

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VERMONT DID NOT PROPERLY  
ALLOCATE MILLIONS TO  
ESTABLISHMENT GRANTS FOR A  
HEALTH INSURANCE  
MARKETPLACE**

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Inspector General**

**September 2016  
A-01-15-02500**

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*From January 2012 through September 2014, Vermont did not allocate \$10.5 million in costs to its establishment grants in accordance with Federal requirements, may not have allocated \$13.9 million in costs to its establishment grants in accordance with Federal requirements, and drew down at least \$736,000 in establishment grant funds in excess of program needs.*

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. The ACA provided grants to States for planning, establishing, and early operation of the marketplaces.

The Vermont Health Benefit Exchange (Vermont marketplace) is administered by the Department of Vermont Health Access, part of Vermont’s Agency of Human Services (State agency). The State agency serves as the lead agency for Vermont marketplace establishment grants and is responsible for complying with applicable requirements.

This review is part of an ongoing series of reviews of establishment grants for State marketplaces across the Nation. We selected the individual State marketplaces to cover States in different parts of the country. Our nationwide audit of State marketplace establishment grants is part of a larger body of ACA work, which also includes audits of State marketplaces’ internal controls over determining individuals’ eligibility for enrollment in health insurance plans offered through the marketplaces.

The objectives of this review were to determine whether the State agency followed Federal requirements for (1) allocating costs to its establishment grants for implementing a health insurance marketplace and (2) drawing down establishment grant funds.

### BACKGROUND

Within the Department of Health and Human Services’ (HHS) Centers for Medicare & Medicaid Services (CMS), the Center for Consumer Information and Insurance Oversight (CCIIO) is responsible for implementing many of the requirements of the ACA, including overseeing the implementation of provisions related to the marketplaces and the private health insurance plans offered through the marketplaces, known as qualified health plans (QHPs). Marketplaces perform many functions, including helping States to coordinate eligibility for enrollment in other State-based public health care programs, such as Medicaid and the Children’s Health Insurance Program (CHIP).

CCIIO’s Establishment Grant Funding Opportunity Announcements and the terms and conditions of the State agency’s Notice of Grant Awards require the State agency to allocate shared costs among Medicaid, CHIP, and the marketplace consistent with cost allocation principles at 2 CFR part 225.

Vermont chose to establish and operate its own State marketplace. Because the Vermont marketplace provides eligibility determination and enrollment services for both QHPs and its State-based public health care programs, such as Medicaid, the State agency sought funding from various Federal sources that provided benefits for these programs. Because the Vermont marketplace is a single entity supporting the shared needs of multiple programs, the State agency developed methodologies for allocating costs according to the anticipated use of the marketplace on the basis of the total State population.

As of December 31, 2014, CCIIO awarded the State agency one planning grant and five establishment grants totaling \$199.7 million. We reviewed \$112.4 million that the State agency allocated in establishment grants from January 2012 through September 2014. We limited our review of internal controls to the State agency's systems and procedures for allocating costs and drawing down funds related to establishment grants.

## **WHAT WE FOUND**

The State agency did not always follow Federal requirements for (1) allocating costs to its establishment grants for implementing a health insurance marketplace and (2) drawing down establishment grant funds. Specifically, the State agency:

- allocated \$10.5 million from July 2012 through September 2013 using a cost allocation methodology that included a material defect,
- may not have allocated \$13.9 million in costs from April through September 2014 in accordance with the relative benefits that each grant program received, and
- drew down establishment grant funds that exceeded actual program costs by \$736,330 from January through September 2014.

The State agency improperly allocated \$10.5 million using a cost allocation methodology that included a material defect because it used a population-based methodology that assumed the entire population of Vermont would use the marketplace to enroll in health insurance. The State agency may seek CMS approval to claim a portion of the \$10.5 million through Medicaid at the Federal financial participation rate up to 90 percent.

The State agency may have improperly allocated \$13.9 million to the establishment grants because the Vermont marketplace could not generate accurate, actual enrollment data to ensure that the State agency allocated costs in accordance with the relative benefits that each grant program received.

For both of the allocation issues above, the State agency did not have policies and procedures that explain how to develop a Cost Allocation Plan (CAP) based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis.

The State agency drew down establishment grant funds in excess of program needs because the State agency's grant policies and procedures did not include a requirement to reconcile reported expenditures and drawdowns to cumulative actual spending, and officials said they experienced turnover among the staff involved in the reconciliation process.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- amend its CAP for July 2012 through September 2013 and either refund \$10.5 million to CMS that was allocated to the establishment grants using a methodology that included a material defect or work with CMS to determine the appropriate allocation to the establishment grants;
- use the actual enrollment data for April through September 2014 to determine the appropriate allocation to the establishment grants, work with CMS to determine what portion of \$13.9 million was properly allocated to the establishment grants, and refund any portion that was not properly allocated;
- reduce establishment grant drawdowns after our audit period or refund \$736,330 to CMS that was overdrawn in establishment grants as of September 30, 2014;
- develop policies and procedures that explain how to develop a CAP based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis; and
- ensure that procedures are in place and the updated policies are followed for the reconciliation of reported grant expenditures and drawdowns to cumulative actual spending.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency stated that for the first and second recommendations it would work with CMS to determine the appropriate allocation and action. For the fourth recommendation, the State agency stated that it would enhance its policies and procedures accordingly. For the third and fifth recommendations, the State agency stated that it had returned the funds to CMS and implemented procedures to reconcile draws and Federal reporting to cumulative expenses.

