Cover Page

FY2016 MNsure Programmatic Audit Report

and

Agency Response Letter

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INDEPENDENT EXTERNAL AUDIT: 2016 AUDIT FINDINGS REPORT

MINNESOTA

MINNESOTA HEALTH INSURANCE EXCHANGE (MNSURE)

INDEPENDENT EXTERNAL AUDIT: 2016 FINDINGS REPORT

TO: CCIIO STATE EXCHANGE GROUP

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

DATE: MAY 23, 2017

SUBJECT: AUDIT FINDINGS REPORT FOR RHODE ISLAND

I. EXECUTIVE SUMMARY

PURPOSE

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

Name of SBM: MNsure

State of SBM: Minnesota

Name of Auditing Firm: BerryDunn

Our responsibility was to perform a programmatic audit to report on MNsure'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 was limited to an examination of MNsure's compliance with the programmatic requirements under 45 CFR 155. The engagement did not include an audit of the Statement of Appropriations and Expenditures of MNsure, nor did it include an examination of MNsure's financial controls and compliance with the financial accounting and reporting requirements of 45 CFR 155.

We conducted our audit in accordance with U.S. GAGAS contained in Government Auditing Standards, issued by the Comptroller General of the United States. We completed an examination of MNsure's compliance with the programmatic requirements under 45 CFR 155 and issued our reports, dated May 23, 2017.

We reviewed processes and procedures, read pertinent documents, and performed inquiries, observations, testing, and staff interviews to obtain reasonable assurance regarding whether MNsure is in compliance with 45 CFR 155, Subparts D, E, F, K, and M in all material respects. We also selected different samples of clients and tested for compliance with requirements under Title 45, Part 15:

- Subparts D and E for eligibility determination, verification of data, and enrollment with a QHP.
- Subpart F – Appeals testing

METHODOLOGY

Audit Firm Background:
BerryDunn is the largest certified public accounting and consulting firm headquartered in New England, with more than 300 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 Financial and Programmatic audits of four Health Benefit Exchanges, including MNsure as well as Office of Management and Budget Circular Uniform Guidance (UG) 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 UG.

Programmatic Audit:
As described below, we have examined MNsure's compliance with certain programmatic requirements in 45 CFR 155 for the year ended June 30, 2016, and have issued a report thereon dated May 23, 2017.

Summary of Programmatic Audit Procedures
Our audit consisted of specific procedures and objectives to evaluate instances of noncompliance and to perform procedures to test MNsure's compliance with and program effectiveness of certain requirements in Title 45, Part 155, Subparts D, E, F, K, and M of the Code of Federal Regulations. Our examination for Subpart K was limited to a review of the Exchange's policies and procedures to test whether those policies and procedures are in compliance with the programmatic requirements under those Subparts.

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

We also reviewed the edibility determination of all the applications that were processed to determine eligibility for insurance assistance within FY16 while having indicators from the Federal Data Services Hub that that the applicants might have access to minimum essential coverage.

We selected a sample of cases and tested for compliance with requirements under Title 45 CFR 155 Subpart F for Appeals.

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 policies 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:

- Eligibility Determinations (Subpart D)
- Enrollment Functions (Subpart E)
- Appeals of Eligibility Determinations (Subpart F)
- Certification of Qualified Health Plans (Subpart K)
- Oversight and Program Integrity Standards (Subpart M)

We reviewed the following documentation, which was obtained directly from MNsure, or located on either the MNsure or the CMS website:

- Appeals Cases (listing showing appeals processed in 2016; included extracts from systems and copies of appeals decisions)
- Appeals Policies and Procedures, Including:
    - Appeals Division Orientation Manual
    - MN Appeal Rules Document
    - MNsure Appeals Policy Guidance for Appeals Examiners
    - MNsure Definitions (Minnesota Rules 7700.0101)
    - MNsure Hearing Process (Minnesota Rules 7700.0105)
    - MNsure Process to Appeal to District Court Guide
    - MNsure Specific Procedures for Administrative and Legal Support Staff
- CMS Quality Ratings Information Bulletin
- Enrollment notices, including:
    - Authorization to Obtain Tax Data
    - Employer Notice of Coverage
    - Open Enrollment Assisted Path Notice
    - Open Enrollment Unassisted Path Notice
    - Redetermination notice (Auto-renewal)
    - Redetermination notice (Modified Need to Renew)
    - Special Enrollment Assisted Path Notice
    - Special Enrollment Unassisted Path Notice

  - Termination of Coverage Notice
- Processes & Procedures documents:
- Individual Market Policy Manual
- Minnesota Health Care Programs Eligibility Policy Manual
- MNsure Board Meeting Minutes 01/07/2015 – 6/15/2016
- MNsure Board Members & Backgrounds
- MNsure Carrier Business Agreement
- MNsure Cost Sharing Reductions Guide
- MNsure Federal Compliance Audit – Year Ended June 30, 2015
- MNsure Household Composition and Income Rules Tip Sheet
- MNsure Plan Certification Guidance for 2016 Plans
- MNsure Plan Certification Guidance for Qualified Dental Plans – Plan Year 2016
- Organizational Chart
- Plan Premiums for 2016 Guide
- Population data for Eligibility and Enrollment Testing
- QHP Certification Overview Presentation
- Review of Nov. 2015 – Jan. 2016 IV&V
- Security Documents, Including:
  - MNsure-DHS Computer Matching Agreement
  - MNsure Privacy Impact Assessment
  - MNsure Safeguard Security Report & IRS Letter of Acceptance
  - MNsure System Interconnection Agreement
  - MNsure System Security Plan
- SERFF Walkthrough (On-site)
- Training Material Modules/Documentation Reviewed:
  - Initial Enrollment – Calculating the Advance Premium Tax Credit Guide
  - MA & MNCare Renewal Process for Cases in the New Eligibility System Guide
  - MN QHP Certification Requirements Guide
  - MNsure How to Respond to an Employer Notice Guide
- Verification Policies and Procedures, Including:
  - Procedures in the Minnesota State-Based Exchange Document
  - Verifications Manual

