medicare enrollment for some and subsequent savings to DHS and the Commonwealth.

Overall Summary

The delay in notifying DHS of a participant's death or incarceration has resulted in significant delays in disenrolling participants from UPMC and in additional capitation payments made by DHS to UPMC for ineligible participants. The cause for the delay was, in part, a result of UPMC not being required to make regular contact with NFI participants. Additionally, due to CHC Agreement language restricting the timeframe for recovering capitation payments, DHS was unable to recover $120,977 in payments made to UPMC based on incorrect eligibility information. Further, UPMC's focus appeared to be on eligibility information that resulted in underpayments to UPMC rather than both underpayments and overpayments, further compounding delays that lead to prolonged enrollment of ineligible participants. Finally, if UPMC was required to perform outreach to participants aged 65 or older who are not enrolled in Medicare, there is potential cost savings for the Commonwealth if these participants are successfully enrolled in Medicare.

Recommendations for Finding 2

We recommend that UPMC management:

1. Implement review procedures to ensure all death notifications received by UPMC are forwarded to DHS as required by the CHC Agreement.

2. Implement procedures to perform a monthly check of participants enrolled in the UPMC CHC program against the Social Security Administration Death Master File (SSADMF) to timely disenroll deceased individuals.

3. Perform follow up on all discrepancies identified between UPMC's internal eligibility membership information, eligibility status listed in the DHS 834 Eligibility File, and payments listed in the DHS 820 Capitation Payment File regardless of whether the result was an underpayment or an overpayment to UPMC for participants enrolled with UPMC.

4. Require UPMC staff to contact NFI participants at least one time per year to allow for timely determinations of changes in participants' status.

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5. Implement procedures requiring UPMC staff to perform outreach regarding Medicare eligibility for Non-Dual participants aged 65 or older.

We recommend that DHS management:

1. Ensure timely investigations occur when UPMC forwards information regarding potentially deceased participants enrolled in the CHC program.

2. Remove from future CHC Agreements the restrictions regarding recovery of capitation payments.

3. Implement procedures to ensure follow-up is performed on all participants identified during the SSADMF match to ensure deceased participants are disenrolled from DHS programs.

4. Require UPMC staff to contact NFI participants at least one time per year to allow for timely determinations of changes in participants' status.

UPMC Health Plan's Response and Auditor's Conclusion

We provided copies of our draft audit findings and related recommendations to the UPMC Health Plan (UPMC) for its review. On the pages that follow, we included UPMC's response in its entirety. Following UPMC's response is our auditor's conclusion.

Audit Response from UPMC Health Plan

UPMC Community HealthChoices

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February 12, 2025

Scott D. King, CPA
Director
Bureau of Performance Audits
SKing@paauditor.gov

Dear Mr. King:

UPMC *for You* (UPMCFY) confirms receipt of your email dated January 23, 2025, entitled "Draft report of findings and recommendations - UPMC Health Plan." UPMCFY has thoroughly reviewed the transmittal letter and the draft findings and recommendations, along with the introduction and background and related appendices, pertaining to your performance audit of the UPMC Health Plan regarding the Community HealthChoices contract. Per the instructions outlined in the transmittal letter, below; please find UPMCFY's response (agree/disagree) to each of the identified recommendations the Department outlined within the report and where we disagreed, an explanation outlining why.

Finding #1: UPMC failed to adequately perform all required participant assessments and did not notify DHS of changes to participants' program eligibility status.

Finding #1 recommendations:

1. ***Ensure service coordinator supervisors are monitoring to ensure all service coordinators are conducting timely assessments and reassessments of participants.***

   UPMC Response: UPMCFY agrees with the recommendation of the Auditor General that it maintain meaningful oversight of the timely performance of assessments and reassessments by its Service Coordination staff. In furtherance of our commitment to ensuring timely needs assessments, we have robust CHC service coordination

oversight processes that regularly undergo review to improve effectiveness and efficiency, as well as to incorporate new or modified requirements from regulatory and oversight agencies such as DHS, NCQA, and HEDIS. UPMCFY has also developed and implemented multiple proprietary operations and performance dashboards to enable an ongoing and landscape view of all active Participants and their corresponding assessment/reassessment due dates. These dashboards are not only monitored routinely Service Coordinators and their Supervisors, but the entire UPMCFY Service Coordination team as well to assure alignment. An early model of this oversight was in operation during the audit period. As part of ongoing continuous improvement efforts, UPMCFY completed significant enhancements to the process in 2023, and routinely adapts its oversight mechanisms to make the approach more effective and impactful wherever possible. UPMCFY is confident that its enhanced service coordination oversight processes are robust and valuable tools to ensure that UPMC CHC Service Coordinators are conducting timely assessments and reassessments of participants' needs.

