

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**KENTUCKY MISALLOCATED MILLIONS  
TO ESTABLISHMENT GRANTS FOR A  
HEALTH INSURANCE MARKETPLACE**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Kentucky did not allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements. Specifically, it may not have allocated \$23.6 million in costs in accordance with relative benefits, and it misallocated \$25.5 million in costs by not using updated, better data.*

### 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 the planning, establishment, and early operation of marketplaces.

The Office of the Kentucky Health Benefit Exchange (Kentucky marketplace) is administered by the Cabinet for Health and Family Services (State agency). The State agency serves as the lead agency for Kentucky marketplace establishment grants and is responsible for complying with applicable requirements.

This review is part of a 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 objective was to determine whether the State agency allocated costs to its establishment grants for establishing a health insurance marketplace in accordance with Federal requirements.

### BACKGROUND

Within the Department of Health and Human Services’ 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 Announcement and the Kentucky marketplace’s Notice of Grant Awards terms and conditions require the Kentucky marketplace to allocate shared costs among Medicaid, CHIP, and the marketplace consistent with cost principles at 2 CFR part 225.

Kentucky chose to establish and operate its own State marketplace. Because the Kentucky marketplace provided eligibility determinations 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 to these programs. Because the Kentucky

marketplace was a single entity supporting the shared functional needs of multiple programs, it developed a cost methodology according to anticipated enrollment in CHIP and Medicaid.

Kentucky transitioned to HealthCare.gov, a health insurance exchange Web site operated by the Federal Government under the provisions of the ACA, for the 2017 open enrollment period that began in the fall of 2016. Kentucky residents currently use HealthCare.gov as the marketplace's enrollment platform.

As of December 31, 2014, CCIIO awarded the State agency one planning and four establishment grants totaling about \$288.8 million. Of this amount, the State agency expended about \$182.4 million in establishment grant funds from November 2010 through December 2014. We reviewed about \$59.1 million that the Kentucky marketplace allocated to the establishment grants from October 2013 through December 2014. We limited our review of internal controls to the State agency's systems and procedures for claiming costs to establishment grants and to Medicaid.

## **WHAT WE FOUND**

The State agency did not allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements. Specifically, the State agency:

- used a flawed methodology to allocate \$23.6 million in costs from October 1, 2013, through April 15, 2014, and
- misallocated \$25.5 million in costs from April 16 through December 31, 2014, because it continued using a flawed methodology and did not update its cost-allocation methodology using updated, better data.

The State agency misallocated these costs because it used a cost-allocation methodology that did not allocate costs to particular cost objectives relative to the benefits received. In addition, the State agency did not have a written policy that explained the necessity to use updated, better data when available. Contrary to Federal requirements, the State agency, with CMS's permission, continued to use a flawed allocation methodology even after CMS informed the State agency of the significant difference between the estimated enrollment projections and the actual enrollment activity.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- work with CMS to determine what portion of \$23.6 million was properly allocated in accordance with the relative benefits the establishment grants received from October 1, 2013, through April 15, 2014;

- refund \$25.5 million to CMS that was misallocated to the establishment grants by not using updated, better data, or work with CMS to resolve the amount misallocated to the establishment grants, from April 16 through December 31, 2014;
- work with CMS to ensure that the \$123.3 million that was allocated to the establishment grants on the basis of a flawed cost-allocation methodology from November 2010 through September 2013 was allocated correctly and refund any unallowable amount;
- work with CMS to ensure that costs claimed after our audit period were allocated correctly using updated, better data, and refund any unallowable amount; and
- issue a written policy that explains how to develop and perform cost allocations on the basis of relative benefits received and to reassess and revise allocations when necessary.

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

In written comments on our draft report, the State agency did not fully concur with our first four recommendations. The State agency concurred with our fifth recommendation and said that it would issue a marketplace-specific written policy that explains how to develop, reassess, and revise its cost allocations. The State agency said that it would work with CMS to ensure that funds are properly allocated. However, the State agency explained why it did not fully concur with our first four recommendations:

- The State agency said that it had developed its cost allocations in accordance with CMS guidance and that it consistently received approval from CMS to use the original cost-allocation methodology for all developmental activities.
- The State agency did not concur with the recommendation to refund \$25.5 million to CMS because it had received approval from CMS for Federal funding through April 30, 2015, the end of the second enrollment period. Because of the ACA's requirements that States be fully operational after the second open enrollment period, the State agency did not begin using an operational cost-allocation methodology until May 1, 2015. In addition, the State agency said that its communication with CMS, which we referenced in our report, was about the operational cost-allocation methodology that was being developed for the future, not the development cost-allocation methodology that was being used.
- The State agency did not concur that the grant allocation of \$123.3 million, which was allocated to the establishment grants from November 2010 through September 2013, was based on an inappropriately applied methodology.
- For costs claimed after our audit period, the State agency said that it understands cost allocations continued to be made in accordance with CMS guidance and approved methodology.

