Performance Audit of Centers for Medicare and Medicaid Services (CMS) Rule 9957 Requirements
For the Year Ending June 30, 2017

Commonwealth Health Insurance Connector Authority

EideBailly®

May 14, 2018

Louis Gutierrez Executive Director
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, Massachusetts 02108

Dear Mr. Gutierrez:

This report presents the results of Eide Bailly LLP's (Eide Bailly) work conducted to address the performance audit (the Audit) objectives of our signed statement of work dated November 16, 2017, related to the Commonwealth Health Insurance Connector Authority's (CCA) compliance with Centers for Medicare and Medicaid Services (CMS) Rule 9957 (45 C.F.R.§155) requirements. We conducted our test work during the period January 8, 2018 through April 20, 2018, and our results, reported herein, are for the period July 1, 2016 - June 30, 2017.

We conducted this Audit in accordance with Generally Accepted Government Auditing Standards (GAGAS) issued by the Comptroller General of the United States. Those standards require that we plan and perform the Audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and recommendations based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and recommendations based on our audit objectives.

We have evaluated GAGAS independence standards for the Audit and affirm that we are independent of CCA and the relevant subject matter to perform this engagement.

Attached to this letter is our report detailing the background, objective, scope, approach, findings, and recommendations as they relate to the Audit.

Based upon the audit procedures performed and the results obtained, we have met our audit objectives. Due to the exceptions noted in detail in this report, we documented findings that could increase CCA's risk of ineffective oversight and program integrity practices.

This Audit did not constitute an audit of financial statements in accordance with GAGAS or U.S. Generally Accepted Auditing Standards. Eide Bailly was not engaged to, and did not, render an opinion on the CCA's internal controls over financial reporting or over financial management systems.

This report is intended solely for the information and use of the CCA and CMS and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Eide Bailly LLP

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Executive Summary

In this section, we provide a summary of the detailed report to follow on the Commonwealth Health Insurance Connector Authority's (CCA) background, objective, scope, approach, and summary of results and findings related to this Audit. The remainder of this document details the audit methodology as well as the findings and recommendations that resulted from our test work.

Background

The Patient Protection and Affordable Care Act (ACA) was enacted by the U.S. Congress on October 23, 2010 and established the framework for the operation of health insurance Exchanges. Specific regulations were further detailed in the Centers for Medicare and Medicaid Services (CMS) Final Rule 9957, published July 19, 2013 and incorporated into 45 C.F.R. §155. In accordance with general program integrity and oversight requirements, 45 C.F.R. §155.1200 requires entities operating as state-based marketplaces (SBMs) to engage an independent qualifying auditing entity that follows generally accepted government auditing standards to perform an annual independent external performance audit. The SBM must ensure that the Audit addresses compliance with Rule 9957 generally and specifically with program integrity and oversight requirements, processes and procedures designed to prevent improper eligibility determinations and enrollment transactions, and identification of errors that have resulted in incorrect eligibility determinations. The SBM is required to provide the results of the performance audit to CMS and publish a public summary of the results.

CCA was created in 2006 pursuant to Massachusetts General Laws Chapter 176Q and is an independent public authority responsible for facilitating the availability, choice, and adoption of private health insurance plans to eligible individuals and groups. With major ACA provisions effective as of January 1, 2014, CCA was designated as the SBM for Massachusetts. CCA administers ACA programs for Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs) for eligible individuals, performs eligibility determinations for federal and state subsidies and cost-sharing reductions, administers a Small Business Health Options Program (SHOP), and administers a Navigator program providing grants to community organizations that assist individuals and small businesses with enrollment. CCA has also taken on the responsibility of premium billing collections and remittance to issuers.

CCA personnel perform various business administration, program oversight, and support functions (e.g., finance, legal, communications, public policy and outreach, plan management, operations and information technology (IT), and member appeals). CCA contracts portions of its operations to private vendors (e.g., customer service and call center operations, select financial processing activities, some IT development and maintenance, and SHOP operations) and relies on other public agencies and their private vendors to provide other key services relating to core IT systems.

