

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEVADA MISALLOCATED COSTS  
FOR ESTABLISHING A HEALTH  
INSURANCE MARKETPLACE TO ITS  
ESTABLISHMENT GRANTS**

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Inspector General**

**February 2016  
A-09-14-01007**

# ***Office of Inspector General***

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## EXECUTIVE SUMMARY

*Nevada did not allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements. As a result, Nevada misallocated \$893,000 in costs to the establishment grants instead of the Medicaid program over 3 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 Silver State Health Insurance Exchange (Nevada marketplace) is an independent unit of the Nevada government. The Nevada marketplace serves as the lead agency for the State’s marketplace establishment grants and is responsible for complying with applicable requirements.

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

Our objective was to determine whether the Nevada marketplace allocated costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements.

### BACKGROUND

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

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

Nevada chose to establish and operate its own State-based marketplace. Because the Nevada marketplace provides eligibility determination and enrollment services for both QHPs and its State-based public health care programs, such as Medicaid, the marketplace sought funding from various Federal sources that provided benefits for these programs. Additionally, because the Nevada marketplace is a single entity supporting the shared needs of multiple programs, it developed separate methodologies for allocating costs related to the system for determining eligibility and to the business operations solution (BOS). The BOS is a system that supports the business functions of the Nevada marketplace, including application and enrollment services, plan management, and consumer assistance. For the eligibility system, the basis of its methodology was the estimated populations of those eligible for QHPs, Medicaid, and CHIP. For the BOS, the basis of its methodology was the ratio of the number of customers the marketplace estimated would visit the marketplace to the number of customers it estimated would be referred to Medicaid. Our findings relate to the BOS methodology.

As of December 31, 2014, CCIIO had awarded Nevada one planning grant and six establishment grants totaling \$101 million. Of this amount, the Nevada marketplace expended \$53.2 million in establishment grant funds during Federal fiscal years (FFYs) 2012 through 2014 (October 1, 2011, through September 30, 2014). We reviewed \$37.2 million that the Nevada marketplace allocated to the establishment grants for FFYs 2012 through 2014. Of this amount, \$23 million comprised costs for the eligibility system, and \$14.2 million comprised costs for the BOS. We limited our review of internal controls to the systems and procedures for allocating costs to establishment grants and to Medicaid.

## **WHAT WE FOUND**

The Nevada marketplace did not allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements:

- The Nevada marketplace allocated \$88,950 to the establishment grants and Medicaid on the basis of a cost allocation methodology that used outdated, estimated data instead of updated, better data that were available. As a result, for the BOS, the marketplace misallocated \$26,685 to the establishment grants instead of to Medicaid.
- The Nevada marketplace allocated \$13.9 million in costs only to the establishment grants for some BOS project components that also benefited Medicaid. Using the original estimates and then updated, better data, we determined that, for the BOS, the marketplace misallocated \$866,779 to the establishment grants instead of to Medicaid.

In total, the Nevada marketplace misallocated \$893,464 in costs to the establishment grants instead of to Medicaid. The marketplace misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs. Specifically, the marketplace (1) did not have a written policy that explained how to perform the allocations or explained the necessity to use updated, better data when available and (2) had insufficient staff oversight. The Nevada marketplace, working with its State Medicaid agency, may seek CMS approval to claim a portion of the \$893,464 through Medicaid at Federal financial participation rates ranging from 50 percent to 90 percent.

## **WHAT WE RECOMMEND**

We recommend that the Nevada marketplace:

- refund to CMS \$893,464, consisting of \$26,685 that was misallocated to the establishment grants by not using updated, better data and \$866,779 that was misallocated to the establishment grants for BOS components that also benefited Medicaid, or work with CMS to resolve the amounts misallocated to the establishment grants;
- work with CMS to ensure that costs claimed after our audit period are allocated correctly, using an updated cost allocation methodology;
- develop a written policy that explains how to perform cost allocations and emphasizes the necessity to use updated, better data when available; and
- strengthen staff oversight to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.

## **NEVADA MARKETPLACE COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the Nevada marketplace concurred with our second, third, and fourth recommendations, and it provided information on actions that it planned to take to address those recommendations. However, it did not concur with our first recommendation. Specifically, the Nevada marketplace stated that our finding assumed that the marketplace should have updated its cost allocation methodology immediately after the end of the first open enrollment period (March 31, 2014). The marketplace also stated that our assumption was not consistent with the most recent CMS guidance, which states that States should reassess their cost allocations annually.

After considering the Nevada marketplace's comments, we maintain that our first recommendation is valid. The marketplace had updated, better data available that showed a significant difference from its original estimates. In addition, even though CMS strongly recommended that States update their cost allocation methodologies annually, CMS also strongly recommended that States reassess their cost allocations "if there is a substantive change in program participation." The Nevada marketplace should have used the updated, better data to update its cost allocation methodology.