After considering the State agency’s comments on our draft report, we maintain that all of our findings and recommendations are valid. Specifically, CMS guidance explains that “States are expected to update their cost-allocation methodology and plan based on updated or better data ...” and when “there is a substantive change in program participation.” At the end of the enrollment period on April 15, 2014, actual enrollment numbers demonstrated a substantive change in program enrollment because the updated data were significantly different from the enrollment percentages that the State agency initially estimated. Specifically, the State agency allocated 75 percent to the establishment grants, but the actual QHP enrollment percentage was 22 percent. In addition, the State agency allocated 23 percent to Medicaid, but the actual Medicaid enrollment percentage was 76 percent at the end of the first open enrollment period.

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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 the planning, establishment, and early operation of marketplaces.

The Office of the Kentucky Health Benefit Exchange (Kentucky marketplace) was administered by the Cabinet for Health and Family Services (State agency). The State agency served as the lead agency for Kentucky marketplace establishment grants and was responsible for complying with applicable requirements.

This review is part of a 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. See “Affordable Care Act Reviews” on the Office of Inspector General (OIG) Web site for a list of related OIG reports on marketplace operations.<sup>3</sup>

### OBJECTIVE

Our objective was to determine whether the State agency allocated costs to its establishment grants<sup>4</sup> for establishing a health insurance marketplace in accordance with Federal requirements.

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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> Available online at <https://oig.hhs.gov/reports-and-publications/aca/>.

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

## **BACKGROUND**

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

Within the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), the Center for Consumer Information and Insurance Oversight (CCIIO)<sup>5</sup> is responsible for implementing many of the requirements of ACA, including overseeing the implementation of provisions related to the marketplaces and the private health insurance plans offered on the marketplaces 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).

### **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 Grant Awards terms and conditions require the State agency to allocate shared costs among Medicaid, CHIP, and the Kentucky 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 Oct. 2012). CMS guidance says "States are expected to update their cost-allocation methodology and plan based on updated or better data..."<sup>7</sup>

State Medicaid agencies must submit Advance Planning Documents (APD) to obtain enhanced Federal funding for Medicaid information technology (IT) system projects related to Medicaid

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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 (OCIO) in April 2010 as part of the HHS Office of the Secretary. In January 2011, OCIO 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 OCIO and CCIIO.

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

<sup>7</sup> Toward the end of our audit period, CMS issued further 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..." or whenever a State seeks additional funding. *FAQ on the Use of 1311 Funds, Project Periods, and updating the cost-allocation methodology* (issued Sept. 2014).

eligibility and enrollment, including eligibility and enrollment through a marketplace system (42 CFR § 433.112).

## **Health Insurance Marketplace Programs**

The ACA provided funding assistance<sup>8</sup> to a State for planning and establishing 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 Kentucky Marketplace**

Kentucky chose to establish and operate its own State marketplace.<sup>9</sup> Because the Kentucky marketplace provided eligibility determinations and enrollment services for both QHPs and its State-based public health care programs, such as Medicaid, the Kentucky marketplace sought funding from various Federal sources that provided benefits to these programs. Additionally, because the Kentucky marketplace was a single entity supporting the shared functional needs of multiple programs, it developed a methodology for allocating costs according to the anticipated use of the marketplace on the basis of the total State population.

The basis of its methodology was the sum of its existing number of Medicaid enrollees plus the projected number of Medicaid and CHIP-eligible individuals who would enroll through the Medicaid expansion, divided by the State's population. This cost-allocation methodology yielded a percentage of 25 for Medicaid and CHIP combined and 75 percent for the establishment grants.

Kentucky submitted an APD to claim enhanced Medicaid funding for costs incurred by the Kentucky marketplace and allocated to Medicaid using the above methodology. CMS approved the Kentucky marketplace's cost-allocation methodology effective February 22, 2012.

As of December 31, 2014, CCIIO had awarded the State agency one planning grant and four establishment grants totaling about \$288.8 million.<sup>10</sup> Of this amount, the State agency expended about \$182.4 million from November 2010 through December 2014. The Medicaid program

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<sup>8</sup> Projects and programs are carried out under various 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 the project or program, it awards a cooperative agreement (*HHS Grants Policy Statement, p. ii*).

<sup>9</sup> Kentucky transitioned to HealthCare.gov, a health insurance exchange Web site operated by the Federal Government under the provisions of ACA, for the 2017 open enrollment period that began in the fall of 2016. Kentucky residents currently use [HealthCare.gov](http://HealthCare.gov) as the marketplace's enrollment platform.

<sup>10</sup> This amount consisted of planning and establishment grants totaling \$469,088 and Level One and Level Two exchange establishment grants, with total award amounts of \$69,990,613 and \$218,312,913, respectively. See Appendix B for detailed information about Level One and Level Two grants.

also provided Kentucky with Federal financial participation (FFP) to support marketplace eligibility determination and enrollment services for Medicaid beneficiaries.

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

## **HOW WE CONDUCTED THIS REVIEW**

We reviewed \$59.1 million that the State agency allocated to the establishment grants from October 2013 through December 2014 (audit period). We limited our review of internal controls to the State agency's systems and procedures for allocating costs to establishment grants, Medicaid, and CHIP. We obtained an understanding of how the State agency developed the Kentucky marketplace's cost-allocation methodology. We used updated, better data for the Kentucky marketplace to calculate the amounts that should have been allocated to the establishment grants and assessed the impact of allocating costs using estimated versus updated, better data.

