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Community Behavioral Health Did Not Comply With Requirements When Denying Prior Authorization Requests

REPORT HIGHLIGHTS



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Why OIG Did This Audit

- OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of behavioral health care services provided to Medicaid enrollees.
- We audited Community Behavioral Health (CBH), a Pennsylvania behavioral health Medicaid managed care organization (BH-MCO), because it had the highest number of denied service requests of any BH-MCO in Pennsylvania.
- This audit is part of a series of reports examining Medicaid MCO denials; this is the first to review behavioral health service denials.

What OIG Found

None of the 100 denied service requests we sampled met all requirements for denying behavioral health service requests that required prior authorization. The findings raise concerns about CBH's ability to protect enrollee rights under the Medicaid program.

- CBH may have delayed or denied medically necessary services or appeals.
- CBH sent denial notices to incorrect addresses.
- CBH issued unclear denial notices.
- Pennsylvania's denial notice templates provided to CBH and other BH-MCOs did not inform Medicaid enrollees of their right to request copies of all documents and records relevant to the denial at no charge to the enrollee.

Example: Potential Delay of Care

- **The Patient:** A 2-year-old enrollee diagnosed with autism spectrum disorder
- **The Request:** Applied Behavior Analysis services
- **The Denial:** CBH sent a standard request for additional information and denied the services after 14 days. CBH did not document further attempts to contact the prescriber as is required when the enrollee is a child. CBH's denial cited a lack of information, but most of the information cited as missing was actually in the request.
- **The Potential Delay of Care:** CBH approved the same requested services 27 days later

What OIG Recommends

We made five recommendations for CBH to improve how it communicates service denials—especially for children. We also made one recommendation for Pennsylvania to improve its denial notice templates. The full recommendations are in the report.

CBH did not indicate concurrence or nonoccurrence with our recommendations but stated that it concurred with two of our findings and detailed steps it has taken and plans to take in response to our recommendations. Pennsylvania concurred with the recommendation addressed to it.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of behavioral health care services provided to individuals enrolled in Medicaid. Medicaid managed care organizations (MCOs) provide Medicaid enrollees with health care services through a network of health care providers. In Pennsylvania, behavioral health MCOs (BH-MCOs) provide Medicaid enrollees with behavioral health services, which consist of all mental health, drug, and alcohol services, through a network of behavioral health care providers.

This audit is part of a series of OIG audits examining Medicaid MCO denials, including work examining the use of prior authorizations that may result in delays for enrollees seeking to access behavioral health services. Previous OIG reports have highlighted concerns related to the Medicaid managed care program and its oversight, such as high prior authorization denial rates and limited State oversight.^{1, 2} We selected Community Behavioral Health (CBH), a Pennsylvania BH-MCO, for audit because CBH had the highest number of denied service requests of any BH-MCO in Pennsylvania.

OBJECTIVE

Our objective was to determine whether CBH complied with Federal and State requirements when it denied requested behavioral health services that required a prior authorization.

BACKGROUND

Medicaid Program

The Medicaid program provides medical and behavioral health services to eligible low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its own Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

To enhance access to and the quality of behavioral health care for Medicaid enrollees, many States implemented managed care delivery systems. Under these systems, States may contract with BH-MCOs to deliver covered services. In risk-based managed care arrangements, State

¹ OIG, [High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care \(OEI-09-19-00350\)](#), July 17, 2023.

² OIG, [CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements \(A-02-22-01016\)](#), Mar. 25, 2024.

Medicaid agencies pay BH-MCOs a fixed monthly capitation payment for each enrollee. The State Medicaid agency makes the capitation payment regardless of whether the enrollee receives services during the period covered by the payment.

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

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

Pennsylvania's Medicaid Managed Care Program

The Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (State agency) oversees the behavioral health portion of Pennsylvania's Medicaid managed care program, known as HealthChoices. Under HealthChoices, behavioral health services are administered through county mental health and intellectual disabilities program offices, and the actual behavioral health services are delivered by licensed practitioners and provider agencies under contract with the county or local program offices.

Between January 1, 2023, and December 31, 2023 (audit period), the State agency paid a total of \$5.5 billion to the five BH-MCOs with which it had contractual agreements.

To support the State agency's oversight responsibilities, BH-MCOs provide the State agency with a monthly list of all denied service requests. The State agency randomly selects and reviews some of these denied service requests to verify that the denials met standards identified in agreements between the BH-MCOs and the State agency.

Community Behavioral Health

Headquartered in Philadelphia, CBH was established by the City of Philadelphia's Department of Public Health and operates as a not-for-profit entity responsible for administering behavioral health services. Although CBH is legally a separate organization, it is considered a component unit of the City of Philadelphia. CBH oversees a network of contracted providers, including hospitals, urgent care centers, and various outpatient facilities. These providers deliver covered behavioral health services to enrollees.

In 2023, CBH received approximately \$1.28 billion in Medicaid capitation payments from the State agency to provide behavioral health services to eligible Philadelphia residents. Of the more than 830,000 Philadelphians eligible for CBH services, approximately 100,600 individuals received care through CBH. CBH reported spending nearly \$863 million on behavioral health treatment during the same period.

Since 2018, the number of services requiring prior authorization that CBH denied has substantially declined. (See Appendix D for more information.) Of the 96,130 behavioral health service requests that required a prior authorization during our audit period, CBH denied 1,102. Enrollees filed grievances for 63 of the 1,102 denials and, through the appeals process, CBH subsequently overturned 13 of the 63 grievances.

CBH's Prior Authorization Process

CBH's HealthChoices Agreement defines prior authorization as any determination made by its BH-MCO "to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service." Under CBH's Medicaid MCO plan, services must be deemed medically necessary to be covered.³

CBH's Member Handbook outlines the services that require prior authorization. Except for emergency services or emergency inpatient admissions, CBH approval must be obtained before the service is rendered for behavioral health care services that require prior authorization.

For community-based services, CBH's prior authorization process begins when an enrollee's health care provider submits a written order for services related to mental illness, substance use disorder, or other behavioral conditions. The request must include documentation supporting the medical necessity of the service. This generally includes the enrollee's diagnosis, the level of care requested, the treatment plan and goals, and the duration of the requested services. Most written requests are submitted electronically via a secure file server.

For urgent or emergency behavioral health services requiring inpatient admission, most requests are submitted by phone. In such cases, clinicians generate pre-certification records during the call and document the request details. Once the enrollee is admitted, CBH begins collecting the required documentation to support the service request.

For both community-based and emergency services, CBH's Clinical Care Managers (CCMs) review requests using clinical guidelines approved by the State agency. If a CCM approves the request, the provider is notified; if the CCM cannot approve the request, it is escalated to a CBH

³ As stated in CBH's HealthChoices Agreement, medically necessary means that a service or medicine does one of the following: (1) it will, or is reasonably expected to, prevent an illness, condition, or disability; (2) it will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability; or (3) it will help a member to get or keep the ability to perform daily tasks, taking into consideration both the member's abilities and the abilities of someone the same age.

physician or psychologist advisor for review. See Figure 1 for the steps in CBH's prior authorization denial process.

