



Medicaid Dr. Dynasaur Program

Department of Vermont Health Access
Does Not Monitor or Take Required
Action on Overdue Premium Payments



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Dear Colleagues,

A 2015 audit by my office found that there was no process to disenroll Dr. Dynasaur members from Medicaid for non-payment of premiums. Therefore, we decided to conduct an audit to determine whether this deficiency had been corrected. Our audit objectives were to: (1) determine the extent to which Medicaid premiums owed to DVHA in fiscal years 2018 and 2017 were collected and (2) assess whether past-due Medicaid premiums affect a member's enrollment and the State's payment of claims.

Dr. Dynasaur provides low-cost or free Medicaid health coverage to young Vermonters under age 19. Eligibility is determined through the Department of Vermont Health Access's (DVHA) Vermont Health Connect (VHC) and is based on household income. At certain income levels, households are required to pay a monthly premium of \$15, \$20, or \$60.

As of June 30, 2018, 15.2 percent of the 34,353 households with members enrolled in Dr. Dynasaur were required to pay a premium. Many households pay their required premium, but some do not. DVHA does not monitor when households are delinquent in making payments and it does not enforce state payment requirements. As a result, it does not treat all households owing Dr. Dynasaur premiums equitably.

Our audit found that while DVHA knew the amount of Dr. Dynasaur premiums collected (\$1.85 million and \$1.48 million in fiscal years 2018 and 2017 respectively), it did not know the total amounts owed or uncollected. DVHA had not established a process to routinely obtain this information. This is not consistent with the State's best practice guidance. Without such a process, DVHA has no way to monitor the extent to which households fail to remit required payments or track its performance in collecting Dr. Dynasaur premiums.

Furthermore, past-due premiums for Medicaid's Dr. Dynasaur program have no effect on members' enrollment status. The State continues to pay claims on delinquent members' behalf, which is not consistent with State rules that require payment of the premiums as a condition of initial and continued eligibility for households with a premium obligation.

For a selection of 297 households that did not comply with the initial payment or grace period (a minimum of 60 days) rules, DVHA paid nearly \$2.4 million in Dr. Dynasaur claims.¹ This selection of households was only part of the universe of households that did not comply with payment rules, and there are many more households with unpaid premiums.

¹ We made our selections from a DVHA preliminary analysis of households with past-due Medicaid premiums who appeared to have an active account as of June 30, 2018 and were at least six months past their grace period. The claims amount was for services provided from the time of incorrect enrollment or post grace period through June 30, 2018, paid as of October 14, 2018 and so were for anywhere from three-months to multiple years.

Since 2013, DVHA has attempted to remedy this problem twice without success at a public cost of at least \$1.9 million. DVHA now indicates that it intends to disenroll members for past-due premiums when it implements its planned Integrated Eligibility and Enrollment system. DVHA expects the premium processing part of this planned system to be completed no earlier than October 2020.

Because the State does not plan to resolve this matter until then, it will have been in violation of its own rules pertaining to non-payment since VHC's inception. This means that for at least seven years, the State will have: (1) not collected premiums due as required, (2) paid millions of dollars in claims for individuals whose households are not paying premiums, and (3) treated members who have not paid premiums the same as those who have met their obligations.

We recommend that DVHA develop and implement a process to monitor the amount of Dr. Dynasaur premiums that are due to the State, develop and implement a process to disenroll members whose premiums go unpaid, and correct flaws that allow a member to enroll without meeting the initial premium payment requirement.

I would like to thank the management and staff at DVHA and its vendor WEX Health for their cooperation and professionalism throughout the course of this audit. This report is available on our website, <https://auditor.vermont.gov>.

Sincerely,



DOUGLAS R. HOFFER
State Auditor

ADDRESSEES

The Honorable Mitzi Johnson
Speaker of the House of Representatives

The Honorable Tim Ashe
President Pro Tempore of the Senate

The Honorable Phil Scott
Governor

Ms. Susanne Young
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Commissioner, Department of Finance and Management

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Introduction

Dr. Dynasaur is a low-cost or free Medicaid health coverage program for young Vermonters under the age of 19.² In fiscal year 2018, the Department of Vermont Health Access (DVHA) paid \$165.66 million in Medicaid claims for children covered under this program.

Eligibility for Dr. Dynasaur is based on household income. Vermont's Health Benefit Eligibility and Enrollment (HBEE) rules require payment of monthly Dr. Dynasaur premiums for members whose households meet certain income levels.³ These payments are a condition of initial and continued eligibility and enrollment.

Vermonters apply for Dr. Dynasaur coverage through DVHA's Vermont Health Connect (VHC), the State's health insurance exchange for private and public plans. VHC determines applicants' eligibility for Medicaid,⁴ including the Dr. Dynasaur program, as well as financial assistance pertaining to private market insurance plans, known as qualified health plans (QHP). Plan information for households that have a premium is transmitted to WEX Health, DVHA's contractor for premium processing services. WEX Health, in turn, sends invoices to households, collects premiums, and remits Dr. Dynasaur premiums to DVHA and QHP premiums to the applicable private insurer.

A 2015 audit⁵ by the State Auditor's Office (SAO) found that there was no process to disenroll Dr. Dynasaur members from Medicaid for non-payment of premiums. The SAO, therefore, decided to conduct an audit to determine whether DVHA had fixed this issue. The objectives of the audit were to: (1) determine the extent to which Medicaid premiums owed to DVHA in fiscal years 2018 and 2017 were collected and (2) assess whether past-due Medicaid premiums affect a member's enrollment and the State's payment of claims. Appendix I details the scope and methodology of the audit. Appendix II contains a list of abbreviations used in this report.

² Pregnant women who meet the income eligibility requirements are also eligible for Dr. Dynasaur but because they have no premium requirements, we did not include them in our audit. We limited our audit to Dr. Dynasaur premiums collected by DVHA and did not include other Medicaid premiums the State collects.

³ Throughout the report, the term member refers to the young Vermonter enrolled in a Dr. Dynasaur plan requiring a premium, whereas the term household includes the person responsible for paying the premium.

⁴ VHC determines eligibility for income-based Medicaid. Other types of Medicaid eligibility are established in another system.

⁵ *Vermont Health Connect: Future Improvement Contingent on Successful System Development Project*, (Rpt. No. 15-03, April 14, 2015).

Highlights

Under Vermont's Medicaid Dr. Dynasaur program, the State charges premiums of \$15, \$20, or \$60 per month for Vermonters under the age of 19 if their households meet certain income levels. The SAO's 2015 audit of Vermont Health Connect (VHC) found that there was no process to disenroll Dr. Dynasaur members from Medicaid for their households' non-payment of premiums. The SAO conducted an audit of Vermont's Dr. Dynasaur program to: (1) determine the extent to which Medicaid premiums owed to the Department of Vermont Health Access (DVHA) in fiscal years 2018 and 2017 were collected and (2) assess whether past-due Medicaid premiums affect a member's enrollment and the State's payment of claims.

Objective 1 Finding

DVHA did not know the total amount of Medicaid premiums owed or uncollected, only that it collected \$1.85 million and \$1.48 million in Dr. Dynasaur premiums during fiscal years 2018 and 2017, respectively. WEX Health provided weekly information on premiums collected, which DVHA reconciled to the amounts that WEX Health remitted to the State. DVHA's contract with WEX Health does not require the vendor to provide the amounts owed or delinquent by household or in total and DVHA does not routinely request such information. This is inconsistent with the State's guidance for funds owed to the State but not received, which calls for organizations to devise and implement techniques and procedures to properly account for, record, manage, and collect these funds. As a result, DVHA does not have the information to effectively monitor its performance in collecting Dr. Dynasaur premiums, including the extent to which households fail to pay required premiums.