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 allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements. Specifically, the State agency:

- used a flawed methodology to allocate \$23.6 million in costs from October 1, 2013, through April 15, 2014, and
- misallocated \$25.5 million in costs from April 16 through December 31, 2014, because it continued using a flawed methodology and did not update its cost-allocation methodology using updated, better data.

The State agency used a flawed cost-allocation methodology that did not allocate costs to particular cost objectives relative to the benefits received. In addition, the State agency did not have a written policy that explained the necessity to use updated, better data when available. Contrary to Federal requirements, the State agency, with CMS's permission, continued to use a flawed allocation methodology even after it informed the State agency of the significant difference between the estimated enrollment projections and the actual enrollment activity.

## **THE STATE AGENCY USED A FLAWED METHODOLOGY TO ALLOCATE COSTS**

### **Federal Requirements**

States must comply with the applicable cost principles for State Governments in 2 CFR part 225 as made applicable by 45 CFR § 92.22(b). The cost principles specify that for a cost to be allowable, it must be allocable, among other requirements (2 CFR part 225, App. A, § C.1). Specifically, 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, App. A, § C.3).

CMS guidance requires that costs be allocated among Medicaid, CHIP, and the marketplace for services or functions that include the Health Care Coverage Portal, Business Rules Management and Operations System (including eligibility determination), interfaces for the Federal Data Services Hub, and customer service support (CMS's *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0), page 6).

Finally, the terms and conditions of the grant award require the State agency to allocate costs for shared services among Medicaid, CHIP, and the marketplace by the benefitting program.

### **The State Agency Used a Flawed Methodology To Allocate Costs**

The State agency did not allocate costs in accordance with the relative benefits received by each program from October 1, 2013, through April 15, 2014, because it used the entire State's population in determining its cost-allocation methodology. The State agency based its cost-allocation methodology on the rationale that there would be a reduction in Kentucky's spending on uncompensated care that would benefit the entire population of the State. The State agency presented this methodology and communicated this rationale to CMS, and CMS approved the cost-allocation methodology.

Federal requirements do not require States to adopt a specific methodology to allocate their costs. However, in accordance with the terms and conditions of the grant award and applicable cost principles, Kentucky should have used a methodology that allocated costs to cost objectives relative to the benefits received. Marketplace costs were allocated among three cost objectives: the establishment grants (i.e., QHP enrollees), Medicaid, and CHIP. These three programs benefited from the marketplace because individuals could determine their eligibility for the programs through the marketplace. However, only the portion of the population—those associated with each of those three cost objectives—should have been used to determine the allocation percentages.

Instead, the State agency used the entire State population when calculating the allocation percentages. Specifically, using the State's methodology, the percent allocated to Medicaid and CHIP was the ratio of the existing and estimated Medicaid and CHIP population to the total population (25 percent), and the percent allocated to the establishment grant was the remainder of the population (75 percent). The 75 percent included groups of citizens who would not typically use the marketplace at all. For example, certain population groups—Federal

employees, military employees, Medicare beneficiaries, or large groups (an employer with 50 or more full-time employees or equivalent)—should not have been expected to use and, thus, would not have benefitted from the Kentucky marketplace. Kentucky should not have used a methodology that included the entire population because the cost objective (the establishment grants) would not incur costs for these population groups. Because the methodology did include the entire population, the percentage of costs allocated to the establishment grants was too high.

As a result of the flawed methodology for cost allocation, the State agency may not have allocated costs totaling \$23.6 million to the establishment grants in accordance with the relative benefits received by the program because it used the entire State’s population in determining the cost-allocation percentages. The State agency may seek CMS approval to claim a portion of the \$23.6 million through Medicaid at FFP rates ranging from 50 to 90 percent.

### **THE STATE AGENCY CONTINUED USING A FLAWED METHODOLOGY AND DID NOT UPDATE ITS COST-ALLOCATION METHODOLOGY USING UPDATED, BETTER DATA**

#### **Federal Requirements**

A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objectives in accordance with relative benefits received (2 CFR part 225, App. A, § C.3).

According to CMS guidance published in May 2011, “If development is in progress, states must recalculate and adjust cost allocation on a prospective basis. [CMS] will work with states to ensure proper adjustments on an expedited basis and encourage states to consult with [CMS] early as [the States] identify such circumstances” (CMS’s *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0), page 7).

In addition, “States are expected to update their cost-allocation methodology and plan based on updated or better data.... CMS expects States to adjust cost allocation plans based on changing realities” (CMS’s *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, “Questions and Answers,” Oct. 5, 2012, pages 3 and 4, questions 6 and 9).

#### **The State Agency Continued Using a Flawed Methodology and Did Not Recalculate and Adjust Its Allocation Percentages Prospectively**

The State agency continued using a flawed methodology from April 16 through December 31, 2014, and did not recalculate and adjust its allocation percentages prospectively by using the updated, better data that were available on April 15, 2014. The updated data were significantly different from the enrollment percentages that the State agency initially estimated. For example, the State agency allocated 75 percent to the establishment grants, but the actual QHP enrollment percentage was 22 percent. In addition, the State agency allocated 23 percent to Medicaid, but the actual Medicaid enrollment was 76 percent.

