

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MARYLAND MISALLOCATED
MILLIONS TO ESTABLISHMENT
GRANTS FOR A HEALTH
INSURANCE MARKETPLACE

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Office of Inspector General

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EXECUTIVE SUMMARY

Maryland did not allocate costs to its establishment grants and Medicaid in accordance with Federal requirements, the terms and conditions of the establishment grants, and its Cost Allocation Plan. As a result, Maryland misallocated \$28.4 million in costs to the establishment grants instead of the Medicaid program over approximately 2 years.

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 the early operation of marketplaces.

The Maryland Health Benefit Exchange (Maryland marketplace) is an independent unit of the Maryland Government. The Maryland Department of Health and Mental Hygiene (State agency) serves as the lead agency for Maryland marketplace establishment grants and is responsible for complying with applicable requirements. In response to a congressional request, we conducted a review of how costs incurred to create the Maryland marketplace were allocated to establishment grants.

Our objective was to determine whether the State agency allocated costs for establishing a health insurance exchange to its establishment grants in accordance with Federal requirements, the terms and conditions of the establishment grants, and its Cost Allocation Plan (CAP).

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 on the marketplaces known as qualified health plans (QHPs).

Marketplaces carry out a number of 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.

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

From September 30, 2010, through December 31, 2014, CCIIO awarded the State agency establishment grants totaling \$182 million. Of the total amount awarded, the State agency expended \$122 million during State fiscal years (SFYs) 2011 through 2014.

Our review focused on the \$76.6 million that the State agency allocated in establishment grants for SFYs 2013 and 2014. We limited our review of internal controls to the State agency's systems and procedures for claiming the costs of establishment grants and to Medicaid to the extent necessary to accomplish our objective.

WHAT WE FOUND

The State agency did not allocate costs to its establishment grants and Medicaid in accordance with Federal requirements, the terms and conditions of the establishment grants, and its CAP. The State agency allocated a total of \$76.6 million to its establishment grants on the basis of a cost allocation methodology that (1) did not prospectively use updated or better data when available and (2) included a "material defect." As a result, the State agency misallocated \$28.4 million in costs to the establishment grants instead of the Medicaid program, as follows:

- \$15.9 million using outdated estimated enrollment data instead of updated actual enrollment data and
- \$12.5 million using a cost allocation methodology that included a material defect.

The State agency misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs. The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at Federal financial participation rates ranging from 50 to 90 percent.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$15.9 million to CMS that was misallocated to the establishment grants because it did not prospectively use updated actual enrollment data;
- refund \$12.5 million to CMS that was misallocated to the establishment grants using a methodology that included a material defect;
- immediately amend the CAP and the Advance Planning Document for the period July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received;
- develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data; and

- oversee operations to ensure (1) the identification and correction of enrollment projection errors, (2) the use of better or updated enrollment data, and (3) the application of these data to allocate costs.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with recommendations four and five and said it will develop a written cost allocation policy and implement steps to oversee operations effectively. The State agency did not concur with the first three of our recommendations. The State agency said it complied with CMS guidance on the frequency of cost allocation updates and that our assumption that the Maryland marketplace “should have updated its cost allocation immediately after the first open enrollment” is not consistent with the most recent CMS guidance.

After considering the State agency’s comments on our draft report, we maintain that all of our findings and recommendations are valid. Specifically, the CMS guidance explains that, “States are expected to update their cost allocation methodology and plan based on updated or better data ...” and “if there is a substantive change in program participation.” The March 31, 2014, enrollment numbers, reported by the State agency and made available to the public, demonstrated a substantive change in program enrollment because there was a 37-percentage point difference between the estimated enrollment split used initially to allocate costs and the actual enrollment split at the end of the first open enrollment period.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS said it “worked with states to review and revise projections based on the timing of availability of actual enrollment data for use when making accurate cost allocation adjustments.” CMS said it issued additional guidance in August 2014 to States “to make cost allocation adjustments annually and when seeking additional federal funds using actual enrollment numbers when available. CMS provided this guidance to OIG on February 27, 2015.” CMS also said, “The Maryland Health Benefits Exchange (MHBE) adjusted its cost allocation based on actual enrollments and redeterminations both in June 2014 when it sought to repurpose its federal grant funds and again in November 2014 when it applied for the last round of federal grant funding. MHBE provided the revised cost allocation in June because of the time needed for Medicaid and QHP enrollment data to stabilize and be successfully verified after the conclusion of the 2014 Open Enrollment.”

After considering CMS’s comments on our draft report, we maintain that all of our findings and recommendations are valid. Even though CMS directed States to update their cost allocation methodology annually, CMS also directed States to reassess their cost allocation “if there is a substantive change in program participation.” CMS has not issued specific guidance that directs the State-based marketplaces to update their cost allocation methodology using enrollment data that are “final” at a certain point in time or that have stabilized. Absent any specific guidance from CMS, the State agency should have used updated and better enrollment data on March 31, 2014, to update the cost allocation methodology. We plan to work with CMS as it reviews our

findings to determine next steps to address the issues identified and measures that CMS can take to improve its guidance to States.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
Patient Protection and Affordable Care Act	1
Federal Requirements and the Centers for Medicare & Medicaid Services Guidance	2
Health Insurance Marketplace Programs	2
Maryland Health Benefit Exchange	3
How We Conducted This Review	3
FINDINGS	4
For 3 Months the State Agency Used Outdated Estimated Enrollment Data to Calculate Allocation Costs Instead of Updated, Actual Enrollment Data	4
Federal Requirements	4
The State Agency Did Not Recalculate and Adjust Its Cost Allocation Prospectively	5
For 21 Months the State Used a Cost Allocation Methodology That Included a Material Defect	6
Federal Requirements	6
The State Agency Allocated Costs Using a Methodology That Included a Material Defect	6
Causes of Misallocated Claimed Costs	7
RECOMMENDATIONS	7
STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	8
Recommendation One: Refund \$15.9 Million That Was Misallocated to the Establishment Grants Because It Did Not Prospectively Use Updated Enrollment Data	8

Recommendation Two: Refund \$12.5 Million That Was Misallocated to the Establishment Grants Using a Methodology That Included a Material Defect	9
Recommendation Three: Immediately Amend the Cost Allocation Plan and the Advance Planning Document for the Period July 1 Through December 31, 2014, so That Allocated Costs Correspond to the Relative Benefits Received	11
CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	11
APPENDIXES	
A: Federal Grants to States for the Planning, Establishing, and Early Operation of Marketplaces	13
B: Audit Scope and Methodology.....	16
C: State Agency Misallocation of Costs	18
D: State Agency Comments.....	19
E: Centers for Medicare & Medicaid Services Comments.....	36

INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)¹ 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 marketplaces.

The Maryland Health Benefit Exchange (Maryland marketplace) is an independent unit of the Maryland government. The Maryland Department of Health and Mental Hygiene (State agency) serves as the lead agency for Maryland marketplace establishment grants and is responsible for complying with applicable requirements. In response to a congressional request, we conducted a review of how costs incurred to create the Maryland marketplace were allocated to establishment grants.²

OBJECTIVE

Our objective was to determine whether the State agency allocated costs for establishing a health insurance exchange to its establishment grants³ in accordance with Federal requirements, the terms and conditions of the establishment grants, and its Cost Allocation Plan (CAP).

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)⁴ is responsible for implementing many of the requirements of ACA, including overseeing the implementation of provisions related to the

¹ 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.”

² Our review examined the following specific establishment grants received by the State agency: a Planning and Establishment Grant totaling \$999,226; Early Innovator Cooperative Agreements totaling \$6,277,454; and Level One and Level Two Exchange Establishment Cooperative Agreements totaling \$27,186,749 and \$147,594,183, respectively. See Appendix B for more information about the scope of this audit.

³ For purposes of this report, the term “establishment grants” includes all funding made available to States under the ACA § 1311(a). 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 type of grants and cooperative agreements available to States related to the establishment of a marketplace.