2. ***Require service coordinator supervisors to review and approve all InterRAI Assessment documents.***

   UPMC Response: UPMCFY agrees with the recommendation that it implement and maintain meaningful processes for review and approval of InterRAI Assessment documents and as part of our ongoing continuous improvement efforts, we will further evaluate our current approach to identify any potential areas for enhancement. UPMCFY notes that its methods for ensuring comprehensive and timely completion of InterRAI Assessment documents begins with its Service Coordinators, who are required to meet specific educational and experiential requirements upon hire and must complete robust and continual topic-specific training, including training on proper completion of InterRAI Assessments. Additionally, as part of the process through which it monitors submission of assessment documentation, UPMCFY participant management system now includes functionality that identifies potential documentation gaps within individual participant files and provides prompt notice to Service Coordinators, Supervisors, and other key leadership of the need for remediation of any such gaps as necessary. In addition, UPMCFY has developed and implemented a supervisory-level audit model that includes, for example, case reviews to identify timeliness and compliance, phone audits with the participant to inquire as to satisfaction, and "ride-alongs," each of which improve documentation quality and help avoid assessment document gaps. UPMCFY's current monitoring and oversight processes provide

targeted identification, review, and remediation of assessment gaps; as such, we consider them to be even more effective, efficient, and impactful to address completion of assessment documentation than requiring supervisory review of all assessments (which average more than 1,200 per week for UPMCFY).

3. ***Reinforce to service coordinators that notes need to be maintained for all contact and attempted contact with participants.***

   UPMC Response: UPMCFY agrees with the recommendation that it reinforce with its Service Coordination staff the need to document all contact and attempted contact with Participants; we will do so in accordance with our current policies and practices, which already require the same.

4. ***Reinforce to service coordinators the need to document when and from whom status change information was provided.***

   UPMC Response: UPMCFY agrees with the recommendation that it reinforce with its Service Coordination staff the need to document when and from whom status change information is received; we will do so in accordance with our current policies and practices, which already require the same.

5. ***Ensure all changes to participants' status are documented and timely forwarded to the appropriate CAO on a CAO Notification Form, when required by the CHC Agreement.***

   UPMC Response: UPMCFY agrees with the recommendation that it ensure that all changes to participant status are documented and timely forwarded to the appropriate CAO on a CAO Notification Form when required by the CHC Agreement; we will do so through reinforcement of our current policies and practices, which already require the same.

6. ***Ensure DHS is timely notified of all events in the Weekly Enrollment/Disenrollment/Alert file, when required by the CHC Agreement.***

UPMC Response: UPMCFY agrees with the recommendation that it ensure that DHS is timely notified of all events required to be reported via the Weekly Enrollment/Disenrollment/Alert file under the applicable terms of the CHC Agreement; we will do so through reinforcement of our current policies and practices, which already require the same.

Finding #2 recommendations: UPMC did not consistently provide CHC participant eligibility information to DHS, which resulted in incorrect capitation payments. Additional procedures are needed by UPMC in its capitation payment reconciliation process and Medicare eligibility outreach to participants.

Finding #2 recommendations:

1. ***Implement review procedures to ensure all death notifications received by UPMC are forwarded to DHS as required by the CHC Agreement.***

   UPMC Response: UPMCFY agrees with this recommendation and notes that it has implemented process improvements and system enhancements since the audit period as part of ongoing continuous improvement efforts. These improvements and enhancements now facilitate a more effective and efficient process for forwarding death notifications to DHS in compliance with the timeframes outlined in the CHC agreement and/or related DHS-issued Operations Memoranda.

2. ***Implement procedures to perform a monthly check of participants enrolled in the UPMC CHC program against the Social Security Administration Death Master File (SSADMF) to timely disenroll deceased individuals.***

   UPMC Response: UPMCFY agrees with the importance of checking enrolled participants against the SSADMF to timely disenroll deceased individuals. However, this process is already a functional accountability of the individual County Assistance Offices as outlined in the Medical Assistance Eligibility Handbook. CHC Managed Care Organizations like UPMC FY are thus not obligated under the CHC Agreement to perform the same review of the SSADMF for the purposes of identifying and reporting participant deaths. UPMCFY does, however, have a process by which we provide DHS with timely notification of participant deaths as soon as we are made aware of them, and indeed, our MMIS is able to ingest death information first known by the CAOs, via

our 834 files. We then verify every date of death received on 834 files and report identifiable incorrect death information back to the CAOs for additional review.

3. ***Perform follow up on all discrepancies identified between UPMC's internal eligibility membership information, eligibility status listed in the DHS 834 Eligibility File, and payments listed in the DHS 820 Capitation Payment File regardless of whether the result was an underpayment or an overpayment to UPMC for participants enrolled with UPMC.***

   UPMC Response: UPMCFY agrees with this recommendation. In fact, we have implemented an update to our process since the audit period as part of ongoing continuous improvement efforts to help ensure that we are appropriately reviewing and reporting potential eligibility discrepancies that result in either an underpayment or overpayment to UPMCFY.

4. ***Require UPMC staff to contact NFI participants at least one time per year to allow for timely determinations of changes in participants' status.***

   UPMC Response: UPMCFY agrees that timely determination of changes in the status of our NFI participants is critical and is fully committed to maintaining contact with the identified population.

   While the Community Health Choices Agreement does not require CHC MCOs to conduct annual outreach to NFI participants, UPMCFY utilizes various activities through which we engage with NFI participants multiple times each year. Upon enrollment, UPMCFY promptly conducts outreach to NFI Participants who indicate any additional need for services or supports coordination in their returned Health Risk Assessment (HRA). Beyond HRA-related outreach, the CHC Agreement and DHS-required participant materials such as the Participant Handbook provide that NFI participants may outreach to their CHC MCO should they subsequently self-identify a need for long-term services and supports and/or a comprehensive needs assessment and we are responsive as necessary and appropriate to those outreaches we receive. All UPMCFY CHC participants (including NFI participants) also receive a CHC newsletter three times a year which includes articles on health promotion as well as instructions regarding how to contact UPMC CHC should they self-identify as needing long-term services and supports or desire to undergo a needs assessment.