If a request is denied, CBH issues a denial letter to the provider and the enrollee, detailing the reason for the denial and timeframes for requesting a peer-to-peer consultation.^{4, 5}

If the enrollee or enrollee's representative disagrees with CBH's decision, they may file an appeal (grievance) with CBH within 60 days from the date on the denial letter.⁶ After exhausting CBH's appeals process, the enrollee may request a State fair hearing through the Pennsylvania's Department of Human Services' Bureau of Hearings and Appeals.⁷

As stated in CBH's HealthChoices Agreement, if a decision is not communicated to the enrollee and provider within 21 days from the date the request was received, the service is automatically approved.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 1,102 service requests requiring prior authorization that were denied during the audit period including grievances associated with 63 of those denied service requests. We selected and reviewed a random sample of 100 denied service requests that required a prior authorization to determine whether CBH complied with Federal and State requirements. Specifically, we reviewed the

Figure 1: CBH's Prior Authorization Denial Process

1. The MCO physician or psychologist advisor determines that the request does not meet medical necessity.
2. The MCO Clinical Care Manager informs the provider of the decision and sends the Outcome Notification form.
3. A standard letter is mailed to the member and provider to give additional time for information to be submitted.
4. When the additional time has elapsed, the MCO makes the approval/denial decision based upon the information received.
5. If the request is denied, the MCO mails the denial letter to the member and the provider.

⁴ According to CBH's HealthChoices Agreement, Appendix AA, a Denial of Service is "a determination made by a BH-MCO in response to a Provider's or Enrollee's request for approval to provide a service of a specific amount, duration and scope which: (A) disapproves the request completely; (B) approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; (C) approves provision of the requested service(s), but by a Network Provider; (D) disapproves provision of the requested service(s), but approves provision of an alternative service(s); or (E) reduces, suspends, or terminates a previously authorized service."

⁵ A peer-to-peer consultation is a discussion between a BH-MCO physician or clinical reviewer and the provider requesting the service authorization.

⁶ Appendix H of CBH's HealthChoices Agreement, defines a grievance as "a request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service."

⁷ Enrollees or enrollees' representatives may request (in writing) a State fair hearing if they disagree with MCO grievance decisions associated with denied service requests.

denied service requests to determine whether CBH denied the requests in accordance with Federal and State requirements.

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

Appendix A contains the details of our audit scope and methodology, Appendix B contains related OIG reports, Appendix C contains service requests denials by category, Appendix D contains details about annual service denial trends and numbers, Appendix E contains the details of our statistical sampling methodology, Appendix F contains our sample results and estimates, and Appendix G contains Federal and State requirements for Medicaid MCO services that require a prior authorization.

FINDINGS

CBH did not comply with Federal and State requirements when it denied behavioral health service requests that required a prior authorization. None of the 100 sampled service requests met all applicable administrative and procedural requirements.⁸ Specifically, CBH did not:

- Follow address-change notification procedures and sent the denial notices to incorrect addresses (17 denied service requests)
- Provide timely notification that a request was denied (1 denied service request)
- Inform enrollees of their right to access all relevant documents free of charge (all 100 denied service requests)
- Issue denial notices that clearly explained the adverse benefit determinations (14 denied service requests)
- Document the extra steps it took to request that the enrollee's representative contact the provider before CBH denied services for enrollees under 21 (34 denied service requests)

CBH did not follow these required procedures because its policies and procedures were not specific enough to ensure compliance, and the State's denial templates did not include required language. These findings raise concerns about CBH's ability to protect enrollee rights under the Medicaid program and whether CBH may have incorrectly delayed or denied medically

⁸ Of the 100 sampled denied service requests, 58 did not comply with more than 1 requirement.

necessary services or appeals. Additionally, CBH may have received improper capitation payments for enrollees who no longer resided in Pennsylvania.

Based on our sample results, we concluded that none of the 1,102 service requests denied complied with all Federal regulations and State requirements.

INCORRECT ADDRESSES USED IN DENIAL NOTICES

Federal requirements at 42 CFR section 438.210(c) state that each contract must provide for the MCO to notify the requesting provider and give the enrollee written notice of any decision by the MCO to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested. The written notice to the enrollee must meet the requirements of section 438.404.

CBH's HealthChoices Agreement requires the BH-MCO to develop a written compliance program that includes promptly notifying the State when the BH-MCO receives information about changes in an enrollee's circumstances, including changes to the enrollee's residence, that may affect the enrollee's eligibility.⁹ CBH's HealthChoices Agreement also outlines that "the BH-MCO must establish mechanisms to inform the [County Assistance Office (CAO)] of any change or update to the enrollee's residency or eligibility status within 10 days of the date of learning of the change."¹⁰ The BH-MCO must use the CAO Notification Form to report to the CAO any enrollee changes or updates.¹¹ The CAO will only take immediate action for a change of address if the BH-MCO has received direct verification of the change of address. Direct verification is defined as the enrollee, the enrollee's authorized representative, or other adult member of the household confirming the address change is correct.

For 17 of the 100 sampled denied service requests, CBH did not comply with requirements regarding address updates and verification when issuing denial notices. Specifically, for these 17 denied service requests, CBH sent the notification to an incorrect address. For all 17, CBH sent the denial notices to the address on file with the CAO instead of to the updated address documented in the provider submission.

- Of the 17 denial notices, 6 were for enrollees experiencing homelessness who had disclosed their housing status and updated address to the provider.
- One denial notice was for an enrollee who had resided in New Jersey since January 2021. To qualify for Medicaid, individuals must be residents of the State in which they are receiving Medicaid benefits. If this enrollee was no longer a resident of Pennsylvania, this enrollee would be ineligible for Medicaid coverage in Pennsylvania.

⁹ CBH's HealthChoices Agreement, part II, § II-5.I.1.i.

¹⁰ CBH's HealthChoices Agreement, part II, § II-3.A.1.

¹¹ Office of Mental Health and Substance Abuse Services (OMHSAS) Systems Notice, OMHSAS-2023-001.

These 17 denied service requests were sent to incorrect addresses because CBH did not submit the required Notification Form to the CAO to report the enrollee address change. CBH sent all denial notices to the enrollee addresses on file with the CAO. It did not have a policy or procedure in place to compare enrollee addresses reported by service providers with the addresses maintained in its records and did not have processes to verify when a change in residence had occurred and to notify the CAO of the updates. Further, CBH said that it is required to use the address on file with the CAO when contacting an enrollee by mail and that address updates must occur in the State's system for CBH to use an updated address. However, CBH failed to notify the CAO to make the change.

Because CBH sent denial service requests to incorrect addresses, enrollees may not have received denial notices or may not have received them timely. As a result, some enrollees may have been unable to file timely appeals and may have received delayed care. Further, for the enrollee who resided in New Jersey, CBH received capitation payments for the potentially ineligible enrollee for over 4 years.

In response to this finding, CBH said it was planning to enhance its verification procedures to reconcile discrepancies between addresses of record and addresses given to treatment providers to ensure that enrollees receive timely and accurate notifications.

Based on our sample results, we estimated that CBH did not comply with requirements regarding proper notification procedures and address verification when issuing denial notices for 187 of the 1,102 service request denials.

A SERVICE REQUEST THAT SHOULD HAVE BEEN AUTOMATICALLY APPROVED WAS DENIED

Federal requirements at 42 CFR section 438.210(d)(1) state that BH-MCOs must provide notice of authorization decisions as expeditiously as the enrollee's health condition requires and within State-established timeframes.

In all cases, if the enrollee does not receive written notification of the decision to approve or deny a covered service within 21 days from the date the BH-MCO received the request, the service is automatically approved.¹²

For 1 of the 100 sampled denied service requests, CBH did not meet Federal and State requirements for timely authorization decisions and communication of service denials. For this denied service request, CBH sent the initial denial notice 31 days after receiving the initial request. The original written request was received by CBH on December 4, 2023, and CBH mailed the denial notice to the enrollee and provider on January 4, 2024.

