

## **2015 SMART Report: Executive Summary**

More than one in three Vermonters is now covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA). As of December 2015, over 213,000 Vermonters possessed such coverage. QHP enrollment consisted of more than 68,000 Vermonters covered either as individuals through the exchange or direct-enrolled through a small business employer. MCA enrollment included more than 81,000 adults and 64,000 children.

By all accounts, Vermont Health Connect has helped drive down the state's uninsured rate. At the start of 2015, the Vermont Household Health Insurance Survey revealed that Vermont's uninsured rate was cut nearly in half from fall 2012 to fall 2014 (from 6.8% to 3.7%). The survey also reported that Vermont had done particularly well in terms of covering children in the state. The number of uninsured children in Vermont fell from nearly 2,800 in 2012 to fewer than 1,300 in 2014.

In early 2016, the National Center for Health Statistics used U.S. Census Bureau data to estimate that Vermont's uninsured rate was driven even lower in 2015, down to 2.7%. This followed fall 2015 reports from the Census Bureau that Vermont had passed Hawaii and Washington, D.C. to attain one of the two lowest uninsured rates in the nation.

Vermont's enrollment success is commonly attributed to an integrated approach to QHP and Medicaid enrollment to ensure that Vermonters don't fall through the cracks or face multiple applications, a commitment to state programs to reduce the cost of health insurance, and a strong consumer assistance program that offers telephone support and online tools while collaborating with community partners and stakeholders across the state.

Vermont Health Connect's Assister Network consists of more than 200 Navigators, Brokers, and Certified Application Counselors. These Assistors provided in-person enrollment assistance in all 14 counties of the state. They also coordinated with Vermont Health Connect's outreach campaign to promote health insurance literacy, helping customers understand the total cost of insurance, and ensuring that Vermonters were aware of the increasing federal fee for not having health insurance. In fall 2015, Vermont Health Connect partnered with community libraries and pharmacies to hold a series of "Health Insurance 101" workshops across the state. The sessions were free to the public and designed to help customers and potential customers better understand health insurance terms, financial help, and how to interact with the Vermont Health Connect system.

During open enrollment, Vermont Health Connect launched a new online Plan Comparison Tool to help Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by Robert Wood Johnson.

In terms of health plan offerings, the Department of Vermont Health Access (DVHA) maintained the same benchmark plan that has been in place for Vermont since 2014. Vermont Health Connect determined that the basic configuration of benefits should be continued into 2016 for market stability. Minimal changes were made to enrollee cost-share amounts in order to remain within required actuarial values (AVs) for all 2016 standard plans. Also for 2016, medical carriers were asked to prepare one additional non-standard plan at the Gold metal level with equal deductible and maximum out-of-pocket values. This plan design had been popular among small businesses in Vermont and was determined to be a valuable addition to the array of QHPs offered in the marketplace. In compliance with the Affordable Care Act, Vermont Health Connect expanded availability of qualified health plans to small businesses with up to 50 employees to those with up to 100 employees for 2016.

The 2015 legislative session brought changes to the Vermont marketplace. In particular, Act 54 allowed the direct sale of qualified health plans in the individual market, thus opening an alternative pathway for enrollment and billing. The only products available for direct enrollment are the certified QHPs also offered through VHC. VHC is working closely with the QHP issuers to ensure that customers are aware of the unavailability of subsidies for direct-enroll QHPs. Finally, the legislature directed the State to closely monitor the progress of VHC, including the implementation of automated functionality for change of circumstances and renewals, and consider exchange alternatives if certain milestones are not met.

Technology-wise, Vermont Health Connect faced major challenges in 2015 and made significant progress over the course of the year. Because of a lack of automated functionality, the year started with time-intensive contingencies for processing renewals and making changes to accounts. While processes were in place to ensure that all customers had access to care, many customers experienced delays. Renewals weren't completed until May and the queue of customers awaiting change requests topped 10,000 at that time. In late May, Vermont Health Connect met the first milestone by delivering functionality to support automated changes of circumstance (COC) and changes of information (COI). These system upgrades enabled customer service staff to efficiently process changes and reduce the COC backlog.