- Websites and Webpages, including:
  - Minnesota Department of Health and Human Services Website
  - MNsure 2016 Online Application for Health Care Coverage
  - MNsure Application Process for New Customers Webpage
  - MNsure Health Benefit Exchange Website
  - MNsure Notice of Privacy Practices Webpage
  - MNsure Q&A from 2017 QHP Renewal Webinar
- 834 Enrollment Companion Guide V2.1

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 MNsure staff:

- Appeals Manager/Deputy General Counsel – Jessica Kennedy
- Appeals Representatives – Mikailah Lim-Honerbrink, Gretchen Fittzgerald
- Business Analyst – Jason Emerick
- Compliance Coordinator – Katie DeGrio Channing
- Compliance & Program Integrity Manager – John Nyanjom
- Data Specialist – Lydia Aryeetey
- DHS Appeals Administrator – Patrick Kontz
- DHS Human Services Judge – Amylynne Hermanek
- DHS Internal Audit Director – Gary Johnson
- Eligibility & Enrollment Director – Bob Paulson
- Health Plan & 1095 Data Manager – Melinda Domzalski-Hansen
- General Counsel/Chief Compliance Officer – Dave Rowley
- Government Affairs Director – Marcus Schmit
- Senior Business Analyst – Derek Standahl
- Senior Data Analyst – Ben Thomas

We also performed walkthroughs of data systems and operations and interviewed the following non-MNsure staff:

- Minnesota Department of Commerce staff:
  - Kristi Bohn – Health Actuary
  - Donna Watz – Deputy General Counsel

  - Marybeth Moses – Health Rate and Form Coordinator
  - David Saxton – Actuarial staff, Insurance Division
  - Candace Gergen – Health Policy Analyst 3
- Minnesota Department of Health (MDH) staff:
  - Lisa Taft – Management Analyst 4, CM/MCS
  - Tom Major – Health Program Manager Senior, HRD
  - MaryAnn Benke – Management Analyst 4, CM/MCS
  - Patti Fuller – Health Program Rep Senior, CM:MCS
  - Elaine Johnson – Research Analysist Specialist Senior, CM/MCS

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

- A listing of 533,658 applicants who had an eligibility determination completed on or before June 30, 2016. We selected a sample of 95 cases to test the compliance with 45 CFR 155 Subpart D Eligibility and a second sample of 95 cases to test the compliance with 45 CFR 155 Subpart E Enrollment.
- A listing of all 152 appeals that were filed on or before June 30, 2016 and had not been resolved as of August 30, 2016. We reviewed and discussed the status of all these cases with MNsure to test compliance with 45 CFR 155 Subpart F Appeals.

CONFIDENTIAL INFORMATION OMITTED
N/A

FINDING #2016-001

Criteria:

Subpart D – Eligibility, 45 CFR §155.315 requires that a State-Based Marketplace (SBM) make a determination based upon the data provided by an applicant in the application, and data received from automated data sources. Under 45 CFR §155.315 (f), Minnesota Health Insurance Exchange d/b/a MNsure (the Exchange) must make a reasonable effort to identify and address any inconsistency between the self-attested data in the application and the information obtained from outside sources by contacting the applicant and requesting them to provide additional information to resolve the inconsistency.

Pursuant to 45 CFR §155.315, when the Exchange is unable to verify an applicant's self-attested data related to their social security number, citizenship, status as a national, or lawful presence, through applicable outside sources, the Exchange must provide the applicant with a period of 90 days from the date on which the notice regarding the inconsistency is received to provide satisfactory documentary evidence or resolve the inconsistency. The notice received date is defined as 5 days after the date on the notice unless the individual demonstrates that he or she did not receive the notice within the 5 day period. If the data inconsistency is related to information other than social security number, citizenship, status as a national, or lawful presence, the Exchange must provide an applicant with a period of 90 days from the date on which the notice is sent to the applicant to resolve the inconsistency.

Pursuant to 45 CFR §155.315 (f) (3), the Exchange can extend the period if an applicant demonstrates a good-faith effort to provide sufficient documentation to resolve the inconsistency. During this inconsistency period, an applicant (who is otherwise qualified) is eligible to enroll in a Qualified Health Plan and is eligible for insurance affordability programs (45 CFR § 155.315(f) (4)). If, after the 90-day timeframe (or applicable extensions), the Exchange is unable to resolve the discrepancy between the self-attested information and the outside sources with customer-provided information, then it must re-perform the eligibility calculations and notify the applicant of their new eligibility determination.

Condition and Context:

This is a repeat finding. There were a significant number of cases in which self-attested data was not properly verified within the required 90-day timeframe. The defined procedure requires MNsure to initially determine eligibility based upon the applicant's self-attested data in his or her application and subsequently verify that data through a match with the Federal Data Services Hub. In cases where there is no relevant data available within the Federal Data Services Hub, or the data is not reasonably compatible with the self-attested data (i.e., within defined parameters), MNsure is required to notify the applicant and ask for documentation to resolve the inconsistency. We sampled 95 cases to test MNsure's data verification process. Of the 95 cases reviewed, 53 cases (56%) initially had a verification flag and required verification of the self-attested data. Out of the 53 cases, 9 (10% of 95) resolved the inconsistency by submitting valid verification documents within the 90-day timeframe; 7 (7% of 95) did not receive an applicable

notification (see Finding #2016-004); and 36 (38% of 95) did not respond to the notification and were left with the verification flag open over the 90-day timeframe.

Cause:

MNsure utilizes the Federal Data Services Hub as the electronic source to verify applicant's self-attested data by checking records against various data sources, including federal tax return information, wage income reported by employers (TALX), social security income and citizenship (SSA), wages or unemployment income (DEED), alimony income (PRISM), the Systematic Alien Verification for Entitlements Program (SAVE), and federal incarceration records. When the electronic source data differs from verify the applicant's attested data, the applicant's account is flagged for verification, and a notice is generated and sent to the applicant, providing him or her 95 days from the date the notice is issued to resolve the inconsistency. When the applicant fails to resolve the data inconsistency within the given timeframe, MNsure's verification manual requires a manual procedure to clear the verification flag and enter a case note in Curam system. MNsure did not allocate appropriate resources to monitor the status of verification flags and enforce the proper steps that needed to be taken when the data inconsistency was not resolved after the 90-day period. A critical factor, resulting in the lack of adequate resources, was the absence of system functionality to support the automated processing of cases where verifications have not been received after the end of the reasonable opportunity period.

