Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Medicaid

Fraud, Waste, and Abuse Vulnerabilities Remain as Steps to Address Program Integrity Findings Were Not Always Taken

January 23, 2025

Rpt. No. 25-01

Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Mission Statement

The mission of the Auditor's Office is to hold State government accountable by evaluating whether taxpayer funds are being used effectively and identifying strategies to eliminate waste, fraud, and abuse.

Audit Team

Linda Lambert, Director, Information Technology and Performance Audits
Corina Niner, Senior Auditor

January 23, 2025 Rpt. No. 25-01

DOUGLAS R. HOFFER
Vermont State Auditor

132 STATE STREET • MONTPELIER, VERMONT 05633-5101
PHONE: (802) 828-2281
AUDITOR@VERMONT.GOV • WWW.AUDITOR.VERMONT.GOV

Dear Colleagues,

Vermont Medicaid providers, including hospitals, nursing homes, general practitioners, and specialists deliver critical access to healthcare across the state to serve some of Vermont's most vulnerable populations. The State spent more than $2 billion in fiscal year 2024 on Vermont Medicaid and Medicaid-related activities, providing vital healthcare support to almost 197,000 individual Vermonters. Because of its size, scope, and complexity, though, Medicaid is vulnerable to fraud, waste, and abuse.

To fight fraud, waste, and abuse, the Agency of Human Services (AHS) is responsible for overseeing the program integrity activities of its subordinate organization, the Department of Vermont Health Access (DVHA), Vermont's managed care-like entity. DVHA's Special Investigation Unit (SIU), in turn, conducts reviews, audits, and investigations which may result in a variety of outcomes, including the recovery of improper payments, provider termination from the Medicaid program, and the identification of Medicaid control weaknesses. The SIU's work to identify and prevent fraud, waste, and abuse is critical to ensuring Medicaid funds can be spent as intended on the health and welfare of Vermont Medicaid recipients.

Because of Medicaid's impact on State government and Vermonters, we decided to conduct an audit focused on actions being taken in response to the SIU's findings. We found that DVHA and partner State organizations did not consistently act in response to SIU-identified findings, vulnerabilities, and policy concerns, thereby putting Medicaid funds at risk. In addition, in 20 investigations initiated between 2020 and 2023, the SIU identified about $1.2 million in improper payments to providers of which almost $517,000 will not be recovered due almost entirely to decisions by DVHA's leadership at the time to retroactively change a rule that was the basis for the SIU's findings and to backdate the Medicaid provider enrollment of certain clinicians.

Another issue we identified was that program vulnerabilities identified by the SIU were largely not addressed, potentially leading to additional risk to the State. For example, the Agency of Education and DVHA have still not been able to reach an agreement on how to address SIU-identified vulnerabilities reported in June 2021 related to the school-based health services program despite escalation to the Secretaries of Human Services and Education. These vulnerabilities pertained to ensuring that services billed under a bundled rate were actually provided and that they did not duplicate claims billed under another program.

We also looked at DVHA's oversight of the program integrity activities of OneCare, an accountable care organization with a provider network that is accountable for the quality, cost, and overall care of designated patients. DVHA's contract with OneCare can exceed $300 million annually. DVHA's oversight of OneCare's program integrity activities, however, fell short. In particular, DVHA did not exercise its authority under the contract to conduct in-depth analysis of the program integrity activities OneCare was supposed to be doing, largely

DOUGLAS R. HOFFER
Vermont State Auditor

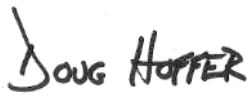
132 STATE STREET • MONTPELIER, VERMONT 05633-5101
PHONE: (802) 828-2281
AUDITOR@VERMONT.GOV • WWW.AUDITOR.VERMONT.GOV

limiting its oversight activities to reviewing documents submitted by OneCare. Thus, DVHA did not verify whether OneCare was fulfilling its program integrity obligations.

We made recommendations to AHS and DVHA to improve their processes related to Vermont Medicaid program integrity and ensure those funds are being protected so they may serve Vermonters as envisioned.

I would like to thank AHS and DVHA staff for their cooperation and professionalism through the course of this audit.

Sincerely,



DOUGLAS R. HOFFER
State Auditor

ADDRESSEES

The Honorable Jill Krowinski
Speaker of the House of Representatives

The Honorable Philip Baruth
President Pro Tempore of the Senate

The Honorable Phil Scott
Governor

Ms. Sarah Clark
Secretary, Agency of Administration

Mr. Adam Greshin
Commissioner, Department of Finance and Management

Ms. Jenney Samuelson
Secretary, Agency of Human Services

Dr. DaShawn Groves
Commissioner, Department of Vermont Health Access

Contents

Page

Highlights

In fiscal year 2024, Vermont's Medicaid and Medicaid-related expenditures exceeded $2 billion for a caseload of almost 197,000 individuals who are served by thousands of Vermont Medicaid providers, including hospitals, nursing homes, general practitioners, and specialists. Because of its size, scope, and complexity, Medicaid is vulnerable to fraud, waste, and abuse (FWA). For instance, health care providers may bill for unfurnished or unnecessary services or submit claims that result in a higher payment than is justified. For example, in a January 2024 settlement with the Vermont Attorney General's Medicaid Fraud & Residential Abuse Unit (MFRAU), a provider agreed to repay Medicaid $326,000 for billing for an individual who had been disenrolled as a client and for services that were not provided or were otherwise ineligible. Medicaid overpayments may also result from other circumstances. For example, a Vermont provider voluntarily came forward after realizing that they had been overpaid due to an error in their system and is now in the process of repaying about $40,600 to Medicaid.

States are required to have a program integrity function in place to identify, investigate, and report Medicaid FWA. Under Federal regulation, the Agency of Human Services (AHS) is responsible for Vermont's program integrity responsibilities as the Single State Medicaid Agency. AHS fulfills this role by overseeing the program integrity activities of the State's managed care-like entity, the Department of Vermont Health Access (DVHA). An example of a DVHA program integrity activity is the FWA investigations performed by the Special Investigations Unit (SIU). The SIU works collaboratively with the MFRAU, making referrals when the SIU identifies potential fraud. DVHA also contracts with OneCare Vermont Accountable Care Organization, LLC (OneCare), which has a provider network that is accountable for the quality, cost, and overall care of designated patients. The contract requires OneCare to perform specified program integrity activities.

Because of Medicaid's impact on State government and Vermonters and the program's vulnerability to FWA, we decided to conduct an audit with the following objectives: (1) to determine if and what actions were taken in response to findings and vulnerabilities associated with Medicaid providers identified by DVHA's SIU and (2) to assess DVHA's oversight of OneCare's program integrity activities.[1]

Objective 1 Finding

DVHA and partner State organizations did not consistently act in response to SIU-identified findings to reduce Medicaid vulnerability to FWA. The SIU identified about $1.2 million in improper payments in the 20 investigations we reviewed. In

[1] Appendix I details the scope and methodology of the audit. Appendix II contains a list of abbreviations used in this report.

most of these cases, the SIU collected or is in the process of collecting these improper payments from providers. However, almost $517,000 will not be recovered due almost entirely to DVHA management's decisions that effectively nullified the SIU's improper payment findings.

The $517,000 that will not be collected stems largely from a DVHA decision that affected three SIU investigations of providers that inappropriately billed for supervised non-licensed and non-certified (NLNC) clinicians and for licensed clinicians who failed to enroll as Medicaid providers. In these three investigations, the SIU found that almost all reviewed providers had submitted claims for NLNC clinicians that did not have adequate documentation, did not otherwise meet Medicaid rules, or had failed to respond to the SIU. Initially, the SIU started to recover the improper claims from some of these providers.

Four providers submitted appeals to the former DVHA Commissioner as allowed by SIU procedures. The Commissioner, or designee, ruled in three of these appeals that the SIU findings were correct. However, the former Commissioner also made a retroactive change to a Vermont Medicaid rule that was the basis for the SIU's findings, nullifying the SIU's overpayment findings. As a result, DVHA returned about $72,000 to providers that the SIU had collected based on their original findings and no longer sought recovery of the overpayment balances related to these findings. The fourth appeal was related to this rule but also involved a provider billing for clinicians that were licensed but had not enrolled as Medicaid providers, which violates Vermont Medicaid rules. The DVHA Deputy Commissioner approved backdating the licensed clinicians' enrollments in Medicaid. The provider was then allowed to resubmit and be paid for claims that the SIU had determined had been improperly paid. The provider then withdrew the appeal request.

Summarized plainly, the SIU identified improper payments and DVHA management agreed with those determinations, but then changed an existing rule to make what had been unacceptable acceptable.

The SIU also identified programmatic risks during the course of their investigations and sent vulnerability memos to DVHA and other State Medicaid organizations related to 8 of the 20 investigations we reviewed. In most cases the organizations did not act to address all the vulnerabilities the SIU identified. For example, a June 2021 SIU vulnerability memo pertaining to the Agency of Education's (AOE) school-based health services program reported that some services provided under a bundled rate were not always received or provided in full and were duplicative with claims billed under another program. Three years later, despite escalation to the Secretaries of Human Services and Education, DVHA and the Agency of Education have not been able to reach an agreement on how to address the vulnerability.

Our audit found two root causes for inaction in response to the SIU's vulnerability memos: (1) while the SIU makes itself available to discuss its findings, they do not follow up on whether, or the extent to which, organizations address the identified vulnerabilities, and (2) the memorandum of understanding (MOU) between the

State Medicaid organizations does not clearly define roles and responsibilities for these organizations when there is a dispute, leaving no clear path to resolution.

Lastly, we found that DVHA generally took any SIU concerns into account when making policy changes. However, in three of the 20 (15 percent) policy changes we reviewed, the SIU's program integrity concerns were not addressed, leaving Medicaid open to potential risk including in two high-cost healthcare categories. For example, the former SIU director refused to approve a policy change that would reduce system controls for a service known nationally to have FWA issues. Despite the known risk, a DVHA Deputy Commissioner, in favor of streamlining the process, decided to implement the change against the SIU's recommendation. This newly introduced risk would be addressed, the Deputy Commissioner asserted, through planned provider education and monitoring. The SIU has since opened an investigation to monitor claims affected by this specific change. At the time of our audit, this investigation was ongoing but the SIU's tentative findings found improperly paid claims.

Objective 2 Finding

Even though DVHA's contract with OneCare can exceed $300 million annually, its oversight of OneCare's program integrity activities has not been robust. DVHA's oversight was largely limited to the SIU's reviews of program integrity documents submitted by OneCare as required by the contract.

DVHA has the authority to conduct more in-depth analyses of OneCare's program integrity activities. Since 2017, DVHA's contract with OneCare has allowed the SIU to conduct oversight reviews of OneCare's compliance program or other program integrity related activities. Yet, the SIU has never performed such a review. Moreover, the SIU did not investigate a 2022 allegation that OneCare was not following contract requirements and had presented misleading information in its reports to DVHA. The allegations may not be true, but they deserved to be investigated, as allowed by the OneCare contract.

Lastly, even though OneCare is part of a sector that is a frequent target of FWA, OneCare has never reported to DVHA suspected FWA or provider terminations or denials due to program integrity concerns, both of which it is contractually required to do. There could be several reasons why there has been no such reports, such as (1) there were no instances of FWA or provider terminations for program integrity reasons, (2) there were such instances and OneCare failed to report them, or (3) OneCare's processes are not designed to identify such instances. Without a review of OneCare's compliance program or other program integrity activities, DVHA does not know which of these reasons, or any other, is the cause of the lack of reporting.