⁴ 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’s responsibilities were transferred to CMS’s CCIIO (76 Fed. Reg. 4703 (Jan. 26, 2011)). In this report, we refer to “CCIIO” to mean both OCIIO and CCIIO.

marketplaces and the private health insurance plans offered on the marketplaces known as qualified health plans (QHPs).

Marketplaces perform a number of 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 and the Centers for Medicare & Medicaid Services Guidance

The Establishment Grant Funding Opportunity Announcement and the State agency's Notice of Award require the State agency to allocate shared costs among Medicaid, CHIP, and the Maryland marketplace consistent with cost allocation principles at 2 CFR part 225 (previously Office of Management and Budget Circular A-87). 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). Primarily, CMS guidance says, "States are expected to update their cost allocation methodology and plan based on updated or better data"

State Medicaid agencies must submit Advance Planning Documents (APDs) to obtain enhanced Federal funding for Medicaid IT system projects related to Medicaid eligibility and enrollment, including eligibility and enrollment through a marketplace system (42 CFR § 433.112).

States must also establish CAPs that identify, measure, and allocate costs to each State-operated program (45 CFR part 95, subpart E). States are required to amend their CAPs if there are significant changes in program levels or a material defect is discovered in the CAPs (45 CFR §§ 95.509(a)(1) and (2)).

Health Insurance Marketplace Programs

The ACA provides for funding assistance⁵ to a State for the 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.

⁵ Projects and programs are carried out under a variety of types of grants, including the use of a specific type of grant known as cooperative agreements. 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*).

Maryland Health Benefit Exchange

Maryland chose to establish and operate its own State marketplace.⁶ Because the Maryland 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 Maryland marketplace is a single entity supporting the shared needs of multiple programs, the State agency developed a method for allocating costs according to the anticipated use of the marketplace on the basis of enrollment in QHPs and in Medicaid.

In 2010, the State agency hired a contractor to estimate the number of people who would enroll in QHPs offered through the Maryland marketplace and in Medicaid. The State agency used the contractor's initial enrollment projections to determine the program budgets and the percentages of costs that should be allocated to the establishment grants and Medicaid.

The State agency submitted an APD to claim enhanced Medicaid funding for Medicaid costs incurred by the Maryland marketplace. Similarly, the State agency also amended its CAP to establish the cost allocation methodology to allow the State agency to claim Medicaid funding for costs incurred by the Maryland marketplace. HHS's Division of Cost Allocation (DCA) approved the amendment to the State agency's CAP effective April 12, 2011.

From September 30, 2010, through December 31, 2014, CCHIO awarded the State agency establishment grants totaling \$182 million. Of the total amount awarded, the State agency expended \$122 million during State fiscal years (SFYs) 2011 through 2014. The Medicaid program also provided Maryland with Federal financial participation to support marketplace eligibility determination and enrollment services for Medicaid beneficiaries.

HOW WE CONDUCTED THIS REVIEW

We reviewed \$76.6 million that the State agency allocated to the establishment grants for SFYs 2013 and 2014 (July 1, 2012, through June 30, 2014) on the basis of the contractor's original estimated enrollment data. We reviewed the State agency's internal controls for allocating costs to establishment grants and to Medicaid.

We conducted our fieldwork at the State agency's offices in Baltimore, Maryland, from March through September 2014.

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

⁶ The entity responsible for administration of the Maryland marketplace is also known as Maryland Health Connection.

FINDINGS

The State agency did not allocate costs to its establishment grants and Medicaid in accordance with Federal requirements, the terms and conditions of the establishment grants, and its CAP. The State agency allocated a total of \$76.6 million to its establishment grants on the basis of a cost allocation methodology that (1) did not prospectively use updated or better data when available and (2) included a “material defect.” As a result, the State agency misallocated \$28.4 million in costs to the establishment grants instead of the Medicaid program, as follows:

- \$15.9 million using outdated estimated enrollment data instead of updated, actual enrollment data and
- \$12.5 million using a cost allocation methodology that included a material defect.

The State agency misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs.

FOR 3 MONTHS THE STATE AGENCY USED OUTDATED ESTIMATED ENROLLMENT DATA TO CALCULATE ALLOCATION COSTS INSTEAD OF UPDATED, ACTUAL ENROLLMENT 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 objective in accordance with relative benefits received (2 CFR part 225, Appendix A, C.3).

According to CMS guidance published in May 2011, “[i]f development is in progress, states must recalculate and adjust their cost allocation on a prospective basis. [CMS] will work with States to ensure proper adjustment on an expedited basis and encourages 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)).

In addition, “States are expected to update their cost allocation methodology and plan based on updated or better data ...” and “on changing realities” (CMS’s *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, “Questions and Answers”).

A State agency must promptly amend its CAP if the procedures shown in the existing CAP “become outdated because of ... significant changes in program levels, affecting the validity of the approved cost allocation procedures” (45 CFR § 95.509(a)(1)). If a State agency fails to submit an amended cost allocation plan when there are significant changes in program levels, the costs improperly claimed will be disallowed (45 CFR § 95.519).

The State Agency Did Not Recalculate and Adjust Its Cost Allocation Prospectively

The State agency allocated costs for the April through June 2014 period on the basis of estimates that its contractor made during 2010 and 2012. The contractor estimated that 42 percent of the total enrollment population would enroll in Medicaid and 58 percent would enroll in a QHP.⁷ The contractor's enrollment estimates differed significantly from the updated, actual enrollment data available to the State agency as of March 31, 2014. The updated, actual enrollment data showed that 79 percent of the total enrollment population selected Medicaid and that the remaining 21 percent selected a QHP.⁸

Despite the availability of better and updated data, the State agency did not recalculate and adjust its cost allocation prospectively by using the March 31, 2014, actual enrollment data. Consequently, the costs allocated to Medicaid and to the establishment grants did not correspond to the relative benefits received (as required by 2 CFR part 225). On this basis, the State agency claimed improper costs that were misallocated. Further, the State agency did not amend its CAP (as required by 45 CFR § 95.509) even though significant changes in program levels occurred. Because the State agency did not amend its CAP to account for a significant change in program level enrollment, the costs improperly claimed must be disallowed (as required by 45 CFR § 95.519). The State agency misallocated \$15.9 million to the establishment grants, as shown in Table 1. The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at Federal financial participation rates ranging from 50 to 90 percent.

**Table 1: State Agency Allocation Costs From April Through June 2014:
Cost Allocation Not Recalculated and Adjusted Prospectively
(dollars in millions)**

Total Costs	Allocation Percentages		State Agency's Allocation		March 2014 Updated Percentages		Office of Inspector General's Allocation		State Agency Improperly Claimed QHP
	Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	
\$42.9	42%	58%	\$18.0	\$24.9	79%	21%	\$33.9	\$9.0	\$15.9

CMS officials stated the actual program enrollment data reported to the public by the Maryland marketplace on March 31, 2014, may not reflect final enrollment data that the State agency should have used to recalculate the cost allocation. According to CMS, the earliest expected date for enrollment data to be considered final would have been June 2014. However, CMS has not issued specific guidance that directs the State-based marketplaces to update only the cost allocation methodology using enrollment data that are final at a certain point in time. The State agency possessed updated and better enrollment data on March 31, 2014.

⁷ In 2010, the contractor projected an estimated program enrollment split of 88,509 individuals in QHPs and 63,370 individuals in Medicaid, resulting in a 58-percent QHP and 42-percent Medicaid cost allocation. In 2012, the contractor provided a revised estimate of program enrollment that resulted in a cost allocation percentage that was approximately the same as the 2010 allocation. The State agency used the 2012 contractor enrollment estimates in its Level Two cooperative agreement application.

⁸ As of March 31, 2014, the Maryland marketplace reported an actual program enrollment split of 232,075 in Medicaid and 63,002 in QHPs (reported publicly on April 4, 2014). See Appendix C.