Effect:

The absence of adequate resources to ensure that discrepancies between self-attested data and data provided by external sources were resolved within the 90-day timeframe resulted in some cases retaining the eligibility status determined using the original self-attested data, without the completion of a verification process. In our sample of the 95 reviewed cases, the verification process was not completed within the required 90-day timeframe for 38% of the sample (36 cases). Had the verification process been completed, some of those cases may have been assigned a different eligibility status. If an applicant was enrolled in a Qualified Health Plan (QHP) and received Advanced Premium Tax Credit (APTC) eligibility inappropriately beyond the 90-day timeframe, they will reconcile their actual premium tax credit eligibility through the tax filing process. However, there is no recoupment of benefits if an applicant was enrolled in a QHP and incorrectly received Cost Sharing Reduction (CSR) benefits. Therefore, it is possible that, if MNsure had completed the verification process for all of the cases as required, some of the cases that received APTC or CSR would ultimately have been determined ineligible for such benefits.

FINDING #2016-002

Criteria:

Subpart D – Eligibility, 45 CFR §155.305(f) (1) (i) (B) states that an individual may not be eligible for APTC if they are eligible for minimum essential coverage. 45 CFR §155.305(g) (1) (B) states that a person may not be eligible for CSR if they are not also eligible for APTC.

Per 26 CFR 1.36B 2(c)(2)(iii), a special rule applies for coverage for veterans and other individuals under chapter 17 or 18 of title 38, U.S.C.: An individual is eligible for minimum essential coverage under a healthcare program under chapter 17 or 18 of title 38, U.S.C., only if the individual is enrolled in a healthcare program under chapter 17 or 18 of title 38, U.S.C., identified as minimum essential coverage in regulations issued under section 5000A, which includes TRICARE.

Pursuant to 45 CFR §155.320, the Exchange must verify whether an applicant reasonably expects to be enrolled in, or is eligible for, minimum essential coverage in the benefit year for which coverage is requested (45 CFR § 155.320(d)(1)(i)). As part of this process, the Exchange is required to verify whether the applicant has coverage through TRICARE and other government-sponsored programs by transmitting identifying information through the Federal Data Services Hub (45 CFR § 155.320(b)).

Condition and Context:

This is a repeat finding. We conducted testing to follow up on the previous year's #2015-2 audit finding regarding the cases determined eligible for APTC while having access to TRICARE. During fiscal year (FY) 2016, 4,636 filed applications that were processed to determine eligibility for insurance assistance received indicators from the Federal Data Services Hub that that the applicants might have access to minimum essential coverage. Out of the 4,636 cases, 4,334 cases were determined eligible for insurance assistance, as shown below. However, it was not determined how many of the 4,334 cases were enrolled in QHP and receiving APTC or CSR benefits.

	Eligibility Determination Result		
Minimum Essential Coverage	Eligible for Insurance Assistance	Not Eligible for Insurance Assistance	Grand Total
Basic Health Program	3	2	5
Medicare	23	10	33
Peace Corps	3	2	5
Tricare	4,295	288	4,583
Veterans Health Program	10		10
Grand Total	4,334	302	4,636

Cause:

The Affordable Care Act mandates that applicants be permitted 90 days to resolve an inconsistency. MNsure's policy was to issue a notice and request the applicant verify whether he or she, in fact, was eligible for minimum essential coverage. The Minnesota Eligibility Technology System (METS) did not appear to have sufficient controls in place to bar applicants who were eligible for, or enrolled in, minimum essential coverage from receiving APTC or CSR. This issue appears to be most prevalent with applications that indicated TRICARE eligibility.

Effect:

Veterans and other qualified individuals covered under chapter 17 or 18 of title 38, U.S.C, who enrolled in minimum essential coverage, and other individuals who were eligible for minimum essential coverage, were able to receive APTC or CSR, even though they were not entitled to that benefit.

FINDING #2016-003

Criteria:

Subpart F – Appeals, 45 CFR § 155.545 states that the appeal entity must issue a written notice of the appeal decision to the appellant within 90 days of the date of an appeal request under 155.520 (b) or (c) is received, as administratively feasible.

Minnesota Rules, Part 7700.0105, subpart 4 states that a person involved in a fair hearing, or the agency, may request a rescheduling ("continuance") of a hearing for a reasonable period of time. Additionally, subpart 16(F) allows the parties to submit evidence after the scheduled hearing under certain circumstances, and allows for an opportunity to the opposing party to review and respond to the new evidence ("continuance"). Subpart 4 lists the circumstances for which the appeals examiner may approve a requested continuance. The agency has adopted a long-standing practice that when a continuance request is approved, the approved time period for the continuance tolls the procedural clock.

Condition and Context:

There were delays in processing appeal information and submitting a written notice of the appeal decision to the appellant within the 90-day timeframe. A response was not deemed timely for all appeal requests. BerryDunn initially examined a sample of 10 appeals that were filed within FY2016 and were open beyond the 90-day timeframe. Two of these were resolved after the 90-day timeframe without a continuance. We expanded our sample to include all appeals that were open as of August 30, 2016, which was the date we obtained a list of all appeals filed within FY2016 from MNsure. BerryDunn identified that there were 152 MNsure-related appeals open as of August 30, 2016, and verified the status of these cases in February 2017. The status of these cases are summarized below.

	Resolved within 90 days	Resolved within the 90-day timeframe with continuance	Resolved after the 90-day timeframe/ Still open as of February 2017	Total
Number of appeals open as of August 30, 2016	50	78	24	152

We noted that there were cases where the appellant agreed with the appeal decision but the dispute was not formally identified as resolved until the appellant received verifiable proof from the carrier of the resolution. For these cases, the dispute may have been informally resolved within the 90-day timeframe, although the formal closed date was after the 90-day timeframe.

