D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2015 PROGRAMMATIC AUDIT REPORT

BSC
BERT SMITH & CO.
CERTIFIED PUBLIC ACCOUNTANTS
& MANAGEMENT CONSULTANTS

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June 1, 2016

D.C. Health Benefit Exchange Authority
Washington, D.C.

This report presents the results of our work conducted to address the programmatic audit objectives relative to the D.C. Health Benefit Exchange Authority (the Exchange) Programmatic audit fiscal year 2015 (October 1, 2014 to September 30, 2015). Our work was performed during the period of March 11, 2016 through May 31, 2016 and our results are as of May 31, 2016.

Report on Compliance with 45 CFR: Part 155

We have audited the D.C. Health Benefit Exchange Authority's compliance with the types of compliance requirements described in the 45 CFR: Part 155 for the fiscal year ended September 30, 2015.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable under and pursuant to 45 CFR: Part 155.

Auditor's Responsibility

Our responsibility is to express an opinion on the Exchange's compliance with 45 CFR: Part 155 subparts C, D, E and K. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on the program occurred. An audit includes examining, on a test basis, evidence about the Exchange's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance with 45 CFR: Part 155. However, our audit does not provide a legal determination of the D.C. Health Benefit Exchange Authority's compliance.

Opinion on Compliance with 45 CFR: Part 155

In our opinion, except for the instances of noncompliance, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2015.

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Other Matters

The Exchange's response to the noncompliance findings is identified in the accompanying corrective action plan. 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.

This programmatic audit did not constitute an audit of any portion of the Exchange's fiscal year 2015 financial statements in accordance with *Government Auditing Standards*. Additionally, we were not engaged to, and did not, audit or render an opinion on the Exchange's internal controls over financial reporting or over financial management systems.

Sincerely,

Bert Smith & Co.

Bert Smith & Co.

EXECUTIVE SUMMARY

I. BACKGROUND

In 2010, the federal Patient Protection and Affordable Care Act (ACA) was enacted to reform the health care system in the United States. A key requirement of the Affordable Care Act is that all Americans obtain public or private health insurance or pay a penalty (42 U.S.C. 18091 and 26 U.S.C. 5000A). To accomplish this requirement, the ACA authorizes federal funding to: (1) establish health insurance exchanges, (2) allow states to expand Medicaid eligibility, and (3) provide federal tax credits to individuals who are ineligible for Medicaid but have incomes between 100 and 400 percent of federal poverty guidelines.

As one of the key components of the ACA, each state is required to make available a health insurance exchange for individuals and small businesses to compare and select health insurance plans. These exchanges, also known as "marketplaces" were to be established and managed by individual states, by the federal government for a state, or through a federal-state partnership. Pursuant to Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011, the District of Columbia established its own state-based health insurance marketplace to meet the needs of District residents and small businesses.

II. PURPOSE OF AUDIT

The purpose of this programmatic audit was to determine the D.C. Health Benefit Exchange Authority's compliance with the rules, regulations and guidelines under 45 CFR: Part 155 governing the programmatic requirements set forth by the Centers for Medicare & Medicaid Services (CMS).

III. SCOPE OF AUDIT

The scope of the programmatic audit covers the Exchange's compliance with the requirements under 45 CFR: Part 155 subparts C, D, E, F and K for the period October 1, 2014 through September 30, 2015.

We did not audit the requirements under (1) Subpart B - General Standards Related to the Establishment of an Exchange; (2) Subpart G - Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions; (3) Subpart H - Exchange Functions Small Business Health Options Program (SHOP); (4) Subpart M - Oversight and Program Integrity Standards for State Exchanges; (5) Subpart N - State Flexibility and (6) Subpart O - Quality Reporting Standards for Exchanges.

