2015 Transitional Reinsurance (RI) Payment Audit Report

for

Hawaii Medical Service Association (HMSA)
HIOS Issuer ID 18350

March 29th, 2023

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I. EXECUTIVE SUMMARY

The 2015 Transitional Reinsurance (RI) Audit Report is an assessment of Hawaii Medical Service Association's (HMSA) compliance with the applicable federal requirements related to payments made under the Transitional Reinsurance program established under section 1341 of the Patient Protection and Affordable Care Act (ACA)[1] and implementing regulations.[2,3] This report details the audit procedures[4] and the resulting findings and/or observations for the Benefit Year (BY) 2015 RI payment audit of HMSA.

Background

HMSA, HIOS Issuer ID (18350), is a health insurance issuer that received BY 2015 RI payments consistent with the BY 2015 national RI payment parameters.[5] HMSA submitted enrollment, medical, and pharmacy claims data to its External Data Gathering Environment (EDGE) Server for calculation of the BY 2015 RI payments. The payments are reflected in the issuer's 2015 EDGE Reinsurance Detailed Enrollee Report (BY 2015 RIDE Report). This issuer's total BY 2015 RI payments were $16,281,376.23.

Audits to Determine Compliance with the Transitional RI Program

Under title 45 of the Code of Federal Regulations (CFR) § 153.410(d), the Department of Health and Human Services (HHS) may audit issuers to assess the degree of compliance with the federal RI program requirements. HHS designated CMS to conduct these audits to achieve the following:

- Safeguard federal funds;
- Instill confidence amongst regulated entities concerning data quality, soundness, and robustness;
- Evaluate health insurance issuers' compliance with federal program rules and regulations; and

[1] The ACA (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the ACA, was enacted on March 30, 2010. In this report, we refer to the two statutes collectively as the ''Patient Protection and Affordable Care Act'' or ''ACA.''

[2] See 42 U.S.C. 18061. Also see 45 C.F.R. Part 153, Subparts A, C, E, H.

[3] Consistent with section 1321(c)(1) of ACA, the HHS Secretary is responsible for operating the transitional reinsurance program on behalf of any state that elected not to do so. For the 2015 benefit year, Connecticut was the only state to elect to operate the transitional reinsurance program. See the HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 FR 10749 at 10759 (February 27, 2015) (2016 Payment Notice).

[4] To provide the flexibility needed when reviewing compliance with program requirements and to ensure that issuers are able to provide CMS with their most accurate data, audit protocols allow for dialogue between auditor and issuer to identify and correct errors in data submission that differ somewhat from some independence and reporting standards set forth 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.

[5] The final BY 2015 national RI payment parameters consisted of a $45,000 attachment point and $250,000 cap. The After accounting for actionable late-filed discrepancies related to reinsurance overpayments and overlapping claims, including some additional adjustments that occurred after CMS published the Amendment to the 2015 Benefit Year Summary Report, the final BY 2015 coinsurance rate was 55.48%.

- Develop a successful and coordinated risk-based audit program that maximizes resources.

This audit is part of CMS's program to validate the BY 2015 enrollee-level data submitted to selected issuers' EDGE servers as of May 2, 2016[6] and to analyze controls and policies related to BY 2015 RI payments. Additional RI payments will not be provided for claims identified during this audit that are not reflected in the BY 2015 RIDE Report.[7]

CMS findings and observations from this audit for the BY 2015 RI payments made to HMSA are documented below.

- *Finding*: Results from cases of confirmed non-compliance or discovery of evidence suggesting non-compliance with applicable RI program federal requirements related to RI payments, which require a recoupment of RI payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2015 RIDE Report, associated with an RI payment enrollee, that result in a recoupment of RI payments.
- *Observation*: Results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable RI program federal requirements, or when there may be evidence of non-compliance with applicable RI program federal requirements, related to RI payments, that does not require recoupment of RI payments.
    - Example: Claim level discrepancies identified within the issuer's claims data extract and the issuer's BY 2015 RIDE Report, associated with RI payment enrollees where the claim adjustment would not result in a recoupment of RI payments.

Results of Review

CMS identified zero (0) findings and zero (0) observations during HMSA's BY 2015 RI payment audit. The results of the BY 2015 RI payment audit do not require a recoupment of amounts the issuer received for BY 2015 RI payments.