## **CMS COMMENTS AND OUR RESPONSE**

We provided CMS a courtesy copy of our draft report, and CMS responded with written comments. CMS stated that, on the basis of its review of the records, costs for all grant awards and supplements were allocated between Medicaid and the Nevada marketplace as reflected in the grant awards and information that the marketplace submitted to CMS. CMS also stated that it strongly recommends that States reassess their cost allocation methodologies annually and if there is a substantive change in program participation or the scope of the jointly funded

activities. CMS stated that Nevada adjusted the cost allocation on the basis of actual enrollment data in April 2015 when it sought additional Federal funds. In addition, CMS stated that the Nevada State Medicaid agency has since paid the Nevada marketplace for its appropriately allocated share of costs on the basis of the updated cost allocation plan from April 2015. CMS stated that, as a result, the Nevada marketplace followed and complied with CMS cost allocation guidance.

After considering CMS's comments, we maintain that all of our findings and recommendations are valid. Even though CMS strongly recommended that States update their cost allocation methodologies annually, CMS also strongly recommended that States reassess their cost allocations "if there is a substantive change in program participation." CMS has not issued specific guidance that directs State-based marketplaces to update their cost allocation methodologies using enrollment data that are final at a certain point in time or that have stabilized. On the basis of our review of CMS's guidance and the data available to the Nevada marketplace during our audit period, we maintain that the Nevada marketplace should have used the updated, better data that indicated a substantive change in program participation to update its cost allocation methodology. We did not review any cost allocations that the Nevada marketplace made in April 2015 because they were outside the scope of our review.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

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

The Silver State Health Insurance Exchange (Nevada marketplace) is an independent unit of the Nevada government. The Nevada marketplace serves as the lead agency for the State’s marketplace establishment grants and is responsible for complying with applicable requirements.

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

### OBJECTIVE

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

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

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

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

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

## **BACKGROUND**

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

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

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

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

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

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

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

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

<sup>7</sup> Toward the end of our audit period, CMS issued further guidance, which states: "CMS strongly recommends that states continue to reassess their cost allocation on an annual basis and/or if there is a substantive change in program participation ..." or whenever a State seeks additional funding. *FAQs on the Use of 1311 Funds, Project Periods, and updating the cost allocation methodology* (issued Sept. 2014).

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

## **Health Insurance Marketplace Programs**

The ACA provides for funding assistance<sup>8</sup> 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 on the Federal assistance available to States to establish marketplaces.

### **The Nevada Marketplace**

Nevada chose to establish and operate its own State-based marketplace. Because the Nevada marketplace provides eligibility determination and enrollment services for both QHPs and its State-based public health care programs, such as Medicaid, the Nevada marketplace sought funding from various Federal sources that provided benefits for these programs. Additionally, because the Nevada marketplace is a single entity supporting the shared needs of multiple programs, it developed separate methodologies for allocating costs related to the system for determining eligibility and to the business operations solution (BOS):

- The Nevada marketplace, through a subaward to Nevada's Division of Welfare and Supportive Services (the Division), obtained eligibility determination services using the Division's eligibility system. For the eligibility system, the basis of the Nevada marketplace's allocation methodology was the estimated populations of those eligible for QHPs, Medicaid, and CHIP.
- The Nevada marketplace's BOS is a system that supports the business functions of the Nevada marketplace, including application and enrollment services, plan management, and consumer assistance. For the BOS, the basis of the Nevada marketplace's allocation methodology was the ratio of the number of customers the marketplace estimated would visit the marketplace to the number of customers it estimated would be referred to Medicaid (i.e., routing of applicants).

Our findings relate to the BOS methodology.

The Nevada marketplace submitted an APD to claim enhanced funding for Medicaid IT costs incurred that were related to the BOS. Separately, the Division submitted an APD to claim enhanced funding for Medicaid IT costs incurred that were related to the eligibility system.

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<sup>8</sup> Projects and programs are carried out under a variety of types of grants, including the use of a specific type of grant known as a cooperative agreement. When a Federal agency expects to be substantially involved in carrying out the project or program, it awards a cooperative agreement (*HHS Grants Policy Statement*, p. ii).

As of December 31, 2014, CCIIO had awarded Nevada one planning grant and six establishment grants totaling \$101 million.<sup>9</sup> Of this amount, the Nevada marketplace expended \$53.2 million in establishment grant funds during Federal fiscal years (FFYs) 2012 through 2014 (October 1, 2011, through September 30, 2014). The Medicaid program also provided Nevada with Federal financial participation (FFP) to support marketplace eligibility determination and enrollment services for Medicaid beneficiaries.

