



***Advance Payments of the Premium Tax Credit (APTC) & Federally-facilitated Exchange (FFE) User Fee (UF) Program Assessment Report***

***for***

***Magnolia Health Plan (Magnolia)***

***March 14<sup>th</sup>, 2023***

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## I. EXECUTIVE SUMMARY

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### Background

Magnolia Health Plan (Magnolia) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market Federally-facilitated Exchange (FFE) in Mississippi during the 2015 benefit year. Magnolia submitted its final restated 2015 benefit year data in the October 2017 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$74,005,776.08 in advance payments of the premium tax credit (APTC) from the Centers for Medicare & Medicaid Services (CMS) and paid a total of \$3,103,081.76 in FFE user fees (UF) to CMS for its 2015 benefit year individual market plans.

This report is an assessment of Magnolia's compliance with the APTC, and FFE user fee programs established in sections 1311 and 1401 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) enacted on March 23, 2010, and further amended and revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) enacted on March 30, 2010 (collectively referred to throughout as PPACA) and implementing regulations.

### Audits to Determine Compliance with the Administration of APTC and FFE User Fee Programs

Under title 45 of the Code of Federal Regulations (CFR), sections [156.480](#) and [156.705](#), the Department of Health and Human Services (HHS) may audit<sup>1</sup> issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC and FFE user fee program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following:

- Safeguard Federal funds;
- Instill confidence amongst regulated entities of data quality, soundness, and robustness;
- Evaluate health insurance issuer compliance with program rules and regulations; and
- Develop a successful and coordinated risk-based, multi-year audit program that maximizes resources.

This audit is part of CMS's program to validate the enrollment and payment data reported on the final 2015 EPDW, and to analyze controls and policies of selected issuers pursuant to the authority defined in the 45 CFR §§ 155.480 and 156.705.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment, then CMS classified it as a *finding*. If CMS found a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of

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<sup>1</sup> To provide the flexibility needed when standing up a new oversight program and to ensure that issuers are able to provide CMS with their most accurate data, audit protocols allow for dialogue between auditor and issuer to identify and correct errors in data submission that differ somewhat from some independence and reporting standards laid out under Generally Accepted Government Auditing Standards (GAGAS). These procedures were defined and executed consistent with the competence, integrity, and analytical discipline required for performance audits as defined by GAGAS.

improving compliance in future program years, but that does not require correction to payment, then CMS categorized it as an *observation*.

## **Results of Review**

CMS identified five (5) findings and no observations for Magnolia. The net financial impact of the five (5) findings is a payment due to CMS of \$44,151.68, consisting of \$2,141.74 in FFE user fees to be returned to Magnolia and \$46,293.42 in APTC to be returned to CMS. The findings include the following:

1. Inclusion of enrollment and payment data in the Payment Desk Audit File for fifty-two (52) subscribers with coverage that was not effectuated in the issuer's systems;
2. Inclusion of incorrectly prorated payment data for sixty-two (62) duplicate subscribers in the Payment Desk Audit File;
3. Inclusion of enrollment and payment data for three (3) subscribers with a coverage period of five (5) days or fewer in the Payment Desk Audit File;
4. Inclusion of incorrectly prorated premium and APTC amounts for two (2) of the forty-five (45) selected subscribers in the Payment Desk Audit File; and
5. Inclusion of payment data in the Payment Desk Audit File for one (1) of the forty-five (45) selected subscribers with coverage that should have been cancelled.

Please refer to section IV for details on the findings listed above, including the condition, cause, effect, corrective actions, and the issuer's responses.

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## **II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY**

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### **A. Background**

Sections 1401 and 1412 of the PPACA established the APTC program to support the provision of affordable health care coverage to individuals. Additionally, section 1311 of the PPACA allows the FFEs to charge participating issuers user fees to support FFE operations.

CMS has the responsibility to confirm successful implementation of, and adherence to, the PPACA provisions and implementing regulations governing the APTC and FFE user fee programs. As such, CMS established this audit program.