The results of the zero (0) observations do not require a recoupment of the issuer's BY 2015 RI payments. In some instances, an observation may also affect an enrollee who received an RI payment but not result in an impact to the RI payment for that enrollee (e.g., the issuer's aggregated paid claims for the enrollee, after correcting the observation and application of the BY 2015 RI payment parameters, results in the same or a larger[8] RI payment for the enrollee).[9]

[6] See 45 C.F.R. § 153.730. When April 30th has fallen on a weekend or holiday, CMS extended the EDGE data submission deadline to the following business day. This practice resulted in the BY 2015 deadline shifting to May 2, 2016. See REGTAP FAQ 14472a.

[7] As communicated in the Entrance Conference, additional RI payments will not be provided for underpayments identified as a result of the BY 2015 RI Audits.

[8] See supra note 7.

[9] Please refer to Section II C. Findings to view the aggregated amount of paid claim differences associated with each audit procedure, used for calculating the "Total Financial Impact."

II. REINSURANCE PAYMENT PROGRAM ASSESSMENT

A. BACKGROUND, OBJECTIVES, SCOPE, and METHODOLOGY

1. Background

Section 1341 of ACA established a transitional RI program to stabilize premiums in the individual market inside and outside of the Exchanges for benefits years 2014 through 2016.[10] The transitional RI program collected contributions from contributing entities to fund RI payments to issuers of non-grandfathered individual market reinsurance-eligible plans[11], the administrative costs of operating the program, and the General Fund of the U.S. Treasury. The program helped reduce the uncertainty of insurance risk in the individual market as the federal ACA insurance market requirements and Exchanges were implemented by partially offsetting issuer's claims associated with high-cost enrollees.[12] Under the program, payments were made to issuers of reinsurance-eligible plans for a percentage of covered claims (coinsurance rate) above the attachment point and below the reinsurance cap.[13] For BY 2015, the attachment point was $45,000, the reinsurance cap was $250,000, and the final coinsurance rate was 55.48%.[14]

HHS implemented a distributed data collection (DDC) approach where issuers of reinsurance-eligible plans were required to establish external data gathering environment (EDGE) servers to make accessible data required to calculate RI payments when HHS was responsible for operating the RI program.[15,16] Issuers were required to submit enrollee and claims data on their EDGE servers by April 30th of the year following the applicable benefit year.[17] Non-orphan claims (i.e., those that are linked to enrollees in a valid individual market reinsurance-eligible plan) were selected for the RI calculation and considered as a request for payment pursuant to 45 C.F.R. § 153.410. Each issuer's EDGE server calculated the issuer's estimated RI payment, while the EDGE Calculation Module (ECM), a CMS internal system, calculated the amount of each issuer's actual RI payment, taking into consideration total available RI contributions.

HHS has authority to conduct audits to confirm successful implementation of, and adherence to, the applicable federal requirements related to the RI program.[18] As such, CMS established this

[10] See supra note 3.
[11] See 45 C.F.R. § 153.20 for a definition of "reinsurance-eligible plan."
[12] See, e.g., Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchange and Qualified Health Plans; Small Business Health Options Program; Proposed Rule, 78 FR 15410 (March 11, 2013) (2014 Payment Notice); and the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule, 79 Fed. Reg. 13743 (March 11, 2014).
[13] Ibid. Also see supra note 5.
[14] See supra note 5.
[15] See 45 C.F.R. §§ 153.420 and 153.700.
[16] While Connecticut elected to operate the RI program for BY 2015, issuers in Connecticut leveraged the EDGE server data submission process.
[17] See supra note 6.
[18] See 45 C.F.R. § 153.410(d).

audit program. CMS established audit protocols to assess health insurance issuers' compliance with the following regulations governing the RI program:

- 45 C.F.R. § 153.410: Requests for reinsurance payment;
- 45 C.F.R. § 153.420: Data collection; and
- 45 C.F.R. § 153.700, et seq.: Distributed data collection for HHS-Operated Programs.

Please refer to Appendix 3 – Applicable Federal Regulations for further details.

2. Objectives

The objectives of this audit are to:

(1) Evaluate issuer-submitted enrollment and claims files against applicable federal RI program requirements for compliance and completeness;
(2) Assess validity and compliance of issuer-submitted plan reference data and associated enrollee data;
(3) Evaluate whether issuer-submitted data supports the BY 2015 RIDE Report[19] data at the enrollee level;
(4) Evaluate accuracy of the RI payments as calculated by the EDGE server,[20] in instances where there is a deviation in the detailed enrollee and claims submission to the EDGE server;
(5) Assess issuer controls, policies, and procedures surrounding RI data submissions to the EDGE server; and
(6) Assess compliance with maintenance of records requirements in 45 C.F.R. § 153.410(c) (i.e., 10 years of file retention).