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

## **HOW WE CONDUCTED THIS REVIEW**

We reviewed \$37.2 million that the Nevada marketplace allocated to the establishment grants for FFYs 2012 through 2014 (audit period).<sup>10</sup> Of this amount, \$23 million comprised costs for the eligibility system, and \$14.2 million comprised costs for the BOS. We limited our review of internal controls to the Nevada marketplace's systems and procedures for allocating costs to establishment grants and to Medicaid. We obtained an understanding of how the Nevada marketplace's cost allocation methodologies were developed. We used updated, better data for the Nevada marketplace to recalculate the amounts allocated to the establishment grants and assessed the impact of allocating costs using estimated versus updated, better data.

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

Appendix C contains the details of our audit scope and methodology.

## **FINDINGS**

The Nevada marketplace did not allocate costs for establishing a health insurance marketplace to its establishment grants in accordance with Federal requirements:

- The Nevada marketplace allocated \$88,950 to the establishment grants and Medicaid on the basis of a cost allocation methodology that used outdated, estimated data instead of updated, better data that were available. As a result, for the BOS, the marketplace misallocated \$26,685 to the establishment grants instead of to Medicaid.

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<sup>9</sup> This amount consisted of a planning and establishment grant totaling \$1,000,000 and Level One and Level Two exchange establishment grants, with total award amounts of \$39,757,756 and \$60,243,312, respectively. See Appendix A for detailed information about Level One and Level Two grants.

<sup>10</sup> In addition to the \$37.2 million, the Nevada marketplace expended \$16 million in establishment grant funds that did not need to be allocated.

- The Nevada marketplace allocated \$13.9 million in costs only to the establishment grants for some BOS project components that also benefited Medicaid. Using the original estimates and then updated, better data, we determined that, for the BOS, the marketplace misallocated \$866,779 to the establishment grants instead of to Medicaid.

In total, the Nevada marketplace misallocated \$893,464 in costs to the establishment grants instead of to Medicaid. The marketplace misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs. Specifically, the marketplace (1) did not have a written policy that explained how to perform the allocations or explained the necessity to use updated, better data when available and (2) had insufficient staff oversight. The Nevada marketplace, working with its State Medicaid agency, may seek CMS approval to claim a portion of the \$893,464 through Medicaid at FFP rates ranging from 50 percent to 90 percent.

## **THE NEVADA MARKETPLACE ALLOCATED COSTS USING OUTDATED, ESTIMATED DATA INSTEAD OF UPDATED, BETTER DATA**

### **Federal Requirements**

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

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

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,” Oct. 5, 2012, pp. 3, 4).

### **The Nevada Marketplace Did Not Recalculate and Adjust Its Cost Allocation Prospectively**

For the BOS, the Nevada marketplace allocated IT personnel costs of \$88,950 to the establishment grants and Medicaid for the period April through September 2014 on the basis of estimates that it made in 2012. The marketplace estimated that 5 percent of the total number of marketplace customers would be referred to Medicaid or CHIP and that 95 percent would visit the marketplace for other purposes, including enrollment in QHPs.<sup>11</sup> The marketplace’s estimates differed significantly from the updated, better data from October 2013 through March 2014. The Nevada marketplace had actual data for this period that showed that

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<sup>11</sup> In March 2012, the Nevada marketplace projected that, of approximately 200,000 customers that would visit the Nevada marketplace, approximately 10,000 of these applicants would be referred to Medicaid and CHIP. The Nevada marketplace was unable to provide information to support the basis for these estimates.

35 percent of the total applicants were referred to Medicaid or CHIP and that the remaining 65 percent were QHP applicants. Specifically, of the 380,002 applicants, 132,306 were referred to Medicaid or CHIP, and the remaining 247,696 were QHP applicants.<sup>12</sup>

Despite the availability of updated data, the Nevada marketplace did not recalculate and adjust its cost allocation prospectively by using better data. Consequently, costs allocated to Medicaid and to the establishment grants did not correspond to the relative benefits received, as required by 2 CFR part 225. The Nevada marketplace misallocated \$26,685 to the establishment grants, as shown in Table 1.

**Table 1: Allocation of Nevada Marketplace Costs Not Recalculated and Adjusted Prospectively (April Through September 2014)**

Total Costs	Allocation Percentages		Allocation Amounts	
	Medicaid	Establishment Grants	Medicaid	Establishment Grants
<b>Nevada Marketplace's Allocations Not Recalculated and Adjusted Prospectively</b>				
\$88,950	5%	95%	\$4,448	\$84,502
<b>Office of Inspector General's Recalculated Allocations Using Updated Data</b>				
88,950	35%	65%	31,133	57,817
<b>Difference in Allocations</b>				<b>\$26,685</b>

The Nevada marketplace, working with its State Medicaid agency, may seek CMS approval to claim a portion of the \$26,685 through Medicaid at FFP rates ranging from 50 percent to 90 percent.