Recommendations

We made recommendations to the Secretary of AHS and the Commissioner of DVHA, including that the Commissioner direct the SIU to follow up on SIU-identified

vulnerabilities and to report to the Commissioner and AHS the extent to which these vulnerabilities are eliminated or mitigated.

Background

Vermont administers most of the Medicaid program under the Global Commitment to Health Section 1115 Demonstration agreement with the Centers for Medicare and Medicaid Services (CMS). Under this agreement, Vermont delivers Medicaid services to beneficiaries through a managed care-like model. AHS serves as the Single State Medicaid Agency. AHS has an intergovernmental agreement (IGA) with DVHA, which is a department within AHS and serves as the Medicaid managed care-like entity. Other AHS component departments, such as the Department for Children and Families (DCF) and the Department of Disabilities, Aging and Independent Living (DAIL) help administer Vermont's Medicaid program. AOE also plays a role in administering the Medicaid program.

DVHA'S MISSION

To "improve Vermonters' health and well-being by providing access to high-quality, cost-effective health care."

The SIU resides in DVHA and is charged with conducting reviews, audits, and investigations to detect instances of fraud, waste, and abuse and to determine the most appropriate action. The SIU's investigations are generated from referrals from a wide variety of sources, including SIU staff, other State employees, providers, members of the public, and law enforcement agencies. Once it receives a referral, the SIU conducts a preliminary investigation and determines if a full investigation is warranted. In a full investigation, an auditor records actions in a case log and performs procedures, which could include data analysis of Medicaid claims, requests for medical records from the target provider, and/or site visits and writes a final investigation report with the results. SIU investigations may result in the recovery of improper payments, provider termination from the Medicaid program, a vulnerability memo to address a Medicaid control weakness, or a finding that the allegation was unsubstantiated. If the SIU believes that it has found reliable evidence of fraud, it is required to refer the matter to the MFRAU.

The SIU also educates providers in a proactive effort to prevent FWA, so Medicaid funds can be spent on the health and welfare of Medicaid recipients in Vermont who really need it. The SIU reports on its performance by measuring cost avoidance, which is an estimate of how much was saved after the SIU (1) educated providers on how to fix billing pattern and (2) caused ineligible beneficiaries to be removed from Medicaid.[2] The SIU reported cost

[2] DVHA Performance Accountability Scorecard (clearimpact.com)

avoidance for State fiscal year 2023 was $2.5 million and for 2024 was $4.4 million.[3]

DVHA contracts with OneCare Vermont Accountable Care Organization (ACO), LLC to provide services under the Vermont Medicaid Next Generation (VMNG) program.[4] The VMNG program, administered by DVHA's Payment Reform Unit, allows a risk-bearing ACO (OneCare) to receive a prospective payment and assume responsibility for the costs and quality of care for attributed Medicaid members. An attributed member is a Medicaid beneficiary who meets certain criteria.

DVHA makes two primary types of payments to meet the healthcare needs of Medicaid beneficiaries under this contract.[5]

- **Monthly fixed prospective payments.** DVHA pays OneCare in advance for a wide range of defined health care services for attributed members. Under this payment methodology, providers continue to submit claims, but these claims are not paid. Instead, DVHA pays OneCare a per member per month amount for each attributed member. OneCare, in turn, pays the participating providers the fixed prospective payment for each attributed member in a given month whether they receive medical services or not. The per member per month payments in 2024 ranged from $65.42 to $367.66 depending on Medicaid category of the beneficiary. In 2023, DVHA paid OneCare $202 million in monthly fixed prospective payments.

- **Fee-for-service payments.** Claims for providers not participating in the fixed prospective payments or for participating providers for services that are not covered by the prospective payment, are paid directly to the provider (not through OneCare) on a fee-for-service basis. In 2023, DVHA paid providers $152 million in fee-for-service claims under the OneCare contract.

[3] The accuracy of the cost avoidance amounts was not reviewed as part of this audit and therefore we have not verified them.

[4] In 2017, DVHA signed a contract with OneCare for an ACO pilot program for a one-year period. Four subsequent amendments to this contract covered 1-year performance periods for the years 2018 – 2021. In 2022, DVHA signed a second contract with OneCare to administer the ACO program. There have been two subsequent amendments to this contract covering the 2023 and 2024 performance years. For purposes of readability, this report refers to the contract amendments as "contracts" and includes the performance year to specify which document is being referred to.

[5] DVHA also makes other payments to OneCare. For example, in 2023, DVHA paid OneCare Provider Reform Support Payments of $6.9 million, which it is required to distribute to participating practices and preferred providers.

Objective 1: SIU Identified Improper Payments and Vulnerabilities That Were Not Consistently Addressed

DVHA and other partner State organizations did not consistently act in response to SIU-identified findings, vulnerabilities, and policy concerns. About $1.2 million in improper payments was identified by the SIU in the 20 investigations we reviewed, of which just over $500,000 will not be recovered largely due to DVHA management's decisions to retroactively change a rule and backdate provider enrollments in Medicaid that were the basis for the SIU's findings. This decision meant that the overpayments identified by the SIU were not collected. During the course of their investigations, the SIU identified potential risks and sent program vulnerability memos to DVHA and other State Medicaid organizations who largely failed to address the vulnerabilities. **For example, in June 2021, the SIU sent a vulnerability memo about the AOE school-based Medicaid program to DVHA management. More than three years later, despite escalation to the Secretaries of Human Services and Education, DVHA and AOE have not been able to reach an agreement on how to address the vulnerability.** Further contributing to the issue of unaddressed vulnerabilities, is the lack of a formal follow up process for SIU recommendations which is inconsistent with sound internal control standards. We also found three examples in which DVHA did not address SIU-articulated program integrity concerns when adopting policies. For example, the former SIU director refused to approve a policy change that would reduce system controls for a service known nationally to have FWA issues. A DVHA Deputy Commissioner decided to implement the change against the SIU's recommendation. That decision is contrary to DVHA's own policy, which requires SIU approval.

Results of SIU Investigations

According to DVHA's Program Integrity Medicaid Program Compliance Plan, SIU investigations are supposed to detect instances of suspected FWA and determine the most appropriate action. Between 2020 and 2023, 142 SIU investigations were started. We reviewed 20 investigations all of which had one or more findings (an investigation may include more than one provider). We identified that the SIU took three primary types of action: (1) recovery of an improperly paid claim, (2) reporting on program vulnerabilities, and/or (3) referral to the MFRAU of possible fraudulent action by the provider.

Recovery of Improper Payments

The SIU identified $1,183,632 in improperly paid claims to be recovered from providers in 16 of the 20 cases we reviewed, as shown in Exhibit 1 (some cases reviewed claims from multiple providers).[6] Examples of improperly paid claims were those that did not have sufficient supporting documentation or used incorrect procedure codes. The SIU also sought to recover claims in which the provider failed to provide requested documentation that supported the claim to the SIU. Additionally, two investigations are ongoing and final amounts of improper payments have not yet been determined.

Exhibit 1: SIU Identified Claim Recovery Status as of October 2024

Case #	SIU Claim Recovery			
	Identified	Collected	Collection On-Going	Will Not Be Collected
2642	$ 6,182	$ 6,182		
2643	$ 6,600	$ 6,600		
2653	$ 1,894	$ 1,894		
2802	$ 12,347	$ 12,347		
2826[a]	$ 34,273	$ 32,445	$ 344	$ 1,484
2893	$ 270,341	$ 270,341		
2910[b]	$ 23,361	$ 1,768	$ 21,593	
2941	$ 59,110	$ 35,225	$ 23,885	
2946	$ 11,998	$ 11,998		
2987	$ 40,428	$ 7,170		$ 33,258
2992[a]	$ 582	$ 582		
2999	$ 269,654	$ 3,380		$ 266,274
3007	$ 274,289	$ 51,817	$ 6,640	$ 215,832
3054	$ 137,085	$ 137,085		
3103	$ 14,186	$ 9,905	$ 4,281	
3186[a]	$ 21,302[c]	$ 21, 302		
3199	Unknown[c]	—	—	—
Total[d]	**$ 1,183,632**	**$ 610,041**	**$ 56,743**	**$ 516,849**
%[d]		**52%**	**5%**	**44%**

[a] About $12,500 in these three cases were for services covered by the monthly fixed prospective payment to OneCare as previously described. Because these were not fee-for-service claims (which are paid individually) there were no payments to be recovered from the providers although the claims were corrected in the Medicaid Management Information System.

[b] This provider was terminated from the Medicaid program and referred to the MFRAU before the full amount of the improper payment was collected. The SIU is waiting until the MFRAU investigation concludes to pursue collection.

[c] These cases were ongoing and final total amount of improper payments were not yet identified as of December 2024.

[d] Totals may not add due to rounding.

[6] We judgmentally selected these 20 investigations to review as described in Appendix I. The results do not necessarily reflect what would have been found with the investigations that were not selected.

The more than half a million dollars in SIU-identified improperly paid claims that will not be collected in cases #2987, 2999, and 3007 are the result of DVHA leadership decisions.[7] In 2024, the SIU completed these three investigations into multiple providers that billed for NLNC clinicians they supervised.

In these investigations, the SIU found that almost all providers had submitted claims for clinicians that did not have adequate documentation, did not otherwise meet Medicaid rules, or that the provider failed to respond to the SIU. The services did not meet the definition for a reimbursable service at the time the services were provided because clinicians had violated state requirements by (1) exceeding time limitations on the state-maintained Office of Professional Regulation (OPR) roster, (2) failing to enroll as a Vermont Medicaid provider despite eligibility, and/or (3) not seeking licensure from OPR. The importance of OPR rostering is not just related to the payment of Medicaid claims (see quote to the right).

> "OPR provides oversight and protection to VT recipients, as a rostered status indicates adherence to state regulations … The supervising provider did not verify the NLNC clinicians' time on the OPR roster to ensure they were within the outlined requirements for VT Medicaid to bill for clinical services … Verification of the time on the OPR roster ensures that the highly vulnerable population is receiving quality care from competent individuals."
>
> SIU Vulnerability Notice to DVHA's Commissioner, November 3, 2023

Four providers that billed for NLNCs in the three cases noted above appealed the SIU findings to the former DVHA Commissioner, or designee, as allowed by SIU procedures. While the SIU findings were not overturned by the appeals, DVHA leadership made decisions that retroactively permitted most of the claims the SIU had previously found to be improperly paid.

- For three of the appeals, the former DVHA Commissioner, or designee, ruled that the SIU findings were correct. However, in November 2023, this Commissioner also approved a change to the rule that governed NLNC billing that was the basis for the SIU's findings and in the following month made this change retroactive. These decisions were made after hearing complaints from providers. DVHA's notification to providers of this change noted that it was made after feedback from providers that the

[7] The amount in case #2826 is due to the age of the claims.

original rule "may have unforeseen consequences and may cause confusion among providers."[8]

- The fourth appeal involved an NLNC clinician as well as three clinicians that were licensed but had not enrolled as Medicaid providers, which also violates a Medicaid rule. Some of SIU's findings in this case were also effectively nullified with the retroactive rule change described in the previous bullet. In addition, the DVHA Deputy Commissioner approved the clinicians' enrollment in Medicaid and backdated their enrollment. The provider, who then withdrew the appeal, was allowed to resubmit and be paid for claims that the SIU had previously determined had been improperly paid.