Further, the updated, actual enrollment data the Maryland marketplace reported in June 2014 had a comparable enrollment split of 81 percent Medicaid and 19 percent QHP to the March 2014 enrollment split of 79 percent Medicaid and 21 percent QHP. As a factual matter, the difference between the March 2014 and the June 2014 enrollment split was minimal. The March 2014 enrollment data indicated there was a significant change between estimated enrollment amounts used to allocate costs and the actual enrollment amounts. Therefore, in the absence of clear CMS guidance to the contrary, the State agency should have used enrollment figures from March 31, 2014, to amend its cost allocation methodology.

FOR 21 MONTHS THE STATE AGENCY USED A COST ALLOCATION METHODOLOGY THAT INCLUDED A MATERIAL DEFECT

Federal Requirements

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 the 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 a material defect is discovered in the CAP by the State (45 CFR § 95.509(a)(2)). 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).

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

The State agency allocated costs for July 2012 through March 2014 using an estimate that 42 percent of the total enrolled population would enroll in Medicaid and 58 percent would enroll in a QHP. In a February 2014 letter to the Maryland marketplace, the State agency's contractor acknowledged an error in its presentation of the 2012 estimated enrollment data. Using the corrected data presented by the contractor as a reasonable enrollment estimate, the State agency should have allocated costs at 56 percent Medicaid and 44 percent QHP.⁹

The State agency did not amend its CAP despite discovering that its methodology included a material defect. Without amending the CAP to correct the defect, the costs assigned to the establishment grants as claimed must be disallowed as required by 45 CFR § 95.519.

As a result, the State agency misallocated \$12.5 million to the establishment grants, as shown in Table 2. The State agency may seek CMS approval to claim a portion of these costs through the Medicaid program at Federal financial participation rates ranging from 50 to 90 percent.

⁹ The contractor informed the Maryland marketplace that the estimate of 147,233 QHP enrollees for the first open enrollment period should have been approximately 70,000 and that the estimate of 101,685 Medicaid enrollees for 6 months of enrollment during the corresponding SFY should have been approximately 90,000.

**Table 2: State Agency Allocation of Costs From July 2012 Through March 2014:
Methodology Included a Material Defect (dollars in millions)**

Total Costs	Allocation Percentages		State Agency's Allocation		Updated Percentages		Office of Inspector General's Allocation		State Agency Improperly Claimed QHP
	Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	
\$89.0	42%	58%	\$37.4	\$51.7	56%	44%	\$49.9	\$39.1	\$12.5

CAUSES OF MISALLOCATED CLAIMED COSTS

The State agency misallocated costs of \$28.4 million¹⁰ to establish a marketplace because the State agency did not have adequate internal controls to ensure the proper allocation of costs. Specifically:

- There was no written policy that explained how to perform the allocations or the necessity to use updated enrollment data.
- There was insufficient staff oversight to: (1) identify and correct enrollment projection errors; (2) obtain better, updated enrollment data; and (3) ensure the application of these data to the allocation of costs.
- The State agency initially assigned the responsibility for computing cost allocations to a staff accountant who did not have the requisite skills for the assigned duty. Further, the State agency did not hire a chief financial officer for the Maryland marketplace until January 2014.
- The State agency did not amend its CAP for the establishment of its health insurance exchange to allocate costs corresponding to program benefits received.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$15.9 million to CMS that was misallocated to the establishment grants by not prospectively using updated actual enrollment data;
- refund \$12.5 million to CMS that was misallocated to the establishment grants using a methodology that included a material defect;
- immediately amend the CAP and the APD for the period July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received;

¹⁰ The \$28.4 million of improperly claimed costs consists of \$15.9 million misallocated because the State agency did not recalculate and adjust its cost allocation prospectively and \$12.5 million misallocated because of a material defect in the allocation methodology.

- develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data; and
- oversee operations to ensure (1) the identification and correction of enrollment projection errors, (2) the use of better or updated enrollment data, and (3) the application of these data to allocate costs.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with recommendations four and five and said it will develop a written cost allocation policy and implement steps to oversee operations effectively.

The State agency did not concur with the first three of our recommendations. We have summarized below the State agency's comments regarding these recommendations and included the State agency's comments in their entirety as Appendix D.

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

RECOMMENDATION ONE: REFUND \$15.9 MILLION THAT WAS MISALLOCATED TO THE ESTABLISHMENT GRANTS BECAUSE IT DID NOT PROSPECTIVELY USE UPDATED ENROLLMENT DATA

State Agency Comments

The State agency did not concur with this recommendation. Specifically, the State agency said:

- The Maryland marketplace had complied with CMS guidance on the frequency of cost allocation updates because it "provided a revised cost allocation in June [2014] when it submitted a new [APD] and an amendment to the Establishment Level II grant that realigned various budget line items but did not actually request additional grant dollars."
- "CMS guidance provides that a state should update its cost allocation on an annual basis, and 'whenever a state seeks additional 1311 (a) Funding and/or [APD] funding.' In doing these updates, states should 'reassess the initial cost allocation that was approved prior to open enrollment based on projections.'"
- The Office of Inspector General's (OIG) assumption that the Maryland marketplace "should have updated its cost allocation immediately after the first open enrollment, which ended on March 31, 2014, ... is not consistent with the most recent guidance from [CMS] addressing when states should update their cost allocation methodology between the Marketplace and the State Medicaid agency for jointly funded activities."

Office of Inspector General Response

We maintain that this recommendation is valid. Specifically:

- The State agency submitted a revised cost allocation plan in June 2014 because it was planning to upgrade its Web site technology. It applied this allocation only to the selected costs related to the technology upgrade; it did not apply it to the \$42.9 million in total costs, which included the initial Web site technology costs, that was the basis for the \$15.9 million we questioned. For the period April through June 2014, the State agency did not reallocate the \$42.9 million in total costs in accordance with Federal requirements to revise the allocation to reflect significant program changes to ensure that the allocated costs correspond to the program benefits received.
- The State agency's comments included an incomplete summary of the CMS guidance on the requirements for cost allocation plans. In addition to including the portion quoted by the State, the CMS guidance in August 2014 also explains that: "In addition, CMS strongly recommends states continue to reassess their cost allocation on an annual basis and/or if there is a substantive change in program participation" The State agency did not revise the cost allocation to reflect the substantive change in program participation for the costs in question.
- In addition to the CMS guidance, Federal requirements state that a State agency must promptly amend its CAP if the procedures shown in the existing CAP "become outdated because of ... significant changes in program levels, affecting the validity of the approved cost allocation procedures" (45 CFR 95.509(a)(1)). If a State fails to submit an amended CAP when there are significant changes in program levels, the costs improperly claimed will be disallowed (45 CFR 95.519). The State agency's submission of a revised CAP did not address these Federal requirements.

RECOMMENDATION TWO: REFUND \$12.5 MILLION THAT WAS MISALLOCATED TO THE ESTABLISHMENT GRANTS USING A METHODOLOGY THAT INCLUDED A MATERIAL DEFECT

State Agency Comments

The State agency did not concur with this recommendation. Specifically, the State agency said:

- OIG's "finding relies on the [Maryland marketplace] contractor's projection that [the marketplace] would have 70,000 QHP enrollments in the first 2014 open enrollment period instead of 147,000. (In the initial, uncorrected projection, the 147,000 was intended to cover calendar year 2014, which included both the first and second 2014 open enrollment periods.) The contractor makes clear, however, that the 70,000 for the first six months reflects only the *newly* insured, and the total projected enrollment must include the 5,000 to 30,000 individuals who previously did have health coverage. Thus, for an accurate cost allocation based on fiscal year, OIG should use the total corrected projections, which include up to 30,000 individuals previously with coverage. Including

these individuals changes the allocation to 53 [percent] QHP/47 [percent] Medicaid (100,000 QHP and 90,000 Medicaid).”

