

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS'S INTERNAL CONTROLS
DID NOT EFFECTIVELY ENSURE
THE ACCURACY OF AGGREGATE
FINANCIAL ASSISTANCE
PAYMENTS MADE TO
QUALIFIED HEALTH PLAN
ISSUERS UNDER THE
AFFORDABLE CARE ACT**

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EXECUTIVE SUMMARY

CMS's internal controls (i.e., processes in place to prevent or detect any possible substantial errors) did not effectively ensure the accuracy of nearly \$2.8 billion in aggregate financial assistance payments made to insurance companies under the Affordable Care Act during the first 4 months that these payments were made.

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. The Centers for Medicare & Medicaid Services (CMS) operates the Federal marketplace and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits (APTCs) and advance cost-sharing reductions (CSRs)) for the Federal and State-based marketplaces. Our review covered the period from January 1, 2014, to April 30, 2014, during which CMS was using an interim process for approving financial assistance payments.

The ACA vested in the Department of Health and Human Services substantial responsibilities for increasing access to health insurance for those who are eligible for coverage, improving access to and the quality of health care, and lowering health care costs and increasing value for taxpayers and patients. This report is part of a broader portfolio of Office of Inspector General reviews examining various aspects of marketplace operations, including payment accuracy, eligibility verifications, management and administration, and data security.

The objective of this review was to determine whether CMS's internal controls were effective to ensure the accuracy of financial assistance payments to QHP issuers made during the first 4 months that these payments were made.

BACKGROUND

Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance payments; and enroll in the QHP of their choice. QHPs are grouped into four “metal levels”: bronze, silver, gold, and platinum. An issuer may offer multiple QHPs through a marketplace.

Individuals in States without a State-based marketplace (State marketplace) could choose a QHP through the CMS-administered Federal marketplace. States were also able to establish State-partnership marketplaces in which they shared responsibilities for core functions with CMS. As of December 17, 2014, 34 States, including 7 State-partnership marketplaces, used the Federal marketplace, and the other 17 States had State marketplaces.

CMS's Process for Reviewing, Approving, and Generating Financial Assistance Payments to Qualified Health Plan Issuers

The ACA provides financial assistance payments to lower certain enrollees' insurance premiums or out-of-pocket insurance costs or both. The Federal Government distributes financial assistance payments to QHP issuers on behalf of eligible enrollees:

- **Advance Premium Tax Credits (APTCs):** APTCs are advance payments of premium tax credits (PTCs). APTCs assist certain low-income enrollees with the cost of their premiums. For enrollees determined eligible for APTCs, the applicable marketplace determines the APTC amounts using the price of the second-lowest-priced silver-level plan available in the area in which the enrollees reside and the enrollees' reported income and family size. Eligible enrollees may opt to enroll in any plan, regardless of metal level.
- **Advance Cost-Sharing Reductions:** CSRs assist certain low-income enrollees with their out-of-pocket costs. To receive CSRs, eligible enrollees must enroll in a silver-level plan, which generally covers 70 percent of covered medical services costs. CSRs assist these enrollees in paying a portion of their remaining costs. The Federal Government makes an advance monthly CSR payment to QHP issuers to cover the issuers' estimated CSR costs.

QHP issuers cannot receive financial assistance payments unless CMS certifies their plans through CMS's vendor management process. CMS uploads information for certified plans to its financial management and accounting system. CMS personnel then access U.S. Department of the Treasury (Treasury) systems to allow Treasury to transmit CMS-authorized payments to QHP issuers.

Under CMS's interim process for approving financial assistance payments in effect during our audit period, issuers submitted to CMS a monthly "Enrollment and Payment Data Template" (template) covering enrollees in all of the issuers' plans. Each template contained the aggregate financial assistance amounts that the issuer submitted for reimbursement on the basis of its confirmed enrollment totals. Confirmed enrollees were defined as those who had paid their first month's premium to the QHP issuer and had their enrollment information approved by the issuer.

Under its interim process, CMS required QHP issuers to submit attestation agreements stating that all template information was accurate and in compliance with Federal policies and regulations before CMS processed their payments. CMS officials stated that they plan to implement a permanent process to authorize payments to issuers by automating enrollment and payment data on an enrollee-by-enrollee basis in late 2015.

CMS's Methodology for Calculating Advance Cost-Sharing Reduction Payment Rates

CMS calculated advance CSR payment rates before QHP issuers began covering enrollees in January 2014. The rates were based on issuers' projected claims cost information for their plans, in conjunction with CMS guidance. Specifically, marketplaces submitted to CMS index rates that represented projected costs for their plans. CMS then multiplied the index rates by a CMS-derived utilization factor. CMS then multiplied the result by the difference between each particular plan's standard coverage rate (e.g., 70 percent for silver plans) and the plan's actual coverage rate (e.g., 73 percent for some CSR silver plans). From this three-part calculation, CMS derived the CSR payment rate to be applied for each confirmed, eligible enrollee in a particular CSR plan for calendar year 2014.

HOW WE CONDUCTED THIS REVIEW

We reviewed financial assistance payments totaling approximately \$2.8 billion authorized by CMS to QHP issuers for the period January 1, 2014, through April 30, 2014, under CMS's interim process. Of this amount, we reviewed a random sample of 100 payee group-months totaling approximately \$302 million reimbursed to QHP issuers. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one taxpayer identification number of a parent entity for 1 month. We reviewed CMS's internal controls for (1) certifying QHP issuers as qualified to receive financial assistance payments, (2) calculating advance CSR payment rates, (3) collecting financial assistance payment data from QHP issuers, and (4) transmitting financial assistance payment information to Treasury.

WHAT WE FOUND

We determined that CMS's internal controls (i.e., processes put in place to prevent or detect any possible substantial errors) for calculating and authorizing financial assistance payments were not effective. Specifically, we found that CMS:

- relied on issuer attestations that did not ensure that advance CSR payment rates identified as outliers were appropriate,
- did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts,
- did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments, and
- did not always follow its guidance for calculating advance CSR payments and does not plan to perform a timely reconciliation of these payments.

The internal control deficiencies that we identified limited CMS's ability to make accurate payments to QHP issuers. On the basis of our sample results, we concluded that CMS's system of internal controls could not ensure that CMS made correct financial assistance payments during the period January through April 2014. With respect to advance CSR payments, we identified

both overpayments and underpayments. During our audit period, advance CSRs were paid at a fixed rate per enrollee. Because the issuer templates included aggregate enrollment numbers, we could determine whether the aggregate advance CSR amounts authorized were correctly computed given the aggregate information provided. This does not mean that on an enrollee-by-enrollee basis all advance CSR payments were correctly determined.

With respect to APTC payments, because CMS obtains APTC payment data from QHP issuers on only an aggregate basis, it is unable to verify the amounts requested through QHP issuers' attestations on an enrollee-by-enrollee basis. Unlike advance CSR payments, APTC amounts vary by enrollee. Thus, CMS cannot ensure that APTC payment amounts were appropriately applied on behalf of confirmed enrollees. Further, CMS's lack of APTC payment data on an enrollee-by-enrollee basis affected our ability in this review to identify any potential overpayments and underpayments related to APTC payments at the individual level.

Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount (approximately \$2.8 billion) of Federal funds are at risk (e.g., there is a risk that funds were authorized for payment to QHP issuers in the incorrect amounts). Our review focused on the effectiveness of CMS's internal controls and, for the aforementioned reasons, did not verify whether these Federal funds were accurately applied on behalf of confirmed enrollees on an enrollee-by-enrollee basis.

We note that CMS has the responsibility to verify that financial assistance payments made to QHP issuers are accurate. CMS also has the authority to (1) require QHP issuers to restate enrollment totals and payment amounts for prior months to reflect prior inaccurate payments and (2) recoup these payments by offsetting them against future payments or other means. Because CMS has not developed the systems to obtain enrollment and payment information on an enrollee-by-enrollee basis, CMS cannot verify the accuracy of the nearly \$2.8 billion it authorized for financial assistance payments during our audit period. We plan to conduct an additional review that will address financial assistance payments on an enrollee-by-enrollee basis. The planned review will include the audit period covered by this review and collect information necessary to determine payment accuracy.

WHAT WE RECOMMEND

We recommend that CMS correct these internal control deficiencies by:

1. requiring its Office of the Actuary to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identifies as outliers,
2. implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on QHP issuers' attestations in calculating payments,
3. implementing a computerized system so State marketplaces can submit enrollee eligibility data,

4. following its guidance for calculating estimated advance CSR payments, and
5. developing interim reconciliation procedures to address potentially inappropriate CSR payments.

CMS COMMENTS AND OUR RESPONSE

In written comments on our draft report, CMS concurred with our second, third, and fifth recommendations. CMS generally agreed with our first and fourth recommendations but indicated that the recommendations are no longer applicable because of regulatory action. CMS stated that it conducted an internal controls review over its financial reporting that determined its processes to be effective. In addition, an independent accounting firm conducted a similar review and reported no significant issues.

