



***Advance Payments of the Premium Tax Credit (APTC) Program Assessment Report***

***for***

***MetroPlus Health Plan (New York)***

***November 19, 2020***

## Table of Contents

<b>I. EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>II. BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY .....</b>	<b>5</b>
<b>III. RESULTS OF REVIEW .....</b>	<b>8</b>
<b>IV. FINDINGS AND OBSERVATIONS.....</b>	<b>10</b>
<b>V. MANAGEMENT RESPONSES .....</b>	<b>19</b>
<b>Appendix 1 – Issuer Management Response to Net Financial Adjustment .....</b>	<b>20</b>
<b>Appendix 2 – Applicable Regulations .....</b>	<b>21</b>
<b>Appendix 3 – Glossary of Terms and Acronyms .....</b>	<b>24</b>

---

## I. EXECUTIVE SUMMARY

---

### Background

MetroPlus Health Plan (MetroPlus) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in New York during the 2015 benefit year. MetroPlus submitted its final restated 2015 benefit year data in the November 2016 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$57,852,812.34 in advance payments of the premium tax credit (APTC) from CMS and reported a total of \$115,800,570.55 in premiums for its 2015 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of MetroPlus's compliance with the APTC program established in sections 1401 and 1412 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. This report also details the results of the assessment of premiums for information purposes only as CMS did not charge user fees to issuers offering QHPs through SBEs during the 2015 benefit year.

### Audits to Determine Compliance with the Administration of APTC Program

Under title 45 of the Code of Federal Regulations (CFR) sections §§ [155.1210](#) and [156.480](#), 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 program requirements. HHS designates the Centers for Medicare & Medicaid Services (CMS) to conduct these audits and to achieve the following objectives:

- 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 in the final 2015 EPDW submitted by the issuer, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to the APTC reported in

---

<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 dialog 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.

the final EPDW, then CMS classified it as a *finding*. If CMS found a deviation from CMS or Exchange requirements that we are calling to the attention of management for purposes of 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 two (2) findings and five (5) observations for MetroPlus. The net APTC financial impact of the two (2) findings is an overstatement of \$47,987.01 in APTC in the final EPDW and therefore a payment to CMS of \$47,987.01, consisting of APTC owed to CMS. The net premium impact of the five (5) observations is an overstatement of \$65,386.83 in premiums in the final EPDW. The findings and observations include the following:

### **Findings:**

1. Differences in APTC amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by MetroPlus to a Payment Desk Audit File containing subscriber level data from MetroPlus's systems; and
2. Inclusion of enrollment and APTC payment data in the Payment Desk Audit File for two (2) subscribers with coverage that was not effectuated in the issuer's systems.

### **Observations:**

1. Differences in premium amounts identified in the comparison of the issuer's data included in the November 2016 EPDW submitted by MetroPlus to a Payment Desk Audit File containing subscriber level data from MetroPlus's systems;
2. Inclusion of enrollment and premium data in the Payment Desk Audit File for two (2) subscribers with coverage that was not effectuated in the issuer's systems;
3. Provision of coverage and reporting of enrollment and payment data in the Payment Desk Audit File for five (5) unreconciled subscribers with coverage that should have been cancelled but remained active in the issuer's systems;
4. Billing of the incorrect APTC amount for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File as the amounts were not updated following a retroactive transaction received from the SBE; and
5. Receipt of incorrect premium payments and continuation of coverage for two (2) of the fifteen (15) selected subscribers in the Payment Desk Audit File.

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

---

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

---

### **A. Background**

Sections 1401 and 1412 of the PPACA established the APTC program to support the provision of affordable health care coverage to individuals.

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

#### **Interim Payment Process**

In 2015, CMS implemented a temporary process (“interim payment process”) to calculate and make monthly payments of APTC and advance cost-sharing reduction (CSR) amounts. CMS used this interim payment process to calculate payments for all SBE issuers for the 2014-2017 benefit years. CMS transitioned most SBE issuers to policy-based payments (PBP) in 2018, and transitioned the last SBE to PBP in 2020.

For the 2015 benefit year, the interim payment process required SBE issuer submitters, including issuers in New York, 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. SBE issuer submitters were required to calculate the QHP enrollment and payment amounts and to submit that information in the EPDW using their internal source data.