The State agency provided the Kentucky marketplace's actual enrollment percentages<sup>11</sup> as of April 15, 2014. The actual percentages were 76 percent in Medicaid, 22 percent in QHPs, and 2 percent in CHIP.

Despite the availability of updated, better data, the State agency did not recalculate and adjust its allocation percentages prospectively by using the April 15, 2014, actual enrollment data that it provided to CMS. The State agency did not update its cost-allocation methodology as required by CMS guidance, even though significant changes in program levels had occurred. Consequently, the costs allocated to Medicaid and the establishment grants did not correspond to the relative benefits received (as required by 2 CFR § 225). The State agency misallocated \$25.5 million to the establishment grants. The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at FFP rates ranging from 50 to 90 percent.

## **CAUSES OF FLAWED METHODOLOGY AND NOT UPDATING THE COST-ALLOCATION METHODOLOGY USING UPDATED, BETTER DATA**

### **CMS Allowed the State Agency To Use a Flawed Methodology**

CMS approved the State agency's population-based cost-allocation methodology even though the approval was not consistent with Federal requirements.

In addition, contrary to 2 CFR part 225, App. A, § C.3 and CMS's *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0), page 7, the State agency, with CMS's permission, continued to use its original allocation percentages to allocate costs, even after the State agency had provided the actual enrollment numbers and statistics. Specifically:<sup>12</sup>

- In September 2014, CMS requested from the State agency an updated cost-allocation methodology on the basis of actual enrollment because CMS stated that it believed that the percentage allocated to the establishment grants should have been lower than the allocation percentage in effect at the time.
- In September 2014, State agency officials responded with the following information:
  - State agency officials became aware, during a budget meeting before the end of the first enrollment period in April 2014, that the establishment grants' portion was lower than the 75-percent rate that the State agency was using.

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<sup>11</sup> The Kentucky marketplace's actual enrollment numbers, which the State agency provided as of April 15, 2014, were 290,072 in Medicaid, 82,159 in QHPs, and 9,043 in CHIP. While the Kentucky marketplace's estimated cost-allocation methodology included the entire population of Kentucky, we used a methodology that corresponded with the relative benefit received. Specifically, to determine if costs were allocated relative to the benefits received, and consistent with CMS's guidance, we used actual enrollment data for populations that obtained coverage with Medicaid, CHIP, or QHPs by using the Kentucky marketplace.

<sup>12</sup> These communications were in the form of email correspondence between the State agency and CMS.

- State agency officials were in the process of reviewing actual enrollment data, and system reports indicated that the Kentucky marketplace enrolled more Medicaid than QHP applicants.
- In October 2014, the State agency requested confirmation from CMS that CMS had no further questions regarding the continued use of the original allocation percentages and that the State agency could continue using them. According to the email response from CMS to the State agency, CMS stated that there were no additional questions regarding the State agency's cost-allocation methodology, and CMS allowed the State agency to continue using the original allocation percentages (75 percent to establishment grants and 25 percent to Medicaid and CHIP).

### **The State Agency Did Not Have Adequate Internal Controls**

The State agency did not allocate costs in accordance with the relative benefits to each program and did not recalculate and adjust its cost allocation prospectively because it did not have adequate internal controls to ensure the proper allocation of costs. Specifically, the State agency did not have written policies and procedures that explained how to properly establish the cost-allocation methodology or when to update it.

## **RECOMMENDATIONS**

We recommend that the State agency:

- work with CMS to determine what portion of \$23.6 million was properly allocated in accordance with the relative benefits the establishment grants received from October 1, 2013, through April 15, 2014;
- refund \$25.5 million to CMS that was misallocated to the establishment grants by not using updated, better data, or work with CMS to resolve the amount misallocated to the establishment grants, from April 16 through December 31, 2014;
- work with CMS to ensure that the \$123.3 million that was allocated to the establishment grants on the basis of a flawed cost-allocation methodology from November 2010 through September 2013 was allocated correctly and refund any unallowable amount;
- work with CMS to ensure that costs claimed after our audit period were allocated correctly using updated, better data, and refund any unallowable amount; and
- issue a written policy that explains how to develop and perform cost allocations on the basis of relative benefits received and to reassess and revise allocations when necessary.



## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency did not fully concur with our first four recommendations. The State agency concurred with our fifth recommendation and said that it would issue a Marketplace-specific written policy that explains how to develop, reassess, and revise its cost allocations.

After considering the State agency's comments on our draft report, we maintain that all of our findings and recommendations are valid.

We have summarized below the State agency's comments regarding our recommendations and included the State agency's comments in their entirety as Appendix D.