IV. AUDITING STANDARDS

We conducted this programmatic audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

V. METHODOLOGY

The methodology was used to determine the Exchange's compliance with the programmatic audit requirements. Specific procedures included the following:

- Conducted meetings and interviews with Exchange personnel, contractors and personnel from other District agencies to gain an insight and understanding of the policies, procedures and types of supporting documents required for our testing. Personnel interviewed included:
  - General Counsel and Chief Policy Advisor
  - Associate General Counsel and Policy Advisor
  - Director of Marketplace Innovation, Policy, and Operations
  - Chief Financial Officer
  - Senior Deputy for Operations/Chief Operating Officer
  - Director of Information Technology
  - Assistant Director of Marketplace Innovation, Policy, and Operations for Plan Management and Enrollment
  - Assistant Director of Marketplace Innovation, Policy, and Operations for the Individual Market
  - Senior Curam Developer
  - Chief Security Officer and Privacy Architect
  - DIMS/CATCH Project Manager
  - Technical Project Manager

- We reviewed the following key documents, regulations and requirements, and policies and procedures:
  - Bylaws for the District of Columbia Health Benefit Exchange Authority
  - Centers for Medicare and Medicaid Services Frequently Asked Questions about the Annual Independent External Audit of State-based marketplaces dated June 18, 2014
  - 45 CFR: Part 155
  - Minimum Acceptable Risk Standards for Exchanges (MARS-E)
  - Applicable sections of the Affordable Care Act of 2010
  - D.C. Health Link Assister's Resource Guide
  - D.C. HBX Uniform Carrier Agreement
  - D.C. HBX Benefit Enrollment (834) Companion Guide
  - D.C. Transaction Error Handling Guide
  - Memorandum of Agreement Between the Health Benefit Exchange Authority and the Department of Health Care Finance
  - Memorandum of Agreement Between the Health Benefit Exchange Authority and the Department of Human Services Economic Security Administration for Eligibility Determination Services
  - Memorandum of Agreement Between the Health Benefit Exchange Authority and the D.C. Office of Administrative Hearing for Eligibility Appeal Hearings
  - D.C. Conflicts of Interest Restrictions D.C. Official Code § 31-3171-10
  - D.C. Ethics Act – D.C. Official Code § 1-1162.03
  - Privacy and Securities Policies for Exchange Operations
  - D.C. Primary Care Association – Conflict of Interest Plan and Disclosures
  - Navigator Grant Agreement
  - Training Modules and Examinations
- Reviewed governance documents.
- Reviewed legislation relating to the Exchange.
- Reviewed oversight monitoring policies and procedures.

- Reviewed processes and procedures designed to prevent improper enrollment.
- Reviewed supporting documentation over subpart requirements.
- Tested the compliance and effectiveness of internal controls over the subpart requirements.
- Reviewed policies and procedures for certification of qualified health plans.
- Reviewed policies and procedures over the appeals process.
- Reviewed standards designed to prevent and mitigate conflicts of interests, financial or otherwise.
- Reviewed policies and procedures over navigator program standards.
- Reviewed evidence for the existence of consumer assistance tools.
- Tested oversight and program integrity standards.
- Tested privacy and security standards.
- Tested training standards.

VI. NATURE OF CONFIDENTIAL OR SENSITIVE INFORMATION OMMITTED

We have deemed that the contents of this report are not considered confidential or sensitive and as such, the report is presented in its entirety.

AUDIT FINDINGS AND RECOMMENDATIONS

I. SUMMARY OF RESULTS AND FINDINGS

The results and findings are as follows:

45 CFR: Part 155	Compliance/Internal Control	Results
Subpart C – General Operations	1. Privacy and security of navigators.	The Exchange is in compliance with this requirement.
	2. Processes and procedures for addressing complaints.	The Exchange is in compliance with this requirement.
	3. Processes and procedures for providing assistance in culturally and linguistically appropriate manner.	The Exchange is in compliance with this requirement.
	4. Training standards.	The Exchange is in compliance with this requirement.
	5. Breaches of security or privacy by a navigator grantee.	The Exchange is in compliance with this requirement.
	6. Standards designed to prevent and mitigate any conflicts of interest, financial or otherwise.	The Exchange is in compliance with this requirement.
	7. Confirmation that assures funding for navigator grants does not come from Federal funds.	The Exchange is in compliance with this requirement.
	8. Privacy and security safeguards.	The Exchange is in compliance with this requirement.
	9. Call center information provided in plain language and in a manner that is accessible to individuals with disabilities and individuals with limited English proficiency.	The Exchange is in compliance with this requirement.
Subpart D – Eligibility	1. Process and procedures for conducting eligibility determinations.	The Exchange is in compliance with this requirement.
	2. Verification of eligibility for enrollment in a Qualified Health Plan (QHP) and/or insurance affordability programs.	The Exchange is not in compliance with this requirement. **Finding # 2015-001:** The Exchange did not provide an eligibility determination for all QHP applications.
	3. Redeterminations, both during the benefit year and the annual open enrollment period.	The Exchange is in compliance with this requirement.
	4. Process for the administration of payments of advance premium tax credits (APTCs).	The Exchange is not in compliance with this requirement. **Finding # 2015-002:** The Exchange did not notify HHS of termination of coverage promptly and without undue delay.
	5. Processes and procedures for addressing appeals.	The Exchange is in compliance with this requirement.
	6. Data and records maintenance related to eligibility.	The Exchange is in compliance with this requirement.
Subpart E – Enrollments	1. Management review/internal controls associated with the prevention of improper enrollment transactions, including processes to ensure that enrollees are receiving accurate advance premium tax credits	The Exchange is in compliance with this requirement.

45 CFR: Part 155	Compliance/Internal Control	Results
	(APTC's), cost sharing reductions (CSR's), and premiums (and for correction of any discrepancies).	
	2. Compliance with Centers for Medicaid and Medicare Services (CMS) - issued Standard Companion Guides (e.g. ASC X12 820 and 834).	The Exchange is in compliance with this requirement.
	3. Processes to reconcile enrollment information with qualified health plan (QHP) issuers and CMS no less than on a monthly basis.	The Exchange is not in compliance with this requirement. **Finding # 2015-003:** The Exchange did not consistently reconcile enrollment information with Carriers and HHS.
	4. Data and records maintenance related to enrollments.	The Exchange is in compliance with this requirement.
Subpart F – Appeals of Eligibility Determinations	1. Process for appeals for eligibility determinations.	The Exchange is in compliance with this requirement.
Subpart K – Certification of QHP's	2. Policies and procedures for certification of qualified health plans.	The Exchange is in compliance with this requirement.
	3. Process for recertification of Qualified Health Plans (QHPs).	The Exchange is in compliance with this requirement.
	4. Process for decertification of QHPs.	The Exchange is not in compliance with this requirement. **Finding # 2015-004:** The Exchange does not have documented Standard Operating Policies and Procedures for the decertification of QHPs.

II. FINDINGS AND RECOMMENDATIONS

Based upon the results of our testing, we have outlined the findings below:

2015-001: ***Lack of QHP Determination for Submitted Applications***

Condition: An eligibility determination for submitted applications was not always provided to customers seeking a QHP or Medicaid. Due to various system processing errors on the D.C. Health Link website, we noted 93 customers submitted multiple requests in order to obtain a non-Medicaid eligibility determination. These 93 applications represent 7% of all "stuck" applications which required multiple submissions before a determination was made.

Of the 93 non-Medicaid customers identified above, eligibility determination for 62 customers were provided within 3 months and 31 customers were provided within 91 days to 365 days from the initial application.

Criteria: 45 CFR: Part 155.310(c) states that the Exchange must "make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year."

45 CFR: Part 155.310(d) states that the Exchange must "determine an applicant's eligibility, in accordance with the standard specified in 45 CFR: Part 155.305."

Memorandum of Agreement (MOA) between the Health Benefit Exchange Authority and the Department of Health Care Finance (Medicaid) Section C.4 states that "The parties agree to ensure the implementation of a streamlined system for eligibility determinations that minimizes the burden on individuals, provides prompt determination of eligibility and enrollment into Medicaid, other IAPs, and QHPs, and provides timely notifications of eligibility decisions to applicants and enrollees."