#### **Interim Payment Process**

Since automated payment systems were not yet developed during the first years of FFE implementation, CMS implemented an interim payment process to calculate and make monthly payments of APTC and advance Cost-sharing Reduction (CSR) amounts, and to collect FFE user fees. The interim payment process required issuers to self-report enrollment and payment data on a monthly basis, including any adjustments to previous months' requests, via manual submission of an EPDW, and to attest to the accuracy of the data.

For the 2015 benefit year, CMS used this interim payment process to calculate and make monthly payments based on QHP data submitted in the EPDW. While using this interim process, CMS designed and implemented a robust set of internal controls within a larger program integrity framework to ensure payment accuracy. CMS required submitters to send the following QHP plan information at the variant level via the password-protected template:

1. State
2. Tax Identification Number (TIN)
3. Health Insurance Oversight System (HIOS) ID
4. QHP ID
5. Total premium amount for all enrollments
6. Total APTC amount
7. Total advance CSR amount
8. Total FFE User Fee amount
9. Total effectuated enrollment groups
10. Total effectuated enrollment groups with APTC
11. Total effectuated enrollment groups with advance CSR
12. Total effectuated members
13. Total effectuated members with APTC
14. Total effectuated members with advance CSR

FFE issuers were required to calculate the QHP enrollment and payment amounts and submit that information on the EPDW template using their internal source data.

## **B. Regulations Governing APTC and FFE User Fee Programs**

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC and FFE user fee programs:

- 45 CFR § [156.50](#): Financial Support;
- 45 CFR § [156.460](#): Reduction of enrollee's share of premium to account for advance payments of the premium tax credit;
- 45 CFR § [156.480](#): Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs; and
- 45 CFR § [156.705](#): Maintenance of records for Federally-facilitated Exchanges.

Please refer to Appendix 2 for the specific requirements established under the authorities listed above.

## **C. Objectives**

The objectives of this audit are to:

- (1) Evaluate the accuracy and integrity of issuer-generated EPDW data reported for the APTC and FFE user fee programs;
- (2) Identify potential CMS APTC payment and FFE user fee collection errors resulting from issuer data reporting errors; and
- (3) Test accuracy and integrity of issuer processes for reducing an enrollee's share of premium to account for APTCs.

## **D. Scope and Methodology**

CMS selected Magnolia for an audit on issuer compliance with 45 CFR §§ 156.50, 156.460, 156.480 and 156.705. CMS evaluated Magnolia's activities related to the 2015 benefit year (January 1, 2015, through December 31, 2015) individual market data reported on the final EPDW submitted in October 2017 by the issuer to CMS to support APTC and FFE user fee collections.

CMS sent Magnolia an electronic letter on May 11, 2018, to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to Magnolia on May 15, 2018, that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by Magnolia and used CMS's audit procedures to assess compliance with APTC and FFE user fee program rules and regulations.

CMS's audit contractor applied CMS's audit protocol to identify the findings and observations listed in sections IV and V of this report. CMS's audit contractor performed the following procedures:

- Validations of the Payment Desk Audit File<sup>2</sup> data submitted to CMS:
  - EPDW Validations: Review and comparison of the issuer's final submitted 2015 EPDW to the Payment Desk Audit File from the issuer's systems.
  - Unreconciled Subscribers Review: Review and comparison of the subscribers reported on the Payment Desk Audit File to the subscribers included in CMS's

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<sup>2</sup> The Payment Desk Audit File is CMS's standard document for issuers to provide information in support of this audit.

systems to determine if the subscribers existed and their coverage was effectuated in the issuer's system (i.e., the amount the subscriber is responsible to pay toward the first month's total premium amount has been paid in full by the subscriber).