### **RECOMMENDATION ONE: DETERMINE WHAT PORTION OF \$23.6 MILLION WAS PROPERLY ALLOCATED**

#### **State Agency Comments**

The State agency said that it would continue to work with CMS; however, it said:

- It created the cost-allocation methodology for development activities in 2011. At that time, CMS had not yet established the standards for developing cost-allocation methodologies for the marketplaces. Additionally, CMS did not provide a specific methodology for how States should develop cost-allocation methodologies for a marketplace.
- It consistently received approval from CMS to use the original cost-allocation methodology for all development activities. Consequently, the State agency adhered in good faith with the CMS guidance and approved methodology when allocating costs for development expenditures.

#### **Office of Inspector General Response**

We maintain that this recommendation is valid. Specifically:

- Federal requirements state that a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objectives in accordance with relative benefits received (2 CFR part 225, App. A, § C.3).
- The State agency used the entire State's population in determining its cost-allocation methodology based on the rationale that there would be a reduction in Kentucky's spending on uncompensated care that would benefit the entire population of the State. Kentucky should not have used a methodology that included the entire State's population because it included groups of citizens who would not typically use the marketplace at all. For example, certain population groups—Federal employees, military employees,

Medicare beneficiaries, or large groups (an employer with 50 or more full-time employees or equivalent)—should not have been expected to use and, thus, would not have benefitted from the Kentucky marketplace. That is, the cost objective (the establishment grants) would not have incurred costs for these population groups.

- Even though CMS approved using the original cost-allocation methodology for development activities and did not provide a specific methodology for how States should develop cost-allocation methodologies for a marketplace, CMS directed States to reassess their cost allocation. Specifically, CMS guidance states that “States are expected to update their cost-allocation methodology and plan based on updated or better data.... CMS expects States to adjust cost-allocation plans based on changing realities” (CMS, *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, “Questions and Answers,” Oct. 5, 2012, pages 3 and 4, questions 6 and 9).

## **RECOMMENDATION TWO: REFUND \$25.5 MILLION TO CMS OR WORK WITH CMS TO RESOLVE THE AMOUNT MISALLOCATED**

### **State Agency Comments**

The State agency said that it did not concur with the recommendation to refund \$25.5 million to CMS but said that it would continue to work with CMS to ensure funds are appropriately allocated; however, it also said:

- Per the ACA requirements, States were required to be self-sustaining by January 1, 2015, to coincide with the end of the second open enrollment period of the marketplace. The State agency received approval from CMS for Federal funding through April 30, 2015, the end of its second open enrollment period. On May 1, 2015, Kentucky was considered to be in the operational phase.
- This original development cost-allocation methodology was used through the entire grant period because CMS approved it for development activities. CMS has not issued specific guidance for marketplaces to update cost-allocation methodologies with nonstabilized enrollment data that pertains to a certain point in time. Because of ACA’s requirement that States be fully operational after the second open enrollment period, the State agency did not begin using an operational cost-allocation methodology until the operational period began on May 1, 2015.
- OIG referenced that, in September 2014, CMS requested from the State agency an updated cost-allocation methodology on the basis of actual enrollment and that State agency officials replied that they became aware, during a budget meeting before the end of the first enrollment period in April 2014, that the establishment grants’ portion was lower than the 75-percent rate that the State agency was using. However, the State agency’s response to CMS was in reference to the operational cost-allocation methodology that it was developing for the future, not the development cost-allocation methodology that it was using. The State agency also responded that the approved

development cost-allocation methodology applied through the end of Federal funding on December 31, 2014, when the marketplace (which it called the “Exchange”) was supposed to be fully developed.

## Office of Inspector General Response

We maintain that this recommendation is valid. Specifically:

- CMS guidance, published in May 2011, says, “If development is in progress, states must recalculate and adjust cost allocation on a prospective basis. [CMS] will work with states to ensure proper adjustments on an expedited basis and encourage states to consult with [CMS] early as [the States] identify such circumstances” (CMS, *Guidance for Exchange and Medicaid Information Technology (IT) Systems* (version 2.0), page 7).
- Supplemental CMS guidance states that “States are expected to update their cost-allocation methodology and plan based on updated or better data... CMS expects States to adjust cost allocation plans based on changing realities” (CMS, *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, “Questions and Answers,” Oct. 5, 2012, pages 3 and 4, questions 6 and 9).
- We referred to the September 2014 email communication from CMS to the State agency regarding the cost-allocation methodology to indicate that the State agency became aware that there was a substantive change in program participation in April 2014. Specifically, at the end of the enrollment period on April 15, 2014, actual enrollment percentages were 76 percent Medicaid and 22 percent QHP versus the estimated 23 percent Medicaid and 75 percent QHP that was in the cost-allocation methodology and the basis for allocating costs. These numbers demonstrated that there was a substantive change in program enrollment and that the estimates the State agency used were no longer accurate. Yet, the State agency did not reassess its cost-allocation methodology at that time or use these enrollment figures to update the cost-allocation methodology. Therefore, in September 2014, when CMS requested from the State agency an updated cost-allocation methodology on the basis of actual enrollment, the State agency should have used the updated, better data that indicated a substantive change in participation to update its cost-allocation methodology.