3. Scope and Methodology

CMS selected HMSA for an audit to assess the issuer's compliance with the federal requirements related to the BY 2015 RI program. CMS evaluated HMSA's information and activities related to the BY 2015 (January 1, 2015 through December 31, 2015) enrollee and claim-level data submitted to the issuer's EDGE server as of May 2, 2016, to support RI payments received.

CMS sent HMSA an electronic letter on April 19, 2022, to notify them of this audit. CMS's audit contractor sent a follow-up letter to HMSA on April 21, 2022, which identified the data and other requirements related to conducting the audit. CMS's audit contractor reviewed HMSA's documentation, including an issuer-provided data extract, and used CMS's applicable audit procedures to assess compliance with applicable federal RI payment program regulations.

CMS's audit contractor applied CMS's audit protocols to identify findings and observations. The contractor performed audit procedures on data and information for 100% of known on-Exchange and off-Exchange enrollees in RI eligible plans who received BY 2015 RI payments. For CMS's audit procedures please review Appendix 2 – Procedure Criteria & Effect.

[19] The RIDE report contains enrollee-level plan and claim details used for the RI payment calculation and is made available only to issuers through EDGE servers.

[20] Issuer EDGE servers process enrollment and claims data according to the EDGE Server Business Rules (ESBR) to select claims to be included in RI payment calculations. See 45 C.F.R. §§ 153.410, 153.420, 153.700, 153.710, and 153.720.

B. RESULTS OF REVIEW

CMS assessed HMSA's compliance with applicable federal requirements related to the transitional RI program using the following procedures: Unreconciled Claims Review, RI Eligible Plan Review, Claim Coverage Period Validation, Paid Claim Amount Validation, BY 2015 Cross Year Claim Validation, Duplicate Claim Validation, Enrollee Validation, Issuer RI Policies and Procedures Review, Issuer RI Attestation Review, and Issuer Compliance with CMS RI Payment Audit Requirements. Below are the results of this review.[21]

(1) Unreconciled Claims Review

No findings resulted from the review of HMSA's claims data extract to determine if the claims reported on the BY 2015 RIDE Report existed in the data extract.

(2) RI Eligible Plan Review

No findings and no observations resulted from the review of HMSA's claims data extract to determine if the enrollee's plan ID matched the corresponding enrollee's plan ID reported in the issuer's BY 2015 RIDE Report and if the claim was paid by an RI eligible plan.

(3) Claim Coverage Period Validation

No findings resulted from the review of HMSA's claims data extract to determine if the service begin date of claims were within the enrollee's coverage period.

(4) Paid Claim Amount Validation

No findings and no observations resulted from the review of HMSA's claims data extract to determine if the claim paid amount matched the corresponding claim paid amount in the issuer's BY 2015 RIDE Report.

(5) BY 2015 Cross Year Claim Validation

No findings resulted from the review of HMSA's claims data extract to identify cross year claims and determine if the service end date of claims fell within the applicable benefit year.

(6) Duplicate Claim Validation

No findings resulted from the review of HMSA's claims data extract to determine if claims were reported more than once on the EDGE server.

(7) Enrollee Validation

No findings resulted from the review of HMSA's claims data extract to determine if the enrollee and related claims included in the issuer's claims data extract matches the enrollee associated with the applicable claim on the EDGE server.

(8) Issuer RI Policies and Procedures Review

No observations resulted from the review of HMSA's RI policies and procedures to determine compliance with applicable CMS rules, regulations, and policies.

(9) Issuer RI Attestation Review

No observations resulted from the review of HMSA's RI Attestation to validate that the issuer

[21] This review was primarily focused on the BY 2015 RIDE Report titled: 18350.RIDE.D20160503T010649.P.xml.

provided a completed attestation signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other authorized official who has reviewed the documentation submitted for this audit.

(10) Issuer Compliance with CMS RI Payment Audit Requirements

No observations resulted from the review of HMSA's compliance with the applicable CMS audit requirements, including an assessment of the completeness of audit documentation, for the BY 2015 RI payment audit.