We acknowledge the State agency's efforts to address our recommendations. However, the State agency did not fully address our first recommendation to amend its CAP, which included a material defect. We maintain the validity of our first finding and our recommendation that the State agency amend its CAP for July 2012 through September 2013.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. The ACA provided grants<sup>2</sup> to States for planning, establishing, and early operation of the marketplaces.

The Vermont Health Benefit Exchange (Vermont marketplace) is administered by the Department of Vermont Health Access, part of Vermont’s Agency of Human Services (State agency). The State agency serves as the lead agency for Vermont marketplace establishment grants and is responsible for complying with applicable requirements.

This review is part of an ongoing series of reviews of establishment grants for State marketplaces across the Nation. We selected the individual State marketplaces to cover States in different parts of the country. Our nationwide audit of State marketplace establishment grants is part of a larger body of ACA work, which also includes audits of State marketplaces’ internal controls over determining individuals’ eligibility for enrollment in health insurance plans offered through the marketplaces. See “Affordable Care Act Reviews” on the Office of Inspector General Web site for a list of related reports on marketplace operations.<sup>3</sup>

### OBJECTIVES

Our objectives were to determine whether the State agency followed Federal requirements for (1) allocating costs to its establishment grants<sup>4</sup> for implementing a health insurance marketplace and (2) drawing down establishment grant funds.

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<sup>1</sup> P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as “ACA.”

<sup>2</sup> Under section 1311(a) of the ACA, the Centers for Medicare & Medicaid Services (CMS) provided several different funding opportunities available to States, including Early Innovator Cooperative Agreements, Planning and Establishment Grants, and Establishment Cooperative Agreements. See Appendix A for more detailed information about the types of grants and cooperative agreements available to States related to the establishment of a marketplace.

<sup>3</sup> <http://oig.hhs.gov/reports-and-publications/aca/>.

<sup>4</sup> For the purposes of this report, we reviewed Level One and Level Two Establishment Cooperative Agreements. See Appendix A for more detailed information about the establishment grants.

## **BACKGROUND**

### **Patient Protection and Affordable Care Act**

Within the Department of Health and Human Services' (HHS) CMS, the Center for Consumer Information and Insurance Oversight (CCIIO)<sup>5</sup> is responsible for implementing many of the requirements of the ACA, including overseeing the implementation of provisions related to the marketplaces and the private health insurance plans offered through the marketplaces. These plans are known as qualified health plans (QHPs).

A marketplace performs many functions, such as certifying QHPs; determining eligibility for premium tax credits and cost-sharing reductions; responding to consumer requests for assistance; and providing a Web site and written materials that individuals can use to assess their eligibility, evaluate health insurance coverage options, and enroll in selected QHPs (ACA, §1311(d)(4)). Additionally, marketplaces help States to coordinate eligibility for and enrollment in other State-based public health care programs, such as Medicaid and the Children's Health Insurance Program (CHIP). The ACA further authorizes each State to have a marketplace for individuals and a Small Business Health Options Program (SHOP) marketplace for small businesses to access health coverage for their employees.

### **Federal Requirements Related to Cost Allocation and Enhanced Funding for Marketplaces**

CCIIO's Establishment Grant Funding Opportunity Announcement and the State agency's Notice of Award terms and conditions require the State agency to allocate shared costs among Medicaid, CHIP, and the Vermont marketplace consistent with cost allocation principles.<sup>6</sup> CMS provides additional guidance to States that is specific to cost allocation for the marketplaces in *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0, May 2011) and *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems* (issued in October 2012). CMS guidance says, "States are expected to update their cost allocation methodology and plan based on updated or better data ...."<sup>7</sup>

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<sup>5</sup> To implement and oversee the ACA's marketplace and private health insurance requirements, HHS established the Office of Consumer Information and Insurance Oversight (OCIIO) in April 2010 as part of the HHS Office of the Secretary. In January 2011, OCIIO was transferred to CMS under a new center named CCIIO (76 Fed. Reg. 4703 (Jan. 26, 2011)). In this report, we use "CCIIO" to refer to both OCIIO and CCIIO.

<sup>6</sup> Office of Management and Budget (OMB) Circular No. A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, was relocated to 2 CFR part 225 and made applicable by 45 CFR § 92.22(b). After our audit period, OMB consolidated and streamlined its guidance, which is now in 2 CFR part 200. HHS has codified the guidance in regulations found in 45 CFR part 75.

<sup>7</sup> Toward the end of our audit period, CMS issued additional guidance, which states: "CMS strongly recommends that States continue to reassess their cost allocation on an annual basis and/or if there is a substantive change in program participation ...." A State must provide an updated cost allocation methodology whenever the State seeks additional funding. CMS also advised States to reassess a cost allocation approved on the basis of projections once "actual enrollment and transactional volume data is available" (*FAQs on the Use of 1311 Funds, Project Periods, and updating the cost allocation methodology* (issued Sept. 2014)).

