INDEPENDENT EXTERNAL AUDIT:
2015 AUDIT FINDINGS REPORT

RHODE ISLAND
RHODE ISLAND HEALTH INSURANCE EXCHANGE
DBA HSRI (HEALTHSOURCE RHODE ISLAND)

INDEPENDENT EXTERNAL AUDIT: 2015 FINDINGS REPORT

TO: CCIIO STATE EXCHANGE GROUP

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

DATE: DECEMBER 21, 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 Rhode Island (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 Rhode Island (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 December 21, 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 material 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 280 professionals. BerryDunn has for more than 40 years provided comprehensive audit and tax services for a broad range of healthcare, not-for profit, and governmental entities throughout the Northeast. Those services include conducting 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 United States 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, 2015, and related notes to the statement, and have issued a report thereon dated December 21, 2015.

Programmatic Audit:

We have examined HSRI's compliance with the programmatic requirements described in 45 CFR 155 for the year ended June 30, 2015, and have issued a report thereon dated December 21, 2015.

Summary of Programmatic Audit Procedures

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

- Navigators/Contact Center Processes and Procedures
- Certified Application Counselors
- QHP Certification.

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

We reviewed the open issues from the previous year's audit to identify whether any issues remained open during the current year audit.

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

- General 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 the following documentation, which was obtained directly from HSRI, or located on either the HSRI website or the CMS website:

- 42 CFR Parts 431, 435, and 457 Medicaid Program Eligibility Changes Under the Affordable Care Act of 2010
- Affordable Care Act (ACA) # 22—Conversion of Net Income Standards to MAGI Equivalent Income Standards
- Appeals Cases (listing showing appeals processed in 2015)
- Backlog and Exceptions Reporting
- Calculation of Advance Premium Tax Credits
- Certified Application Counselor Conflict of Interest/Privacy forms
- Certified Application Counselor Training Presentations
- Citizenship/Immigration Documentation and Verification
- Conditional Eligibility—Manual Process to Review 90 Day Cases
- CMS Monthly Process Flow—2015
- CMS Monthly Reports
- CMS Quarterly Reports
- Comprehensive Annual Financial Report_06-30-2015
- Contact Center Policies and Procedures
- Contact Center Flow—2015
- Contracts:
  - Connextions
  - Deloitte, LLP
  - Freedman Healthcare, LLC
  - KPMG, LLP

  - Wakely Consulting Group, Inc.
- Eligibility Operations Manual
- Enrollment Operations Manual
- Enrollment Screenshots
- Exemption Tasks
- 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 Policy Manual
- HSRI Rules and Regulations
- HSRI Website
- Information Reporting By Exchanges
- MAGI Logic Spreadsheet
- Minutes of Exchange Advisory Board
- Minutes of Expert Advisory Committee
- Office of Health Insurance Commissioner (OHIC) Regulations
- QHP Application (reviewed Blue Cross Blue Shield's application documents posted on the SERFF system
- Rates Under ACA
- Reconciliation of Daily Discrepancies
- Reconciliation of Enrollment Processes
- Reconciliation Processes Update
- RI ACA Regulations
- 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
  - Let's 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
- User Acceptance Test (UAT) Summary Reports
- UHIP Business Process Reviews
- UHIP Functional Design—Eligibility
- UHIP Interagency Agreement
- UHIP IV&V Monthly Status Reports
- UHIP Operations Manual
- Verification Screen Shots

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:

- Data Management Team
- Data and Analysis Team
- 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 and Budget Management
- Finance Manager
- Operations Manager

- Technology Consultant
- Technology Lead
- Training Coordinator

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
- OHIC (Office of the Health Insurance Commissioner)
  - Director of Operations
  - Principal Policy Associate
- 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

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

- A listing of 217,911 applicants who had an eligibility determination completed on or before June 30, 2015. We selected a sample of 95 cases to test the compliance with 45 CFR 155 Subpart D Eligibility and Subpart E Enrollment.

CONFIDENTIAL INFORMATION OMITTED
N/A

II. AUDIT FINDINGS

KEY FINDINGS

FINDING #2015-001

Criteria:

Subpart D - Eligibility, §155.315 requires that an applicant be made conditionally eligible based upon the data he or she entered in his or her application and data received from automated data sources. 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 or a reasonable explanation. If, after the 90-day period, the Exchange is unable to resolve the discrepancy between the self-attested information and the data sources with customer-provided information, then it must re-run eligibility and notify the applicant of their new eligibility determination.

Condition:

As reported in the audit for the year ended June 30, 2014, HSRI identified 937 cases in which accounts with conditional eligibility with unverified citizenship and immigration had not been resolved with a new eligibility determination within the 90 day timeframe. That is, consumers remained eligible beyond the 90-day period. This condition still existed during the year ended June 30, 2015, but at a significantly reduced level, because HSRI conducted two manual reviews of the database to identify cases that exceeded the 90-day period review. One review was conducted in September 2014 and another in June 2015.

Cause:

The UHIP system was intended to have the capability to identify cases that have been open for more than 90 days, and to generate related tasks to be completed by the Contact Center. The tasks should require 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 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 mechanism to ensure cases did not exceed the 90-day limit was manual monitoring of the cases.