Staff were able to enter changes into the Vermont Health Connect system using a simple wizard tool with pre-populated data, and then have those changes updated automatically into the insurance carriers' and payment processor's systems. Prior to this upgrade, requested changes required staff to re-enter entire health insurance applications – often more than one hundred fields of data – and then work with additional teams of workers to transmit and update the information into as many as six different systems over a period of weeks. The new functionality greatly reduced the amount of time it takes to process change requests.

At the beginning of October, Vermont Health Connect deployed a system upgrade to support automated renewal functionality for QHP customers. The upgrade also included self-service plan selection during open enrollment, self-service change reporting, and the ability to make recurring payments. When open

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*Agency of Human Services*

enrollment began in November, this automated process took care of four out of five renewing households. State staff assisted with the completion of the remainder of the cases, which typically needed additional information before they could be processed into 2016 health plans.

In early November, key subcontractor Exeter announced that it was going out of business. The State quickly secured the license to Exeter's OneGate software and moved to transition key personnel to System Integrator Optum and other contractors. Prior to closing its doors, Exeter delivered code to support such additional upgrades as Medicaid redetermination integration, Department of Labor verifications, billing and payment functionality, and notices. The State and its contractors focused on testing the code and preparing multiple deployments in order to manage scope and deliver the best service for Vermonters.

Redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries began in November and, in December, a plan for 2016 MAGI Medicaid redeterminations was finalized. The plan's schedule focused on verifying and transitioning 9,000 MAGI Medicaid households per month from the State's legacy system (ACCESS) to Medicaid or qualified health plans in the Vermont Health Connect system from January through April, followed by monthly redeterminations from May through October for 9,000 MAGI Medicaid households that are already in the Vermont Health Connect system.

Goals for 2016 include: 1) concluding major system development activities in March, thus enabling Medicaid renewals for enrollees already in the VHC system, 2) improving system performance by performing root cause analysis of errors, remediating existing issues, and preventing future incidents, 3) providing quality customer service, 4) completing Medicaid renewals, 5) working with stakeholders to finalize a comprehensive state rule detailing policies and procedures for recertification of existing QHPs and issuers, as well as the processes for new medical and dental issuers wishing to become certified, 6) providing a smooth 2017 renewal/open enrollment process for QHP customers and supporting their plan selection process, and 7) advancing the state's progress toward universal coverage by continuing to enroll Vermonters and drive down the uninsured rate.



**INDEPENDENT EXTERNAL AUDIT:  
2015 AUDIT FINDINGS REPORT  
VERMONT  
VERMONT HEALTH BENEFIT EXCHANGE  
DBA VERMONT HEALTH CONNECT (VHC)**



# INDEPENDENT EXTERNAL AUDIT: 2015 FINDINGS REPORT

TO: CCIIO STATE EXCHANGE GROUP

FROM: BERRY DUNN MCNEIL & PARKER, LLC (BERRYDUNN)

DATE: JUNE 17, 2016

SUBJECT: AUDIT FINDINGS REPORT FOR VERMONT

AUDIT PERIOD: JULY 1, 2014 – JUNE 30, 2015

## I. EXECUTIVE SUMMARY

### PURPOSE

The purpose of this independent external audit is to assist the State of Vermont in determining whether Vermont Health Benefit Exchange d/b/a Vermont Health Connect (VHC), the Vermont State-Based Marketplace (SBM), is in compliance with the programmatic requirements set forth by the Centers for Medicare and Medicaid Services (CMS).

Name of SBM: VHC

State of SBM: Vermont

Name of Auditing Firm: BerryDunn

Our responsibility was to perform a financial and programmatic audit to report on VHC's compliance with 45 CFR 155 as described in the CMS memo dated June 18, 2014, Frequently Asked Questions about the Annual Independent External Audit of State-Based Marketplaces (SBMs). The Program Integrity Rule Part II ("PI, Reg."), 45 CFR 155.1200 (c), states, "The State Exchange must engage an independent qualified auditing entity which follows generally accepted governmental auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to the United States (U.S.) Department of Health and Human Services for review."