State Medicaid agencies must submit Advance Planning Documents (APDs) to obtain enhanced Federal funding<sup>8</sup> for Medicaid information technology (IT) system projects related to Medicaid eligibility and enrollment, including eligibility and enrollment through a marketplace system (42 CFR § 433.112). In addition, the APD also identifies the allocation percentage between establishment grants and Medicaid.

States must also establish Cost Allocation Plans (CAPs) that identify, measure, and allocate costs to each State-operated program (45 CFR part 95, subpart E). After CMS's approval of the APD, the Division of Cost Allocation (DCA)<sup>9</sup> provides final approval of the allocation methodology percentages for Medicaid and the establishment grants in the CAP. A State must promptly amend its CAP if there are significant changes in program levels or a material defect is discovered in its CAP (45 CFR §§ 95.509(a)(1) and (2)).

### **Health Insurance Marketplace Programs**

The ACA provides for funding assistance<sup>10</sup> to a State for planning and establishment of a marketplace that incorporates eligibility determination and enrollment functions for all consumers of participating programs, such as Medicaid and private health insurance offered through a marketplace (ACA, § 1311).

See Appendix A for details about the Federal assistance available to States to establish marketplaces.

### **The Vermont Marketplace**

Vermont chose to establish and operate its own State marketplace. In May 2011, Vermont passed Act 48, which intended to ensure that all Vermont residents would receive health coverage subject to Federal waiver approval. Because Vermont sought to provide health coverage for all State residents through the marketplace,<sup>11</sup> the State agency developed a methodology for allocating costs according to the anticipated use of the marketplace on the basis of the total State population.

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<sup>8</sup> Enhanced funding refers to 90-percent and 75-percent Federal financial participation (FFP), which is greater than the 50 percent FFP available for most Medicaid administrative expenses.

<sup>9</sup> The State is required to submit a CAP to the Director of DCA in the appropriate HHS Regional Office (45 CFR § 95.507(a)). HHS is designated by OMB as the cognizant Federal agency for reviewing and negotiating public assistance CAPs. DCA is currently known as Cost Allocation Services (CAS), and resides within the HHS Program Support Center.

<sup>10</sup> Projects and programs are carried out under a variety of types of grants, including the use of a specific type of grant known as a cooperative agreement. When a Federal agency expects to be substantially involved in carrying out a project or program, it awards a cooperative agreement (*HHS Grants Policy Statement*, p. ii (January 1, 2007)).

<sup>11</sup> Section 1(a) of Act 48 says that it is the intent of the law to provide “comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage.”

In 2012, the State agency assigned all Vermont residents to projected group populations<sup>12</sup> using the 2010 United States Census for Vermont as the basis for its allocation calculation. The State agency used projected group populations to determine the corresponding budgets and the percentages of costs that should be allocated to the establishment grants and Medicaid from July 2012 through September 2013.

The State agency submitted several APDs to claim enhanced funding for Medicaid costs incurred by the Vermont marketplace, effective July 1, 2012. After CMS approved these APDs, DCA approved the program allocation percentages for the CAP.

In July 2013, CMS requested that the State revise its allocation percentages based only on populations that would use the marketplace for enrollment in health insurance. Effective October 2013, the State agency revised its allocation methodology to use only these populations<sup>13</sup> when calculating the Vermont marketplace allocation percentages for establishment grants and Medicaid by submitting APDs to CMS with a revised enhanced funding for Medicaid. Once CMS approved the APDs, DCA subsequently approved the marketplace program allocations, which became effective October 1, 2013.

The State further revised its allocation methodology effective October 1, 2014, based primarily on actual QHP and Medicaid enrollment data.

As of December 31, 2014, CCHIO awarded the State agency one planning grant and five establishment grants totaling \$199.7 million.<sup>14</sup> Of this amount, the State agency expended \$113.4 million in grant funds from September 2010 through September 2014. The Medicaid program also provided Vermont with FFP to support marketplace eligibility determination and enrollment services for Medicaid beneficiaries.

See Appendix B for details about grants awarded for planning, establishing, and early operation of the Vermont marketplace as of December 31, 2014.

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<sup>12</sup> The State agency assigned Vermont residents to the following group populations: QHP enrollment, uninsured (based on the ACA premise that all individuals will obtain health insurance coverage), small groups (also known as SHOP), Federal employees, military employees, Medicare, large groups (an employer with 50 or more full-time employees or equivalent), and Medicaid.

<sup>13</sup> In its revised calculation, the State agency removed from the allocation methodology the following population groups: Medicare, large groups, Federal employees, and military employees. The revised State agency allocation included the following population groups: Medicaid, QHP enrollees, small groups, and uninsured.

<sup>14</sup> This amount consists of a planning grant totaling \$1 million, as well as four Level One and one Level Two grants, with total award amounts of \$77,777,129 and \$120,941,413, respectively. See Appendix B for detailed information about Level One and Level Two grants.

## HOW WE CONDUCTED THIS REVIEW

We reviewed \$112.4 million that the State agency allocated to the establishment grants for January 2012 through September 2014 (audit period).<sup>15</sup> We limited our review of internal controls to the State agency's systems and procedures for allocating costs and drawing down funds related to establishment grants. We obtained an understanding of how the State agency cost allocation methodologies were developed and recalculated the allocated amounts to establishment grants using only ACA-eligible populations. We verified general ledger accounting data relative to cost allocations, and reconciled reported grant expenditures and grant drawdowns relative to actual costs allocated to the grants.