- Duplicate Exchange-assigned Subscriber IDs Check: Review of the Payment Desk Audit File containing subscriber level data from the issuer's systems to verify that duplicate Exchange-assigned subscriber IDs (i.e., Exchange-assigned subscriber IDs that were reported on the file twice in the same month with full month or incorrectly prorated payment data) were not reported on the file.
- Premium Less than APTC Validation: Review of the Payment Desk Audit File to verify that the subscribers' premium amounts reported on the file were not less than the APTC amounts reported on the file.
- Coverage Days Validation: Review of the Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems.
- Validations on samples of issuer's systems data:
  - Forty-five (45) Subscribers Sample Review: Review and comparison of the coverage periods, premium and APTC amounts from the issuer's systems to the corresponding data included in CMS's systems for a selected sample of forty-five (45) subscribers.
  - Fifteen (15) Subscribers Sample Review: Analysis and review of data and documentation from the issuer's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

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### **III. RESULTS OF REVIEW**

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CMS assessed issuer compliance with regulations using the following procedures: EPDW Validations, Unreconciled Subscribers Review, Duplicate Exchange-assigned Subscriber IDs Check, Premium Less than APTC Validation, Coverage Days Validation, Forty-five (45) Subscribers Sample Review, Fifteen (15) Subscribers Sample Review, and Policy and Procedure Review. Below are the results of this review.

#### **EPDW Validations**

No findings or observations resulted from the comparison of the final 2015 EPDW to Magnolia's Payment Desk Audit File.

#### **Unreconciled Subscribers Review**

One (1) finding and no observations resulted from the review of Magnolia's Payment Desk Audit File to determine if the subscribers reported on the file existed and their coverage was effectuated in the issuer's systems. Please refer to Finding No. 1 included in section IV for details on the finding.

#### **Duplicate Exchange-assigned Subscriber IDs Check**

One (1) finding and no observations resulted from the review of Magnolia's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported on the file. Please refer to Finding No. 2 included in section IV for details on the finding.

#### **Premium Less than APTC Validation**

No findings or observations resulted from the review of Magnolia's Payment Desk Audit File to verify that subscribers were not reported on the file with premium amounts that were less than the APTC amounts.

#### **Coverage Days Validation**

One (1) finding and no observations resulted from the review of Magnolia's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported on the file were effectuated and had active coverage in the issuer's systems. Please refer to Finding No. 3 included in section IV for details on the finding.

#### **Forty-five (45) Subscribers Sample Review**

Two (2) findings and no observations resulted from the review and comparison of the data from Magnolia's systems to the corresponding data included in CMS's systems to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers. Please refer to Finding No. 4 and Finding No. 5 included in section IV for details on the findings.

#### **Fifteen (15) Subscribers Sample Review**

No findings or observations resulted from the review of the data and documentation from Magnolia's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.



**Policy and Procedure Review**

No findings or observations resulted from the review of Magnolia's APTC policies and procedures.

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#### IV. FINDINGS

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A finding is an identification of an instance of issuer non-compliance with APTC and FFE user fee program requirements that requires correction to payment. CMS's audit procedures identified five (5) findings that resulted in a change to Magnolia's reported EPDW for individual market plans for the 2015 benefit year. In light of the five (5) findings, the adjusted 2015 benefit year EPDW APTC and FFE user fee amounts for individual market plans are shown in the following table.

##### Recalculated EPDW for the 2015 Benefit Year

	FFE User Fees	APTC
EPDW as Filed in October 2017	\$(3,103,081.76)	\$74,005,776.08
Finding No. 1 - Unreconciled Subscribers Review Adjustment	\$2,130.28	\$(47,309.19)
Finding No. 2 - Duplicate Exchange-assigned Subscriber IDs Check	\$2.78	\$1,220.21
Finding No. 3 – Coverage Days Validation	\$1.55	\$1.72
Finding No. 4 – Forty-five (45) Subscriber Review Adjustment (Incorrectly Prorated Payment Data)	\$(0.19)	\$2.42
Finding No. 5 – Forty-five (45) Subscriber Review Adjustment (Cancelled Enrollment)	\$7.32	\$(208.58)
EPDW As Recalculated	\$(3,100,940.02)	\$73,959,482.66
<b>Total Financial Impact</b>	<b>\$2,141.74</b>	<b>\$(46,293.42)</b>

**Note:** Positive values indicate funds owed to the issuer.

The net financial impact of the five (5) findings is a payment due to CMS of \$44,151.68, consisting of \$2,141.74 in FFE user fees to be returned to Magnolia and \$46,293.42 in APTC to be returned to CMS.

For the five (5) findings, CMS documented the criteria, cause, effect, corrective actions, and Magnolia's responses as seen in the charts below.