### SCOPE

The scope of this engagement included an audit of the Statement of Appropriations and Expenditures of VHC as well as an examination of VHC's compliance with the requirements of 45 CFR 155, Subparts C, D, E, K, and M. We conducted our audit in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. We completed an examination of VHC's compliance with the programmatic requirements under 45 CFR 155 and an audit of its financial statement and issued our reports, dated June 17, 2016.

We reviewed processes and procedures, read pertinent documents, and performed inquiries, observations, testing, and staff interviews to obtain reasonable assurance regarding whether VHC is in compliance with 45 CFR 155 in all material respects.

## METHODOLOGY

### **Audit Firm Background:**

BerryDunn is the second largest certified public accounting and consulting firm headquartered in New England, with more than 280 professionals. BerryDunn has for more than 40 years provided comprehensive audit and tax services for a broad range of healthcare, not-for profit, and governmental entities throughout the Northeast. Those services include conducting audits in accordance with Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance, previously referred to as OMB Circular A-133) for several sizable healthcare organizations, many of which receive U.S. Department of Health and Human Services federal grants or funding. In addition, we provide audit services for higher education, social service, and economic development organizations, as well as other entities that receive federal grants and are subject to the Uniform Guidance.

### **Financial Statement Audit:**

We have audited, in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the statement of appropriations and expenditures of VHC for the year ended December 31, 2015, and related notes to the statement, and have issued a report thereon dated June 17, 2016.

### **Programmatic Audit:**

We have examined VHC's compliance with the programmatic requirements described in 45 CFR 155 for the year ended June 30, 2015, and have issued a report thereon dated June 17, 2016.

### **Summary of Programmatic Audit Procedures**

Our audit consisted of specific procedures and objectives to evaluate instances of non-compliance and to perform procedures to test VHC's compliance and program effectiveness of the subparts C, D, E, K, and M of 45 CFR Part 155. BerryDunn examined compliance with the requirements under Title 45, Part 155, in the following programmatic areas:

- General Standards and Practices of the SBM
- Navigators, Certified Application Counselors and Brokers
- Contact Center Processes and Procedures
- Eligibility Processes and Procedures
- Compliance and Program Integrity
- Qualified Health Plan Certification.

We selected a sample of clients and tested for compliance with requirements under Title 45, Part 155 for eligibility determination, verification of data, and enrollment with a QHP.

We reviewed the processes and procedures under Title 45, Part 155 in the following programmatic areas in order to determine whether they had significantly changed from what was identified and tested during the prior year's audit:

- General Functions (Subpart C)
- Eligibility Determinations (Subpart D)
- Enrollment Functions (Subpart E)
- Certification of Qualified Health Plans (Subpart K)
- Oversight and Program Integrity Standards (Subpart M)

We reviewed the following documentation, which was obtained directly from VHC, or located on either the VHC website or the CMS website:

- 26 CFR 601.105 – Calculation of Premium Tax Credit
- 42 CFR Parts 431, 435, and 457 Medicaid Program Eligibility Changes Under the Affordable Care Act of 2010
- Affordable Care Act (ACA) # 22—Conversion of Net Income Standards to MAGI Equivalent Income Standards
- Advocate Authorization Instructions
- Authority to Connect Letter
- Auto renewal Standard Operating Procedures
- Assister Program Standard Operating Procedures
- Assister Certification Course Materials
- Assister Certification Record
- Benefit Plan Summaries
- Benefit Rate Summaries
- Carrier Enrollment Companion Guide
- Carrier Payment Companion Guide
- Change of Circumstances Standard Operating Procedures
- CMS Monthly Reports
- CMS Quarterly Reports
- Comprehensive Annual Financial Report (CAFR) 2015
- Confidentiality Matrix
- Contact Center Call Statistics
- Contracts
  - Archetype