- OIG “uses fiscal year rather than calendar year 2014 projection data. Its finding, therefore, relies on the contractor’s corrected projections for only the first six months of calendar year 2014. The contractor’s corrected projections, however, cover the whole calendar year. Thus, to be consistent, the cost allocation methodology should rely on the projection data as provided, or, in other words, for the entire calendar year. Using a different basis than the projections may not accurately reflect the contractor’s methodology for projection.”

Office of Inspector General Response

We maintain that this recommendation is valid. Specifically:

- We acknowledge that the State has the opportunity to use better data and submit a cost allocation plan to CMS and DCA for approval. However, when we asked the contractor whether the data regarding 5,000 to 30,000 individuals who previously had health coverage was statistically reliable, the contractor said that this data was a “guesstimate.” The contractor’s letter (February 21, 2014) to the State agency did not indicate that the State agency must include individuals who previously had health coverage in the total projected enrollment.
- We used fiscal year projection data in our calculation because that was the time period approved by CMS and DCA in the State agency’s cost allocation methodology. We acknowledge that the State has the opportunity to use better data and submit a revised cost allocation plan to CMS and DCA for approval, but the State agency had not done so for the costs questioned. In addition, we question whether the use of calendar year data would result in better data to use in the calculation of the allocation. In April 2014 congressional testimony,¹¹ the former Secretary of the Maryland Department of Health and Mental Hygiene acknowledged an error had been made in the contractor’s report (2012) regarding the reporting of enrollment data. This error related specifically to the contractor’s use of calendar year for enrollment estimates, which affected projected program enrollment numbers because the estimates included two enrollment periods for QHP enrollees.

¹¹ Joint Hearing before the Subcommittee on Economic Growth, Job Creation and Regulatory Affairs and the Subcommittee on Energy Policy, Health Care and Entitlements of the Committee on Oversight and Government Reform, House of Representatives, One Hundred Thirteenth Congress, Second Session, April 3, 2014, Serial No. 113-115.

RECOMMENDATION THREE: IMMEDIATELY AMEND THE COST ALLOCATION PLAN AND THE ADVANCE PLANNING DOCUMENT FOR THE PERIOD JULY 1 THROUGH DECEMBER 31, 2014, SO THAT ALLOCATED COSTS CORRESPOND TO THE RELATIVE BENEFITS RECEIVED

State Agency Comments

The State agency said that it did not concur with this recommendation “for the same reasons it does not concur with” recommendations one and two.

Office of Inspector General Response

We maintain that this recommendation is valid for the same reasons that we provided 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 Federal regulations, which require a State agency to promptly amend its CAP when the procedures in the existing CAP become outdated because of significant changes in program levels that affect the approved CAP’s validity.

**CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS
AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, CMS described its understanding of the State agency’s cost allocation practices for the Maryland marketplace establishment grants. We have summarized below CMS’s comments, and included the comments in their entirety as Appendix E.

After considering CMS’s comments on our draft report, we maintain that our findings and recommendations are valid.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS said it “worked with states to review and revise projections based on the timing of availability of actual enrollment data for use when making accurate cost allocation adjustments.” CMS said it issued additional guidance in August 2014 to States “to make cost allocation adjustments annually and when seeking additional federal funds using actual enrollment numbers when available. CMS provided this guidance to OIG on February 27, 2015.”

CMS also said, “The Maryland Health Benefits Exchange (MHBE) adjusted its cost allocation based on actual enrollments and redeterminations both in June 2014 when it sought to repurpose its federal grant funds and again in November 2014 when it applied for the last round of federal grant funding. MHBE provided the revised cost allocation in June 2014 because of the time needed for Medicaid and QHP enrollment data to stabilize and be successfully verified after the conclusion of the 2014 Open Enrollment. CMS will review the OIG’s findings to determine if a cost reallocation is necessary. In addition, CMS will continue to provide guidance to States regarding updating their cost allocations.”

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our recommendations are valid. Even though CMS directed States to update their cost allocation methodology annually, CMS also directed States to reassess their cost allocation “if there is a substantive change in program participation.” Further, in earlier guidance, CMS asserted that States are expected to update their cost allocation methodology and plan based on “updated or better data” and “on changing realities” (CMS’s *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*, “Questions and Answers”). CMS instructed States to make cost-allocation adjustments for three reasons: (1) when updated or better data reflect a substantive change in program participation, (2) on an annual basis, or (3) when seeking additional funds. CMS has not issued specific guidance that directs the State-based marketplaces to update their cost allocation methodology using enrollment data that are “final” at a certain point in time or that have stabilized. The March 31, 2014, enrollment numbers demonstrated a substantive change in program enrollment because there was a 37-percentage point difference between the estimated enrollment split used initially to allocate costs and the actual enrollment split at the end of the first open enrollment period. In our view, absent any specific guidance from CMS, the State agency should have used these enrollment figures to update the cost allocation methodology.

With regard to the adjusted cost allocations Maryland submitted in June 2014, as we noted above in our response to the State agency’s comments, the State agency submitted a revised cost allocation plan in June 2014 because it was planning to upgrade its Web site technology. The State agency applied the revised allocation only to \$1.5 million in selected costs related to the technology upgrade. The State agency did not apply the revised allocation to the \$42.9 million in total costs, which included the initial Web site technology costs, which was the basis for the \$15.9 million we questioned. Even though both costs were incurred during the same periods, the State agency applied two different allocation methodologies.

Our findings questioned only the costs that included the initial Web site technology that were misallocated because the State agency did not update its cost allocation methodology to reflect substantive changes in program participation. As a technical point, the State agency’s revised cost allocation for the \$1.5 million in upgraded Web site technology was not based on actual enrollment data. Rather, the revised cost allocation was based on projections for enrollment created by its contractor in July 2012.

CMS is planning to review our findings to determine next steps, and we plan to work closely with CMS to address the issues we identified in the Maryland marketplace allocations and measures that CMS can take to improve its guidance to States.

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 grants¹² 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 agreements¹³ 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 agreements¹⁴ to support States’ progress towards establishing a marketplace. 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

¹² CCIIO, State Planning and Establishment Grants for the Affordable Care Act’s Exchanges, Funding Opportunity, Number: IE-HBE-10-001, July 29, 2010.

¹³ 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 \$249 million.

¹⁴ 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 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:

- the necessary legal authority to establish and operate a marketplace that complies with Federal requirements available at the time of the application,
- established a governance structure for the marketplace, and
- 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: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed \$76.6 million that the State agency allocated to the establishment grants for SFYs 2013 and 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 office in Baltimore, Maryland, from March through September 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's cooperative agreement application packages;
- reviewed CCIIO'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 gain an understanding of the State's accounting system and internal controls;
- reviewed reports issued by the contractor and interviewed contractor 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 Exchange's public reporting of individuals determined eligible and enrolled in QHPs, Medicaid, or CHIP;
- obtained actual enrollment figures for QHPs, Medicaid, and CHIP through the Maryland marketplace;
- obtained revenue and expenditure general ledger reports for SFYs 2011 through 2014;
- performed tests, such as comparing cash drawdowns to the Federal Payment Management 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 updated enrollment data;
- assessed the impact of allocating costs that used enrollment estimates versus actual enrollment data; and
- discussed the results of our review with the State agency and CMS officials.

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.

APPENDIX C: STATE AGENCY MISALLOCATION OF COSTS

Table 3: State Agency Misallocation of Costs¹⁵
(dollars in millions)

Period	Total Costs	Allocation Percentages		State Agency's Allocation		Updated Percentages		Office of Inspector General's Allocation		State Agency Improperly Claimed QHP
		Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	Medicaid	QHP	
Misallocation using outdated estimated enrollment data										
4/2014 to 6/2014	\$42.9	42%	58%	\$18	\$24.9	79%	21%	\$33.9	\$9	\$15.9
Misallocation using a cost allocation methodology with a material defect										
7/2012 to 3/2014	89	42%	58%	37.4	51.7	56%	44%	49.9	39.1	12.5
Total	\$132			\$55.4	\$76.6			\$83.8	\$48.2	\$28.4

¹⁵ This table combines information from Tables 1 and 2.