## **RECOMMENDATION THREE: WORK WITH CMS TO ENSURE THAT THE \$123.3 MILLION ALLOCATED ON THE BASIS OF A FLAWED COST-ALLOCATION METHODOLOGY WAS ALLOCATED CORRECTLY**

### State Agency Comments

Although the State agency agreed to continue to work with CMS to ensure funds are appropriately allocated, it did not concur that the grant allocation was based on an inappropriately applied methodology. It referred to its responses to the first two recommendations.

## **Office of Inspector General Response**

We maintain that this recommendation is valid for the same reasons that we provided in our responses above. Moreover, the State agency's comments on our first two recommendations did not address the fact that the State agency did not comply with CMS guidance, which requires a State agency to update its cost-allocation methodology and plan based on updated or better data. In addition, CMS guidance stated that, if development was in progress, States must recalculate and adjust cost allocation on a prospective basis.

## **RECOMMENDATION FOUR: ENSURE THAT COSTS CLAIMED AFTER OUR AUDIT PERIOD WERE ALLOCATED CORRECTLY**

### **State Agency Comments**

The State agency said that it concurred with our recommendation to work with CMS; however, it also said that it understands that cost allocations continued to be made in accordance with CMS guidance and approved methodology. Again, it referred to its responses to the first two recommendations.

## **Office of Inspector General Response**

We maintain that this recommendation is valid for the same reasons that we provided in our responses to recommendations one and two above. Moreover, the State agency's comments on our first two recommendations did not address the fact that the State agency did not comply with CMS guidance, which required a State agency to update its cost-allocation methodology and plan based on updated or better data. In addition, CMS guidance stated that if development was in progress, States must recalculate and adjust cost allocation on a prospective basis.

## **APPENDIX A: FEDERAL ASSISTANCE TO STATES FOR PLANNING, ESTABLISHMENT, 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, early innovator cooperative agreements, and two types of marketplace establishment cooperative agreements.

### **PLANNING AND ESTABLISHMENT GRANTS**

CCIIO awarded planning and establishment grants<sup>13</sup> to assist States with initial planning activities 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>14</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 about \$6.2 million (Maryland) to \$59.9 million (Oregon).

### **MARKETPLACE ESTABLISHMENT COOPERATIVE AGREEMENTS**

CCIIO designed establishment cooperative agreements<sup>15</sup> to support States’ progress toward establishing marketplaces. Establishment cooperative agreements awarded through December 31, 2014, were available for States seeking (1) to establish a State-based marketplace, (2) to build functions that a State elects to operate under a State partnership marketplace, and

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<sup>13</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>14</sup> CCIIO, Cooperative Agreements to Support Innovative Exchange Information Technology Systems, Number: TBA, October 29, 2010. In February 2011, CMS announced that it had awarded seven early innovator cooperative agreements. The cooperative agreements totaled about \$249 million.

<sup>15</sup> CCIIO, Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges, Number: IE-HBE-11-004, November 29, 2011, and Cooperative Agreement to Support Establishment of the Affordable Care Act’s Health Insurance Exchange, Number: IE-HBE-12-001, December 6, 2013.

(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 may 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 are open to all States, whether they are (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 date 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,  
ESTABLISHMENT, AND EARLY OPERATION OF THE KENTUCKY  
MARKETPLACE  
AS OF DECEMBER 31, 2014**

The following table summarizes the grants awarded by CCIIO to support the planning, establishment, and early operations of the Kentucky marketplace and expenditures allocated to these grants.

<b>Grant Number</b>	<b>Award Period<sup>16</sup></b>	<b>Award Type</b>	<b>Award Total</b>	<b>Marketplace Expenditures<sup>17</sup></b>
6 HBEIE100037	September 30, 2010 – September 29, 2011	Planning	\$469,088	\$469,088
1 HBEIE110073	August 15, 2011 – August 14, 2012	Level One	7,670,803	7,670,803
1 HBEIE120115	February 22, 2012 – February 21, 2013	Level One	57,896,810	57,896,810
1 HBEIE120132	September 27, 2012 – September 26, 2013	Level One	4,423,000	4,423,000
6 HBEIE130150	January 16, 2013 – December 31, 2014	Level Two	182,707,738	111,968,436
6 HBEIE130150	January 16, 2013 – December 31, 2015	Level Two	35,605,175	
<b>TOTAL</b>			<b>\$288,772,614</b>	<b>\$182,428,137</b>

<sup>16</sup> The award period for the grant number may include no-cost extensions.

<sup>17</sup> Expenditures through December 31, 2014.

## **APPENDIX C: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

We reviewed \$59,111,408 that the State agency allocated to the establishment grants from October 2013 through December 2014 (audit period). We limited our review of internal controls to the State agency's systems and procedures for allocating costs to the establishment grants, Medicaid, and CHIP.