The \$26,685 in misallocated costs does not include the impact of the outdated cost allocation methodology on costs claimed after our audit period. We determined that at least \$2,990,337 in costs for the BOS were not paid until after our audit period because of ongoing negotiations with the BOS contractor. Therefore, use of updated, better data would significantly affect the amounts allocated to Medicaid and the establishment grants after our audit period.

<sup>12</sup> Beginning in January 2014, the weekly reports provided to the Nevada marketplace showed actual data that differed significantly from the marketplace's earlier estimates. Beginning with February 2014 data, percentages based on this actual data had stabilized, and by the quarter ended March 31, 2014, the actual data showed that 35 percent of the total applicants were referred to Medicaid or CHIP and that the remaining 65 percent were QHP applicants.

## **THE NEVADA MARKETPLACE ALLOCATED COSTS ONLY TO THE ESTABLISHMENT GRANTS FOR SOME PROJECT COMPONENTS THAT ALSO BENEFITED MEDICAID**

### **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, App. A, § C.3).

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

The Nevada marketplace's CMS-approved APD included cost allocations for several BOS project components. These components consisted of Nevada marketplace IT personnel (salaries and benefits); design, development, and implementation (DD&I); independent verification and validation (IV&V); maintenance and operations (M&O); and contracted consulting related to the request for proposal (RFP).

### **The Nevada Marketplace Did Not Allocate Costs to Medicaid for Three Project Components That Also Benefited Medicaid**

From June 2012 through September 2014, the Nevada marketplace did not allocate to Medicaid a portion of \$13.9 million in costs for three of the BOS project components: DD&I, IV&V, and contracted consulting related to the RFP.<sup>13</sup> The Nevada marketplace allocated 100 percent of these costs to the establishment grants and 0 percent to Medicaid. For amounts expended through March 31, 2014, the Nevada marketplace should have allocated costs using the original, estimated data (5 percent to Medicaid and 95 percent to establishment grants) because Medicaid also benefited from these three BOS project components. For amounts expended beginning April 1, 2014, the Nevada marketplace should have allocated costs using the updated, better data (35 percent to Medicaid and 65 percent to establishment grants). 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.

Using the original estimates and then updated, better data discussed in the previous finding, we determined that the Nevada marketplace misallocated \$866,779 to the establishment grants instead of to Medicaid, as shown in Table 2 on the following page.

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<sup>13</sup> The Nevada marketplace allocated costs to Medicaid for only the IT personnel and M&O components.

**Table 2: Costs of Nevada Marketplace’s Project Components Not Allocated to Medicaid (June 2012 Through September 2014)**

Period	Total Costs	Allocation Percentages		Allocation Amounts	
		Medicaid	Establishment Grants	Medicaid	Establishment Grants
<b>Nevada Marketplace’s Costs Not Allocated to Medicaid</b>					
Through 3/31/14	\$13,269,481	0%	100%	\$0	\$13,269,481
4/1–9/30/14	580,872	0%	100%	0	580,872
<b>Total</b>	<b>\$13,850,353</b>			<b>\$0</b>	<b>\$13,850,353</b>
<b>Office of Inspector General’s Recalculation of Those Cost Allocations</b>					
Through 3/31/14	\$13,269,481	5%	95%	\$663,474	\$12,606,007
4/1–9/30/14	580,872	35%	65%	203,305	377,567
<b>Total</b>	<b>\$13,850,353</b>			<b>\$866,779</b>	<b>\$12,983,574</b>

The Nevada marketplace, working with its State Medicaid agency, may seek CMS approval to claim a portion of the \$866,779 through Medicaid at FFP rates ranging from 50 percent to 90 percent.

**THE NEVADA MARKETPLACE DID NOT HAVE ADEQUATE INTERNAL CONTROLS TO ENSURE THE PROPER ALLOCATION OF COSTS**

For the BOS, the Nevada marketplace misallocated costs of \$893,464 to the establishment grants because it did not have adequate internal controls to ensure the proper allocation of costs. Specifically, the marketplace:

- did not have a written policy that explained how to perform the allocations or the necessity to use updated, better data when available and
- had insufficient staff oversight to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.

## RECOMMENDATIONS

We recommend that the Nevada marketplace:

- refund to CMS \$893,464, consisting of \$26,685 that was misallocated to the establishment grants by not using updated, better data and \$866,779 that was misallocated to the establishment grants for BOS components that also benefited Medicaid, or work with CMS to resolve the amounts misallocated to the establishment grants;
- work with CMS to ensure that costs claimed after our audit period are allocated correctly, using an updated cost allocation methodology;
- develop a written policy that explains how to perform cost allocations and emphasizes the necessity to use updated, better data when available; and
- strengthen staff oversight to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.