APPENDIX D: STATE AGENCY COMMENTS



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Laura HerreraScott, MD, MPH, Acting Secretary

January 12, 2015

Mr. David M. Lamir
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Report Number: A-01-14-02503

Dear Mr. Lamir:

This letter is in response to a draft report from the Department of Health and Human Services' Office of Inspector General entitled *Maryland Misallocated Millions to Cooperative Agreements for Establishing a Health Insurance Marketplace*. The Department of Health and Mental Hygiene (Department), as well as the Maryland Health Benefits Exchange (MHBE), has reviewed the report and our comments are attached.

We appreciate the opportunity to review the draft report and submit comments. If you have any additional questions, please contact either Carolyn Quattrocki, MHBE Executive Director, at 410-547-1270 or Thomas V. Russell, DHMH Inspector General at 410-767-5784.

Sincerely,

Laura Herrera Scott, MD, MPH
Acting Secretary

Attachments

cc: Carolyn Quattrocki, Executive Director, MHBE
Allan Pack, CFO, MHBE
Caterina Pangilinan, Compliance Officer, MHBE
Thomas V. Russell, Inspector General, DHMH
Elizabeth Morgan, Acting Assistant Inspector General, DHMH
George Nedder, Audit Manager, DHHS, OIG

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Maryland Health Benefit Exchange Response to the DHHS OIG Audit Report
Maryland Misallocated Millions to Cooperative Agreements for Establishing a Health Insurance Marketplace

Audit Recommendation 1: Refund \$15.9 million that was misallocated to the cooperative agreements because it did not prospectively use updated actual enrollment data.

Maryland Health Benefit Exchange (MHBE) Response: MHBE does not concur with the recommendation.

OIG's draft report finds that after March 31, 2014, MHBE used outdated estimated enrollment data instead of updated, actual enrollment data based on the first open enrollment period. OIG recommends, therefore, that MHBE refund the amount that would have been allocated to Medicaid had the agency adjusted its cost allocation formula using actual enrollment data.

OIG's finding assumes that MHBE should have updated its cost allocation immediately after the first open enrollment, which ended on March 31, 2014. This assumption, however, is not consistent with the most recent guidance from the Centers for Medicare & Medicaid Services (CMS) addressing when states should update their cost allocation methodology between the Marketplace and the State Medicaid agency for jointly funded activities.

See http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ_1311_project_FAQs_periods.pdf.

CMS' guidance provides that a state should update its cost allocation on an annual basis, and "whenever a state seeks additional 1311 (a) funding and/or Advance Planning Document (APD) funding." In doing these updates, states should "reassess the initial cost allocation that was approved prior to open enrollment based on projections."

Consistent with CMS guidance, MHBE provided a revised cost allocation in June when it submitted a new Advanced Planning Document and an amendment to the Establishment Level II grant that realigned various budget line items but did not actually request additional grant dollars. Thus, MHBE has complied with CMS's guidance on the frequency of cost allocation updates.

For future administration of MHBE's cost allocation, MHBE will continue to seek guidance from CMS.

Audit Recommendation 2: Refund \$12.5 million that was misallocated to the cooperative agreements using a methodology that included a material defect.

MHBE Response: MHBE does not concur with the recommendation.

OIG's draft report also finds that MHBE allocated costs between July 2012 and March 2014 using a defective enrollment projection. It finds that projection data corrected in February, 2014 by MHBE's contractor should have resulted in a readjustment of MHBE's cost allocation from the original 58% QHP/42% Medicaid to 44% QHP/54% Medicaid.

First, OIG's finding relies on the MHBE contractor's corrected projection that MHBE would have 70,000 QHP enrollments in the first 2014 open enrollment period instead of 147,000. (In the initial, uncorrected projection, the 147,000 was intended to cover calendar year 2014, which included both the first and second

Maryland Health Benefit Exchange Response to the DHHS OIG Audit Report
Maryland Misallocated Millions to Cooperative Agreements for Establishing a Health Insurance Marketplace

2014 open enrollment periods). The contractor makes clear, however, that the 70,000 for the first six months reflects only the *newly* insured, and total projected enrollment must include the 5,000 to 30,000 individuals who previously did have health coverage. Thus, for an accurate cost allocation based on fiscal year, OIG should use the total corrected projections, which include up to 30,000 individuals previously with coverage. Including these individuals changes the allocation to 53% QHP/47% Medicaid (100,000 QHP and 90,000 Medicaid). See Hilltop letter attached as Exhibit B.

Second, in making its finding, OIG uses fiscal year rather than calendar year 2014 projection data. Its finding, therefore, relies on the contractor's corrected projections for only the first six months of calendar year 2014. The contractor's corrected projections, however, cover the whole calendar year. Thus, to be consistent, the cost allocation methodology should rely on the projection data as provided, or, in other words, for the entire calendar year. Using a different basis than the projections may not accurately reflect the contractor's methodology for projection. In addition, a cost allocation using calendar year data covers more of the marketplace's full ramp-up by capturing most of the first two open enrollment periods. MHBE believes that the projected outcome of the first two open enrollment periods, taken together, was more predictive of the enrollment mix on a going-forward basis. The corrected 2014 tables indicate that enrollments for calendar year 2014 were projected to be 138,764 QHP and 101,685 Medicaid, or 58% QHP/42% Medicaid, as reflected in MHBE's original cost allocation.¹ (See Hilltop report attached as Exhibit A.)

Thus, MHBE respectfully requests a correction of Finding 2 that, at a minimum, reflects the fiscal year data which implies an allocation of 53% QHP/47% Medicaid, or, preferably, that the calendar year basis was reasonable given MHBE's contractor's choice of the basis of projection, and that the 58% QHP/42% Medicaid cost allocation was correct.

Audit Recommendation 3: Immediately amend the CAP and the Advanced Planning Document (APD) for the period July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received.

MHBE Response: MHBE does not concur with the recommendation.

MHBE does not concur with this recommendation for the same reasons it does not concur with Recommendations 1 and 2.

Audit Recommendation 4: Develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data.

MHBE Response: The MHBE concurs with the recommendation.

MHBE will develop a written cost allocation policy, and will oversee agency operations, to ensure that enrollment projection errors are timely identified and corrected, and that appropriate enrollment data are used and applied correctly to allocate costs based upon CMS guidance on how best to operationalize its cost allocation methodology between the QHP and Medicaid populations.

¹The Medicaid number includes previously eligible people encouraged to enroll by the new program, or what is referred to as the "woodwork effect".

Maryland Health Benefit Exchange Response to the DHHS OIG Audit Report
Maryland Misallocated Millions to Cooperative Agreements for Establishing a Health Insurance Marketplace

Audit Recommendation 5: Oversee operations to ensure (1) the identification and correction of enrollment projection errors, (2) the use of better or updated enrollment data, and (3) the application of that data to allocate costs.

MHBE Response: MHBE concurs with the recommendation.

MHBE will implement steps to oversee operations effectively to ensure: (1) the identification and correction of enrollment projection errors; (2) the use of better or updated enrollment data; and (3) the application of that data to allocate costs.

EXHIBIT A

The Hilltop Institute



analysis to advance the health of vulnerable populations

Maryland Health Care Reform Simulation Model: Projections

Version 2.1

February 24, 2014



Version History

Version 2.0

Version 2.0 was published July 13, 2012.

Version 2.1

Version 2.1, published February 24, 2014, corrects two incorrectly labeled tables and an erroneous footnote.

- The heading for “Number and Percent Population Uninsured, Number of New Jobs, and Unemployment Rate” on page 1 and “Table VII. Enrollment Projections” on pages 5-6 has been corrected to read “Calendar Years” instead of “Fiscal Years.”
- Note 1 that appeared on page 6 has been deleted because it was incorrect. Note 1 stated, “Health Care Reform programs start on January 2014. Medicaid enrollment data for FY 2014 correspond to 6 months of enrollments. However, Exchange enrollment reflect ‘Open Enrollment’ period, which is from October 2013 through March 2014.”