- Benaissance
- Carriers
- MAXIMUS
- Optum
- Customer Complaint Resolution Process
- Health Benefits Eligibility and Enrollment Rule
- Master Interconnection Security Agreement
- Manual Workaround Procedures
- Minutes of Medicaid and Exchange Advisory Board Meetings
- Open Enrollment Reporting Packets
- Organization Charts
- Plan Designs and Premiums
- Premium Processing Standard Operating Procedures
- Previous CMS Audit Report
- QHP Certification Standard Operating Procedures
- Quality Assurance and IV&V Reports
- Rate Review Templates
- Record Retention Procedures
- Security and Privacy Regulations
- Silver Plans Brochure
- State Based Marketplace Issuer Attestation
- Security Documents, Including
  - 3<sup>rd</sup> Party Independent Security Assessment Report (SAR) [Cross-Reference Control Family SSP]
  - IRS SSR Acceptance Letter
  - IT Governance Flowchart
  - Plan of Action & Milestone (POA&M)
  - Privacy Impact Assessment
  - System Security Plan (SSP) & Workbook
  - Security Policies
- Training Materials
- Verifications Proposal 3.17.15
- Verifications Proposal Income Addendum 3.17.15

- VHC Blueprint Report
- VHC User Account Procedures

In order to understand management and staff responsibilities and processes as they relate to compliance with 45 CFR Part 155, we performed walkthroughs of data systems and operations and interviewed the following VHC staff:

- Archetype Service Delivery Director
- Assister Program Manager
- Benefit Program Specialist
- Business Application Support Unit Supervisor
- Customer Service Director
- Enrollment and Premium Processing Director
- Deputy Commissioner
- Director of Operations
- HAEU Call Center Director
- HAEU Customer Service Representative
- Information Security Director
- Information Technology Director
- MAXIMUS Call Center Director
- MAXIMUS Customer Oversight and Monitoring Director
- Plan Management Director
- Strategic Project Director
- VHC Program Manager

We analyzed the following information to assess VHC's compliance with the requirements of 45 CFR 155:

- A listing of 94,136 applicants who had an eligibility determination completed on or before June 30, 2015. We selected a sample of 95 cases to test the compliance with 45 CFR 155 Subpart D Eligibility and Subpart E Enrollment.

**CONFIDENTIAL INFORMATION OMITTED**

N/A

## II. AUDIT FINDINGS

### KEY FINDINGS

#### FINDING #2015-001

##### *Criteria:*

Subpart D - Eligibility, 45 CFR §155.315 requires that an applicant be made conditionally eligible based upon the data he or she entered in his or her application and data received from automated data sources. Under 45 CFR §155.315 (f), the Exchange must make a reasonable effort to identify and address any inconsistency between the self-attested data in the application and information obtained from outside data sources by contacting the applicant to resolve such inconsistency by providing additional information. Pursuant to 45 CFR §155.315 (f) (2) (ii), the Exchange must provide the applicant with a period of 90 days from when the applicant receives a notice that requests documentation to resolve an inconsistency between the self-attested data and the outside data sources. Pursuant to 45 CFR §155.315 (f) (3), the Exchange can extend the period if an applicant demonstrates a good-faith effort to provide sufficient documentation to resolve the inconsistency.

During this inconsistency period, an applicant who is otherwise qualified is eligible to enroll in a Qualified Health Plan (QHP) and, when applicable, is eligible for insurance affordability programs (45 CFR § 155.315(f) (4)). If after the 90-day period (or applicable extensions), the Exchange is unable to resolve the discrepancy between the self-attested information and the data sources with customer-provided information, then it must rerun eligibility and notify the applicant of their new eligibility determination.

As discussed with VHC staff, and as substantiated by our review of a sample of cases, there were a significant number of cases that did not have their self-attested data properly verified within the required 90-day period. VHC staff acknowledged that while they did match data against the Federal Data Services Hub (Data Hub or FDSH), the OneGate system was not able to effectively and accurately process that information to verify the self-attested data included in the application during the audit period. In January and June 2015, VHC manually verified Social Security Number (SSN), immigration status, and citizenship data, using the U.S. Citizenship and Immigration Services' Systemic Alien Verification for Entitlement (SAVE) Program and Vermont's ACCESS system.