### NEVADA MARKETPLACE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Nevada marketplace concurred with our second, third, and fourth recommendations, and it provided information on actions that it planned to take to address those recommendations. However, it did not concur with our first recommendation. The Nevada marketplace's comments are summarized below and included in their entirety as Appendix D.

#### NEVADA MARKETPLACE COMMENTS

Regarding our first recommendation, the Nevada marketplace stated the following:

- OIG's finding assumes that the marketplace should have updated its cost allocation methodology immediately after the end of the first open enrollment period (March 31, 2014). Such an update would have been impossible given the failure of the BOS system and the resulting lack of data integrity and consistency caused by the inability of that system to accurately reflect enrollments.
- OIG's assumption is not consistent with the most recent CMS guidance, which states that States should reassess their cost allocations on an annual basis. The cost allocation that the Nevada marketplace used to bill Medicaid was approved by CMS, and no guidance issued by CMS has suggested that allocations should be made more often.

In addition, the Nevada marketplace stated that it had worked with the State Medicaid agency to transfer all monies payable from Medicaid to the marketplace as allocated and approved by CMS.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After considering the Nevada marketplace's comments on our draft report, we maintain that our first recommendation is valid:

- Beginning in January 2014, the updated, better data available to the Nevada marketplace showed a significant difference from its original estimates. Although the Nevada marketplace stated in its comments that there was a lack of consistency, the percentage of applicants referred to Medicaid or CHIP and the percentage that were QHP applicants had stabilized as of February 2014. For February and March 2014, the actual data consistently showed a significant difference from the marketplace's original estimates. We relied on the data that the marketplace reported to CMS on a regular basis throughout this period of time.
- The Nevada marketplace's comments on CMS's guidance are an incomplete summary of the guidance. Even though CMS strongly recommended that States update their cost allocation methodologies annually, CMS also strongly recommended that States reassess their cost allocations "if there is a substantive change in program participation." The data from October 1, 2013, through March 31, 2014, demonstrated a substantive change in program participation because there was a 30-percentage-point difference between the estimated data that the Nevada marketplace used initially to allocate costs and the updated, better data available at the end of March 2014.

The Nevada marketplace should have used updated, better data available for the quarter ended March 31, 2014, to update its cost allocation methodology.

## **CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

We provided CMS a courtesy copy of our draft report, and CMS responded with written comments. CMS described its understanding of the Nevada marketplace's cost allocation practices for the establishment grants. CMS's comments are summarized below and included in their entirety as Appendix E.

### **CMS COMMENTS**

CMS stated that it worked closely with the Nevada marketplace to ensure that its cost allocation formulas between Medicaid and the marketplace were reasonable. CMS also stated that, on the basis of its review of the records, costs for all grant awards and supplements were allocated between Medicaid and the Nevada marketplace as reflected in the grant awards and information that the marketplace submitted to CMS.

CMS stated that it required States to provide an updated cost allocation methodology whenever a State seeks additional funding or is requesting changes to its current funding. CMS also stated that it strongly recommends that States reassess their cost allocation methodologies annually and if there is a substantive change in program participation or the scope of the jointly funded activities.

CMS stated that Nevada adjusted the cost allocation on the basis of actual enrollment data in April 2015 when it sought additional Federal funds. In addition, CMS stated that the Nevada State Medicaid agency has since paid the Nevada marketplace for its appropriately allocated share of costs on the basis of the updated cost allocation plan from April 2015. CMS stated that, as a result, the Nevada marketplace followed and complied with CMS cost allocation guidance.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After considering CMS's comments on our draft report, we maintain that all of our findings and recommendations are valid. Although CMS strongly recommended that States update their cost allocation methodologies annually, CMS also strongly recommended that States reassess their cost allocations "if there is a substantive change in program participation." The purpose of making such a reassessment is to ensure that costs charged to grants reflect the relative benefits received. For the data from October 1, 2013, through March 31, 2014, there was a 30-percentage-point difference between the estimated data that the Nevada marketplace used initially to allocate costs and the updated, better data available at the end of March 2014. Therefore, we concluded that this difference demonstrated a substantive change in program participation.

Further, in earlier guidance, CMS asserted that States are expected to update their cost allocation methodologies and plans on the basis of "updated or better data" (CMS's *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems*). CMS instructed States to make cost allocation adjustments (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 methodologies using enrollment data that are final at a certain point in time or that have stabilized. On the basis of our review of CMS's guidance and the data available to the Nevada marketplace during our audit period, we maintain that the Nevada marketplace should have used updated, better data that indicated a substantive change in program participation to update its cost allocation methodology.