Objective 2 Finding

Past-due premiums for Medicaid's Dr. Dynasaur program have no effect on members' enrollment status and the State continues to pay claims on their behalf, which is not consistent with Health Benefits Eligibility and Enrollment (HBEE) rules. Enrollment in Dr. Dynasaur plans that require premiums is contingent upon the first payment being made (called effectuation).⁶ Ongoing enrollment thereafter is contingent upon timely premium payments each

⁶ HBEE rule §70.02(a).

month.⁷ If the initial premium payment is made, but the household fails to make subsequent payments, HBEE rules require a grace period. This period starts the day after the due date, extends 60 days, and then ends on the last day of that month. If the household does not pay the past-due premium by the end of the grace period, the member(s) is supposed to be disenrolled.⁸ However, DVHA does not enforce this requirement and continues to pay members’ claims even after the grace period.⁹

For a selection of 297 households that did not comply with the initial payment or grace period rules, DVHA paid nearly \$2.4 million in Dr. Dynasaur claims (see Table 1). We made our selections from a preliminary analysis performed by DVHA of households that owed past-due Medicaid premiums. Our selection was based on those households in DVHA’s analysis with active Dr. Dynasaur accounts as of June 30, 2018 that we could verify had never paid an initial premium or whose premium payments were at least eight months past due (i.e., six months past the two-month grace period). Because of errors and limitations in the WEX Health and VHC data, there are likely more households in these categories than the SAO identified.

Table 1: Claims Paid for Dr. Dynasaur Members in SAO’s Selection Whose Households Did Not Comply with the Initial Payment or Grace Period Rules^a

Category	Number of Households	Number of Members	Total Amount of Claims Paid
Claims paid for members whose initial premium obligation was never paid.	28	41	\$149,370
Claims paid for members after the grace period ended. ^b	264	425	\$2,206,185
Claims paid for members after the grace period ended and who were later reenrolled without paying the initial premium obligation.	5	7	\$33,414
Total	297	473	\$2,388,969

^a These claims were paid for services provided from the time of incorrect effectuation or post grace period through June 30, 2018, as of October 14, 2018. The time period for these claims can be anywhere from three-months to multiple years.

^b These members may have had multiple grace periods that they exceeded.

More than 90 percent of the Medicaid claims paid in this selection were for Dr. Dynasaur members whose grace period ended after their household missed premium payments. DVHA does not disenroll such members as required by HBEE rules because VHC and the WEX Health systems do not have the

⁷ HBEE rule §64.01(h)(1).

⁸ HBEE rule §64.06(a)(1)(iii).

⁹ The text of the HBEE rules refer to Vermont’s Agency of Human Services, DVHA’s parent agency. The Agency of Human Services is the State’s designated Medicaid agency, but it delegates most of these responsibilities to DVHA. For this reason, throughout the report we will indicate that the rules apply to DVHA.

functionality to implement certain other HBEE rules that must be complied with before disenrollment. The HBEE rules that have not been implemented in these systems require that: (1) partial payments remitted by households be first allocated to pay Dr. Dynasaur premiums (if applicable) before other plans,¹⁰ and (2) the State provide notices to households' of premium nonpayment and ensuing consequences including disenrollment.¹¹ When VHC was launched on October 1, 2013, neither this system nor WEX Health's system could perform the tasks to enforce these rules.

Since 2013, DVHA has twice attempted to modify these systems to implement these rules. The total cost of the two unsuccessful attempts was at least \$1.9 million and could be as high as \$2.7 million. DVHA now indicates that it intends to disenroll for past-due premiums when it implements its planned Integrated Eligibility and Enrollment system. Planning and research for a premium processing project that is part of this initiative recently began, and implementation of the project is expected to be completed no earlier than October 2020.

During the course of our analysis of households with past-due Medicaid premiums, we identified systemic errors that adversely affected the recording and collection of Dr. Dynasaur premiums. These errors often related to flaws that allowed members to enroll without a household paying the initial premium obligation or VHC defects that resulted in households not receiving their monthly premium invoice. In addition, DVHA deleted valid past-due amounts on an ad-hoc basis from household accounts in the WEX Health system even though no payment had been made. This removal of the past-due amounts caused the system to underreport the amounts a household owed.

Recommendations

We recommend that DVHA develop and implement a process to monitor the amount of Dr. Dynasaur premiums that are due to the State, develop and implement a process to disenroll members whose premiums go unpaid (as required by HBEE rules), and correct the flaws that allows a member to enroll without meeting the initial premium payment requirement.

¹⁰ HBEE rule §64.05, which requires partial payment allocation first to Dr. Dynasaur if the payment is sufficient to do so, unless the payer requests otherwise.

¹¹ HBEE rule §64.06.

Background

Dr. Dynasaur is Vermont's low-cost or free Medicaid health coverage program for young Vermonters under age 19 and pregnant women. The State has an agreement with the Centers for Medicare and Medicaid Services to charge premiums for children and teenagers under the age of 19 in households with incomes between 195 percent and 312 percent of the federal poverty level.¹² See Appendix III for more detail regarding the maximum monthly household income levels for each premium level.

The Vermont General Assembly sets Dr. Dynasaur premium levels, which are currently \$15, \$20, or \$60 per month, depending on household income. Households are charged only one Dr. Dynasaur premium obligation regardless of how many members are enrolled.

Table 2 categorizes by premium level the total number of households and members in those households enrolled in Dr. Dynasaur as of June 30, 2018.¹³