Therefore, during the audit period, except for SSN, immigration status, and citizenship, eligibility determinations were based solely upon the applicants' self-attested data.

##### *Cause:*

The OneGate system that VHC uses to support its SBM was not capable of processing data matches with the Data Hub and, therefore, VHC could not perform automated data verifications during the audit period. To address this, VHC performed manual verification processes for SSN, immigration status, and Citizenship data; however, because of limitations in the OneGate system, VHC was not able to issue notifications to applicants. As a result, VHC was not able to

act on any discrepancies found between the applicants' self-attested data and the manual verification for SSN, immigration status, and citizenship.

**Effect:**

The failure to verify the applicants' self-attested data against the Data Hub, and the inability to notify applicants of any discrepancies found in the manual verification with the SAVE program and ACCESS system, meant that VHC did not properly verify that the applicants met the eligibility requirements for enrollment in a QHP or for insurance affordability programs, or that the amounts of the Advanced Payment of Tax Credit (APTC) and cost-sharing reductions were correctly determined.

**FINDING #2015-002**

**Criteria:**

45 CFR §155.305(f) (1) (i) (B) and § 155.305(g) (1) state that a person may not receive APTC (Section 305(f) (1) (i) (B)) or cost-sharing reductions (Section 305(G) (1)) if they are eligible for Minimum Essential Coverage (MEC). MEC consists of Employer-Sponsored Insurance (ESI) and non-employer-sponsored coverage, such as Medicaid, Medicare, or TRICARE. The Exchange must verify whether an applicant reasonably expects to be enrolled in or is eligible for MEC in an ESI or a non-employer plan, such as Medicaid, Medicare, or TRICARE, for the benefit year for which coverage is requested (45 CFR § 155.320(d)).

**Condition:**

VHC confirmed that, during the audit period, it verified whether applicants who were deemed eligible for APTC or cost-sharing reductions had or were eligible for non-employer sponsored MEC. However, applicants were not notified of discrepancies between their self-attested data and any data identified in matches with the Federal Hub. As a result, applicants who were eligible for non-employer sponsored MEC such as TRICARE or Medicare were not identified and some applicants that had MEC were incorrectly made eligible for APTC or cost-sharing reductions.

**Cause:**

OneGate did not have the capability to process data matches to identify non-employer-sponsored coverage that meets the MEC standard.

**Effect:**

Individuals who were eligible for non-employer-sponsored coverage that meets the MEC standard were able to receive APTC or cost-sharing reductions, even though they were not entitled to that benefit.

**FINDING #2015-003****Criteria:**

Pursuant to 42 CFR § 155.310(g) SBMs must provide applicants with timely written notice of any eligibility determination made by the SBM.

**Condition:**

VHC did not issue required eligibility notifications during a substantial portion of the audit period. Although VHC addressed the system defect and issued notices retroactively to all customers whose notices were pending within the audit period, there was a prolonged period of time within the audit period where the required notices were not sent to the customers in a timely manner.

**Cause:**

OneGate had issues that prevented sending notices for portions of the audit period.

**Effect:**

Because there were limitations to VHC's notification capability during the audit period, applicants were not updated on the status of their application, nor were they informed of instances when there were discrepancies between information the applicant included in their application and information available in the Data Hub or other outside data sources.

**FINDING #2015-004****Criteria:**

Pursuant to 42 CFR § 155.1200, SBMs must, at least annually, provide to the U.S. Department of Health and Human Services a financial statement presented in accordance with U.S. generally accepted accounting principles (U.S. GAAP). This necessitates they have financial systems in place to permit preparation of U.S. GAAP financial statements.

**Condition:**

VHC did not have a system in place to permit preparation of a financial statement in accordance with U.S. GAAP.

**Cause:**

The financial statement audit period is not aligned with the State of Vermont's fiscal year end. Interim financial reporting in Vermont is recorded utilizing the cash basis of accounting not the current financial resources measurement focus and the modified accrual basis of accounting. Cutoff procedures are not in place for VHC's reporting period-end.