This lack of a timely enrollee notification occurred because CBH did not have a process for identifying service requests that are considered approved because a decision notification was

¹² CBH's HealthChoices Agreement, Appendix AA, paragraph C.1, Prior Authorization Review and Decision Process, Timeframes for Notice of Decisions.

not sent within the 21-day window. Because the denial notice was sent more than 21 days after CBH received the request, the services were incorrectly denied, and the enrollee did not receive the requested services.

Based on our sample results, we estimated that 11 of the 1,102 service request denials did not meet Federal and State requirements for timely authorization decisions and communication of service denials.

LACK OF NOTIFICATION ABOUT ACCESS TO RECORDS

Federal requirements at 42 CFR section 438.404(b)(2) require that denial notices inform enrollees of their right to obtain, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denial, including medical necessity criteria and any standards used to make coverage decisions.

None of the 100 sampled denied service requests had denial notices that complied with Federal requirements regarding enrollees' rights to access records related to adverse benefit determinations. Although the 100 denied service requests had denial letters that stated that the enrollee has the right to ask for the medical necessity guidelines or other rules CBH used to make the decision at no cost to the enrollee, none of the 100 denial letters stated that the enrollee has the right to request copies of all documents and records relevant to the denial at no charge to the enrollee.

These 100 denial notices did not contain the required language because CBH used a denial notice that the State agency provided as a template in the HealthChoices Agreement, and the template did not contain the required statement that the enrollee has the right to request copies of all documents and records relevant to the denial at no charge to the enrollee.¹³

Providing enrollees with full information regarding their right to access records ensures that the appeal process is transparent to enrollees. Without this information, enrollees may not understand their rights and options to effectively appeal adverse decisions. The HealthChoices Agreement that contains the template was also used by the other BH-MCOs that operate in the State; therefore, we are also making a recommendation to the State.

Based on our sample results, we concluded that none of the 1,102 service request denials complied with Federal requirements regarding enrollees' rights to access records related to adverse benefit determinations.

¹³ CBH's HealthChoices Agreement, Appendix AA, Attachment 2a, "Standard Denial Notice For Requests That Are Denied Completely"; Attachment 2b, "Standard Denial Notice For Requests That Are Approved Other Than Requested"; Attachment 2c, "Standard Denial Notice For Requests That Are Denied As Requested But Have Approved Different Services"; and Attachment 2d, "Standard Denial Notice For Requests For Multiple [Intensive Behavioral Health Services]".

UNCLEAR BENEFIT DETERMINATIONS IN DENIAL NOTICES

Federal regulations at 42 CFR section 438.404(b)(1) require that MCOs explain the specific adverse benefit determination being made or intended in denial notices. Additionally, CBH's HealthChoices Agreement mandates that BH-MCOs issue denial notices using the appropriate templates, including when a service is denied as requested but an alternative service is approved.¹⁴

For 14 of the 100 denied service requests in our sample, CBH issued the denial notice using the "denied completely" template and also included a statement in the notice recommending alternative services that the enrollee should seek; however, the denial notice did not clearly explain to the enrollee that the services that CBH recommended did not require a prior authorization. The denial notice was unclear because it stated that the requested services were "completely denied."

CBH stated that it used the "denied completely" template because the services "recommended" in place of the requested services did not require prior authorization approval. The HealthChoices Agreement did not provide a template that covered situations in which services are denied but other services not requiring a prior authorization are recommended. As a result, enrollees may not have understood that alternative services were available without seeking another prior authorization, and they may not have received those services.

Based on our sample results, we estimated that 154 of the 1,102 denials did not explain clearly the adverse benefit determination, including the specific decision made or intended.

LACK OF CONSULTATION FOR ENROLLEES UNDER 21 YEARS OF AGE

CBH's HealthChoices Agreement requires CBH to make reasonable efforts to consult with the provider before denying a requested service for lack of medical necessity. For enrollees under 21 years of age, these reasonable efforts to consult with the provider must include a request that the enrollee, the enrollee's parent, or an authorized representative contact the provider and ask the provider to communicate with CBH. CBH may request either in writing or by telephone that the enrollee's representative contact the provider. CBH must document its attempts to reach the provider, including its request that the enrollee's representative¹⁵ contact the provider to request that the provider contact CBH.¹⁶

In all 34 denied service requests in our sample associated with enrollees under 21 years of age, CBH did not provide any documentation that it requested that the enrollee's representative

¹⁴ CBH's HealthChoices Agreement, Appendix AA, paragraph C.4.

¹⁵ The term "enrollee's representative" can be used to refer to the enrollee, the enrollee's parent, or an authorized representative.

¹⁶ CBH's HealthChoices Agreement, Appendix AA, paragraph B.2.

contact the provider. For these sample denied service requests, the files showed that CBH generated and mailed a standard letter requesting additional information from the provider and the enrollee's representative and then generated and mailed denial letters citing a lack of information 14 days later. For these 34 denied service requests, CBH did not request either in writing or by telephone that the provider be contacted by the enrollee's representative, and the standard letters that CBH sent did not include a request that the enrollee's representative contact the provider to request that the provider contact CBH.

CBH's policy only required it to generate and mail one request for additional information letter. If no response was received, CBH's policy was to generate and mail a denial notice citing a lack of information. For enrollees under 21 years of age, this policy did not require CBH to document a reasonable effort to consult with the provider, nor did it require CBH to request that the enrollee, the enrollee's parent, or an authorized representative contact the provider and ask the provider to communicate with CBH to provide the additional information requested.

Example of a Denial for Which CBH Did Not Follow Requirements for an Enrollee Under 21 Years of Age

A 2-year-old enrollee was diagnosed with autism spectrum disorder. The provider requested Applied Behavior Analysis Consultation Services for 1 year, up to 6 hours per month, and Behavioral Health Technician Applied Behavior Analysis Services for 1 year, up to 30 hours per month.

The enrollee was denied the services due to a lack of information. Specifically, CBH stated that the written order did not include the signature of a qualified licensed professional, a National Provider Identifier (NPI) number, and a Provider Reimbursement and Operations Management Information System identification (PROMISe ID).^{17, 18} Our review of the file found that the PROMISe ID was not on the order, but the order was signed and contained an NPI number. CBH generated and mailed to the provider and enrollee's representative the standard request for additional information letter but did not specifically request that the enrollee, the enrollee's parent, or an authorized representative contact the provider and ask the provider to communicate with CBH. CBH did not document further attempts to contact the provider before sending the denial letter 14 days later.

The same service was approved 27 days later, resulting in a potential delay of care for the enrollee.

¹⁷ An NPI number is a unique 10-digit identification number that CMS assigns to health care providers.

¹⁸ The PROMISe ID is a unique identification number that the Pennsylvania Department of Human Services issues to providers who serve Pennsylvania Medicaid enrollees.

Based on our sample results, we estimated that 375 of the 1,102 denials did not meet State-mandated consultation requirements when reviewing service authorization requests for enrollees under 21 years of age.

RECOMMENDATIONS

RECOMMENDATIONS TO CBH

- We recommend that CBH update its policies and procedures to include: (1) a requirement to reconcile discrepancies between addresses of record and addresses given to treatment providers and (2) a process for determining when a change of residency occurs and notifying the CAO accordingly.
- We recommend that CBH implement a process for identifying service requests that are considered approved because a decision notification was not sent within the 21-day window.
- We recommend that CBH coordinate with the State agency to implement a revised initial denial notice that informs enrollees that they have the right to be provided, upon request and free of charge, all documents, records, and other information relevant to the adverse benefit determination as required by 42 CFR section 438.404(b)(2).
- We recommend that CBH revise the language it uses in the denial notice to clarify when services are denied as requested but CBH recommends alternate services that do not require a prior authorization, as opposed to services being completely denied with no alternate services recommended.
- We recommend that CBH update its policies to comply with its HealthChoices Agreement by requiring staff to document the following for enrollees under 21 years of age: (1) steps taken to contact the enrollee's representative to request that the enrollee's representative ask the provider to communicate with CBH, and (2) efforts to reach the provider before issuing denial notices.

