INDEPENDENT EXTERNAL AUDIT

D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2017 PROGRAMMATIC AUDIT REPORT

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

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May 31, 2018

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) for the fiscal year 2017 (October 1, 2016 to September 30, 2017). Our work was performed during the period of January 25, 2018 through the date of this report.

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, 2017.

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, F 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.

Our audit disclosed noncompliance with Title 45, Part 155, Subparts C and D applicable to the Exchange during the year ended September 30, 2017, which are described in the Audit Findings and Recommendations section as findings 2017-001, 2017-002, and 2017-003.

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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, 2017.

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 2017 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 lower-income individuals who are ineligible for minimum essential coverage (such as Medicaid or affordable employer-sponsored coverage).

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 (the Exchange or HBX) 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, 2016 through September 30, 2017.

We did not audit the requirements under (1) Subpart A – General Provisions; (2) Subpart B - General Standards Related to the Establishment of an Exchange; (3) Subpart G - Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions; (4) Subpart H - Exchange Functions Small Business Health Options Program (SHOP); (5) Subpart M - Oversight and Program Integrity Standards for State Exchanges; (6) Subpart N - State Flexibility and (7) Subpart O - Quality Reporting Standards for Exchanges.

IV. AUDITING STANDARDS

We conducted this programmatic audit in accordance with Generally Accepted Government Auditing Standards (GAGAS). 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 following procedures were performed to determine the Exchange's compliance with the programmatic audit requirements.

- 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
  - Assistant Director of Marketplace Innovation, Policy, and Operations for Plan Management
  - Assistant Director of Marketplace Innovation, Policy, and Operations for the Individual Market
  - Case Management Supervisor
  - Ethics Officer and Deputy General Counsel
  - Nondiscrimination Coordinator and Associate General Counsel
  - Deputy Director of Marketplace Innovation, Policy, and Operations
  - Assistant Director of Marketplace Innovation, Policy, and Operations for Exchange Data and Transactions
  - Chief Information Officer (CIO) , Health Benefit Exchange Authority (HBX)
  - Interim Privacy Officer, Health Benefit Exchange Authority (HBX)
  - Chief Information Officer (CIO), Department of Human Services (DHS)
  - IT Project Manager, Department of Human Services (DHS)
  - DC Access System (DCAS) Security Manager
  - Identity and Access Management Engineer, Department of Health Care Finance (DHCF)

- 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.
- Tested the compliance and the 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.
- Tested user access to enrollment applications and databases.
- Tested enrollment data backup procedures.
- We analyzed the following information to assess HBX's compliance with the requirements of 45 CFR Part 155:
  - From a record of 22 employees who were hired in FY 2017, we selected a sample of 10 employees to verify compliance with Subpart C - General Functions of an Exchange. Training rosters were reviewed to verify the appropriate Privacy and Security training was provided.
  - The complete record of all user accounts which were assigned access to the eligibility and enrollment applications and databases were reviewed to ensure compliance with Subpart C - General Functions of an Exchange, Subpart D - Eligibility Determinations for Exchange Participation and Subpart E - Enrollment in Qualified Health Plans.
  - From a record of 75,320 applications which were submitted in FY 2017, we selected a sample of 50 (25 EnrollApp and 25 Curam) applications to test the compliance with 45 CFR 155 Subpart D - Eligibility Determinations for Exchange Participation and Insurance Affordability Programs. Applications were tested to verify eligibility approval or denial determinations were accurately assessed.
  - From a record of 26,504 applicants who had enrolled in a Qualified Health Plan in FY 2017, we selected a sample of 45 cases to test the compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans. Enrollment records were tested to verify timely and accurate communication of applicant details and Advance Premium Tax Credit (APTC) determinations to insurance carriers.
  - From a record of 26,504 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2016, we reviewed all applicants (101 instances) whose APTC amounts appeared to be high when compared to the premium reported to HHS/IRS to verify compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans.
  - A sample of four (4) monthly backup procedures which were conducted during the period of review was selected to ensure compliance with Subpart D - Eligibility Determinations for Exchange Participation and Subpart E - Enrollment in Qualified Health Plans. Backup logs and database backup configurations were reviewed to test data and record maintenance procedures related to eligibility and enrollment.
  - From a record of 52 applicants who submitted an appeal to HBX from October 1, 2016 to September 30, 2017, we reviewed a sample of 25 cases to ensure compliance with Subpart F - Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs.