Table 2: Dr. Dynasaur Population by Premium Level as of June 30, 2018

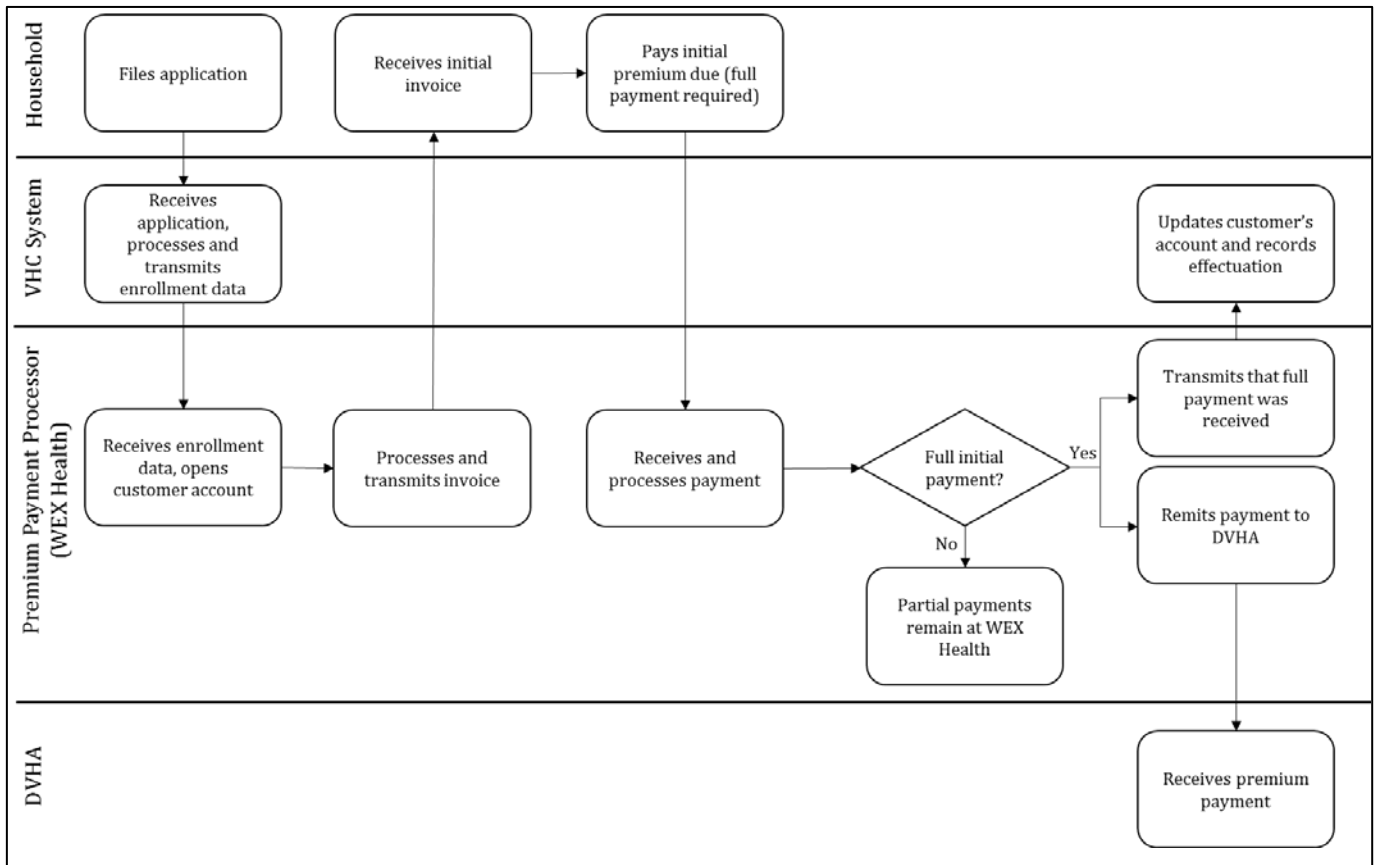
Premium Category	Number of Households	Number of Members
No premium	29,144	52,957
\$15 premium	2,602	4,375
\$20 premium	282	519
\$60 premium	2,325	3,855
Total	34,353	61,706

DVHA contracts with WEX Health to perform the billing and collection of Medicaid premiums. Figure 1 is a simplified overview of how the initial premium payment process is intended to work.

¹² The federal poverty level is a measure of income issued every year by the United States Department of Health and Human Services.

¹³ DVHA provided this breakdown, which we did not verify.

Figure 1: Simplified Overview of the Initial Premium Payment Process



Premiums are billed and payments are due prior to the start of a coverage month. WEX Health sends invoices to the person identified on the application as responsible for payment of the Medicaid premium on behalf of the household.

Objective 1: DVHA Does Not Know the Extent of Premiums Owed, Only the Amount of Dr. Dynasaur Premiums Collected

DVHA collected \$1.85 million in Dr. Dynasaur premiums during fiscal year 2018 and \$1.48 million during fiscal year 2017 but it does not know the total amount owed and therefore the amount that went uncollected. DVHA lacks this knowledge because it has not established a process to obtain this information. WEX Health provides DVHA with the amount of premiums collected on a weekly basis. However, WEX Health has not been asked to

routinely submit to DVHA the amounts that are owed and delinquent, either in total or by household. This is inconsistent with the State's accounts receivable¹⁴ guidance and limits DVHA's ability to monitor its performance in collecting premiums.

WEX Health is contractually obligated to track premium payments. In addition, WEX Health makes a collection file available weekly to DVHA's business office that contains a record of each household that has paid its Dr. Dynasaur premium in full.¹⁵ The business office reconciles this file to the amount of collections remitted to the State. In fiscal years 2018 and 2017, these amounts totaled \$1.85 million and \$1.48 million, respectively. The collections file is not downloaded into VHC. Instead WEX Health transmits a separate nightly file to VHC that contains the date through which the household has paid (known as the paid through date) but does not contain other payment data. DVHA's contract with WEX Health does not require nor has DVHA established a process to routinely obtain amounts owed and unpaid by household or in total via a transmission to VHC or through some other reporting mechanism.

This is not consistent with the State's best practice guidance,¹⁶ which specifies that departments shall devise and implement techniques and procedures to properly account for, record, manage, and collect receivables. According to the guidance, these procedures should include following-up on delinquent accounts. Without such a process, DVHA has no way to monitor its performance in collecting Dr. Dynasaur premiums, including the extent to which households are failing to remit required payments.

Even if DVHA had established a process to monitor the extent to which premiums were not collected, data in VHC and the WEX Health system contained significant errors and limitations that would have limited the usefulness of this data. For example, while WEX Health's system contains a past-due field, both Medicaid and QHP overdue amounts are recorded in this single field because households with multiple plans are tracked under one account. Because of this and system errors and limitations which are discussed more fully in the next section of this report, we did not calculate premiums due that went uncollected.

¹⁴ A receivable is an asset of the State reflecting an amount owed to a department that has not been received.

¹⁵ WEX Health does not remit partial premium payments to the State.

¹⁶ Department of Finance and Management's Internal Control Best Practices for Accounts Receivable issued September 2006 (https://finance.vermont.gov/sites/finance/files/documents/Pol_Proc/IC/FIN-IC_Best_Practices_4_Accounts_Receivable.pdf).

Objective 2: The State Paid Medicaid Claims for Members Whose Premiums Were Unpaid

Dr. Dynasaur members whose household had not paid their premiums were not disenrolled and the State continued to pay claims. For example, DVHA paid nearly \$2.4 million in Medicaid claims for periods in which a selection of 297 households did not comply with the initial payment or grace period rules. DVHA did not disenroll members whose premiums went unpaid because it had not implemented certain other HBEE rules that must be complied with before disenrollment can occur.¹⁷ These rules were not implemented because systems were deployed without the necessary functionality and DVHA has not required that needed modifications be made. During our analysis of the 297 households, we also identified systemic errors that adversely affected the recording and collection of Dr. Dynasaur premiums.

DVHA is Not Compliant with State Rules Pertaining to Unpaid Premiums

Initial enrollment (called effectuation) in a Dr. Dynasaur plan with a premium is contingent upon the first premium payment being made.¹⁸ Ongoing enrollment thereafter is contingent upon timely premium payments each month.¹⁹ If the initial premium payment is made but the household fails to make subsequent payments, the State's HBEE rules require a grace period. This period starts the day after the due date, extends 60 days, and ends on the last day of that month.²⁰ At that time, if payment is still not received, the member is to be disenrolled from Medicaid per HBEE rules.²¹ During the grace period, Medicaid claims are still paid.²² Figure 2 is an example of the grace period in an ongoing premium billing cycle if a premium is not paid as required by HBEE rules.²³ However, DVHA has not fully implemented the processes needed to carry-out the disenrollment of members for non-payment of premiums shown in this figure.

