D.C. HEALTH BENEFIT EXCHANGE AUTHORITY

FISCAL YEAR 2019 PROGRAMMATIC AUDIT REPORT

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

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TRANSMITTAL LETTER

July 29, 2020

Executive Director
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) audit for fiscal year 2019 (October 1, 2018 to September 30, 2019). Our work was performed during the period of February 3, 2020 through July 29, 2020 and our results are as of July 29, 2020.

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 45 CFR Part 155 subparts D and E for the fiscal year ended September 30, 2019.

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 D and E. 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, and Centers for Medicare and Medicaid Services (CMS). 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 subparts D and E. However, our audit does not provide a legal determination of the Exchange's compliance with those requirements.

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Opinion on Compliance with 45 CFR Part 155

In our opinion, except for the instances of noncompliance, which are described in the accompanying schedule of findings and recommendations as items 2019-001 to 2019-004, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2019.

Other Matter

The Exchange's responses to the noncompliance findings are described in the accompanying schedule of findings and recommendations. We did not audit the Exchange's responses and, accordingly, we express no opinion on them.

Sincerely,

Bert Smith & Co.

Washington, D.C.

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. AUDIT OBJECTIVES

The objectives of this audit were to determine the Exchange'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

The scope of the programmatic audit covers the Exchange's compliance with the requirements under 45 CFR Part 155 subparts Subpart D - Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs and Subpart E - Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans for the period October 1, 2018 through September 30, 2019.

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.

To determine the Exchange's compliance with the programmatic audit requirements we performed specific procedures as follows:

- 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, Health Benefit Exchange (HBX)
  - Associate General Counsel and Policy Advisor, Health Benefit Exchange (HBX)
  - Assistant Director of Marketplace Operations for the Individual Market (HBX)
  - Assistant Director for the Individual Market, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX)
  - Attorney/Advisor, Health Benefit Exchange (HBX)
  - Chief Information Officer (CIO), Health Benefit Exchange (HBX)
  - Technical Project Manager, Department of Human Services (DHS)
  - Economic Security Administration Deputy Administrator for Service Centers, Department of Human Services (DHS)
  - Privacy and Records Officer, Department of Human Services (DHS)
  - Assistant Director for Exchange Data and Transactions, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX).
  - Software-Oriented Architect, Office of the Chief Technology Officer
  - Chief Information Security Officer, Office of the Chief Technology Officer
  - IT Specialist, Office of the Chief Technology Officer

- We reviewed the following key documents, regulations and requirements, and policies and procedures:
  - 45 CFR Part 155
  - 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
- 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 effectiveness of internal controls over the subpart requirements.
- 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 53,884 unique applications which were submitted in FY 2019, we selected a sample of 55 (25 EnrollApp and 30 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 53,884 applications which were submitted in FY 2019, we reviewed all applicants (9 instances) who attested to being 'not lawfully present' and enrolled in a QHP to verify compliance with 45 CFR 155 Subpart D - Eligibility Determinations for Exchange Participation and Subpart E - Enrollment in Qualified Health Plans.

- From a record of 29,116 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2018, we selected a sample of 45 cases to test their compliance with 45 CFR 155 Subpart E – Enrollment in Qualified Health Plans. Enrollment records were reviewed to verify timely and accurate communication of applicant details and Advance Premium Tax Credit (APTC) determinations to insurance carriers.

- From a record of 29,116 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2018, we reviewed all instances to verify the calculated Premium amount was not more than the allowed Advance Premium Tax Credit (APTC) amount to test their compliance with 45 CFR 155 Subpart D - Eligibility Determinations for Exchange Participation and Subpart E - Enrollment in Qualified Health Plans.

- From a record of 29,116 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2018, we reviewed all instances where applicants were enrolled in the same QHP more than once to test their 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 Insurance Affordability Programs and Subpart E - Enrollment in Qualified Health Plans. Backup logs and database backup configurations were reviewed to test data and records maintenance procedures related to eligibility and enrollment.