We did not review any cost allocations that the Nevada marketplace made in April 2015 because they were outside the scope of our review.

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

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

### **PLANNING AND ESTABLISHMENT GRANTS**

CCIIO awarded planning and establishment grants<sup>14</sup> to assist States with initial planning activities related to the potential implementation of the marketplaces. States could use these funds in a variety of ways, including to assess current IT systems; to determine the statutory and administrative changes needed to build marketplaces; and to coordinate streamlined eligibility and enrollment systems across State health programs, including Medicaid and CHIP. In September 2010, CCIIO awarded grants in amounts up to a maximum of \$1 million per State to 49 States and the District of Columbia. (Alaska did not apply for a planning and establishment grant.)

### **EARLY INNOVATOR COOPERATIVE AGREEMENTS**

CCIIO awarded early innovator cooperative agreements<sup>15</sup> to States to provide them with incentives to design and implement the IT infrastructure needed to operate marketplaces. These cooperative agreements rewarded States that demonstrated leadership in developing cutting-edge, cost-effective consumer-based technologies and models for insurance eligibility and enrollment for marketplaces. The “early innovator” States received funding to develop IT models, “... building universally essential components that can be adopted and tailored by other States.” In February 2011, CCIIO awarded 2-year early innovator cooperative agreements to six States and one consortium of States. Awards ranged from \$6.2 million (Maryland) to \$59.9 million (Oregon).

### **MARKETPLACE ESTABLISHMENT COOPERATIVE AGREEMENTS**

CCIIO designed establishment cooperative agreements<sup>16</sup> to support States’ progress toward establishing marketplaces. Establishment cooperative agreements awarded through December 31, 2014, were available for States seeking (1) to establish a State-based marketplace, (2) to build functions that a State elects to operate under a State partnership marketplace, and

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<sup>14</sup> CCIIO, *State Planning and Establishment Grants for the Affordable Care Act’s Exchanges*, Funding Opportunity Number: IE-HBE-10-001, July 29, 2010.

<sup>15</sup> CCIIO, *Cooperative Agreements to Support Innovative Exchange Information Technology Systems*, Funding Opportunity 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.

<sup>16</sup> CCIIO, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, Funding Opportunity Number: IE-HBE-11-004, November 29, 2011, and *Cooperative Agreement to Support Establishment of the Affordable Care Act’s Health Insurance Exchanges*, Funding Opportunity 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 State 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 date of the award. These awards were available to States that could demonstrate that they had (1) the necessary legal authority to establish and operate a marketplace that complies with Federal requirements available at the time of the application, (2) established a governance structure for the marketplace, and (3) submitted an initial plan discussing long-term operational costs of the marketplace.

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

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

States must ensure that their marketplaces were self-sustaining beginning on January 1, 2015 (ACA § 1311(d)(5)(A)).

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

Table 3 summarizes the grants awarded by CCIIO to support the planning, establishing, and early operation of the Nevada marketplace and expenditures allocated to these grants.

**Table 3: Federal Grants Awarded and Expenditures Allocated to the Grants**

<b>Grant Number<sup>17</sup></b>	<b>Award Period<sup>18</sup></b>	<b>Award Type</b>	<b>Award Total<sup>19</sup></b>	<b>Marketplace Expenditures<sup>20</sup></b>
HBEIE100022	September 30, 2010– September 28, 2012	Planning	\$1,000,000	\$1,000,000
HBEIE110066/ HBEIE130166	August 15, 2011– August 13, 2013	Level One	4,045,076	4,033,076
HBEIE120110/ HBEIE130165	February 22, 2012– December 31, 2014	Level One	15,295,271	15,295,271
HBEIE120119/ HBEIE130164	May 16, 2012– December 31, 2014	Level One	4,397,926	3,635,959
HBEIE120129	August 23, 2012– December 31, 2015	Level Two	60,243,312	24,792,234
HBEIE130171	July 9, 2013– December 31, 2015	Level One	9,020,798	4,332,641
HBEIE140192	January 22, 2014– December 31, 2015	Level One	6,998,685	1,101,102
<b>Total</b>			<b>\$101,001,068</b>	<b>\$54,190,283</b>

<sup>17</sup> Several grants were initially awarded to the Nevada Department of Health and Human Services before responsibility for the grants was transferred to the Nevada marketplace on July 1, 2013. At that time, the grant numbers changed. We listed both numbers for these grants.

<sup>18</sup> The award period for each grant number includes no-cost extensions.

<sup>19</sup> The award total for the Level Two grant (HBEIE120129) includes an administrative supplement.

<sup>20</sup> Expenditures through September 30, 2014.