<b>Finding No. 1 - Unreconciled Subscribers Review</b>	<b>Condition:</b>	Magnolia overstated the 2015 benefit year premium amounts for fifty-two (52) subscribers, and overstated the 2015 benefit year APTC amounts for forty-eight (48) of those subscribers, in the Payment Desk Audit File by reporting enrollment and payment data for subscribers with coverage that was not effectuated.
	<b>Criteria:</b>	Pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is defined as "any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group."
	<b>Cause:</b>	The issuer indicated that the enrollments were not effectuated in its system and provided explanations surrounding non-payments, loading of bad debt, multiple exchange-assigned IDs and subscriber ID mismatches for the fifty-two (52) non-effectuated subscribers.
	<b>Effect:</b>	The inclusion of the fifty-two (52) non-effectuated enrollments resulted in a change to Magnolia's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment due to CMS of \$45,178.91, consisting of \$2,130.28 in FFE user fees to be returned to Magnolia and \$47,309.19 in APTC to be returned to CMS. Magnolia should confirm the financial impact by filling out Appendix 1.
	<b>Management Response:</b>	Agree

<b>Finding No. 2 - Duplicate</b>	<b>Condition:</b>	Magnolia overstated the 2015 benefit year premium amounts for seventeen (17) subscribers and
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<b>Exchange-assigned Subscriber IDs Check</b>		overstated the 2015 benefit year APTC amounts for twelve (12) of those subscribers and eleven (11) other subscribers. Additionally, Magnolia understated the 2015 benefit year premium amounts for twenty-one (21) subscribers and understated the 2015 benefit year APTC amounts for seventeen (17) of those subscribers and thirteen (13) other subscribers in the Payment Desk Audit File by reporting enrollment and incorrectly prorated payment data for mid-month enrollments or terminations.
	<b>Criteria:</b>	Pursuant to the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a FFE, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.
	<b>Cause:</b>	<p>The issuer indicated for four (4) subscribers. “The over-arching explanation is that the policies switched plans/qhp_identifiers. If that switch happened within a month the policy will be listed more than once for that given month. The dollar amounts and member counts are prorated to correctly reflect the portion of the month in which that policy was associated with the indicated QHP ID. The Benefit Start Date and Benefit End Dates reflect the dates where the policy was first associated with that QHP ID and the last date they were associated with it. If a subscriber left a QHP ID A for QHP ID B and then returned to QHP ID A (action typical for member losing and gaining back APTC) you could wind up with the date like the following that appear to overlap, but the figures are reported as prorated properly, and no duplication is occurring.”</p> <p>For the remaining fifty-eight (58) subscribers, the issuer indicated that the premium and APTC amounts included in the Payment Desk Audit File are prorated based on enrollment changes. CMS recalculated the prorations based on the service start and end dates and noted differences with the premium and APTC amounts in the desk audit file.</p>

	<b>Effect:</b>	The inclusion of incorrectly prorated payment data for the sixty-two (62) subscribers resulted in a change to Magnolia's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment due to Magnolia of \$1,222.99, consisting of \$2.78 in FFE user fees to be returned to Magnolia and \$1,220.21 in APTC to be paid to Magnolia. Magnolia should confirm the financial impact by filling out Appendix 1.
	<b>Management Response:</b>	Agree

<b>Finding No. 3 - Coverage Days Validation</b>	<b>Condition:</b>	Magnolia overstated the 2015 benefit year premium amounts for one (1) subscriber in the Payment Desk Audit File by incorrectly reporting a non-effectuated enrollment. Additionally, Magnolia understated the 2015 benefit year premium and APTC amounts for two (2) subscribers by reporting incorrectly prorated payment data for a coverage period of five (5) days or fewer.
	<b>Criteria:</b>	<p>Pursuant to CMS guidance, the issuer must create a single Inbound Payment Desk Audit File consisting of detailed enrollment group effectuated enrollment records (one per enrollment group, per month) with the corresponding payment data.</p> <p>Pursuant to the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a FFE, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.</p>
	<b>Cause:</b>	The issuer indicated that the enrollment for the one (1) subscriber was not effectuated in its system. Additionally, the issuer indicated that the premium and APTC amounts were incorrectly prorated and provided the correct premium and APTC amounts for two (2) subscribers.