Effect:

The absence of an automated 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. Applicants who were inappropriately provided conditional Advanced Payment of Tax Credit (APTC) eligibility beyond the 90 day period may 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 because there was no automated identification of cases that exceeded the allowed time period. However, during the year ended June 30, 2015, HSRI conducted two manual reviews of the database and did identify cases that had exceeded the 90-day limit and took appropriate actions to either verify eligibility or terminate coverage, so the effect was minimized for this audit period.

FINDING #2015-002

Criteria:

45 CFR §147.120 states that a person must be eligible for insurance under his or her parent's insurance plan until their twenty-sixth birthday, but once they turn 26, they must obtain their own insurance plan. When a consumer turns 65, they are potentially eligible for Medicare, and if they are receiving Part A benefits at no cost, then they have access to Minimum Essential Coverage and are not eligible to receive APTC, as defined by 26 U.S. Code § 500A(f).

Condition:

For the year ended June 30, 2015, there was no process in place to verify whether:

- Individuals over the age of 26 who have coverage under their parents' plans are terminated from that plan; and
- Individuals over the age of 65 are properly notified of their responsibility to report changes in circumstance, in particular that Medicare eligibility is a basis for APTC/CSR ineligibility.

Cause:

The UHIP system did not have a process to identify people who turned 26 or 65 during the audit period. The system was modified in August 2015 to identify consumers who have turned 26, and there are plans to implement new procedures to process cases where the consumer turns 65. However, during the year ended June 30, 2015, there were no processes to identify cases where consumers turned either 26 or 65.

Effect:

Individuals age 26 and older are not entitled to be covered by their parents insurance. Individuals who are covered by their parents' insurance should be terminated from their parent's coverage upon his or her twenty-sixth birthday. Prior to implementing the changes in August 2016, there was no automated way to identify individuals who turned 26 and should have had their coverage under their parent's insurance terminated. An individual who receives Part A benefits under Medicare at no cost is not entitled to APTC benefits and APTC should be terminated upon receipt of those benefits. However, not all individuals 65 and over are entitled to receive Part A benefits at no cost. Absent a process to identify current enrollees who turn 65 and provide them a notice asking them to verify whether they are receiving Part A benefits at no cost, there is no way to identify those consumers who should have their APTC benefits terminated. HSRI does check for Medicare eligibility, regardless of age, upon initial application and upon changes being reported in an account. It appears **that until that process is**

implemented there will be current enrollees turning 65 who will improperly receive APTC until such a process is implemented.

FINDING #2015-003

Criteria:

45 CFR 400(d) requires HSRI must reconcile enrollment information with QHP 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, and the systems at each Carrier.

Effect:

In the absence of proper reconciliations, enrollment transactions 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. As a result, of the improvements made to the reconciliation process, the number of cases negatively impacted was significantly reduced and the amount of time to correct the issue was reduced by 50%.

FINDING #2015-004

Criteria:

45 CFR 155.305(f) requires that a family with income below 100% of the Federal poverty level (FPL), but not Medicaid eligible, is not eligible for APTC unless the cause for Medicaid ineligibility is failure to meet the five-year residency requirement.

Condition:

In one of the cases in the test sample, the applicant had self-declared that the family had no income, but the case was deemed ineligible because the applicant did not provide verification of the zero income. HSRI made the case conditionally eligible for QHP/APTC/CSR. Since the applicant's income is below 100% of FPL, he cannot be eligible for CSR or APTC unless the cause for ineligibility for Medicaid was that the applicant as a legal immigrant failed to meet the five-year residency requirement.

Since the cause for ineligibility for Medicaid was the failure to provide documentation of zero income, the applicant was improperly made eligible for APTC/CSR.

Cause:

The business rules incorrectly provided that all cases deemed ineligible for Medicaid with income below 100% FPL are eligible for APTC/CSR if other eligibility criteria are met.

Effect:
Cases with the characteristics identified in the audit sample were incorrectly made eligible for APTC/CSR.

AUDITOR'S OPINION

We have issued an Independent Auditor's Report on the Schedule of Appropriations and Expenditures for the Year Ended June 30, 2015, reflecting the following type of opinion:

☐	QUALIFIED	☒	UNQUALIFIED	☐	ADVERSE	☐	DISCLAIMER

ADDITIONAL COMMENTS

N/A.

III. RECOMMENDATIONS

FINDING #2015-001
We recommend that HSRI work with the systems integrator to implement, as soon as practical, the code fixes needed to support automated monitoring of the conditionally eligible cases and assign them for resolution by a Customer Service Representative before the 90-day conditional eligibility period concludes. In the interim, HSRI should continue to perform manual reviews of cases and ensure that all conditional eligibility cases are properly processed within the required 90-day period.

FINDING #2015-002
Since the issue related to consumers turning 26 has been remediated, BerryDunn has no further recommendations for this finding.

It is our understanding that HSRI plans to implement new processes and procedures in February 2016 to properly identify and process cases where the enrollee turns 65.

FINDING #2015-003
We recommend HSRI continue to improve the enrollment reconciliation process to further reduce cases negatively impacted and reduce the time to address issues.

FINDING #2015-004
We recommend HSRI change the business logic to make all Medicaid ineligible cases with income below 100% FPL ineligible for APTC/CSR unless the cause for Medicaid ineligibility was failure of lawful immigrants to meet the five-year residency rule.

IV. CONCLUSION

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

SIGNATURE OF AUDIT FIRM: 

COMPLETION DATE OF AUDIT FINDINGS REPORT: DECEMBER 21, 2015


BerryDunn