CMS calculated and made monthly payments based on the 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 effectuated enrollment groups
9. Total effectuated enrollment groups with APTC
10. Total effectuated enrollment groups with advance CSR
11. Total effectuated members
12. Total effectuated members with APTC
13. Total effectuated members with advance CSR

CMS conducted a SBE payment close-out process for the 2015 benefit year in which CMS compared the EPDW data against the policy-level reporting (PLR) data submitted by the SBE. The PLR data was based on the monthly submissions that SBEs sent to the Internal Revenue Service (IRS) for reporting purposes and contained cumulative individual market enrollment APTC data. CMS requested that SBEs append an additional field for the QHP ID for each policy and separately submit these data to CMS for this purpose. CMS asked SBE or SBE issuers to explain any outlier discrepancies between EPDW and PLR data and to re-submit the EPDW, if necessary, or to verify that payment data was accurate despite discrepancies with PLR data.

## **B. Regulations Governing APTC Program**

CMS established an audit protocol to assess health insurance issuers' compliance with the following regulations governing APTC program:

- [45 CFR § 155.1210](#): Maintenance of Records;
- [45 CFR § 156.460](#): Reduction of enrollee's share of premium to account for advance payments of the premium tax credit; and
- [45 CFR § 156.480](#): Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.

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 premiums and the APTC program;
- (2) Identify potential CMS APTC payment errors resulting from issuer data reporting errors;
- (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 MetroPlus for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated MetroPlus's activities related to the 2015 benefit year (January 1, 2015 through December 31, 2015) individual market data reported in the final EPDW submitted in November 2016 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent MetroPlus an electronic letter on February 15, 2019 to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to MetroPlus on February 20, 2019 that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by MetroPlus, as well as the final 2015 EPDW submitted by the issuer to CMS and the PLR data submitted by the SBE to CMS, and used CMS's audit procedures to assess compliance with APTC program rules and regulations.

CMS's audit contractor applied CMS's audit protocol to identify the findings and observations listed in section IV 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 in the Payment Desk Audit File to the subscribers included in the SBE's PLR data 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 in the file twice in the same month with full month or incorrectly prorated payment data) were not reported in the file.
  - Premium Less than APTC Validation: Review of the Payment Desk Audit File to verify that the subscribers' premium amounts reported in the file were not less than the APTC amounts reported in the file.
  - Coverage Days Validation: Review of the Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in 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 the SBE's PLR data 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.

---

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

---

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

---

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.

To build collaborative relationships and identify process improvements that support program integrity goals, CMS conducted a discrepancy phase following the review of the initial audit data submission to work with the issuer to resolve or reduce audit findings, thereby improving compliance. Additional follow-up with the SBE was performed as necessary to confirm or resolve the identified audit findings. Below are the results of this review following the discrepancy phase.

#### **EPDW Validation**

One (1) finding and one (1) observation resulted from the comparison of the final 2015 EPDW submitted by the issuer to MetroPlus's Payment Desk Audit File. Please refer to Finding No. 1 and Observation No. 1 included in section IV for details on the finding and observation.

#### **Unreconciled Subscribers Review**

One (1) finding and two (2) observations resulted from the review of MetroPlus's Payment Desk Audit File to determine if the subscribers reported in the file existed and their coverage was effectuated in the issuer's systems. Please refer to Finding No. 2 and Observation No. 2, and Observation No. 3 included in section IV for details on the finding and observations.

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

No findings or observations resulted from the review of MetroPlus's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file.

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

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

#### **Coverage Days Validation**

No findings or observations resulted from the review of MetroPlus's Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems.

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

No findings and one (1) observation resulted from the review and comparison of the data from MetroPlus's systems to the corresponding data included in the SBE's PLR data 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 Observation No. 4 included in



section IV for details on the observation.

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

No findings and one (1) observation resulted from the review of the data and documentation from MetroPlus's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers. Please refer to Observation No. 5 included in section IV for details on the observation.

#### **Policy and Procedure Review**

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

---

#### IV. FINDINGS AND OBSERVATIONS

---

A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS's audit procedures identified two (2) findings, which resulted in a change to the APTC amounts reported in MetroPlus's EPDW for individual market plans for the 2015 benefit year.

An observation is a deviation from CMS or Exchange requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified five (5) observations, consisting of two (2) observations that resulted in a change to the premium amounts reported in MetroPlus's EPDW for individual market plans for the 2015 benefit year and three (3) observations that did not result in a change to the premium amounts reported in MetroPlus's EPDW but that are noted for purposes of improving compliance in future program years.