Objective

The objective of this Audit was to assess CCA's compliance with 45 C.F.R. §155 regulations for the period July 1, 2016 - June 30, 2017.

Eide Bailly LLP (Eide Bailly) was responsible for performing the Audit in accordance with Generally Accepted Government Auditing Standards (GAGAS) and preparing a written report communicating the results of the Audit, including relevant findings and recommendations. These results may include deficiencies in processes that are significant within the context of the objective of the Audit, any identified instances of fraud or potential illegal acts (unless they are inconsequential within the context of the audit objectives), significant violations of provisions of contracts and grant agreements, and significant abuse that may have been identified as a result of this engagement.

Scope

Program areas subject to audit included processes over:

- Eligibility
- Enrollment
- Financial Processing
- Oversight and Program Integrity Standards
- Qualified Health Plan Certification
- General Exchange Functions, including:
    - Call Center
    - Human Resources (HR) and Training
    - Data and Records Management
    - Navigators and Assisters

Approach

The performance audit was conducted in the following phases: Planning, Pre-Audit, Fieldwork, and Verification and Reporting. Each phase is described below and in the following pages:

- **Planning**: Our performance audit planning included meeting with representatives of the CCA to begin the project, introduce the core team, validate our understanding and the overall scope of the performance audit, confirm functional areas to be included in the performance audit, and develop a tailored performance audit program.

- **Pre-Audit**: This phase included meeting with CCA process owners to initiate the performance audit; refine our understanding of CCA's activities, and processes during the performance audit period; obtain supporting documentation; and conduct preliminary test work.

- **Fieldwork**: This phase consisted of reviewing and testing specific procedures to assess CCA's compliance with regulatory criteria and design and operating effectiveness of select supporting processes within the Eligibility, Enrollment, Financial Processing, and General Exchange functions.

- **Verification and Reporting**: This phase consisted of developing draft findings and recommended improvements, validating the draft findings with CCA process owners, and discussing CCA's plans for corrective action.

Summary of Results and Findings

As a result of our procedures, Eide Bailly identified the following findings relating to specific processes and compliance. These are summarized on the following pages. Those findings that appear to have been remediated, if any, have been designated as such.

In addition, these findings are explained in greater detail and organized by condition, criteria, cause, effect, and recommendation in the Findings and Recommendations section of this report.

Finding #2017-01 PPACA 1311(e)(3)(b) Use of Plain Language.
PPACA 1311(e)(3)(b) requires the use of plain language in order to assist members in making informed and competent decisions. The Ombudsman website instructs members to not enter any personal information including name, social security or date of birth. The form has the following required fields First Name, Last Name, Date of Birth and last four digits of the social security number. (**Remediated**)

Finding #2017-02 Federal Cost Share Reduction (CSR) Reconciliation
The current Massachusetts cost sharing program involves obtaining the federal Cost Share Reduction (CSR) reconciliation that is to be submitted to CMS by the issuers. The file is edit checked for total members and other high level indications of potential errors. The results of adjustments by CMS of data validation audits or other audits is not obtained by the Connector. These steps could potentially identify overpayments to Issuers if they were in place.

Finding #2017-03 Prominently Posting Rate Justifications
45 CFR Section 155 Subpart K 155.1020(a) requires that the Exchange must ensure that the QHP issuer has prominently posted the rate justification on its website. While the Exchange ensured the rate justification was posted on its website and the Department of Insurance also had rate justifications prominently posted on its website, the QHP issuers did not appear to have rate justifications prominently posted on their websites.