**Effect:**

VHC was unable to prepare a U.S. GAAP-basis financial statement for the year ended December 31, 2015.

**AUDITOR'S OPINION**

We have issued an Independent Auditor's Report on the Schedule of Appropriations and Expenditures for the Year Ended December 31, 2015, reflecting the following type of opinion:

QUALIFIED

UNQUALIFIED

ADVERSE

DISCLAIMER

**ADDITIONAL COMMENTS**

N/A.

### III. RECOMMENDATIONS

**FINDING #2015-001**

We understand that VHC has implemented automated verification functionality for some data fields and is conducting manual verifications for the other data fields; we recommend that VHC continue to prioritize implementation of fully automated verification with the external data sources.

**FINDING #2015-002**

We recommend that VHC implement processes and procedures to validate that an applicant is not eligible for Minimum Essential Coverage (MEC) before the applicant is deemed eligible to receive APTC or conditional eligibility.

**FINDING #2015-003**

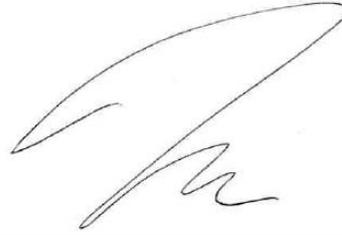
Since the technical issues with VHC notices have been addressed we do not have any recommendation at this time.

**FINDING #2015-004**

We understand VHC is moving its reporting period to June 30 to align with the State of Vermont's fiscal year end; we recommend the appropriate June 30, 2015 and June 30, 2016 accruals be made at that time to allow for the presentation of a financial statement in accordance with U.S. GAAP for the year ending June 30, 2016.

**IV. CONCLUSION**

We confirm to the best of our knowledge that the information included in this Audit Findings Report is accurate and based on a thorough review of the documentation required for this report.

**SIGNATURE OF AUDIT FIRM:****COMPLETION DATE OF AUDIT FINDINGS  
REPORT:**[06/17/16]

**INDEPENDENT EXTERNAL AUDIT:  
2015 AUDIT FINDINGS REPORT  
VERMONT HEALTH CONNECT:  
AUDIT RESPONSE AND CORRECTIVE ACTION PLAN**

TO: CCIIO STATE EXCHANGES GROUP  
FROM: VERMONT HEALTH CONNECT  
DATE: JUNE 20<sup>TH</sup>, 2016  
SUBJECT: CORRECTIVE ACTION PLAN FOR VERMONT  
AUDIT PERIOD: JULY 1, 2014 – JUNE 30, 2015

## **I. RESPONSE TO THE AUDIT REPORT FINDINGS**

*Vermont is in agreement with the key findings. We are engaged in regular communication with CCIIO regarding VHC functionality and resource constraints, and we will provide updates to CCIIO as issues become resolved.*

## **II. CORRECTIVE ACTION PLAN**

### **FINDING #2015-001**

#### ***Criteria:***

Subpart D - Eligibility, 45 CFR §155.315 requires that an applicant be made conditionally eligible based upon the data he or she entered in his or her application and data received from automated data sources. Under 45 CFR §155.315 (f), the Exchange must make a reasonable effort to identify and address any inconsistency between the self-attested data in the application and information obtained from outside data sources by contacting the applicant to resolve such inconsistency by providing additional information. Pursuant to 45 CFR §155.315 (f) (2) (ii), the Exchange must provide the applicant with a period of 90 days from when the applicant receives a notice that requests documentation to resolve an inconsistency between the self-attested data and the outside data sources. Pursuant to 45 CFR §155.315 (f) (3), the Exchange can extend the period if an applicant demonstrates a good-faith effort to provide sufficient documentation to resolve the inconsistency.

During this inconsistency period, an applicant who is otherwise qualified is eligible to enroll in a Qualified Health Plan (QHP) and, when applicable, is eligible for insurance affordability programs (45 CFR § 155.315(f) (4)). If after the 90-day period (or applicable extensions), the Exchange is unable to resolve the discrepancy between the self-attested information and the data sources with customer-provided information, then it must rerun eligibility and notify the applicant of their new eligibility determination.