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 C contains the details of our scope and methodology.

## FINDINGS

The State agency did not always follow Federal requirements for (1) allocating costs to its establishment grants for implementing a health insurance marketplace and (2) drawing down establishment grant funds. Specifically, the State agency:

- allocated \$10.5 million from July 2012 through September 2013 using a cost allocation methodology that included a material defect,
- may not have allocated \$13.9 million in costs from April through September 2014 in accordance with the relative benefits that the grant program received, and
- drew down establishment grant funds that exceeded actual program costs by \$736,330 from January through September 2014.

The State agency improperly allocated \$10.5 million using a cost allocation methodology that included a material defect because it used a population-based methodology that assumed the entire population of Vermont would use the marketplace, including those ineligible under the ACA. The State agency may seek CMS approval to claim a portion of the \$10.5 million through Medicaid at the FFP rate up to 90 percent.

The State agency may have improperly allocated \$13.9 million to the establishment grants because the Vermont marketplace could not generate accurate, actual enrollment data to ensure

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<sup>15</sup> Our audit focused on whether shared costs were correctly allocated to Federal awards. Unlike the establishment grants, costs could be charged directly to the \$1 million planning grant. Therefore, our audit did not cover the planning grant.

that the State agency allocated costs in accordance with the relative benefits that each grant program received.

For both of the allocation issues above, the State agency did not have policies and procedures that explain how to develop a CAP based on relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis.

The State agency drew down establishment grant funds in excess of program needs because the State agency's grant policies and procedures did not include a requirement to reconcile reported expenditures and drawdowns to cumulative actual spending, and officials said they experienced turnover among the staff involved in the reconciliation process.

## **THE STATE AGENCY USED A COST ALLOCATION METHODOLOGY THAT INCLUDED A MATERIAL DEFECT**

### **Federal Requirements**

For a cost to be allowable, it must be allocable to a Federal award (2 CFR part 225, Appendix A, § C.1). A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received (2 CFR part 225, Appendix A, § C.3).

CMS guidance requires prospective adjustments based on updated or better data; however, it is silent on adjusting allocated costs retrospectively when an error was used as the basis for the determination of program cost allocation (CMS's *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0)).

A State agency must amend its CAP if it discovers a material defect in the CAP (45 CFR § 95.509(a)(2)). The effective date of the required modification is retroactive to the date of the original approval (45 CFR § 95.515). If a State agency fails to submit an amended CAP when a material defect is discovered, the costs improperly claimed will be disallowed (45 CFR § 95.519).

On September 28, 2012, the State agency requested that DCA approve its CAP with the statement "Per Approved Health Enterprise [Implementation Advanced Planning Document]" for exchange-related line items requested in its CAP. On December 9, 2014, DCA approved the methodology, effective July 1, 2012, expressly stating that "... approval is based on information provided by the State and is void if the information is later found to be materially incomplete or inaccurate."

### **The State Agency Allocated Costs Using a Methodology That Included a Material Defect**

The State agency allocated \$10.5 million using a cost allocation methodology that included a material defect for July 2012 through September 2013. Specifically, the State agency used a population-based methodology that assumed the entire population of Vermont would use the marketplace to enroll in health insurance.

According to State officials, the State agency allocated costs to the establishment grants and to Medicaid for July 2012 through September 2013 on the basis of Vermont's total 2010 U.S. Census and following the intent of State legislation.<sup>16</sup> The allocation methodology projected the migration of all Vermont residents into defined population groups.<sup>17</sup> The State agency subtracted the Medicaid population from the entire State population to determine the basis for the establishment grant allocation percentage. Therefore, the State agency projected that 74.05 percent of State population would use the Vermont marketplace to enroll in QHPs and 25.95 percent of the population would use the marketplace to enroll in Medicaid.<sup>18</sup> These allocation percentages were identified in the APDs approved by CMS and subsequently approved by DCA, effective July 2012.

In July 2013, CMS requested that the State agency revise its allocation methodology. CMS stated that Vermont's assumption that all residents would use the marketplace to enroll in health insurance, was "inconsistent with the [ACA]'s provisions related to eligible populations, which include Medicaid, CHIP, SHOP, and those who are uninsured and eligible for [financial assistance payments] or who are purchasing a QHP on their own." The State agency amended its cost-allocation methodology to include only population groups that use the marketplace and revised its allocation percentages to 47.01 percent for QHP and 52.99 percent for Medicaid, which CMS approved prospectively beginning October 1, 2013.

In December 2013, the State agency submitted to DCA an amendment to its CAP, which included a request to approve the revised marketplace methodology with a brief notation that CMS had approved the revised methodology. DCA approved the amended CAP, including the marketplace allocation, on a prospective basis, effective October 1, 2013. The State agency did not disclose to DCA that the reason for the change was a defect in the original methodology. That defect was material: the State had assumed that every resident, including populations not eligible under ACA, would use the marketplace to enroll in health insurance. This material defect rendered the original approval void, and, therefore, the required modification should have been retroactive to July 2012, the originally approved effective date.

Using the revised methodology, the State agency should have identified that it allocated \$10.5 million using a cost allocation methodology that included a material defect and retroactively adjusted the costs to its establishment grants for that period.<sup>19</sup> The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at FFP rates up to 90 percent.