We conducted our fieldwork at the State agency's office in Frankfort, Kentucky.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the Kentucky marketplace's establishment grant application packages;
- reviewed CCHIO's Funding Opportunity Announcements and Notice of Grant Awards terms and conditions;
- reviewed the State agency's policies and procedures for financial management;
- interviewed State agency officials to understand their accounting system and internal controls;
- interviewed State agency officials to understand enrollment statistics available to the marketplace for individuals determined eligible for and enrolled in QHP, Medicaid, or CHIP;
- interviewed State agency officials to understand how they developed projections of enrollment in various health care coverage programs;
- obtained and reviewed the cost-allocation methodology and supporting documentation to ensure the accuracy of the percentages used to allocate costs to the grants, Medicaid, and CHIP;
- obtained actual enrollment figures from January 1 through April 15, 2014, for QHPs, Medicaid, and CHIP enrollments through the Kentucky marketplace;
- obtained revenue and expenditure general ledger reports for Federal fiscal years 2011 through 2015;
- analyzed the general ledger reports to obtain an understanding of the information that the Kentucky marketplace used to claim expenditures for Federal reimbursement;



- determined how much would have been allocated to the establishment grants if the Kentucky marketplace had calculated allocation rates using 2014 estimates based on updated, better data instead of the original methodology; and
- discussed the results of our review with the Kentucky marketplace 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 D: STATE AGENCY COMMENTS



Kentucky's Healthcare Connector

Cabinet for Health and Family Services  
Kentucky Office of Health Benefit and Information Exchange

8 Mill Creek Park, Frankfort, KY 40601  
1-855-4kynect (459-6328)  
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Matthew R. Bean  
Governor

Carrie Banahan  
Executive Director

Wickie Yates Brown Glisson  
Secretary

October 14, 2016

Ms. Lori S. Pilcher, Regional Inspector General  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta GA 30303-8931

Dear Ms. Pilcher,

This letter acknowledges receipt and review of the Department of Health and Human Services' Office of Inspector General's draft report for audit #A-04-14-07050 entitled *Kentucky Misallocated Millions to Establishment Grants for a Health Insurance Marketplace*. The Kentucky Office of Health Benefit and Information Exchange's (KOHBE) comments are attached.

We appreciate the opportunity to review the draft report and submit comments. Should you have any questions or require additional information, please contact KOHBE's audit lead Tammy Bullock or me at 502-564-7940.

Sincerely,

Carrie Banahan  
Executive Director

cc: Tammy Bullock, CHFS  
Justin Clark, CHFS  
Vickie Glisson, CHFS  
Cindy Murray, CHFS  
John Watkins, CHFS  
Denise Novak, OIG  
Osvaldo Ordonez, OIG  
Elizabeth Zyga, OIG



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**Kentucky Office of Health Benefit and Information Exchange (KOHBIIE) Response to  
DHHS OIG Draft Audit Report #A-04-14-07050 entitled  
*Kentucky Misallocated Millions to Establishment Grants for a Health Insurance Marketplace***

**Audit Recommendation #1:** Work with CMS to determine what portion of \$23.6 million was properly allocated in accordance with the relative benefits the establishment grants received from October 1, 2013 through April 15, 2014.

**Response:** KOHBIIE concurs with continuing to work with Centers for Medicare and Medicaid Services (CMS); however, KOHBIIE understands cost allocations were made in accordance with CMS guidance and approved methodology.

KOHBIIE created the cost allocation methodology (CAM) for development activities in 2011. At that time standards for developing CAMs for the Marketplaces had not been established by CMS. Additionally, CMS did not provide a specific methodology for how states should develop CAMs for a Marketplace; therefore, KOHBIIE created the CAM based on a simple calculation that could be easily illustrated and supported. We recognize that OIG questions the calculation methodology; however, KOHBIIE continued to work closely with CMS and consistently received approval from the CMS to use the original CAM for all development activities. Consequently, KOHBIIE, in good faith, adhered to the CMS guidance and approved methodology when allocating cost for development expenditures.

**Audit Recommendation #2:** Refund \$25.5 million to CMS that was misallocated to the establishment grants by not using updated, better data, or work with CMS to resolve the amount misallocated to the establishment grants, from April 16, 2014, through December 31, 2014.

**Response:** KOHBIIE concurs with the recommendation to continue to work with CMS to ensure funds are properly allocated; however, KOHBIIE does not concur with the recommendation to refund \$25.5 million to CMS.

Per the Affordable Care Act (ACA) requirements, states were required to be self-sustaining by January 1, 2015 to coincide with the end of the second open enrollment period of the Marketplace. Federal funds could be used through the end of the second open enrollment but beginning January 1, 2015, the Marketplaces would be considered operational and had to move to other revenue sources for operational expenses. However, the Federal government extended the second open enrollment period into 2015 and as a result, states could continue using funds through the end of their extended open enrollment period. KOHBIIE received approval from CMS for federal funding through April 30, 2015, the end of their second open enrollment period. Beginning May 1, 2015, Kentucky was considered to be in operational phase. As a result, KOHBIIE moved to an operational CAM at that time. CMS approved this operational CAM that was based on stabilized eligibility calculations and determinations for KOHBIIE, Medicaid and Kentucky Children's Health Insurance Program (KCHIP). This new CAM was used for operational expenses only while development costs continued to be paid through the approved development CAM.