As discussed with VHC staff, and as substantiated by our review of a sample of cases, there were a significant number of cases that did not have their self-attested data properly verified within the required 90-day period. VHC staff acknowledged that while they did match data against the Federal Data Services Hub (Data Hub or FDSH), the OneGate system was not able to effectively and accurately process that information to verify the self-attested data included in the application during the audit period. In January and June 2015, VHC manually verified Social Security Number (SSN), immigration status, and citizenship data, using the U.S. Citizenship and Immigration Services' Systemic Alien Verification for Entitlement (SAVE) Program and Vermont's ACCESS system.

Therefore, during the audit period, except for SSN, immigration status, and citizenship, eligibility determinations were based solely upon the applicants' self-attested data.

**Cause:**

The OneGate system that VHC uses to support its SBM was not capable of processing data matches with the Data Hub and, therefore, VHC could not perform automated data verifications during the audit period. To address this, VHC performed manual verification processes for SSN, immigration status, and Citizenship data; however, because of limitations in the OneGate system, VHC was not able to issue notifications to applicants. As a result, VHC was not able to act on any discrepancies found between the applicants' self-attested data and the manual verification for SSN, immigration status, and citizenship.

**Effect:**

The failure to verify the applicants' self-attested data against the Data Hub, and the inability to notify applicants of any discrepancies found in the manual verification with the SAVE program and ACCESS system, meant that VHC did not properly verify that the applicants met the eligibility requirements for enrollment in a QHP or for insurance affordability programs, or that the amounts of the Advanced Payment of Tax Credit (APTC) and cost-sharing reductions were correctly determined.

**Recommendation:**

We understand that VHC has implemented automated verification functionality for some data fields and is conducting manual verifications for the other data fields; we recommend that VHC continues to prioritize implementation of fully automated verification with the external data sources.

**Management Response:**

*The State continues to utilize Federal HUB data to verify SSN and immigration and citizenship as a part of the eligibility determination process. If an inconsistency is discovered, the State is manually checking the SAVE and ACCESS systems to verify the information. If the inconsistency remains unresolved, a manual notice is sent to the customer requesting additional documentation. This is an ongoing process for VHC and is documented in our verification mitigation plan with CMS.*

**Corrective Action:**

*Vermont presented its "VHC Verification and Inconsistency Resolution Mitigation Plan" to CCIIO in May, 2016, and is actively working to operationalize the Plan.*

Point of contact: *Anne Petrow, Oversight and Monitoring Director  
Cassandra Gekas, VHC Director of Operations*

**FINDING #2015-002****Criteria:**

45 CFR §155.305(f) (1) (i) (B) and § 155.305(g) (1) state that a person may not receive APTC (Section 305(f) (1) (i) (B)) or cost-sharing reductions (Section 305(G) (1)) if they are eligible for Minimum Essential Coverage (MEC). MEC consists of Employer-Sponsored Insurance (ESI) and non-employer-sponsored coverage, such as Medicaid, Medicare, or TRICARE. The Exchange must verify whether an applicant reasonably expects to be enrolled in or is eligible for MEC in an ESI or a non-employer plan, such as Medicaid, Medicare, or TRICARE, for the benefit year for which coverage is requested (45 CFR § 155.320(d)).

**Condition:**

VHC confirmed that, during the audit period, it verified whether applicants who were deemed eligible for APTC or cost-sharing reductions had or were eligible for non-employer sponsored MEC. However, applicants were not notified of discrepancies between their self-attested data and any data identified in matches with the Federal Hub. As a result, applicants who were eligible for non-employer sponsored MEC such as TRICARE or Medicare were not identified and some applicants that had MEC were incorrectly made eligible for APTC or cost-sharing reductions.

**Cause:**

OneGate did not have the capability to process data matches to identify non-employer-sponsored coverage that meets the MEC standard.