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<sup>16</sup> Act 48 provides that the State agency create a health care system to provide affordable, high-quality health care to all Vermont residents subject to Federal approval.

<sup>17</sup> In 2012, the State agency projected that the 2010 Vermont population of 625,741 State residents would migrate into the following defined groups: 58,515 in QHP, 24,872 in uninsured, 24,205 in small groups, 17,173 in Federal employees, 14,100 in military employees, 67,322 in Medicare, 257,193 in large groups, and 162,361 in Medicaid.

<sup>18</sup> The State agency projected that the Medicaid population group would enroll 162,361 individuals and the remaining population groups, totaling 463,380, would use the Vermont marketplace.

<sup>19</sup> The State agency projected that the Medicaid population group would enroll 121,288 individuals and the remaining eligible population groups would total 107,592 (QHP enrollment, 58,515; uninsured, 24,872; and small group, 24,205).

The State agency misallocated these costs because it did not have policies and procedures that explain how to develop a CAP based on relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis. The State agency developed a CAP that allocated costs using the entire State population because the State intended to provide health coverage to all Vermont residents. When preparing its APDs and CAP, the State agency did not adequately describe that it included populations that were not going to receive any benefit under the establishment grant in the calculation of the allocation percentages.

## **THE STATE AGENCY MAY NOT HAVE ALLOCATED COSTS IN ACCORDANCE WITH THE RELATIVE BENEFITS RECEIVED**

### **Federal Requirements**

For a cost to be allowable, it must be allocable to a Federal award (2 CFR part 225, Appendix A, § C.1). A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received (2 CFR part 225, Appendix A, § C.3).

The terms and conditions of the grant award state that States are required to allocate costs for shared services among Medicaid, CHIP, and the marketplaces in accordance with the benefits to each program. CMS guidance states, “States are expected to update their cost allocation methodology and plan based on updated or better data.” (CMS’s *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, issued in October 2012)

Further, the *Guidance for Exchange and Medicaid Information Technology (IT) Systems*, (version 2.0), issued in May 2011, states that States must take into consideration the principles in OMB Circular A-87 when allocating the costs of their IT systems proposals among the marketplaces, Medicaid, and CHIP.

### **The State Agency May Not Have Allocated Costs Among Programs in Accordance With the Relative Benefits Each Received**

We could not determine whether the State agency allocated costs to the establishment grants in accordance with the relative benefits received from April 1, 2014,<sup>20</sup> through September 30, 2014, because the Vermont marketplace had IT system problems that impeded the State agency from using updated or better data based on actual enrollment. Specifically, the State agency did not update its cost allocation methodology because it had a backlog of more than 10,000 applications that officials had to review manually to identify accurate enrollment. The Vermont marketplace was unable to determine the accurate number of individuals enrolled in QHPs because in certain circumstances when an individual updated his or her application, the system counted this activity as a unique enrollment. This meant that some individuals erroneously had multiple QHP applications attributed to them. As a result, the State agency continued to use the approved allocation methodology implemented effective October 1, 2013.

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<sup>20</sup> After open enrollment, the State agency had actual enrollment data available as the basis for allocating program costs.

Using this methodology, the State agency allocated 47.01 percent to establishment grants and 52.99 percent to Medicaid from April through September 2014 and claimed \$13.9 million to the establishment grants. Because the actual enrollment data was inaccurate as of April 2014, we could not determine whether the \$13.9 million in costs that the State agency allocated to the establishment grants accurately reflected the relative benefits received. Our review period ended September 30, 2014. On October 1, 2014, State agency officials amended the cost allocation methodology, which primarily relied on actual enrollment data for January 1 through August 30, 2014. Unlike the State agency's prior allocation methodology that was based on projected group populations, the revised allocation methodology did not include SHOP enrollees in the calculation because the SHOP population was not enrolled through the marketplace as originally planned. Therefore, the State agency's prior allocation methodology that included 24,205 SHOP enrollees in the allocation calculation was flawed. The amended enrollment-based methodology allocated 34.5 percent to establishment grants and 65.5 percent to Medicaid. On the basis of these updated percentages, and the lack of SHOP enrollees, we have reason to believe that the State agency may not have allocated costs in accordance to relative benefits received from April through September 2014. The State agency should use the actual enrollment data to determine the appropriate allocation to the establishment grants and work with CMS to determine what portion of \$13.9 million was properly allocated in accordance with the relative benefits the establishment grant received.<sup>21</sup>

## **THE STATE AGENCY DREW DOWN ESTABLISHMENT GRANT FUNDS EXCEEDING ACTUAL COSTS**

### **Federal Requirements**

Methods and procedures for grant payment must minimize the time between the transfer of funds to the grantee and disbursement of those funds by the grantee (45 CFR § 92.21(b)). Further, grantees and subgrantees must be paid in advance, provided they maintain or demonstrate the willingness and ability to maintain procedures to minimize the time between the transfer of the funds and their disbursement by the grantee (45 CFR § 92.21(c)).

The terms and conditions of the establishment grant awards require the State agency to report grant expenditures to CMS each quarter and perform accurate and timely reconciliations of reported grant expenditures.