Regarding our first recommendation (requiring the Office of the Actuary to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identified as outliers), CMS stated that it took regulatory action that eliminated the use of index rates in calculating advance CSR payment rates. As such, CMS stated that the Office of the Actuary will not need to review CMS's modified methodology for calculating these rates. CMS indicated that its regulatory action also affected our fourth recommendation—that CMS follow its own guidance for calculating estimated advance CSR payments. Specifically, CMS stated that for the 2015 benefit year, marketplaces now calculate the advance CSR payment amount for a specific policy as the product of the total monthly premium for that policy and a CSR plan "variation multiplier."

After reviewing CMS's comments, we maintain that our findings and recommendations are valid. CMS's regulatory action may appropriately address the findings related to our first and fourth recommendations. However, we have not tested the new advance CSR payment calculation described in the regulation. Therefore, we cannot determine whether the new calculation methodology allows for the type of discrepancies we identified during our audit period. Regarding the independent accounting firm's review of CMS's financial reporting, we note that the accounting firm's review tested basic transactions and security vulnerabilities. Further, the accounting firm reported findings related to advance CSR payments similar to those in this report.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) established health insurance exchanges (commonly referred to as “marketplaces”) to allow individuals and small businesses to shop for health insurance in all 50 States and the District of Columbia. A marketplace allows insurance companies (issuers) to offer individuals private health insurance plans, known as qualified health plans (QHPs), and enrolls individuals in those plans. QHPs must meet certain participation standards and cover a core set of benefits. Appendix A provides a glossary of selected terms used in this report.

The Centers for Medicare & Medicaid Services (CMS) operates the federally-facilitated marketplace (Federal marketplace) and is responsible for reviewing, approving, and generating financial assistance payments (i.e., advance premium tax credits (APTCs) and advance cost-sharing reductions (CSRs)) for the Federal and State-based marketplaces. Under the ACA, individuals who enroll in QHPs may be eligible for one or both of two types of financial assistance: premium tax credits (PTCs) and CSRs. CMS had developed what it described as an interim process for approving these financial assistance payments and is expecting to implement a permanent process in late 2015. Our review covered the period from January 1, 2014, to April 30, 2014, during which CMS was using that interim process.

The Office of Inspector General (OIG) is focused on fighting fraud, waste, and abuse and promoting the economy, efficiency, and effectiveness of the ACA programs across the Department of Health and Human Services (the Department). The ACA vested in the Department substantial responsibilities for increasing access to health insurance for those who are eligible for coverage, improving access to and the quality of health care, and lowering health care costs and increasing value for taxpayers and patients. This report is part of a broader portfolio of OIG reviews examining various aspects of marketplace operations, including payment accuracy, eligibility verifications, management and administration, and data security. Appendix B contains details on OIG’s related work.

OBJECTIVE

Our objective was to determine whether CMS’s internal controls were effective to ensure the accuracy of financial assistance payments to QHP issuers made during the first 4 months that these payments were made.

BACKGROUND

Health Insurance Marketplaces

A marketplace is designed to serve as a one-stop shop at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for financial assistance payments; and enroll in the QHP of their choice. QHPs are grouped into four “metal levels”: bronze, silver, gold, and platinum. These levels determine the percentage that each QHP can expect to pay, on average, for the overall costs of providing

essential health benefits to its plan members. An issuer may offer multiple QHPs through a marketplace.

Individuals in States without a State-based marketplace (State marketplace) could choose a QHP through the CMS-administered Federal marketplace. States were also able to establish State-partnership marketplaces in which they shared responsibilities for core functions with CMS. As of December 17, 2014, 34 States, including 7 State-partnership marketplaces, used the Federal marketplace, and the other 17 States were using established State marketplaces.

Roles and Responsibilities of CMS Offices

Within the Department, CMS is the agency with primary responsibility for implementing and overseeing Title I of the ACA through four components: the Center for Consumer Information and Insurance Oversight (CCIIO), the Office of Financial Management (OFM), the Office of the Actuary (OACT), and the Office of Information Systems (OIS).

Center for Consumer Information and Insurance Oversight

CCIIO oversees implementation of ACA marketplace provisions and provides national leadership in setting and enforcing standards for private health insurers that participate in the marketplaces.¹ CCIIO was responsible for establishing the Federal marketplace and for assisting States in establishing their own marketplaces. CCIIO is also responsible for calculating and approving financial assistance payments to QHP issuers.

Office of Financial Management

OFM prepares CMS financial statements and works with other components to reconcile all CMS financial data. OFM maintains all payment data within CMS's Healthcare Integrated and General Ledger Accounting System (HIGLAS) and submits external payment activity reports to the U.S. Department of the Treasury (Treasury).

Office of the Actuary

OACT directs CMS's actuarial program. OACT created for CCIIO a formula for identifying payment rate outliers. OACT created this formula for CCIIO to identify potentially inappropriate index rates. (Index rates are an issuer's average projected gross claims costs across all plans offered within an individual State.)

¹ In this report, we refer to the Department to acknowledge activities related to the marketplaces that were undertaken by the Office of Consumer Information and Insurance Oversight (OCIIO), which was originally established in the Office of the Secretary; the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS, to which OCIIO's responsibilities were transferred in early 2011.

OIS is responsible for managing CMS's information technology infrastructure, including the Federal marketplace. OIS also operates most of the ACA-related automated controls, such as those over data file integrity and data file sharing.

Types of Financial Assistance Payments

The ACA provides for financial assistance payments to lower certain enrollees' insurance premiums or out-of-pocket insurance costs or both. The Federal Government distributes financial assistance payments to QHP issuers on behalf of eligible enrollees:²

- **Advance Premium Tax Credits:** APTCs are advance payments of PTCs.^{3,4} PTCs reduce the cost of plan premiums and are available at tax filing time or in advance. Generally, PTCs are available on a sliding scale to individuals or families with incomes from 100 through 400 percent of the Federal poverty level.⁵ If a marketplace determines that an enrollee is eligible for a PTC, it determines the amount of the financial assistance payment on the basis of (1) the premium associated with the second-lowest-priced silver plan available in the area in which the enrollee resides and (2) the enrollee's reported income and family size. Eligible enrollees may opt to enroll in any plan, regardless of metal level. Taxpayers must include on their tax returns the amount of any APTC made on their behalf. The Treasury's Internal Revenue Service (IRS) is responsible reconciling APTC payments with the maximum allowable amount of the credit through enrollees' tax returns.⁶
- **Advance Cost-Sharing Reductions:** CSRs help qualifying individuals with out-of-pocket costs, such as deductibles, coinsurance, and copayments.⁷ Generally, an

² For the purpose of this report, the term "enrollee" refers to an applicant who has completed an application, was determined eligible, and has selected a QHP and whose enrollment information was sent to a QHP issuer.

³ ACA §§ 1401, 1412 and 45 CFR § 155.20 (definition of "advance payment of the premium tax credit").

⁴ The Federal Government pays the APTC monthly to the QHP issuer on behalf of the enrollee to offset a portion of the cost of the premium. For example, if an enrollee who selects an insurance plan with a \$500 monthly insurance premium qualifies for a \$400 monthly APTC (and chooses to use it all as an advance payment), the enrollee pays only \$100 to the QHP issuer. The Federal Government pays the remaining \$400 to the QHP issuer.

⁵ An individual or family with income below 100 percent of the Federal poverty level may be eligible for Medicaid under the State's Medicaid rules but would not qualify for the premium tax credit or cost-sharing reductions.

⁶ The maximum allowable amount of the credit is the total amount of the PTC for which an individual may be eligible in a benefit year (26 U.S.C. §§ 36B(a) and (b)). Enrollees may elect to receive any portion of the maximum allowable amount of the credit.

⁷ For example, an individual who visits a physician may be responsible for a \$30 copayment. If the individual qualifies for a CSR of \$20 for the copayment, the individual pays only \$10. The Federal Government pays the remaining \$20.

individual or family is eligible for CSRs if their household income is from 100 through 250 percent of the Federal poverty level. To receive CSRs, eligible enrollees must enroll in a silver-level plan,⁸ which generally covers 70 percent of covered medical services costs. CSRs assist these enrollees in paying a portion of their remaining costs. The Federal Government makes an advance CSR monthly payment to QHP issuers to cover their estimated CSR costs.⁹ Initially, CMS planned to reconcile with the QHP issuers the total amount of advance CSR payments made to the issuers and the actual CSR costs incurred at the end of each calendar year. In February 2015, CMS announced that it will postpone the reconciliation of CSR payments until April 2016.¹⁰

Process for Qualifying Issuers To Receive Financial Assistance Payments

Marketplaces must offer only health plans that meet certification requirements.¹¹ In order to be certified, each issuer must submit information such as its organizational structure, plan identifiers and attributes (e.g., metal-level category, geographic coverage), and support for the plan's premium rates. Each issuer must also meet requirements related to the administration of APTCs and CSRs (e.g., payment, allocation, and reconciliation of APTCs and CSRs).¹² CMS certifies issuers offering plans through the Federal marketplace, and State agencies certify information for issuers offering plans through State marketplaces. State agencies are responsible for sending certified information to CMS.