Cause:

MNsure and Department of Human Services (DHS) encountered a significant increase in the number of appeals filed with the State, arising out of the METS, throughout FY2016. The total number of appeals filed in FY2015 was 4,030, compared to the total number in FY2016 of 7,971, constituting a vast increase in appeals during the audited timeframe.[1] The table below shows the number of appeals filed, the percentage of increase in the number of appeals compared to the previous year, and the number of examiners available. As shown in the table, the number of appeals continuously increased throughout FY2016, having peaks in January and February with over 1,000 appeals filed. It is also apparent that while the number of appeals significantly increased, there was no commensurate increase in the number of appeal examiners.

	Number of MNsure-only related appeals filed	**Number of MNsure + Medicaid appeals filed**	**Number of Medicaid/ Medical Assistance-related appeals filed**	**Number of total appeals filed**	**% increase from the previous year**	**Number of examiners available (FTE)**
July 2015	111	94	144	349	203%	24
August	98	90	223	411	179%	24
September	83	87	174	344	195%	24
October	54	84	193	331	109%	23
November	45	116	203	364	241%	21
December	32	243	624	899	258%	21.5
January 2016	26	286	817	1129	330%	22.5
February	265	335	545	1145	214%	22.5
March	247	288	434	969	158%	23.5
April	179	241	270	690	162%	23.5
May	151	213	230	594	163%	23.5
June	147	239	360	746	202%	23.5
Total	**1,438**	**2,316**	**4,217**	**7,971**		

[1] These totals include appeals with only Medicaid eligibility issues, but which arise out of METS. The increase in appeals during FY2016 was not limited to MNsure eligibility issues; therefore the Medicaid appeals data is included to provide context regarding the scope of the underlying resource issue.

Effect:
The appeal decision must be implemented prospectively or retroactively. The lack of a response within the allotted timeframe delays the implementation of the appeal decision of those appeals that are not informally resolved. Therefore, this is delaying the State from amending an incorrect eligibility determination of appellants in those appeals that are not informally resolved and exceed 90 days from the date of appeal filing.

FINDING #2016-004

Criteria:
Subpart D – Eligibility, 45 CFR § 155.315 (f) (2) states that if the Exchange is unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, it must (i) Provide notice to the applicant regarding the inconsistency; and (ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

Condition and Context:
The defined procedure requires MNsure to initially determine eligibility based upon the applicant's self-attested data in his or her application and subsequently verify that data through a match with the Federal Data Services Hub. Where there is no relevant data available within the Federal Data Services Hub, or the data is not reasonably compatible with the self-attested data (i.e., with defined parameters), then MNsure is required to notify the consumer and ask for documentation to resolve the inconsistency. We sampled 95 cases to test MNsure's data verification process. Of the 95 cases reviewed, we observed 7 cases (7%) did not receive a notification regarding the need for additional information to resolve an inconsistency between the self-attested data and the data returned from the Federal Data Services Hub. Out of the seven cases, six received a Standard Eligibility Determination notice without the verification request. One case received a Pre-populated Auto Renewal Notice (PARN) notification without the verification request. In both instances, the applicants were not notified of the data inconsistency and were not given an opportunity to resolve the inconsistency.

Cause:
METS appears to have failed generating a data verification notice for these applicants, but it is not clear what caused this technical issue. MNsure is currently investigating the cause.

Effect:
Because a data inconsistency notification was not sent, these applicants were not aware of and not given a chance to resolve the inconsistency between the self-attested income and the income data from the Federal Data Services Hub. As a result, these cases retained the eligibility status determined using the self-attested data. Had the verification process been completed, some of those cases may have been assigned a different eligibility status.

AUDITOR'S OPINION

We have issued an Independent Auditor's Report on the Statement of Revenues and Expenditures for the Year Ended June 30, 2016, reflecting the following type of opinion: **N/A**

☐ QUALIFIED ☐ UNQUALIFIED ☐ ADVERSE ☐ DISCLAIMER

ADDITIONAL COMMENTS

N/A.

II. RECOMMENDATIONS

FINDING #2016-001

Recommendation:
We recommend that MNsure implement the corrective action plan provided in response to the previous year's audit findings to address the data inconsistencies as soon as possible.

FINDING #2016-002

Recommendation:
We recommend that MNsure implement processes and procedures to verify that applicants are not enrolled in TRICARE or any other insurance that meets the minimum essential coverage standard as a condition for determining eligibility for APTC and CSR.

FINDING #2016-003

Recommendation:
The number of appeals consistently increased throughout FY2016 and because there is no indication that this was a temporary growth, it is expected that the trend will continue; therefore, we recommend that MNsure develop a resource plan relative to examiner staffing levels that is consistent with the increasing number of appeals.

FINDING #2016-004

Recommendation:
We recommend that MNsure work with the system integrator to identify what caused METS to fail generating a verification notice for some cases, and address the identified issues accordingly.

III. 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: MAY 23, 2017

BerryDunn

MNsure

PROGRAMMATIC COMPLIANCE REPORT

For the Year Ended June 30, 2016

With Independent Accountant's Report

BerryDunn

INDEPENDENT ACCOUNTANT'S REPORT

To Management of Minnesota Health Benefits Exchange, d/b/a MNsure:

Report on Compliance

We have examined the compliance of Minnesota Health Insurance Exchange d/b/a MNsure (the Exchange), an agency within an enterprise fund of the State of Minnesota, with the requirements in Title 45, Part 155, Subparts D, E, F, K and M of the Code of Federal Regulations (CFR) during the year ended June 30, 2016. Management is responsible for the Exchange's compliance with those requirements. Our responsibility is to express an opinion on the Exchange's compliance based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Exchange complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Exchange complied with the specific requirements. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe that our examination provides a reasonable basis for our opinion.

Our examination does not provide a legal determination on the Exchange's compliance with specified requirements. Our examination disclosed the following material noncompliance with Title 45, Part 155, Subparts D, E, F, K and M applicable to the Exchange during the year ended June 30, 2016.