In addition to the HRA process and the above-described avenues made available to participants for self-identification of needs, UPMCFY provides support to our NFI population through the assignment of Telephonic Care Managers for any needed supports where requested. UPMCFY also utilizes Admission, Discharge, and Transition (ADT) reporting to identify potential changes in need that would require a needs assessment or a change in status, and conducts outreach to NFI Participants and/or the Participant's primary medical payor (Medicare) when we are alerted of a possible change in need/status to assist with coordinating care. UPMCFY has also spearheaded universal outreach efforts with all 13 DSNP MCOs in the Commonwealth and conducts plan collaboration and Participant Interdisciplinary Care Team (ICT) reviews at least quarterly. These efforts support all UPMC Participants, including the NFI population.

UPMCFY also developed a DSNP Collaboration form to assist with facilitating CHC MCO and DSNP MCO collaboration for NFI and NFCE Participants, which is currently in use by all Pennsylvania DSNP MCOs and CHC MCOs.

All of these initiatives and approaches enable ongoing contact with and follow-up on behalf of UPMC FY's NFI participants.

5. ***Implement procedures requiring UPMC staff to perform outreach regarding Medicare eligibility for non-dual participants aged 65 or older.***

UPMC Response: UPMCFY agrees that non-dual CHC participants should be encouraged to pursue all potentially available healthcare coverage options, including Medicare eligibility, and would benefit from assistance in that regard. We note, however, that based on the operations of the CHC Program and the fact that CHC MCOs are not expected under the terms of the CHC Agreement to conduct outreach to coordinate an individual's enrollment in a Medicare plan, CHC MCO outreach as recommended may not be the solution. To the extent outreach to non-dual participants regarding their potential eligibility for Medicare is appropriate and beneficial to participants, as well as DHS, we think that such outreach would likely be more effectively and efficiently coordinated though Commonwealth agencies such as the Pennsylvania Medicare Education and Decision Insight (PA MEDI), the statewide Medicare resource service operated by the Pennsylvania Department of Aging.

UPMCFY will continue to work collaboratively with the Department to ensure all eligibility changes are communicated timely. We appreciate your feedback and support as we move forward with implementing your recommendations.

Sincerely,

Brendan Harris
President of UPMC *for You* and State Programs

Auditor's Conclusion to UPMC Health Plan's Response

UPMC Health Plan (UPMC) management agreed with ***Finding 1*** and our recommendations. UPMC management also agreed with ***Finding 2*** and the recommendations made; however, they disagreed that it is their responsibility to implement some of the recommendations. Additionally, UPMC management stated they have already addressed some of the recommendations made in the report; however, we did not perform audit procedures to confirm additional oversight was implemented after our audit period or review its operating effectiveness. Below we address UPMC's response to the audit report and findings along with certain areas we believe warrant further comment based on UPMC's response.

Finding 1

We are pleased UPMC agreed with the information provided in the finding. UPMC indicated that regarding ensuring timely assessments and reassessments of participants occur, significant enhancements were completed in 2023 for additional oversight by Service Coordinator Supervisors and the entire Service Coordinator team.

We are pleased UPMC stated that it has implemented additional procedures and will further evaluate its current approach to identify any potential areas for enhancement regarding service coordinator supervisors' review and approval of all InterRAI Assessment documents.

Finally, we are pleased UPMC agreed with the recommendations regarding the need to: (1) reinforce to service coordinators that notes need to be maintained for all contact and attempted contact with participants; (2) document when and from whom status change information is provided; and (3) ensure all status change information and events are documented and timely forwarded to the appropriate County Assistance Office or to the Pennsylvania Department of Human Services (DHS), utilizing the appropriate notification method as required by the Community HealthChoices (CHC) Agreement with DHS. UPMC further stated that the procedures noted in the recommendations will occur through reinforcement of current policies and practices, which already require the same.

Finding 2

We are encouraged that, as we have recommended, UPMC has implemented process improvements and system enhancements regarding: (1) review procedures to ensure all death notifications received by UPMC are forwarded, as required, to DHS; and (2) performing follow up on all discrepancies identified between UPMC's internal membership information, eligibility status listed in the DHS 834 Eligibility File, and payments listed in the DHS 820 Capitation

Payment File regardless of whether the result was an underpayment or an overpayment to UPMC for participants enrolled with UPMC.

Regarding our recommendations for UPMC to: (1) perform a monthly check of participants against the Social Security Administration Death Master File to timely disenroll deceased individuals; and (2) implement procedures requiring UPMC staff to perform outreach regarding Medicare eligibility for non-dual participants aged 65 or older; UPMC stated that it agreed with the need for these processes to occur. However, UPMC stated that it is not obligated under the CHC Agreement to perform either of these processes and that the processes should be performed by County Assistance Offices and the statewide Medicare resource service operated by the Pennsylvania Department of Aging, respectively. As we acknowledged in the finding, under the CHC Agreement, UPMC is not required to perform these procedures; however, having UPMC perform these procedures to identify deceased participants and to perform outreach to participants that may be eligible for Medicare benefits could result in subsequent savings to DHS and the Commonwealth.