V. NATURE OF CONFIDENTIAL OR SENSITIVE INFORMATION OMITTED

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 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 # 2019-001:** Untimely Resolution of Outstanding Eligibility Verifications. **Finding # 2019-002:** Inadequate Citizenship or Lawful Presence 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 # 2019-003:** 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 # 2019-002:** Inadequate Citizenship or Lawful Presence 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. **Finding # 2019-001:** Untimely Resolution of Outstanding Eligibility Verifications
	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 not in compliance with this requirement. **Finding # 2019-001:** Untimely Resolution of Outstanding Eligibility Verifications
	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 # 2019-004:** Duplicate QHP Enrollments
	4. Data and records maintenance related to enrollments.	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:

2019-001: ***Untimely Resolution of Outstanding Eligibility Verifications***

Condition: Outstanding eligibility requirements submitted through DC Health Link were not fully verified in a timely manner in four (4) of the 25 Curam sample cases reviewed for income and SSN verification requirements.

The four (4) exceptions are described below:

- Three (3) applicants received APTC allowances without timely income verification.
  - One (1) applicant attested to $-0- income; however, due to known system issues, an income verification flag was not raised in the system for HBX to verify the attestation. This resulted in outstanding income verification for a period of 239 days from the date the QHP was selected until the end of the applicant's enrollment period.
  - One (1) applicant's attestation of income was not verified during their enrollment period. This resulted in outstanding income verification for a period of 102 days from the date the QHP was selected until the end of the applicant's enrollment period. The applicant contacted the HBX to correct their income attestation and subsequently cancelled their QHP enrollment.
  - One (1) applicant's attestation of income was not verified throughout their enrollment period. This resulted in outstanding income verification for a period of 308 days from the date the QHP was selected until the end of the applicant's enrollment period.
- One (1) applicant, who was a newborn baby at the time of application, citizenship and residency criteria were not verified for a period of 162 days from the date the QHP was selected until the end of the applicant's enrollment period.

Criteria: 45 CFR §155.320(c)(1)(i)(A): For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

45 CFR §155.320 (c)(3)(vi)(E): If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.

45 CFR §155.315(c)(3) For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the Social Security Administration or the Department of Homeland Security, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security, as applicable.

Cause:

When an applicant attests to not having income, the DC Health Link system does not trigger automatic verification to the federal hub or create an outstanding verification.

Outstanding verifications are reviewed monthly however an adverse action to outstanding eligibility verification procedures are conducted three times a year (every 121 days).

Effect:

HBX permitted applicants to receive APTC payments who may not be eligible.

Recommendation:

HBX should address outstanding verifications in a timelier manner to meet the 90-day threshold. Formal correspondence should be communicated to applicants in instances where exceptions to the defined threshold is granted.

HBX should further evaluate and fix the known system error on the CURAM/HCR platform to ensure verification procedures are performed.

Management's Response:

HBX concurs with this finding in-part and rejects the finding in part.

<u>HBX rejects the finding in part:</u>

HBX rejects the finding in part because HBX in a timely manner terminated the enrollment of one (1) enrollee receiving APTC.

In this case, HBX terminated the enrollment and APTC twelve (12) days after the end of his 90-day inconsistency period to resolve the income inconsistency. The customer called to report a change of income, was found eligible for Medicaid, and his QHP coverage was terminated the

same day. The same-day termination of the QHP, along with the APTC, was 22 days earlier than would have occurred under an adverse action for failure to verify income had such adverse action been taken immediately on the 1st day after the inconsistent period ended. There could not have been any "timelier" action as recommended by the auditor that would have produced a different result. The evidence demonstrates the customer responded, indicated facts had changed, and HBX took appropriate action. Contrary to the finding, and as described in more detail below, HBX has effective procedures to resolve outstanding eligibility verifications and conducts such verifications on a regular basis throughout the year.

HBX concurs with the finding in part:

$-0- Income case

One (1) applicant attested to $-0- income; however, due to known system issues, an income verification flag was not raised and the enrollee was permitted enrollment with APTC.