As a result of the retroactive rule change, the SIU's findings were effectively nullified and DVHA reimbursed the providers about $72,000 that the SIU had already recovered.

Additionally, DVHA lacked the authority to make the 2023 supervised billing rule change under Vermont statute, which defines rules as having the force of law. To change a rule, an organization must follow a formal process. The statute only allows for a waiver or variance in limited circumstances which would require AHS or DVHA to have a rule that defines a process and specific criteria. Neither AHS nor DVHA has such a Medicaid rule. Thus, DVHA disregarded State law and acted outside its authority when making the 2023 change. As of December 2024, DVHA was working on the formal revision of the rule but had not finalized it.

Program Vulnerabilities

SIU investigations may result in the issuance of a program vulnerability memo when the SIU identifies risks in the current process or program that leave the applicable department open to potential FWA. SIU outlines these risks in a memo addressed to the relevant agency or department and typically give recommendations for improving the process to mitigate or avoid such risk(s).

The SIU submitted vulnerability memos related to 8 of the 20 cases we reviewed. In most cases the organizations did not act to address all the vulnerabilities the SIU identified. The reasons for inaction vary, including that the receiving organization unilaterally decided that action was not needed.

[8] Health Care Administrative Rule 9.103, *Supervised Billing*, addresses when a qualified licensed provider can bill for covered clinical services provided by a qualified non-licensed provider when the non-licensed provider is under direct supervision of the licensed provider. Under this rule, a provider cannot bill Medicaid for services provided by a non-licensed provider who has been on a roster maintained by the Office of Professional Regulation for more than five years after January 1, 2016. DVHA granted a retroactive extension to this five-year roster rule for Medicaid reimbursement until December 31, 2025 while it works on revising the language in Rule 9.103.

See Exhibit 2 for a summary of the vulnerabilities and whether they have been addressed.

Exhibit 2: Program Vulnerabilities Identified by the SIU

Case #	State Entity	Date	Description of Vulnerabilities	Vulnerability Addressed?	Explanation
2642	DAIL	8/9/21, 10/14/21	A beneficiary enrolled in two separate DAIL programs resulting in excess payments. The SIU notified DAIL that its manuals did not address this situation or clearly identify whether certain activities could be billed.	**No**	DAIL met with the SIU about the vulnerabilities identified but did not act on the SIU's findings. DAIL officials told us that concurrent enrollment was unusual and that currently only one beneficiary met this circumstance. Thus, they did not believe that SIU-recommended changes were needed.
2653	AOE	6/1/21	School-based services billed under a bundled rate were not always provided as prescribed. In addition, these bundled services were sometimes also billed under a separate program, thus duplicating payments.	**No**	An SIU investigation into the school-based health services program was the basis for this memo, which was presented to DVHA leadership who escalated the issue to AHS. In January 2024, AHS and DVHA officials met with AOE officials in which they outlined risk areas based on this memo. In February 2024, the DVHA general counsel requested that AOE clarify in writing why it did not agree with DVHA's concerns. In early April 2024, the AHS and AOE Secretaries discussed this issue. Still, as of December 20, 2024, AOE had not responded to DVHA's request. In early December 2024, AHS, DVHA, and AOE leadership met and agreed to develop a memorandum of understanding between DVHA and AOE specific to targeting Medicaid compliance gaps.
2710	DCF	7/8/21	Beneficiaries exceeded their dental services limit because DCF's general assistance program lacked prior authorization and clinical oversight of medical necessity and relied on beneficiary attestations.	**No**	DCF stated the memo was sent to an employee no longer in the applicable DCF role and that it did not reach the correct unit. During our audit, DCF staff reviewed the memo. The DCF Economic Benefit's Director stated that since the date of the memo, the general assistance program's dental benefit has been significantly reduced and it did not seem feasible under the current budget to make the memo's recommended changes.

Case #	State Entity	Date	Description of Vulnerabilities	Vulnerability Addressed?	Explanation
2826	DVHA	10/31/22	There was a lack of clear billing rules that adhered to CMS guidelines, which allowed providers to bill for additional services already included in the Partial Hospitalization Program and Intensive Outpatient Program bundled rates.	**Yes**	DVHA made most of the SIU's recommended changes. For the remaining recommendations, the SIU met with applicable DVHA staff and agreed they were not feasible.
2946	DVHA	8/7/23	The SIU found documentation issues and medical nutritional therapy services provided in excess of the coverage allowance for three providers. During the SIU investigation, DVHA changed the Vermont Medicaid rule to remove visit limitations. SIU notified the DVHA Clinical Unit of the lack of clear documentation requirements.	**Partially**	DVHA implemented the SIU's recommendation to review documentation for medical necessity by establishing a procedure for conducting clinical audits that includes a review of medical records. DVHA did not implement other recommendations, such as creating a list of conditions that would qualify for medical nutritional therapy. While DVHA updated its clinical criteria for medical nutritional therapy since the SIU issued the vulnerability memo, the updates did not address this recommendation.
2987 2999 3007	DVHA	11/3/23	The SIU found a variety of improper payments to licensed behavioral health providers supervising NLNC clinicians due to a variety of circumstances. Namely, (1) claims submitted for services that were provided by NLNC clinicians during times when their status on Office of Professional Regulation's roster had lapsed, (2) licensed providers that were eligible to enroll in VT Medicaid, did not enroll, and (3) NLNC clinicians exceeding VT Medicaid's 5-year roster rule continuing to provide services.	**See explanation**	As noted previously, after hearing complaints from providers, DVHA retroactively changed a rule that was the foundation of the improper payment findings and the vulnerability memo. In addition, DVHA established a working group to revise the existing rule. According to the person leading this working group, the revision of the rule, along with related changes to the provider manual, will address the vulnerabilities identified by the SIU although it may not be exactly as recommended by the SIU. As of December 23, 2024, changes to the rule were still being worked on.

There were two root causes for the SIU-identified vulnerabilities not being addressed. First, the SIU does not follow up on whether the issues in its vulnerability memos are addressed, including whether corrective actions were taken or are planned.[9] The lack of monitoring to ensure that corrective actions are taken to address deficiencies and produce improvements is inconsistent with sound internal control standards. In 2024, DHVA initiated a

[9] For instance, our office conducts reviews one and three years after we complete an audit to determine if recommendations have been adopted.

new process whereby SIU program vulnerability memos are also distributed to DVHA's Deputy Commissioner and its Medicaid Compliance Officer to facilitate communication with the entity receiving the vulnerability memo. While this is a step in the right direction, as of November 2024 the process still lacked a documented process for the SIU to perform recommendation follow up to ensure findings are promptly resolved. In addition, without a follow up process, the SIU is not in the position to communicate to AHS and the DVHA Commissioner the extent to which its recommendations are being implemented and to indicate whether they should intervene.

Second, there is inconclusive decision-making authority when it comes to implementing changes to address program vulnerabilities identified by the SIU. AHS is supposed to maintain oversight over all program integrity functions while partner State organizations, such as AOE, are expected to provide support to AHS and DVHA in its FWA mitigation efforts. The program integrity section of the Medicaid MOU between AHS and the partner organizations states in the event of a disagreement between DVHA and a supporting organization, DVHA is supposed to escalate the matter to AHS "to make a final determination as to necessity." Accordingly, when DVHA's discussions with AOE did not reach resolution, the issue was escalated to AHS. Brief discussions were held between AHS and AOE leadership before being passed back to DVHA for continuation. At the time of this audit, more than three years from the date of the SIU's vulnerability memo, no resolution has been reached. An email from DVHA's General Counsel to her AOE counterpart illustrates the importance of resolving this issue (see quote to the right).

> "Just to give you our sense of DVHA's perspective: we are dealing with broad areas of legal noncompliance that put the state at risk of CMS findings."
>
> Email from DVHA General Counsel to the AOE General Counsel, December 14, 2023

The prior DVHA-AOE agreement, which the MOU supersedes, had four escalating steps that explicitly addressed resolving disagreements between the two agencies, culminating in the Secretary of Administration making the final determination if an agreement could not be reached between AHS and AOE. According to the current Medicaid MOU, roles and responsibilities are supposed to be addressed in organization-specific appendices to the MOU. These appendices were supposed to be adopted in the months following the April 2024 signing. As of December 10, 2024, no AOE-specific appendix has been added to the MOU. In the meantime, on December 16, 2024, DVHA's General Counsel sent a separate draft DVHA-AOE MOU to AOE's general counsel solely focused on targeting the compliance gaps.

Referrals to MFRAU of Potential Fraud

Of the 20 SIU investigations reviewed four resulted in referrals made to the MFRAU for possible fraud. Those referrals resulted in: (1) one provider pleading guilty to federal charges of Conspiracy to Commit Unlawful Drug Distribution, (2) the MFRAU filing civil enforcement actions against a provider for fraud, and (3) the MFRAU identifying programmatic concerns but determining that there was not enough evidence to bring criminal or civil charges against a third provider. Additionally, the SIU referred two providers to the MFRAU in the fourth case. As of December 20, 2024, the MFRAU has charged one of the providers with Medicaid fraud along with other charges and is still investigating the second provider.

SIU's Role in Policy Changes

Changes to Medicaid programs, services, and policies undergo a process designed to ensure alignment with federal and state laws and regulations as well as Vermont Medicaid policies and practices called the Policy, Budget, and Reimbursement (PBR) process. The SIU is one of the approvers of PBRs and its role is to document the implications of implementation in the Medicaid Management Information System and assess other program integrity risks. The Medicaid Management Information System processes Vermont's Medicaid claims.

Between 2020 and 2023, there were 319 PBRs initiated for approval. We reviewed 20 PBRs and found that the SIU approved 17 (85 percent) without comment or after changes were made to address their control concerns. An example of the latter is illustrated by a DAIL-proposed PBR to remove a system edit (a type of control) that set an upper limit on the total daily amount that can be billed for certain codes in the Developmental Disabilities Services Division's Targeted Case Management and Crisis Intervention Services.[10] DAIL agreed to an SIU recommendation to increase the daily limit cap instead. The SIU then approved the PBR and a system change that reflected the SIU-recommended control was made.

In 3 of the 20 PBRs we reviewed (15 percent), the SIU's program integrity concerns were not addressed. For example, DVHA management approved changes in the Medicaid Management Information System, including removing system edits in two high-cost healthcare categories, even though the SIU raised concerns that these approaches could result in overpayments. We are not providing detail about the edits that were removed to reduce the likelihood that the SIU-identified vulnerabilities can be exploited. The SIU has

[10] This report uses the term "edit" in a general sense. The Medicaid Management Information System uses the term "error status codes", which includes (1) edits—computerized tests to detect inaccuracies in eligibility, reporting, and payment and (2) audits—a comparison of each new claim to the beneficiary's claims history.

opened proactive investigations and/or run reports to monitor for FWA that could occur as a result of these policy changes and diminished controls.

- The former SIU director refused to approve PBR 21-067, which removed most prior authorization requirements and system edits for a particular service that has seen problems with FWA nationally. The justification for removing prior authorization and service limit requirements was to reduce administrative burden and streamline the process for providers. However, DVHA itself had acknowledged and reported to the Legislature a few months before, that this type of service had a high denial rate for prior authorization requests and the importance of monitoring its usage. The SIU director at the time sent at least five emails indicating his concern that the removal of the system edits would leave the Medicaid program vulnerable to fraud and abuse (see excerpt from one email to the right).