Finally, regarding our recommendation for UPMC staff to contact Nursing Facility Ineligible (NFI) participants at least one time per year to allow for timely determinations of changes in participants' status, UPMC agreed that timely determination is critical and is fully committed to maintaining contact with the identified population. However, UPMC stated that the CHC agreement does not require UPMC to conduct annual outreach to NFI participants. UPMC indicated various activities through which they engage with NFI participants multiple times throughout the year; however, many of those activities/outreach do not require or result in a response from the participant to confirm the participant has not passed away since enrollment with UPMC which is a concern reported in the finding.

In addition to the recommendations made to UPMC, ***Findings 1 and 2*** include six recommendations directed to DHS for which we strongly urge DHS to consider and implement to improve the efficiency and effectiveness of operations within the CHC program.

Appendix A — Objectives, Scope, Methodology, and Data Reliability

The Department of the Auditor General conducted this performance audit of UPMC Health Plan (UPMC) pursuant to Sections 402 and 403 of The Fiscal Code (Code)[99] and in accordance with the Code's Article XVII-B. 2021-2022 Budget Implementation provision,[100] and Article XVII-F.1. 2022-2023 Budget Implementation provision.[101]

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 objective.[102] We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Objective

Our performance audit objective was to determine whether UPMC provided accurate and timely CHC program participant eligibility information to DHS to ensure accurate capitation rates paid to UPMC.

Scope

This performance audit included the period January 1, 2022, through December 31, 2022.

UPMC management is responsible for establishing and maintaining effective internal controls to provide reasonable assurance of compliance with applicable laws and regulations, contracts, grant agreements, and administrative policies and procedures. In conducting our audit, we obtained an understanding of UPMC's internal controls, including information systems controls.

Standards for Internal Control in the Federal Government (also known as and hereafter referred to as the Green Book), issued by the Comptroller General of the United States, provides a

[99] 72 P.S. §§ 402 and 403.
[100] 72 P.S. § 1715-B (Act 24 of 2021, effective July 1, 2021).
[101] 72 P.S. § 1715-F.1(1) (Act 54 of 2022, retroactively applicable to July 1, 2022).
[102] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021.

framework for management to establish and maintain an effective internal control system.[103] We used the framework included in the Green Book when assessing UPMC's internal control systems.

The Green Book's standards are organized into five components of internal control. In an effective system of internal control, these five components work together in an integrated manner to help an entity achieve its objectives. The five components contain 17 related principles, listed in the table below, which are the requirements an entity should follow in establishing an effective system of internal control.

We determined all of the internal control components are significant to the audit objective. The table below represents a summary of the level of the internal control assessment for effectiveness of design (D); implementation (I); or operating effectiveness (OE) that we performed for each principle, along with a conclusion regarding whether issues were found with the principles and if those issues are included in a finding.[104]

Component		Principle	Level of Assessment	Conclusion
Control Environment	1	The oversight body and management should demonstrate a commitment to integrity and ethical values.	D	No issues noted
	2	The oversight body should oversee the entity's internal control system.	D	No issues noted
	3	Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.	D, I	No issues noted
	4	Management should demonstrate a commitment	D	No issues noted

[103] Even though the Green Book was written for the federal government, it explicitly states that it may also be adopted by state, local, and quasi-government entities, as well as not-for-profit organizations, as a framework for establishing and maintaining an effective internal control system.
[104] The Green Book, Sections OV3.05 and 3.06, states the following regarding the level of assessment of internal controls. Evaluating the design of internal control includes determining if controls individually and in combination with other controls are capable of achieving an objective and addressing related risks. Evaluating implementation includes determining if the control exists and if the entity has placed the control into operation. Evaluating operating effectiveness includes determining if controls were applied at relevant times during the audit period, the consistency with which they were applied, and by whom or by what means they were applied.

Component		Principle	Level of Assessment	Conclusion
		to recruit, develop, and retain competent individuals.		
	5	Management should evaluate performance and hold individuals accountable for their internal control responsibilities.	D	No issues noted
Risk Assessment	6	Management should define objectives clearly to enable the identification of risks and define risk tolerances.	D	No issues noted
	7	Management should identify, analyze, and respond to risks related to achieving the defined objectives.	D	No issues noted
	8	Management should consider the potential for fraud when identifying, analyzing, and responding to risks.	D, I	No issues noted
	9	Management should identify, analyze, and respond to significant changes that could impact the internal control system.	D	No issues noted
Control Activities	10	Management should design control activities to achieve objectives and respond to risks.	D, I, OE	Findings 1, 2
	11	Management should design the entity's information system and related control activities to achieve objectives and respond to risks.	D, I	No issues noted
	12	Management should implement control activities through policies.	D, I, OE	Findings 1, 2

Component		Principle	Level of Assessment	Conclusion
Information and Communication	13	Management should use quality information to achieve the entity's objectives.	D, I, OE	Finding 1
	14	Management should internally communicate the necessary quality information to achieve the entity's objectives.	D, I, OE	Finding 2
	15	Management should externally communicate the necessary quality information to achieve the entity's objectives.	D, I, OE	Findings 1, 2
Monitoring	16	Management should establish and operate monitoring activities to monitor the internal control system and evaluate results.	D, I, OE	Findings 1, 2
	17	Management should remediate identified internal control deficiencies on a timely basis.	D	No issues noted

Government Auditing Standards require that we consider information systems controls "…to obtain sufficient, appropriate evidence to support the audit findings and conclusions."[105] This process further involves determining whether the data that supports the audit objectives is reliable. In addition, Publication GAO-20-283G, *Assessing Data Reliability*, provides guidance for evaluating data using various tests of sufficiency and appropriateness when the data are integral to the audit objective(s).[106] *See* our assessment in the *Data Reliability* section that follows.