- Six (6) Issuers whose Qualified Health Plans and Qualified Dental Plans were available for applicant enrollment were reviewed to ensure Issuer and HBX compliance with Subpart K - Exchange Functions Certification of Qualified Health Plans.

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 Functions of an Exchange	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 not in compliance with this requirement. **Finding # 2017-001:** Excessive User Access to Shared Administrator User Account.
	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 Determinations for Exchange Participation and Insurance Affordability Programs	1. Process and procedures for conducting eligibility determinations.	The Exchange is not in compliance with this requirement. **Finding # 2017-002:** Inadequate APTC Verification Procedures (Repeat Finding).
	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 # 2017-003:** Lack of QHP Determination for Submitted Applications (Repeat Finding)
	3. Redeterminations, both during the benefit year and the annual open enrollment period.	The Exchange is not in compliance with this requirement. **Finding # 2017-002:** Inadequate APTC Verification Procedures (Repeat Finding).
	4. Process for the administration of payments of advance premium tax credits (APTCs).	The Exchange is not in compliance with this requirement.

45 CFR Part 155	Compliance/Internal Control	Results
		Finding # 2017-002: Inadequate APTC Verification Procedures (Repeat Finding)
	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 – Enrollment in Qualified Health Plans	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 (APTC's), cost sharing reductions (CSR's), and premiums (and for correction of any discrepancies).	The Exchange is in compliance with this requirement.
	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 in compliance with this requirement.
	4. Data and records maintenance related to enrollments.	The Exchange is in compliance with this requirement.
Subpart F – Appeals of Eligibility Determinations for Exchange Participation	1. The Exchange must allow an applicant or enrollee to request an appeal 90 days of the date of the notice of eligibility determination.	The Exchange is in compliance with this requirement.
	2. The Exchange must send timely acknowledgment to the appellant of the receipt of his or her valid appeal request.	The Exchange is in compliance with this requirement.
	3. The Exchange must promptly and without undue delay, send written notice to the applicant or enrollee informing the appellant of the appeal determination.	The Exchange is in compliance with this requirement.
Subpart K – Certification of Qualified Health Plans	1. Policies and procedures for certification of qualified health plans.	The Exchange is in compliance with this requirement.
	2. The Exchange established contracts with carriers that offer Qualified Health Plans (QHPs) through the DC Health Link.	The Exchange is in compliance with this requirement
	3. Policies and procedures for the recertification of Qualified Health Plans (QHPs).	The Exchange is in compliance with this requirement.
	4. Policies and procedures for the decertification of QHPs.	The Exchange is in compliance with this requirement.

II. FINDINGS AND RECOMMENDATIONS

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

2017-001: ***Excessive User Access to Shared Administrator User Account***

Condition: The Document Imaging Management System (DIMS) Administrator level user account is shared by several Department of Human Services (DHS) DIMS project team members. The DIMS Administrator user account grants full access to all system configurations and underlying data including applicants' Personally Identifiable Information (PII) that is scanned and stored in the system. In FY17, two DHS employees on the DIMS project team had administrator level access, but did not require this level of access in order to perform their job duties.

Furthermore, DHS indicated that a process to periodically change the password for the shared Administrator user account is not in place.

Criteria: 45 CFR §155.260(a)(3) states that the Exchange must "Establish and implement privacy and security standards that are consistent with the following principles:

> (vii) Safeguards. Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure;"

Application access must be aligned to each user's job responsibilities.

Cause: Management did not consider the potential risks associated with inadequate user access controls around the sharing of an Administrator user account.

Effect: Users of the shared Administrator user account may have access to the system that does not correspond with their job responsibilities which could allow the ability to advertently, or inadvertently, use various functions to alter the integrity of application data. In addition, management will not have reliable audit trails to review activities of the individuals performing changes.

Recommendation: The Administrator user account password must be changed when an assigned user no longer requires access to the user account. For the users that share the Administrator user account, Management should assign a unique user account and the appropriate level of access to each user to limit access to the users' associated job functions and to ensure compliance with 45 CFR §155.260.

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

DHCF is the Medicaid agency in the District of Columbia and has a memorandum of understanding with DHS to conduct Medicaid determinations. DIMS is a legacy system that pre-dated DC Health Link and is managed by DHS for document management. It is connected to CURAM/HCR, which is managed by DHCF, for insurance affordability program (IAP) eligibility determinations. Thus, HBX does not control, manage, or have the ability to prioritize fixes related to DIMS or CURAM/HCR.