### **The State Agency Did Not Perform Accurate and Timely Reconciliations of Reported Grant Expenditures and Drawdowns**

The State agency did not minimize the time between the transfer of funds and their disbursement. The State agency drew down establishment grant funds that exceeded actual expenditures by \$736,330 and maintained the funds from this excessive drawdown in a State account from

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<sup>21</sup> The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at FFP rates up to 90 percent.

January 2014 through September 2014. The State agency also did not adjust its reported spending to CMS and its drawdowns to reflect an actual, cumulative net credit amount.

The reported overstatement of grant costs and excessive drawdown occurred because the State agency did not accurately reconcile the cumulative grant expenditures reported to CMS and the drawdowns with its cumulative actual expenditures.<sup>22</sup> As a result, \$736,330 in overstated expenditures and drawdowns remained unidentified into subsequent quarters from January 2014 through September 2014. The discrepancy between the State agency's reported spending to CMS, the drawdown amounts, and its cumulative actual expenditures occurred because the State agency did not have policies and procedures requiring the reconciliation of reported expenditures to cumulative actual spending. After we told State agency officials about this finding, the State agency updated its policies to require reconciliation of reported grant expenditures to cumulative actual spending. The State agency officials also indicated turnover of staff involved in the reconciliation process was a contributing factor and said that steps had been taken to resolve the staffing issue. We did not test the State agency's implementation of grant expenditure reconciliation procedures or review the steps it had taken to resolve the staffing issue because these occurred beyond the scope of this review.

## RECOMMENDATIONS

We recommend that the State agency:

- amend its CAP for July 2012 through September 2013 and either refund \$10.5 million to CMS that was allocated to the establishment grants using a methodology that included a material defect or work with CMS to determine the appropriate allocation to the establishment grants;
- use the actual enrollment data for April through September 2014 to determine the appropriate allocation to the establishment grants, work with CMS to determine what portion of \$13.9 million was properly allocated to the establishment grants, and refund any portion that was not properly allocated;
- reduce establishment grant drawdowns after our audit period or refund \$736,330 to CMS that was overdrawn in establishment grants as of September 30, 2014;
- develop policies and procedures that explain how to develop a CAP based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis; and

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<sup>22</sup> State agency staff attempted to reconcile grant expenditures on a quarterly basis but did not reconcile expenditures to its cumulative actual costs. Therefore, staff did not identify and correct errors from past quarters.

- ensure that procedures are in place and the updated policies are followed for the reconciliation of reported grant expenditures and drawdowns to cumulative actual spending.

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency stated that it received approval of its CAP and advanced planning document and that “Federal grant monies for the expenses of funding the Vermont Health Benefits Exchange were allocated according to the approved plan.” The State agency further stated that CMS recommended a change to its methodology and the State agency “comported with their request prospectively.” The State agency agreed that some costs “may have been misallocated” and that it would “work with CMS to determine the appropriate allocation to the establishment grant.”

For the second recommendation, the State agency stated that it would work with CMS to determine the appropriate action. For the fourth recommendation, the State agency stated that it would enhance its policies and procedures accordingly. For the third and fifth recommendations, the State agency stated that it had returned the funds to CMS and implemented procedures to reconcile draws and Federal reporting to cumulative expenses.

The State agency’s comments are included in their entirety as Appendix D.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We acknowledge the State agency’s efforts to address our recommendations. However, the State agency did not fully address our first recommendation to amend its CAP, which included a material defect. We maintain the validity of this finding and our recommendation that the State agency amend its CAP for July 2012 through September 2013. Although DCA approved the State agency’s CAP, the State agency’s plans included a material defect that was not adequately disclosed. DCA stated that its approval of the CAP would be void if the information provided by the State agency was found to be materially incomplete or inaccurate. Because the material defect rendered the original approval void, the State agency must amend its CAP retroactively to July 2012.

## **APPENDIX A: FEDERAL GRANTS TO STATES FOR PLANNING, ESTABLISHING, AND EARLY OPERATION OF MARKETPLACES**

CCIIO used a phased approach to provide States with resources for planning and implementing marketplaces. CCIIO awarded States and one consortium of States planning and establishment grants, including early innovator cooperative agreements and two types of marketplace establishment cooperative agreements.

### **PLANNING AND ESTABLISHMENT GRANTS**

CCIIO awarded planning and establishment grants<sup>23</sup> to assist States with initial planning related to the potential implementation of the marketplaces. States could use these funds in a variety of ways, including to assess current information technology systems; to determine the statutory and administrative changes needed to build marketplaces; and to coordinate streamlined eligibility and enrollment systems across State health programs, including Medicaid and CHIP. In September 2010, CCIIO awarded grants in amounts up to a maximum of \$1 million per State to 49 States and the District of Columbia. (Alaska did not apply for a planning and establishment grant.)

### **EARLY INNOVATOR COOPERATIVE AGREEMENTS**

CCIIO awarded early innovator cooperative agreements<sup>24</sup> to States to provide them with incentives to design and implement the IT infrastructure needed to operate marketplaces. These cooperative agreements rewarded States that demonstrated leadership in developing cutting-edge and cost-effective consumer-based technologies and models for insurance eligibility and enrollment for marketplaces. The “early innovator” States received funding to develop IT models, “... building universally essential components that can be adopted and tailored by other States.” In February 2011, CCIIO awarded 2-year early innovator cooperative agreements to six States and one consortium of States. Awards ranged from \$6.2 million (Maryland) to \$59.9 million (Oregon).