Finding #2017-04 Minimum Essential Coverage (MEC)
During program eligibility testing the Minimum Essential Coverage (MEC) displayed while the applicant was shopping was incorrect for one of the eighty applications sampled. Even though the MEC displayed was incorrect the applicant's enrollment was not impacted. Additional tests revealed the resulting enrollment was compliant with 45 C.F.R.§155.305. (**Remediated**)

Finding #2017-05 Qualified Program
During program eligibility testing the qualified program displayed while the applicant was shopping was incorrect for one of the eighty applications sampled. Even though the qualified program displayed was incorrect the applicant's enrollment was not impacted. Additional testing revealed the resulting enrollment was compliant with 45 C.F.R.§155.305. (**Remediated**)

Objective, Scope, and Approach

Objective

Eide Bailly was engaged to perform an Audit in accordance with both 45 C.F.R. §155.1200(c) and GAGAS to assess the CCA's compliance with 45 C.F.R. §155 regulations for the fiscal year ended June 30, 2017.

Eide Bailly was responsible for preparing a written report communicating the results of the Audit, including relevant findings and recommendations. These results should include deficiencies in processes that are significant within the context of the objectives of the Audit, any identified instances of fraud or potential illegal acts (unless they are inconsequential within the context of the audit objectives), and significant abuse that was identified as a result of this engagement.

In accordance with GAGAS, Eide Bailly was also required in certain circumstances to report fraud, illegal acts, and violations of provisions of contracts or grant agreements, or abuse that we may detect as a result of this engagement, directly to parties outside the auditee.

Scope

Eide Bailly was engaged to assess CCA's compliance with 45 C.F.R. §155 regulations for the fiscal year ended June 30, 2017 and our procedures were limited to the following areas:

Audit Area	Representative Tasks	Sample Documentation
Eligibility	• Interview process owners and review process control documentation. • Conduct process walk-throughs to identify and classify key processes for testing including verification of basic applicant data, MAGI eligibility, account update procedures, exemption requests, and reporting to federal and state agencies. • Select samples to test design and effectiveness of key processes and document any findings and recommendations.	• Documentation such as policies and procedures for eligibility determinations, account updates and terminations, etc. • Management reports applications and eligibility determinations activity • Member applications paper, electronic

Enrollment	• Interview process owners and review process control documentation.
	• Conduct process walk-throughs to identify safeguards over enrollment actions such as:
	  ◦ Enrolling individuals in QHP offerings
	  ◦ Generating and correctly populating Forms 834
	  ◦ Reporting.
	• Select samples to test design and effectiveness of key processes and document any findings and recommendations.
		• Documentation such as policies and procedures for new members, terminations, status changes, etc.
		• Reconciliations with QHP issuers and CMS

Audit Area	Representative Tasks	Sample Documentation
Financial Processing	• Interview financial process owners and review process control documentation. • Conduct process walk-throughs to review and understand the calculations and reporting of QHP premiums and payments, federal and state APTC/CSR calculations, and associated payment reconciliation activity, suspense payments, and related reporting. • Select samples to test design and effectiveness of key processes and document any findings and recommendations.	• Internal financial policies and procedures • Financial reports such as billing reports, FMS enrollment reports, carrier payment reconciliations, etc.
General Exchange Functions	• Interview process owners of key roles in the target general exchange functions e.g., call center compliance management, training, data/records maintenance, and Navigator/Assistors. • Review process control documentation for these functions. • Conduct process walk-throughs to identify and classify key processes for testing. • Select samples to test design and effectiveness of key processes and document any findings and recommendations.	• Documentation and policies and procedures on general Exchange functions • Customer Service Representative performance reports • CCA employee training records

Eide Bailly reviewed documents, performed inquiries, observed processes, conducted walk-throughs, reviewed applicable third-party reports, and held interviews with CCA management and key process owners who perform select program functions.

Eide Bailly identified processes and controls through walk-throughs with CCA process owners relating to applicable program requirements and identified gaps based on process objectives and associated risks. Eide Bailly conducted Tests of Design to consider whether the processes, individually or in combination with others, is capable of effectively preventing or detecting and correcting noncompliance as well as substantive tests based on risk and tests of processes surrounding eligibility and enrollment to consider whether the process was implemented and operated in a manner appropriate to accomplish its objective. We tested identified processes and oversight activities within the audit scope and identified findings indicating process deficiencies.

Specific to 45 C.F.R. §155.1200(c), the scope of work was designed to assess overall compliance with 45 C.F.R. §155, CCA's processes and procedures designed to identify the functions of the exchange as defined within the statute.