Once an issuer's information is certified, CMS obtains and verifies the issuer's payee and banking information and uploads it to CMS's financial management and accounting system, HIGLAS. CMS then creates a payee record for each issuer in an approved vendor list (vendor master file). CMS uses the vendor master file to ensure that QHP issuers have been approved to offer plans through the marketplaces, are qualified to receive financial assistance payments, and appropriate information for making payments is in the system.

After payee records are created in the vendor master file, CMS assigns payee identification numbers (payee group IDs) to establish what are known as "parent-child company groupings." CMS uses these groupings to organize issuers under the same tax identification number (TIN) for payment purposes (parent entities). Each such group has a unique payee group ID that represents a particular group of QHP issuers under the parent entity.

⁸ American Indians and Alaska Natives are eligible for CSRs if their household income does not exceed 300 percent of the Federal poverty level. These individuals can enroll in any metal level plan to receive CSRs (45 CFR § 155.350(a)).

⁹ CMS makes these advance CSR payments to protect QHP issuers from being required to bear the entire financial burden of providing CSRs over a benefit year (78 Fed. Reg. 15410, 15486 (March 11, 2013)).

¹⁰ *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (February 13, 2015).

¹¹ ACA § 1311(c); 45 CFR § 155.1000(b).

¹² 45 CFR § 156.215.

CMS allows parent entities to determine the number of payee groups and the issuers (child entities) associated with each group. This allows a parent entity to set up its payee groups according to how it prefers to be paid, because payments are made at the payee group level. Table 1 (below) provides an example of how a parent entity may set up its payee groups; in this example, XYZ Inc., has grouped itself to receive three payments for its six QHP issuers.

CMS approves and uploads payee group information from the vendor master file to HIGLAS, enabling CMS to process financial assistance payments to qualified issuers.

Table 1: Example of Payee Grouping for XYZ Inc.

Parent Entity	QHP Issuer Name	Payee Group ID (How Parent Entity is Paid)
XYZ Inc.	123 North	XYZ 1
XYZ Inc.	123 South	XYZ 1
XYZ Inc.	123 Central	XYZ 1
XYZ Inc.	123 East	XYZ 2
XYZ Inc.	123 Midwest	XYZ 3
XYZ Inc.	123 West	XYZ 3

CMS’s Methodology for Calculating Advance Cost-Sharing Reduction Payment Rates

CMS calculated advance CSR payment rates before QHP issuers began covering enrollees in January 2014. The rates were based on issuers’ projected claims cost information for their plans, in conjunction with CMS guidelines. Issuers used a unified rate review template (URRT) containing index rates that represented projected cost information for their plans.¹³ CMS then multiplied the applicable index rates by a CMS-derived utilization factor.¹⁴ CMS then multiplied the result by the difference between the standard silver-level coverage rate (e.g., 70 percent) and the plan’s actual coverage rate (e.g., 73 percent for some CSR silver plans).

Figure 1 provides the formula that CMS used to calculate estimated advance CSR payment rates applied for each confirmed enrollee in a particular plan for calendar year (CY) 2014.

Figure 1: Advance CSR Payment Rate Formula

$\text{Applicable index rate} \times \text{utilization factor} \times$ $(\text{actual coverage rate} - \text{standard coverage rate})$
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See the example (Figure 2, next page) for how CMS used its three-part calculation to derive the CSR payment rate for one plan.

¹³ In cases in which an issuer did not submit a URRT or CMS did not validate the index rate provided through the URRT, the State average index rate was used in the advance CSR payment rate calculation.

¹⁴ 78 Fed. Reg. 15410, 15487 (March 11, 2013).

Figure 2: Example of How CMS Calculated an Advance CSR Payment Rate

An issuer submitted an index rate for a silver-level QHP with an actual coverage rate that covered approximately 87 percent of covered medical costs. The index rate indicated that the projected cost per member per month was \$606.75. The utilization factor for a silver-level QHP with an actual coverage rate covering approximately 87 percent of covered medical costs is 1.12, a figure derived by CMS. The plan's actual coverage rate for covered medical costs is 87 percent, with the standard coverage rate for a typical silver-level plan being 70 percent.

By applying the formula described in Figure 1, the advance CSR payment rate for this QHP would be \$115.53, which would be applied to every confirmed enrollee monthly.

$$\begin{aligned} & \text{Silver-Level QHP With an Actual} \\ & \text{Coverage Rate of 87 Percent} \\ & \$606.75 \times 1.12 \times (0.87 - 0.70) = \$115.53 \end{aligned}$$

Planned and Interim Processes for Collecting Financial Assistance Payment Data

Before the health insurance marketplaces opened, CMS elected to electronically transfer health insurance information between QHP issuers, marketplaces, and CMS through what are called “834 transactions.”¹⁵ Upon applying for health care coverage through the marketplaces, applicants would select their QHP, and the marketplace would determine the amount of any financial assistance payments that applicants were eligible to receive. Once an application was completed, an initial 834 transaction containing the calculation for any applicable financial assistance amount would be sent from the marketplace to the selected QHP.¹⁶ State marketplaces were then required to share the initial 834 transactions with CMS and update these data monthly. CMS, in its role as administrator of the Federal marketplace, maintains initial 834 transactions for enrollees who have applied for health insurance coverage through the Federal marketplace.

Under CMS's initial design of the financial assistance payment process, once QHP issuers received the initial 834 transactions, they were required to review the data in the application and ensure that enrollees paid their portion of the first month's premium (premium amount less APTC).¹⁷ The QHP issuer was then to send a confirmation 834 transaction to the QHP issuer's

¹⁵ “834 transactions” are electronic files used by CMS to share health insurance information between QHP issuers, marketplaces, and CMS. A “confirmation 834 transaction” is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month's premium (premium amount less APTC) to receive any financial assistance payments.

¹⁶ An “initial 834 transaction” contains the calculation for any applicable financial assistance amounts that would be sent from the marketplace to the selected QHP issuer.

¹⁷ Enrollees must pay their share of the first month's premium to be covered by the QHP and to receive any financial assistance (45 CFR § 155.400(e)).

respective marketplace, confirming enrollment and payment of the premium.¹⁸ The marketplaces were to share confirmation enrollment data with CMS and update the information monthly. On the basis of the confirmed enrollment data provided by the marketplaces, CMS would then pay financial assistance payments and provide a monthly report to QHP issuers.

Because CMS had not yet developed the necessary computerized systems in accordance with the initial design to share confirmation 834 transactions for individual enrollees, CMS developed an interim process for approving financial assistance payments to QHP issuers on an aggregate basis. CMS officials stated that they plan to implement a permanent process to authorize payments to issuers by automating enrollment and payment data on an enrollee-by-enrollee basis in late 2015.

Under the interim process, CMS requires QHP issuers to submit an “Enrollment and Payment Data Template” (template) aggregating the confirmed enrollment and advance totals for financial assistance payments covering enrollees in all of the issuers’ plans. The aggregate data contain only enrollment and payment totals that QHP issuers maintain from each individual enrollee’s confirmation 834 transaction. The aggregate data on the template do not contain detailed information on the individual enrollees along with their associated financial assistance payment amounts. The templates are submitted to CMS between the 16th and 23rd of each month and consist of aggregated enrollment totals for confirmed enrollees as of the 15th of that month. CMS authorizes payments during the subsequent month (e.g., after January 16th, QHP issuers send CMS the February templates with enrollment information as of January 15th, and CMS authorizes payments in February). Issuers may also revise enrollment and payment information for all prior months. Along with each template, QHP issuers submit an attestation agreement stating that all aggregate information included in the template is accurate. CMS policy states that CMS will not issue financial assistance payments to QHP issuers if the attestation is not provided.

Process for Transmitting Financial Assistance Payments

After obtaining payment information via the templates, CMS uploads it to HIGLAS and begins generating reports that organize payments into their pre-established payee groups. CMS then transmits payment invoices to Treasury via a payment schedule, accesses Treasury’s Secure Payment System (SPS), and completes the necessary payment reports in the SPS. Finally, CMS certifies that the information entered in Treasury’s SPS was accurate, and Treasury makes the financial assistance payments to the applicable payee groups.