**Effect:**

Individuals who were eligible for non-employer-sponsored coverage that meets the MEC standard were able to receive APTC or cost-sharing reductions, even though they were not entitled to that benefit.

**Recommendation:**

We recommend that VHC implement processes and procedures to validate that an applicant is not eligible for ESI or non-employer coverage that meets the Minimum Essential Coverage (MEC) standard before the applicant is deemed eligible to receive APTC or conditional eligibility.

**Management Response:**

*The State continues to utilize the Federal HUB data to verify access to government-sponsored MEC. Defects related to processing resulting inconsistencies are being addressed.*

**Corrective Action:**

*Vermont presented its "VHC Verification and Inconsistency Resolution Mitigation Plan" to CCIIO in May, 2016, and will provide updates as defects are resolved and functionality becomes available.*

Point of contact: *Anne Petrow, Oversight and Monitoring Director*  
*Cassandra Gekas, VHC Director of Operations*

**FINDING #2015-003**

**Criteria:**

Pursuant to 42 CFR § 155.310(g) SBMs must provide applicants with timely written notice of any eligibility determination made by the SBM.

**Condition:**

VHC did not issue required eligibility notifications during a substantial portion of the audit period. Although VHC addressed the system defect and issued notices retroactively to all customers whose notices were pending within the audit period, there was a prolonged period of time within the audit period where the required notices were not sent to the customers in a timely manner.

**Cause:**

OneGate had issues that prevented sending notices for portions of the audit period.

**Effect:**

Because there were limitations to VHC's notification capability during the audit period, applicants were not updated on the status of their application, nor were they informed of instances when there were

discrepancies between information the applicant included in their application and information available in the Data Hub or other outside data sources.

**Recommendation:**

Since the technical issues with VHC notices have been addressed we do not have any recommendation at this time.

**Management Response:**

*The State began sending eligibility notices for new enrollees using a mail merge process in September 2014, at which time notices were sent retroactively for all customers. Automated initial eligibility notice functionality went live in July 2015 and are sent on a continuous basis.*

*With respect to verification notices, the State began sending these manually in August 2015. For QHP enrollees, the notices address inconsistencies related to SSN, citizenship, and immigration status.*

**Corrective Action:**

*Not applicable.*

**FINDING #2015-004**

**Criteria:**

Pursuant to 42 CFR § 155.1200 SBMs must, at least annually, provide to the Department of Health and Human Services a financial statement presented in accordance with U.S. generally accepted accounting principles (U.S. GAAP).

**Condition:**

VHC did not prepare a financial statement in accordance with U.S. GAAP for the year ended December 31, 2015.

**Cause:**

The financial statement audit period is not aligned with the State of Vermont's fiscal year end. Interim financial reporting in Vermont is recorded utilizing the cash basis of accounting not the current financial resources measurement focus and the modified accrual basis of accounting.

**Effect:**

Noncompliance with the requirement within the 42 CFR § 155.1200.

**Recommendation:**

We understand VHC is moving its reporting period to June 30 to align with the State of Vermont's fiscal year end; we recommend the appropriate June 30, 2015 and June 30, 2016 accruals be made at that time to allow for the presentation of a financial statement in accordance with U.S. GAAP for the year ending June 30, 2016.

**Management Response:**

VHC had not previously produced a standalone Appropriations and Expenditures Statement and began tracking expenditures at the program level beginning January 1, 2015. Going forward, the Appropriations and Expenditures financial statement will be prepared as of fiscal year end so that it aligns with the State's Comprehensive Annual Financial Report.

**Corrective Action**

The State is working with CCIIO to come to an agreement regarding financial statement presentation for Vermont Health Connect, given the State's method of accounting.

Point of contact: Anne Petrow, Oversight and Monitoring Director  
Carrie Hathaway, DVHA Finance Director

**III. CONCLUSION**

We confirm to the best of our knowledge that the information included in this Corrective Action Plan is accurate and based on a thorough review of the Key Findings and Recommendations stated in the Audit Findings Report, which is in compliance with the Marketplace's procedures.

SIGNATURE OF SBM EXECUTIVE DIRECTOR/CEO:

