INDEPENDENT EXTERNAL AUDIT:

2014 AUDIT FINDINGS REPORT

RHODE ISLAND

RHODE ISLAND HEALTH BENEFITS EXCHANGE

DBA HSRI (HEALTHSOURCE RI)

INDEPENDENT EXTERNAL AUDIT:
2014 FINDINGS REPORT

TO: CCIIO STATE EXCHANGE GROUP
FROM: BERRY DUNN MCNEIL & PARKER (BERRYDUNN)
DATE: JUNE 1, 2015
SUBJECT: AUDIT FINDINGS REPORT FOR RHODE ISLAND

I. EXECUTIVE SUMMARY

PURPOSE

The Purpose of this independent external audit is to assist the State of Rhode Island in determining whether HealthSource RI (HSRI), the Rhode Island State-Based Marketplace (SBM), is in compliance with the financial and programmatic requirements set forth by the Centers for Medicare and Medicaid Services (CMS).

Name of SBM: HealthSource RI (HSRI)

State of SBM: Rhode Island

Name of Auditing Firm: BerryDunn

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

SCOPE

The scope of this engagement included an audit of the Statement of Appropriations and Expenditures of HSRI, as well as an examination of HSRI's compliance with the requirements of 45 CFR 155. We conducted our audit in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. We completed an examination of HSRI's compliance with the programmatic requirements under 45 CFR 155 and an audit of its financial statement and issued our reports, dated June 1, 2015.

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

METHODOLOGY

- **Audit Firm background:**

BerryDunn is the largest certified public accounting and consulting firm headquartered in New England, with more than 240 professionals. BerryDunn has for more than 40 years provided comprehensive audit and tax services for a broad range of healthcare, not-for profit, and governmental entities throughout the Northeast. Those services include conducting Office of Management and Budget Circular A-133 audits for several sizable healthcare organizations, many of which receive U.S. Department of Health and Human Services federal grants or funding. In addition, we provide audit services for higher education, social service, and economic development organizations, as well as other entities that receive federal grants and are subject to the compliance requirements of A-133.

- **Financial Statement Audit:**

We have audited, in accordance with generally accepted auditing standards in the U.S. and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the statement of appropriations and expenditures of HSRI, for the year ended June 30, 2014 and related notes to the statement, and have issued a report thereon dated June 1, 2015.

- **Programmatic Audit:**

We have examined HSRI's compliance with the requirements in 45 CFR 155 during the year ended June 30, 2014, and have issued a report thereon dated June 1, 2015.

- **Summary of Programmatic Audit Procedures**

Our audit consisted of specific procedures and objectives to evaluate instances of noncompliance and to perform procedures to test HSRI's compliance and program effectiveness of the subparts of 45 CFR Part 155:

- General Standards (Subpart B)
- General Functions (Subpart C)
- Eligibility Determinations (Subpart D)
- Enrollment Functions (subpart E)
- Appeals of Eligibility Determinations (Subpart F)
- Exemptions (Subpart G)
- SHOP (Subpart H)
- Certification of Qualified Health Plans (Subpart K)
- Oversight and Program Integrity Standards (Subpart M)
- State Flexibility (Subpart N)
- Quality Reporting Standards (Subpart O)

We reviewed documentation obtained from HSRI and found on Rhode Island's and CMS' website:

- 42 CFR Parts 431, 435, and 457 Medicaid Program Eligibility Changes Under the Affordable Care Act of 2010
- 834 Carrier Discrepancy Reporting Process Internal
- Affordable Care Act (ACA) # 22 - Conversion of Net Income Standards to MAGI Equivalent Income Standards
- Calculation of Advance Premium Tax Credits
- Carrier Payment Process Overview
- CMS SMART Reporting
- CMS Conditional Approval Letter
- Citizenship/Immigration Documentation and Verification
- Comprehensive Annual Financial Report_06-30-2014
- Contact Center Complaints Log
- Contact Center Policies and Procedures
- Contracts:
    - CSG Government Solutions, Inc.
    - Deloitte, LLP
    - Faulkner Consulting Group
    - KPMG, LLP
    - Optum, Inc.
    - Wakely Consulting Group, Inc.
- Eligibility Operations Manual
- Enrollment Operations Manual
- Enrollment Screenshots
- Exchange and Trust Fund Overview
- Executive Order 11-09
- Financial Management Functional Design
- Financial Operations Manual
- Flowcharts, Policies and procedures relating to:
    - A/P and Expenditures
    - Payroll
- Healthcare.gov - exemptions
- Healthcare.gov – tax household
- HSRI Advisory Board Overview
- HSRI Business Process Flow
- HSRI – OHIC Interagency Agreement

- HSRI Organization Charts
- HSRI Policies and Procedures
- HSRI Rules and Regulations
- HSRI Website
- Information Reporting By Exchanges
- IRS Form 8965 Exemptions
- IRS - Individuals-and-Families Exemptions
- IRS Publication 525 Income
- IT Compliance Documents
    - System Security Plan
    - System Security Plan Workbook
    - IRS Safeguard Procedures Report
    - IRS Safeguard Review (PFR)
    - IRS Safeguard Review (CAP)
    - CSG Security Assessment
    - Deloitte Security Assessment (CMS Template)
    - Plan of Action & Milestones (POA&M)
    - Privacy Impact Assessment
- MAGI Logic Spreadsheet
- Minutes of Exchange Advisory Board
- Minutes of Expert Advisory Committee
- Navigator Conflict of Interest/Privacy forms
- Navigator Oversight and Monitoring
- Notification Templates
- Office of the Auditor General Single Audit Report for FY 2014
- Office of Health Insurance Commissioner (OHIC) Regulations
- Operations Readiness Report (ORR)
- Optum Process Flow Document
- Permission Matrix Final latest(TAS) Guidance
- Rates Under ACA
- RI ACA Regulations
- RI Department of Administration Fraud Policy
- RI State Blueprint Profile
- Section 1308 of Rhode Island Rules and Regulations - Verification of Medicaid Affordable Care Coverage Group Eligibility Factors
- Training Material Documents Reviewed
    - Broker Training Deck
    - Carrier – BCBSRI & Activity & Assessment

  - Carrier – Neighborhood Health & Activity & Assessment
  - Carrier Overview
  - Carrier – UHC & Activity & Assessment
  - Lets Apply for Coverage – 4 Help Customer Apply
  - Navigator & Assessment
  - Navigator Training Objectives
  - Navigator Training Assessment
  - Privacy & Impartiality
  - UHIP Insurance Affordability Plan Eligibility
  - Verification of Eligibility
- Trust Cash Collections Policy and Procedure
- Trust Disbursements Policy and Procedure
- Trust Fund Overview
- Trust Process Flow
- User Acceptance Test (UAT) Summary Reports
- UHIP Business Process Reviews
- UHIP Functional Design - Eligibility
- UHIP Interagency agreement
- UHIP IV&V Monthly Status Reports
- UHIP Notices
- UHIP Operations Manual
- UHIP Requirements Design Medicaid Verification Batch
- UHIP Requirements Design Post Eligibility Verification
- UHIP Weekly Status Reports

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

- Director
- Chief of Staff
- Deputy Director for Finance and Operations
- Deputy Director for Communications, Marketing and Outreach
- Deputy Director for Legal Affairs
- Deputy Director for Policy Planning and SHOP Development
- Finance & Budget Management
- Operations Manager
- Technology Lead
- Navigator Representative
- Data & Analysis Team

- Technology Consultant
- Grants Manager
- Training Coordinator
- Reporting Representative
- Assistant Administrator
- Finance Manager
- Data Management Team

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

- OAG (Office of Auditor General)
  - Auditor General
  - Senior Audit Manager
- DOIT (Department of Information Technology)
  - UHIP Technology lead
  - Chief information Officer
  - System Administrator
- Deloitte
  - IT Lead
  - Senior Consultants
  - IT Consultant
- RIHCA (Rhode Island Health Center Association)
  - President/ CEO
  - Chief Operating Officer (COO)
  - Senior Director of Finance & Accounting
  - OESP Program manager/ Trainer
- Optum Call Center
  - Operations Manager
  - Training Manger
  - Coach (Supervisor)
  - Back Office Coach (Supervisor)
  - Customer Service Representatives
  - Human Resource Manager
  - Optum Compliance Team

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

- A listing of 191,061 applicants who had an eligibility determination completed on or before June 30, 2014. We selected a sample of 147 cases to test the compliance with 45 CFR 155 Subpart D Eligibility.

- A listing of 580 appeals cases. Since none of the appeals had a final disposition other than "withdrawn" or "dismissed," there were no cases for review in order to assess whether the appeals process had complied with 45 CFR Subpart F - Appeals of Eligibility Determinations.
- A listing of 422 completed exemptions on or before June 30, 2014. We selected a sample of 20 cases to test compliance with 45 CFR Subpart G - Exemptions

We performed site-visits and walkthroughs of HSRI's Contact Center operated by Optum. We interviewed staff at the Call Center to understand operational functions and the application process supported by the Call Center.

CONFIDENTIAL INFORMATION OMITTED

N/A

II. AUDIT FINDINGS

KEY FINDINGS

FINDING #2014-001

Criteria:

Subpart C - General Functions of an Exchange, §155.230 requires that any notice sent by the Exchange to individuals or employers must be written and include: (1) an explanation of the action reflected in the notice, including the effective date of the action, (2) any factual findings relevant to the action, (3) citations to, or identification of, the relevant regulations supporting the action, (4) contact information for available customer service resources, and (5) an explanation of appeal rights, if applicable.

Condition:

There were notices generated by the UHIP system during the initial months of operation that contained inaccurate information.

To address this issue, HSRI placed a hold on notices to provide a quality assurance team the opportunity to review all notices for accuracy and completeness. Following the review, HSRI corrected the faulty system logic and issued a "manual notice of legal precedent," notifying consumers of the inaccurate notices.

Cause:

The generation of improper notices was caused by incorrect logic in the UHIP system design relative to notice templates.

Effect:

Receipt of inaccurate or improper notices may have created confusion for consumers, and inhibited HSRI from conveying important and required information to the consumer.

FINDING #2014-002

Criteria:

Subpart D - Eligibility, §155.315 requires that an applicant be made conditionally eligible based upon the data he or she entered in his or her application. The Exchange must make a reasonable effort to identify and address any inconsistency between the self-attested data in the application and information obtained from outside data sources by contacting the applicant to resolve such inconsistency by providing additional information. The Exchange must provide the applicant with a period of 90 days to present satisfactory documentation. If, after the 90 day period the Exchange is unable to verify the self-attested data with outside data sources, or if the outside data sources do not contain relevant data, then it must deem the case ineligible and notify the applicant of such determination.

Condition:

Our testing, combined with inquiries, identified that for a significant number of cases, conditional eligibility was not verified and consumers remained eligible indefinitely beyond the 90-day period.

Cause:

The UHIP system was designed to identify when a case has been open for more than 90 days, in which case a task would be generated for the Contact Center to either close the case or extend the conditional eligibility period and notify the applicant that additional activities must be completed to validate the data self-attested to by the applicant. However, the logic to perform this function was not operable during the audit period. As a result, the system did not generate tasks to identify cases that approached or passed the 90-day limit; and the only way to make sure cases did not exceed the 90-day limit was to manually monitor the case.

Effect:

The absence of an automated or regular process to review conditionally eligible cases approaching the 90-day limit resulted in some cases being maintained as conditionally eligible for more than the allowed 90-day period. A case is made conditionally eligible because one or more required data elements could not be validated against an outside data source or by documentation provided by the applicant. Applicants inappropriately provided conditional Advanced Payment of Tax Credit (APTC) eligibility would ultimately reconcile the inappropriate benefits through the tax filing process; however, there is no recourse or recoupment of inappropriate benefits for those individuals provided conditional Cost Sharing Reduction (CSR) eligibility. HSRI provided conditional eligibility to covered households beyond the 90-day window without any robust controls to prohibit continuing inappropriate eligibility to applicants neglecting to provide additional information to resolve their conditional status. The conditional eligibility status provided for these cases might have changed if outside data sources or applicant documentation was properly used to validate eligibility.

FINDING #2014-003

Criteria:

Subpart D- Eligibility, §155.320 requires the Exchange to verify household income and family/household size through the Federal hub. The Exchange must accept the applicants self-attestation unless it has a reason to believe the self-attested data is not accurate (§155.320(c)(3)(ii)(C)).

If the Exchange identifies an inconsistency between the self-attested data and verification from outside data sources, or there is no data available in the Federal hub to validate income, the Exchange must notify the applicant and allow him or her an opportunity to provide additional documentation to support their self-attested data (§155.320(c)3(ii)(D)).

If after 90 days the applicant has not provided information to explain why the self-attested information more accurately reflects their current earnings (e.g., supply four weeks of pay stubs), then the Exchange is required to calculate the applicant's eligibility based upon data from the outside data sources and notify the applicant (45 CFR §155.315(f)(5).

The federal regulations do not require states to match income with the State Wage Information Collection Agency (SWICA) and State Unemployment Insurance (SUI). It merely provides that states can match with the Federal hub and other sources. However, in its blueprint for the Exchange, HSRI stated to CMS that it planned to match SWICA and SUI. The HSRI operations manual identifies SWICA and SUI as the primary sources for income verification.

Condition:

HSRI did not verify income data with the SWICA and SUI data sources during the audit period.

As described in §155.320, an Exchange is only required to verify the applicant's self-attested income through the Federal hub. The Federal hub, however, contains tax data that is up to two-years old. Additionally, if the applicant has not filed tax returns, there would be no data available to verify income. During the audit period, the Federal hub was frequently out of service. When this occurred, UHIP generated a task for follow-up and verification of data.

HSRI and the Rhode Island Executive Office of Health and Human Services (EOHHS) were not aware that this interface was not working until May 2014; therefore, applications were processed without being matched with SWICA or SUI during the audit period.

Cause:

There were system deficiencies affecting both the ability of the UHIP system to access the SWICA and SUI data sources and the “refreshing” of the database to periodically update the data with more current wage information.

Effect:

Since the State decided to only fix the issue on a prospective basis and the Office of the Auditor General’s (OAG's) match showed that over 6,000 people based on SWICA data may not have been Medicaid eligible, it appears likely that some individuals were incorrectly determined eligible for Medicaid and received benefits. The OAG audit only reviewed Medicaid cases, but it appears that if a SWICA match showed issues with Medicaid eligibility

determinations, there would have been similar issues with APTC and CSR eligibility determinations.

In June 2014, the logic in UHIP was fixed so that matches with SWICA could be performed. Individuals were requested to provide documentation supporting their self-attestation on income and were only terminated from Medicaid if the individual failed to provide the information. The changes were made on a prospective basis due to the large population impacted and manual effort required by the Medicaid Administrator to determine if claims were filed and paid. The OAG subsequently matched SWICA wage information and identified 6,113 individuals who potentially would not have been eligible for Medicaid if the applicant's self-reported income was verified with SWICA data sources.

FINDING #2014-004

Criteria:

Subpart D – Eligibility, §155.330 Eligibility redetermination during a benefit year (g) - Recalculation of advance payments of the premium tax credit and cost-sharing reductions requires HSRI to recalculate the premium owed net of any reductions from the APTC and take into account changes in the APTC amount, household, size, or other factors that can affect the calculation of the APTC.

Condition:

UHIP was not correctly calculating the Premium net of the APTC owed by some consumers.

Consumers had the ability to change the income data within the UHIP system at multiple times during the year, and HSRI was required to recalculate the premium amount net of the new APTC amount and roll that figure forward, taking into account the APTC already paid. The changes that the consumers made to his or her income data were causing the premiums new APTC to be miscalculated.

Cause:

The logic in the UHIP was not correctly calculating the newly modified APTC and, as a result, the net premium billed to the consumer was not correct.

Effect:

Consumers were being billed incorrect amounts.

FINDING #2014-005

Criteria:

45 CFR §147.120, incorporated by reference in *45 CFR §155*, states that a person must be eligible for insurance until their 26th birthday. *45 CFR §155.305* states that once a consumer turns 65, they are eligible for Medicare and thus have access to Minimum Essential Coverage; hence they are no longer eligible for APTC.

Condition:

There is no process in place to verify that individuals over the age of 26 who have coverage under their parents' plans are terminated from that plan and that individuals over the age of 65 are terminated from APTC.

Cause:

The UHIP system does not have a batch process to sweep the database to identify people who no longer qualify for the APTC based upon age.

Effect:

Some individuals continue to receive the APTC after they are no longer eligible.

FINDING #2014-006

Criteria:

45 CFR §400(d), incorporated by reference in *45 CFR §155,* requires HSRI must reconcile enrollment information with Qualified Health Plans issuers and HHS no less than on a monthly basis.

Condition:

Enrollment information was not accurately reconciled.

Cause:

The reconciliation process for enrollment is complex, involving multiple systems across different entities – UHIP, NFP Health's Financial Management and Billing System (FMS), and the systems at each Carrier. Resources were allocated to more critical functions during the audit period.

Effect:

In absence of proper reconciliations, enrollment between UHIP, FMS and the Carriers' systems may not be correct, resulting in consumers not having the desired coverage and carriers not having appropriate enrollment records. Additionally, incorrect enrollment information may be sent to HHS.

AUDITOR'S OPINION

We have issued the an Auditor's Report on the Schedule of Appropriations and Expenditures for the Year Ended June 30, 2014, reflecting the following type of opinion:

☐	QUALIFIED	☒	UNQUALIFIED	☐	ADVERSE	☐	DISCLAIMER

ADDITIONAL COMMENTS

N/A.

III. RECOMMENDATIONS

FINDING #2014-001

Since these issues were remediated before the end of the audit period, BerryDunn has no further recommendations for this finding.

FINDING #2014-002

HSRI should assign a top priority for Deloitte to support automated monitoring of the conditionally eligible cases and assign them to be worked by a Customer Service Representative before the 90-day conditional eligibility period concludes; in the interim, HSRI should manually monitor the cases and ensure that all conditional eligibility cases are properly processed within the required 90-day period.

FINDING #2014-003

Since this issue has been remediated, BerryDunn has no further recommendations for this finding.

FINDING #2014-004

Since this issue has been remediated, BerryDunn has no further recommendations for this finding.

FINDING #2014-005

HSRI should work with Deloitte to develop a process within UHIP to identify these cases and make sure that appropriate actions are taken to prohibit people from obtaining APTC or CSR benefits to which they are no longer entitled.

FINDING #2014-006

HSRI should work to develop a robust reconciliation process which incorporates all inputs from the various reporting files to verify consistency amongst all parties within the UHIP reporting, billing, and enrollment system.

IV. CONCLUSION

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

SIGNATURE OF AUDIT FIRM: Berry Dunn McNeil & Parker, LLC

COMPLETION DATE OF AUDIT FINDINGS REPORT: June 1, 2015