The Hilltop Institute

Version 2.1 (Revised 2/24/14)

Maryland Health Care Reform Simulation Model: Projections

The Economic Impact of the ACA

Additional Economic Activity Generated from Implementing the ACA (in million \$)

	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Federal Subsidies to Individuals (Tax Credits)	\$224	\$535	\$607	\$716	\$849	\$987	\$1,153
Federal Cost-Sharing Payments to Individuals	\$30	\$72	\$80	\$92	\$108	\$124	\$142
Total Federal Payments for Cost Sharing and Subsidies (Tax Credits)	\$254	\$607	\$687	\$808	\$957	\$1,111	\$1,295
Increase in Total Health Care Expenditures	\$1,057	\$2,085	\$2,321	\$2,719	\$3,111	\$3,497	\$3,930
Additional Output Generated	\$1,174	\$2,020	\$2,123	\$2,421	\$2,693	\$2,965	\$3,283
Total Additional State and Local Taxes Generated (Including Premium Assessments)	\$61	\$140	\$147	\$169	\$191	\$212	\$237

Number and Percent Population Uninsured, Number of New Jobs, and Unemployment Rate

	CY 14	CY 15	CY 16	CY 17	CY 18	CY 19	CY 20
Total Uninsured without ACA	746,337	735,620	727,950	719,148	718,664	722,369	723,957
Total Uninsured with ACA	599,003	514,388	488,539	472,749	439,614	415,441	390,352
Decrease in Number of Uninsured with ACA	147,334	221,232	239,411	246,399	279,050	306,928	333,605
Uninsured as % of Total Population (without ACA)	12.6%	12.3%	12.1%	11.9%	11.8%	11.7%	11.6%
Uninsured as % of Total Population (with ACA)	10.1%	8.6%	8.1%	7.8%	7.2%	6.7%	6.3%
New Employment Due to ACA	9,122	16,117	17,065	19,582	21,895	24,238	26,970
Unemployment Rate without ACA	6.9%	5.8%	5.0%	4.5%	4.3%	4.3%	4.3%
Unemployment Rate with ACA	6.7%	5.5%	4.6%	4.1%	3.9%	3.8%	3.7%
Change in Unemployment Rate	-0.2%	-0.4%	-0.4%	-0.4%	-0.5%	-0.5%	-0.6%



The Hilltop Institute

Maryland New Health Care Expenditures

Analysis excludes baseline programs that predated federal health care reform and were not altered by the Affordable Care Act

(Total funds, midpoint of range, in million \$)

RANGE
(plus/minus 25%)

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
I. Total New Health Care Expenditures												
1. Medicaid Coverage Expansion	\$0	\$0	\$144	\$292	\$345	\$404	\$448	\$491	\$524	\$2,649	\$1,987	\$3,311
2. Transfer of PAC Enrollees to MA Expansion	\$0	\$0	\$126	\$272	\$296	\$318	\$348	\$383	\$422	\$2,165	\$1,624	\$2,706
3. Medicaid "Woodwork" Effect	\$0	\$0	\$40	\$182	\$267	\$340	\$373	\$401	\$431	\$2,033	\$1,525	\$2,541
4. Medicaid and CHIP Administration	\$20	\$40	\$55	\$37	\$45	\$53	\$58	\$64	\$69	\$442	\$332	\$553
5. Total Expenditures through the Exchange	\$0	\$0	\$481	\$1,156	\$1,312	\$1,545	\$1,820	\$2,092	\$2,414	\$10,819	\$8,115	\$13,524
6. Insurance Exchange Administration	\$0	\$15	\$30	\$31	\$31	\$32	\$32	\$33	\$34	\$238	\$179	\$298
7. Increase in PCPs Payments to 100% of Medicare Fees	\$0	\$75	\$166	\$91	\$0	\$0	\$0	\$0	\$0	\$332	\$249	\$415
8. State Employees/Retirees Health Insurance	\$0	\$9	\$11	\$20	\$21	\$22	\$27	\$30	\$33	\$173	\$130	\$216
9. Admin costs (non-DHMH agencies, outreach, etc.)	\$2	\$2	\$4	\$4	\$4	\$4	\$4	\$4	\$4	\$32	\$24	\$40
Increase in Total Health Care Expenditures	\$22	\$141	\$1,057	\$2,065	\$2,321	\$2,719	\$3,111	\$3,487	\$3,930	\$18,887	\$14,163	\$23,604

Note: increase in Total Health Care Expenditures includes out-of pocket expenditures of individuals with new health care coverage

II. Federal Assessments, Subsidies, and Cost Sharing												
1. Federal Assessment of Employers	\$0	\$0	\$148	\$316	\$340	\$364	\$389	\$419	\$454	\$2,429	\$1,822	\$3,036
2. Federal Subsidies (Tax Credits) (Million \$)	\$0	\$0	\$224	\$535	\$607	\$716	\$849	\$987	\$1,153	\$5,071	\$3,803	\$6,339
3. Federal Cost Share Payments (Million \$)	\$0	\$0	\$30	\$72	\$80	\$92	\$108	\$124	\$142	\$648	\$486	\$810
Net New Federal Funds for Insurance Coverage through the Exchange (Million \$) (row 2 + row 3 - row 1)	\$0	\$0	\$107	\$291	\$347	\$444	\$557	\$682	\$843	\$3,290	\$2,468	\$4,113

Maryland New Health Care Expenditures continued

Analysis excludes baseline programs that predated federal health care reform and were not altered by the Affordable Care Act

RANGE

(Total funds, midpoint of range, in million \$)

(plus/minus 25%)

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
III. Flow of New Funds through the State Economy (in millions, used for economic impact analysis)												
<i>Includes physician expenditures and expenditures for insurance coverage through Exchange</i>												
1. Total Professional Services + PCP to 100% Mc Fees	\$0	\$75	\$293	\$397	\$360	\$423	\$480	\$539	\$604	\$3,172	\$2,379	\$3,965
2. Total Additional Hospital Services	\$0	\$0	\$239	\$541	\$628	\$733	\$839	\$929	\$1,040	\$4,949	\$3,712	\$6,186
3. Total Pharmacy	\$0	\$0	\$42	\$104	\$124	\$149	\$172	\$197	\$224	\$1,012	\$759	\$1,265
4. Other Health Services	\$0	\$0	\$47	\$123	\$158	\$200	\$244	\$293	\$350	\$1,416	\$1,062	\$1,770
5. Administrative Costs	\$0	\$15	\$61	\$68	\$77	\$85	\$91	\$97	\$103	\$596	\$447	\$745
Total	\$0	\$90	\$682	\$1,233	\$1,347	\$1,589	\$1,827	\$2,055	\$2,321	\$11,145	\$8,359	\$13,931
Note: Flow of new funds through the state economy excludes out-of pocket expenditures of individuals with new health care coverage												
Reduction in Uncompensated Hospital Care	\$0	\$0	\$118	\$306	\$404	\$452	\$519	\$613	\$714	\$3,126	\$2,345	\$3,908
IV. Additional Health Expenditures by Individuals (OoP Costs)												
	\$0	\$0	\$227	\$549	\$625	\$737	\$863	\$981	\$1,119	\$5,100	\$3,825	\$6,375
V. Additional Economic Activity Generated from Implementing the ACA (from the IMPLAN Model Output)												
1. Additional Output Generated	\$0	\$138	\$1,174	\$2,020	\$2,123	\$2,421	\$2,693	\$2,965	\$3,283	\$16,817	\$12,613	\$21,022
2. Additional Taxes Generated (Exclude Premium Assessments)	\$0	\$7	\$53	\$98	\$103	\$118	\$132	\$146	\$163	\$819	\$614	\$1,024
VI. Total Additional Federal Health Expenditures by Provider Type (in million \$)												
1. Total, All Professional Services (+ Federal PCP Payments)	\$0	\$58	\$219	\$285	\$253	\$296	\$340	\$386	\$433	\$2,271	\$1,703	\$2,839
2. Total Additional Hospital Services	\$0	\$0	\$140	\$305	\$358	\$418	\$497	\$562	\$639	\$2,918	\$2,188	\$3,647
3. Total Pharmacy	\$0	\$0	\$40	\$96	\$117	\$139	\$162	\$188	\$215	\$956	\$717	\$1,196
4. Other Health Services	\$0	\$0	\$33	\$86	\$111	\$140	\$173	\$210	\$251	\$1,004	\$753	\$1,255
Total	\$0	\$58	\$402	\$772	\$839	\$993	\$1,172	\$1,345	\$1,537	\$7,149	\$5,361	\$8,936