Our procedures to assess the design, implementation, and/or operating effectiveness accordingly are discussed in the *Methodology* section that follows. Deficiencies in internal controls which we identified during the conduct of our audit and determined to be significant within the context of our audit objectives are summarized in the conclusion section below and described in detail

[105] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021. Paragraph 8.59 through 8.67.
[106] U.S. Government Accountability Office. *Assessing Data Reliability*. December 2019.

within the respective audit findings in this report. *See* the table above for descriptions of each of the principle numbers included in the conclusions below.

Conclusion:

Our assessment of management's internal controls did not find issues associated with Principles 1 through 9, 11, and 17. We found, however, issues with management's controls regarding Principles 10, and 12 through 16. These areas include issues with UPMC: (1) failing to adequately perform all required participant assessments; (2) failing to notify DHS of changes to participants' program eligibility status which resulted in incorrect capitation payments; (3) not having procedures in place to perform assessments of Nursing Facility Ineligible participants to determine their current eligibility status; (4) not having procedures in place to identify participants that have died; (5) appearing to, during its reconciliation of participant eligibility to capitation payments, focusing on issues that only resulted in underpayments; and (6) not performing Medicare eligibility outreach for Non-Dual[107] participants aged 65 or older. These issues are described in detail in *Findings 1 and 2* of this report.

Methodology

The following procedures were performed to address our audit objective. Items selected for review within this audit were based on auditor's professional judgment and not through statistical selection. The results of our review, therefore, cannot be projected to, and are not representative of, the corresponding populations.

- Obtained an understanding of UPMC's overall organization structure and purpose from our review of its organizational chart, information published on its website, responses to our fraud and information technology questions, and from interviews and correspondence with UPMC and DHS management. [All Principles]

- Obtained an understanding of the following from interviews and correspondence with UPMC and DHS management and staff; and review of: (1) the 2022 Community HealthChoices (CHC) Agreement between DHS and UPMC (specific sections are listed in detail below); (2) assessments performed on participants; (3) service coordinator notes; and (4) eligibility and capitation payment reconciliations performed. [All Principles]:
  - UPMC's enrollment process
  - Participant eligibility
  - Participant status changes
  - Notification to DHS of a participant's status changes

[107] Participants enrolled in Medicaid but not in Medicare.

- Reconciliation process between eligibility and capitation payment files as well as the subsequent follow-up investigation performed on discrepancies noted
- Procedures performed to identify participants that are:
    - Eligible for Medicare benefits
    - Deceased

- Reviewed UPMC's: (1) responses to an internal control questionnaire; (2) internal policies and procedures; and interviewed UPMC management and staff to gain an understanding of what controls were in place regarding each of the 17 Principles within the five components of internal control in order to establish an effective system of internal control. [All Principles]

- Obtained an understanding from UPMC through correspondence and a review of UPMC information technology (IT) related policies as to the IT systems used to process information regarding assessments and reconciliations performed and the general IT controls over those systems applicable to our audit objective. [Principle 11]

- Reviewed the CHC Agreement between DHS and UPMC, and UPMC written policies and procedures to determine requirements related to the audit objective, including the following:
    - 2022 CHC Agreement
        - Section II: Definitions, Capitation Payment
        - Section IV: Applicable Statutes and Regulations
            - Section A: Certification, Licensing, and Accreditation
        - Section V: Program Requirements
            - Section B: Prior Authorization of Services
              B.1: General Prior Authorization Requirements
              B.2: Time Frames for Notice of Decisions
            - Section D: Choice of Provider
            - Section E: Comprehensive Needs Assessments and Reassessments
            - Section H: Care Management Plan
            - Section K: Service Coordinator and Service Coordinator Supervisor Qualification Requirements
            - Section O: Participant Enrollment, Disenrollment, Outreach, and Communications
              O.6: Enrollment Procedures
              O.8: Transitioning Participants Between CHC-MCOs
              O.9: Transitioning Participants Between the CHC-MCO and LIFE
              O.10: Change in Participant Status
              O.11: Participant Files

        - Section P: Participant Services
        - Section X: Administration
            - 6: Management Information Systems
        - Section AA: Provider Services
        - Section BB: Provider Network
    - Section VII: Financial Requirements
        - Section A: Financial Standards
        - Section B: Department Capitation Payments
            - B.2: Capitation Payments
        - Section D: Claims Processing Standards, Monthly Report and Sanctions
            - D.1: Timeliness Standards
    - Section VIII: Reporting Requirements
    - Exhibit B: Standard Terms and Conditions
        - Section 6: Compensation/Expenses
        - Section 8: Payment
    - Exhibit E: Prior Authorization Guidelines for the CHC-MCO
    - Exhibit J: Participant CHC-MCO Selection an Assignment
    - Exhibit K: CHC-MCO Participant Coverage Document
        - B: Participant Files/Coverage Dates/Eligibility
        - C: Exceptions and Clarifications (1) and (4)
    - Appendix 3(d) Overview of Methodologies for Rate Setting, (f) Participant Enrollment Mix Adjustment.
  - UPMC Health Plan Policy and Procedure Manual, Policy Number: MED.003: Capitation/Membership Reconciliation Process, Effective November 2005 and Revised November 2021 [Principle 12]
  - DHS, CHC Operations Memorandum #2019-05, dated November 20, 2019