> "We should not design a system where there are no caps/guardrails in place to prevent intentional or unintentional fraud, waste, and abuse. … It's easy to say, let's do post-pay review and recoupment, but that only works if: 1) you identify/notice it, and most importantly 2) if you can recoup as the provider could be closed, etc., 3) not to mention the resources wasted to try to recover something that should not have gone out to begin with."
>
> Email from former SIU Director, April 13, 2022

  Instead of removing the edit, the former director recommended setting higher limits, which he said would allow greater provider flexibility and less administrative burden while maintaining a control to safeguard against the payment of improper claims. He stated he was "not comfortable signing this PBR as it goes against 25 years of knowledge." After receiving this email, a DVHA Deputy Commissioner made the decision to move forward in favor of streamlining the process, without implementing the SIU-suggested control or the SIU's approval. The Deputy Commissioner cited planned provider education and post-payment monitoring in support of her decision. The SIU has since opened an investigation to monitor claims affected by the changes. At the time of our audit, this investigation was ongoing but the SIU's tentative findings found potentially improperly paid claims that are undergoing further review.

- The SIU approved PBR 20-085 after its recommendation was accepted. This recommendation was that instead of removing a system edit that

required manual review before paying certain claims that (1) the edit remain but with a higher threshold and (2) DVHA's clinical unit conduct an annual review of the relevant claims and report concerns to the SIU. Less than one-year later, DVHA's clinical unit, without consulting with the SIU, approved removing the system edit and ceased its annual review. Once the SIU was notified of this change, the SIU implemented a post-payment review of the claims that had been covered by the edit. While this post-payment detective control has been put in place by the SIU to identify incorrectly paid claims, the process of recovering payments is more arduous than preventing them to begin with.

- The SIU approved PBR 20-065 after its recommendation was accepted. The recommendation was that instead of removing a system edit, a new edit would be added with an increased annual cap amount for a respite program instead. Changes were made to the PBR to reflect this recommendation and the PBR was approved. However, when we followed up with Gainwell Technologies to confirm the implementation of the system edit, Gainwell reported that the change was never implemented and that DVHA had put the project on-hold. Gainwell Technologies could not locate the reason for the hold or the identity of the individual requester.

These three cases highlight problems with the PBR process itself. First, the PBR standard operating procedure does not include a process about what to do when a required approver, such as the SIU, does not approve a PBR, including who, if anyone, has the authority to decide to go forward without the approval. Second, the PBR process does not include procedures to approve post-implementation changes to previously agreed-upon decisions. Put another way, there is no process in place to track when agreements are undone.

Objective 2: DVHA Lacked Robust Oversight of OneCare's Program Integrity

DVHA's contract with OneCare includes a variety of program integrity requirements but DVHA's oversight to ensure that OneCare complied with these requirements has not been robust and has been largely limited to reviewing documents submitted by OneCare. Even though the OneCare contracts have always allowed the SIU to conduct oversight reviews of OneCare's compliance program or other program integrity activities, it never did. The lack of review is particularly questionable considering that the SIU had received an allegation in 2022 that OneCare's operations were not being performed in accordance with contractual requirements. In addition, the

2024 OneCare contract added a new program that has been exempted from the program integrity section of the contract. AHS Medicaid officials did not review this contract, which appears contrary to requirements.

Because the SIU had not reviewed OneCare's program integrity activities, we requested documents from OneCare via DVHA to check the effect of this lack of a review. For example, we wanted to determine whether OneCare's internal documentation supported its communication to DVHA that it had not received any suspected reports of FWA. OneCare refused to provide us with the requested documentation and the AHS Deputy Secretary would not invoke a contract clause to require that they provide DVHA with the documents and to designate the SAO as an authorized representative under the contract's audit clause. Effectively, this means AHS chose not to verify whether OneCare was satisfying its program integrity requirements.

In early November 2024, OneCare announced that it planned to wind down its operations at the end of 2025. OneCare's announcement stated that this decision coincided with the scheduled conclusion of the State's Vermont All-Payer ACO Model agreement with CMS in 2025.[11] In place of this model, CMS chose Vermont to participate in the All-Payer Health Equity Approaches and Development (AHEAD) model. The first of Vermont's eight performance years under the AHEAD model is scheduled to begin in January 2027. Because DVHA's relationship with OneCare will be ending in about a year, we are generally not making recommendations pertaining to the contract or DVHA's oversight. However, if AHS or DVHA signs other contracts in the future that requires the contractor perform program integrity activities, they should take into account the results of this audit and put controls in place to oversee these activities.

DVHA Oversight of OneCare Program Integrity Activities

Since 2020, DVHA's OneCare contracts have allowed for payments of more than $300 million annually. For example, DVHA agreed to pay up to $373,581,606 for services performed by OneCare and its network of providers in 2024.

The two primary types of payments DVHA makes for healthcare services provided to Medicaid beneficiaries under this contract carry different program integrity risks. Monthly fixed prospective payments carry a heightened risk that a provider may skimp on care, discriminate against more costly patients, or submit inaccurate performance data. Fee-for-service

[11] In 2020 we issued a report, *Vermont's All-Payer Accountable Care Organization (ACO) Model: An Overview of the All-Payer Model and the State's Oversight of Vermont's Only ACO, OneCare Vermont LLC* (Rpt 20-02, June 26, 2020), that describes this model.

payments have increased risk of overutilization or more expensive use of items or services than are needed.

Each annual DVHA contract with OneCare since 2017 includes program integrity provisions although some of the clauses were added or had wording changes over that time frame (e.g., the 2020 contract added that the OneCare code of conduct must include disciplinary guidelines to enforce the standard).

DVHA's 2024 contract with OneCare contain several provisions that include program integrity activities, mostly in section 10 (Program Integrity) in the contract. For example, OneCare is required to:

- Establish a compliance program that includes, among other things, a regulatory compliance committee and procedures and staff to conduct routine monitoring and auditing of compliance risks.
- Develop a written compliance plan that describes how it will detect FWA and other required elements of the plan, including processes for internal monitoring and auditing.
- Establish a code of conduct that includes a prohibition against retaliation for reporting compliance concerns.

The various program integrity reports OneCare submitted to DVHA covered most of these requirements, but some of the requirements were not met or were not met in a timely manner. In addition, DVHA did not verify that OneCare was performing the program integrity activities that it reported.

SIU's Review of OneCare Program Integrity Reports

DVHA's oversight of OneCare's program integrity activities required by the contract was largely limited to the SIU's reviews of OneCare utilization data and program integrity documents required by the contract. As part of the review of these documents, an SIU liaison to OneCare would also meet with the OneCare compliance officer. DVHA provided us with all the contractually required program integrity documents OneCare submitted between 2022 and the 3rd quarter of 2024 along with the SIU's comments, when applicable.[12] As shown in Exhibit 3, the SIU's and our review of these documents showed mixed results although the more recent documents have generally been more responsive to the SIU's comments.

[12] Sometimes the SIU submitted its comments directly to OneCare while in other cases they were conveyed by DVHA's program manager for the OneCare contract.

Exhibit 3: OneCare's Compliance with Program Integrity Documentation Requirements Mixed

Required Document	Frequency	DVHA Oversight Results	SAO Comments
Compliance Plan: Documents, through detailed and specific internal procedures, how OneCare will detect FWA in accordance with Federal and State law and regulation. OneCare includes its compliance policies and procedures as attachments.	Annually	DVHA did not document its review and approval of OneCare's 2022, 2023, or 2024 compliance plans, nor had it checked whether the plans had all required elements. The former SIU liaison to OneCare stated that he and the former SIU director verbally told the DVHA program manager that sections of the plans were vague and not productive. The current SIU liaison with OneCare had no comments on the 2024 plan.	OneCare's 2022, 2023, and 2024 compliance plans do not address the contractual requirement that the plan include that OneCare promptly notify DVHA of changes in a beneficiary's circumstances, including a change in residence or death. We brought this non-compliance to the DVHA program manager's attention, who inquired of OneCare. OneCare agreed that they had not addressed this requirement and agreed to do so in the 2025 compliance plan.
Risk Assessment Report: Identifies and prioritizes the top three areas of risk and provides an action plan to mitigate them.	Semi-annually	In the past, the SIU has found the OneCare risk assessment reports to be inadequate and several times the DVHA program manager or the SIU liaison reported to OneCare that its risk assessments were not acceptable. The SIU approved the most recent three risk assessments.	The risk assessment requirement has been in place since 2017 yet the second risk assessment of 2023, which was submitted in October of that year, was the first time the SIU approved the OneCare original deliverable without a revision.
Program Integrity Plan Summary: Outlines OneCare's compliance and program integrity related activities.	Quarterly	The SIU approved the summary without comment for 7 of the 11 submissions between the first quarter 2022 and the third quarter 2024. For the remaining 4 submissions, the SIU approved the summary but requested additional information/clarification from OneCare.	The 11 OneCare summaries submitted between the first quarter 2022 and third quarter 2024, often reported that OneCare had performed an activity, such as screening for debarred or excluded individuals or reviews to detect FWA but not the results found. In 2023, the SIU revised the format and content of the summary and provided more explicit instructions about the information expected to be in this document. This resulted in more detailed OneCare responses.
Program Integrity Referrals Report: Identifies and monitors referrals to DVHA's SIU.	Ad hoc and Annual	Before 2024, these were quarterly reports, none of which included referrals. The SIU approved the 8 2022 and 2023 reports without comment.	Starting in 2024, OneCare is to submit this report on an ad hoc basis if it submits a referral and annually even if no referral was made. As of November 5, 2024, OneCare has submitted no ad hoc reports with referrals.

SIU Oversight of OneCare Program Integrity Activities

Since 2017, the OneCare contract has allowed the SIU to conduct oversight reviews of OneCare's compliance program or other program-integrity related activities. The SIU has performed no such reviews.

The SIU also did not request documents from OneCare to verify that actions required by OneCare's compliance and program integrity documents occurred. For example, the SIU did not request the charters of the OneCare audit or regulatory compliance committees, the log of potential compliance events, or audits. The SIU OneCare liaison stated that the SIU's emphasis has been on the required reporting, utilization, and data and not on OneCare's policies or checking whether OneCare is performing against criteria.

The SIU's failure to review OneCare's program integrity activities is particularly troubling since it received an anonymous tip in 2022 alleging multiple OneCare improprieties. One allegation was that providers were being directed to inappropriately use certain codes, which an SIU investigation found to be unsubstantiated. However, the SIU did not review other allegations contained in the anonymous tip, including that (1) the program integrity documents submitted to DVHA included misrepresentations, (2) OneCare was not performing required monthly screenings for debarred and excluded individuals, (3) OneCare's policies and procedures did not match contractual requirements, and (4) management had retaliated against staff. While these allegations may not be true, they are serious enough to warrant an SIU investigation, as allowed by the OneCare contract.

The allegation about the screening for debarred or excluded individuals should have raised a red flag since OneCare's first risk assessment submission in 2022 reported that its process for checking subcontractors against Federal sources to determine whether any were debarred or excluded from participation Medicaid was not occurring regularly. This is an important process because, per Federal requirement, no payments may be made for any items or services furnished by a person excluded from participation in a Federal health care program by the Department of Health and Human Services' Office of Inspector General. Payments may also not be made for services provided at the medical direction or on the prescription of an excluded person.