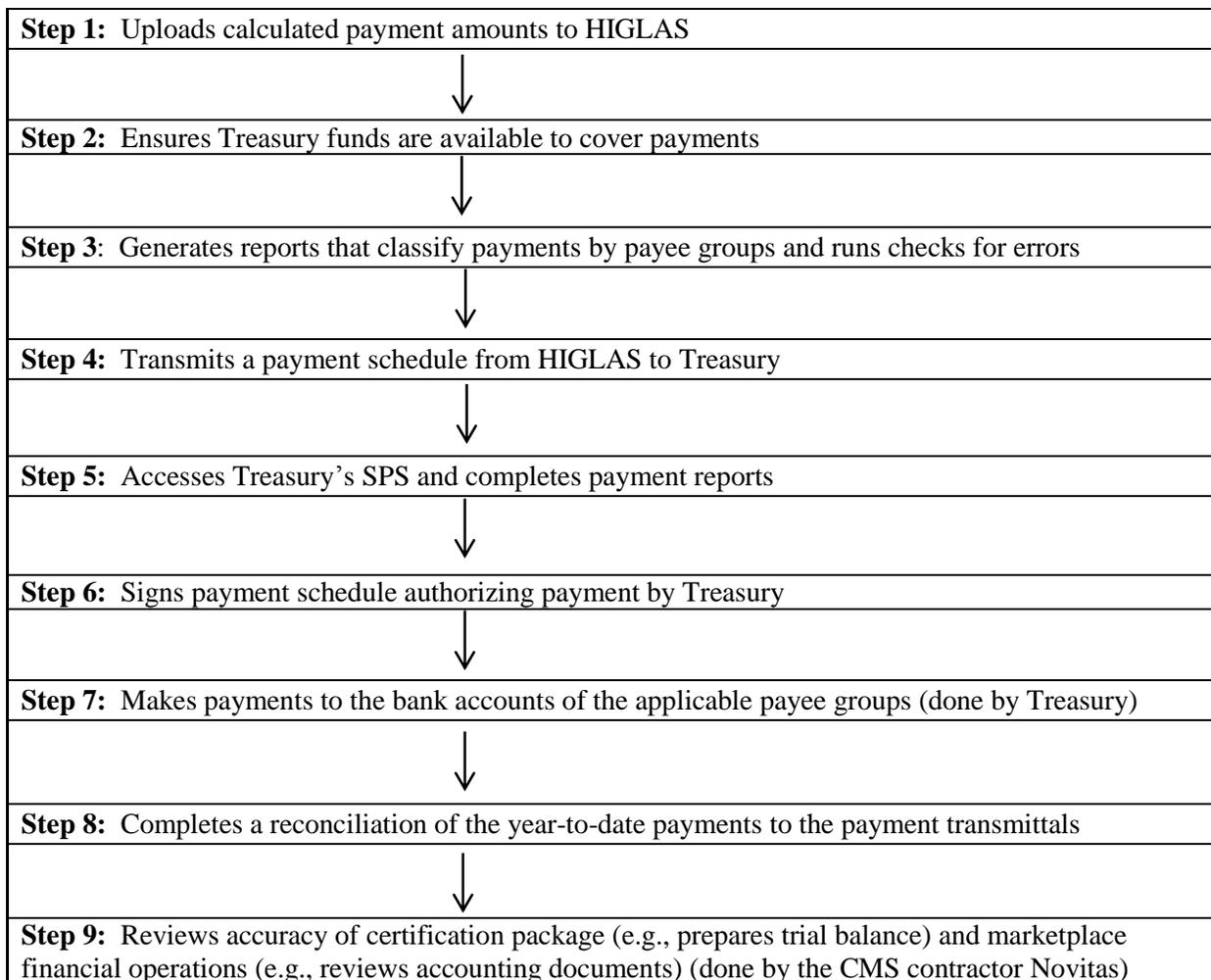
CMS creates and certifies a reconciliation of payments as evidence that a review was performed to ensure that marketplace payments (on a year-to-date basis) posted on the CMS general ledger, HIGLAS, reconcile to the payment transmittals.¹⁹ CMS has contracted with Novitas Solutions,

¹⁸ A “confirmation 834 transaction” is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month’s premium (premium amount less APTC) in order to receive any financial assistance payments.

¹⁹ This is a different reconciliation than the one previously discussed for comparing the amount of advance CSR payments made to the actual CSR costs incurred. This reconciliation is intended to ensure that payment records match amounts recorded in the accounting system.

Inc. (Novitas), to oversee CMS’s administration of certain marketplace functions, assist it in reporting CMS’s financial position, reconcile CMS financial records to HIGLAS, and prepare a trial balance of all marketplace-related ledgers to detect any errors. Novitas also attests to the accuracy of the information reported on the statement of financial position related to marketplace operations²⁰ at the end of each month. Figure 3 (below) illustrates CMS’s steps for transmitting financial assistance payments.

Figure 3: CMS’s Steps for Transmitting Financial Assistance Payments



HOW WE CONDUCTED THIS REVIEW

We reviewed financial assistance payments totaling approximately \$2.8 billion made to QHP issuers for the period January 1, 2014, through April 30, 2014, under CMS’s interim process. Of this amount, we reviewed a random sample of 100 payee group-months totaling approximately \$302 million reimbursed to QHP issuers. A payee group-month is defined as all financial

²⁰ This statement reflects the overall financial position (assets minus liabilities) of CMS’s marketplace operations at a given moment in time.

assistance payments made for a group of QHP issuers under one TIN of a parent entity for 1 month.

The scope of our audit did not include analyses of enrollee eligibility or the accuracy of calculations of actual financial assistance payments claimed for reimbursement. Rather, we limited our review to CMS's internal controls for determining advance payment amounts and processing payments to QHP issuers. Specifically, we reviewed CMS's internal controls for (1) certifying QHP issuers as qualified to receive financial assistance payments, (2) calculating advance CSR payment rates, (3) collecting financial assistance payment data from QHP issuers, and (4) transmitting financial assistance payment information to Treasury.

Appendix C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

FINDINGS

We determined that CMS's internal controls (i.e., processes put in place to prevent or detect any possible substantial errors) for calculating and authorizing financial assistance payments were not effective. Specifically, we found that CMS:

- relied on issuer attestations that did not ensure that advance CSR payment rates identified as outliers were appropriate,
- did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts,
- did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments, and
- did not always follow its guidance for calculating advance CSR payments and does not plan to perform a timely reconciliation of these payments.

The internal control deficiencies that we identified limited CMS's ability to make accurate payments to QHP issuers. On the basis of our sample results, we concluded that CMS's system of internal controls could not ensure that CMS made correct financial assistance payments during the period January through April 2014. With respect to advance CSR payments, we identified both overpayments and underpayments. During our audit period, advance CSRs were paid at a fixed rate per enrollee. Because the issuer templates included aggregate enrollment numbers, we could determine whether the aggregate CSR amounts authorized were correctly computed given the aggregate information provided. This does not mean that on an enrollee-by-enrollee basis all advance CSR payments were correctly determined.

With respect to APTC payments, because CMS obtains APTC payment data from QHP issuers on only an aggregate basis, it is unable to verify the amounts requested through QHP issuers' attestations on an enrollee-by-enrollee basis. Unlike advance CSR payments, APTC amounts vary by enrollee. Thus, CMS cannot ensure that APTC payment amounts were appropriately

applied on behalf of confirmed enrollees. Further, CMS’s lack of APTC payment data on an enrollee-by-enrollee basis affected our ability in this review to identify any potential overpayments and underpayments related to APTC payments at the individual level.

Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount (approximately \$2.8 billion) of Federal funds are at risk (e.g., there is a risk that funds were authorized for payment to QHP issuers in the incorrect amounts). Our review focused on the effectiveness of CMS’s internal controls and, for the aforementioned reasons, did not verify whether these Federal funds were accurately applied on behalf of confirmed enrollees on an enrollee-by-enrollee basis.

We note that CMS has the responsibility to verify that financial assistance payments made to QHP issuers are accurate. CMS also has the authority to (1) require QHP issuers to restate enrollment totals and payment amounts for prior months to reflect prior inaccurate payments and (2) recoup these payments by offsetting them against future payments or other means.²¹ However, because CMS has not developed the systems to obtain enrollment and payment information on an enrollee-by-enrollee basis, CMS cannot verify the accuracy of the nearly \$2.8 billion it authorized for financial assistance payments during our audit period. We plan to conduct an additional review that will address financial assistance payments on an enrollee-by-enrollee basis. The planned review will include the audit period covered by this review and collect information necessary to determine payment accuracy.

CMS RELIED ON ISSUER ATTESTATIONS TO ENSURE THAT ADVANCE COST-SHARING PAYMENT RATES IDENTIFIED AS OUTLIERS WERE RELIABLE AND DID NOT USE QUALIFIED PERSONNEL TO REVIEW THESE OUTLIERS

The ACA directs a QHP issuer to notify CMS of CSRs made under the statute and directs CMS to make periodic and timely payments to the QHP issuer equal to the value of those CSRs.²² The ACA permits advance payments of CSR amounts to QHP issuers on the basis of the amount specified by the Secretary.²³ An operation deficiency exists when personnel performing a control—in this instance, reviewing and approving actuarial support for index rates—are not qualified or properly skilled to perform the control effectively.²⁴

For 2014, to calculate the advance CSRs, the marketplaces sent the applicable data from the QHP issuers to the Department. These data included the essential health benefit portion of the expected claim costs (called the “index rate” in this report). To determine the index rate, the

²¹ *MOU Between IRS and CMS*; CMS control number MOU 13-150 (effective January 31, 2013); 45 CFR §§ 156.430(d) and (e).

²² ACA § 1402(c)(3).

²³ ACA § 1412(c)(3).