- Obtained information for the background of the report regarding UPMC and the CHC Agreement including:
  - The areas covered by the CHC Agreement.
  - The services and supports provided to individuals in the CHC program.
  - The four managed care organizations that provide services in the CHC program.
  - The number of individuals served in the CHC program.
  - The five geographic zones in the CHC program.
  - The total amount of CHC program expenditures for the fiscal years ended June 20, 2022, and June 30, 2023.
  - The seven regions served in the CHC program.
  - Descriptions of levels of nursing facility clinical care of participants (individuals in the CHC program).

- The total amount of capitation payments DHS made to UPMC during the calendar year 2022.
- Descriptions of the types of assessments and the reassessment performed on participants.
- The enrollment information by eligibility and region for participants enrolled in UPMC's CHC program as of January 1, 2022, and December 31, 2022.

- Obtained from DHS a file of 156,732 records totaling $357,127,667, associated with 156,267 CHC program participants regarding capitation payments made to UPMC for participant services provided during the audit period January 1, 2022, through December 31, 2022 (audit period). The information in the file also included the participants' rate cell[108] and region. We then separated the participants into the following four categories:
  - **New Participants** – newly enrolled with UPMC during the audit period (21,431 records).
  - **Participants with No Changes** – participant did not have a change to their rate cell or region during the audit period (111,930 records).
  - **Participants with Changes** – participant had a change to their rate cell and/or region during the audit period (7,358 records).
  - **Dropped Participants** – participants that dropped from UPMC during the audit period (16,013 records).

  Based on auditor professional judgment, we selected 66 participants to perform our audit procedures. Our selection of 66 participants included 10 New Participants, 30 Participants with No Changes, 15 Participants with Changes, 10 Dropped Participants, and one additional participant from the Participants with Changes category that during our initial analysis, we were unable to determine the participant's rate cell.[109] The number selected from each category was generally determined based on total population within each category, with less emphasis placed on New Participants category due to the determination of a participant's rate cell by an Independent Enrollment Broker[110] prior to the participant signing up for services with UPMC.

  Within the four categories, 15 selections were made based upon analysis performed on participants that were identified as having more than one transaction in a single month. The remaining 50 participants were selected judgmentally, ensuring adequate coverage within all of the rate cells and regions with consideration given to the population within each of the rate cells. Additional emphasis was also placed on the two Non-Dual rate

[108] A rate cell is assigned to participants based on characteristics such as age, gender, and eligibility.
[109] This was not an issue with incomplete DHS data. Through further correspondence with UPMC, we determined the participant's rate cell.
[110] As described in the *Introduction and Background*, an Independent Enrollment Broker is contracted by DHS to facilitate the enrollment process for individuals seeking support services.

cells since participants in these categories have a more significant impact on funding since Non-Dual participants are only enrolled in, and only receive benefits from Medicaid. They are not enrolled in, nor received benefits from Medicare.

As previously noted, one additional participant, whose rate cell we were initially unable to determine, was also selected for review.

- Obtained from UPMC management the following documents that were prepared or used by service coordinators to determine if assessments were conducted on the 66 participants selected for review, in accordance with the CHC Agreement: [Principles 7, 10 through 16]
    - InterRAI Assessment[111]
    - Nursing Facility Assessment[112]
    - Independent Enrollment Broker (IEB) Packet[113]
    - Alert file[114]
    - County Assistance Office (CAO) Notification Form[115]

- Obtained from UPMC management the following documents to perform analysis and determine if the correct monthly capitation payments were made by DHS to UPMC for the 66 participants selected for review: [Principles 7, 10 through 16]
    - Calendar Year 2022 Community HealthChoices Participant Enrollment Mix Adjustment
    - 2022 CHC Agreement, Appendix 3c, Capitation Rates
    - Calendar Year 2021 Community HealthChoices Participant Enrollment Mix Adjustment
    - Community Health Choices Calendar Year 2021 Contract Rates
    - Capitation payments files of payments made by DHS to UPMC during the audit period for the 66 participants selected for review

[111] As described in the *Introduction and Background*, an InterRAI Assessment form is used by UPMC to document the annual Comprehensive Needs Assessment, Reassessment, Trigger Event Assessment, and Assessments performed at the request of the participant's designee or family member.
[112] A Nursing Facility Assessment is similar to an InterRAI Assessment; however, it is designed to be specific to participants who reside in a nursing facility.
[113] As described in the *Introduction and Background*, individuals enroll in CHC through an Independent Enrollment Broker (IEB). The IEB is contracted to facilitate the enrollment process for individuals seeking services and support. The IEB Packet provides participant information gathered by the IEB.
[114] As described in the *Introduction and Background*, UPMC must report weekly, to DHS on the Alert file, events such as a pregnancy, death, and returned mail alerts.
[115] As described in the *Introduction and Background*, UPMC must report a participant's change in status to the appropriate CAO using the CAO Notification Form within 10 business days of the change becoming known.