As described in the accompanying schedule of findings as Findings 2016-001 through 2016-004, during the year ended June 30, 2016 the Exchange did not comply with the requirements of Subparts of Title 45, Part 155 examined by us.

In our opinion, except for the material noncompliance described in the preceding paragraph, the Exchange complied, in all material respects, with the aforementioned requirements for the year that ended June 30, 2016.

The Exchange's responses to the findings identified in our examination of compliance are described in the accompanying schedule of findings. The Exchanges responses were not subjected to the procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated May 23, 2017 on our consideration of the Exchange's internal control over compliance with certain provisions of laws, regulations, contracts, and grant agreements. The purpose of that report is to describe the scope of our testing of internal control over compliance and the results of that testing, and not to provide an opinion on internal control over compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Exchange's internal control over compliance.

Management of Minnesota Health Benefits Exchange
d/b/a MNsure

Intended Use

This report is intended to describe the scope of our audit of compliance and the results of the audit based on attestation standards established by the AICPA and *Government Auditing Standards* and it is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
May 23, 2017

MINNESOTA HEALTH INSURANCE EXCHANGE D/B/A MNSURE

Schedule of Findings

Year Ended June 30, 2016

FINDING #2016-001

Criteria:
Subpart D – Eligibility, 45 CFR §155.315 requires that a State-Based Marketplace (SBM) make a determination based upon the data provided by an applicant in the application, and data received from automated data sources. Under 45 CFR §155.315(f), Minnesota Health Insurance Exchange d/b/a MNsure (the Exchange) must make a reasonable effort to identify and address any inconsistency between the self-attested data in the application and the information obtained from outside sources by contacting the applicant and requesting them to provide additional information to resolve the inconsistency.

Pursuant to 45 CFR §155.315, when the Exchange is unable to verify an applicant's self-attested data related to their Social Security number, citizenship, status as a national, or lawful presence, through applicable outside sources, the Exchange must provide the applicant with a period of 90 days from the date on which the notice regarding the inconsistency is received to provide satisfactory documentary evidence or resolve the inconsistency. The "notice received date" is defined as five days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period. If the data inconsistency is related to information other than Social Security number, citizenship, status as a national, or lawful presence, the Exchange must provide an applicant with a period of 90 days from the date on which the notice is sent to the applicant to resolve the inconsistency.

Pursuant to 45 CFR §155.315(f)(3), the Exchange can extend the period if an applicant demonstrates a good-faith effort to provide sufficient documentation to resolve the inconsistency. During this inconsistency period, an applicant (who is otherwise qualified) is eligible to enroll in a Qualified Health Plan and is eligible for insurance affordability programs (45 CFR §155.315(f)(4)). If, after the 90-day timeframe (or applicable extensions), the Exchange is unable to resolve the discrepancy between the self-attested information and the outside sources with customer-provided information, then it must re-perform the eligibility calculations and notify the applicant of their new eligibility determination.

Condition and Context:
This is a repeat finding. There were a significant number of cases in which self-attested data was not properly verified within the required 90-day timeframe. The defined procedure requires MNsure to initially determine eligibility based upon the applicant's self-attested data in his or her application and subsequently verify that data through a match with the Federal Data Services Hub. In cases where there is no relevant data available within the Federal Data Services Hub, or the data is not reasonably compatible with the self-attested data (i.e., within defined parameters), MNsure is required to notify the applicant and ask for documentation to resolve the inconsistency. We sampled 95 cases to test MNsure's data verification process. Of the 95 cases reviewed, 53 cases (56%) initially had a verification flag and required verification of the self-attested data. Out of the 53 cases, 9 (10% of 95) resolved the inconsistency by submitting valid verification documents within the 90-day timeframe; 7 (7% of 95) did not receive an applicable notification (see Finding #2016-004); and 36 (38% of 95) did not respond to the notification and were left with the verification flag open over the 90-day timeframe.

Cause:
MNsure utilizes the Federal Data Services Hub as the electronic source to verify applicant's self-attested data by checking records against various data sources, including federal tax return information, wage income reported by employers (TALX), Social Security income and citizenship (SSA), wages or unemployment income (DEED), alimony income (PRISM), the Systematic Alien Verification for Entitlements Program (SAVE), and federal incarceration records. When the electronic source data differs

from the applicant's attested data, the applicant's account is flagged for verification, and a notice is generated and sent to the applicant, providing him or her 95 days from the date the notice is issued to resolve the inconsistency. When the applicant fails to resolve the data inconsistency within the given timeframe, MNsure's verification manual requires a manual procedure to clear the verification flag and enter a case note in Curam system. MNsure did not allocate appropriate resources to monitor the status of verification flags and enforce the proper steps that needed to be taken when the data inconsistency was not resolved after the 90-day period. A critical factor, resulting in the lack of adequate resources, was the absence of system functionality to support the automated processing of cases where verifications have not been received after the end of the reasonable opportunity period.

Effect:
The absence of adequate resources to ensure that discrepancies between self-attested data and data provided by external sources were resolved within the 90-day timeframe resulted in some cases retaining the eligibility status determined using the original self-attested data, without the completion of a verification process. In our sample of the 95 reviewed cases, the verification process was not completed within the required 90-day timeframe for 38% of the sample (36 cases). Had the verification process been completed, some of those cases may have been assigned a different eligibility status. If an applicant was enrolled in a Qualified Health Plan (QHP) and received Advanced Premium Tax Credit (APTC) eligibility inappropriately beyond the 90-day timeframe, they will reconcile their actual premium tax credit eligibility through the tax filing process. However, there is no recoupment of benefits if an applicant was enrolled in a QHP and incorrectly received Cost Sharing Reduction (CSR) benefits. Therefore, it is possible that, if MNsure had completed the verification process for all of the cases as required, some of the cases that received APTC or CSR would ultimately have been determined ineligible for such benefits.

Recommendation:
We recommend that MNsure implement the corrective action plan provided in response to the previous year's audit findings to address the data inconsistencies as soon as possible.