²⁴ Office of Management and Budget (OMB) Circular A-123, *Management’s Responsibility for Internal Control*, Appendix A, section II.D. OMB Circular A-123 defines a Federal agency’s management responsibility for internal controls in that Federal agency.

issuer is required to submit to CMS complex actuarial calculations for all QHPs that an issuer offers in a State and a memorandum supporting those calculations.²⁵

CMS did not independently review index rates it identified as outliers but relied on attestations from QHP issuers' financial officer or actuary that the index rates were accurate and consistent with the issuers' rate development practices. The index rates that issuers reported to CMS were the key factor in establishing advance CSR payment rates. The higher the index rate, the higher the advance CSR payment rate for all of a QHP's confirmed enrollees. To identify index rates that might have been excessive, CMS used a formula for identifying payment rate outliers developed by actuaries in its OACT. CMS defined outliers as index rates at or above the 90th percentile of index rates nationwide. Issuers with an index rate that CMS identified as an outlier were required to provide a financial officer's or actuary's attestation that the index rate was accurate and consistent with the issuer's rate development practices. After having received the attestation, CMS accepted the index rate as valid and calculated the advance CSR payment rate using the issuer's information.

CMS elected to have CCIIO—not OACT—be responsible for identifying and resolving potential outlier rates that were based on actuarial information. On the basis of CMS's written procedures for analyzing outlier index rates and discussions with CCIIO, we note that the personnel tasked with reviewing the rates did not have the skills needed to review index rate calculations or their actuarial support. Absent review by skilled staff, some of these rates may have resulted in inflated advance CSR payments. We note that OACT actuaries have the skills to review this documentation and could determine whether the identified outlier rates submitted by QHP issuers are appropriate.

CMS DID NOT HAVE SYSTEMS IN PLACE TO ENSURE THAT FINANCIAL ASSISTANCE PAYMENTS WERE MADE ON BEHALF OF CONFIRMED ENROLLEES AND IN THE CORRECT AMOUNTS

The Federal and State marketplaces must transmit eligibility and enrollment information to the Department "promptly and without undue delay" (45 CFR §§ 155.340(a)(1) and (d)). According to two memoranda of understanding (MOUs) between CMS and IRS,²⁶ the marketplaces must transmit records identifying confirmed enrollees to CMS at the start of each monthly payment cycle. The Department needs this information so that it knows when to begin, modify, or end enrollee financial assistance payment processes for both APTC and CSR.

CMS did not have controls in place to ensure that financial assistance payments were made on behalf of only confirmed enrollees and in the correct amounts. During our audit period, CMS's electronic database for receiving and maintaining confirmed enrollee and payment information was being developed. As a result, CMS authorized financial assistance payments to QHP issuers

²⁵ An index rate is an issuer's average projected gross claims costs across all plans offered within an individual State.

²⁶ *MOU Between IRS and CMS*; CMS control numbers MOU 13-150 (effective January 31, 2013) and MOU 14-127, (effective January 17, 2014).

for enrollees associated with all 100 payee group-months in our sample but could not ensure that the financial assistance payments were properly applied to those enrollees.

While the electronic database was under development, CMS was using an interim process for calculating financial assistance payments. Under this interim process, CMS relied on QHP issuers to submit confirmed enrollee and payment information in the aggregate. Because issuers do not provide payment information on an enrollee-by-enrollee basis, CMS was unable to ensure that payments were applied correctly to individual enrollees.²⁷ CMS relied on issuers to attest that payments were applied to the appropriate enrollees. In addition, CMS required QHP issuers to restate enrollment totals and payment amounts for prior months through their monthly template submissions. Under the interim process, CMS is unable to verify that QHP issuers are properly adjusting enrollment totals and payment amounts on their templates to account for any improper financial assistance payments previously authorized by CMS.

For the 100 payee group-months included in our sample, CMS authorized financial assistance payments totaling \$301,665,077 (\$267,849,339 for APTCs and \$33,815,738 for CSRs). On the basis of our sample results and our review of CMS's interim calculation process, we concluded that CMS did not verify that it correctly applied to confirmed enrollees any of the \$2,767,169,143²⁸ in financial assistance payments that it made during the period January through April 2014. Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly, a significant amount of Federal funds are at risk.

CMS DID NOT HAVE SYSTEMS IN PLACE FOR STATE MARKETPLACES TO SUBMIT ENROLLEE ELIGIBILITY DATA FOR FINANCIAL ASSISTANCE PAYMENTS

The marketplaces must transmit eligibility and enrollment information to the Department “promptly and without undue delay” so that the Department knows when to begin, modify, or end enrollee financial assistance payments” (45 CFR §§ 155.340(a)(1) and (d)). CMS did not have systems in place for State marketplaces to submit enrollee eligibility data for financial assistance payments. For 29 of the 100 sampled payee group-months, CMS did not verify the associated enrollees’ eligibility for financial assistance payments.²⁹ This occurred because CMS did not maintain any confirmed enrollment and payment information data on enrollees who applied through State marketplaces, and State marketplaces were unable to share this information with CMS.³⁰ As of January 22, 2015, CMS was in the process of developing a computerized

²⁷ This affected our ability to identify financial assistance payments on an enrollee-by-enrollee basis and compare these amounts, when combined, to aggregate payments made to QHP issuers. If we had been able to do this, we could have ensured that aggregate payments were appropriately applied on behalf of eligible enrollees.

²⁸ This amount represents the known value of the sampling frame. Appendix E contains more detail on the sample results and estimates.

²⁹ The remaining 71 sampled payee group-months were associated with enrollees who applied through the CMS-administered Federal marketplace; therefore, CMS was able to verify their eligibility for financial assistance.

³⁰ This information is maintained by the agency charged with operating each State’s marketplace.

system that State marketplaces could use to submit enrollee data. CMS maintains initial enrollment and payment information for QHP issuers in the Federal marketplace and can determine that at least the totals submitted by issuers on their templates do not exceed the maximum enrollment and payment threshold on the basis of initial enrollment. For State marketplaces, CMS must rely exclusively on issuers to attest to enrollee eligibility for financial assistance.

CMS made financial assistance payments totaling \$26,713,614 (\$22,399,969 for APTCs and \$4,313,645 for CSRs) during the 29 sampled payee group-months associated with enrollees for whom CMS did not verify financial assistance eligibility. On the basis of our sample results, we estimated that CMS did not verify that \$262,861,958 in financial assistance payments was authorized for eligible enrollees who applied through State marketplaces during the period January through April 2014.³¹ Without effective internal controls that ensure that State marketplace enrollees are eligible for financial assistance, a significant amount of Federal funds are at risk.

CMS DID NOT ALWAYS FOLLOW ITS GUIDANCE FOR CALCULATING ADVANCE COST-SHARING REDUCTION PAYMENTS AND DOES NOT PLAN TO PERFORM A TIMELY RECONCILIATION OF THESE PAYMENTS

The marketplaces must use the Department's methodology for calculating advance CSR payments and transmitting these amounts to the Department.³² A CMS contractor prepared guidance for CMS to use in calculating advance CSR payments. This guidance states that advance CSR payments should be calculated by multiplying the per-member-per-month (PMPM) rate by the number of confirmed members.³³ As established in regulation, the Department will periodically reconcile the amount of advance CSR payments against the actual amount of CSR payments issuers made to QHP issuers on behalf of enrollees.³⁴

Incorrect Advance Cost-Sharing Reduction Payments

For 17 of the 100 sampled payee group-months, CMS did not follow its guidance for calculating advance CSR payments. We calculated that CMS authorized payments to issuers that were, in total, \$314,485 less than what should have been paid for these group-months. The incorrect payments occurred for one of the following three reasons.

³¹ The \$262,861,958 is the point estimate and is not mutually exclusive of the estimation amount of \$2,767,169,143 for verification of financial assistance payments appropriately applied. Appendix E contains more detail on the sample results and estimates.

³² 45 CFR §155.1030(b)(3). The methodology, known as the Department's Notice of Benefit and Payment Parameters for 2014, is published in the Federal Register (78 Fed. Reg. 15410 (March 11, 2013)).

³³ The guidance, *Data Changes & Clean-ups Opera Made in Pre-Audit As of 4/19/14*, was prepared for CMS by the contractor (Opera Solutions, LLC) to assist CMS in correcting deficiencies in the data contained within the initial 834 transactions, which included the advance CSR payment amounts calculated for enrollees.

³⁴ 45 CFR § 156.430(d).