RECOMMENDATION TO THE STATE AGENCY

We recommend that the State agency revise the denial notice template in the HealthChoices Agreement to include a statement that the enrollee has the right to be provided, upon request and free of charge, all documents, records, and other information relevant to the adverse benefit determination.

COMMUNITY BEHAVIORAL HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CBH did not specifically address our recommendations but stated that it concurred with our first and second findings and did not concur with the remaining three findings addressed to it. Further, CBH outlined corrective

actions that it has taken and plans to take that would address our recommendations. We appreciate the corrective actions that CBH has taken and plans to take that would address our first two recommendations. We maintain that our findings and recommendations are valid.

CBH's comments are included in their entirety as Appendix H.

ADDRESS VERIFICATION PROCEDURES

CBH concurred with this finding and stated that it created an agencywide policy titled, *Prompt Notification of Changes Affecting Member Eligibility to the County Assistance Office, 96-267*, pending approval. This policy will require staff to reconcile address discrepancies between the CAO and the treatment providers, verify changes in residency, and ensure that the CAO is notified promptly of such updates. Further, CBH stated that it developed a centralized repository to maintain all submitted CAO Notification Forms and will continue to utilize its reporting procedures to ensure that members receive timely and accurate notifications.

We appreciate the corrective actions that CBH has taken and plans to take, which would address our first recommendation. CBH's new policy, once finalized, should help ensure that address discrepancies are identified and reported to the County Assistance Office as required.

TIMELINESS OF DENIAL NOTIFICATIONS

CBH concurred with this finding and acknowledged the service request for which a denial notice was issued late and denied as requested. However, CBH disagreed with the finding that it lacked a mechanism to identify requests eligible for automatic approval after the 21-day window. CBH highlighted its existing multi-tiered oversight, which includes daily reviews of pending and insufficient denial letters, monthly timeliness reports, and quarterly evaluations by clinical leadership. CBH stated that it is using this case to refine existing internal controls by reinforcing notification protocols, clarifying escalation steps, and making timeliness reviews a central part of monthly reporting discussions.

We acknowledge CBH's stated daily, monthly, and quarterly procedures for monitoring denial notice timeliness as well as the additional internal control enhancements CBH described. These actions should help ensure compliance with the 21-day notification requirement in the HealthChoices Agreement.

RIGHT TO ACCESS RECORDS FREE OF CHARGE

CBH did not concur with this finding, citing State-level mandates as the cause. According to CBH, BH-MCOs in Pennsylvania are required to use standardized denial notice templates provided by the State agency, and these templates cannot be modified or supplemented without prior State agency approval. CBH maintained that the omission of Federal language—specifically regarding an enrollee's right to request copies of all relevant documents free of charge—is a deficiency in the State-issued template rather than an internal procedural failure.

CBH stated that it cannot alter State-issued denial notice templates; however, Federal regulations at 42 CFR section 438.404(b)(2) require every managed care organization to ensure that denial notices inform enrollees of their right to obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the adverse benefit determination. This requirement applies regardless of whether the State issues a template or whether the MCO is permitted to modify that template. CBH's use of a State-issued template does not relieve it of its responsibility to ensure that its notices meet all Federal requirements. CBH will need to use an updated template to meet Federal requirements.

CLARITY OF DENIAL NOTICES WHEN ALTERNATIVE SERVICES ARE RECOMMENDED

CBH did not concur with this finding. CBH stated it used the State agency-issued "denied completely" template because the requested services were denied in full. CBH explained that there is no standardized template that currently exists for situations in which a service is denied but CBH recommends alternative services that do not require prior authorization. CBH further noted that it cannot create or modify a template independently and must use only those templates issued by the State agency.

We maintain that, although the requested services were appropriately categorized as "denied completely," denial notices must still clearly communicate the adverse benefit determination under 42 CFR section 438.404(b)(1). The use of a template that does not differentiate between "denied services" and "available alternative services not requiring prior authorization" creates inconsistency and may confuse enrollees about what services are being authorized. While we recognize that the State agency has not issued a template specific to this scenario, CBH must still ensure that its denial notices comply with all Federal notice content requirements. We continue to recommend that CBH revise the language it uses in the denial notice.

DOCUMENTATION OF CONSULTATION EFFORTS FOR ENROLLEES UNDER 21 YEARS OF AGE

CBH did not concur with this finding. CBH stated that, for pediatric cases, it uses the State agency-issued *Notice of Request for Additional Information* template to inform both the provider and the enrollee's representative that additional information is required. CBH stated that this process satisfies its obligation to make reasonable efforts to obtain the necessary information before rendering adverse determination. CBH further stated that it cannot modify this State-mandated notice and that any revision to require the enrollee's representative to contact the provider would need to be directed and implemented by the State agency.

We maintain that, regardless of whether CBH relies on the State-issued *Notice of Request for Additional Information* template, the HealthChoices Agreement requires documentation of: (1) the steps taken to contact the enrollee's representative to request that the representative ask the provider to communicate with CBH, and (2) CBH's efforts to reach the provider before issuing a denial.

The current template does not document these required steps, and CBH did not provide documentation that these steps were taken in the files we reviewed. We continue to

recommend that CBH update its policies and processes to ensure that staff document all required consultation efforts before issuing denials for enrollees under 21.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The State agency concurred with our recommendation and stated that it has implemented the recommendation by revising the applicable language in the 2026 HealthChoices Agreements, which should now be in use by each BH-MCO. The State agency also acknowledged that the first five recommendations were addressed to CBH and stated that it has continued to work collectively with CBH through onsite reviews and monitoring to address them.

We appreciate the actions the State agency has taken to address the recommendation addressed to it. The State agency's revision of the denial template will help ensure that enrollees across all five BH-MCOs are informed of their right to request copies of all documents and records relevant to a denial at no charge and will promote transparency in the appeals process. In addition, the State agency stated that it has continued to work collectively with CBH to address the recommendations that were made to CBH and noted that onsite reviews and monitoring were previously conducted.

The State agency's comments are included in their entirety as Appendix I.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During our audit period (January 1, 2023, through December 31, 2023), CBH denied 1,102 behavioral health service requests that required a prior authorization. Our audit covered all 1,102 denied service requests that required a prior authorization, including 63 denials that were appealed (grievances). We reviewed a random sample of 100 denied service requests that required a prior authorization.

We reviewed the design, implementation, and operating effectiveness of CBH's internal controls related to our objective. We obtained an understanding of the laws and regulations relevant to CBH's monitoring process to ensure that CBH complied with requirements for services that required a prior authorization. We reviewed CBH's 2023 Utilization Management activities (such as prior authorization requirements and concurrent review) that it used to ensure that CBH complied with recognized standards set forth by the National Committee for Quality Assurance (which works to improve health care quality through the administration of evidence-based standards, measures, and accreditation programs for healthcare organizations) and Federal and State regulations.