C. FINDINGS

A finding results from cases of confirmed non-compliance or discovery of evidence suggesting non-compliance with applicable federal RI payment requirements, which requires a recoupment of all or a portion of the RI payment. In BY 2015, for an issuer to be eligible for reinsurance payments for an enrollee, the enrollee must have had claims paid by the issuer in an amount that fell between the attachment point of $45,000 and the reinsurance cap of $250,000. The amount of total paid claims was then required to be adjusted downward for enrollees for whom the issuer also received a 2015 advance CSR payment (a process collectively referred to as the CSR Maximum Out-of-Pocket (MOOP) adjustment). CMS's audit contractor considered the MOOP adjustment amounts reported in the issuer's BY 2015 RIDE Report, the BY 2015 coinsurance rate of 55.48%, as well as the paid claim amount differences identified from the claim-level audit procedures, for purposes of determining the financial impact of the findings in HMSA's BY 2015 RI payment audit. Please refer to the Findings Summary Results table below to view the aggregated amount of paid claim differences associated with each audit procedure.

Findings Summary Results:

Finding No.	Claim Level Procedure	Total	
		Total Count of Claims	Total Claim Level Differences
No findings noted.			

Based on the claim-level audit procedures performed, zero (0) findings were identified for enrollees associated with a BY 2015 RI payment. Please refer to the Findings Summary Results table above to view the aggregated amount of paid claim differences associated with each audit procedure used for calculating the "Total Financial Impact" amount shown in the table below.

Financial Impact Summary Results:

	Total RI Payment Amount
Total RI Payment per HMSA's BY 2015 Final Coinsurance Rate	$16,281,376.23
Total RI Payment as Recalculated	$16,281,376.23
Total Financial Impact[22]	$0.00

Please review Appendix 2 – Procedure Criteria & Effect for more information.

[22] Financial impact derived from BY 2015 RI payment audits only includes findings where funds are subject to recoupment by HHS. These amounts will be collected as part of the next available monthly payment cycle consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215 after this report is finalized. If all or part of the recoupment amount is unable to be netted, the remaining amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c).

D. OBSERVATIONS

An observation results from the identification of areas for improvement when there is no evidence of actual non-compliance with applicable RI federal requirements related to RI payments or when there may be evidence of non-compliance with applicable federal requirements related to RI payments that does not require recoupment of RI payments. CMS is making HMSA's management aware of these areas by bringing the identified observations to their attention.

Based on the claim-level audit procedures performed, no observations were identified for enrollees associated with a BY 2015 RI payment. Additionally, no observation was identified for the Issuer RI Policies and Procedures Review and no observation was identified for Issuer Compliance with CMS RI Audit Requirements. Please review the Observations Summary Results table below for more information on the observations identified.

Observations Summary Results

Observation No.	Claim Level Procedure	Total
		Total Count of Claims
No observations noted.		
Observation No.	**Policies and Procedures**	
No observations noted.		
Observation No	**Issuer Compliance with Audit Requirements**	
No observations noted.		

III. ISSUER MANAGEMENT RESPONSES

HMSA's completed attached Appendix 1 – Issuer Management Response **is due within thirty (30) calendar days from the date of this draft audit report.** If CMS does not receive HMSA's management response within this timeframe, we will assume your management's agreement and issue the final audit report.

Agreement

If HMSA's management agrees with the reported finding(s), observation(s), and recoupment amount (if applicable) the issuer should initial "Agree", sign, and submit the attached Appendix 1.

Disagreement

If HMSA's management disagrees with the reported finding(s), observation(s), and/or recoupment amount (if applicable) and requests a review of additional information that may impact the results of the audit, the issuer should initial "Disagree", sign, and submit the attached Appendix 1. You must provide a written explanation with any such additional documentation within thirty (30) calendar days of the date of this draft audit report along with a completed Appendix 1. If this option is selected, CMS will consider this draft only a preliminary audit report. CMS will review the written explanation and supporting documentation submitted as part of your response to this report to determine if the report can be amended in a mutually acceptable manner. CMS maintains discretion to determine whether amendments to the report are appropriate. Your response(s) to this report will be included in the final published audit report.

Regardless of whether the issuer agrees or disagrees with the reported finding(s) and observation(s), HMSA's management should review and return the draft audit report, including completed Appendix 1, within thirty (30) calendar days from the date of this draft audit report. Review of this draft report is the final opportunity to provide information to correct any inaccuracies or address concerns before it is finalized. CMS will provide HMSA a copy of the final audit report and publish the final report on the Center for Consumer Information and Insurance Oversight (CCIIO) website, including the recoupment amount(s) (if applicable) along with an updated Appendix 1, after receipt of HMSA's management's response. CMS will finalize and process the final adjustment recoupment amount consistent with 45 C.F.R. § 156.1210 and the netting regulation at 45 C.F.R. § 156.1215 in the next available monthly payment cycle. If all or part of the adjustment amount was unable to be netted, the remaining adjustment amount is a determination of a debt that is owed to the federal government. See 45 C.F.R. § 156.1215(c). In such circumstances, CMS will send an invoice to the issuer for the remaining amount to collect the debt.