HBX case workers have non-administrator access to DIMS to achieve coordination with the agency conducting Medicaid eligibility determinations (DHS) and to ensure that HBX does not reach out to a customer requesting paper verification documents when such documents have already been submitted to DHS. Such coordination is mandated by 45 C.F.R. §155.345(g)(4) when a customer submits an Insurance Affordability Program application seeking Medicaid, Advance Premium Tax Credits, and Cost-Sharing Reductions.

In contrast, the document retention systems managed by HBX does not use a centralized administrator account. Instead, consistent with the recommendation contained here, each user has a unique username and password which can be turned off when the user terminates service or job functions change. These systems, managed by HBX, are used for the purpose of retaining documents submitted directly to the DC Health Link Customer Service Center or online through EnrollApp - the eligibility system used by applicants who are not seeking Medicaid, APTC, or CSR.

To address the concerns raised by this finding, upon learning of the issues, HBX management liaised with DHS management and received assurances that the issues raised by this finding will be addressed expeditiously. DHS has already terminated access for one of the two employees mentioned in this finding. Additionally, within weeks of the issuance of this report, DHS will remove administrator access rights for the other employee. DHS proposes to limit administrator account privileges to just the DIMS project manager and lead developer. Consistent with the recommendation, DHS will also change the administrator account password and individuals will have separate DIMS user accounts assigned to them. These changes will take several weeks to complete and test, but all such work is expected to occur on or before July 17, 2018. According to DHS, these changes cannot occur immediately because the password is embedded into the DIMS application in several places so the DHS technical staff need to investigate and test to ensure that the password is changed in all locations in the system.

Point of Contact: Jason Sparks, Chief Information Officer, DC Health Benefit Exchange Authority, Jason.Sparks@dc.gov, (202) 741-8911.

Point of Contact: Boyle Stuckey, Chief Information Officer, DC Department of Human Services. Boyle.Stuckey@dc.gov, (202) 442-3273.

2017-002: ***Inadequate APTC Verification Procedures (Repeat Finding)***

Condition: Eligibility applications submitted electronically through the DC Health Link website were not fully verified in 11 of the 101 targeted cases reviewed for income verification requirements. These 101 targeted cases were identified, due to high APTC amounts when compared to the premium reported to HHS/IRS for a given month, from the 26,504 applicants who enrolled in a QHP during FY17.

The 11 exceptions are described below:

In eight (8) instances, the system accepted customers' assertion of $0 income without further verification. Erroneous calculation of APTC for these instances of customer renewal process resulted in an APTC amount that either exceeded or was equal to the Essential Health Benefits (EHB) premium.

In three (3) instances, incorrect data entry procedures resulted in the incorrect calculation of applicant's APTC amount. Data entry errors include the notation of applicant's incorrect date of birth, number or household members and income. These erroneous attributes affect the calculation in APTC amounts thus resulted in incorrect APTC determinations.

Criteria: 45 CFR §155.305(k): Incomplete application states that "If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must – (3).... not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost-sharing reductions.

45 CFR §155.305(f)(1): In general. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that he or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested;

45 CFR §155.330(c): Verification of reported changes. The Exchange must (1) Verify any information reported by an enrollee in accordance with the processes specified in 45 CFR Part 155.315 and 155.320 prior to using such information in an eligibility redetermination; and

Cause: Inadequate controls over the income verification requirement process. Attestation will be accepted in error without any verification even when contrary information or a lack of information from an electronic data source exists.

Effect: HBX provided inaccurate eligibility determinations to applicants beyond the allowable period as defined in 45 CFR §155.305.

Recommendation: Management should strengthen its procedures for secondary reviews of manual entries and ensure all electronic verifications are successfully completed or manually verified.

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

Attestations of $0 Income Accepted Without Verification

Eight of the 101 cases targeted by the auditors for review, out of 26,504 applications with enrollments, showed that APTC eligibility procedures were not properly followed because of a design flaw within the off-the-shelf CURAM/HCR software. CURAM/HCR can only place outstanding verifications on pieces of "evidence" within the system. Generally, when a consumer attests to zero income, no income "evidence" is created. As such, even when there is contrary information, or no information, from an electronic data source, CURAM/HCR erroneously accepts attestations of no income without requesting verification.

When this error was identified by this audit, HBX began working with DHCF to identify how to make changes to the CURAM/HCR platform. DHCF (Medicaid) is responsible for CURAM/HCR. DHCF will prioritize this fix within the context of other Medicaid priorities.

Household Enrolled Fewer Than All Eligible Individuals

CURAM/HCR is used for all eligibility determinations for those applying for IAPs. A person who receives an APTC determination then uses EnrollApp to select and enroll in a private health insurance plan. DHCF is responsible for CURAM/HCR, while HBX is responsible for EnrollApp.

One of the 101 cases targeted by the auditors for review, out of 26,504 applications with enrollments, showed that APTC eligibility procedures were not properly followed because APTC was calculated based on more people enrolling than ultimately selected a plan. In this case, the household included more individuals on their IAP application in CURAM/HCR than ultimately decided to enroll in a qualified health plan through EnrollApp. Therefore, the APTC passed from CURAM/HCR to EnrollApp represented a larger enrollment household and greater APTC amount. Although this rarely occurs – approximately 85% of enrollments households are single-member and of the multi-member households typically all eligible individuals enroll in coverage – HBX is committed to fixing this issue. HBX has developed and is currently testing a fix.

Manual APTC Calculation

One of the 101 cases targeted by the auditors for review, out of 26,504 applications with enrollments, showed that APTC eligibility was not properly completed because CURAM/HCR did not request an APTC calculation from the federal hub's calculation service. The calculation

was conducted manually by an HBX case manager who inadvertently inverted the age for one of the enrollees (indicated she was 65 rather than 56). The enrollment system calculated the proper premiums, and Essential Health Benefit (EHB) cap on the premium, based on age. However, the associated benchmark plan for the APTC calculation was incorrect. The error that occurred in this case is from a manual workaround for CURAM/HCR. The error was corrected for plan year 2018 when the APTC was auto-calculated during the renewal process. Prior to this finding being made by the auditors, HBX developed and deployed a fix that allows our workaround to the CURAM/HCR deficiency to import data directly from CURAM/HCR and fix the APTC calculation, which will reduce the need for manual data entry that can lead to such errors. This fix is currently in testing.

EHB Premium Check on Auto Renewal

One of the 101 cases noted by the auditors for review, out of 26,504 applications with enrollments, showed that APTC submitted to HHS/IRS exceeded the EHB premium for the plan the customer enrolled in by $0.36/month (approximately $^{1}/_{20}$% of the total $661.91 EHB premium for the plan). HBX has an internal control within DC Health Link on initial enrollments and active renewals that checks the amount of APTC a customer qualifies for against the EHB premium for the plan the customer enrolled in to ensure that the APTC authorized does not exceed the EHB premium. As demonstrated through the audit, in nearly all cases reviewed, this internal control successfully reduced the APTC sent to the carrier to ensure that APTC did not exceed the EHB premium, even where the customer would have qualified for more APTC had they selected a more expensive plan. However, this control was not in place for auto renewals. As a corrective action, HBX will add the same automated internal control already in place on initial enrollments and active renewals to auto renewals. This will ensure that the APTC authorization sent to the carrier will always be capped at the EHB premium for the plan at initial enrollment, active renewal, and auto renewal. While HBX works to implement this control on auto renewals, we will continue to manually review all auto renewals to ensure this error does not re-occur on any auto renewals for plan year 2019.

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

2017-003: ***Lack of QHP Determination for Submitted Applications (Repeat Finding)***

Condition: An eligibility determination for submitted applications was not always provided to customers seeking a QHP. The Exchange utilizes the Curam software to process eligibility determinations for Insurance Affordability Program (IAP) applications via the DC Health Link website and supplements the online application process with in-person assisters and secondary review teams. However, we noted that it did not provide an

eligibility determination in 562 instances which represents 2% of submitted IAP applications.

Criteria:

45 CFR §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 §155.310(d) states that the Exchange must "determine an applicant's eligibility, in accordance with the standard specified in 45 CFR §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" IAP application cases and the lack of eligibility determinations.

Effect:

IAP applicants may not receive timely eligibility determinations in order to enroll in a QHP.

Recommendation:

Management must continue to strengthen compensating controls to identify and address 'stuck' applications in a timely manner in order to ensure compliance with 45 CFR §155.310(c), 45 CFR §155.310(d) and the MOA.

Management's Response:

The Exchange concurs with the finding with the following explanation.