In light of the two (2) findings and five (5) observations, the adjusted 2015 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

**Recalculated EPDW for the 2015 Benefit Year**

	APTC	Premium (Observations)
EPDW as Filed in November 2016	\$57,852,812.34	\$115,800,570.55
Finding No. 1 and Observation No. 1 - EPDW Validations Adjustment	\$(46,116.96)	\$(60,756.41)
Finding No. 2 and Observation No. 2 – Unreconciled Subscribers Review Adjustment	\$(1,870.05)	\$(4,630.42)
Observation No. 3 – Unreconciled Subscribers Review Adjustment	\$0.00	\$0.00
Observation No. 4 – Forty-five (45) Subscribers Sample Review Adjustment	\$0.00	\$0.00

	APTC	Premium (Observations)
Observation No. 5 – Fifteen (15) Subscribers Sample Review Adjustment	\$0.00	\$0.00
EPDW As Recalculated	\$57,804,825.33	\$115,735,183.72
<b>Total Impact</b>	<b>\$(47,987.01)</b>	<b>\$(65,386.83)*</b>

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

The net financial impact of the two (2) findings is a payment of \$47,987.01, consisting of APTC owed to CMS.

\*Note: The premium impact of the five (5) observations is an overstatement of \$65,386.83 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the two (2) findings and five (5) observations, CMS documented the criteria, cause, effect, corrective actions, and MetroPlus's responses as seen in the charts below.

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
<b>Condition:</b>	<p><b>APTC Differences (Finding)</b> – For one (1) or more months of 2015 benefit year enrollment in thirteen (13) QHPs, the net "Total APTC Amount by QHP ID for effectuated enrollments" included in MetroPlus's EPDW was greater than the total APTC amount included in MetroPlus's Payment Desk Audit File, resulting in an overpayment of \$46,116.96 in APTC. For the one or more months of 2015 benefit year enrollment in thirteen (13) QHPs, the total net enrollment in the EPDW was overstated by one hundred and eleven (111) APTC enrollment groups and two hundred and one (201) APTC members.</p> <p><b>Premium Differences (Observation)</b> – For one (1) or more months of 2015 benefit year enrollment in thirteen (13) QHPs, the net "Total Premium Amount by QHP ID for effectuated enrollments" included in MetroPlus's EPDW was greater than the total premium amount included in MetroPlus's Payment Desk Audit File, resulting in an overstatement of \$60,756.41 in premiums. For the one or more months of 2015 benefit year enrollment in thirteen (13) QHPs, the total net enrollment in the EPDW was overstated by three hundred and forty-seven (347) enrollment groups and three hundred and forty-six (346) members.</p>
<b>Criteria:</b>	Pursuant to CMS guidance and EPDW submission requirements:

<b>Finding No. 1 and Observation No. 1 – EPDW Validations</b>	
	<p>The “Total APTC amount by QHP ID for effectuated enrollments” submitted on the EPDW is the "total APTC toward the total premium amount for effectuated enrollments within a 16-digit QHP ID."</p> <p>The “Total premium amount by QHP ID for effectuated enrollments” submitted on the EPDW is the "total premium amount for the health coverage for all effectuated enrollments within that plan.”</p>
<b>Cause:</b>	<p>The issuer indicated the following explanation surrounding the root causes of the APTC and premium differences noted in the condition:</p> <p>“We pulled data fields submitted and narrowed the discrepancies to 367 member months. A deep dive indicates a variety of reasons for the discrepancies:</p> <ol style="list-style-type: none"> <li>1) When New York State of Health (NYSoH) transmits the 834 files with APTC changes, the incorrect effective date is transmitted to us. These cases typically need correction files from NYSoH.</li> <li>2) Incorrect file processing on our end</li> <li>3) Retro-active files sent by NYSoH several months after the policy end dates. Since these files are received out of sequence, the files are overridden by the automatic enrollment file processing and need manual intervention.”</li> </ol> <p>The issuer further indicated that “The desk audit file was accurate and had the current snapshot of what was in the systems.”</p>
<b>Effect:</b>	The APTC and premium differences resulted in a change to MetroPlus’s final, restated 2015 benefit year EPDW data.
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$46,116.96, consisting of APTC owed to CMS. MetroPlus should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an overstatement of \$60,756.41 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>MetroPlusHealth agrees with this finding, and will furnish the requested payment. The plan has made various updates to enrollment system logic to automatically process updates thereby minimizing the need for manual intervention. This has reduced errors such as this which stemmed from untimely processing of enrollment transactions. The plan has also implemented a process to reconcile outbound file rejection with the SBE to further reduce errors. Management will continue to implement process improvement initiatives to improve compliance in future years.</p>