We conducted our audit work from February 2024 to December 2025.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal regulations, State law, and the HealthChoices Agreements
- Interviewed CBH personnel to obtain an understanding of how enrollees request services requiring a prior authorization as well as CBH processes, training, and oversight and monitoring activities
- Obtained and reviewed CBH's policies and procedures for requesting, approving and denying service requests that require a prior authorization
- Reviewed CBH's procedures to determine which services required a prior authorization in 2023 and compared them to those services that required a prior authorization before our audit period to determine why denials substantially declined over the past years
- Obtained and reviewed documentation related to prior authorization processes, such as the denial logs (database) and CBH's Provider Manuals

- Selected from the 1,102 denied service requests that required a prior authorization a simple random sample of 100 denied service requests that required a prior authorization and for each:
 - Requested the entire denial package file (documentation of prior authorization request; denial and denial timelines, notes, etc.; and related grievance information and outcomes)
 - Reviewed denial letters to verify that they were sent to the enrollee and provider in the required timeframe and included the correct content and details (e.g., reason for denial, policy citation, facts underlying finding, language that is easily understood)
 - Reviewed CBH's Medicaid Benefit Package to determine whether denials were for covered services
 - Reviewed whether the denial decision was made by an individual at CBH who had appropriate credentials in addressing the services requested
 - Reviewed the administrative process CBH used to determine whether the services requested were medically necessary, and supported by the Letters of Medical Necessity submitted by treating physicians and other supporting documentation for those services that were denied and appealed
- Discussed the results of our audit with CBH and State agency officials

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid</i>	<u>OEI-09-21-00410</u>	06/26/2025
<i>CMS Did Not Ensure That Selected States Complied with Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements</i>	<u>A-02-22-01016</u>	03/28/2024
<i>New York Did Not Ensure That a Managed Care Organization Complied With Requirements For Denying Prior Authorization Requests</i>	<u>A-02-21-01016</u>	9/18/2023
<i>Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made</i>	<u>A-07-22-07007</u>	9/13/2023
<i>High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care</i>	<u>OEI-09-19-00350</u>	07/17/2023
<i>Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization</i>	<u>A-03-20-00201</u>	12/20/2022
<i>Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care</i>	<u>OEI-09-18-00260</u>	4/27/2022

APPENDIX C: SERVICE REQUEST DENIALS BY CATEGORY

Type of Service Requested	What Was Denied (Service Category Examples)	Number of Denied Requests	Percentage of All Denied Requests	Number of Denied Requests Sampled
Intensive Behavioral Health Services (IBHS)/Other 400 Series	➤ Behavioral therapy (Applied Behavior Analysis (ABA)) ➤ Assessment for ABA ➤ Initial ABA treatments ➤ ABA Behavior Consultations	395	36%	34
Residential Rehabilitation	➤ American Society of Addiction Medicine (ASAM) Medically Monitored Inpatient Withdrawal Management ➤ ASAM Clinically Managed High Intensity Residential Services	369	33	40
Inpatient Psychiatric Hospitalization	➤ Acute Hospital Services ➤ Subacute Hospital Services ➤ Acute 302 ➤ Extended Acute Hospital Based Services	187	17	13
Community Residential Rehabilitation (CRR)/Mental Health Residential	➤ Residential Services Other ➤ Other Mental Health Services ➤ Intensive Maximum CRR	89	8	9
Detoxification	➤ ASAM Medically Managed Intensive Inpatient Withdrawal Management ➤ ASAM Medically Managed Intensive Inpatient Services	41	4	4
Other Service Types ¹⁹	Not specified in detail	21	2	0
Totals		1,102	100%	100

¹⁹ The three categories are Community Support, Outpatient Mental Health, and Residential Treatment Facility.

APPENDIX D: ANNUAL SERVICE DENIAL TRENDS AND NUMBERS

Summary of Trends

Since 2018, the number of denials of service requests requiring prior authorization at CBH has substantially declined, from nearly 15,000 in 2018 to just over 1,000 in 2023. See Table 1 below. This decline is largely attributed to:

- The State’s elimination of prior authorization requirements for inpatient psychiatric hospitalization
- CBH’s removal of prior authorization requirements for residential rehabilitation services
- CBH’s implementation of changes to prior authorization procedures and documentation requirements for IBHS

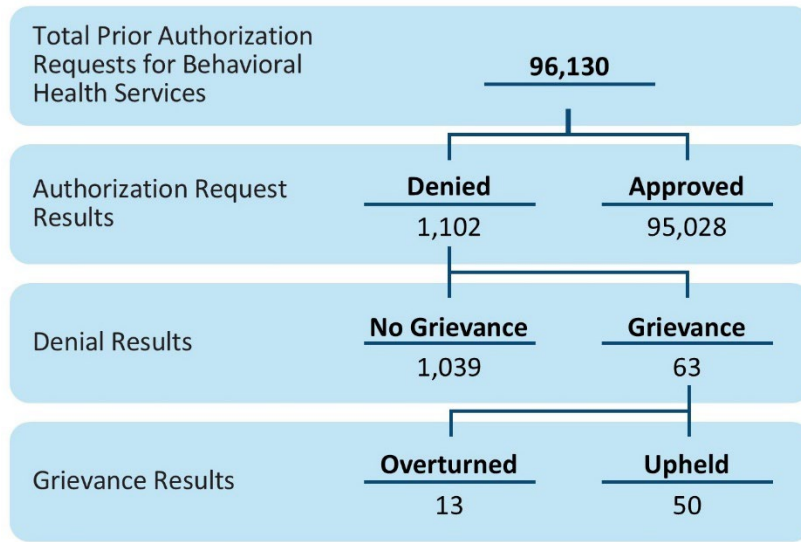
Table 1: Trends in Denials Requiring a Prior Authorization²⁰

Year	Number of Denials
2018	14,934
2019	8,115
2020	1,046
2021	355
2022	951
2023	1,039

For 2023, there were 1,039 denials for which enrollees did not file grievances, as shown in Table 1 above. Enrollees filed grievances for an additional 63 denials. In total, CBH denied 1,102 of 96,130 service requests in 2023. See Figure 2 on the following page for more information about service request denials in 2023, including the results of grievances.

²⁰ The number of denials identified in this table does not include denials for which enrollees filed appeals (grievances); therefore, the number of denials in the report is higher than the number provided in this table.

Figure 2: 2023 Grievance Results



APPENDIX E: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame included 1,102 service request denials for behavioral health services requiring prior authorization, including those denials with grievances. These 1,102 service requests were denied between January 1, 2023, and December 31, 2023.

SAMPLE UNIT

The sample unit was a CBH denied service request that required a prior authorization.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample of 100 CBH denied service requests.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted the sample units by “Service Request Date,” “Denial Unique ID,” and “Member ID.” We then consecutively numbered the items in the sampling frame. After generating the random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the number and percentage of CBH service requests improperly denied in the sampling frame. We generated separate estimates for each of the five reviewed characteristics, as well as an overall estimate. We used the software to calculate the point estimate and the corresponding two-sided 90-percent confidence interval.

APPENDIX F: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details

Requests in Sampling Frame	Sample Size
1,102	100

Table 3: Sample Results²¹

Incorrect Address Used in Denial Notices	Denied Service Request Should Have Been Automatically Approved	Lack of Notification About Access to Records	Unclear Benefit Determinations	Lack of Consultation for Enrollees Under the Age of 21	Denial Had One or More Errors
17	1	100	14	34	100

Table 4: Estimated Number and Percentage of Improperly Denied Service Requests in the Sampling Frame
(Limits Calculated for a 90-Percent Confidence Interval)

	Percentage			Number		
	Point Estimate	Lower Limit	Upper Limit	Point Estimate	Lower Limit	Upper Limit
Incorrect Address Used in Denial Notices	17%	11.4%	24.4%	187	126	265
Denied Service Request Should Have Been Automatically Approved	1	0.10	4.4	11	1	49
Lack of Notification About Access to Records	100	97.1	100	1,102	1,071	1,102
Unclear Benefit Determinations	14	8.8	20.6	154	98	228
Lack of Consultation for Enrollees Under 21	34	26.4	42.1	375	292	465
One or More Errors Overall	100%	97.1%	100%	1,102	1,071	1,102

²¹ Of the 100 sampled service request denials, 58 had more than 1 error.