MNsure Response:
MNsure agrees with this repeat finding. MNsure also notes that this is a repeat finding from the February 12, 2016, HHS OIG audit report on Minnesota's marketplace. This finding results from a lack of METS functionality to support reasonable opportunity period procedures, reporting functionality and MNsure staffing resources to process verifications. For instance, until recently, MNsure did not have an accurate METS report of cases with pending verifications (also known as inconsistencies) and identification of which verifications were outside of the reasonable opportunity period. MNsure continues to experience staffing shortages in this area, which has resulted in a backlog of unprocessed verifications.

In March 2016, MNsure implemented a two-phase plan to address the outstanding verification work needing to be completed. Phase 1 involved addressing citizenship, lawful presence, Social Security numbers and incarceration verifications. Phase 2 focused on verifications related to income and household composition. Both phases were suspended due to staffing pressures related to the 2017 open enrollment.

Corrective Action Plan: MNsure is re-initiating the two-phase plan described above. A report has been developed that identifies all verifications. Testing of the report continues with an anticipated implementation date of June 5, 2017. Dedicated operations staff have been hired to address the backlog of verifications.

Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

Scheduled Completion Date: In progress. To be determined.

FINDING #2016-002

Criteria:
Subpart D – Eligibility, 45 CFR §155.305(f)(1)(i)(B) states that an individual may not be eligible for APTC if they are eligible for minimum essential coverage. 45 CFR §155.305(g)(1)(B) states that a person may not be eligible for CSR if they are not also eligible for APTC.

Per 26 CFR 1.36B 2(c)(2)(iii), a special rule applies for coverage for veterans and other individuals under chapter 17 or 18 of title 38, U.S.C.: An individual is eligible for minimum essential coverage under a healthcare program under chapter 17 or 18 of title 38, U.S.C., only if the individual is enrolled in a healthcare program under chapter 17 or 18 of title 38, U.S.C., identified as minimum essential coverage in regulations issued under section 5000A, which includes TRICARE.

Pursuant to 45 CFR §155.320, the Exchange must verify whether an applicant reasonably expects to be enrolled in, or is eligible for, minimum essential coverage in the benefit year for which coverage is requested (45 CFR §155.320(d)(1)(i)). As part of this process, the Exchange is required to verify whether the applicant has coverage through TRICARE and other government-sponsored programs by transmitting identifying information through the Federal Data Services Hub (45 CFR §155.320(b)).

Condition and Context:
This is a repeat finding. We conducted testing to follow up on the previous year's #2015-002 audit finding regarding the cases determined eligible for APTC while having access to TRICARE. During fiscal year (FY) 2016, 4,636 filed applications that were processed to determine eligibility for insurance assistance received indicators from the Federal Data Services Hub that the applicants might have access to minimum essential coverage. Out of the 4,636 cases, 4,334 cases were determined eligible for insurance assistance, as shown below. However, it was not determined how many of the 4,334 cases were enrolled in QHP and receiving APTC or CSR benefits.

	Eligibility Determination Result		
Minimum Essential Coverage	Eligible for Insurance Assistance	Not Eligible for Insurance Assistance	Grand Total
Basic Health Program	3	2	5
Medicare	23	10	33
Peace Corps	3	2	5
Tricare	4,295	288	4,583
Veterans Health Program	10		10
Grand Total	4,334	302	4,636

Cause:
The Affordable Care Act mandates that applicants be permitted 90 days to resolve an inconsistency. MNsure's policy was to issue a notice and request the applicant verify whether he or she, in fact, was eligible for minimum essential coverage. The Minnesota Eligibility Technology System (METS) did not appear to have sufficient controls in place to bar applicants who were eligible for, or enrolled in, minimum essential coverage from receiving APTC or CSR. This issue appears to be most prevalent with applications that indicated TRICARE eligibility.

Effect:
Veterans and other qualified individuals covered under chapter 17 or 18 of Title 38, U.S.C, who enrolled in minimum essential coverage, and other individuals who were eligible for minimum essential coverage, were able to receive APTC or CSR, even though they were not entitled to that benefit.

Recommendation:
We recommend that MNsure implement processes and procedures to verify that applicants are not enrolled in TRICARE or any other insurance that meets the minimum essential coverage standard as a condition for determining eligibility for APTC and CSR.

MNsure Response:
MNsure agrees with this repeat finding and we are working with our MNIT and IT vendor partners on this issue.

Corrective Action Plan: MNsure continues to evaluate this issue.

Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

Scheduled Completion Date: To be determined.

FINDING #2016-003

Criteria:
Subpart F – Appeals, 45 CFR §155.545 states that the appeal entity must issue a written notice of the appeal decision to the appellant within 90 days of the date of an appeal request under 155.520(b) or (c) is received, as administratively feasible.

Minnesota Rules, Part 7700.0105, subpart 4 states that a person involved in a fair hearing, or the agency, may request a rescheduling ("continuance") of a hearing for a reasonable period of time. Additionally, subpart 16(F) allows the parties to submit evidence after the scheduled hearing under certain circumstances, and allows for an opportunity to the opposing party to review and respond to the new evidence ("continuance"). Subpart 4 lists the circumstances for which the appeals examiner may approve a requested continuance. The agency has adopted a long-standing practice that when a continuance request is approved, the approved time period for the continuance tolls the procedural clock.

Condition and Context:
There were delays in processing appeal information and submitting a written notice of the appeal decision to the appellant within the 90-day timeframe. A response was not deemed timely for all appeal requests. BerryDunn initially examined a sample of ten appeals that were filed within Fiscal Year (FY) 2016 and were open beyond the 90-day timeframe. Two of these were resolved after the 90-day timeframe without a continuance. We expanded our sample to include all appeals that were open as of August 30, 2016, which was the date we obtained a list of all appeals filed within FY2016 from MNsure. BerryDunn identified that there were 152 MNsure-related appeals open as of August 30, 2016, and verified the status of these cases in February 2017. The status of these cases are summarized below.

	Resolved within 90 days	Resolved within the 90-day timeframe with continuance	Resolved after the 90-day timeframe/ Still open as of February 2017	Total
Number of appeals open as of August 30, 2016	50	78	24	152

We noted that there were cases where the appellant agreed with the appeal decision, but the dispute was not formally identified as resolved until the appellant received verifiable proof from the carrier of the resolution. For these cases, the dispute may have been informally resolved within the 90-day timeframe, although the formal closed date was after the 90-day timeframe.