¹⁷ The text of the HBEE rules refer to Vermont's Agency of Human Services, DVHA's parent agency. The Agency of Human Services is the State's designated Medicaid agency, but it delegates most of these responsibilities to DVHA. For this reason, throughout the report we indicate that the rules apply to DVHA.

¹⁸ HBEE rule §70.02(a).

¹⁹ HBEE rule §64.01(h)(1).

²⁰ HBEE rule §64.06(a)(1)(iii).

²¹ HBEE rule §64.06(b)(2)(ii).

²² HBEE rule §64.06(a)(4).

²³ HBEE rule §64.04 and §64.06(b)(2).

Figure 2: Example of How a Grace Period is Supposed to Work

	JUNE	JULY	AUGUST	SEPTEMBER
For coverage month: JULY	6/5 July invoice mailed	6/30 July payment due	7/1 - 8/31 Grace period	9/1 Member Disenrolled

In the summer of 2018, DVHA performed a preliminary analysis of households that owed past-due Medicaid premiums. Our discussions with DVHA indicated that there were integrity problems with some of the data in their analysis. As a result, we decided to limit our analysis of claims to those households in the preliminary analysis that had (1) active Dr. Dynasaur accounts on June 30, 2018 and (2) never paid a premium²⁴ and/or whose premium payments were at least eight months past due (i.e., six months past the 2-month grace period). We verified that 297 households with 473 members met these criteria.²⁵ Appendix I explains our methodology for identifying these households in detail. Because of limitations in the WEX Health and VHC data, there are likely more households in these categories than we identified.

Table 3 summarizes the nearly \$2.4 million in Medicaid claims paid on behalf of 473 members (in 297 households) who: (1) never should have been enrolled because their initial premium obligations were not paid, (2) remained enrolled in Medicaid after the grace period expired, and (3) remained enrolled in Medicaid after the grace period ended and were later reenrolled without meeting the initial premium obligation.²⁶ The cost of claims paid on behalf of an individual member ranged from zero to \$220,481, with a median of \$1,080.²⁷

²⁴ There are flaws that we explain later in this report that resulted in members effectuating into Dr. Dynasaur without the household paying the initial premium.

²⁵ DVHA’s preliminary analysis indicated that there were many more households that had overdue unpaid premiums than we reviewed. It was not practical for us to verify the premium data for all of these households, which is why we limited our review to these criteria.

²⁶ When DVHA disenrolls a member, reenrollment is contingent upon the household paying the new initial premium.

²⁷ The costs include both the State and the federal share which is based on the Federal Medical Assistance Percentage that is set quarterly. As of June 30, 2018, the federal share for members with \$15 and \$20 premiums was 53.47 percent and 90.43 percent for members with a \$60 premium. We asked the Centers for Medicare and Medicaid Services whether the State would be required to repay the federal share of these payments, and they indicated that Vermont’s agreement with them does not describe the consequences for non-payment and therefore, it is the State’s choice whether or not to disenroll for non-payment of premiums.

Table 3: Claims Paid for Dr. Dynasaur Members in SAO's Selection Whose Households Did Not Comply with the Initial Payment or Grace Period Rules^a

Category	Number of Households	Number of Members	Total Amount of Claims Paid
Claims paid for members whose initial premium obligation was never paid.	28	41	\$149,370
Claims paid for members after the grace period ended. ^b	264	425	\$2,206,185
Claims paid for members after the grace period ended and who were later reenrolled without paying the initial premium obligation.	5	7	\$33,414
Total	297	473	\$2,388,969

^a These claims were paid for services provided from the time of incorrect effectuation or post grace period through June 30, 2018, as of October 14, 2018. The time period for these claims can be anywhere from three-months to multiple years.

^b These members may have had multiple grace periods that they exceeded.

The following are examples of households who never paid their initial premium obligation or stopped paying the premium and exceeded the grace period.

- Two members of a household were enrolled in Dr. Dynasaur on April 1, 2017 even though the household never paid the initial premium required to have these members enrolled. DVHA paid \$4,700 in Medicaid claims from April 1, 2017 to June 30, 2018 for the members in this household.
- A household had two Dr. Dynasaur members, and the household paid premiums through April 30, 2017. Under the HBEE rules, the members' grace period started May 1, 2017 and ended June 30, 2017. Subsequent to the end of the grace period, DVHA paid \$3,280 in Medicaid claims from July 1, 2017 to June 30, 2018 for these members.

More than 90 percent of the Medicaid claims paid in Table 3 were for Dr. Dynasaur members whose premium grace period expired. DVHA does not disenroll such members as the HBEE rules require because it never implemented the following HBEE rules that must be complied with before disenrollment. Those rules that have not been implemented are:

- *Allocation of partial payments to Dr. Dynasaur first for households with multiple insurance plans.* Households with multiple insurance plans (e.g., both QHP and Medicaid) receive a combined monthly bill for all plans. According to Vermont rules, if the household sends payment for only part of the entire bill, it must be allocated first to cover Dr. Dynasaur

premiums before other plans.²⁸ However, the WEX Health system does not apply partial premium payments to any plan,²⁹ and the system continues to show the premium as unpaid.³⁰

- *Notices of premium nonpayment and its consequences including disenrollment.* DVHA is required to send notices to households that have not paid their Medicaid premiums. First, HBEE rules require that if the full Dr. Dynasaur premium payment is not received by the due date, DVHA is to send a notice within five days after the due date advising that the member is in grace period status. Then, at least 11 days before the end of the grace-period, DVHA is required to send the individual a closure notice advising that enrollment will terminate at the end of the grace period.³¹

These rules have never been implemented because at the time of VHC's launch on October 1, 2013, neither VHC nor the WEX Health system had the functionality to execute these rules, and this has not yet been rectified. DVHA made two unsuccessful attempts to add the necessary functionality to these systems so as to comply with State rules to disenroll members from Dr. Dynasaur when premiums remain unpaid. First, WEX Health³² developed a modification to its system to allocate partial premium payments that was scheduled to be implemented in February 2014.³³ However, the requirements DVHA provided to WEX Health for modifying its system did not comply with Vermont rules, and this modification was never implemented. Second, in 2015, DVHA determined that a two-phase plan was necessary to achieve compliance: Phase I entailed modifications to the WEX Health system to separate Medicaid billing from other premium billing (QHP billing) so that Medicaid payment status could be tracked separately. Phase II would modify the VHC system to accept the separate Medicaid billing data from WEX Health, thereby enabling accurate nonpayment notices and terminations for nonpayment as required by state rules. Under a 2016 contract, WEX Health completed Phase I, but it was not placed into production because DVHA did not require its VHC contractor to implement Phase II modifications due to

²⁸ HBEE rule §64.05, which requires partial payment allocation first to Dr. Dynasaur if the payment is sufficient to do so, unless the payer requests otherwise.

²⁹ Under the State's contract with WEX Health, the vendor maintains a bank account "for the benefit of" the State of Vermont. This account includes unallocated partial payments until such time the household supplies the rest of the payment (at which time it is submitted to DVHA or the insurance carrier, as applicable) or the partial payment is refunded.

³⁰ In our analysis of households with overdue premiums, we applied unallocated partial payments to overdue Dr. Dynasaur premium amounts and adjusted their delinquency period as applicable.

³¹ HBEE rule §64.06.

³² For ease of reading, we use the term WEX Health to refer to the State's premium processor in this report although the vendor was Benaissance, LLC prior to this company's acquisition by WEX, Inc. in 2015.