<b>Finding No. 2 and Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Condition:</b>	MetroPlus overstated the 2015 benefit year premium and APTC amounts for two (2) subscribers in the Payment Desk Audit File by reporting enrollment and payment data for the subscribers with coverage that was not effectuated.
<b>Criteria:</b>	<p>Pursuant to New York SBE guidance, “Enrollment is not effectuated until CONTRACTOR receives initial payment of premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless required otherwise by federal law, CONTRACTOR shall provide a grace period of no less than ten (10) days to Enrollees for their initial premium payment to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect shall be considered timely. Contractor will be financially responsible for any claims incurred by Enrollee during the ten (10) day grace period provided that the Enrollee pays the initial premium prior to or during such ten (10) day grace period.”</p> <p>Additionally, 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.”</p>
<b>Cause:</b>	<p>The issuer indicated the following for the two (2) subscribers:</p> <ul style="list-style-type: none"> <li>• For one (1) subscriber, the issuer indicated “Effectuation never sent” for the subscriber and indicated a “No” in the “Effectuated in Issuer’s System” field.</li> <li>• For one (1) subscriber, the issuer indicated “Member was not active for 2015. No payment received. We have confirmed that the 2014 premium totals were re-routed by the system to the 2015 year. However, the member was not active for the 2015 window and we have not been able to identify the source of the misapplication. The original processing was correct but a system change occurred in December 2015 that misapplied the monies.”</li> </ul>
<b>Effect:</b>	The inclusion of the two (2) non-effectuated enrollment resulted in a change to MetroPlus’s final, restated 2015 benefit year EPDW data.

<b>Finding No. 2 and Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment of \$1,870.05, consisting of APTC owed to CMS. MetroPlus should confirm the financial impact and coordinate on resolution with CMS.</p> <p>The premium impact of this observation is an overstatement of \$4,630.42 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>MetroPlusHealth agrees with this finding, and will furnish the requested payment. The plan has made various updates to enrollment system logic to automatically process updates thereby minimizing the need for manual intervention. This has reduced errors such as this which stemmed from untimely processing of enrollment transactions. The plan has also implemented a process to reconcile outbound file rejection with the SBE to further reduce errors. Management will continue to implement process improvement initiatives to improve compliance in future years.</p>

<b>Observation No. 3 – Unreconciled Subscribers Review</b>	
<b>Condition:</b>	<p>MetroPlus provided coverage and reported enrollment and payment data in the Payment Desk Audit File for four (4) subscribers with enrollments that should have been cancelled and for which no binder payments were received. Additionally, MetroPlus provided coverage and reported enrollment and payment data in the Payment Desk Audit File for one (1) subscriber with an enrollment that should have been cancelled instead of auto-renewed.</p>
<b>Criteria:</b>	<p>Pursuant to NY SBE guidance, “Enrollment is not effectuated until CONTRACTOR receives initial payment of premium, if applicable, from the prospective enrollee and sends a confirmation 834 transaction to the STATE (the "Coverage Effective Date"). Unless required otherwise by federal law, CONTRACTOR shall provide a grace period of no less than ten (10) days to Enrollees for their initial premium payment to effectuate coverage. Initial payments received by the 10th of the month in which the initial coverage is in effect shall be considered timely. Contractor will be financially responsible for any claims incurred by Enrollee during the ten (10) day grace period provided that the Enrollee pays the initial premium prior to or during such ten (10) day grace period.”</p> <p>Additionally, pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated</p>

<b>Observation No. 3 – Unreconciled Subscribers Review</b>	
	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>	<p>For the five (5) subscribers with enrollments that were reported in the issuer’s Payment Desk Audit File but that did not exist in the SBE’s PLR data, the SBE indicated “Coverage does not exist – coverage canceled effective [SBE provided date].”</p> <p>For four (4) of the five (5) subscribers, the issuer was unable to provide proof of a binder payment and therefore proof of effectuation. In addition, the issuer indicated the following:</p> <ul style="list-style-type: none"> <li>• “Cancellation was received 11/16/2014 but was not processed appropriately.” (One (1) subscriber)</li> <li>• “Cancellation was received on 12/29/2015 and was not processed because member was already terminated as of [issuer provided date in 2015].” (Three (3) subscribers)</li> </ul> <p>For one (1) subscriber with January 2015 coverage reported in the Payment Desk Audit File that had prior 2014 coverage, the issuer indicated “Cancellation received from the State. Member was auto renewed and cancellation was received after the renewal on 12/13/2014.”</p> <p>The issuer further indicated for each of the five (5) subscribers that “Members were active in our system but they did not use the services.”</p>
<b>Effect:</b>	The issuer did not follow SBE and CMS enrollment guidance and requirements as the issuer effectuated and provided coverage for enrollments that should have been cancelled.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	MetroPlusHealth agrees with this observation, and has implemented several reconciliation processes in recent years to improve compliance in this area. The plan has made various updates to enrollment system logic to automatically process updates thereby minimizing the need for manual intervention. This has reduced errors such as this which stemmed from untimely processing of enrollment transactions. The plan has also implemented a process to reconcile outbound file rejection with the SBE to further reduce errors. Management will continue to review opportunities to develop any further improvement plans.

