

D.C. HEALTH BENEFIT EXCHANGE AUTHORITY
FISCAL YEAR 2021 PROGRAMMATIC AUDIT REPORT



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TRANSMITTAL LETTER

May 27, 2021

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 2021 (October 1, 2020 to September 30, 2021). Our work was performed during the period of February 7, 2022 through May 27, 2022 and our results are as of May 27, 2022.

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, 2021.

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.

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 2021-001 to 2021-002, the Exchange complied in all material respects, with the types of compliance requirements referred to above for the fiscal year ended September 30, 2021.

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,

A handwritten signature in black ink that reads "Bert Smith & Co." with a period at the end. The signature is written in a cursive, slightly stylized font.

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. 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, 2020 through September 30, 2021.

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, Health Benefit Exchange (HBX)
 - Deputy General Counsel and Policy Advisor, Health Benefit Exchange (HBX)
 - Associate General Counsel and Policy Advisor, Health Benefit Exchange (HBX)
 - Deputy Director, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX)
 - Individual Market Member Services Manager, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX)
 - EDI & XML Program Analyst, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX)
 - Assistant Director for Exchange Data and Transactions, Marketplace Innovation, Policy, and Operations Department, Health Benefit Exchange (HBX).
 - Chief Information Officer (CIO), Health Benefit Exchange (HBX)
 - Technical Project Manager, Health Benefit Exchange (HBX)
 - Economic Security Administration Deputy Administrator for Program Operations, Department of Human Services (DHS)
 - IT Specialist, Office of Information Systems, Department of Human Services (DHS)

- 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 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 28,346 unique applications which were submitted in FY 2021, we selected a sample of 45 EnrollApp and 45 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 28,346 applications which were submitted in FY 2021, we reviewed all applicants (7 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.

EXECUTIVE SUMMARY (CONTINUED)

- From a record of 22, 236 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2020, 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 22, 236 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2020, 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 22, 236 applicants who had enrolled in a Qualified Health Plan on or after October 1, 2020, 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 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 # 2021-001: 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 in compliance with this requirement. |
| | 4. Process for the administration of payments of advance premium tax credits (APTCs). | The Exchange is in compliance with this requirement. |
| | 5. 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 not in compliance with this requirement. Finding # 2021-002: Duplicate QHP Enrollments (Repeat Finding). |
| | 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:

2021-001: 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. One of the two software platforms utilized to process eligibility determinations for IAP applications via the DC Health Link website, Curam, continues to experience processing errors. In 208 instances where applicants met the eligibility criteria, which represents 1.07% of eligible submitted Insurance Affordability Program (IAP) applications submitted via Curam, the software did not provide a timely eligibility determination.

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 Response:

The Exchange concurs with the finding with the following explanation:

Separate Application and Eligibility Systems

DC Health Link includes CURAM, which is managed by the Department of Health Care Finance (DHCF), and EnrollApp, which is managed by HBX. Prior to March 2, 2021, all insurance affordability program (IAP) were handled in CURAM whereas all applications for private insurance without Advance Premium Tax Credits (APTCs) or Cost-Sharing Reductions (CSRs) were handled by EnrollApp. Private plan shopping and enrollment occurred exclusively through EnrollApp. Starting March 2, 2021, residents could initiate their IAP application with either the Medicaid agency (through CURAM) or HBX (through EnrollApp). Prior to application, customers are

AUDIT FINDINGS AND RECOMMENDATIONS (CONTINUED)

screened for IAP eligibility. Anyone screened as potentially eligible for Medicaid or wanting a Medicaid determination applies through CURAM. Others apply through HBX's IAP application (EnrollApp). The starting point for either pathway is the DC Health Link website. Private plan shopping and enrollment continued to occur exclusively through EnrollApp.

This finding demonstrates that:

- 100% of the applications through EnrollApp successfully received a timely eligibility determination; and
- 98.93% of the applications through CURAM successfully received an eligibility determination while 1.07% did not receive a timely determination.