- For the 66 participants selected for review, we performed analysis on participants aged 65 or older to determine if they are enrolled in Medicare. For those participants not enrolled in Medicare, we inquired of UPMC management if outreach had been performed to the participants. [Principles 7, 10 through 16]

- Reviewed the computer code used by UPMC to identify participants whose eligibility status in the 834 Eligibility File did not match the monthly capitation payment amount received by UPMC listed in the 820 Capitation File to determine if discrepancies that result in both overpayments and underpayments to UPMC are identified. [Principle 11]

- Obtained from UPMC, management reconciliation files from the audit period to determine the procedures performed by UPMC staff to reconcile DHS 834 Eligibility Files to the DHS 820 Capitation Payment Files and the follow-up correspondence from UPMC to DHS identifying discrepancies found during their analysis. [Principles 7, 10 through 16]

- Reviewed participants' records in DHS' client information system (eCIS) to determine participant eligibility information during the audit period. [Principle 13]

Data Reliability

Government Auditing Standards requires us to assess the sufficiency and appropriateness of computer-processed information that we used to support our findings, conclusions, and recommendations. The assessment of the sufficiency and appropriateness of computer-processed information includes considerations regarding the completeness and accuracy of the data for the intended purposes.[116]

In addition to the procedures described in the remainder of this section, as part of our overall process in obtaining assurance of the reliability of computer-processed information and data files, we obtained a management representation letter from UPMC. This letter, signed by UPMC management, included a confirmation statement indicating the information provided to us had not been altered and was a complete and accurate duplication of the information from its original source.

[116] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021. Paragraph 8.98.

Regarding CHC program participant eligibility information (rate cell and region) and accurate capitation rates paid, we obtained monthly capitation payment files[117] from DHS for CHC program payments/transactions made by DHS each month during the audit period of January 1, 2022, through December 31, 2022 (audit period) as well as the period of July 1, 2018, through December 31, 2021.[118] In order to confirm the completeness and accuracy of the payment files, we performed the following:

- Obtained an understanding of the Information Technology (IT) environment including general IT controls of the PROMISe system through audit procedures performed during the audit of the Commonwealth's Annual Comprehensive Financial Report and the Single Audit for fiscal years ended June 30, 2022, and June 30, 2023.[119]

- As part of the Single Audits for fiscal years ended June 30, 2019, through FYE June 30, 2024, audit procedures were performed to ensure that the control totals provided by DHS materially agreed to capitation payment data to an independent source (PROMISe 4710 Report).

- Extracted from the January 2022, through December 2022, monthly capitation payment files, the records specific to UPMC and separated the records into four categories: (1) New Participants; (2) Participants with No Changes; (3) Participants with Changes; and (4) Dropped Participants. The following audit procedures were performed to determine data reliability of the DHS records:
  - Reconciled the totals of the DHS records to remittance advices obtained from UPMC.
  - For the participants that had multiple records in a single month, reviewed, for reasonableness, adjustment codes associated with the record that explained the cause for more than one record for the participant in a single month.
  - For 66 of the UPMC participants selected for review, we performed the following:
    - Confirmed participants' eligibility information to support documents such as assessments performed on the participants, service coordinator notes, and information maintained in DHS' client information system.

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[117] The payment files included transactions pertaining to all the managed care organizations (MCO) that provided services for the CHC program during the audit period, which includes UPMC. Transactions included capitation payments made to MCOs as well as transactions for DHS to recover money from the MCOs.
[118] The capitation payment files obtained for the time prior to the audit period were utilized in our audit procedures to determine overpayment amounts made by DHS to UPMC, prior to the audit period, for participants selected in our review.
[119] The purpose of the Single Audit is to provide assurance to the federal government about the management and use of federal funds by state governments.

- Confirmed participants' monthly capitation payment amounts to capitation payment files provided by UPMC and by recalculating payments based on the participants' eligibility status and the agreed upon capitation rates in the 2022 CHC Agreement.

- Extracted from the July 2018, through December 2021, monthly capitation payment files, the records for 14 of the 66 participants selected for review. These records were used to determine the amounts of overpayments made to UPMC, and amounts recovered, if applicable, prior to the audit period.

Based on the results from the above procedures, we found no limitations with using the DHS capitation payment files for our intended purposes. In accordance with Government Auditing Standards, we concluded the capitation payment files for the audit period of January 1, 2022, through December 31, 2022, as well as the period of July 1, 2018, through December 31, 2021, which include records related to payments DHS made to UPMC for participants enrolled with UPMC for the CHC program, were sufficiently reliable regarding completeness and accuracy for the purposes of this engagement.

Appendix B UPMC Community HealthChoices Program Enrollment

The following table provides enrollment information by rate cell[120] and region[121] for the individuals (referred to as participants) enrolled in UPMC's Community HealthChoices (CHC) program as of January 1, 2022, and December 31, 2022, the first and last day of our audit period. The information in the table supports enrollment totals included in the *Introduction and Background* of our report.

[120] A "rate cell means a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment. Characteristics may include age, gender, eligibility category, and region or geographic area." *See* 42 CFR Part 438.2 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.2 (accessed October 18, 2024).