The FY17 programmatic audit revealed that when a consumer attested to not having any income, no income "evidence" is created. The CURAM/HCR system can only place outstanding verifications on pieces of "evidence" within a customer's record. As such, CURAM/HCR erroneously accepted the attestations of no income without requesting verification.

Consistent with our manager's response to the FY17 finding, dated 6/1/2018, HBX began working with DHCF to identify how to make changes to the CURAM/HCR platform. DHCF (the Medicaid agency) is responsible for CURAM/HCR system design changes. On 10/16/18, approximately 4 months after the FY17 audit report was issued, a code fix effecting new application was deployed to CURAM/HCR in time for the plan year 2019 Open Enrollment Period. However, this case is not considered a "new application". Instead, it is a "renewal". As indicated in our response to the FY17 finding, HBX continued to work on this issued over the course of FY19. Additional code fixes were deployed in 2019. On 10/31/19 a code fix related to renewals was deployed, in time for plan year 2020 renewals. On 12/2/19, a code fix was released related to cases involving the addition of a new household member. At that point, the $0 case issue has been fully addressed through code fixes.

Other 2 cases

HBX has established a process for reviewing outstanding verifications that exceed the 90-day inconsistency period with a holistic viewpoint supported by federal regulation. These regulations permit both extensions of the inconsistency period and waivers of the verification requirement in appropriate circumstances. Contrary to the recommendation by the auditors in this finding, formal correspondence is not required by regulation and would not form a part of HBX's verification resolution process. Instead, HBX finds that direct communication by phone or e-mail is more appropriate. In large

part based on the low volume of consumers receiving APTC (6.15% of FY19 enrollees), and building on these regulatory flexibilities, our staff work directly one-on-one with consumers to resolve these verifications without needing to resort to adverse action.

With this approach in-mind, the HBX process utilizes monthly reports of customers who have exceeded their 90-day period and adverse actions are taken on a quarterly basis (March, June, and September). The case managers review the monthly reports not only to see who has exceeded the period, but they track those cases they are working with. During the adverse action months, HBX takes adverse action against those customers who have not been granted an extensions based on good faith attempts to resolve the inconsistency or been granted a waiver based on special circumstances. Both are based on work with an HBX case manager. At a minimum, the customer has 30 days beyond the 90-day expiration to respond to calls from the case manager attempting to prevent adverse action.

Additionally, adverse actions do not occur in the months of November through February because of the interaction with other federal regulations. Any appeals of an adverse action would revert to a reinstatement of coverage or APTC pending appeal, causing us to be back where we started, attempting to resolve the inconsistency through conversation. Additionally, during open enrollment, once terminated, a customer could simply re-apply and immediately re-enroll pending a new 90-day inconsistency period. This would overlap the one-on-one work the caseworker is already engaged in with the customer, creating confusion.

We believe it causes less consumer confusion and is consistent with the regulations taken as a whole to suspend adverse actions during open enrollment as long as case managers continue to receive outstanding verification reports during this period and continue working with consumers to resolve them.

Going forward, HBX will continue to work to ensure case managers adhere to the follow-up and adverse action protocols to ensure verification procedures are performed while supporting consumer enrollment.

Point of Contact: Eliza Bangit, Director of Marketplace Innovation, Policy, and Operations, Eliza.Bangit@dc.gov, (202) 741-7640

2019-002: ***Inadequate Citizenship or Lawful Presence Verification Procedures (Repeat Finding)***

Condition: Three (3) enrollees attested to an ineligible immigration status and their citizenship or lawful presence attestation was not verified and were permitted to enroll in a QHP.

The three (3) exceptions are described below:

- In two (2) instances, the individuals updated their prior lawful presence status to an attestation of being "not lawfully present" and the change did not result in a subsequent verification of citizenship. The applicants were passively enrolled in a QHP for FY19.