<b>Observation No. 4 - Forty-five (45) Subscribers Sample Review</b>	
<b>Condition:</b>	MetroPlus did not update the APTC amount based on a retroactive change received from the SBE and therefore reported and billed the incorrect 2015 benefit year APTC amount for one (1) of the forty-five (45) selected subscribers in the Payment Desk Audit File.
<b>Criteria:</b>	Pursuant to 45 CFR § 156.460, 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 reduce the portion of the premium charged to or for the individual for the applicable months by the amount of the advance payment of the premium tax credit and notify the Exchange of the reduction in the portion of the premium charged to the individual.
<b>Cause:</b>	<p>The issuer indicated that “The APTC was adjusted in August 15 from \$279.00 to \$251.00 but the Plan did not appropriately adjust the change on our end.” The SBE indicated “APTC was changed to \$251.00 effective 1/1/15-12/31/15” based on a transaction that was sent 9/1/15.</p> <p>The issuer further indicated that “Based on files received on 09/05/2015 the APTC was retro changed to \$251.00 as of 01/01/2015. Initial enrollment for 01/01/2015 was cancelled on 09/05/2015. Member was re-enrolled effective 10/01/2015. 10/01/2015 enrollment was retro changed to 01/01/2015. All these transactions were received on the same day. This case was an anomaly based on the fact that the changes were received 9 months after the initial 01/01/2015 enrollment. It is extremely challenging to be able to accurately quantify the number of members impacted, as we are in constant receipt of retro-active files months even years past the policy effective date. This challenge is further exacerbated by correction files that have incorrect and unusable data.”</p>
<b>Effect:</b>	The issuer did not follow the CMS enrollment guidance and requirements as the issuer did not adjust the subscriber’s account to include the correct APTC amount resulting from a retroactive change received from the SBE.
<b>Corrective Action Required:</b>	CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	MetroPlusHealth agrees with this observation, and has implemented several reconciliation processes in recent years to improve compliance in this area. The plan has made various updates to enrollment system



<b>Observation No. 4 - Forty-five (45) Subscribers Sample Review</b>	
	logic to automatically process updates thereby minimizing the need for manual intervention. This has reduced errors such as this which stemmed from untimely processing of enrollment transactions. The plan has also implemented a process to reconcile outbound file rejection with the SBE to further reduce errors. Management will continue to review opportunities to develop any further improvement plans.

<b>Observation No. 5 - Fifteen (15) Subscribers Sample Review</b>	
<b>Condition:</b>	MetroPlus received premium payments that were less than the premium responsibility amounts but provided coverage for two (2) of the fifteen (15) selected subscribers in the Payment Desk Audit File. The enrollments therefore should have been terminated due to exhaustion of the three (3) month grace period as all outstanding premiums were not received by the end of the third month.
<b>Criteria:</b>	Pursuant to 45 CFR § 156.270, a QHP issuer must return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period. Additionally, if an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, if applicable, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in 155.430(d)(4) of this subchapter (i.e., the last day of the first month of the 3-month grace period).
<b>Cause:</b>	<p>The issuer indicated the following for the two (2) subscribers:</p> <ul style="list-style-type: none"> <li>For the subscriber included in the Payment Desk Audit File with a premium amount of \$765.14 and APTC amount of \$0.00 for January and a premium amount of \$765.14 and an APTC amount of \$579.00 for February through December, the issuer indicated "Feb 2015 Responsibility Amount Applied to Jan 2015 Coverage. This was the Plan's decision." The issuer further indicated "The plan applied the \$186.14 premium responsibility from 01/01/2015 - 12/31/2015 and collected from the member a total of \$2233.68. The APTC amount applied for 01/01/2015 was \$566. Our leadership decided to honor the Dec 2014 for Jan 2015."</li> <li>For the subscriber included in the Payment Desk Audit File with a premium amount of \$537.88 and APTC amount of</li> </ul>