Payment Was Within \$2 of CMS's Approved Advance Cost-Sharing Reduction Payment Amount

During 10 payee group-months, CMS's advance CSR payment calculation differed from what should have been paid because the value of the PMPM rate was within \$2 of the plan's approved PMPM advance CSR amount—an arbitrary threshold set by CMS under its interim payment process. Under this process, CMS calculates an advance CSR for each issuer using the total CSR amount requested for all of the issuer's plans. CMS then validates the requested advance CSR amount by dividing the total amount requested for each plan by the number of confirmed enrollees reported to receive advance CSR payments in that plan. If that value is within \$2 of the plan's approved PMPM advance CSR amount, CMS authorizes the total amount requested despite knowing that the amount differs from what it should actually authorize according to its own guidance. CMS stated that it allowed the variance in the plan's approved PMPM advance CSR amount because QHP issuers encountered “operational difficulties” when reporting accurate data. For the 10 payee group-months, we calculated that CMS authorized payments that were \$34,742 more than they should have been.³⁵

CMS Based Payments on Amounts Requested by Issuers Instead of on Confirmed Enrollment

Each month, QHP issuers submit a template to CMS that includes a variety of data, including the QHP's number of confirmed enrollees. This number is used in CMS's calculation of advance CSR payments. Contrary to CMS's own guidance, for four payee group-months we found that CMS did not calculate advance CSR payments using the number of confirmed enrollees reported on issuers' templates. Instead, CMS based payments on a separate column of the template where issuers reported the amount of advance CSR payments they were requesting.³⁶ Specifically:

- For two payee group-months, the issuers reported confirmed enrollment but did not request advance CSR payments in the separate column. Therefore, CMS did not make advance CSR payments to those issuers.
- For another two payee group-months, issuers requested and CMS paid more in advance CSR payments than the issuers' confirmed enrollment allowed them to receive.³⁷

For these four payee group-months, CMS should have calculated the advance CSR payments using QHP issuer-provided confirmed enrollment data in accordance with CMS's own guidance. However, CMS authorized payments only if QHP issuers requested them—an accounting practice that resulted in CMS having to regularly reconcile QHP issuers' accounts, a process with potential for error. As previously stated, CMS deviated from its own contractor's

³⁵ We calculated total advance CSR payment amounts by multiplying the number of confirmed enrollees in each plan by that plan's approved PMPM advance CSR amount, per the guidance described in footnote 33 (*Data Changes & Clean-ups Opera Made in Pre-Audit As of 4/19/14*).

³⁶ The amount requested did not always equal the amount the issuer was allowed to receive per the guidance prepared by Opera Solutions, LLC.

³⁷ The issuers requested additional advance CSR payments to reconcile underpayments received in prior payee group-months.

guidance because QHP issuers encountered “operational difficulties” when reporting accurate data. In total, CMS authorized monthly payments that were \$20,072 less than they should have been for these four payee group-months.

CMS Made an “Operational Policy Decision” During 1 Month To Authorize Requested Advance Cost-Sharing Reduction Amounts, Regardless of the Amount

For advance CSR payments requested for February 2014, CMS made what a high-level CMS official described as an “operational policy decision” to authorize all requested advance CSR payments because of the volume of templates received by CMS that exceeded the \$2 PMPM threshold described above. (In practice, the decision was a management override of CMS’s internal controls.) To address any February 2014 overpayments, CMS adjusted issuers’ March 2014 payments, if appropriate. Three of our sampled payee group-months were affected by the operational policy decision. For these three payee group months, we calculated that CMS-authorized payments were \$329,155 less than they should have been.³⁸

On the basis of our sample results, we estimated that CMS incorrectly calculated advance CSR payments that were \$3,094,529³⁹ less than they should have been for 167 payee group-months during the period January through April 2014.

Timely Reconciliation of Advance Cost-Sharing Reduction Payments Not Performed

In 2013, CMS stated that advance CSR payment amounts reimbursed to QHP issuers served as estimated payments and that all of these payments would be reconciled to actual CSR amounts that should have been paid to all plans for confirmed enrollees.⁴⁰ In addition, during our field work, CMS officials stated that this reconciliation would serve as CMS’s primary control to address potentially inappropriate advance CSR payments. However, on February 13, 2015, CMS issued guidance stating that it will postpone until 2016 the reconciliation of advance CSR payments made for the 2014 benefit year.⁴¹

According to the CMS guidance, QHP issuers are having difficulty upgrading their systems and producing credible data to reconcile advance CSR payments to actual amounts. Due to the risk of QHP issuers providing inaccurate data to calculate actual CSR amounts, CMS stated that it has postponed reconciling advance CSR payments made to all QHP issuers for the 2014 benefit year until April 30, 2016. Without effective internal controls for ensuring that advance CSR payments are reconciled in a timely manner, a significant amount of Federal funds are at risk.

³⁸ Two of the three payee group-months were for March 2014, with total underpayments of \$389,865. For the remaining payee group-month (February 2014), CMS authorized an overpayment of \$60,710.

³⁹ This estimate is relatively imprecise; this imprecision is reflected in the associated 90-percent confidence interval, which ranges from -\$8,127,641 to \$1,938,583. The \$3,094,529 is the point estimate. Appendix E contains more detail on the sample results and estimates.

⁴⁰ 78 Fed. Reg. 15541, 15544 (Mar. 11, 2013). Further, according to Federal regulations, CMS must perform periodic reconciliations of any advance CSRs provided to a QHP issuer (45 CFR § 156.430(d)).

⁴¹ *Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year* (February 13, 2015).

RECOMMENDATIONS

We recommend that CMS correct these internal control deficiencies by:

1. requiring OACT to review and validate QHP issuers' actuarial support for index rates used to calculate advance CSR payment rates that CMS identifies as outliers,
2. implementing computerized systems to maintain confirmed enrollee and payment information so that it does not have to rely on QHP issuers' attestations in calculating payments,
3. implementing a computerized system so State marketplaces can submit enrollee eligibility data,
4. following its guidance for calculating estimated advance CSR payments, and
5. developing interim reconciliation procedures to address potentially inappropriate CSR payments.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS COMMENTS

In written comments on our draft report, CMS concurred with our second, third, and fifth recommendations. CMS generally agreed with our first and fourth recommendations but indicated that the recommendations are no longer applicable because of regulatory action.

CMS stated that it was pleased to note that we did not report any deficiencies in our review of APTCs included in our sample of 100 payee group-months. CMS also stated that our findings related to advance CSR payments represented 0.1 percent of the total payments included in our sample. In addition, CMS acknowledged that it has not established a computerized payment system; however, it is currently testing a pilot program that will enable CMS to obtain individual enrollment data. Nevertheless, even when this system is fully implemented, CMS stated that QHP issuers will continue to be its source for confirming enrollment data. CMS also stated that it conducted an internal controls review over its financial reporting that determined its processes to be effective. In addition, an independent accounting firm conducted a similar review and reported no significant issues.

Regarding our first recommendation (requiring OACT to review and validate QHP issuers' actuarial support for index rates identified as outliers), CMS stated that it took regulatory action that eliminated the use of index rates in calculating advance CSR payment rates. As such, CMS stated that OACT will not need to review CMS's modified methodology for calculating these rates. CMS indicated that its regulatory action also affected our fourth recommendation—that CMS follow its own guidance for calculating estimated advance CSR payments. Specifically, CMS stated that for the 2015 benefit year, marketplaces now calculate the advance CSR payment

amount for a specific policy as the product of the total monthly premium for that policy and a CSR plan “variation multiplier.” CMS also stated that we based our findings related to advance CSR payments on an “alternative interpretation” of CMS guidance that produced a “point-in-time payment amount” that did not reflect corrections to past underpayments or overpayments. Finally, CMS stated that to address OIG concerns, by April 2015 it would eliminate its \$2 PMPM threshold for when it requests advance CSR amounts from QHP issuers.

CMS’s comments are included in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS’s comments, we maintain that our findings and recommendations are valid. CMS’s regulatory actions may appropriately address the findings related to our first and fourth recommendations. However, we have not tested the new advance CSR payment calculation described in the regulation. Therefore, we cannot determine whether the new calculation methodology allows for the type of discrepancies we identified during our audit period.

We disagree with CMS’s statement that we did not report any deficiencies in our review of APTCs included in our sample of 100 payee group-months. As we noted in the report, CMS does not maintain enrollment data on an enrollee-by-enrollee basis. (QHP issuers’ templates did not identify the confirmed enrollees in their plans.) This affected our ability to identify any potential deficiencies with APTC payments, as these amounts vary by enrollee. If CMS maintained adequate APTC data for specific enrollees, we could have tested the appropriateness of aggregate payments made on their behalf. Regarding the independent accounting firm’s review of CMS’s financial reporting, we note that the accounting firm’s review tested for basic transactions and security vulnerabilities. Further, the accounting firm reported findings related to advance CSR payments similar to those in this report.⁴²

We also disagree with CMS’s statement that our findings related to advance CSR payments represented 0.1 percent of the total payments included in our sample. A sample payee-group month included both aggregate APTC and advance CSR payments; therefore, it would not be appropriate to associate the approximately \$314,000 in advance CSR payments identified in our report as an underpayment with all of the payments included in our sample. We used CMS’s calculation methodology described in its own guidance to identify the advance CSR underpayments. In addition, we reviewed restatements of prior months when they were included in our sample payee-group month. However, because CMS did not have systems in place to ensure that financial assistance payments were made on behalf of confirmed enrollees and in the correct amounts or for State marketplaces to submit enrollee eligibility data for financial assistance payments, we could not verify that CMS correctly applied any of the nearly \$2.8 billion in financial assistance payments that it made during the period January through April 2014.

⁴² CMS did not provide us with a copy of its internal controls review. Therefore, we cannot comment on that report.

APPENDIX A: GLOSSARY OF SELECTED TERMS

This glossary is not intended to be a comprehensive source of technical or regulatory definitions. Rather, it provides basic definitions for a general understanding of selected terms used in this report.