	<b>Effect:</b>	The inclusion of the enrollment and payment data for the one (1) subscriber and incorrectly prorated payment data for two (2) subscribers resulted in a change to Magnolia's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment due to Magnolia of \$3.27, consisting of \$1.55 in FFE user fees to be returned to Magnolia and \$1.72 in APTC to be paid to Magnolia. Magnolia should confirm the financial impact by filling out Appendix 1.
	<b>Management Response:</b>	Agree

<b>Finding No. 4 – Forty-five (45) Subscribers Sample Review (Incorrect Proration)</b>	<b>Condition:</b>	Magnolia understated the 2015 benefit year premium and APTC amounts for two (2) of the forty-five (45) selected subscribers in the Payment Desk Audit File by reporting incorrectly prorated payment data.
	<b>Criteria:</b>	Pursuant to the HHS Notice of Benefit and Payment Parameters for 2015 and 45 CFR § 155.240, in a FFE, the premium for coverage lasting less than one month must equal the product of (i) The premium for one month of coverage divided by the number of days in the month; and (ii) The number of days for which coverage is being provided in the month.
	<b>Cause:</b>	The issuer indicated that the premium and APTC amounts included in the Payment Desk Audit File are prorated based on mid-month terminations. Based on the feedback that the payment data included in the Payment Desk Audit File is prorated, CMS calculated the prorated premium and APTC amounts based on the full month payment data and concluded that the 2015 benefit year premium and APTC amounts were understated for two (2) subscribers due to the incorrect proration.
	<b>Effect:</b>	The inclusion of the incorrect premium and APTC amounts for two (2) subscribers resulted in a change

		to Magnolia's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment due to Magnolia of \$2.23, consisting of \$0.19 in FFE user fees to be paid to CMS and \$2.42 in APTC to be paid to Magnolia. Magnolia should confirm the financial impact by filling out Appendix 1.
	<b>Management Response:</b>	Agree

<b>Finding No. 5 – Forty-five (45) Subscribers Sample Review (Cancelled Enrollment)</b>	<b>Condition:</b>	Magnolia overstated the 2015 benefit year premium and APTC amounts for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File by reporting enrollment and payment data for the subscriber with coverage that was not effectuated.
	<b>Criteria:</b>	Pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is described as “any enrollment in which the amount the enrollment group is responsible to pay toward the total premium amount has been paid in full by the enrollment group.”
	<b>Cause:</b>	The issuer indicated “Looking at the last Pre-Audits, the member is canceled for the 1/1 and 2/1 spans. CMS conducted a reconciliation and canceled coverage for 2015. Our records now match CMS records.”
	<b>Effect:</b>	The inclusion of the one (1) non-effectuated enrollment resulted in a change to Magnolia's final, restated 2015 benefit year EPDW data.
	<b>Corrective Action Required:</b>	The net financial impact of this finding is a payment due to CMS of \$201.26, consisting of \$7.32 FFE user fees to be returned to Magnolia and \$208.58 APTC to be returned to CMS. Magnolia should confirm the financial impact by filling out Appendix 1.

	<b>Management Response:</b>	Agree
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## **V. OBSERVATIONS**

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An observation is a deviation from APTC and FFE user fee program requirements that we are calling to the attention of management for purposes of improving compliance in future years but that does not require correction to payment. CMS's audit procedures identified no observations.

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## **VI. MANAGEMENT RESPONSES**

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Please provide management's response to the five (5) findings identified in the draft audit report and complete the attached Appendix 1 - Issuer Management Response to Net Financial Adjustment (Appendix 1), within thirty (30) calendar days from the draft audit report date. Management's response should indicate agreement or disagreement.

### **Agreement**

If management agrees with the five (5) findings, complete the "Management Response" field of the findings in the draft audit report, and initial "Agree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 within thirty (30) calendar days from the draft audit report date. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report. CMS will process the final adjustment amount in the next available monthly payment cycle.