³³ While this modification, which was intended to allocate partial payments to Dr. Dynasaur first for households with multiple insurance plans, would not achieve full compliance on its own, it was needed in order for WEX Health to transmit correct past-due information to the VHC system. The VHC system could then be modified to send nonpayment notices and disenroll for premium nonpayment.

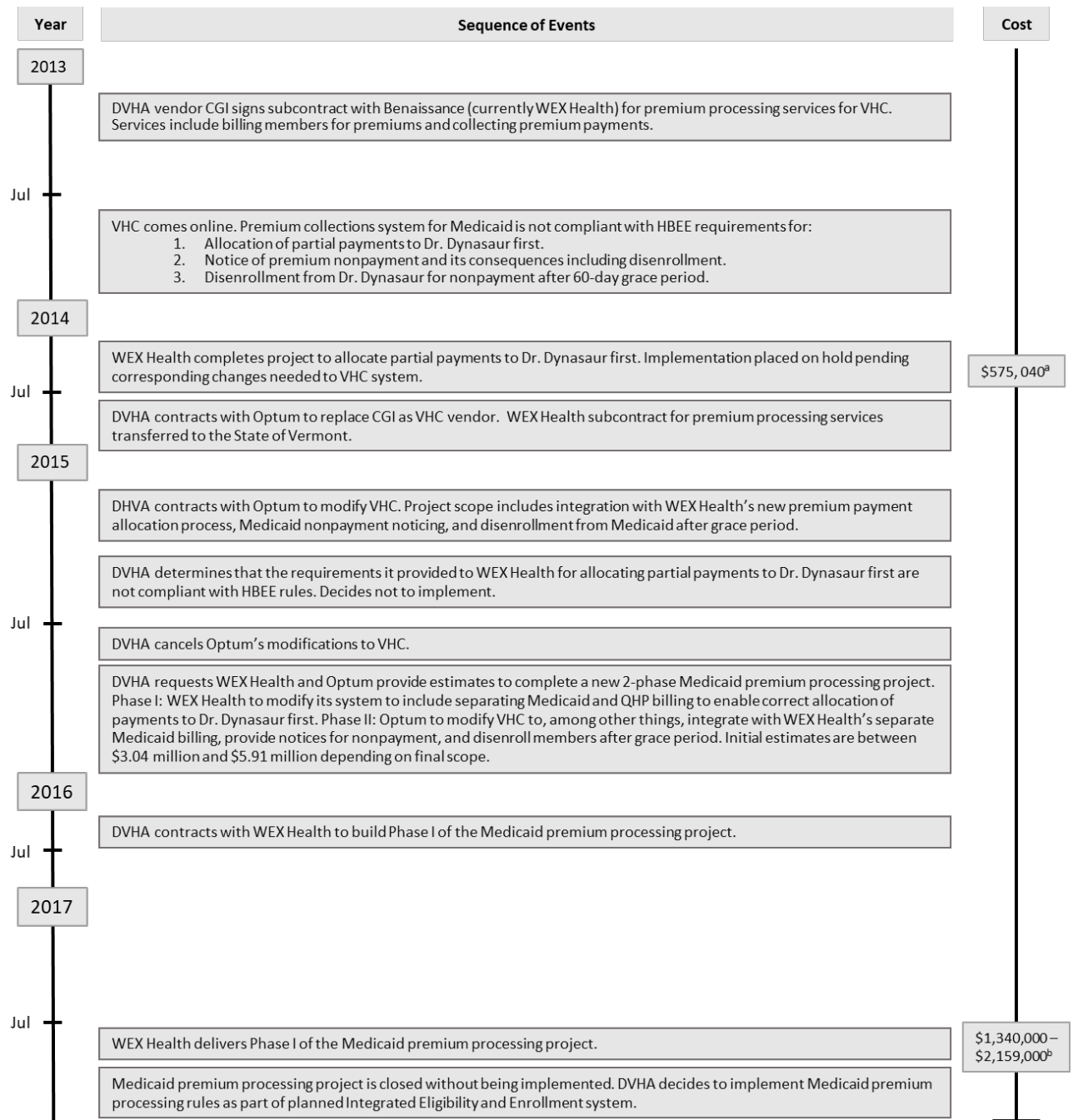
concerns about cost. According to a DVHA deputy commissioner, at the time these decisions were being made, the Department was dealing with a multitude of problems with VHC, and there were higher priorities that required fixes.

Figure 3 provides a timeline of DVHA's unsuccessful efforts to comply with State enrollment rules pertaining to premium collection. The total cost of the two unsuccessful attempts was between \$1,915,040 and \$2,734,040.³⁴ DVHA could not provide a breakdown of the amounts paid to WEX Health for the 2016 contract to correct Medicaid billing issues, and some deliverables in that contract related to other issues. Therefore, the SAO calculated a cost range of the unsuccessful attempts to implement these modifications.³⁵

³⁴ These amounts do not include \$414,750 in retainage that, as of March 7, 2019, the State had not paid relative to its 2016 contract with WEX Health. Per the contract, the retainage is to be paid after issuance of final acceptance of the deliverables, which is contingent on the deliverables working with VHC without defect or the need for remediation.

³⁵ The minimum excludes payment for any deliverable that included other issues; the maximum includes payment for all deliverables.

Figure 3: Timeline of DVHA’s Unsuccessful Efforts to Implement Medicaid Disenrollment for Nonpayment of Premiums



^a WEX Health reported that it was paid in full by CGI for all work performed during the subcontract period. The State, in turn, paid CGI under the VHC contract.

^b DVHA did not have a breakdown of the amounts directly related to correcting Medicaid billing compliance issues. DVHA made payment for four broad milestones, some of which included deliverables related to other issues. The minimum amount excludes payment for any milestone that included deliverables related to other issues; the maximum amount includes payment for all deliverables.

Currently, DVHA has suspended efforts to comply with state rules requiring disenrollment for premium nonpayment because it intends to fold this fix into a planned Integrated Eligibility and Enrollment system. This planned system is comprised of multiple projects, one of which pertains to premium processing. According to a DVHA deputy commissioner, this project will implement a process to comply with the State's rules for disenrollment of Medicaid members due to non-payment of premiums. The deputy commissioner further stated that planning and research for this project recently began. DVHA expects the project charter³⁶ for the premium processing project to be approved in June 2019 and procurement to begin the following month. According to DVHA's latest plan, the premium processing project is expected to be completed no earlier than October 2020.

Since the State does not plan to implement a fix until October 2020 at the earliest, it will have been in violation of HBEE rules pertaining to non-payment for at least seven years (i.e., from the date of VHC's inception on October 1, 2013). This means that for at least seven years, (1) the State will not have collected premiums due as required, (2) the State will have paid millions of dollars in claims for individuals whose households are not paying premiums, and (3) members who have not paid premiums have been treated the same as those who have met their obligations.

Errors that Affect the Recording and Collection of Premiums

During the course of our analysis of past-due Medicaid premiums we identified systemic errors that adversely affected the recording and collection of Dr. Dynasaur premiums.

Flaws in Recording Whether the Household Paid the Initial Premium

Enrollment in Dr. Dynasaur is contingent upon the household paying the initial premium when applicable, and the same holds true for a household that applies to have a disenrolled member receive coverage again. When a household pays the initial premium, the WEX Health system is supposed to send this information to VHC, and the member is then enrolled in Dr. Dynasaur.