834 transactions: Electronic files used to share health insurance information between QHP issuers, marketplaces, and CMS. These files are also commonly used by employers, unions, and government plan sponsors (e.g., Medicare Part D) to enroll members in a health insurance plan, the standards of which are set by the Health Insurance Portability and Accountability Act. An initial 834 transaction contains the calculation for any applicable financial assistance amounts that would be sent from the marketplace to the selected QHP issuer. A confirmation 834 transaction is created after the QHP issuer reviews the data in the application and ensures that enrollees paid their portion of the first month's premium (premium amount less APTC) in order to receive any financial assistance payments.

attestation agreements: For purposes of this report, the act of the signing of a document verifying that all information provided is accurate and in compliance with Federal policies and regulations.

confidence interval: Consists of a range of values (interval) that act as good estimates of the unknown population parameter. The level of confidence of the confidence interval would indicate the probability that the confidence range captures this true population parameter given a distribution of samples.

confirmed enrollees: Individuals enrolled in a QHP who have paid their first month's premium and have had their enrollment information approved by the QHP issuer.

funds at risk: Risk that material errors could occur in an account balance or class of transactions that will not be prevented or detected on a timely basis by the system of internal accounting controls.

index rate: For purposes of this report, the estimated amount a QHP issuer expects to pay for allowed claims for essential health benefits to enrollees for all of the QHP issuer's plans offered in a State.

internal controls: Processes in place to prevent or detect any possible substantial errors. According to the Government Accountability Office's *Standards for Internal Control in the Federal Government*, internal controls are processes effected by an entity's oversight body, management, and other personnel that provide reasonable assurance that the objectives of an entity will be achieved. These objectives and related risks can be broadly classified into one or more of the following three categories: operations (effectiveness and efficiency of operations), reporting (reliability of reporting for internal and external use), and compliance (compliance with applicable laws and regulations).

internal control deficiencies: Deficiencies in internal controls exist when the design or operation of a control does not allow management or employees to prevent or detect substantial errors in a timely manner. Materiality of the control deficiency is not just determined by the actual misstatement (i.e., dollar amount of the error) but by the potential dollar amounts that could also be incorrect.

marketplace: A health insurance exchange designed to serve as a “one-stop shop” where individuals can obtain information about health insurance options, determine eligibility for QHPs and insurance affordability programs, and select the plan of their choice.

metal-level: Health insurance plans in each “metal-level” pay different amounts of the total costs of an average person’s care, which take into account the plans’ monthly premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums. Metal-levels are categorized as bronze, silver, gold, and platinum.

operation deficiency: Exists when personnel performing a control are not qualified or properly skilled to perform the control effectively.

outlier: A value that diverges greatly (i.e., much smaller or larger) from most of the other values in a data set.

point estimate: For statistical purposes, involves the use of sample data to calculate a single value that serves as an estimate of an unknown (fixed or random) population parameter.

premium: The monthly amount due QHP issuers for an individual policyholder to receive health coverage.

qualified personnel: Individuals with characteristics or abilities gained through training, experience, or both, as measured against the established requirements for a particular industry.

utilization factor: For purposes of this report, adjusts cost-sharing amounts to account for greater utilization of health care services induced by lower enrollee cost sharing in higher metal level plans.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL WORK

<p>The <i>OIG Work Plan</i> for fiscal year 2015 summarizes new and ongoing reviews and activities, including Affordable Care Act reviews, that OIG plans to pursue with respect to HHS programs and operations during the current fiscal year and beyond. In addition, OIG has issued several reports on marketplace issues related to the Affordable Care Act. (See below.)</p>		
Report Title	Report Number	Date Issued
<i>California Implemented Security Controls Over the Web Site and Databases for Its Health Insurance Exchange but Could Improve Protection of Personally Identifiable Information</i>	A-09-14-03005	04/30/2015
<i>Early Alert: Without Clearer Guidance, Marketplaces Might Use Federal Funding Assistance for Operational Costs When Prohibited by Law</i>	A-01-14-02509	04/27/2015
<i>Review of the Accounting Structure Used for the Administration of Premium Tax Credits</i>	OEI-06-14-00590	3/31/2015
<i>Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace</i>	A-01-14-02503	3/26/2015
<i>Federal Marketplace: Inadequacies in Contract Planning and Procurement</i>	OEI-03-14-00230	01/20/2015
<i>Health Insurance Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls</i>	A-18-14-30011	09/22/2014
<i>An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace</i>	OEI-03-14-00231	08/26/2014
<i>Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data</i>	OEI-01-14-00180	07/02/2014
<i>Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements</i>	A-09-14-01000	06/30/2014
<i>Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange—Data Services Hub</i>	A-18-13-30070	08/02/2013

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered financial assistance payments made for 984 payee group-months, totaling \$2,767,169,143, for which CMS reimbursed QHP issuers during the period January through April 2014. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one TIN for 1 month.

The scope of our audit did not require us to review enrollee eligibility or calculate actual financial assistance payments claimed for reimbursement. Rather, we limited our review to CMS's internal controls for determining financial assistance amounts and processing payments to QHP issuers.

We performed our fieldwork at CMS's central office in Baltimore, Maryland, and at the OIG Office of Audit Services New York regional office from April through December 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- met with CMS officials from CCIIO, OFM, and OACT to gain an understanding of their processes for administering and approving financial assistance payments, determining financial assistance amounts, and authorizing payments to QHP issuers;
- obtained the final master vendor management file for January through April 2014 to identify all QHP issuers approved to receive financial assistance payments;
- obtained from CMS's HIGLAS a sampling frame of 984 payee group-months for payments, totaling \$2,767,169,143, for which CMS authorized reimbursement to QHP issuers for financial assistance payments for the period January through April 2014;
- selected a simple random sample of 100 payee group-months from the sampling frame and, for each payee group:
 - reviewed advance CSR payment rate information provided by issuers used in their calculations for payment,
 - verified that the QHP issuers that made up the payee group were certified to receive financial assistance payments, and
 - attempted to verify that calculated financial assistance amounts were accurate;

- estimated (1) the total amount of financial assistance payments that CMS was unable to verify and (2) the total amount and number of advance CSR payments that CMS incorrectly calculated in our sampling frame of 984 payee group-months; and
- discussed the results of our review with CMS officials.

Appendix D contains our statistical sampling methodology and Appendix E contains our sample results and estimates.

We conducted this performance 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 on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all payee group-months for financial assistance payments made to QHP issuers submitted to CMS for reimbursement during the period January through April 2014. A payee group-month is defined as all financial assistance payments made for a group of QHP issuers under one TIN for 1 month.

SAMPLING FRAME

The sampling frame was an Excel file containing 984 payee group-months with payments totaling \$2,767,169,143 for which CMS reimbursed QHP issuers for financial assistance payments during the period January through April 2014. The data for payee group-month payments were provided by CCIIO's HIGLAS.

SAMPLE UNIT

The sample unit was a payee group-month.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 payee group-months.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG Office of Audit Services statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the payee group-months in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items for our sample.

ESTIMATION METHODOLOGY

We used the OIG Office of Audit Services statistical software to calculate our estimates. We estimated the total amount of financial assistance payments that CMS was (1) unable to verify were appropriately applied on behalf of confirmed enrollees and (2) unable to verify were made for eligible enrollees who applied through State marketplaces. We also estimated the total amount and number of advance CSR payments that CMS incorrectly calculated. The confidence intervals for the reported point estimates can be found in Appendix E.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

CMS DID NOT HAVE SYSTEMS IN PLACE TO ENSURE THAT FINANCIAL ASSISTANCE PAYMENTS WERE MADE ON BEHALF OF CONFIRMED ENROLLEES AND IN THE CORRECT AMOUNTS

Table 2: Sample Details and Results

Payee Group-Months in Frame	Value of Frame	Sample Size	Value of Sample	Payee Group-Months With Payments Not Verified To Be Appropriately Applied	Value of Payments Not Verified To Be Appropriately Applied
984	\$2,767,169,143	100	\$301,665,077	100	\$301,665,077

Table 3: Estimated Value of Financial Assistance Payments Not Verified To Be Appropriately Applied
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$2,767,169,143 ⁴³
Lower limit	1,902,548,635
Upper limit	2,767,169,143 ⁴³

CMS DID NOT HAVE SYSTEMS IN PLACE FOR STATE MARKETPLACES TO SUBMIT ENROLLEE ELIGIBILITY DATA FOR FINANCIAL ASSISTANCE PAYMENTS

Table 4: Sample Details and Results

Payee Group-Months in Frame	Value of Frame	Sample Size	Value of Sample	Payee Group-Months With State Marketplace Payments for Which Enrollee Eligibility Was Not Verified	Value of State Marketplace Payments for Which Enrollee Eligibility Was Not Verified
984	\$2,767,169,143	100	\$301,665,077	29	\$26,713,614

⁴³ The point estimate and upper limit calculated using the OIG Office of Audit Services statistical software were \$2,968,384,362 and \$4,034,220,088, respectively. The estimates were adjusted downward based on the known value of the sampling frame.