Cause:

MNsure and Department of Human Services (DHS) encountered a significant increase in the number of appeals filed with the State, arising out of the METS, throughout FY2016. The total number of appeals filed in FY2015 was 4,030, compared to the total number in FY2016 of 7,971, constituting a vast increase in appeals during the audited timeframe.[1] The table below shows the number of appeals filed, the percentage of increase in the number of appeals compared to the previous year, and the number of examiners available. As shown in the table, the number of appeals continuously increased throughout FY2016, having peaks in January and February with over 1,000 appeals filed. It is also apparent that while the number of appeals significantly increased, there was no commensurate increase in the number of appeal examiners.

	Number of MNsure-only related appeals filed	Number of MNsure + Medicaid appeals filed	Number of Medicaid/ Medical Assistance-related appeals filed	Number of total appeals filed	% increase from the previous year	Number of examiners available (FTE)
July 2015	111	94	144	349	203%	24
August	98	90	223	411	179%	24
September	83	87	174	344	195%	24
October	54	84	193	331	109%	23
November	45	116	203	364	241%	21
December	32	243	624	899	258%	21.5
January 2016	26	286	817	1129	330%	22.5
February	265	335	545	1145	214%	22.5
March	247	288	434	969	158%	23.5
April	179	241	270	690	162%	23.5
May	151	213	230	594	163%	23.5
June	147	239	360	746	202%	23.5
Total	**1,438**	**2,316**	**4,217**	**7,971**		

Effect:

The appeal decision must be implemented prospectively or retroactively. The lack of a response within the allotted timeframe delays the implementation of the appeal decision of those appeals that are not informally resolved. Therefore, this is delaying the State from amending an incorrect eligibility determination of appellants in those appeals that are not informally resolved and exceed 90 days from the date of appeal filing.

[1] These totals include appeals with only Medicaid eligibility issues, but which arise out of METS. The increase in appeals during FY2016 was not limited to MNsure eligibility issues; therefore the Medicaid appeals data is included to provide context regarding the scope of the underlying resource issue.

Recommendation:
The number of appeals consistently increased throughout FY2016 and because there is no indication that this was a temporary growth, it is expected that the trend will continue; therefore, we recommend that MNsure develop a resource plan relative to examiner staffing levels that is consistent with the increasing number of appeals.

MNsure Response:
MNsure agrees with this finding that in FY2016, a number of decisions were issued untimely. MNsure also agrees with the stated context that the number of appeals consistently increased throughout FY2016.

Corrective Action Plan: While eligibility appeals may be traditionally adversarial, MNsure has built its eligibility appeals process as an extension of its customer service. MNsure's appeals process has become much more of a dispute resolution practice than an oppositional forum. In FY2016, 47.09% of all MNsure appeals were withdrawn before an appeals judge issued a decision. Only 18.66% of all MNsure appeals are substantively decided by an appeals judge. Based on reporting for FY2016, the average actual elapsed time for MNsure appeals was 58.9 - 65.4 days.

Nevertheless, MNsure agrees with the recommendation herein and is committed to improving its processes and consumer experience. MNsure will work with its contracted appeals adjudication vendor, DHS, to ensure a resource plan.

Responsible MNsure Official: David Rowley, General Counsel/Chief Compliance Officer.

Scheduled Completion Date: To be determined.

FINDING #2016-004

Criteria:
Subpart D – Eligibility, 45 CFR §155.315(f)(2) states that if the Exchange is unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, it must (i) provide notice to the applicant regarding the inconsistency; and (ii) provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

Condition and Context:
The defined procedure requires MNsure to initially determine eligibility based upon the applicant's self-attested data in his or her application and subsequently verify that data through a match with the Federal Data Services Hub. Where there is no relevant data available within the Federal Data Services Hub, or the data is not reasonably compatible with the self-attested data (i.e., with defined parameters), then MNsure is required to notify the consumer and ask for documentation to resolve the inconsistency. We sampled 95 cases to test MNsure's data verification process. Of the 95 cases reviewed, we observed seven cases (7%) did not receive a notification regarding the need for additional information to resolve an inconsistency between the self-attested data and the data returned from the Federal Data Services Hub. Out of the seven cases, six received a Standard Eligibility Determination notice without the verification request. One case received a Pre-populated Auto Renewal Notice (PARN) notification without the verification request. In both instances, the applicants were not notified of the data inconsistency and were not given an opportunity to resolve the inconsistency.

Cause:
METS appears to have failed generating a data verification notice for these applicants, but it is not clear what caused this technical issue. MNsure is currently investigating the cause.

Effect:
Because a data inconsistency notification was not sent, these applicants were not aware of and not given a chance to resolve the inconsistency between the self-attested income and the income data from the Federal Data Services Hub. As a result, these cases retained the eligibility status determined using the self-attested data. Had the verification process been completed, some of those cases may have been assigned a different eligibility status.

Recommendation:
We recommend that MNsure work with the system integrator to identify what caused METS to fail generating a verification notice for some cases, and address the identified issues accordingly.

MNsure Response:
MNsure agrees with this finding.

Corrective Action Plan: MNsure has entered METS defect tickets for both the missing verifications on the Standard Eligibility Determination notice and pre-populated Auto Renewal Notice.

Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

Scheduled Completion Date: To be determined.

BerryDunn

REPORT ON INTERNAL CONTROL OVER COMPLIANCE
REQUIRED BY *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Minnesota Health Benefits Exchange
d/b/a MNsure

We have examined, in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States, Minnesota Health Benefits Exchange d/b/a MNsure's (the Exchange), an agency within an enterprise fund of the State of Minnesota, with the requirements in Title 45, Part 155, Subparts D, E, F, K, and M of the Code of Federal Regulations during the year ended June 30, 2016. Our examination for Subpart K was limited to a review of the Exchange's policies and procedures to test whether those policies and procedures are in compliance with the programmatic requirements under that Subpart. We have issued our report on the Exchange's compliance with the above stated requirements dated May 23, 2017**,** which contained a modified opinion due to material noncompliance with these requirements.