Since 2017, the OneCare contract stated that DVHA shall (1) monitor OneCare's performance utilizing a random sample audit of all program documentation and payments and (2) review OneCare's compliance with its internal policies and procedures to ensure the accuracy and timeliness of the payments to providers and services provided to members. **In the almost**

eight years since this clause has been in place, DVHA has only performed one review. The review was conducted in late 2023 and was limited to sending an SIU survey to about 1,000 OneCare patients who had received care covered as part of the monthly prospective payment. The SIU received 314 responses about whether services were received and the quality of care. The SIU concluded that there were no anomalies in the responses to suggest that beneficiaries were receiving rushed or substandard care and no further work was done.

OneCare FWA Training

The OneCare contract requires it to conduct annual training on the detection and reporting of FWA. OneCare is also required to submit its training schedules, content, and participation lists to DVHA. OneCare has never submitted this material. After we brought this to the DVHA's attention, they requested that OneCare start providing this training information, which they agreed to do. OneCare is also supposed to have documentation that confirms internal staff attendance at training. OneCare's relevant 2024 procedure requires that attendance records be maintained and documented but does not reference a tracking process to ensure that all required individuals took the training and what is to be done if they do not. Because OneCare had not provided the participation lists to the SIU as required, neither we nor DVHA had information to check whether individuals were taking the required training.

OneCare FWA Reporting

According to CMS, OneCare's direct relationship with providers gives them a unique opportunity to identify and report fraudulent behavior to DVHA. This is important because the health care industry is a frequent target of FWA. Since 2017, the OneCare contract has required it to report to DVHA, suspected or confirmed FWA or providers that were disenrolled, terminated, or denied for program integrity reasons. OneCare has never reported such information in the almost eight years of this contract. There could be several reasons why there has been no such reports, such as that (1) there were no instances of fraud, waste, or abuse or provider terminations for program integrity reasons, (2) there were such instances and OneCare failed to report them, or (3) OneCare's processes are not designed to identify FWA. Without a review of OneCare's compliance program or other program integrity activities, DVHA is not positioned to know which of these reasons, or any other, is the cause of the lack of reporting.

Global Payment Program

The 2024 OneCare contract amendment includes a new program, the Global Payment Program (GPP). The state fiscal year 2025 "Big Bill" appropriated $9.3 million for this program, which was effective for independent physician practices on January 1, 2024 and hospitals on August 1, 2024. Under GPP, OneCare is issued a monthly payment as reimbursement for covered services delivered by participating hospitals or independent primary care practices to non-attributed members or ACO-attributed members who do not qualify for value-based payments in a given month.

GPP payments are excluded from program integrity provisions of the contract. For example, the contract states that section 10 (Program Integrity) and other program integrity clauses do not apply to the GPP. Thus, the following requirements do not apply to the GPP: (1) reporting alleged or suspected FWA and (2) reporting providers that are disenrolled, terminated, or denied enrollment for program integrity reasons. Moreover, the contract provision allowing the SIU to conduct reviews of OneCare's compliance program and other program integrity-related activities is part of section 10 so therefore not applicable to the GPP.

OneCare's proposal to exclude the GPP program from the contract's program integrity section was discussed as part of the DVHA-OneCare contract negotiations. In an email sent in advance of a contract negotiation discussion, the DVHA general counsel asked a OneCare attorney to explain the specific risk that section 10 (Program Integrity) posed to OneCare if the language was not struck from the contract for GPP. The DVHA general counsel did not have a record of OneCare's response to this request. There was only an email from the OneCare attorney stating that there was an agreement to exclude the GPP from section 10 of the contract.

The DVHA program manager to the OneCare contract stated that the program integrity section of the contract did not apply to the GPP because the prospective payment made to OneCare for GPP will be reconciled back to the fee-for-service claims at the end of the performance year. Thus, essentially the GPP pays OneCare as fee-for-service. The program manager's explanation is not consistent with how the contract treats non-GPP fee-for-service claims under the OneCare contract. Such fee-for-service claims, which totaled $152 million in 2023, are subject to the program integrity section of the contract. The result of GPP being exempted from the program integrity section of the contract is to apply the FWA protections in the OneCare contract against some fee-for-service activities but not others.

Moreover, **according to SIU officials, they were not consulted on the decision to exclude GPP from the program integrity provisions of the OneCare contract.** This seems contrary to the DVHA procedure, the *Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Program,* which calls for coordinating and facilitating meetings with subject matter experts as part of contract negotiations. Such a consultation may have raised program integrity issues that should have been considered before DVHA agreed to OneCare's proposal.

AHS Review of the OneCare Contract

The AHS Deputy Secretary approved the 2024 OneCare contract. However, neither the AHS Medicaid Executive Director nor the AHS individual tasked with oversight of DVHA's program integrity reviewed this contract or the exclusion of the GPP from the program integrity requirements. The individual tasked with DVHA program integrity oversight stated that he has not reviewed the contract since 2021. In addition, he has not reviewed how DVHA has overseen OneCare's program integrity activities under the contract nor requested information on the extent to which OneCare has reported FWA.

The lack of review of the OneCare contract by these AHS officials appears contrary to its obligations. For example, the 2024 Medicaid MOU among Vermont Medicaid partners states that AHS will ensure compliance with a federal regulation by ensuring that its "compliance policies and procedures provide for a formal, documented process for comprehensive program integrity oversight of DVHA." In addition, the 2023 and 2024 AHS-DVHA Intergovernmental Agreements state that AHS must ensure that DVHA and any of its contractors follow standard program integrity principles and practices. Moreover, the purpose statement of a draft standard operating procedure issued in December 2021 on AHS's monitoring of DVHA's program integrity activities stated that it included ensuring that the activities of DVHA's "subcontractors, including but not limited to OneCare VT around exclusions, withholds, and FWA investigations are implemented and communicated as needed to AHS and the Secretary according to state and federal requirements." This language was removed when the final procedure was issued in February 2024, which no longer explicitly addresses OneCare or other DVHA's contractors.[13]

[13] *AHS Monitoring of Program Integrity Activities*, February 21, 2024.

Our Request for OneCare Documents

We are not asserting that OneCare's processes and operations do or do not comply with the DVHA contract, including whether OneCare knew of suspected FWA that it should have reported to the SIU. We requested that the DVHA Program Manager for the OneCare contract and the DVHA General Counsel obtain documents from OneCare that may have allowed us to draw such conclusions and to assess the effect of DVHA's limited program integrity oversight.

Our request included a list of audits and assessments conducted by the OneCare compliance officer, the log of potential or actual violations of OneCare's compliance program, and the charters and minutes of the compliance and audit committees. OneCare would not provide us with any of these documents. The OneCare Chief Legal Counsel stated that OneCare had provided DVHA with all materials related to compliance monitoring required by the contract but added that to the extent DVHA had additional information requests they were "willing to discuss" such requests.

After receiving this email, we asked AHS or DVHA to obtain these documents and to designate us as an authorized representative covered by the State's standard audit clause. This clause, which is included in the OneCare contract, requires that records be made available "for inspection by any authorized representatives of the State or Federal government."

AHS's Deputy Secretary declined our request (see Appendix III), stating that it could be considered bad faith and citing a Vermont Supreme Court decision pertaining to a request we made directly to OneCare in a prior audit. The Deputy Secretary stated that AHS had "no desire to involve ourselves in potential litigation exercising our contract rights on behalf of a party that the Supreme Court has already determined is not a third-party beneficiary of the contract."

The Deputy Secretary also stated that should DVHA have a reason to exercise its rights to audit OneCare "it may well seek the assistance of the SAO and designate the Auditor as an authorized representative under the contract." We believe that sufficient reason exists. As we advised the AHS and DVHA general counsels in June 2024, our inquiries had established that OneCare had not referred a FWA case and that DVHA had not checked whether OneCare complied with certain requirements or conducted an oversight review.

Other Matters

During our audit we identified two issues that, while related to our audit objectives, were not significant to those objectives. Nevertheless, they constitute internal control and compliance issues that warrant the attention of management.

SIU Reporting of Investigations

The first issue we identified is a wide gap between the number of investigations AHS reported having conducted to CMS and the number of investigations recorded by the SIU.

In response to the 2020 CMS Vermont Focused Program Integrity report, the State indicated in its corrective action plan to CMS that it would provide quarterly reports detailing the number of provider investigations conducted as well as the number of suspected fraud referrals provided to the Single State Medicaid Agency (AHS). Since that time, these quarterly reports have been reported to CMS via inclusion in the Global Commitment to Health Report that AHS is required to submit to CMS per the Global Commitment to Health Waiver.

Between 2020 and 2023, the SIU recorded 322 provider "cases" in the SIU Case Management System. More than half of these cases were not SIU investigations. Instead, these "cases" included (1) preliminary reviews of allegations that the SIU had determined did not warrant an investigation, (2) work performed by others for which the SIU collects the debt (e.g., the MFRAU or the Federal government), and (3) other SIU debt collection activity from overdue accounts receivable. Of the 322 "cases," 142 were SIU provider investigations between 2020 and 2023.

Further, between 2021 and 2023, DVHA reported to AHS that the SIU had conducted 257 provider investigations and AHS reported to CMS that the SIU had conducted 336 investigations. The responsible AHS official's explanation for why there were such significant differences between what AHS reported and the number of actual SIU provider investigations, was that technical challenges with the process led to inconsistent reporting to CMS. It is likely that an overarching reason is that neither AHS nor the SIU defined and reached agreement on what was supposed to be reported to CMS.

Compliance Officer

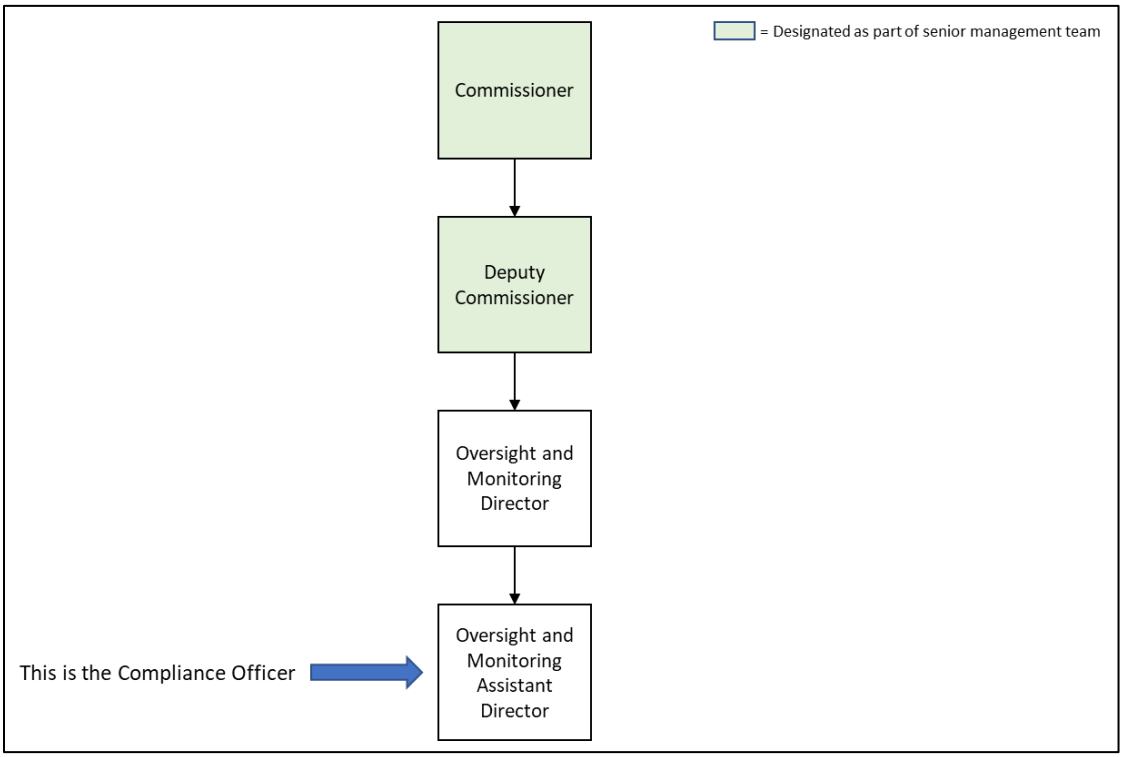
The second issue we identified is that the program integrity officer within DVHA does not report to the Commissioner as required by CMS regulation.