Maryland Health Care Reform Financial Modeling Tool

Analysis excludes baseline programs that predated federal health care reform and were not altered by the Affordable Care Act
(State funds only, midpoint of range, in million \$)

RANGE
(plus/minus 25%)

	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
Impact on State Budget												
A. Increase in Costs Compared to Baseline												
1. Medicaid Coverage Expansion	\$0	\$0	\$0	\$0	\$0	\$15	\$26	\$33	\$49	\$123	\$92	\$153
2. Medicaid "Woodwork" Effect	\$0	\$0	\$20	\$91	\$133	\$170	\$186	\$200	\$215	\$1,016	\$762	\$1,271
3. Medicaid and CHIP Administration	\$2	\$4	\$12	\$19	\$23	\$27	\$29	\$32	\$34	\$181	\$136	\$226
4. Reduction in Medicaid DSH	\$0	\$0	\$0	\$9	\$10	\$11	\$12	\$13	\$15	\$70	\$52	\$87
5. Increase in PCPs Payments to 100% of Medicare Fees	\$0	\$17	\$36	\$20	\$0	\$0	\$0	\$0	\$0	\$73	\$55	\$91
6. State Employees/Retirees Health Insurance	\$0	\$9	\$11	\$20	\$21	\$22	\$27	\$30	\$33	\$173	\$130	\$216
7. Admin costs (non-DHMH agencies, outreach, etc.)	\$3	\$4	\$4	\$4	\$4	\$4	\$4	\$3	\$3	\$33	\$25	\$41
Category Total	\$5	\$34	\$83	\$163	\$191	\$249	\$284	\$312	\$349	\$1,669	\$1,252	\$2,086
B. Reductions in Costs Compared to Baseline												
1. Enhanced Title XXI SCHIP-FMAP rate	\$0	\$0	\$0	\$0	-\$56	-\$78	-\$82	-\$87	-\$23	-\$327	-\$245	-\$409
2. Transfer of PAC Enrollees to MA Expansion	\$0	\$0	-\$71	-\$151	-\$161	-\$146	-\$143	-\$146	-\$135	-\$952	-\$714	-\$1,190
3. Increase in Manufacturers' Drug Rebates	-\$12	-\$12	-\$16	-\$19	-\$22	-\$24	-\$27	-\$29	-\$32	-\$193	-\$144	-\$241
4. Medicaid Drug Rebates extended to MCOs	-\$35	-\$37	-\$43	-\$47	-\$52	-\$57	-\$62	-\$67	-\$72	-\$471	-\$353	-\$589
5. Medicaid: Breast & Cervical Cancer converts to insurance	\$0	\$0	-\$2	-\$4	-\$4	-\$4	-\$4	-\$4	-\$4	-\$26	-\$20	-\$33
6. Seniors Prescript Drug Assist (SPDAP)	-\$2	-\$2	-\$2	-\$2	-\$3	-\$3	-\$4	-\$4	-\$5	-\$27	-\$20	-\$34
Category Total	-\$48	-\$51	-\$133	-\$224	-\$297	-\$313	-\$321	-\$337	-\$271	-\$1,996	-\$1,497	-\$2,495
C. New Revenue												
1. Insurance Premium Assessment	\$0	\$0	-\$8	\$43	-\$45	-\$51	-\$59	-\$66	-\$74	\$345	-\$259	\$432
Overall Total Change in Costs, Compared to Baseline	-\$43	-\$17	-\$58	-\$104	-\$151	-\$115	-\$96	-\$91	\$4	-\$672	-\$504	-\$840

Version 2.1 (Revised 2/24/14)

4

VII. Enrollment Projections

A. Population Insurance Coverage Status	Calendar Years						
	2014	2015	2016	2017	2018	2019	2020
Total Maryland Population	5,924,320	5,962,013	6,012,841	6,063,669	6,114,498	6,165,326	6,216,155
Medicaid ¹	1,088,032	1,128,677	1,156,494	1,185,380	1,207,779	1,227,410	1,243,952
Medicare ¹	832,755	859,944	892,748	925,551	958,355	991,158	1,023,962
CHAMPUS/Tricare	188,188	187,247	186,311	185,379	184,453	183,530	182,613
Commercial Insurance Coverage ²	3,247,574	3,279,889	3,282,342	3,282,888	3,285,083	3,284,280	3,284,853
Maryland Exchange	147,233	169,836	184,323	208,145	234,721	257,870	283,743
Total Uninsured ²	599,003	514,388	488,539	472,749	439,614	415,441	390,352
Adjustment for Dual Coverage	-178,465	-177,968	-177,916	-196,423	-195,507	-194,363	-193,320
Total Coverage including Dual Coverage	6,102,785	6,139,981	6,190,757	6,260,092	6,310,005	6,359,689	6,409,475
B. Medicaid Enrollment							
1. Current Medicaid (Excluding PAC) w/o ACA	986,347	993,275	1,004,559	1,018,234	1,032,785	1,045,455	1,056,676
2. Total Increase in Medicaid (incl. PAC) (D.1.+D.2.)	101,685	135,402	151,935	167,146	174,994	181,955	187,276
3. Medicaid with ACA Law (B.1.+B.2.)	1,088,032	1,128,677	1,156,494	1,185,380	1,207,779	1,227,410	1,243,952
4. MCHP (included in lines 1. and 3.)	107,500	107,500	107,500	107,500	107,500	107,500	107,500
5. Total Uninsured Medicaid Eligible (w/o ACA)	184,224	178,552	174,065	169,056	167,896	168,674	168,473
6. Remaining Medicaid Eligible Not Enrolled	152,453	115,116	96,256	77,749	71,765	68,837	66,469
New Medicaid Take Up Rate	40.0%	54.0%	61.2%	68.3%	70.9%	72.6%	73.8%
Total Medicaid Take Up Rate	87.7%	90.7%	92.3%	93.8%	94.4%	94.7%	94.9%
C. Exchange Enrollment							
1. Total Exchange (Sum of Rows D.3 thru D.6)	147,233	169,836	184,323	208,145	234,721	257,870	283,743
2. Potential Exchange Enrollment (Remaining US Citizens >138% FPL, without coverage)	241,819	213,072	193,918	164,816	137,431	115,727	90,158
Health Insurance Exchange Take Up Rate	37.8%	44.4%	48.7%	55.8%	63.1%	69.0%	75.9%