Additionally, CCA contracted for a limited scope from the previous audit. Information technology privacy and security was excluded from the current year scope. The scope was not included in the minimum requirements included in 45 C.F.R. §155. In addition the Small Business Health Options Program (SHOP) was excluded from the scope. A confirmation from a regional contact from CMS to CCA confirmed the scope limitations were appropriate.

Approach

The performance audit was conducted in the following phases: Planning, Pre-Audit, Fieldwork, and Verification and Reporting. Each phase is described below.

Planning

The first phase of this project involved embedding performance audit project management protocols to effectively conduct the audit, manage stakeholder expectations, and execute communications protocols from the outset.

A formal project kickoff meeting was held to introduce key CCA stakeholders to the Eide Bailly engagement team and confirm our mutual understanding of the performance audit scope and objectives. During the course of the performance audit, regular status meetings were also conducted with the CCA Compliance Manager.

Pre-Audit

Following planning, this phase involved further developing our understanding of CCA's activities and processes and controls for the performance audit period and developing our performance audit approach. Specifically, we performed the following tasks:

- Reviewed existing documentation: We obtained background documentation from CCA process owners including, where applicable, policies and procedures, process flows, sample management reports, and other background documentation. We reviewed this documentation to augment and refine our understanding of CCA's processes and activities.

- Conducted interviews, walkthroughs, and high-level process reviews: We met with relevant CCA process owners, line management, and staff to expand our understanding of the specific and general Exchange functions identified in our performance audit scope. We sought to develop our understanding of the interactions, respective duties, and responsibilities of key roles in targeted general function areas and corresponding key procedures.

Fieldwork

This phase consisted of finalizing our performance audit program and executing tests of CCA's processes and compliance with regulatory requirements within 45 C.F.R. §155. This involved the following activities:

- Reviewing and testing specific procedures to assess the processes around Financial Processing activities, including premium billing, member payment and refund processing, transaction reporting to health insurance carriers, management review and reconciliation procedures, and Exchange sustainability protocols
- Reviewing and testing safeguards over member eligibility determinations
- Reviewing and testing safeguards over enrollment actions such as enrolling individuals in QHP offerings and generating enrollment reporting forms
- Reviewing and testing specific procedures relating to oversight and financial integrity responsibilities of general Exchange functions, including call center operations and vendor management, governance activities, navigator and assister programs, and QHP/QDP certification.

Verification and Reporting

This phase consisted of validating the draft findings with CCA process owners, developing findings and recommendations for improvement, and obtaining CCA's plans for corrective action. Our detailed findings are documented below in the Results section.

Procedures and Methodology

We reviewed the requirements of 45 C.F.R. §155 to identify performance audit objectives relevant to CCA's Exchange functions. We performed this engagement in accordance with GAGAS and developed performance audit programs and testing procedures in accordance with GAGAS and Eide Bailly performance audit methodologies.

Document Review, Interview, and Walk-Through Procedures

We reviewed CMS Final Rule 9957 and associated regulations under 45 C.F.R. §155 to identify compliance requirements subject to this performance audit. Eide Bailly worked with CCA management to identify process owners for key activities and performed interviews and walk-throughs to document processes existing during the performance audit period. Based on this information, Eide Bailly requested supporting documentation to help confirm our understanding of the processes identified and developed audit procedures to test the design and operating effectiveness of selected processes.

Sample Testing Approach

In support of testing the design and effectiveness of select processes, Eide Bailly made sample selections of transactions and other activities to perform test procedures. One of the factors that one may consider necessary when determining the extent of evidence necessary to persuade us that the process is effective is the risk of failure of the process. As the risk of failure of the process decreases, the evidence that we obtain also decreases. Conversely, as the risk of failure of the process increases, the evidence we obtain also increases such that we might choose to obtain more persuasive audit evidence or otherwise adjust testing procedures. This allows us to vary the evidence obtained for each individual process based on the risk of failure of the individual process.