- In one (1) instance, the applicant attested to being "alien lawfully present" however lawful presence was not verified, and an outstanding verification trigger was not automatically created. The applicant successfully enrolled in a QHP during FY19.

Criteria: 45 CFR §55.330(a): Eligibility redetermination during a benefit year - General requirement. The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee.

45 CFR §155.330(c)(1): Verification of reported changes. The Exchange must 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.

Cause: Inadequate controls over citizenship verification during applicants' eligibility redetermination process. Applicants' prior "lawfully present" status verification would be accepted without verifying subsequent updated attestations to being "not lawfully present".

Effect: HBX provided inaccurate eligibility determinations to applicants as defined in 45 CFR §155.305(a)(1).

Recommendation: Management should strengthen its procedures for secondary reviews of lawful presence attestations during the eligibility determination and redetermination processes to ensure all electronic verifications are successfully completed.

Management's Response: The Exchange concurs with the finding with the following explanation. The three (3) cases identified as being improperly handled are out of the 29,116 QHP enrollees during FY19, thus representing 0.01% of all QHP enrollees during the fiscal year. To find these cases, the auditors did not use a sampling method. The auditors identified *all* cases where individuals identified themselves as being not lawfully present in FY19 but were enrolled in coverage.

Two (2) of the three (3) cases involve applications where the customers changed their answers post-enrollment from being lawfully present to not being lawfully present, but the systems did not properly process that information in relation to their existing enrollment. HBX will review the verification processes of caseworkers and whether reported changes to lawful/not lawful presence status by a customer trigger appropriate action in HBX's enrollment system, including connecting with the CURAM system managed by DHCF where appropriate. In addition, in FY19, HBX began developing technical parameters for a monthly report that would identify situations such as those identified by this audit. HBX case managers will then initiate appropriate actions to resolve the discrepancies. This report will be implemented in Q4 of FY20.

Point of Contact: Eliza Bangit, Director of Marketplace Innovation, Policy, and Operations, Eliza.Bangit@dc.gov, (202) 741-7640.

2019-003: ***Lack of QHP Determination for Submitted Applications (Repeat Finding)***

Condition: An eligibility determination for submitted applications was not always provided to consumers seeking a QHP. The D.C. Health Link website did not provide a timely eligibility determination in 174 instances which represents 1.2% of eligible submitted Insurance Affordability Program (IAP) applications. The software which is utilized to process eligibility determinations for IAP applications via the DC Health Link website, Curam, continues to experience various processing errors.

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 were unable to receive timely eligibility determinations and therefore could not enroll in a QHP.

Recommendation: Management must continue to strengthen compensating controls to identify and address 'stuck' application in a timely manner 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 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 and is managed by DHCF. This finding demonstrates that:

- 100% of the applications through EnrollApp successfully received a timely eligibility determination; and
- 99% of the applications through CURAM successfully received an eligibility determination while 1% did not receive a timely determination.

EnrollApp

The EnrollApp platform handles non-IAP eligibility as well as all QHP shopping and enrollment for all private plan enrollees. It was developed by HBX in part to address systemic issues and deficiencies with CURAM (identified by HBX when HBX managed CURAM in the past) and was deployed for plan year 2016.

While CURAM 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 the Medicaid program to resolve IT issues.

EnrollApp has not had any "stuck cases" for applications submitted since the platform launched. The success of EnrollApp has been verified by every programmatic audit where it was reviewed (FY16, FY17, FY18, and FY19).

CURAM

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. In FY19, 87.8% of new CURAM applications in the District had one or more person determined eligible 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 CURAM system issues that lead to cases becoming stuck in the first instance. DHS case workers are responsible for working cases to get customers' issues resolved. HBX's relies on CURAM to make APTC and CSR eligibility determinations. Customers that are not seeking Medicaid, APTC, or CSR eligibility do not apply through CURAM, but instead through EnrollApp.