## APPENDIX C: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed \$37,159,851 that the Nevada marketplace allocated to the Level One and Level Two establishment grants for FFYs 2012 through 2014. Of this amount, \$22,950,646 comprised costs for the eligibility system, and \$14,209,205 comprised costs for the BOS. We limited our review of internal controls to the Nevada marketplace's systems and procedures for allocating costs to establishment grants and to Medicaid.

We conducted our fieldwork at the Nevada marketplace's offices in Carson City, Nevada, from July 2014 to January 2015.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the Nevada marketplace's establishment grant application packages;
- reviewed CCIIO's Funding Opportunity Announcements and Notice of Grant Awards terms and conditions;
- reviewed the Nevada marketplace's policies and procedures for financial management;
- interviewed Nevada marketplace officials to gain an understanding of their accounting system and internal controls;
- interviewed Nevada marketplace officials to understand how they developed projections of enrollment in various health care coverage programs mandated by the ACA;
- interviewed Nevada marketplace officials to gain an understanding of enrollment statistics available to the marketplace for individuals determined eligible for and enrolled in QHPs, Medicaid, or CHIP;
- obtained actual enrollment figures for the period October 1, 2013, through March 31, 2014, for QHP, Medicaid, and CHIP enrollments through the Nevada marketplace;<sup>21</sup>
- obtained revenue and expenditure general ledger reports for FFYs 2012 through 2014;

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<sup>21</sup> Beginning in January 2014, the weekly reports provided to the Nevada marketplace showed actual data that differed significantly from the marketplace's earlier estimates. Beginning with February 2014 data, percentages based on this actual data had stabilized, and by the quarter ended March 31, 2014, the actual data showed that 35 percent of the total applicants were referred to Medicaid or CHIP and that the remaining 65 percent were QHP applicants.

- performed tests, such as comparing the Nevada marketplace’s cash drawdowns with the disbursement amounts in the Federal Payment Management System reports and the Nevada marketplace’s expenditures with the disbursement amounts in the 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 Nevada marketplace used to claim expenditures for Federal reimbursement;
- recalculated the amounts allocated to the establishment grants using updated, better data;
- assessed the impact of allocating costs that used estimates versus updated, better data; and
- discussed the results of our review with Nevada marketplace 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 D: NEVADA MARKETPLACE COMMENTS



Brian Sandoval  
Governor

Florence Jameson, MD  
Chairwoman

Bruce Gilbert  
Executive Director

### Silver State Health Insurance Exchange

2310 S. Carson Street, Suite 2, Carson City, NV 89701 • T: 775-687-9939 F: 775-687-9937  
exchange.nv.gov

October 14, 2015

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of the Inspector General  
Office of Audit Services, Region IX  
90 – 7<sup>th</sup> Street, Suite 3-650  
San Francisco, CA 94103

Re: Report Number A-09-14-01007

Dear Ms. Ahlstrand:

This letter acknowledges the Silver State Health Insurance Exchange's receipt and review of the draft report from the Department of Health and Human Services' Office of the Inspector General entitled *Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants*. The Exchange's comments are attached.

We appreciate the opportunity to review the draft and submit comments. Should you have any questions or require additional information, please feel free to contact me.

Cordially,

/Bruce Gilbert/

Bruce Gilbert  
Executive Director

#### Attachments

cc: Dennis Belcourt, Deputy Attorney General, State of Nevada  
Florence Jameson, MD, Chair, Silver State Health Insurance Exchange

**Silver State Health Insurance Exchange Response to the DHHS OIG Audit Report**  
Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment  
Grants

**Audit Recommendation 1:** Refund to Centers for Medicare & Medicaid Services (CMS) \$893,464, consisting of \$26,685 that was misallocated to the establishment grants by not using better, updated data and \$866,779 that was misallocated to the establishment grants for business operating solution (BOS) components that also benefited Medicaid; or, work with CMS to resolve the amounts misallocated to the establishment grants.

**Response:** The Silver State Health Insurance Exchange (Exchange) does not concur with Recommendation 1.

**Comments:** The Office of the Inspector General's (OIG) draft report finds that the Nevada marketplace did not recalculate and adjust its cost allocation for BOS components prospectively by using better available data and that consequently costs allocated to Medicaid and to the establishment grants did not correspond to the relative benefits received.

The OIG's finding assumes that the Exchange should have updated its cost allocation immediately after the conclusion of its first open enrollment, which ended on March 31, 2014. Such an update would have been impossible given the failure of the BOS system and the resultant lack of data integrity and consistency caused by the inability of the BOS system to accurately reflect enrollments. Multiple attempts were made to reconcile the reported and actual numbers of enrollees, with participants including Exchange staff, the BOS vendor, consultants, and issuers. The Exchange believes that it would have been impractical and inappropriate to attempt to determine the monies payable by Medicaid under a new allocation formula before resolving the data issues.