Consideration of Fraud, Illegal Acts, Misconduct, and Abuse

In planning the performance audit, we had a responsibility to gather and review information to identify and assess the risk of fraud occurring that is significant within the context of the performance audit objectives. When fraud risk factors were identified that the engagement team believed were significant within the context of the performance audit objectives, we had the responsibility to design procedures to provide reasonable assurance of detecting if such fraud occurred or is likely to have occurred. Assessing the risk of fraud is an ongoing process throughout the performance audit and relates not only to planning the Audit but also to evaluating evidence obtained during the performance audit. We considered the risks of potential fraud, misconduct, and abuse within each testing area and adjusted testing procedures and sample sizes accordingly based on potential risks. Examples of approach modifications we applied for higher-risk testing areas included increasing sample size, adjusting timing of testing procedures to focus on higher-risk periods, applying judgmental selection of samples, applying analytic procedures, and applying more precise tests.

Results – Findings and Recommendations

In accordance with GAGAS, Eide Bailly prepared this report communicating the results of the completed Audit, including relevant findings and recommendations. The findings presented as part of this engagement are restricted to the use stipulated in our contract. We disclaim any intention or obligation to update or revise the findings whether as a result of new information, future events, or otherwise. Should additional documentation or other information become available that impacts the findings reached in our deliverable, we reserve the right to amend our findings and summary documents accordingly.

Summary of Findings

Our detailed findings are noted below. Please note that each finding is split into five areas:

1. **Condition:** Explains the issue found as part of the audit
2. **Criteria:** Explains the requirements related to the issue and a determination of how criteria and processes should be executed
3. **Cause:** Assessment of the source of the risk area
4. **Effect:** Potential result if the condition continues
5. **Recommendations:** A short discussion on what should be done to improve the identified condition

As a result of our audit procedures, we identified findings relating to specific processes that were subject to review. These findings are detailed further below and organized by condition, criteria, cause, effect, and recommended corrective action.

CMS Rule 9957 generally requires state-based Exchanges to perform oversight and financial integrity activities over Exchange operations, keep an accurate accounting of receipts and expenditures, and perform monitoring and reporting activities on Exchange-related activities. Eide Bailly identified processes through our walk-throughs with CCA process owners and identified gaps based on process objectives and associated risks. We tested identified processes and oversight activities within the audit scope and identified several findings indicating process deficiencies. These deficiencies could increase CCA's risks of ineffective oversight and program integrity practices.

Finding #2017-01 PPACA 1311(e)(3)(b) Use of Plain Language

Condition: The Ombudsman Contact Form on the Health Connector website instructs members to not enter any personal information including name, social security or date of birth. The form then has the following required fields First Name, Last Name, Date of Birth and last four digits of the social security number.

Criteria: PPACA 1311(e)(3)(b) requires the use of plain language in order to assist members in making informed decisions.

Cause: The website development and change management quality assurance process (QA) did not identify the anomaly.

Effect: Users of the website may not understand the instructions which may lead to erroneous entries or increase the number of calls for assistance.

Recommendation: Update the website development and change management quality assurance process.

CCA Response: The Health Connector has changed the wording in the instructions on the Ombudsman Contact Form to ensure there are no contradictory statement with the information that is requested. This was resolved during the fiscal year 2017 audit period.

Evaluation : Following evaluation of the response and updated information received from the Health Connector we believe this finding has been sufficiently remediated prior to issuance of this report.

Finding #2017-02 Federal Cost Sharing Reduction (CSR) Reconciliation

Condition: The current attestation process does not request for information communicated by other regulatory authorities as a result of their oversight functions.

Criteria: The Massachusetts cost sharing reduction payments are contingent upon accurate payments from the issuer to providers.

Cause: Data validation or other audit information from CMS to the issuer is not being obtained by the Connector for evaluation. .

Effect: CMS data validation audits or other audits of the issuer may identify overpayment of claims that could impact the amount of funds the exchange would have made available under the Massachusetts cost sharing reduction program if this information was known.