### **MARKETPLACE ESTABLISHMENT COOPERATIVE AGREEMENTS**

CCIIO designed establishment cooperative agreements<sup>25</sup> to support States’ progress toward establishing a marketplace. Establishment cooperative agreements awarded through December 31, 2014, were available for States seeking (1) to establish a State-based marketplace,

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<sup>23</sup> CCIIO, *State Planning and Establishment Grants for the Affordable Care Act’s Exchanges*, Funding Opportunity Number: IE-HBE-10-001, July 29, 2010.

<sup>24</sup> CCIIO, *Cooperative Agreements to Support Innovative Exchange Information Technology Systems*, Funding Opportunity Number: IE-HBE-11-001, October 29, 2010. In February 2011, CMS announced that it had awarded seven early innovator cooperative agreements. The cooperative agreements totaled \$249 million.

<sup>25</sup> CCIIO, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, Funding Opportunity Number: IE-HBE-11-004, November 29, 2011, and *Cooperative Agreement to Support Establishment of the Affordable Care Act’s Health Insurance Exchange*, Funding Opportunity Number: IE-HBE-12-001, December 6, 2013.

(2) to build functions that a State elects to operate under a State partnership marketplace, and (3) to support State activities to build interfaces with the federally facilitated marketplace. Cooperative agreement funds were available for approved and permissible establishment activities and could include startup year expenses to allow outreach, testing, and necessary improvements during the startup year. In addition, a State that did not have a fully approved State-based marketplace on January 1, 2013, could have continued to qualify for and receive establishment cooperative agreement awards in connection with its activities related to establishment of the federally facilitated marketplace or partnership marketplace, subject to certain eligibility criteria. States were eligible for multiple establishment cooperative agreements.

There were two categories of establishment cooperative agreements: Level One and Level Two. Level One establishment cooperative agreements were open to all States, whether they were (1) participating in the federally facilitated marketplace (including States collaborating with the federally facilitated marketplace through the State partnership model) or (2) developing a State-based marketplace. All States could have applied for Level One establishment cooperative agreements, including those that previously received exchange planning and establishment grants. Level One award funds were available for up to 1 year after the date of the award.

Level Two establishment cooperative agreements were available to States, including those that previously received exchange planning and establishment grants. Level Two establishment cooperative agreement awards provided funding for up to 3 years after the dates of award. These awards were available to States that could demonstrate that they had (1) the necessary legal authority to establish and operate a marketplace that complies with Federal requirements available at the time of the application, (2) established a governance structure for the marketplace, and (3) submitted an initial plan discussing long-term operational costs of the marketplace.

States could have initially applied for either a Level One or a Level Two establishment cooperative agreement. Those that had received Level One establishment cooperative agreements could have applied for another Level One establishment cooperative agreement by a subsequent application deadline. Level One establishment grantees also could have applied for a Level Two establishment cooperative agreement provided the State had made sufficient progress in the initial Level One establishment project period and was able to satisfy the eligibility criteria for a Level Two establishment cooperative agreement.

In determining award amounts, CCIIO looked for efficiencies and considered whether the proposed budget would be sufficient, reasonable, and cost effective to support the activities proposed in the State's application. According to the Funding Opportunity Announcement, the cooperative agreements funded only costs for establishment activities that were integral to marketplace operations and meeting marketplace requirements, including those defined in existing and future guidance and regulations issued by HHS. A marketplace must use ACA, § 1311(a), funds consistent with ACA requirements and related guidance from CCIIO. States must ensure that their marketplaces were self-sustaining beginning on January 1, 2015 (ACA, § 1311(d)(5)(A)).

**APPENDIX B: FEDERAL GRANTS AWARDED FOR PLANNING, ESTABLISHING,  
AND EARLY OPERATION OF THE VERMONT MARKETPLACE AS OF  
DECEMBER 31, 2014**

The following table summarizes the grants awarded by CCIIO to support planning, establishing, and early operation of the Vermont marketplace and expenditures allocated to these grants.

<b>Grant Number</b>	<b>Award Period<sup>26</sup></b>	<b>Award Type</b>	<b>Award Total</b>	<b>Marketplace Expenditures<sup>27</sup></b>
HBEIE100009	September 29, 2010– September 29, 2011	Planning	\$1,000,000	\$1,000,000
HBEIE120080/ HBEIE120095	November 29, 2011– August 27, 2013	Level One	\$22,607,369	\$22,607,368
HBEIE120130	August 23, 2012– December 31, 2015	Level Two	\$120,941,413	\$71,080,084
HBEIE130147	January 16, 2013– December 31, 2015	Level One	\$2,662,737	\$1,552,653
HBEIE130168	July 9, 2013– December 31, 2015	Level One	\$48,428,223	\$17,123,155
HBEIE150216	December 22, 2014– December 21, 2015	Level One	\$4,078,800	--
<b>Total</b>			<b>\$199,718,542</b>	<b>\$113,363,260</b>

<sup>26</sup> The award period for each grant number may include no-cost extensions.

<sup>27</sup> Expenditures through September 30, 2014. The marketplace expenditures consist of establishment grants of \$112,363,260 and a planning grant of \$1,000,000.