The AHS Global Commitment to Health agreement with CMS that governs Vermont's Medicaid program requires AHS and DVHA to comply with the Federal regulation related to program integrity for managed care-like entities. This regulation requires DVHA, as the managed care-like entity, to designate a compliance officer who reports directly to the chief executive officer (i.e., DVHA Commissioner). A commentator to the rule that established this requirement recommended that the compliance officer be allowed to report to another executive level position for supervisory purposes as long as the job description clearly provides for the direct reporting of compliance activities to the chief executive officer. CMS stated that this construct would be permissible.

The 2022 and 2023 AHS-DVHA IGAs required DVHA to designate a compliance officer who reports directly to the Commissioner. The 2024 AHS-DVHA IGA changed this clause to the compliance officer *provides reports* to the Commissioner. Neither the AHS nor the DVHA general counsel had documentation regarding the decision to change this clause. Similarly, DVHA changed the language between its 2023 and 2024 Medicaid program integrity compliance plans from the compliance officer being directly accountable to the DVHA Commissioner to the compliance officer provides reports directly to the DVHA Commissioner, respectively.

In May 2024, DVHA named the Oversight and Monitoring Assistant Director as the compliance officer. This position is organizationally two reporting layers below the DVHA Commissioner and does not directly report to someone on the senior management team (see Exhibit 4). Moreover, the job specification of this position does not state that the assistant director directly reports compliance activities to the DVHA Commissioner.

Exhibit 4: Excerpt from DVHA's Organization Chart, October 1, 2024



The former DVHA compliance officer also did not report directly to the Commissioner. According to the former compliance officer, DVHA has never interpreted the Federal regulation that the compliance officer must be a direct subordinate to the Commissioner even though this requirement was in the 2022 and 2023 AHS-DVHA IGAs.

According to the U.S. Department of Health and Human Services, Office of the Inspector General guidance, the compliance officer should have sufficient stature within an entity to interact as an equal of other senior leaders. Designating a compliance officer with appropriate authority is essential to the success of a compliance program.

Conclusions

AHS, DVHA leadership, and other State organizations that support the Medicaid program have not always taken action in support of the SIU's findings. In particular, DVHA made a retroactive change to a rule, which allowed the payment of claims the SIU had determined were improper. In addition, when the SIU has found program vulnerabilities, fewer than half have been fully addressed. This has occurred because neither the SIU, DVHA leadership, or AHS have monitored whether corrective actions have been

taken in response to the SIU's findings nor was there an explicit process to resolve disputes with other organizations. The SIU itself also did not follow up on an allegation that OneCare was not complying with contract requirements even though the contract allowed the SIU to conduct oversight reviews.

Recommendations

We make the recommendations in Exhibit 5 to the Secretary of the Agency of Human Services:

Exhibit 5: Recommendations and Related Issues

Recommendation	Report Pages	Issue
1. Amend the MOU with the other State partner organizations to establish a process to resolve disputes between the SIU and these organizations about vulnerabilities. The Secretary of Administration should be consulted decisions on how disputes between agencies are handled.	12-13	A root cause to SIU-identified vulnerabilities not being addressed was inconclusive decision-making authority when it comes to implementing changes to address program vulnerabilities identified by the SIU.
2. Revise the procedure on overseeing DVHA's program integrity activities to include reviewing activities pertaining to DVHA's contracts, such as OneCare.	23	The 2023 and 2024 AHS-DVHA Intergovernmental Agreements state that AHS must ensure that DVHA and any of its contractors follow standard program integrity principles and practices. The February 2024 AHS standard operating procedure on monitoring DVHA's program integrity activities does not explicitly address OneCare or other DVHA contractors and AHS Medicaid officials did not review the 2024 OneCare contract.
3. Establish guidance for SIU investigations data to ensure reporting to CMS is accurate.	25	Between 2021 and 2023, DVHA reported to AHS that the SIU had conducted 257 provider investigations and AHS reported to CMS that the SIU had conducted 336 investigations. Neither AHS nor the SIU defined and reached agreement on what was supposed to be reported to CMS.
4. Clarify the organizational placement of the DVHA compliance officer in the IGA to be consistent with Federal regulation.	25-27	Federal regulation requires DVHA, as the managed care-like entity, to designate a compliance officer who reports directly to the chief executive officer (i.e., DVHA Commissioner). The 2022 and 2023 AHS-DVHA IGAs required DVHA to designate a compliance officer who reports directly to the Commissioner. The 2024 AHS-DVHA IGA changed this clause to the compliance officer *provides* reports to the Commissioner.

We make the recommendations in Exhibit 6 to the Commissioner of the Department of Vermont Health Access:

Exhibit 6: Recommendations and Related Issues

Recommendation	Report Pages	Issue
1. Direct the SIU to follow up on program vulnerabilities that it identifies. This process should include issuing a report to the Commissioner and AHS summarizing the extent to which vulnerabilities have been eliminated or mitigated on at least an annual basis.	12-13	A root cause to SIU-identified vulnerabilities not being addressed is that the SIU does not follow up on whether the issues in its vulnerability memos are dealt with, including whether corrective actions were taken or are planned. Without a follow up process, the SIU is not in the position to communicate to AHS and the DVHA Commissioner the extent to which its recommendations are being implemented and to indicate whether they should intervene
2. Reinstate the edits that were removed as a result of PBR 21-067 and PBR 20-085 if the related SIU investigations that are currently on-going find significant improper payments.	15-16	DVHA removed system edits without the SIU's approval for two PBRs we reviewed. At the time of our audit, the SIU was monitoring the claims related to the removal of these edits to determine whether claims are being incorrectly paid.
3. Implement the system edit agreed to as part of PBR 20-065	16	For one of the PBRs we reviewed, a new system edit was supposed to be added to address an SIU concern but was not.
4. Establish a process, overseen by the DVHA Commissioner, for PBR resolution in the event not all approvers sign off.	16	The PBR standard operating procedure does not include a process about what to do when a required approver, such as the SIU, does not approve a PBR, including who has the authority to decide to go forward without the approval.
5. Establish a process that includes obtaining SIU approval for PBR post implementation changes.	16	The PBR process does not include procedures for the SIU to approve post-implementation changes to previously agreed-upon decisions.
6. Direct the SIU to investigate the September 2022 allegations related to OneCare's operations. This should include requesting and reviewing documentation that supports that the program integrity activities outlined in OneCare's reports to DVHA were carried out.	20	Since 2017, the OneCare contract has allowed the SIU to conduct oversight reviews of OneCare's compliance program or other program-integrity related activities. The SIU has performed no such reviews. The SIU's failure to review OneCare's program integrity activities is particularly questionable since it received an anonymous tip in 2022 alleging multiple OneCare improprieties. However, the SIU did not review allegations contained in the anonymous tip that (1) the program integrity documents submitted to DVHA included misrepresentations, (2) OneCare was not performing required monthly screenings for debarred and excluded individuals, (3) OneCare's policies and procedures did not match contractual requirements, and (4) management had retaliated against staff.

Recommendation	Report Pages	Issue
7. Ensure the compliance officer position reports directly to the DVHA Commissioner, in accordance with Federal regulation.	25-27	Federal regulation requires DVHA, as the managed care-like entity, to designate a compliance officer who reports directly to the chief executive officer (i.e., DVHA Commissioner). In May 2024, DVHA named the Oversight and Monitoring Assistant Director as the compliance officer. This position is organizationally two reporting layers below the DVHA Commissioner and does not directly report to someone on the senior management team.

Management's Comments and Our Evaluation

On January 21, 2024, the AHS Vermont State Medicaid Director and the DVHA Commissioner provided written comments on a draft of this report, which are reprinted in Appendix IV. Our evaluation of these comments is in Appendix V.

As part of addressing both objectives, we reviewed Federal regulations pertaining to Medicaid program integrity, including 42 CFR Part 455 and Part 438. We also reviewed the AHS's Global Commitment to Health Section 1115 Demonstration agreement with CMS.

Other criteria that we considered as part of our first objective are:

- AHS-DVHA's IGAs for 2022 – 2024.
- The April 2024 MOU among the Vermont Medicaid supporting departments (AHS, DVHA, DAIL, DCF, AOE, and the Departments of Correction, Health, and Mental Health). We also considered the agreements that this MOU superseded.
- The July 2024 MOU between the MFRAU and AHS as well as the prior MOU that this superseded.
- The July 2024 MOU between the MFRAU and the AHS Division of Medicaid Services and DVHA's SIU and the prior MOU that this superseded.

We also reviewed the DVHA Medicaid Compliance Plans issued in 2017, 2023, and 2024, standard operating procedure for the policy, budget, and reimbursement process, and the SIU's procedure manual, which contains information on establishing and conducting investigations and reporting on their results.

We conducted interviews with relevant AHS and DVHA officials, including the SIU director and staff, to gain an understanding of the roles and programs relevant to our objective. We also met with officials from DAIL, Gainwell Technologies, and MFRAU.

DVHA provided us with a list of 322 provider cases in its Surveillance Utilization Review Subsystem entered between January 1, 2020 and December 31, 2023. Based on an interview with the SIU director and SIU data analyst, we discovered that some of the cases represented SIU investigations while others reflected other activities. For example, there were cases that represented settlements from investigations by others, such as CMS or the MFRAU. As a result, we asked the SIU to manually identify those provider cases that were SIU investigations. The SIU identified 142 cases as SIU investigations.

We judgmentally selected 20 cases from the 142 SIU investigations to review. We chose investigations in which there were SIU findings (e.g., recovery

and/or a vulnerability memo) or were referred to the MFRAU. We also selected multiple cases spanning our scope period (2020 – 2023). The results of these 20 investigations are not projectable to the 142 SIU investigations in our scope period.

The SIU provided us with access to the electronic files associated with each of the cases we selected. Included in these files were case logs, investigation reports, improper payment notices, appeal decisions, and emails with the providers, other State employees, and Gainwell Technologies, as applicable. In those cases in which there was a recovery, we validated the amounts collected by reviewing copies of checks or the records in the Medicaid Management Information System. In those cases in which a vulnerability memo was issued, we contacted the relevant official at DVHA or other Medicaid supporting organization (e.g., DCF) and requested documentation of any changes that were made in response to the memo. If no changes were made, we requested an explanation. If the SIU referred a case to the MFRAU, we obtained the referral and documented the result of the case or obtained status information from the MFRAU director.