Recommendation: Update your current issuer attestation for Massachusetts CSR payments to require the issuer to attest that they have communicated the results of all audits of other regulatory bodies regarding disapproval of any claim based payments. Evaluate this information when received to determine if there is a need to recoup previous Massachusetts cost sharing reduction payments previously submitted to the issuer.

CCA Response: The Health Connector has reviewed its processes and knowing the future of the Federal CSR program, implementing a new process to capture this information is not feasible. However, we have reviewed the mandatory attestation form required by the Issuers during the state reconciliation process, and will determine the best way to obtain this information from issuers. The added attestation language will request that issuers provide any adjustment data received from any regulatory authority pertaining to claim based payments.

Audit Report Corrective Action Plan		
Issue Title: Finding #2017-02– Federal Cost Sharing Reeducation (CSR) Reconciliation		
Audit Report Recommendation: Performing member and/or plan level validation of Cost Share Reductions and analyze the CMS results of data validation.		
Description of Remediation: • The Health Connector will review current Attestation Form A collected from Issuers • The Health Connector will either revise Attestation Form A or draft a new attestation asking Issuers to provide any adjustment data received from CMS as part of their reconciliation.		
Milestone	**Target Date**	**Completion Date**
1. Health Connector internal review of current attestations collected from Issuers	July 2018	
2. Edit current Attestation Form A, or draft a new attestation, asking Issuers to provide information received from CMS for adjustments	August 2018	
3. Distribute the revised Attestation Form A or new Attestation to Issuers as part of their monthly data submission	September 2018	
Plan for Monitoring and Validation: Receipt of attestation from issuers at time of reconciliation and review of any subsequent claim data received from the issuers		
Responsible Entity or Individual: Finance, Legal, Compliance		

Evaluation: Following evaluation of the response received from the Health Connector we agree with their corrective action plan related to this finding.

Finding #2017-03 Prominently Posting Rate Justifications

Condition: The QHP issuers did not have rate justifications prominently posted on their websites.

Criteria: 45 CFR Section 155 Subpart K 155.1020(a) requires that the Exchange must ensure that the QHP issuer has prominently posted the rate justification on its website.

Cause: There is no external issuer website management quality assurance process in place to identify the anomaly.

Effect: Users of the websites may not have access to rate justifications related to their coverage.

Recommendation: Adopt a process or delegate a new process to provide oversight of issuers compliance with rate filing justifications.

CCA Response: The Health Connector works with the Division of Insurance (DOI) annually in its Seal of Approval (SOA) process to ensure that Issuers comply with both state and federal obligations. DOI has regulatory authority over Issuers' premium rates in Massachusetts, including authority to conduct rate review and directly enforce other federal requirements related to rate transparency. During the Health

Connector's SOA, Issuers are provided with a set of requirements that they must meet in order to offer Qualified Health and Dental Plans through the Health Connector, including compliance with state and federal laws, and Issuers agree through contract that they comply with such requirements. DOI collects rate justification information from Issuers and submits that data to CMS to post on their publically accessible website, https://ratereview.healthcare.gov/, based on DOI's authority as a regulatory agency. The Health

Connector requires all Issuers to make this information available on their websites through its SOA contracts with the Issuers.

In review of the initial sample selected, of the two Issuers, only one (1) did not post this information on its website. In order to ensure that all Issuers comply with the requirement to make rate justifications available on their websites the Health Connector has created a Corrective Action Plan (CAP) which outlines its process to remediate this discrepancy. The Health Connector will work to ensure this discrepancy is remediated as soon as possible, and will monitor future Issuer compliance with 45 CFR § 155.1020(a) and 45 CFR § 156.210.