DC Health Link includes CURAM/HCR which is for eligibility determinations for those applying for insurance affordability programs (IAPs), and EnrollApp which is for eligibility determinations for those applying for private insurance and not IAPs.

As described below, the eligibility system for IAP applications is CURAM/HCR and is managed by DHCF. The finding demonstrates that 98% of the applications through CURAM/HCR successfully received an eligibility determination while 2% did not receive a timely determination.

The EnrollApp platform for eligibility, shopping, and enrollment was developed by HBX in part to address some of the systemic issues and deficiencies with CURAM/HCR (identified by HBX when HBX managed CURAM/HCR). EnrollApp is for applicants not seeking insurance affordability programs. EnrollApp has not had any "stuck cases" for applications submitted since the platform launched. The success of EnrollApp has been verified by last year's and this year's programmatic audits.

CURAM/HCR

In the District of Columbia, the Department of Health Care Finance (DHCF), the Department for Human Services (DHS), and HBX coordinate in the operation of DC Health Link. DHCF is the Medicaid agency in the District of Columbia. DHCF has a memorandum of understanding with DHS to conduct Medicaid eligibility determinations. DHCF manages CURAM/HCR, the system used by customers applying for IAPs, specifically Medicaid, Advance Premium Tax Credits, and Cost-Sharing Reductions..

Consistent with federal regulations, all IAP applications submitted through DC Health Link are first reviewed by the Medicaid agency. Eligibility data from 2013 through the present demonstrates that approximately 90% of IAP applicants and renewing customers qualify for Medicaid. DHCF is responsible for the operation and management of CURAM/HCR, as well as for clearing "stuck cases" and for diagnosing and ameliorating the system issues that lead to cases becoming stuck in the first instance. DHS case workers are responsible for working cases to get issues resolved. HBX's relies on CURAM/HCR to make APTC and CSR eligibility determinations. Customers that are not seeking Medicaid, APTC, or CSR eligibility do not apply through CURAM/HCR, but instead through EnrollApp.

In FY2017, as noted in the finding, 2% of CURAM/HCR applications failed to receive an eligibility determination. The joint DHCF/DHS team continues to identify code fixes and perform data cleanup to reduce the number of applications that can become stuck. A weekly recurring meeting is held on 2pm each Monday to review the cases in stuck status by age of case, so that appropriate mitigation actions can be taken by DHCF/DHS. The DHS Division of Program Operations (DPO) continues to monitor team workloads using new management reports from CURAM/HCR and a new workflow management system, PathOS, to ensure all eligibility teams are adequately staffed. Additionally, since the finding last occurred, HBX management has held monthly meetings with DHCF management to receive updates on the on-going work addressing CURAM/HCR issues, both clearing "stuck cases" and instituting code fixes to prevent future issues. The CURAM/HCR efforts are challenging with new problems arising as old ones are remedied.

EnrollApp

In FY2016, to address this issue as it related to non-IAP applications and for other purposes, HBX developed and launched EnrollApp. The eligibility rules engine was built with the lessons learned from experience processing non-IAP applications through CURAM/HCR in plan years 2014 and 2015. While CURAM/HCR uses commercial off-the-shelf software from an outside software vendor, EnrollApp is built locally by HBX's own system architects and coders using open source coding that is nimble in changes, fixes, and improvements. Thus, HBX is not relying on version upgrades by the vendor. HBX can address code

problems when and if they arise. Also because all applications that go through EnrollApp are for an exchange product, HBX does not have competing priorities with Medicaid to resolve issues that arise.

Corrective Action

As recommended in this finding, HBX will continue its work with DHCF "to strengthen compensating controls to identify and address 'stuck cases' in a timely manner" within CURAM/HCR. HBX recognizes that DHCF and DHS will prioritize fixes related to Medicaid, impacting approximately 90% of CURAM/HCR users.

Despite our efforts and the efforts of DHCF and DHS, the problem of stuck cases continues to persist for the third year in a row. In 2016, HBX began developing an open source cloud-based alternative to CURAM/HCR for APTC and CSR determinations. Later in 2018, that alternative will be fully built. HBX will work with DHCF to develop a path forward.

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Point of Contact: Trey Long, Deputy Administrator for Innovation and Change Management, Economic Security Administration, Department of Human Services. Trey.Long@dc.gov, (202) 645-3129.

CONCLUSION

We confirm that we have reviewed relevant documentation and determined that except for the noncompliance findings noted, 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, 2018