However, there are flaws in the way that the initial payment is recorded in the WEX Health and VHC systems that result in members effectuating into Dr. Dynasaur without the household paying the initial premium. WEX Health's system has a field that flags whether the household paid the initial monthly premium in full. This field is not Medicaid specific, and the flag is set for any payment made by the household, whether for QHP or Medicaid. This field

³⁶ When signed, a project charter provides the formal authorization to commit resources (funding and people) to a project.

does not reset when a household has a new initial Medicaid premium obligation. As a result, the WEX Health system sometimes sends information to VHC indicating that the household paid the initial Dr. Dynasaur premium when the payment had not been. This causes VHC to enroll the member in Dr. Dynasaur even though the household never paid the initial premium. For example, in April 2017, VHC recorded the effectuation into Dr. Dynasaur of two members based on WEX Health's system having set the initial premium payment flag, even though the initial premium was not paid. The flag was set based on the household's payment of QHP premiums more than a year earlier.

System Limitations and Errors

The following system limitations and errors resulted in some households not receiving their monthly premium invoices.

- A member's Medicaid eligibility is supposed to be redetermined annually. However, due to a flaw in VHC's reporting logic that informs DVHA of those Dr. Dynasaur members' plans that are up for renewal, some did not undergo the renewal process, and VHC and the WEX Health system recorded the plans as lapsed. For example, a household had two members whose plans lapsed on September 1, 2016, and the plans were not renewed until February 1, 2017. Nevertheless, these members continued to receive Medicaid because the lapse in coverage was not transmitted to the system that pays Medicaid claims.³⁷ DVHA identified that they were not getting a complete list of members whose plans were up for renewal because of deficiencies in the VHC reporting logic. As of January 2019, DVHA was in the process of fixing this problem and reported that in the interim it had implemented a manual workaround.³⁸
- Other errors were caused by problems DVHA terms as "integration errors," which resulted in the WEX Health system not receiving and/or recording changes in the household's account and thereby not invoicing the household accordingly. For example, due to this problem, WEX Health did not send invoices to one household that owed a \$15 monthly Dr. Dynasaur premium from September 2017 thru June 2018. Within the past few months, DVHA implemented a bi-weekly manual reconciliation process to identify and correct these instances.³⁹

³⁷ VHC is the system of record for determining Dr. Dynasaur eligibility. VHC transmits eligible member information to another system called ACCESS which is the system of record for Medicaid enrollment. ACCESS then sends information to the Medicaid claims payment system. A plan lapsing in VHC did not trigger disenrollment information to be transmitted to these systems, and therefore claims continued to be paid.

³⁸ The SAO did not test the effectiveness of this workaround.

³⁹ The SAO did not review this manual reconciliation process.

DVHA concluded that accurately billing households for missed invoices would require substantial resources from DVHA and its contractors. Therefore, DVHA's policy is to not retroactively bill for missed invoices when plan information in VHC lapses or when plan information does not get transmitted to the WEX Health system. As a result, WEX Health's system will not show any premiums owed for these periods even though members received Dr. Dynasaur coverage.

DVHA Removal of Past-Due Premium Amounts

DVHA removed valid past-due amounts on an ad-hoc basis from household accounts in the WEX Health system. For example, DVHA removed 15 months of past-due Dr. Dynasaur premiums at \$60 per month (\$900 in total) from a household's account. DVHA did this because it had not established a process to hold these households accountable for non-payment. In October 2018, DVHA issued new internal guidance to stop the practice of removing valid past-due Dr. Dynasaur premiums unless a member was disenrolled and the past-due balance prevented an individual from enrolling in a Medicaid or QHP plan. Nevertheless, because of DVHA's prior practice, the WEX Health's system underreports the amounts households owe.

Conclusions

DVHA has not devised a process to monitor the amount of Dr. Dynasaur premiums that are due to the State. The Department only knows the amount of Dr. Dynasaur premiums collected, not the amount that went uncollected. Furthermore, DVHA continues to pay Medicaid claims for Dr. Dynasaur members when their premiums go unpaid because DVHA has not devised system modifications to comply with State rules regarding nonpayment of Dr. Dynasaur premiums. For 297 households we selected, DVHA spent nearly \$2.4 million on Dr. Dynasaur claims for periods in which these households did not comply with the initial payment or grace period rules. To date, DVHA has made two unsuccessful attempts to fix this problem at a cost of between \$1,915,040 and \$2,734,040. At this time, DVHA has suspended efforts to comply with state rules requiring disenrollment for premium nonpayment until at least October 2020, when it reaches the point in the planned Integrated Eligibility and Enrollment system when it expects to implement a new premium process.

Recommendations

We make the recommendations in Table 4 to the Commissioner of the Department of Vermont Health Access.

Table 4: Recommendations and Related Issues

Recommendation	Report Pages	Issue
1. Develop and implement a process to monitor the amount of Dr. Dynasaur premiums that are due to the State, including the amount unpaid.	10	DVHA’s contract with WEX Health does not require nor has DVHA established a process to routinely obtain amounts owed and unpaid by household or in total via a transmission to VHC or through some other reporting mechanism.
2. Develop and implement a mechanism, in accordance with HBEE rules, to disenroll members whose premiums go unpaid.	13-14	DVHA does not disenroll Medicaid members when their premiums remain past due. This practice is not compliant with state rules.
3. Correct the flaws that allow a member to enroll without meeting the initial premium payment requirement.	17-18	There are flaws in the way the initial premium payment is recorded in the VHC and WEX Health systems. These flaws result in the systems showing that a household paid an initial premium when it had not.

Management’s Comments

On April 8, 2019, we received a joint set of comments on a draft of this report from the Secretary of the Agency of Human Services and the Commissioner of the Department of Vermont Health Access. These comments are reprinted in Appendix IV along with our evaluation.

Appendix I

Scope and Methodology

For the audit as a whole, we reviewed sections of the following criteria that pertain to Dr. Dynasaur premiums:

- Vermont statutes;
- The Social Security Act;
- The federal code of regulations;
- Vermont's HBEE rules;
- The Vermont State Medicaid plan;
- The Global Commitment to Health Section 1115 Demonstration waivers dating from 2013 to 2018; and
- DVHA's contracts with CGI, Optum, and WEX Health (formerly Benaissance).

To address our first objective, we interviewed DVHA and WEX Health officials to gain an understanding of the premium collection process and the flow of information between VHC and the WEX Health system. We obtained examples of WEX Health reports that contained the weekly premium payments remitted to the State. We also reviewed the business office's written procedures for (1) reconciling the information in these reports to the weekly amounts WEX Health remits to the State and (2) monitoring monthly bank reconciliations of WEX Health bank accounts used for the Vermont Health Connect program. We reviewed an example of how these procedures were implemented. We also reviewed the Department of Finance and Management's Internal Control Best Practices for Accounts Receivable.

We identified the amount of Dr. Dynasaur premiums that DVHA collected in fiscal years 2018 and 2017 by obtaining and reviewing premium collection tracking spreadsheets from the Agency of Human Services. We confirmed that the information in those spreadsheets agreed to the deposit information contained in Vermont's statewide accounting system for Dr. Dynasaur premiums collected by DVHA.

To address our second objective, we gained a general understanding of the Dr. Dynasaur premium process via interviews with DVHA operations, reconciliation, and policy staff, as well as WEX Health officials. We also reviewed DVHA's premium processing manual.