Cause: Processing errors on the D.C. Health Link website led to "stuck" application cases and the lack of eligibility determinations.

Recommendation: Management must continue to investigate and resolve system issues in order to ensure compliance with 45 CFR: Part 155.310(c), 45 CFR: Part 155.310(d) and the MOA.

Management's Response: The Exchange concurs with the finding with the following explanation.

HBX is aware of the issue noted by the auditors. In FY2015 there were 114,541 applications for eligibility. Of those, 31 applications did not receive timely eligibility determinations for QHP coverage. All customers received an eligibility determination.

HBX shares a joint eligibility IT rules engine with the DC Department of Health Care Finance (the Medicaid agency/DHCF). CURAM HCR is the IT software used for Medicaid, advance premium tax credit, and cost sharing reductions eligibility determinations.

DHCF uses another District agency, the DC Department of Human Services (DHS), for Medicaid eligibility determinations. HBX also uses DHS for verifications and eligibility processing of applications where customers will receive APTC or CSRs. To prevent a duplication of resources, HBX leverages DHS for this role. This is in part because nearly all applications for financial assistance result in Medicaid eligibility determinations.

Currently, the technical team runs weekly reports to check for stuck cases and works to determine the source of the case becoming stuck to identify technical fixes that may be necessary. According to DHS, their caseworkers follow-up on these cases. The process entails monitoring how many new stuck/malformed applications appear each week and how quickly they are resolved. To track this, weekly meetings and status reports are in place, which has allowed for the creation of trending data that informs on how the cleanup is progressing. The goal is to catch and resolve these applications within just a few days.

In FY2015, HBX, DHCF, and DHS identified and fixed numerous technical issues in CURAM HCR resulting in stuck applications. Some examples include:

- Applicant had already created an application
  - Fix has been deployed to prevent multiple applications by the same customer.
- Customer submitted an address that could not be validated
  - Fixed by modifying custom code for address validation.
- Customers added a hyphen to the Zip Code
  - Fixed by inserting custom code validation to allow only five digits to be entered by customer.

In these FY 2015 cases, according to DHS, their caseworkers utilized a case banking system wherein workers processed cases by date, in order of receipt. There were also periodic status checks and follow-up by the Deputy Administrator to determine the number of cases that required processing. However, the current corrective action process is more robust and allows the Deputy Administrator and staff to more proactively address stuck applications timelier, resulting in a reduction in the number of stuck cases.

Point of Contact: Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

Point of Contact: Trey Long, Deputy Administrator, Division of Program Operations, Economic Security Administration, Department of Human Services. Trey.Long@dc.gov, (202) 698-3904.

2015-002: ***Lack of Coverage Termination Notification to HHS***

Condition: The Exchange was unable to demonstrate that termination of coverage was communicated to HHS promptly and without undue delay.

Criteria: 45 CFR: Part 155.340 (b)(3) states that the Exchange must "Transmit the individual's name and taxpayer identification number and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury;"

45 CFR: Part 155.430(c)(2) states that the Exchange must "send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with §155.400(b)."

Cause: The Exchange's policies and procedures for the transmittal of coverage termination to HHS were not enforced.

Recommendation: The Exchange should periodically verify that monthly enrollment reconciliation procedures with Carriers and HHS are adhered to.

Management's Response:

The Exchange concurs with the finding. The reporting of termination information is done as a part of general reporting to the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS) and Internal Revenue Service (IRS). Please see management response to 2015-003.

2015-003: ***Inadequate Enrollment Reconciliation with QHPs and HHS***

Condition: For plan year 2015, the Exchange did not consistently reconcile enrollment information for each QHP Issuer and with HHS.

Criteria: 45 CFR: Part 155.400(d) states that "The Exchange must reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis."

Cause: The Exchange's policies and procedures for reconciliation with QHPs issuers and HHS were not enforced.