APPENDIX G: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Availability of Services, 42 CFR § 438.206(c)

(1) *Timely access.* Each MCO must do the following:

- (i) meet and require its network providers to meet State standards for timely access to care and services taking into account the urgency of the need for services.

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

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

Authorization of Services, 42 CFR § 438.210(b)

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

- (2)(i) That the MCO, have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
- (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

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

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

Timeframe for Decisions, 42 CFR § 438.210(d)

- (1) For standard authorization decisions, the MCO must provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following

receipt of the request for service, with a possible extension of up to 14 additional calendar days, if –

- (i) the enrollee, or the provider, requests an extension; or
 - (ii) the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- (2) For expedited authorization decisions,
- (i) For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
 - (ii) The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State Medicaid agency upon request) a need for additional information and how the extension is in the enrollee's interest.
- (3) For all covered outpatient drug authorization decisions, the MCO must provide notice as described in section 1927(d)(5)(A) of the Act.

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

The notice must explain the following:

- (1) The adverse benefit determination the MCO has made or intends to make.
- (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. . .
- (3) The enrollee's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c).
- (4) The procedures for exercising the rights specified in this paragraph (b).

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

Resolution and Notification [Grievances and Appeals], 42 CFR § 438.408(b)(3)

For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO receives the appeal. This timeframe may be extended.

STATE REQUIREMENTS

Medically Necessary, 55 Pa. Code §§ 1101.21, 1101.21a

These sections specify that to be considered medically necessary:

A service, item, procedure, or level of care must be: (1) compensable under the Medical Assistance Program; (2) necessary to the proper treatment or management of an illness, injury, or disability; and (3) prescribed, provided, or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that: (1) will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability; (2) will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (3) will assist the enrollee to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the enrollee and the functional capacities appropriate for recipients of the same age.

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

CBH's HealthChoices Agreement, Appendix AA, Paragraph B.2

Health care providers who have qualified and trained in accordance with the CMS Guidelines, the Request for Proposal, the HealthChoices Agreement, and applicable legal settlements must determine whether a requested service is medically necessary.

Requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the Member's condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or
- that the service or item is not medically necessary, after making a reasonable effort to consult the prescriber.

Additionally, if the Member is under 21 years of age, the reasonable efforts to consult with the prescriber must include a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO. The BH-MCO may request either in writing or by telephone that the prescriber be contacted by the Member, parent, or authorized representative of the Member at the same time the BH-MCO is attempting to consult the prescriber. The BH-MCO's decision on whether to approve or deny the requested service cannot take into account whether the Member, parent, or the authorized representative chose to contact the prescriber. The BH-MCO must document its attempts to reach the prescriber, including its request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO.

CBH's HealthChoices Agreement, Time Frames for Notice of Decisions, Appendix AA, Paragraph C.1

- If the requested information is not received within fourteen (14) days, the BH-MCO must make a decision to approve or deny the service based upon the available information and notify the Member orally within two (2) Business Days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member, and the prescribing Provider within two (2) Business Days after the decision is made.
- In all cases, if the Member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) Days from the date the BH-MCO received the request, the service is automatically approved.

CBH's HealthChoices Agreement, Denial Notice, Appendix AA, Paragraph C.4

When a BH-MCO denies a request for services as defined in Section C.2. of this Appendix a written denial notice must be issued to the Member using the

appropriate denial notice template. The BH-MCO must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the denial notice. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare.

CBH's HealthChoices Agreement, Section II-3.A.1

The BH-MCO must establish mechanisms to inform the CAO of any change or update to the member's residency or eligibility status within 10 days of the date of learning of the change.

CBH's HealthChoices Agreement, Section II-5.I

1. The Primary Contractor and its BH-MCO must develop a written compliance program that is consistent with 42 CFR § 438.608(a) and includes the following:
 - i. Prompt notification to the Department when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence and the death of a member.

Office of Mental Health and Substance Abuse Services (OMHSAS) Systems Notice, OMHSAS-2023-001, CAO Notification Form

The BH-MCO must use the CAO Notification Form to report enrollee changes or updates to the CAO.

APPENDIX H: COMMUNITY BEHAVIORAL HEALTH COMMENTS



March 2, 2026

Via Secured Link

Nicole Freda
Regional Inspector General for Audit Services
U.S. Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region III
801 Market Street, Suite 8500
Philadelphia, PA 19107

Re: CBH Response to OIG Report Number: A-03-24-00204

Dear Inspector General Freda:

Community Behavioral Health (“CBH”) appreciates the opportunity to formally respond to the findings and recommendations outlined in the above-referenced draft report by the Department of Health and Human Services, Office of Inspector General (“OIG”) resulting from an OIG audit of CY 2023 behavioral health services denials by CBH. CBH respects the oversight role of the OIG in advancing accountability and transparency. CBH further takes seriously the responsibility to ensure that the OIG’s report accurately reflects CBH’s operations, compliance efforts, and corrective actions.

Enclosed is CBH’s Official Response to the Office of Inspector General Report (“Official Response”). This document sets forth CBH’s official position on each finding, including areas of agreement, clarification, or disagreement, as appropriate. Where improvements are warranted, CBH has identified specific corrective actions.

CBH remain steadfast in its commitment to operational integrity, regulatory compliance, and continuous organizational improvement. If you have any questions or comments about CBH’s Official Response, please contact me at Donna.Bailey@phila.gov.

Sincerely,

Donna E.M. Bailey
Donna E.M. Bailey (Mar 2, 2025 10:02:54 EST)

Donna E.M. Bailey, MEd, MBA
Chief Executive Officer

Community Behavioral Health
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Phone: 215.413.3100 | Fax: 215.413.3240 | cbhphilly.org
A division of the Department of Behavioral Health and Intellectual disAbility Services



Official Response to the Office of Inspector General Report

OIG Report Title: *Medicaid Managed Care Behavioral Health Service Denials in Philadelphia by Community Behavioral Health*

Report Number: A-03-24-00204

Date of OIG Report: *February 5, 2026*

Date of Organizational Response: *March 2, 2026*

Background.

CBH is a not-for-profit 501(c)(3) corporation contracted by the City of Philadelphia, by and through the Department of Behavioral Health and Intellectual disAbility Services ("DBHIDS"), for the primary purpose of arranging for the delivery of, and paying for, mental health and substance abuse services for eligible Medical Assistance ("MA" or "Medicaid") recipients in Philadelphia.

HealthChoices is the mandatory managed care program for MA beneficiaries in the Commonwealth. For mental health and substance abuse treatment services provided via the HealthChoices program and funded by Medicaid, each county in the Commonwealth contracts with a behavioral health managed care organization ("BH-MCO"). CBH is the contracted BH-MCO for Philadelphia County, the most populous county in the Commonwealth and the 24th-most populous county in the nation.

CBH strives to continuously deliver high-quality, person-centered care to its members, maintain the integrity of its care management and utilization management processes, and ensure operations comply with federal and state requirements.

The following is CBH's official response to the Findings and Recommendations in the OIG's report. CBH anticipates that its response will provide the OIG with greater clarity and context in relation to its audit findings and report and demonstrates CBH's commitment to continuous improvement in ensuring members have timely access to appropriate services.