Appendix I

Scope and Methodology

We obtained a preliminary DVHA analysis of households that owed past-due Dr. Dynasaur premiums as of June 30, 2018. Based on discussions with DVHA staff that performed this preliminary analysis and our review of the analysis, we determined that it was not of sufficient reliability for the purposes of our audit. Accordingly, we limited our use of DVHA's analysis to identifying households and members that had a plan in active status as of June 30, 2018,⁴⁰ and who appeared to have six or more months of unpaid premiums past their grace period end date. There were 656 members in 404 households that met this criterion in the preliminary analysis. We eliminated an additional 14 members (in 7 households) because the analysis indicated that they had made sufficient payments so as not to be delinquent in their Dr. Dynasaur premiums.

For the remaining 642 members in 397 households, we worked with DVHA reconciliation staff to obtain Dr. Dynasaur plan information contained in VHC and plan and payment information contained in WEX Health's system. We also obtained information about how DVHA's policies should be applied from DVHA's policy staff. Based on this work, we identified 473 members in 297 households who: (1) never should have been enrolled because their initial premium obligations were not paid, and/or (2) remained enrolled in Medicaid after the grace period expired. The remaining 169 members did not meet these criteria, or we could not determine based on the data available, whether they met these criteria.

We also obtained a data file of all Medicaid claims for services between October 1, 2013 and June 30, 2018, paid as of October 14, 2018 from the Medicaid claims payment system. We performed limited data reliability testing of the claims data to determine whether the data was reasonably complete and accurate. For example, we looked for anomalies in the data provided, such as dates outside plausible ranges, and whether all claim types were included. We determined that the claims data was sufficiently reliable for our limited audit purposes. Using our data analysis software, we identified claims that had been paid for services delivered to the 473 members in the 297 households that did not comply with the initial payment or grace period rules during these non-compliant periods.

We sought to understand the causes for DVHA not implementing the HBEE rule requiring that it disenroll Dr. Dynasaur members who do not pay premiums by interviewing a DVHA deputy commissioner and DVHA operations staff. Based on these discussions, we obtained documentation of DVHA's previous attempts to be comply with this requirement. This documentation included business requirements, project tracking notices (such as change requests), and emails between the parties assigned to the

⁴⁰ We confirmed this status by comparing the data in the preliminary analysis to an enrollment file obtained from the Medicaid claims system.

Appendix I

Scope and Methodology

projects. We also obtained invoices and summary data from the State accounting system to determine whether and how much DVHA paid for deliverables in its attempts to implement requirements pertaining to disenrollment. Lastly, we learned of DVHA's current plans to address this issue.

We also reviewed the following reports to identify whether there were previously identified internal control deficiencies that could pertain to our objectives. They were: (1) KPMG's Auditors' Reports as Required by Uniform Guidance and Government Auditing Standards and Related Information for year ended June 30, 2017, (2) BerryDunn's Independent External Audit: 2017 Audit Findings Report of the VHC, (3) SAO's *Vermont Health Connect: Future Improvement Contingent on Successful System Development Project*, (Rpt. No. 15-03, April 14, 2015), and (4) Service Organizational Control reports for WEX Health and the State's Medicaid claims processor. We followed up on why control deficiencies existed that (1) prevented the accurate monitoring of Dr. Dynasaur premiums owed and unpaid, (2) allowed members to enroll in Dr. Dynasaur without the household paying the initial premium obligation, and (3) prevented DVHA from disenrolling members whose premiums continued to go unpaid.

Our audit work was conducted between July 2018 and March 2019, primarily at DVHA's offices in Waterbury and Essex Junction. We conducted this performance audit in accordance with generally accepted government auditing standards, which 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 II Abbreviations

DVHA	Department of Vermont Health Access
HBEE	Health Benefits Eligibility and Enrollment
QHP	Qualified Health Plans
SAO	State Auditor's Office
VHC	Vermont Health Connect

Appendix III Monthly Household Income Levels for Dr. Dinosaur Premiums

The State has an agreement with the Centers for Medicare and Medicaid Services to charge premiums for children and teenagers under the age of 19 in households that meet or exceed certain income levels. The three different monthly premium amounts are \$15, \$20, and \$60. The \$20 and \$60 premium have the same household income level requirements. The difference is that if a Dr. Dinosaur member also has coverage under another health insurance plan then that member qualifies for the \$20 premium instead of the \$60 premium.

Table 5 shows the maximum monthly household income levels and the associated monthly premiums that DVHA charges for Dr. Dinosaur.

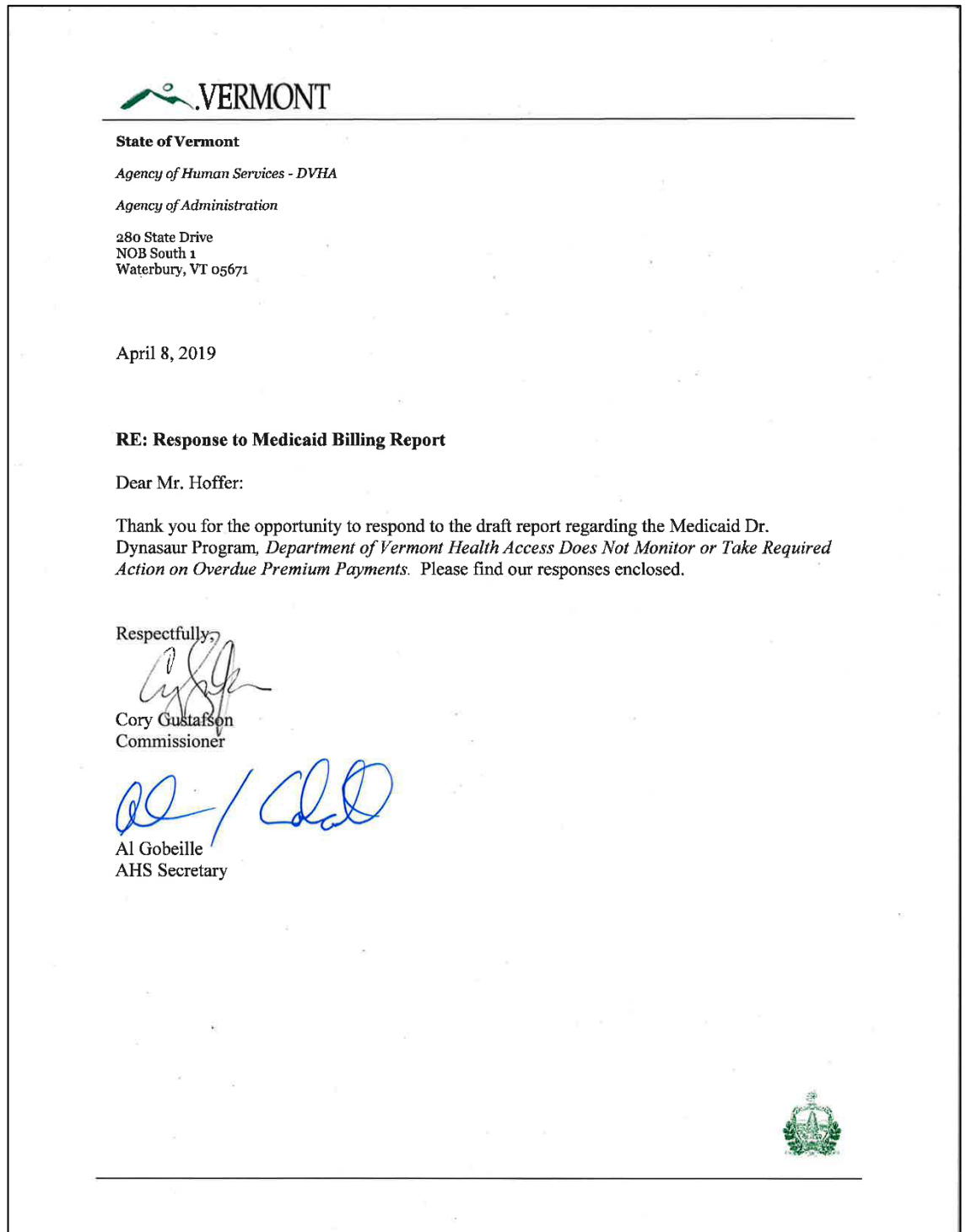
Table 5: Maximum Monthly Household Income Levels for Calendar Year 2018 and Corresponding Monthly Premiums