As part of objective 1, we also requested a list of approved PBRs that were initiated between 2020 and 2023. Out of this list of 319 PBRs, we judgmentally selected 20 PBRs to review. We chose PBRs that had a potential connection to an SIU investigation and to obtain a mix of PBRs across the entire scope period. For each of the selected PBRs, we checked whether the SIU approved the PBR and what, if any, changes were recommended and either agreed to or not as a result of the SIU review. For those PBRs in which changes were agreed to as a result of the SIU review, we confirmed that the change was made or, if not, obtained an explanation. In the one case in which the SIU did not approve the PBR, we obtained documentation and inquired about the rationale for the decision.

For objective 2, we reviewed each of the annual OneCare contracts since 2017 and identified the program integrity provisions and how they changed through the years. We also obtained and reviewed OneCare's contractually required compliance plans, risk assessments, program integrity plan summary, and program integrity referral reports submitted to DVHA in 2022, 2023 and through the 3rd quarter of 2024. We reviewed internal and external comments made by the SIU about these documents. We interviewed the current and former SIU liaisons to OneCare to obtain information about how they oversaw OneCare's program integrity activities. We also inquired of the DVHA program manager for the OneCare contract and the AHS Medicaid Executive Director and the individual tasked with overseeing DVHA's program integrity.

Once we discovered that the SIU had not conducted oversight reviews of OneCare's program integrity activities, we requested OneCare documentation supporting their activities via the DVHA program manager for the OneCare contract. OneCare would not provide us with requested documentation, so we requested that AHS or DVHA obtain the documents on our behest. The AHS Deputy Secretary sent us a letter declining to do so.

We determined which internal controls were significant to our audit objectives and analyzed DVHA's implementation of these controls. In addition, we identified weaknesses in internal controls as a cause of some findings.

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 II
Abbreviations

ACO	Accountable Care Organization
AHEAD	All-Payer Health Equity Approaches and Development
AHS	Agency of Human Services
AOE	Agency of Education
CMS	Centers for Medicare and Medicaid Services
DAIL	Department of Disabilities, Aging and Independent Living
DCF	Department for Children and Families
DVHA	Department of Vermont Health Access
FWA	Fraud, waste, and abuse
GPP	Global Payment Program
IGA	Intergovernmental Agreement
MFRAU	Medicaid Fraud & Residential Abuse Unit
MOU	memorandum of understanding
NLNC	non-licensed and non-certified
OneCare	OneCare Vermont Accountable Care Organization, LLC
OPR	Office of Professional Regulation
PBR	Policy, Budget, and Reimbursement
SIU	Special Investigations Unit
VMNG	Vermont Medicaid Next Generation

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Todd W. Daloz, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

July 16, 2024

Douglas Hoffer, Vermont State Auditor
Office of the State Auditor
132 State Street
Montpelier, VT 05633-5101

Re: Medicaid Program Integrity Audit

Dear Auditor Hoffer,

I write to you on behalf of the Agency of Human Services. As you are aware, your office (SAO) is currently performing an audit of the Department of Vermont Health Access's oversight of the program integrity activities of one of DVHA's vendors, OneCare. As part of that audit, the SAO has identified and requested specific documents from OneCare. DVHA has communicated the SAO's requests directly to OneCare, which has represented that it has provided all materials related to compliance monitoring and that it is willing to discuss with DVHA any further documents requested related to OneCare's contract with DVHA.

In response to OneCare's position, the SAO has now requested that DVHA exercise DVHA's own contractual rights in order to obtain the documents the SAO specifically identified from OneCare, and that DVHA additionally designate the SAO as an "authorized representative" of DVHA under clause 13 of Attachment C of the contract in order for the SAO to include additional information[1] in its audit of DVHA.

Both DVHA and the Agency have previously expressed to the SAO their joint concern that exercising DVHA's contractual rights in the manner the SAO has requested could be viewed as bad faith in light of the Vermont Supreme Court's decision in *Vermont State Auditor v. OneCare Accountable Care Organization, LLC*, 2022 VT 29 ("*OneCare*"). In *OneCare*, the Court reviewed a prior version of the very same contract between DVHA and OneCare and specifically held that "neither the OneCare-DVHA contract not the statutes governing the Auditor's authority give the Auditor the right to access OneCare's accounting records." We do not see how we can avoid that holding by having DVHA exercise its audit rights on behalf of the SAO under these circumstances.

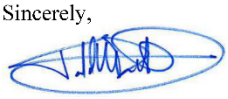
Should DVHA independently have a reason to exercise its right to audit OneCare, or any one of its other contractors, it may very well seek the assistance of the SAO and designate the Auditor as

[1] Specifically, DVHA and AHS understand that the SAO seeks this further insight into OneCare in order to assess the impact that DVHA's oversight has had on OneCare's contract performance.

an authorized representative under the contract. That is not the case here. Rather, the SAO is asking DVHA to exercise its audit rights to augment the SAO's ongoing audit of DVHA. We have no desire to involve ourselves in potential litigation exercising our contract rights on behalf of a party that the Supreme Court has already determined is not a third-party beneficiary of the contract.

We look forward to continuing to work with the SAO on this and other matters, as we have with audits in the past. Please do not hesitate to reach out with any further questions or concerns.

Sincerely,



Todd W. Daloz, Deputy Secretary

cc: Linda Lambert, Director of Information Technology & Performance Audits
Adaline Strumolo, Acting DVHA Commissioner

VERMONT

Appendix IV
Comments from AHS and DVHA

The following is a reprint of management's response to a draft of this report. Our evaluation of these comments is contained in Appendix V.

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

January 21, 2025

Sent via email to Doug.Hoffer@vermont.gov

Doug Hoffer
Vermont State Auditor's Office
132 State Street
Montpelier, VT 05633

AHS and DVHA Management Responses to Vermont State Auditor's Office Report, Fraud, Waste, and Abuse Vulnerabilities Remain as Steps to Address Program Integrity Findings were Not Always Taken

Dear Auditor Hoffer:

Thank you for the opportunity to respond to the above-mentioned audit of the Agency of Human Services ("AHS" or the "Agency") and the Department of Vermont Health Access ("DVHA" or the "Department"), a State Auditor's Office ("SAO") audit intended to:

> (1) determine if and what actions were taken in response to findings and vulnerabilities associated with Medicaid providers identified by DVHA's Special Investigations Unit ("SIU") and
>
> (2) assess DVHA's oversight of OneCare's program integrity activities.

This letter represents a combined AHS and DVHA response to the audit.

Firstly, we thank you and your staff for your time in conducting the audit and compiling recommendations for the Agency and Department. The audit looked specifically at 2020 to early 2024 and since that time, both a new Commissioner and a new SIU director have been appointed at DVHA.[1] Partly as a result of these leadership changes, some of the SAO's recommendations overlap with changes the Agency and Department have already made. These include recommendations like directing the SIU to follow up on program vulnerabilities (DVHA Recommendation 1), or establishing guidance to ensure SIU data reporting to CMS is accurate (AHS Recommendation 3). We will be formalizing those changes in response to the report, and we appreciate and agree with the specific corresponding recommendations.

[1] DVHA's current Commissioner joined the Department in September 2024, and DVHA's current SIU director was appointed to her role in January 2024.

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

We also agree with many of the recommendations proposing new processes. The SAO has identified an instance of regulatory noncompliance that we are currently working to rectify (AHS recommendation 4 & DVHA recommendation 7) and proposed new process fixes that we believe will be valuable changes to our operations as we embrace a culture of continuous improvement (DVHA recommendations 4 & 5).

In other cases, the SAO's recommendations will require coordination with parties external to the audit to be implemented (AOA and AOE for AHS recommendation 1; DAIL for DVHA recommendation 3). Although neither AHS nor DVHA can speak for those entities, which were not privy to the audit, we nevertheless see the value of these recommendations and hope to coordinate with those state partners in order to determine whether we can move forward with implementation of these specific recommendations.

Accordingly, this letter represents a combined AHS and DVHA response to the audit and focuses primarily on those portions of the report which speak to the remaining recommendations: AHS recommendation 2, and DVHA recommendations 2 and 6. We hope that this management response will provide additional context critical to understanding AHS and DVHA's program integrity operations, and again, we thank you for your time.

Objective 1: SIU Identified Improper Payments and Vulnerabilities That Were Not Consistently Addressed (Pages 7-16)

Management Response:

Comment 1

As a threshold matter, we agree with much of this portion of the report, and almost all of the associated recommendations. However, while DVHA provided the SAO with over 100 SIU investigation folders, the report appears to reflect a review of a limited subset (20) of those cases. We understand the need to work from a targeted sampling in what was already a long and complex audit process, but we also would stress that the SAO pursued a limited subset of cases, which at exit conference were identified as some of the most thorny and complex. As the SAO admitted during the exit conference, the trends identified in Exhibit 1 are not projectible. Thus, we want to ensure that a reader does not understand these cases to be a representative sample of DVHA's response to SIU findings or that trends should be extrapolated from the data. Additionally, there is no indication that the Department ignored the SIU's findings; rather, the SIU's findings were part of a larger policy determination with respect to addressing the propriety of those claims.

We raise this here largely because of DVHA recommendation 2, which directs the Department to "reinstate the edits that were removed as a result of PBR 21-067 and PBR 20-085 if the related

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

SIU investigations that are currently on-going find significant improper payments." DVHA fully plans to reconvene and reconsider the referenced system edits when SIU concludes its related investigations. However, even if SIU were to find evidence of improper payments, the SIU findings will form one of many factors the Department will have to consider. Many of the vulnerabilities raised by SIU, possibly including those which will correspond to PBR 21-067 and PBR 20-085, also have profound consequences for member access and an associated concern, provider availability and enrollment. For example, on page 17 of the audit report, the SAO cites an SIU investigation which resulted in SIU advising the department to develop a list of qualifying conditions related to medical nutritional therapy. The SAO thereby records that the SIU-identified vulnerability was only "partially" addressed.

The Department would disagree with any implication here that medical nutritional therapy concerns were not adequately resolved purely because SIU did not decide the Department's total and final course of action. The Department's decision to not cap conditions and instead update its clinical criteria as to medical nutritional therapy followed from *both* the SIU recommendations and data and utilization trend tracking conducted by the Department's clinical team. In other words, the SIU findings were a part of the decision, but they did not make the decision. This may also be the case with PBR 21-067 and PBR 20-085. The Department expects that the SIU findings will be critical in illuminating a path forward. This does not mean that that path will permit the SIU alone to determine the final and total content of those PBRs. For this reason, the Department hesitates to agree in full with the SAO's recommendation 2 to DVHA. We do, however, commit to reconvening on the referenced PBRs as soon as SIU completes the related investigations.

Objective 2 Finding: DVHA Lacked Robust Oversight of OneCare's Program Integrity (Pages 16-25)

Comment 2

Management Response: First, as raised at exit conference, we would supplement the portion of this section which focuses on the Global Payment Program to add that GPP claims are in no way exempt from the program integrity requirements imposed on the Medicaid program as a whole. All claims, including GPP claims, are subject to SIU audit.

Second, this section appears to have resulted in recommendation 2 to AHS and recommendation 6 to DVHA. To the extent that these recommendations ask AHS and/or DVHA to review their policies or decisions, we are committed to doing so in light of the findings in the Report. Prior to completing our own review, however, we cannot commit to policy revisions or a specific course of action. We will now address each recommendation in turn.