VII. Enrollment Projections continued

D. Health Care Reform Components	Calendar Years						
	2014	2015	2016	2017	2018	2019	2020
1. Medicaid Expansion (Includes PAC Enrollees)	90,639	112,285	119,634	126,996	133,201	138,999	143,207
2. Medicaid "Woodwork" Effect	11,046	23,117	32,301	40,150	41,793	42,956	44,069
3. Exchange (138-200% FPL) with Subsidy	37,452	42,308	45,088	49,859	55,823	61,336	67,249
4. Exchange (200-400% FPL) with Subsidy	67,289	77,937	84,888	96,245	108,691	119,423	131,508
5. Exchange (Above 400% FPL) without Subsidy	34,023	41,038	44,240	51,903	60,066	66,974	74,829
6. Small Business Health Options Program (SHOP)	8,469	8,553	10,107	10,138	10,141	10,137	10,157
Total New Medicaid and Exchange Coverage	248,918	305,238	336,258	375,291	409,715	439,825	471,019
E. Uninsured							
1. Total Uninsured without ACA ³	746,337	735,620	727,950	719,148	718,664	722,369	723,957
2. Total Remaining Uninsured with ACA	599,003	514,388	488,539	472,749	439,614	415,441	390,352
3. Remaining Uninsured US Citizens	394,272	328,188	290,174	242,565	209,196	184,564	156,627
Uninsured as % of Total Population (w/o ACA)	12.6%	12.3%	12.1%	11.9%	11.8%	11.7%	11.6%
Uninsured as % of Total Population (with ACA)	10.1%	8.6%	8.1%	7.8%	7.2%	6.7%	6.3%
Uninsured US Citizens % of Population (w. ACA)	6.7%	5.5%	4.8%	4.0%	3.4%	3.0%	2.5%
F. Economic Impact							
New Employment due to ACA	9,122	16,117	17,065	19,582	21,895	24,238	26,970
Unemployment Rate without ACA	6.9%	5.8%	5.0%	4.5%	4.3%	4.3%	4.3%
Unemployment Rate with ACA	6.7%	5.5%	4.6%	4.1%	3.9%	3.8%	3.7%

Notes:

1 - There is some overlap in insurance coverage. Medicare coverage includes individuals dually eligible for Medicare and Medicaid. Commercial insurance includes Medicare gap coverage.

2 - Numbers in section A. and section E. take an overall view of insurance coverage in Maryland. They take into account number of uninsured over age 65, and change in coverage from employer sponsored insurance, Medicare, etc.

3 - Changes in Total Uninsured without ACA reflect improvements in the economy through the forecast period.



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EXHIBIT B

The Hilltop Institute

analysis to advance the health of vulnerable populations



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February 21, 2014

Ms. Carolyn Quattrocki,
Interim Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 16th Floor
Baltimore, MD 21202

Dear Ms. Quattrocki:

I am writing regarding the enrollment projections for the Maryland Health Benefit Exchange and the Medicaid expansion as presented in the Maryland Health Care Reform Simulation Model which was produced by The Hilltop Institute in July 2012 on behalf of the Maryland Health Benefit Exchange. We have identified some mis-labeling of tables and an erroneous footnote in the Model description. The purpose of this letter is to correct these issues and clarify the estimates presented in the Model.

The report as published in July 2012 estimated a total newly insured enrollment of approximately 249,000 in fiscal year 2014, including (a) 147,233 through the first open enrollment through March 31; and (b) 101,685 in Medicaid through June 30. Specifically, footnote 1 of Enrollment Projections table stated, "Health Care Reform programs start on January 2014. Medicaid enrollment data for FY 2014 correspond to 6 months of enrollments. However, Exchange enrollment reflect 'Open Enrollment' period, which is from October 2013 through March 2014."

However, this footnote was in error. The 147,233 figure actually represented the newly insured in Maryland for both the first and second Exchange open enrollment periods in 2014, and the 101,685 figure reflected the model's estimate for Medicaid enrollment through the end of calendar year 2014.

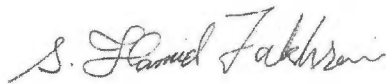
Given these estimates for calendar year 2014, a reasonable estimate of combined enrollment for Exchange and Medicaid in fiscal year 2014 would be approximately 160,000 newly covered individuals, including (a) approximately 70,000 in the Exchange through March 31, 2014 and (b) approximately 90,000 in Medicaid through June 30, 2014.

It is important to note that the simulation model projections and the estimates cited above do not include individuals who were insured immediately prior to their 2014 coverage. Some private insurers have estimated that 30,000 to 50,000 insured people who purchase coverage in the Individual Market would qualify for Federal subsidies through the Exchange. However, an unknown percentage of these individuals will actually obtain coverage through the Exchange. A broad range of estimates for the number of individuals who were previously insured prior to initiating new coverage in the Exchange might be 5,000 to 30,000. This brings the total estimate for enrollment in fiscal year 2014 to a range between 165,000 to 190,000.

Finally, The Hilltop Institute is planning to revise the current Model estimates based on more recent data and analysis of the Census Bureau's Current Population Survey. The revision will be completed in six to eight weeks.

Please contact me if I can be of further assistance in clarifying the Simulation Model estimates and assumptions.

Sincerely,



S. Hamid Fakhraei
Director of Economic Analysis

cc: Joshua M. Sharfstein, M.D.
Cynthia H. Woodcock



APPENDIX E: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES


Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: MAR 17 2015

TO: Daniel Levinson, Inspector General
Office of the Inspector General

FROM: Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services 

SUBJECT: Office of Inspector General (OIG) Draft Report: "Maryland Misallocated Millions to Cooperative Agreements for Establishing a Health Insurance Marketplace" (A-01-14-02503)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review the OIG's draft report on the Maryland state-based marketplace (SBM).

CMS is committed to enhancing transparency and accountability and takes its oversight responsibility of SBMs seriously. The key principles underlying CMS's oversight include effectiveness, efficiency, integrity, coordination, transparency, and accountability in SBM operations. It also builds on state oversight efforts and supports coordination with state authorities to address compliance issues and concerns. CMS has an oversight infrastructure and resources to carry out its responsibility in a transparent manner in order to use federal funds appropriately in the administration of SBM activities.

CMS follows an established grant-making process to ensure oversight and monitoring of section 1311 spending. All grant awards made by CMS follow a standard grant-making process, which has been successfully used for decades. This process complies with applicable Federal requirements, including OMB Circulars and Department of Health and Human Services (HHS) grant regulations. CMS is responsible for administering the grant awards. Like all grant recipients, states receiving 1311 grants are subject to post-award monitoring with respect to whether they are meeting the grant's terms and conditions. CMS monitors grantees' progress toward the establishment of a Marketplace through face-to-face meetings with policy and operations experts, calls to monitor progress and provide assistance, semi-annual progress reports, quarterly financial reports and monthly budget reports.

HHS and CMS are committed to policies and processes that are transparent and promote public accountability. CMS has designed and developed the framework for the oversight of SBMs at CMS's Center for Consumer Information and Insurance Oversight (CCIIO), including overseeing SBMs as they transition from grant funding to self-sustainability. CCIIO's oversight and monitoring program of SBMs will include monitoring of state oversight activities and review

and assessment of required reports on operations per HHS regulations (45 CFR 155.1200), which will be submitted by the states starting April 1, 2015. Each SBM will submit several types of reports to CMS that demonstrate the transparency of SBM activities, including financial statements, reports on eligibility determination errors, non-discrimination safeguards, accessibility of information, and incidences of fraud and abuse.

The OIG reviewed whether Maryland allocated costs for establishing a health insurance Exchange to its grants in accordance with Federal requirements. CMS worked with states to review and revise projections based on the timing of availability of actual enrollment data for use when making accurate cost allocation adjustments. In August 2014, CMS issued additional guidance to states to make cost allocation adjustments annually and when seeking additional federal funds using actual enrollment numbers when available. CMS provided this guidance to OIG on February 27, 2015.

The Maryland Health Benefits Exchange (MHBE) adjusted its cost allocation based on actual enrollments and redeterminations both in June 2014 when it sought to repurpose its federal grant funds and again in November 2014 when it applied for the last round of federal grant funding. MHBE provided the revised cost allocation in June because of the time needed for Medicaid and QHP enrollment data to stabilize and be successfully verified after the conclusion of the 2014 Open Enrollment. CMS will review the OIG's findings to determine if a cost reallocation is necessary. In addition, CMS will continue to provide guidance to States regarding updating their cost allocations.

CMS appreciates the opportunity for continued dialogue on these issues with the OIG.