Moreover, the OIG's assumption is not consistent with the most recent guidance from CMS which specifically sets out the timing and methodology by which states are to update their cost allocation between the Marketplace and the State Medicaid agency for jointly funded activities. According to FAQs on the use of 1311 Funds and updating cost allocation methodology as issued by CMS ([https://www.cms.gov/cciiio/resources/Fact-Sheets-and-FAQs/Downloads/FAQ\\_1311\\_project\\_FAQs\\_periods.pdf](https://www.cms.gov/cciiio/resources/Fact-Sheets-and-FAQs/Downloads/FAQ_1311_project_FAQs_periods.pdf)), states should reassess their cost allocation on an annual basis. The cost allocation the Exchange used to bill Medicaid was approved by CMS and no guidance issued has suggested that allocations should be made more often.

Notwithstanding the Exchange's disagreement with the OIG's determination and methodology, upon being advised of OIG's issue with grant allocations, the Exchange acted to resolve the issue, with both our agency and Medicaid implementing work programs that transferred to the Exchange all monies payable from Medicaid as allocated and approved by CMS.

Medicaid has now paid the Exchange nearly \$1.4 million in recognition of its appropriately allocated share of costs. CMS expressed no disapproval of or disagreement with the Exchange's proposed course of action; the dollars paid by Medicaid were used in lieu of grant funds to defray BOS-related expenses. In the aggregate, the Exchange has satisfied the cost allocation plan submitted in support of those grant awards and done just as the OIG recommends by reaching agreement with CMS on how best to resolve the amounts alleged to have been misallocated to the establishment grants.

**Audit Recommendation 2:** Work with CMS to ensure that costs claimed after the audit period are allocated correctly using an updated cost allocation methodology.

**Response:** The Silver State Health Insurance Exchange concurs with Audit Recommendation 2.

**Comments:** The Exchange has always allocated expenses in a manner 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. For future administration of the Exchange's cost allocation, it will continue to seek guidance from CMS.

**Audit Recommendation 3:** Develop a written policy that explains how to perform cost allocations and emphasizes the necessity to use updated, better data when available.

**Response:** The Silver State Health Insurance Exchange concurs with Audit Recommendation 3. A written policy will be developed which specifically requires the Exchange to allocate expenses in a manner consistent with the most recent guidance from the CMS.

**Audit Recommendation 4:** Strengthen staff oversight to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.

**Response:** The Silver State Health Insurance Exchange concurs with Audit Recommendation 4. The Exchange will implement steps to oversee operations effectively to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.

## APPENDIX E: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

NOV 18 2015

200 Independence Avenue SW  
Washington, DC 20201

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Andrew M. Slavitt   
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants" (A-09-14-01007)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review the OIG's draft report on the Nevada establishment grants.

CMS follows an established grant-making process that has been successfully used for decades to ensure oversight and monitoring of section 1311 spending. This process complies with applicable Federal requirements, including Office of Management and Budget (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.

The OIG reviewed whether Nevada allocated costs for establishing a Health Insurance Exchange to its grants in accordance with Federal guidelines. In this regard, CMS worked closely with the Silver State Health Insurance Exchange (Nevada Exchange) to ensure that its cost allocation formulas between Medicaid and the Exchange were reasonable. Based on our review of the records, all grant awards and supplements were cost allocated between Medicaid and the Exchange as reflected in the grant awards and information submitted to CMS by the Nevada Exchange.

Per CMS' September, 2014 FAQ, States are required to provide CMS with an updated cost allocation methodology whenever a state seeks additional 1311 funding and/or is requesting changes to their current funding. In addition, CMS strongly recommends that States reassess their cost allocation methodologies on an annual basis and/or if there is a substantive change in program participation or the scope of the jointly-funded activities.<sup>1</sup>

The State of Nevada, including both the Medicaid Agency and the Nevada Exchange, adjusted the cost allocation based on actual enrollment data in April of 2015 when it sought additional

<sup>1</sup> [https://www.cms.gov/cciio/resources/Fact-Sheets-and-FAQs/Downloads/FAQ\\_I311\\_project\\_FAQs\\_periods.pdf](https://www.cms.gov/cciio/resources/Fact-Sheets-and-FAQs/Downloads/FAQ_I311_project_FAQs_periods.pdf)

Levinson Page 2

federal funds. In addition, the Nevada State Medicaid Agency has since paid the Nevada Exchange for its appropriately allocated share of costs based on the updated cost allocation plan from April 2015. As a result, the State of Nevada followed and complied with CMS cost allocation guidance.

CMS takes oversight of State-Based Marketplaces (SBM) seriously and has promulgated program integrity regulations and payment recovery channels to safeguard taxpayer funds. CMS works with the SBMs on continuous improvement of their management and operations through an array of technical assistance activities, and implementation of oversight and accountability measures.

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