This original development CAM was utilized through the entire grant period because it was approved by CMS for development activities. CMS has not issued specific guidance for Marketplaces to update CAMs with non-stabilized enrollment data that pertains to a certain point in time. Because of ACA's requirement that States be fully operational after the second open enrollment period, KOHBIE did not begin utilizing an operational CAM until the operational period began on May 1, 2015. Prior to and even after that point, development activities continued, thus the reason why KOHBIE continued using the development CAM beyond when OIG states should have occurred. Normally projects of this magnitude would have more time to be implemented but the states had one year to develop a Marketplace. As a result, development activities continued long after those systems went live because there was insufficient time to implement the full system design.

OIG referenced in September 2014 the Centers for Medicare and Medicaid Services (CMS) "requested from the State agency an updated cost-allocation methodology on the basis of actual enrollment" and that State officials replied they "became aware, during a budget meeting before the end of the first enrollment period in April 2014, that the establishment grants' portion was lower than the 75-percent rate that the State agency was using." However, KOHBIE's response to CMS was in reference to the operational CAM that was being developed for the future, not the development CAM that was being used. The non-stabilized enrollment data for use in the operational CAM required many months of further data input and calculations to mature for its use. "Department representatives are in the process now of reviewing actual enrollment data from the [Marketplace] to come to a consensus for how the *operational* CAM should be developed and the basis for the enrollment data that will be used." KOHBIE's response also stated, "The approved [development] CAM was through the end of federal funding on December 31, 2014 when the Exchange was planned to be fully developed so that beginning January 1, 2015, [KOHBIE] would be deemed fully operational and would transition to an operational CAM." (This email exchange with CMS occurred in September 2014, prior to CMS approving KOHBIE's open enrollment period extension through April 2015 and operations beginning on May 1, 2015.)

KOHBIE has consistently been transparent with CMS with the submission and reviews of both its development and operational CAMs. KOHBIE also received repeated approvals from CMS in using the original CAM for development activities and consequently, KOHBIE has adhered to the CMS approved methodology when cost allocating development expenditures. Furthermore, KOHBIE has requested approval for new CAMs (operational) using stabilized and fully developed/updated eligibility/enrollment numbers in Implementation Advance Planning Document Updates (IAPDUs) submitted to CMS since August 2014. KOHBIE implemented the first operational CAM on May 1, 2015 when the Exchange was considered to be in operations and federal funding could no longer be spent on operations. CMS has consistently approved the use of the development and operational CAMs submitted in the IAPDUs each time the documents were submitted for review.

**Audit Recommendation #3:** Work with CMS to ensure that the \$123.3 million that was allocated to the establishment grants on the basis of a flawed cost-allocation methodology from

November 2010 to September 2013 were allocated correctly and refund any unallowable amount.

**Response:** KOHBIE concurs with the recommendation to continue to work with CMS to ensure funds are appropriately allocated, however, KOHBIE does not concur that grant allocation was based on an inappropriately applied methodology.

Refer to the responses to recommendations #1 and #2.

**Audit Recommendation #4:** Work with CMS to ensure that costs claimed after our audit period were allocated correctly using updated, better data and refund any unallowable amount.

**Response:** KOHBIE concurs with the recommendation to work with CMS, however, KOHBIE understands cost allocations continued to be made in accordance with CMS guidance and approved methodology.

Refer to the responses to recommendations #1 and #2.

**Audit Recommendation #5:** Develop a written policy that explains how to develop and perform cost allocations on the basis of relative benefits received and to reassess and revise allocations when necessary.

**Response:** KOHBIE concurs with the recommendation to develop a more formalized written policy that explains how to develop and perform such cost allocations including when to reassess and revise accordingly.

During OIG's review, KOHBIE provided significant cost allocation detail that included cost allocation steps and how the Cabinet developed Cabinet-wide cost allocation plans (CAP). Department staff who work for the Marketplace, Medicaid and other programs utilizing the eligibility and enrollment system have access to these documents. However, KOHBIE will develop written Marketplace specific CAP policy and processes to explain how and when the CAPs for the Marketplace system and operations should be developed, monitored and revised.

**Additional comments:**

In addition to OIG's recommendations, KOHBIE reviewed other items within the draft report that we respectfully request OIG consider when finalizing their report.

**Audit Title**

The title "*Kentucky Misallocated Millions to Establishment Grants for a Health Insurance Marketplace*" is misleading in its characterization of Kentucky. KOHBIE respectfully requests OIG revise the title to "Kentucky May Not Have Properly Allocated Establishment Grants for a Health Insurance Marketplace". KOHBIE developed CAMs for specific purposes (e.g.

development activities versus operations) using the information available to the department with no specific guidance provided from CMS for how to approach the CAM development. OIG even stated in their draft report that “the State agency requested confirmation from CMS that CMS had no further questions regarding the continued use of the original allocation percentages and that the State agency could continue using them. According to the email response from CMS to the State agency, CMS stated that there were no additional questions regarding the State agency’s cost-allocation methodology, and CMS allowed the State agency to continue using the original allocation percentages (75 percent to establishment grants and 25 percent to Medicaid and CHIP).” KOHBIE has submitted and received CMS approval for new operational CAMs since August 2014 when Kentucky was preparing to transfer to operational status in 2015. These operational CAMs (and continued use of the development CAM) are approved through IAPDUs submitted at least annually. Therefore, KOHBIE believes they have allocated all establishment grants appropriately.