Management of the Exchange is responsible for establishing and maintaining effective internal control over compliance with the compliance requirements described in Title 45, Part 155, Subparts D, E, F, K, and M of the Code of Federal Regulations. In planning and performing our audit of compliance, we considered the Exchange's internal control over compliance with the types of requirements described above to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance with those requirements, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Exchange's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We consider the deficiencies in internal control over compliance described in the accompanying schedule of findings as Findings 2016-001 through 2016-004 to be material weaknesses.

The Exchange's response to the internal control over compliance findings identified in our audit is described in the accompanying schedule of findings. The Exchange's response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of *Government Auditing Standards*. Accordingly, this report is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
May 23, 2017

MNsure℠
Where you choose health coverage

June 1, 2017

CDR John Maynard, Ph.D., BCD
State Exchange Group
Division of State Operations
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)

Dear CDR Maynard,

Enclosed is the *Independent External Audit: 2016 Audit Findings Report, Minnesota* which was completed by the auditing firm of Berry Dunn McNeil & Parker, LLC ("Berry Dunn"). As you know, we welcome this annual review and view it as part of an ongoing process of improvement of MNsure as well as the Minnesota Eligibility Technology System ("METS").

MNsure agrees with the findings in the report and our response and corrective action plan for each finding is attached.

Minnesota has the highest rate of health coverage in state history, with 96 percent of Minnesotans having health coverage—among the best in the nation. Through the end of 2017, Minnesotans are projected to save more than $300 million through tax credits, thanks to financial help only available through MNsure.

MNsure also has made dramatic improvements to the consumer experience. We recently completed a record-setting fourth open enrollment period. During that time, MNsure consumers continued to see strong, steady improvements. Evidence of this includes:

- As of April 16, 2017, we have enrolled 124,646 consumers in qualified health plans (QHP). Additionally, Minnesota also set a record for public program enrollments with 50,039 Minnesotans enrolled in MinnesotaCare and 219,142 enrolled in Medical Assistance.
- Approximately 65 percent of MNsure enrollees are receiving tax credits.
- Nearly 2,000 navigators, brokers and other assisters statewide were in place to help consumers enroll.
- We have a strong, multi-agency project management team and decision-making process in place to set priorities.
- We have a deep commitment to transparency and accountability.
- We are listening, and our partners and stakeholders are informed and engaged with us as we continue to grow and improve.

The work to improve MNsure not only includes this organization, but also the dedicated staff at the Minnesota Department of Human Services (DHS) and the Office of MNIT Services (MNIT). We are grateful for their partnership and look forward to continuing our work together.

We continue to take our responsibility to be an accountable and transparent organization seriously. We have been working as an organization since early 2014 to proactively identify and make improvements to all areas of MNsure, including those documented in various state and federal audit reports completed on MNsure.

Reviews such as this one are important tools for us to improve. In the interest of transparency and accountability, we will continue to make necessary adjustments to the organization, while maintaining our focus on improving the consumer experience.

Finally, we thank Berry Dunn for the work that has been done on this review.

Sincerely,

Allison O'Toole
Chief Executive Officer

MNsure Responses

A. Detailed Responses to Findings

1. Finding #2016-001

MNsure Response: MNsure agrees with this repeat finding. MNsure also notes that this is a repeat finding from the February 12, 2016, HHS OIG audit report on Minnesota's marketplace. This finding results from a lack of METS functionality to support reasonable opportunity period procedures, reporting functionality and MNsure staffing resources to process verifications. For instance, until recently, MNsure did not have an accurate METS report of cases with pending verifications (also known as inconsistencies) and identification of which verifications were outside of the reasonable opportunity period. MNsure continues to experience staffing shortages in this area, which has resulted in a backlog of unprocessed verifications.

In March 2016, MNsure implemented a two-phase plan to address the outstanding verification work needing to be completed. Phase 1 involved addressing citizenship, lawful presence, Social Security numbers and incarceration verifications. Phase 2 focused on verifications related to income and household composition. Both phases were suspended due to staffing pressures related to the 2017 open enrollment.

Corrective Action Plan: MNsure is re-initiating the two-phase plan described above. A report has been developed that identifies all verifications. Testing of the report continues with an anticipated implementation date of June 5, 2017. Dedicated operations staff have been hired to address the backlog of verifications.

Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

Scheduled Completion Date: In progress. To be determined.

2. Finding #2015-002

MNsure Response: MNsure agrees with this repeat finding and we are working with our MNIT and IT vendor partners on this issue.

Corrective Action Plan: MNsure continues to evaluate this issue.

Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

Scheduled Completion Date: To be determined.

3. **Finding #2015-003:**

   MNsure Response: MNsure agrees with this finding that in FY2016, a number of decisions were issued untimely. MNsure also agrees with the stated context that the number of appeals consistently increased throughout FY2016.

   Corrective Action Plan: While eligibility appeals may be traditionally adversarial, MNsure has built its eligibility appeals process as an extension of its customer service. MNsure's appeals process has become much more of a dispute resolution practice than an oppositional forum. In FY2016, 47.09% of all MNsure appeals were withdrawn before an appeals judge issued a decision. Only 18.66% of all MNsure appeals are substantively decided by an appeals judge. Based on reporting for FY2016, the average actual elapsed time for MNsure appeals was 58.9 - 65.4 days.

   Nevertheless, MNsure agrees with the recommendation herein and is committed to improving its processes and consumer experience. MNsure will work with its contracted appeals adjudication vendor, DHS, to ensure a resource plan.

   Responsible MNsure Official: David Rowley, General Counsel/Chief Compliance Officer.

   Scheduled Completion Date: To be determined.

4. **Finding #2015-004:**

   MNsure Response: MNsure agrees with this finding.

   Corrective Action Plan: MNsure has entered METS defect tickets for both the missing verifications on the Standard Eligibility Determination notice and pre-populated Auto Renewal Notice.

   Responsible MNsure Official: Nathan Clark, Chief Operating Officer.

   Scheduled Completion Date: To be determined.