Household Size ^a	Monthly Income Level		
	No Monthly Premium	\$15 Monthly Premium Per Household	\$20 Monthly Premium Per Household If Child(ren) Have Other Insurance; \$60 Monthly Premium If Child(ren) Are Uninsured
1	\$1,973	\$2,398	\$3,157
2	\$2,675	\$3,251	\$4,280
3	\$3,377	\$4,105	\$5,403
4	\$4,079	\$4,958	\$6,526
5	\$4,781	\$5,811	\$7,650
6	\$5,483	\$6,664	\$8,773
7	\$6,185	\$7,517	\$9,896
8	\$6,887	\$8,371	\$11,019

^a A young Vermonter under the age of 19 who is not claimed as a tax dependent by someone else is a household size of 1.

Appendix IV Comments from Management and Our Evaluation

The following is a reprint of management's response to a draft of the report we provided for comment and our evaluation of those comments.



Appendix IV Comments from Management and Our Evaluation

See SAO Comment 1
on page 29.

See SAO Comment 2
on page 29.

See SAO Comment 3
on page 29.

See SAO Comment 4
on page 29.

Management Response

Findings

DVHA does not have a specific comment on the Objective 1 Finding but addresses the related recommendation in the Recommendations section below. This portion of the response addresses the Objective 2 Finding (beginning page 10) that the State paid Medicaid claims for members whose premiums were unpaid.

The report indicates that 297 households with 473 members had active Dr. Dynasaur accounts on 6/30/2018 and had never paid a premium or had premium payments at least 8 months past due. For context, there are approximately 60,000 children on Dr. Dynasaur plans today and less than 10,000 have a premium obligation. Monthly premiums range from \$15 to 60.

The report concludes that \$2.4 million in claims were paid from the time of incorrect effectuation or post grace period for these households who either (1) should never have been enrolled because their initial premium obligations were not paid or (2) remained enrolled in Medicaid after the grace period expired. For context, DVHA paid approximately \$166 million in claims for the Dr. Dynasaur population in state fiscal year 2018.

It is true that members have not been disenrolled for non-payment of premiums since Vermont Health Connect began enrollment in 2014. Due to the unsuccessful build, the VHC premium processing system does not have the functionality to implement Vermont administrative rules that require (1) allocation of partial payments to Medicaid first for households with multiple insurance plans, and (2) member notices of premium nonpayment and its consequences (including disenrollment).

However, the State does not agree with the assumption that the State paid for claims that it otherwise would not have because the members would have been disenrolled for nonpayment had the technology been functioning properly. To the contrary, DVHA's historical experience is that, once noticed for nonpayment of premiums, a majority of members paid their obligations and avoided termination. DVHA's experience in ACCESS is that only a small minority of members actually failed to pay premiums during the grace period and became disenrolled. Therefore, we would expect that a majority of the claims cited in the report would have still been paid because the members would have paid their premiums after proper notice and would not have been terminated for nonpayment.

Recommendations

DVHA does not disagree with the recommendations made in this report (see pages 18-19). This section of the management response provides (1) context for why DVHA has not yet addressed the issue and (2) its plan for addressing the lacking functionality.

Vermont Health Connect launched in October of 2013 with significant technical deficiencies, which resulted in poor customer service, operational stress, and challenging relationships with key stakeholders. The State is not content nor pleased with any functionality shortfalls and has

Appendix IV Comments from Management and Our Evaluation

See SAO Comment 5
on page 29.

been methodically working to address outstanding issues. Specifically, DVHA spent the next several years triaging operational and technical challenges with the goal of achieving stability and ensuring that it could meet the health coverage needs of Vermonters while providing good customer service. Key activities included eliminating processing backlogs, remediating system defects which prevented accurate enrollment, and enhancing system functionality to ensure compliance with federal MAGI Medicaid rules during verification and renewals. The State feels strongly that functionality failures should not impact children's health care and did not prioritize the implementation of new functionality to terminate Medicaid coverage of children during this time.

With the most urgent challenges largely behind us, the State is now focused on addressing premium processing deficiencies, as well as critical areas of noncompliance with federal non-MAGI Medicaid rules due to lack of integration between eligibility systems. Vermont is remediating these issues as a part of its Integrated Eligibility and Enrollment (IE&E) roadmap.

The IE&E team has already begun planning for its premium processing project, which will kick off officially in July. This project has two objectives: (1) to return Qualified Health Plan premium processing to insurance carriers, and (2) to achieve compliance with Vermont Medicaid premium rules. The State's approach to IE&E involves breaking projects into smaller increments in order to deliver progress more frequently and to reduce financial risk to the State. To that end, the State will focus first on successfully returning premium processing to carriers by October 1, 2020, before delivering the additional Medicaid functionality.



SAO Evaluation of Management's Comments

SAO Comment 1.	In the final report, the objective 2 finding starts on page 11.
SAO Comment 2.	We consider the nearly \$2.4 million DVHA paid for claims on behalf of members in 297 households that have not met their premium obligations to be significant. It means that, on average, taxpayers paid a benefit for these households of \$8,044 even though they chose not to fulfill their obligation to the State by paying required premiums. Moreover, a comparison of the total amount of Dr. Dynasaur claims in fiscal year 2018 to the amount of claims for members in our selection of 297 households that did not comply with the initial payment or grace period rules is not valid. According to DVHA's preliminary analysis, there were many more households that had overdue unpaid premiums than we reviewed. It was not practical for us to verify the premium data for all of these households.
SAO Comment 3.	We reported on what transpired since the launch of VHC, namely that DVHA did not disenroll members of households who did not pay required premiums from Dr. Dynasaur as mandated by State rules and paid claims on behalf of these members. We did not speculate, as the Secretary and Commissioner do in their comments, about what may have happened had VHC been fully functional and able to support the State's rules.
SAO Comment 4.	In the final report, recommendations start on page 19.
SAO Comment 5.	The State's Dr. Dynasaur premium collection requirements have been in place for over five and a half years. Therefore, the functionality to implement these requirements should not be considered "new." DVHA's understandable interest in children's health care does not excuse its inability to implement the State's own requirements particularly since the Department paid at least \$1.9 million for two unsuccessful attempts to fix this problem. In addition, as we noted in the report, as a result of its shortcomings, (1) the State will not have collected all premiums due, (2) the State will have paid millions of dollars in claims for individuals whose households are not paying premiums, and (3) members who have not paid premiums have been treated the same as those who have met their obligations.