[121] There are seven regions which include:

1) Northwest – counties include Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Potter, Venango, and Warren.
2) Northeast – counties include Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming.
3) Lehigh/Capital – counties include Adams, Berks, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York.
4) Southwest – counties include Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland.
5) Southwest – Allegheny County.
6) Southeast – counties include Bucks, Chester, Delaware, and Montgomery.
7) Southeast – Philadelphia County.

Participants Enrolled in the UPMC CHC Program as of January 1, 2022, and December 31, 2022[1/] by Rate Cell and Region

Rate Cell	Region							Total
January 1, 2022	**Northwest**	**Northeast**	**Lehigh/Capital**	**Southwest**	**Southwest - Allegheny**	**Southeast**	**Southeast - Philadelphia**	
NFCE Dual 21-59	722	432	912	1,411	831	434	1,148	**5,890**
NFCE Dual 60+	3,258	3,044	5,717	4,562	3,641	2,898	4,979	**28,099**
NFCE Non-Dual 21-59	790	219	907	1,153	1,035	229	1,156	**5,489**
NFCE Non-Dual 60+	341	105	625	432	592	211	606	**2,912**
NFI Dual 21-59	5,613	4,941	7,039	9,291	4,756	2,051	3,344	**37,035**
NFI Dual 60+	6,449	6,849	9,602	12,949	7,854	3,379	7,659	**54,741**
Total	**17,173**	**15,590**	**24,802**	**29,798**	**18,709**	**9,202**	**18,892**	**134,166**

Rate Cell	Region							Total
December 31, 2022	**Northwest**	**Northeast**	**Lehigh/Capital**	**Southwest**	**Southwest - Allegheny**	**Southeast**	**Southeast - Philadelphia**	
NFCE Dual 21-59	780	455	940	1,457	865	451	1,176	**6,124**
NFCE Dual 60+	3,438	3,209	6,134	4,858	3,841	3,066	5,295	**29,841**
NFCE Non-Dual 21-59	892	235	1,141	1,283	1,127	275	1,268	**6,221**
NFCE Non-Dual 60+	374	164	771	477	613	251	617	**3,267**
NFI Dual 21-59	5,487	4,836	6,833	9,214	4,565	1,937	3,062	**35,934**
NFI Dual 60+	6,944	7,321	10,308	14,058	8,454	3,508	7,677	**58,270**
Total	**17,915**	**16,220**	**26,127**	**31,347**	**19,465**	**9,488**	**19,095**	**139,657**

[1/] - Enrollment numbers are actual numbers as of January 1, 2022, and December 31, 2022. They do not include any retroactive adjustments made to correct a rate cell or region determined at a later date to be incorrect.

Source: Produced by staff of the Department of the Auditor General based on information provided by UPMC management. This information is being presented for background purposes only.

Appendix C UPMC Participants Test Selection

The following table provides information that supports the selection of the 66 participants, from the total population, whose results from the audit procedures performed are discussed in ***Finding 1*** and ***Finding 2*** of our report:

Participants Selected for Testing from UPMC Participant Transactions By Rate Cell and Category
During the Period January 1, 2022, through December 31, 2022

	Rate Cell								Totals	
	NFCE [a] Dual[b]		NFCE Non-Dual[c]		NFI[d] Dual		Undetermined[e]			
Category	Number of Participants Selected	Number of Transactions	Number of Participants Selected	Number of Transactions	Number of Participants Selected	Number of Transactions	Number of Participants Selected	Number of Transactions	Number of Participants Selected	Number of Transactions
New	2	4,892	4	2,392	4	13,199	0	948	10	21,431
No Changes	8	27,148	13	6,463	9	78,305	0	14	30	111,930
With Changes	5	3,941	5	431	5	2,398	1	588	16	7,358
Dropped	4	5,904	3	924	3	8,659	0	526	10	16,013
Total	**19**	**41,885**	**25**	**10,210**	**21**	**102,561**	**1**	**2,076**	**66**	**156,732**

[a/] – Nursing Facility Clinically Eligible (NFCE). Participant's clinical needs that require the level of care provided in a nursing facility. However, participants can receive that care in their own home or a nursing facility.
[b/] – Dual – Participant is enrolled in both Medicaid and Medicare.
[c/] – Non-Dual – Participant is enrolled only in Medicaid.
[d/] – Nursing Facility Ineligible (NFI). Participant's clinical needs do not require the level of care provided in a nursing facility.
[e/] – During our initial analysis, we were unable to determine the participant's rate cell. This, however, was not an issue with incomplete DHS data. Through further correspondence with UPMC, it was determined that the participant we selected for testing was NFI Dual.

Source: Produced by staff of the Department of the Auditor General. Totals for participant record numbers based on information in monthly CAP Medicaid Payment files provided by DHS.

Appendix D Distribution List

This audit report was distributed to the following individuals:

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Governor

Mr. Brendan Harris
President of UPMC *for You* and State Programs
UPMC Health Plan

Mr. Alexander Matolyak, CPA
Director, Division of Audit and Review
Pennsylvania Department of Human Services

The Honorable Scott Martin
Senate Majority Appropriations Chairman
Pennsylvania Senate

The Honorable Vincent Hughes
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A Performance Audit

UPMC Health Plan
Community HealthChoices contract with the Pennsylvania Department of Human Services

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