AHS Recommendation 2

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Recommendation 2 to AHS states that the Agency should: "Revise the procedure on overseeing DVHA's program integrity activities to include reviewing activities pertaining to DVHA's contracts, such as OneCare." AHS and DVHA are federally required to implement and maintain specified arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. This requirement is extended *not* to all DVHA contracts, but rather to a subset of contracts DVHA holds, contracts in which contractors are specifically delegated responsibility for coverage of service and payment of claims under Medicaid. 42 CFR 438.608.

In addition to the specific contractual requirements imposed by the Code of Federal Regulation, the Agency as a whole also delegates responsibility to all contractors to comply with numerous other State and Federal laws, as applicable.

As is the case with all contracts, the contractor is responsible for complying with the contract requirements or is liable for breach of contract, and AHS and its departments maintain the right to audit the contractor to ensure that the contractor is acting in compliance with the contract requirements. AHS will review its oversight policies in light of the SAO's findings, but without further detail in the recommendation, we are unsure of what specific measures the SAO would like for us to implement and which particular contracts the SAO believes should be subject to the additional oversight.

Comment 3

Moreover, as a part of this audit, you requested that DVHA exert its contractual rights with OneCare to obtain documents from OneCare so that the SAO could assess DVHA's oversight of OneCare. This request came on the heels of the Vermont Supreme Court specifically addressing whether the SAO had the right to independently obtain documents from OneCare as a third-party beneficiary of DVHA's contract and concluding that it did not. Requesting documents for the benefit of the SAO in light of this Supreme Court decision subjected DVHA and AHS to potential liability for violating its contractual obligation to enforce the contract in good faith and had the potential to damage the State's relationship not only to this contractor, but all contractors doing business with the State or contemplating doing business with the State. AHS and DVHA would like to avoid this result.

Comment 4

Nevertheless, we welcome a discussion with the SAO to establish a process by which we can obtain the assistance of the SAO in carrying out an audit of a contractor who we believe is not in compliance with its program integrity obligations.

DVHA Recommendation 6

Recommendation 6 to DVHA states that the Department should: "Direct the SIU to investigate the September 2022 allegations related to OneCare's operations. This should include requesting

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

and reviewing documentation that supports that the program integrity activities outlined in OneCare's reports to DVHA were carried out."

As the SAO notes on page 20 of the audit report, the SIU did actively investigate a portion of the complaint and closed the investigation. The SAO nevertheless asserts that the SIU "failed to investigate other allegations contained in the anonymous tip, including that (1) the program integrity documents submitted to DVHA included misrepresentations, (2) OneCare was not performing required monthly screenings for debarred and excluded individuals, (3) OneCare's policies and procedures did not match contractual requirements, and (4) management had retaliated against staff."

Comment 5

The DVHA executive team is in the process of reviewing what occurred here, given that a record shows the complaint was investigated at least in part; identifying what occurred with respect to the other portions of the complaint and if the complaint was properly closed; and determining whether the complaint should be reopened. If the Department determines that this investigation should be reopened, the investigation shall be conducted according to the set processes of the SIU.

Final Summary of Management Responses to Recommendations

For ease of reference, we close by providing on the following pages (6-8) a summary of AHS and DVHA's responses to each of the recommendations.

AHS Recommendation	AHS Response
1. Amend the MOU with the other State partner organizations to establish a process to resolve disputes between the SIU and these organizations about vulnerabilities. The Secretary of Administration should be consulted decisions on how disputes between agencies are handled.	The MOU with the Agency of Education (AOE), as well as MOUs with other agencies or departments that are not within AHS, are not unilateral documents subject to the exclusive control of AHS. AHS does not object to establishing a process to escalate issues to the attention of the Agency of Administration (AOA); however, the establishment of such a process requires agreement by our partnering agencies, departments and AOA.
2. Revise the procedure on overseeing DVHA's program integrity activities to include reviewing activities pertaining to DVHA's contracts, such as OneCare.	AHS will review its policies with respect to oversight of contractor compliance with program integrity requirements. Without further detail in the recommendation it is unclear what specific measures the SAO would like for us to implement and which particular contracts would be subject to this additional oversight.

Comment 3

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

3. Establish guidance for SIU investigations data to ensure reporting to CMS is accurate.	AHS and DVHA have already begun to review the SIU investigation reports to identify why there would be a discrepancy between the reported number of investigations. We agree with this recommendation and intend to implement it.
4. Clarify the organizational placement of the DVHA compliance officer in the IGA to be consistent with Federal regulation.	We agree with this recommendation and intend to implement it.

DVHA Recommendation	DVHA Response
1. Direct the SIU to follow up on program vulnerabilities that it identifies. This process should include issuing a report to the Commissioner and AHS summarizing the extent to which vulnerabilities have been eliminated or mitigated on at least an annual basis.	DVHA has already implemented a process for the SIU to follow up on program vulnerabilities and intends to formalize that process in an SOP as a result of the audit.
2. Reinstate the edits that were removed as a result of PBR 21-067 and PBR 20-085 if the related SIU investigations that are currently on-going find significant improper payments.	DVHA agrees partly with this recommendation. For the reasons identified above, DVHA commits to reconvening on these PBRs once the related SIU investigations are complete. At that time, DVHA will make a determination as to the edits.
3. Implement the system edit agreed to as part of PBR 20-065	We thank the SAO for uncovering this, as we were not aware of the system edit never being implemented prior to this audit. The decision not to implement this edit appears to have originated outside of the Department. Because the PBR involves the Department of Disabilities, Aging, and Independent Living ("DAIL"), we intend to share the audit report with DAIL as a first step. Accordingly, we do not disagree with the recommendation, but we also cannot agree to it absent input from DAIL.
4. Establish a process, overseen by the DVHA Commissioner, for PBR resolution in the event not all approvers sign off.	We agree with this recommendation and intend to implement it.
5. Establish a process that includes obtaining SIU approval for PBR post implementation changes.	We agree with this recommendation and intend to implement it.

Comment 5

Docusign Envelope ID: D0FBFB1C-E091-4464-BA03-EA6517A43799

State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671
www.humanservices.vermont.gov

Jenney Samuelson, *Secretary*
Kristin McClure, *Deputy Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

6. Direct the SIU to investigate the September 2022 allegations related to OneCare's operations. This should include requesting and reviewing documentation that supports that the program integrity activities outlined in OneCare's reports to DVHA were carried out.	The referenced complaint was investigated at least in part. The DVHA executive team will review and determine if the investigation should be reopened. If the Department reopens the related investigation, the investigation will be conducted according to the established processes of the SIU.
7. Ensure the compliance officer position reports directly to the DVHA Commissioner, in accordance with Federal regulation.	We agree with this recommendation and intend to implement it.

We thank the SAO again for all your time spent on this audit.

Sincerely,

Signed by:
Monica Ogelby
B54C9D1DDEF74E2...

Monica Ogelby
Vermont State Medicaid Director

Signed by:
DaShawn Groves
AAF9E7992536479...

DaShawn Groves
DVHA Commissioner

CC: Jenney Samuelson, AHS Secretary, Jenney.Samuelson@vermont.gov
DaShawn Groves, DVHA Commissioner, DaShawn.Groves@vermont.gov

7

Appendix V
SAO Evaluation of Management's Comments

In accordance with generally accepted government auditing standards, the following tables contain our evaluation of management's comments.

Comment #	Management's Response	SAO Evaluation
1	*However, while DVHA provided the SAO with over 100 SIU investigation folders, the report appears to reflect a review of a limited subset (20) of those cases. We understand the need to work from a targeted sampling in what was already a long and complex audit process, but we also would stress that the SAO pursued a limited subset of cases, which at exit conference were identified as some of the most thorny and complex. As the SAO admitted during the exit conference, the trends identified in Exhibit 1 are not projectible.*	At our request, DVHA provided us with access to 22 SIU investigation folders (20 for objective 1 and 2 for objective 2). While planning for this audit, we did request some other investigation reports and limited investigation documents that we ultimately did not review as part of the audit. We did so to get examples of how they were written and the type of issues the SIU was addressing. We did not request, nor did we receive, anything close to 100 SIU investigation folders. Nevertheless, the gist of the AHS/DVHA comment that the results of the 20 investigations that we reviewed as part of objective 1 were not necessarily representative of those we did not examine is correct and our report does not say otherwise. To make this even clearer, we added explicit language to that effect in a footnote to the body of the report and to an appendix. Appendix I acknowledges that we judgmentally selected the 20 cases and explains that we chose them to include those that had findings so we could determine the actions taken in response, as established in our objective. In any case, the size of the sample does not call into question our findings and recommendations derived from our review of the chosen investigations.
2	*First, as raised at exit conference, we would supplement the portion of this section which focuses on the Global Payment Program to add that GPP claims are in no way exempt from the program integrity requirements imposed on the Medicaid program as a whole. All claims, including GPP claims, are subject to SIU audit.*	We added language to the report clarifying that the GPP was excluded from the program integrity requirements of the OneCare contract.

Appendix V
SAO Evaluation of Management's Comments

Comment #	Management's Response	SAO Evaluation
3	*AHS will review its oversight policies in light of the SAO's findings, but without further detail in the recommendation, we are unsure of what specific measures the SAO would like for us to implement and which particular contracts the SAO believes should be subject to the additional oversight.*	The 2023 and 2024 AHS-DVHA Intergovernmental Agreements state that AHS must ensure that DVHA *and any of its contractors* follow standard program integrity principles and practices. As we note in the report, AHS's current standard operating procedure on monitoring program integrity activities does not explicitly address oversight of DVHA's contracts. This audit cannot identify all the circumstances that would warrant AHS review of specific DVHA contracts in the future. As we stated in the exit conference with AHS/DVHA, this is a management decision and we believe that it would behoove AHS to develop criteria to identify the contracts, such as OneCare, that would warrant oversight from a program integrity perspective.
4	*Moreover, as a part of this audit, you requested that DVHA exert its contractual rights with OneCare to obtain documents from OneCare so that the SAO could assess DVHA's oversight of OneCare. … Requesting documents for the benefit of the SAO in light of this Supreme Court decision subjected DVHA and AHS to potential liability for violating its contractual obligation to enforce the contract in good faith … Nevertheless, we welcome a discussion with the SAO to establish a process by which we can obtain the assistance of the SAO in carrying out an audit of a contractor who we believe is not in compliance with its program integrity obligations.*	As we made clear in the audit, we have not asserted that OneCare's processes and operations do or do not comply with the DVHA contract, including whether OneCare knew of suspected FWA that it should have reported to the SIU. Rather, we requested that DVHA obtain documents from OneCare that may have allowed us to draw such conclusions and to assess the effect of DVHA's limited program integrity oversight. While it was our office that requested the documents, the beneficiaries of our work in this case could include the Federal government, AHS, DHVA, and Vermont taxpayers. We are always open to discussing how to assist state agencies to determine whether a contractor is not in compliance with program integrity requirements. We were disappointed that AHS/DVHA did not take this opportunity on this audit.
5	*The DVHA executive team is in the process of reviewing what occurred here, given that a record shows the [2022 OneCare] complaint was investigated at least in part; identifying what occurred with respect to the other portions of the complaint and if the complaint was properly closed; and determining whether the complaint should be reopened.*	We based our conclusion on the limitation of the SIU review of the 2022 OneCare allegations on a review of the investigation report, and an interview and email with the SIU investigator and the SIU liaison with OneCare during 2022, respectively. During the exit conference and again in an email after this meeting we offered to consider additional evidence that would demonstrate that the SIU had reviewed all the allegations about OneCare's operations. No such evidence was provided.