### **Disagreement**

If management disagrees with any of the five (5) findings and corrective actions, complete the "Management Response" field of the findings in the draft audit report, and initial "Disagree" and sign the attached Appendix 1. Return the draft audit report including Appendix 1 and any supporting documentation that substantiates management's response within thirty (30) calendar days from the draft audit report date. This will be the final opportunity to provide information or supporting documentation to correct any inaccuracies in the report before it is finalized.

CMS will review the written explanations in the "Management Response" field of the findings and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

CMS will provide an updated audit report, including the stated final adjustment amount along with an updated Appendix 1, following receipt and review of management's response. Please return the updated audit report with management responses and signed Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report and process the final adjustment amount in the next available monthly payment cycle.

## Appendix 1 – Issuer Management Response to Net Financial Adjustment

Issuer HIOS ID: 94327


Issuer Name: Magnolia Health Plan (Magnolia)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2015 benefit year APTC and FFE UF program participation, resulting in a payment due to CMS of \$44,151.68, consisting of \$2,141.74 in FFE user fees to be returned to Magnolia and \$46,293.42 in APTC to be returned to CMS, and:

(INITIAL)   KC   Agrees with the audit net adjustment amount above, confirming the audit finding(s) and observation(s), if applicable, and as such this report will be considered final and published.

**Or**

(INITIAL)            Disagrees and requests a review of additional information that may impact the audit net adjustment amount resulting from the 2015 benefit year audit. If review is requested, CMS will consider this draft only a preliminary audit report. If the review option is selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

Signed:  \_\_\_\_\_  
(Signature of authorized person acting on behalf of the issuer.)

Printed Name:   Kevin Counihan    
(Print name of signature)

Title: President \_\_\_\_\_  
(Title of authorized person acting on behalf of the Issuer)

Telephone Number:   314-445-0011  

(Direct Telephone Number)

Date:   03/29/2023

## **Appendix 2 – Applicable Regulations**

The following table identifies the specific regulatory requirements around which CMS has organized its audits.

<b>Regulation</b>	<b>Rules</b>
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<p><b>45 CFR § 156.50 – Financial Support</b></p>	<p><b>(a) <i>Definitions.</i></b> The following definitions apply for the purposes of this section:  <i>Participating issuer</i> means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.</p> <p><b>(b) <i>Requirement for State-based Exchange user fees.</i></b> A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.</p> <p><b>(c) <i>Requirement for Federally-facilitated Exchange user fee.</i></b> To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.</p>
<p><b>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</b></p>	<p><b>(a) <i>Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</i></b> A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—</p> <ol style="list-style-type: none"> <li>(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;</li> <li>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</li> <li>(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.</li> </ol>

<p><b>Regulation</b></p>	<p><b>Rules</b></p>
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<p><b>45 CFR § 156.480 - Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.</b></p>	<p><b>(a) Maintenance of records.</b> An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.</p> <p><b>(b) Annual reporting requirements.</b> For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.</p> <p><b>(c) Audits.</b> HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.</p>
<p><b>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</b></p>	<p><b>(a) General standard.</b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:</p> <p><b>(1)</b> Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and</p> <p><b>(2)</b> Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.</p> <p><b>(b) Records.</b> The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.</p> <p><b>(c) Record retention timeframe.</b> Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.</p> <p><b>(d) Record availability.</b> Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

### Appendix 3 – Glossary of Terms and Acronyms

<b>Terms &amp; Acronyms</b>	<b>Definition</b>
<b>APTC</b>	Advance Payments of the Premium Tax Credit
<b>CEO</b>	Chief Executive Officer
<b>CFO</b>	Chief Financial Officer
<b>CFR</b>	Code of Federal Regulations
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CSR</b>	Cost-sharing Reduction
<b>EPDW</b>	Enrollment and Payment Data Workbook
<b>FFE</b>	Federally-facilitated Exchange
<b>GAGAS</b>	Generally Accepted Government Auditing Standards
<b>HHS</b>	Department of Health and Human Services
<b>HIOS</b>	Health Insurance Oversight System
<b>PPACA</b>	Patient Protection and Affordable Care Act
<b>QHP</b>	Qualified Health Plan
<b>SBE</b>	State-based Exchange
<b>TIN</b>	Tax Identification Number