In FY2018, as noted in the finding, 1.2% of CURAM applications failed to receive a timely 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. That team holds meetings each Monday to review the cases in stuck status by age of case, so that appropriate mitigation actions can be taken. The DHS Division of Program Operations (DPO) continues to monitor volume using workflow management reports created by PathosOS. However, these CURAM/HCR corrective action efforts are challenging, with new problems arising as old ones are remedied.

Corrective Action

As recommended in this finding, HBX will continue its work with DHCF and DHS "to strengthen compensating controls to identify and address 'stuck cases' in a timely manner" within CURAM. HBX recognizes that DHCF and DHS will prioritize fixes related to Medicaid, impacting the 87.8% of new CURAM applications processed in FY19 that received a Medicaid eligibility determination. Despite our efforts and the efforts of DHCF and DHS, the problem of stuck cases in CURAM continues to persist for the fifth year in a row.

Due to the lack of progress in correcting this issue within CURAM, HBX started, in 2016, to develop an open source cloud-based alternative to CURAM for APTC and CSR determinations. Developmental efforts on this solution have reached the point where integrating with our Medicaid partners would achieve the smoothest interoperability and transitions for consumers. HBX continues to work with DHCF to develop a path forward toward this solution.

Point of Contact: Eliza Bangit, Director of Marketplace Innovation, Policy, and Operations, Eliza.Bangit@dc.gov, (202) 741-7640.

Point of Contact: Justin Stokes, Technical Program Manager, Department of Health Care Finance. Justin.Stokes2@dc.gov, (202) 880-4433.

2019-004: ***Duplicate QHP Enrollments***

Condition: HBX erroneously maintained duplicate enrollments for two (2) customers, in the same QHP.

The two (2) exceptions are described below:

- One customer submitted two applications with two different SSNs. DC Health Link assigned different HBX IDs, and permitted the duplicate enrollment, under the separate SSNs. One SSN was electronically verified by the federal hub and the other was not. An outstanding verification for the unverified SSN as well as outstanding verifications for citizenship and residency was raised. The outstanding verifications were erroneously manually removed by a caseworker. The customer selected the same QHP for each application and both QHP selections were communicated to the issuer.

- One customer, with the same HBX ID, selected the same plan twice for the same coverage period. The duplicate QHP selection is reflected in the enrollment file that was communicated to the issuer.

Criteria: 45 CFR § 155.315 (b)(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration.

45 CFR § 155.400 (d) Reconcile files. The Exchange must reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

Cause: HBX Caseworker's oversight in manually approving customer eligibility requirement caused a duplicate enrollment to persist. HBX's failure to note a duplicate enrollment, for a customer with the same HBX ID, allowed a duplicate enrollment to persist.

Effect: HBX maintained duplicate enrollments to the issuer for the same coverage period.

Recommendation: HBX should strengthen controls around the review of enrollment records to prevent duplicate enrollments from occurring or persisting.

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

HBX appreciates the work of the auditors, which shows this is an extremely remote issue. The two (2) cases identified as being improperly handled are out of the 29,116 QHP enrollees that enrolled during FY19, thus representing less than 0.01% of all QHP enrollees during the fiscal year. To find these cases, the auditors did not use a sampling method, but instead checked for duplicate enrollments in the entire FY19 enrollment report.

Of the 2 cases identified by the auditors, none involve customers receiving APTC, in any plan year, when enrolled through HBX.

This audit confirmed that the current HBX controls prevented duplicate enrollments in 99.9% of cases. In the first case identified by this audit, a human error overrode the system control that alerted the case manager to a problem. This case will be used in the training of caseworkers. In the second case, based on HBX reconciliation protocols already in place, the duplicate enrollment for the same member ID should have been caught on monthly reconciliation and removed. HBX management will review this case with the team that handles the reconciliation process. In both cases, the carrier serves as the checks and balances and their systems only provided for one enrollment.

Point of Contact: Eliza Bangit, Director of Marketplace Innovation, Policy, and Operations, Eliza.Bangit@dc.gov, (202) 741-7640.

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: July 29, 2020