Audit Report Corrective Action Plan		
Issue Title: Finding #2017-03– Prominently Posting Rate Justifications		
Audit Report Recommendation: Adopt a process or delegate a new process to provide oversight of issuer's compliance with rate filing justifications.		
Description of Remediation: • For 2018, the Health Connector will review all of Issuers' websites to see which Issuers have posted this information, determine it is sufficient, and conduct reviews when rates are posted for the plan year. • For 2019 and beyond, the Health Connector will partner with DOI to determine the most streamlined way to enforce this requirement moving forward.		
Milestone	**Target Date**	**Completion Date**
1. Health Connector internal review of all Issuers' websites, to determine if this information was posted, and assessing ease of consumer access.	May 2018	
2. Reach out to Issuers regarding their websites and the posting of rate justification information for consumers and determine if there is an undue burden that impacts the Issuers complying with the regulation and terms of the agreement.	June 2018	
3. Issuers are to update their websites with the rate justifications for plan year 2018, both small group and individual, as well as a link to the CMS website: https://ratereview.healthcare.gov/	August 2018	
4. Health Connector to review the Issuers' websites to confirm they have updated their websites with the plan year 2018 rate justification. If not, the Health Connector must reach out to the Issuers regarding the posting of rate justifications.	September 2018	
5. Health Connector will partner with DOI to determine the most streamlined way to enforce this requirement moving forward.	Ongoing	
Plan for Monitoring and Validation: For 2018, check by Plan Management team documenting review in an Excel Spreadsheet. For subsequent years, partner with DOI regarding ongoing approach.		
Responsible Entity or Individual: Plan Management, Legal, Compliance		

Evaluation: Following evaluation of the response received from the Health Connector we agree with their corrective action plan related to this finding.

Finding #2017-04 Minimum Essential Coverage (MEC)

Condition: The Minimum Essential Coverage (MEC) displayed was incorrect for one of the eighty applications sampled.

Criteria: 45 C.F.R. §155.305 requires that applicants must not be eligible for minimum essential coverage in order to be determined eligible by CCA.

Cause: The website quality assurance process (QA) did not identify the anomaly.

Effect: Users of the website may view incorrect information which may lead to erroneous decisions or increase the number of calls for assistance.

Recommendation: Perform root cause analysis on the error and determine if changes are needed in the development or website QA process.

CCA Response: The Health Connector identified this error and worked with its vendor to remedy this User Interface (UI) error, which was completed in July 2017. As this error was only a UI defect, there was no impact to an individual's eligibility determination.

Evaluation : Following evaluation of the response and updated information received from the Health Connector we believe this finding has been sufficiently remediated prior to issuance of this report.

Finding #2017-05 Qualified Program

Condition: The qualified program displayed was incorrect for one of the eighty applications sampled.

Criteria: The qualified program displayed on the website application should display the correct qualified program.

Cause: The website quality assurance process (QA) did not identify the anomaly.

Effect: Users of the website may view incorrect information which may lead to erroneous decisions or increase the number of calls for assistance.

Recommendation: Perform root cause analysis on the error and determine if changes are needed in the development or website QA process.

CCA Response: The Health Connector identified this issue and resolved this with Release 11, which went live in May 2017. This issue did not have any impact on the member's ability to enrolling in the plans they qualified for.

Evaluation : Following evaluation of the response and updated information received from the Health Connector we believe this finding has been sufficiently remediated prior to issuance of this report.

Assistant General Counsel
Associate Director of Public Outreach and Education
Chief Actuary
Chief Financial Officer
Compliance Manager
Deputy Chief of Policy & Strategy
Deputy Executive Director & Chief Operating Officer
Director of Accounting
Director of Customer Experience
Director of Human Resources
Director of Member Implementation
Director of Policy and Applied Research
Director of Reporting
Enrollment Manager
Enterprise Architect
Executive Director
General Counsel
Ombudsman/Member Services Manager
Operations Coordinator
Product Manager Health & Dental Programs
Quality & Training Coordinator
Senior Manager Member Policy
Senior Outreach Coordinator and Policy Analyst

ACA	Patient Protection and Affordable Care Act
CCA	Commonwealth Health Insurance Connector Authority
C.F.R.	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
GAS	Government Auditing Standards
HHS	U.S. Department of Health and Human Services
MassIT	Massachusetts Office of Information Technology
PII	Personally Identifiable Information
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SBM	State based Marketplace