**Table 5: Estimated Value of State Marketplace Payments for Which
Enrollee Eligibility Was Not Verified
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$262,861,958
Lower limit	103,644,991
Upper limit	422,078,925

**CMS DID NOT ALWAYS FOLLOW ITS GUIDANCE FOR CALCULATING
ADVANCE COST-SHARING REDUCTION PAYMENTS**

Table 6: Sample Details and Results

Payee Group-Months in Frame	Value of Frame	Sample Size	Value of Sample	Payee Group-Months With Incorrect Advance Cost-Sharing Reduction Payments	Value of Incorrect Advance Cost-Sharing Reduction Payments
984	\$2,767,169,143	100	\$301,665,077	17	(\$314,485)

**Table 7: Estimated Number of Payee Group-Months and
Value of Incorrect Advance Cost-Sharing Reduction Payments
(Limits Calculated for a 90-Percent Confidence Interval)**

	Payee Group-Months With Incorrect Advance Cost-Sharing Reduction Payments	Value of Incorrect Advance Cost-Sharing Reduction Payments
Point estimate	167	(\$3,094,529)
Lower limit	113	(8,127,641)
Upper limit	236	1,938,583

APPENDIX F: CMS COMMENTS



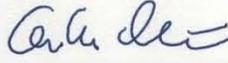
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 17 2015

TO: Daniel R. Levinson, Inspector General
Office of the Inspector General

FROM: Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services 

SUBJECT: OIG Draft Report "CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act" (A-02-14-02006)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review the Office of the Inspector General's (OIG) draft report on advance payment of the premium tax credits (APTC) and Cost-Sharing Reductions (CSR). CMS has continuously worked to implement a rigorous and effective set of internal controls over the interim manual payment process. CMS is addressing or has already addressed all of the OIG's recommendations in this report. CMS is also pleased to note the majority of the CSR underpayments identified in this report are a result of policies that CMS has already revised or changed. CMS is also pleased to note that, while the OIG reviewed a random sample of 100 monthly payments for APTC and CSR from CMS to qualified health plan (QHP) issuers, the OIG did not have any findings related to APTCs.

Each month, CMS receives completed templates from issuers and certain State Based Marketplaces (SBMs) on behalf of its issuers to calculate the payment amounts owed to issuers for Marketplace financial assistance on behalf of eligible enrollees. Once a month, issuers restate/update their prior month enrollment counts for a number of events including retroactive enrollments, terminations, special enrollment periods, and grace periods. This payment process is designed to account for fluctuations in issuer data that are the result of normal business processes, while protecting taxpayer dollars by reconciling issuer data on an ongoing basis. This restatement/update process is similar to that of other programs including Medicare Advantage and Part D.

CMS takes the stewardship of tax dollars seriously and implemented a series of payment and process controls to assist in making manual financial assistance payments accurately to issuers. These controls include parallel processing and multiple levels of review of the data at CMS, and requiring QHP issuers to certify the accuracy of their data submissions each month as a prerequisite for payment. A deliberate misstatement of data in the face of this certification would

constitute fraud. In addition, under CMS's Office of Management and Budget A-123 internal controls review over financial reporting, key controls surrounding this payment process were tested and determined to be operating effectively. Moreover, an independent certified public accounting firm conducted its review of the payment process and reported no significant issues. Both reviews were completed with no significant deficiencies or material weaknesses identified over the payment process. While CMS lacks fully automated payment systems, it has implemented a rigorous and effective set of internal controls to make accurate payments.

Issuers are the source of information on who has paid their premiums, which is the criterion for enrollment effectuation. Issuers will continue providing data on effectuated enrollment to CMS even after a fully automated payment process has been implemented. CMS is working to implement a process to receive effectuated enrollment information through the Federally Facilitated Marketplace (FFM) and is currently pilot testing this process with issuers. CMS continues this process as part of its work toward making APTC and CSR payments to issuers based on policy-level (individual) enrollment data. In addition, CMS continues to conduct internal validation checks for payment accuracy with policy level enrollment data from issuers.

Finally, OIG identified approximately \$314,000 as a reported underpayment. This finding represents approximately 0.1 percent of the sample of approximately \$301 million in total payments. The majority of CSR underpayments identified in the report are a result of an alternate interpretation of CMS's guidance by the OIG of the calculation methodology, which does not take into account restatements of the monthly payment amounts.

OIG Recommendation

We recommend that CMS correct internal control deficiencies by requiring the Office of the Actuary (OACT) to review and validate QHP issuers' actuarial support for index rates that CMS identifies as outliers.

CMS Response

We note that the recommendation is not applicable to 2015 or future years as the CSR rate calculation formula has been changed by regulation. For the 2015 benefit year, CMS modified the methodology for calculating cost-sharing reduction advance payment rates. Marketplaces will use a methodology for calculating the advance payment amounts that will not require QHP issuers to submit an estimate of the value of cost-sharing reductions to be provided for the EHB portion of expected allowed claims costs. Instead, Marketplaces will calculate the monthly advance payment amount for a specific policy as the product of the total monthly premium for the specific policy and a cost-sharing reduction plan variation multiplier. Because this process no longer involves reliance on index rates, this review does not occur, and OACT will not need to review.

OIG Recommendation

We recommend that CMS correct internal control deficiencies by implementing computerized systems to maintain confirmed enrollee and payment information so that CMS does not have to rely on QHP issuers' attestations in calculating payments.

CMS Response

CMS concurs with this recommendation. Issuers are the source of information on who has paid their premiums, which is the criterion for enrollment effectuation. Issuers will continue providing data on effectuated enrollment to CMS even after an automated payment process has been fully implemented. CMS is working to implement a process to receive effectuated enrollment information through the FFM and is currently pilot testing this process with issuers. CMS continues this process as part of its work toward making APTC and CSR payments to issuers based on policy-level (individual) enrollment data. In addition, CMS continues to conduct internal validation checks for payment accuracy with policy level enrollment data from issuers.

OIG Recommendation

We recommend that CMS correct internal control deficiencies by implementing a computerized system so State marketplaces can submit enrollee eligibility data.

CMS Response

CMS concurs with this recommendation. CMS is working to implement an automated process to receive effectuated enrollment information from State Based Marketplaces.

OIG Recommendation

We recommend that CMS correct internal control deficiencies by following its guidance for calculating estimated advance CSR payments.

CMS Response

We note that the recommendation is not applicable to 2015 or future years, as the CSR rate calculation formula has been changed by regulation. In 2015, CMS used a different method to calculate the advance CSR payments to issuers. Marketplaces now calculate the monthly advance payment amount for a specific policy as the product of the total monthly premium for the specific policy, and a cost-sharing reduction plan variation multiplier.

In addition, the OIG based their findings on an alternative interpretation of CMS's guidance. In some cases the OIG's method produces a point-in-time payment amount that does not reflect corrections to past underpayments or overpayments. In other cases, it leads to a different payment amount due to the \$2 per member per month (PMPM) variance we allowed. CMS allowed a slight variance in the CSR PMPM rate to account for the effects of operational difficulties faced by many issuers and SBMs in receiving accurate CSR data. To address the OIG concern, this \$2 PMPM allowance will be completely eliminated and payment adjustments made accordingly for all 2014 payment months in the April 2015 payment cycle. As stated above, there is a new process in place for advance CSR payment for 2015.

OIG Recommendation

We recommend that CMS correct internal control deficiencies by developing interim reconciliation procedures to address potentially inappropriate CSR payments.

CMS Response

CMS concurs with this recommendation. In order for CMS to enhance the accuracy of reconciliation of CSR payments to issuers, and to fully reimburse issuers for reductions in out-of-pocket expenses provided to eligible low- and moderate-income enrollees, and American

Indian/Alaska Native enrollees in 2014, CMS will reconcile 2014 benefit year cost-sharing reductions for all issuers in April 2016.

CMS permitted issuers that selected the simplified methodology for calculating CSR payments to switch to the more accurate standard methodology¹, and will reconcile 2014 benefit year cost-sharing reductions for all issuers beginning on April 30, 2016. This new reconciliation deadline for all issuers will promote accurate reimbursement of cost-sharing reductions by permitting issuers that switch to, or previously selected, the more accurate standard methodology to complete their operational upgrades.

CMS continues to provide technical assistance to issuers and, in advance of pilot testing for 2016 cost-sharing reduction reconciliation data submission for benefit years 2014 and 2015, CMS will provide technical data submission standards and appropriate instruction.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

¹ Advanced payments of cost-sharing reductions are reconciled by comparing the cost sharing that an enrollee pays under a cost-sharing reduction plan variation of the QHP to the cost sharing the enrollee would have paid under the standard plan. The cost sharing that would have been paid under the standard plan is most accurately calculated by adjudicating an enrollee's claims history for the year through the standard plan cost-sharing parameters, a process sometimes referred to as "double adjudication," and referred to under CMS regulations as the "standard methodology."

Under CMS regulations, as a transitional measure, issuers were permitted to elect either to calculate cost sharing that an enrollee would have paid under the standard plan using the standard methodology – the most accurate approach – or to estimate that cost sharing using a simplified methodology based on actuarial estimates of certain key cost-sharing parameters.

On February 13, 2015, CMS announced that issuers that previously elected to use the simplified methodology may choose to switch to the more accurate standard methodology and that CMS will reconcile 2014 benefit year CSRs for all issuers beginning on April 30, 2016.