CURAM

In the District of Columbia, the 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. Until March 2, 2021, CURAM was the only system used by customers applying for IAPs, specifically Medicaid, APTCs, and CSRs. After that date, customers could initiate an IAP application in either CURAM or EnrollApp, but Medicaid determinations always occur via CURAM.

Consistent with federal regulations, all IAP applications are first reviewed for Medicaid eligibility. In FY21, 74% of new CURAM IAP applications in the District had one or more person determined eligible for Medicaid. DHCF is responsible for the operation and management of CURAM, 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.

In FY2021, as noted in the finding, 1.07% of CURAM applications failed to receive a timely eligibility determination. The joint DHCF/DHS team continued to identify code fixes and perform data cleanup to reduce the number of applications that can become stuck. That team held meetings each Monday to review the cases in stuck status by age of case, so that appropriate mitigation actions could be taken. The DHS Division of Program Operations (DPO) continued 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.

EnrollApp

The EnrollApp platform 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 starting with 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, HBX does not

AUDIT FINDINGS AND RECOMMENDATIONS (CONTINUED)

have competing priorities with the Medicaid program to resolve IT issues in EnrollApp.

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, FY19, FY20, and FY21).

Corrective Action

As recommended in this finding and previous findings, during FY21, HBX continued its work with DHCF and DHS “to strengthen compensating controls to identify and address ‘stuck cases’ in a timely manner” within CURAM. However, HBX recognized that DHCF and DHS has continued to prioritize fixes related to Medicaid and human services benefit programs based on the large volume of customers impacted by those programs. Despite our efforts and the efforts of DHCF and DHS, the problem of stuck cases in CURAM continues to persist for the seventh year in a row, though volume remains low.

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 residents to submit IAP applications directly to HBX via EnrollApp. This HBX-managed IAP application launched on March 2, 2021. As demonstrated by this finding, there are no “stuck cases” among the EnrollApp IAP applications.

Point of Contact: Jennifer Beeson, Director of Marketplace Innovation, Policy, and Operations, Jennifer.Beeson@dc.gov, (202) 741-0656.

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

AUDIT FINDINGS AND RECOMMENDATIONS (CONTINUED)

2021-002:

Duplicate QHP Enrollments (Repeat Finding)

Condition:

HBX transmitted duplicate QHP enrollments for five (5) customers to carriers and failed to initiate cancellation for those duplicate enrollments.

Criteria:

45 CFR §155.430(b)(2)(v) - The Exchange must terminate a prior QHP enrollment when it is replaced with a new QHP enrollment.

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

Cause:

HBX failed to identify a duplicate enrollment, for customers with duplicate enrollments for the same carrier and QHP.

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 five (5) cases identified as being improperly handled are out of the 22,236 unique QHP enrollees that enrolled during FY21, thus representing 0.02% of all unique 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 FY21 enrollment report.

HBX's investigation of this matter reveals that it is caused by duplicate records rather than duplicate enrollments. In the 5 cases identified by the auditors as having duplicate enrollments in HBX's records, none involved an actual duplicate enrollment by the carrier. HBX has EDI transaction protocols in place wherein carriers automatically override a prior enrollment with the new enrollment. In no instance, including in these five cases, would a customer be enrolled in multiple QHPs, or the same QHP, covering the same time period. Adherence to these protocols was confirmed by HBX during this audit; HBX checked the weekly enrollment reports and monthly reconciliation files provided by carriers to confirm the five customers did not have duplicate enrollments in the carrier systems.

While duplicate enrollment remains an extremely remote issue, HBX was unable during FY21 to implement the planned corrective action (from the FY20 finding) of more frequent checks of the enrollment records to cancel duplicate enrollments. These efforts were postponed while HBX focused on efforts associated with the COVID-19 pandemic and particularly implementation of enhanced APTC/CSR under the American Rescue Plan. Efforts to eliminate duplicate enrollment records will remain part of HBX's ongoing review of reconciliation protocols with carriers.

Point of Contact: Jennifer Beeson, Director of Marketplace Innovation, Policy, and Operations, Jennifer.Beeson@dc.gov, (202) 741-0656.

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, C.

COMPLETION DATE OF AUDIT FINDINGS REPORT:

May 27, 2022