## APPENDIX C: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed \$112.4 million that the State agency allocated to the establishment grants from January 2012 through September 2014. We limited our review of internal controls to the State agency's systems and procedures for allocating costs to the establishment grants and to Medicaid.

We conducted our fieldwork at the State agency's offices in Winooski and Williston, Vermont, from December 2014 through October 2015.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's establishment grant application packages;
- reviewed CCIIO's Funding Opportunity Announcements and Notice of Grant Awards terms and conditions;
- reviewed CMS's approvals of the APDs and DCA's approval of the CAPs;
- reviewed the State agency's policies and procedures for financial management;
- interviewed State agency officials to gain an understanding of the State's accounting system and internal controls;
- reviewed reports issued by the contractor and the State that projected group populations and interviewed State officials to understand how they developed projections of enrollment in various health care coverage programs mandated by the ACA;
- interviewed State agency officials to gain an understanding of the Vermont marketplace public reporting of individuals determined eligible for and enrolled in QHPs, Medicaid, or CHIP;
- obtained enrollment figures for QHPs, Medicaid, and CHIP through the Vermont marketplace;
- obtained expenditure general ledger reports for January 2012 through September 2014;
- performed tests, such as comparing system reports and expenditures to Federal financial reports, to determine whether the detailed general ledger reports were reliable and complete;

- analyzed the general ledger reports to obtain an understanding of the information that the State agency used to claim expenditures for Federal reimbursement;
- recalculated the amounts allocated to the establishment grants using only ACA-eligible populations; and
- discussed the results of our review with the State agency.

We conducted this performance audit in accordance with generally accepted government accounting 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.



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*Agency of Human Services*

July 27, 2016

Mr. David Lamir  
Regional Inspector General  
Office of Audit Services, Region I  
15 New Sudbury Street, Room 2425  
Boston, MA 02203

**RE: RESPONSE TO REPORT NUMBER A-01-15-02500**

Dear Mr. Lamir:

Thank you for the opportunity to respond to the draft report on the cost allocation of establishment grants for implementing Vermont Health Connect and draw down of establishment grant funds (A-01-15-02500). Please find our responses enclosed.

In accordance with the instructions of the letter we will provide responses in both letter and electronic format.

Respectfully,

A handwritten signature in blue ink that reads "Steven M. Costantino". The signature is written in a cursive style.

Steven M. Costantino  
Commissioner



## Findings & Recommendations Response

1. The State agency improperly allocated \$10.5 million from July 2012 through September 2013 using a cost allocation methodology that included a material defect because it used a population-based methodology that assumed the entire population of Vermont would use the marketplace, including those ineligible under ACA to enroll in health insurance. The State agency may seek CMS approval to claim a portion of the \$10.5 million through Medicaid at the Federal financial participation rate up to 90 percent.

**OIG Recommendation:** Amend the CAP for the period July 2012 through September 2013 and either refund \$10.5 million to CMS that was allocated to the establishment grants using a methodology that included a material defect or work with CMS to determine the appropriate allocation to the establishment grants.

**State Agency Response:**

*Vermont sought and received approval of the Cost Allocation Plan and the Advanced Planning document. Federal grant monies for the expenses of funding the Vermont Health Benefits Exchange were allocated according to the approved Plan. CMS recommended a change to our methodology, and we comported with their request prospectively. We agree that some cost may have been misallocated and will work with CMS to determine the appropriate allocation to the establishment grant.*

2. The State agency may have improperly allocated \$13.9 million in costs from April through September 2014 to the establishment grants because the Vermont marketplace could not generate accurate, actual enrollment data to ensure that the State agency allocated costs in accordance with the relative benefits that each grant program received.

**OIG Recommendation:** Use the actual enrollment data for the period April through September 2014 to determine the appropriate allocation to the establishment grants, work with CMS to determine what portion of \$13.9 million was properly allocated to the establishment grants, and refund any portion that was not properly allocated.

**State Agency Response:**

*We will work with CMS to take the appropriate action.*

3. For both of the allocation issues above, the State agency did not have policies and procedures that explain how to develop a Cost Allocation Plan (CAP) based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis.

**OIG Recommendation:** Develop policies and procedures that explain how to develop a CAP based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis.

**State Agency Response:**

*Policies and procedures will be enhanced accordingly.*

4. The State agency drew down establishment grant funds in excess of program needs (exceeded actual program costs by \$736,330 from January through September 2014) because the State agency's grant policies and procedures did not include a requirement to reconcile reported expenditures and drawdowns to cumulative actual spending, and officials said they experienced turnover among the staff involved in the reconciliation process.

**OIG Recommendation:**

Reduce establishment grant drawdowns after our audit period or refund \$736,330 to CMS that was overdrawn in establishment grants as of September 30, 2014. Ensure that procedures are in place and the updated policies are followed for the reconciliation of reported grant expenditures and drawdowns to cumulative actual spending.

**State Agency Response:**

*These funds were returned to CMS on 9/15/15. The overdrawn amount was reported on the 6/30/2015 CMIA Annual Interest Report. The State's interest liability for this overdraw of \$499 was paid to the U.S. Treasury, as part of our annual interest exchange on March 31, 2016.*

*Procedures to reconcile draws and federal reporting to the cumulative expenses were implemented beginning with the 9/30/15 quarterly reports.*