Appendix 1 – Issuer Management Response

Issuer ID: 18350

Issuer Name: Hawaii Medical Service Association

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other individual with authority to legally and financially bind this issuer has reviewed the information included in the Audit Report of the issuer's compliance with applicable federal requirements related to RI payments made through the HHS-operated RI program for BY 2015. This audit resulted in no payment adjustment.

Agreement/Disagreement

(INITIAL)_____Agrees with the recoupment amount (if applicable) for this issuer's BY 2015 RI payment audit, as such this report will be considered a final audit report and will be published. If this option is selected, you must return this response within thirty (30) calendar days of the date of this draft audit report. Your response(s) to this report will be included in the final published audit report.

Or

(INITIAL)_____Disagrees and requests a review of additional information that may impact the recoupment amount (if applicable) for this issuer's BY 2015 RI payment audit. If a review is requested, CMS will consider this draft only a preliminary audit report. If this option is selected, you must provide a written explanation with any additional supporting documentation that may impact the results of the audit 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 submitted as part of your response to this report to determine if the report can be amended in a mutually acceptable manner. CMS maintains discretion to determine whether amendments to the report are appropriate. Your response(s) to this report will be included in the final published audit report.

Signed: _____
(Signature of authorized person acting on behalf of the issuer)

Printed Name: Gina L. Marting
(Print name of signature)

Title: Executive Vice President & CFO
(Title of authorized person acting on behalf of the issuer)

Telephone Number: 808-948-5696
(Direct Telephone Number)

Date: April 14, 2023

Appendix 2 – Procedure Criteria & Effect

Procedure	Criteria	Effect
Unreconciled Claims Review	RI eligible claims submitted to the EDGE server only include claims the issuer can substantiate in its claims system. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[23]	The inclusion of unreconciled claims in the BY 2015 RIDE Report results in a finding and a change to the issuer's BY 2015 RI payments.
RI Eligible Plan Review	RI eligible claims submitted to the EDGE server only include claims incurred and paid by an applicable RI eligible plan. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[24]	The inclusion of claims that were not paid by an RI eligible plan results in a finding and a change to the issuer's BY 2015 RI payments. The inclusion of claims reported as paid by an incorrect RI eligible plan results in an observation and no change to the issuer's BY 2015 RI payments.
Claim Coverage Period Validation	RI eligible claims submitted to the EDGE server only include claims incurred during the active enrollment period for the enrollee within the applicable BY. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[25]	The inclusion of claims that were not incurred within the enrollee's coverage period results in a finding and a change to the issuer's BY 2015 RI payments.
Paid Claim Amount Validation	RI eligible claims submitted to the EDGE server only include the amounts paid by the issuer. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI	The inclusion of claims with overstated paid claim amounts results in a finding and a change to the issuer's BY 2015 RI payments. The inclusion of claims with understated paid claim amounts results in an observation and no

[23] EDGE Server: Reinsurance (RI) Quick Reference Guide (hhs.gov)
[24] See supra note 24.
[25] See supra note 24.

Procedure	Criteria	Effect
	Reference Guide (Version 2.0 March 17, 2016)[26]	change to the issuer's BY 2015 RI payments.[27]
BY 2015 Cross Year Claim Validation	RI eligible claims submitted to the EDGE server only include claims that have a service end date within the applicable BY. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[28]	The inclusion of claims that were reported in the incorrect BY results in a finding and a change to the issuer's BY 2015 RI payments.
Duplicate Claim Validation	RI eligible claims submitted to the EDGE server only include claims the issuer can substantiate in its claims system and are only reported one time. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[29]	The inclusion of duplicate claims results in a finding and a change to the issuer's BY 2015 RI payments.
Enrollee Validation	RI eligible claims submitted to the EDGE server should only include claims associated with the appropriate eligible enrollee ID. See 45 C.F.R. §§ 153.410, 153.420, 153.700, and 153.710. See the RI Reference Guide (Version 2.0 March 17, 2016)[30]	The inclusion of claims associated with an enrollee that does not match the enrollee reported to the BY 2015 RIDE Report results in a finding and a change to the issuer's BY 2015 RI payments.
Issuer RI Policies and Procedures Review	Issuers should implement policies and procedures that adequately address and document their implementation and compliance with the federal requirements related to HHS-operated RI program. Issuers must maintain documents and records for each benefit year for at least 10 years and must	The absence of adequate documentation regarding the issuer's RI policies and procedures results in an observation and no change to the issuer's BY 2015 RI payments.