CBH wishes to provide context to the OIG statements regarding CBH's denials

The Department of Human Services, Office of Inspector General's ("OIG") stated rationale for auditing Community Behavioral Health ("CBH") is because CBH "had the highest number of denied service requests of any BH-MCO in Pennsylvania." However, CBH



would like to add context to this statement as it may be potentially misleading by failing to consider several factors as set forth below.

For Calendar Year (“CY”) 2023, CBH processed **96,130 prior authorization requests**. Of those requests, **1,102 were denied**, resulting in a denial rate of **1.15%**. Stated differently, **98.85% of all prior authorization requests were approved**, and denials occurred in only **1 out of approximately every 87 requests reviewed**. This rate is statistically minimal and does not support any characterization of systemic over-denial or restricted access to care.

The OIG’s assertion that CBH has the “highest number of denials” further fails to account for the overall volume of prior authorization requests processed by CBH in comparison to other behavioral health managed care organizations (“BH-MCOs”). Philadelphia is the most densely populated region in the Commonwealth, and CBH correspondingly processes a substantially higher volume of service requests than other BH-MCOs operating in smaller, less populated regions.

In CY 2023 alone, CBH reviewed **96,130 prior authorization requests**. Any comparison based solely on the raw number of denials—without adjusting for total volume—does not provide a valid or meaningful assessment of utilization management practices. When volume is properly considered, the relevant metric is the denial rate, which for CY 2023 was **1.15%**, reflecting approval of **98.85%** of requests. Raw counts, without denominator context, can create a misleading impression and do not accurately reflect access to care or clinical decision-making practices.

The CY 2023 data demonstrates that prior authorization at CBH functions as an appropriate clinical review safeguard—not as a barrier to medically necessary services. The overwhelming majority of requested services were authorized, reflecting appropriate provider alignment with medical necessity criteria and careful, measured utilization management practices.

Characterizing CBH as having an excessively high denial rate is not supported by the CY 2023 data. On the contrary, the data demonstrates:

- Strong alignment between provider requests and medical necessity criteria.
- Appropriate and restrained use of denial authority; and



- A clear commitment to ensuring member access to clinically appropriate services.

If comparative benchmarks were used to support the “highest denial numbers” assertion, CBH requests that those benchmarks, methodologies, and data sources be disclosed. Without considering additional context regarding BH-MCO mix, service categories reviewed, volume differences, and calculation methodology, such a characterization is incomplete and potentially misleading.

CBH Responses to OIG Findings.

1. CBH did not follow address change notification procedures and sent denial notices to incorrect addresses (17 denied service requests)

Response: CBH concurs with this finding.

Many CBH members are often transient, struggle with homelessness, and use treatment provider locations as their current address. Accordingly, CBH uses the address on file with the County Assistance Office (“CAO”) when contacting a member by mail as the CAO has the responsibility of updating and ensuring current addresses for our members.

In alignment with CBH’s HealthChoices Agreement, CBH has created an agency-wide policy to reconcile discrepancies between addresses of record with the CAO and addresses given to treatment providers, confirm when a change in residency occurs, and promptly notify the CAO of the same. *See Appendix A attached hereto and incorporated herein by reference.* CBH has further created and will maintain a repository of the CAO Notification Forms submitted by CBH to the CAO. CBH will continuously work to ensure that members receive timely and accurate notifications through its reporting procedures for address discrepancies to the CAO.

2. CBH did not provide timely notification that a request was denied (1 denied service request)

Response: CBH concurs that it did not provide timely notification for one (1) denied service request. However, **CBH does not concur with the OIG’s statement that CBH**



does not have a process for identifying service requests that are considered approved because a decision notification was not sent within the 21-day window.

Contrary to the OIG's position that CBH does not have a process for identifying service requests that are considered approved when a decision notification is not sent within the requisite 21-day window, CBH does have a multi-tiered process, as set forth below, of ensuring that members are notified in a timely manner if a request is denied:

- Daily – A CBH Denials Specialist reviews each insufficient and denial letter prior to mailing. If any date is incorrect or if a request needs to be administratively approved, the Denial Specialist will make the correction or flag the letter and follow up with the appropriate team. Prior to the close of business each day, the Denials Specialist emails Intensive Behavioral Health Services ("IBHS") leadership with a list of all pending insufficient and denial letters.
- Monthly – The Denials Specialist runs a report of all denial letters mailed in the previous month. This report includes timeframes from request to decision and from signature to mailing and is shared with CBH Clinical Directors during the first week of each month.
- Quarterly – The monthly timeliness reports are shared in CBH's Clinical Workgroup, which includes all Clinical Directors and Coordinators.

With respect to the denied service request identified in the OIG report, CBH conducted a thorough review of the circumstances surrounding the notification timeframe. Although the issue involved a single request, we treated it as an opportunity to evaluate and tighten existing internal controls.

Upon review, CBH strengthened and formalized several steps within the current process, including reinforcing daily leadership notification of pending insufficient and denial letters, clarifying escalation protocols when regulatory timeframes are approaching, and incorporating more explicit timeliness review into monthly reporting discussions with Clinical leadership.

As a result, our existing oversight structure has been further reinforced to ensure consistent monitoring, shared accountability, and early identification of potential delays.



3. CBH did not inform enrollees of their right to access all relevant documents free of charge (all 100 denied service requests)

Response: CBH does not concur with this finding.

BH-MCOs in Pennsylvania are required to use standardized templates provided by the Commonwealth Medicaid agency. Accordingly, CBH is required to use templates issued by the Pennsylvania Department of Human Services (“DHS”), Office of Mental Health & Substance Abuse Services (“OMHSAS”). The denial notice template is a standardized template issued by OMHSAS and mandated for use by all contracted BH-MCOs. CBH is required to utilize this template as issued and is not permitted to modify, supplement, or alter its content without express direction from the Commonwealth.

State Medicaid agencies are responsible for ensuring denial notice templates strictly adhere to federal notice requirements as set forth in 42 CFR § 438.404. The specific concern identified—regarding the absence of language stating that enrollees may obtain copies of records and documents relevant to the denial at no charge—is attributable to the Commonwealth-issued template itself, not to CBH-developed language.

CBH has previously informed the OIG of this constraint, and DHS is aware that its template does not contain the regulatory required language. It is unreasonable to place on a single managed care organization the responsibility of coordinating with the state Medicaid agency to bring a state-issued standardized template—that is mandated to be used by all BH-MCOs—into alignment with federal regulations.

As a contracted managed care organization for Pennsylvania’s HealthChoices program, CBH must comply with and use Commonwealth-mandated templates and communication formats. Any modification to required notice language must originate from, or be expressly authorized by, the Commonwealth. In sum, CBH does not have discretion to alter the mandated format of the Commonwealth denial notice template.

4. CBH did not issue denial notices that clearly explained the adverse benefit determinations (14 denied service requests)

Response: CBH does not concur with this finding.



For all fourteen (14) denied service requests in the OIG's sample, the originally requested service was denied and CBH therefore used the Commonwealth-issued "denied completely" template to accurately reflect the determination of the prior authorization request reviewed. In the denial notices, CBH included statements recommending alternative services, which did not require prior authorization and were not subject to determination through the prior authorization process.

There is no Commonwealth standardized denial notice template for situations where a requested service is denied and alternative services that are not subject to prior authorization are recommended. The "denied completely" template is the only available notice format that accurately corresponds to the status of the submitted request in all fourteen (14) cases reviewed by the OIG. OMHSAS concurred with CBH's approach to these specific situations. The use of a different denial template where an alternative, non-preauthorized service is recommended would need to be reviewed and mandated by OMHSAS. As aforementioned in CBH's response to Finding #3 (above), CBH, as a contracted managed care organization, is required to use Commonwealth templates and does not have the ability to alter the mandated format of the Commonwealth's denial notice template.