Recommendation: The Exchange should ensure that monthly reconciliation procedures with Issuers and HHS are conducted in accordance with CFR regulations.

Management's Response:

The Exchange concurs with the finding with the following explanation.

Reconciliation with Issuers

Accuracy of consumer enrollment information is a priority for HBX. With some exceptions in plan year 2015, HBX has produced, and continues to produce in 2016, a reconciliation file for issuers on a monthly basis. Issuers are unable to send monthly reports. However, the frequency and quality of the reports have improved. In addition to the file interchanges, HBX holds weekly technical meetings with each of our issuers to discuss further steps we can take together to improve the reconciliation process.

Each issuer must continue to update their IT systems before a fully automated monthly reconciliation process can occur. While issuers work to improve their IT systems, HBX staff is utilizing a partially automated and partially manual process to achieve reconciliation.

Reconciliation with HHS and IRS

HBX works closely with the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) on reporting. When DC Health Link was originally built, CMS and IRS had not released the reporting specifications. HBX has since devoted significant resources to reconfigure its system to provide the required reports. After working closely together through 2015, the IRS has successfully received reports and is able to use the data provided by HBX. CMS has been unable to accept a similar report. HBX continues to work with CMS on this problem.

Like all marketplaces, HBX continues to work with the federal government as their reporting requirements evolve. At this time, both IRS and CMS are redesigning their reporting requirements and have informed HBX that monthly reporting should be halted until that work is complete.

Issuance of 1095-A Forms

HBX has prioritized providing timely and accurate information to both consumers and IRS in preparation for the 2015 tax filing season. Starting in 2014, state based marketplaces were required to issue a new form called the 1095A which is used by enrollees to prove their health insurance coverage when filing their annual federal tax returns. In addition, this form documents the receipt of any advanced premium tax credits so the amount can be reconciled on the federal tax filings.

Accurate enrollment information is key to producing accurate 1095As for our customers – and it is a responsibility HBX takes very seriously. HBX worked closely with issuers in preparation for the 2015 tax filing season. HBX reviewed and reconciled consumer information with issuers and sent it to CMS and IRS. For the 2015 tax filing season, HBX issued 16,762 Form 1095A's. Of those, only 75 customer corrections were requested and issuers provided updated data for 780 customers. The correction rate of less than 5% further demonstrates HBX's commitment to accurate reporting.

Point of Contact for Corrective Action Plan

Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

2015-004: ***Lack of QHP Decertification Policy***

Condition: The Exchange does not have documented Standard Operating Policies and Procedures for the decertification of QHPs. The DCHBX Carrier Reference Manual states that "decertification procedures will be developed through the Plan Management Standing Advisory Committee," however; these procedures were not yet developed.

Criteria: 45 CFR: Part 155.1080(b) states that the Exchange must "establish a process for the decertification of QHPs, which at a minimum meets the requirements of this section."

Cause: The Exchange has not established policies and procedures to ensure the decertification of QHPs.

Recommendation: The Exchange must document the QHP decertification policy and procedures for inclusion to the HBX Carrier Manual.

Management's Response: The Exchange concurs with the finding with the following explanation.

In 2016, HBX will focus one of its Plan Management Advisory Committee meetings on the topic of QHP decertification procedures. That Committee includes representation from the carriers offering QHPs in the DC Health Link. HBX will also research the approach of other state-based marketplaces and the federally-facilitated marketplace for best practices.

Point of Contact for Corrective Action Plan:
Robert Shriver, Director of Marketplace Innovation, Policy, and Operations, Robert.Shriver@dc.gov, (202) 741-8820.

CONCLUSION

We confirm that we have reviewed relevant documentation and determined that the D.C. Health Benefit Exchange Authority is in compliance with CMS requirements and GAGAS.

SIGNATURE OF AUDIT FIRM: Bert Smith & Co.

COMPLETION DATE OF AUDIT FINDINGS REPORT: May 31, 2016