<b>Observation No. 5 - Fifteen (15) Subscribers Sample Review</b>	
	<p>\$282.00 for January through December, the issuer indicated “The member continued to pay their 2014 premium of \$143.69. This resulted in the member being short every month and being terminated in April 2015 (thus the outstanding balance in the 04/6/2015 invoice). The member was then retro termed with a benefit end date of Feb 2015 and billing was rerun to undo the payments received (reflected in the invoice of 05/06/2015). The member was then reinstated in July with the invoicing picking back up for March 2015 as reflected in the 07/21/2015 invoice.”</p>
<b>Effect:</b>	<p>The issuer did not follow CMS enrollment guidance and requirements as the issuer continued to provide coverage but should have terminated the enrollment as incorrect premium payments were received and therefore all outstanding premiums were not received.</p>
<b>Corrective Action Required:</b>	<p>CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	<p>MetroPlusHealth agrees with this observation, and has implemented several reconciliation processes in recent years to improve compliance in this area. The plan has made various updates to enrollment system logic to automatically process updates thereby minimizing the need for manual intervention. This has reduced errors such as this which stemmed from untimely processing of enrollment transactions. The plan has also implemented a process to reconcile outbound file rejection with the SBE to further reduce errors. Management will continue to review opportunities to develop any further improvement plans.</p>

---

## **V. MANAGEMENT RESPONSES**

---

Please provide management's response to the two (2) findings and five (5) observations 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 two (2) findings and five (5) observations, complete the "Management Response" field of the findings and observations 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 on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

### **Disagreement**

If management disagrees with either of the two (2) findings and corrective actions or any of the five (5) observations, complete the "Management Response" field of the findings and observations 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 observations 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.

Please return the updated Appendix 1 within fifteen (15) calendar days. Upon receipt of the signed Appendix 1, CMS will finalize and publish the report on the CCIIO webpage. CMS will process the final payment adjustment amount in the next available monthly payment cycle.

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

Issuer HIOS ID: 11177

Issuer Name: MetroPlus Health Plan (MetroPlus)

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 program participation, resulting in a payment of \$47,987.01 to CMS and:

(INITIAL) u<sup>DS</sup> 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: Lauren Leverich  
DocuSigned by: 7562846FA7824BF...  
 (Signature of authorized person acting on behalf of the issuer)

Printed Name: Lauren Leverich  
 (Print name of signature)

Title: Acting Chief Financial Officer  
 (Title of authorized person acting on behalf of the Issuer)

Telephone Number: 212.908.8798  
 (Direct Telephone Number)

Date: 12/23/2020

## Appendix 2 – Applicable Regulations

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

Regulation	Rules
<b>45 CFR § 155.1210 – Maintenance of Records</b>	<p><b>(a) General.</b> The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following:</p> <ul style="list-style-type: none"><li>(1) Accommodate periodic auditing of the State Exchange's financial records; and</li><li>(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State- Exchange's compliance with Federal standards.</li></ul> <p><b>(b) Records.</b> The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:</p> <ul style="list-style-type: none"><li>(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;</li><li>(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;</li><li>(3) Any financial reports filed with other Federal programs or State authorities;</li><li>(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and</li><li>(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information.</li></ul> <p><b>(c) Availability.</b> A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.</p>

Regulation	Rules
<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) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</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> <p>(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;</p> <p>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</p> <p>(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.</p>
<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>

Regulation	Rules
<p><b>45 CFR § 156.705 – Maintenance of records for Federally-facilitated Exchanges</b></p>	<p>(a) <b>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>(1) 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>(2) 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>(c) <b>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>(d) <b>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

Terms & Acronyms	Definition
<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>DHHS</b>	Department of Health and Human Services
<b>EPDW</b>	Enrollment and Payment Data Workbook
<b>GAGAS</b>	Generally Accepted Government Auditing Standards
<b>HIOS</b>	Health Insurance Oversight System
<b>IRS</b>	Internal Revenue Service
<b>PPACA</b>	Patient Protection and Affordable Care Act
<b>PLR</b>	Policy-level Reporting
<b>QHP</b>	Qualified Health Plan
<b>SBE</b>	State-based Exchange
<b>TIN</b>	Tax Identification Number