Importantly, CBH members were not denied access to clinically appropriate care and were directed to available clinically appropriate alternative services that did not require prior authorization.

5. CBH did not document the extra steps it took to request that the enrollee's representative contact the provider before CBH denied services for enrollees under 21 (34 denied service requests)

Response: CBH does not concur with this finding regarding pediatric cases.

The OIG suggests that, prior to denying a request for service for lack of medical necessity for a member under 21 years of age, CBH should request in writing or by telephone that an enrollee's representative contact the provider that requested authorization of a service and ask the provider to contact CBH.



CBH's current prior authorization process for pediatric members, as outlined in the below schematic, is clear, consistent, and protective, and is in line with federal and state regulations.



When a request for services for a member under 21 years old lacks sufficient clinical information to determine whether medical necessity is met, CBH is required to provide written notice to **both** the child's parent, guardian, or authorized representative, and to the requesting provider. The notice identifies the specific additional information needed to determine medical necessity and provides fourteen (14) calendar days for submission pursuant to regulatory timelines. The "insufficient information" notice acts as an additional safeguard and is applied to all pediatric members.

CBH sends the "insufficient information" notice using a mandated standardized template—titled "Notice of Request for Additional Information"—supplied by the Department. *See* Appendix B attached hereto and incorporated herein by reference. As with other Commonwealth-mandated templates, the "Notice of Request for Additional Information" template cannot be modified by any MCO. If the OIG recommends that the standardized Commonwealth-issued notice template be revised to specifically include "a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the provider to request that the provider contact the BH-MCO," that modification would need to be reviewed and mandated by OMHSAS.

Of note, OMHSAS is aware that CBH uses the above "insufficient information process" to satisfy the requirement set forth in Appendix AA of the HealthChoices Behavioral Health's Program – Program Standards and Requirements (PS&R).

CBH's current prior authorization process ensures that pediatric members are afforded a meaningful opportunity to supplement the record before any adverse determination is



made. If additional information is received within the 14-day period, it is fully considered. If not, a determination is rendered based on the information available, and, where appropriate, a denial notice is issued.

Requiring a child's representative to serve as an intermediary between the provider and CBH introduces unnecessary procedural complexity and creates a risk of confusion or delay. The prior authorization framework is designed to ensure clear lines of responsibility; placing the burden on families to coordinate provider-to-plan communication is inconsistent with that structure.

CBH's process establishes a clear timeline, direct notification to responsible parties, and an opportunity to cure deficiencies—without creating unnecessary intermediaries or procedural confusion.



APPENDIX A

Community Behavioral Health
801 Market Street, 7th Floor | Philadelphia, PA 19107
Phone: 215-413-3100 | Fax: 215-413-3240 | www.cbhphilly.org
A division of the Department of Behavioral Health and Intellectual disAbility Services

Status **Pending** PolicyStat ID **20009979**



Community Behavioral Health

A DIVISION OF DBHIDS | CBHPHILLY.ORG

Origination N/A

Last N/A

Approved

Effective Upon
Approval

Last Revised N/A

Next Review 1 year after
approval

Owner MaryEllen
Robinson

Area Agency Wide

Prompt Notification of Changes Affecting Member Eligibility to the County Assistance Office, 96-267

POLICY:

This policy outlines the process for ensuring prompt notification to the Pennsylvania Department of Human Services (DHS) and the County Assistance Office (CAO) when Community Behavioral Health (CBH) receives information about changes or updates in a member's circumstances that may impact eligibility. This includes, but is not limited to, changes or updates in a member's contact/residency information and notification of a member's death.

This ensures timely coordination, accurate eligibility status, and helps prevent potential fraud, waste, or abuse.

DEFINITIONS:

GUIDELINES/ PROCEDURE:

Residential Discrepancies

CBH staff will review the address reported by a rendering provider or the member against the address on file in the electronic medical record (MCO). CBH must report any change or update to a member's residency, including in-county, out-of-county, or out-of-state moves, within **10 days of learning of the change**.

When the PA-DHS address differs from what the member or provider reports. CBH staff must:

- A. Inform the member and document the following in the electronic medical record:
 - "PA DHS records do not match the address reported. CBH is required to submit the update to PA-DHS on their behalf."
- B. Complete and submit the CAO Notification Form, indicating the change or update to the Member's residency or eligibility status, **within 10 days of the date of learning of the change**.
 - The CAO Notification Form can be found online at: <https://www.dhs.pa.gov/HealthChoices/HCPProviders/Pages/BH-HealthChoices-Systems-Management.aspx>
- C. Please see departmental protocols for step-by-step guidance pertaining to reporting and tracking the above procedure.

Notice of Member Death

- A. Follow departmental procedure regarding verification and documentation of the death in the electronic medical record.
- B. Complete and submit the CAO Notification form **within 10 days of learning of the death**.
- C. Follow departmental protocol pertaining to tracking submission of the CAO form.

REFERENCES (IF APPLICABLE)

- 42 CFR §438.608(a)(3)
- DHS Policy Part II-5 (I)(1)(j)
- [Program Standards and Requirements](#)

Attachments



OMHSAS_2023_001 CAO Notification Form-Change in Family Status Address Form - Attachment 1.pdf

Approval Signatures

Step Description	Approver	Date
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Prompt Notification of Changes Affecting Member Eligibility to the County Assistance Office, 96-267. Retrieved 03/2026.
Official copy at <http://cbhphilly.policystat.com/policy/20009979/>. Copyright © 2026 Community Behavioral Health (CBH)

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Officer Approval	Andrew Devos	Pending
Director Approval	MaryEllen Robinson: Director, Compliance	02/2026
Work Group Approval	Melissa Pavlow: Interim Legal & Compliance	02/2026
Work Group Approval	Erika Desjardins	02/2026
Policy Owner	MaryEllen Robinson: Director, Compliance	02/2026

COPY

APPENDIX I: STATE AGENCY COMMENTS



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

April 3, 2026

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

Dear Ms. Freda:

The Department of Human Services (DHS) has received the draft report number A-03-24-00204 titled "Community Behavioral Health Did Not Comply With Requirements When Denying Prior Authorization Requests". The objective of this audit was to determine whether Community Behavioral Health (CBH) complied with Federal and State requirements when it denied requested behavioral health services that required a prior authorization.

The first five recommendations in the draft report were for CBH. Our Office of Mental Health and Substance Services has continued to work collectively with CBH to address these recommendations. Onsite reviews and monitoring were previously conducted. Responses to these recommendations were provided to you by CBH under separate cover dated March 2, 2026.

Our response to the recommendation for the State agency is below:

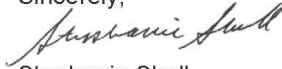
Office of Inspector General (OIG) Recommendation 1: We recommend that the State agency revise the denial notice template in the HealthChoices Agreement to include a statement that the enrollee has the right to be provided, upon request and free of charge, all documents, records, and other information relevant to the adverse benefit determination.

Department of Human Services (DHS) Response: DHS concurs with this recommendation. DHS has implemented the recommendation by making the necessary change to the applicable 2026 HealthChoices Agreements, which should currently be in use by each Behavioral Health-Managed Care Organization.

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Stephanie Shell".

Stephanie Shell
Deputy Secretary for Administration

c: Mr. Charles Hubbs, Office of Inspector General
Mr. David R. Bryan, Bureau of Financial Operations, Audit Resolution Section

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.



TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. [Learn more about complaints OIG investigates.](#)

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Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of [whistleblowing](#) or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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