[26] See supra note 24.
[27] See supra note 7.
[28] See supra note 24.
[29] See supra note 24.
[30] See supra note 24.

Procedure	Criteria	Effect
	make those documents and records available to substantiate the request for RI payments. See 45 C.F.R. § 153.410.	
Issuer Compliance with CMS RI Payment Audit Requirements	Issuers should adhere to audit specifications, documentation requests, and timelines . See 45 C.F.R. § 153.410(d)	The failure to comply with applicable CMS audit requirements, including the failure to provide complete audit documentation, results in an observation and will not result in a change to the issuer's BY 2015 RI payments if this deficiency does not impact the issuer's ability to adequately substantiate its payment amounts.

Appendix 3 – Applicable Federal Regulations

The following table identifies select regulatory requirements related to the CMS RI payment audits.

Citation	Regulatory Text
45 C.F.R. § 153.410 – Requests for Reinsurance Payments	**(a)** ***General requirement.*** An issuer of a reinsurance-eligible plan may make a request for payment when that issuer's claims costs for an enrollee of that reinsurance-eligible plan has met the criteria for reinsurance payment set forth in subpart B of this part and the HHS notice of benefit and payment parameters and State notice of benefit and payment parameters for the applicable benefit year, if applicable. **(b)** ***Manner of request.*** An issuer of a reinsurance-eligible plan must make requests for payment in accordance with the requirements of the annual HHS notice of benefit and payment parameters for the applicable benefit year or the State notice of benefit and payment parameters described in subpart B of this part, as applicable. **(c)** ***Maintenance of records.*** An issuer of a reinsurance-eligible plan must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 10 years, and must make those documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, or, in a State where the State is operating reinsurance, the State or its designee, to any such entity, for purposes of verification, investigation, audit, or other review of reinsurance payment requests. **(d)** ***Audits. Audits and compliance reviews.*** HHS or its designee may audit or conduct a compliance review of an issuer of a reinsurance-eligible plan to assess its compliance with the applicable requirements of this subpart and subpart H of this part. Compliance reviews conducted under this section will follow the standards set forth in § 156.715 of this subchapter. **(1)** ***Notice of audit.*** HHS will provide at least 30 calendar days advance notice of its intent to conduct an audit of an issuer of a reinsurance-eligible plan.

Citation	Regulatory Text
	(i) ***Conferences.*** All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed. **(2)** ***Compliance with audit activities.*** To comply with an audit under this section, the issuer must: **(i)** Ensure that its relevant employees, agents, contractors, subcontractors, downstream entities, and delegated entities cooperate with any audit or compliance review under this section; **(ii)** Submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial audit response deadline established by HHS at the entrance conference described in paragraph (d)(1)(i) of this section for the applicable benefit year; **(iii)** Respond to all audit notices, letters, and inquiries, including requests for supplemental or supporting information, as requested by HHS, no later than 15 calendar days after the date of the notice, letter, request, or inquiry; and **(iv)** In circumstances in which an issuer cannot provide the requested data or response to HHS within the timeframes under paragraph (d)(2)(ii) or (iii) of this section, as applicable, the issuer may make a written request for an extension to HHS. The extension request must be submitted within the timeframe established under paragraph (d)(2)(ii) or (iii) of this section, as applicable, and must detail the reason for the extension request and the good cause in support of the request. If the extension is granted, the issuer must respond within the timeframe specified in HHS's notice granting the extension of time. **(3)** ***Preliminary audit findings.*** HHS will share its preliminary audit findings with the issuer, who will then have 30 calendar days to respond to such findings in the format and manner specified by HHS. **(i)** If the issuer does not dispute or otherwise respond to the preliminary findings, the audit findings will become final. **(ii)** If the issuer responds and disputes the preliminary findings, HHS will review and consider such response and finalize the audit findings after such review.

Citation	Regulatory Text
	(4) ***Final audit findings.*** If an audit results in the inclusion of a finding in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following: **(i)** Within 45 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval. **(ii)** Implement that plan. **(iii)** Provide to HHS written documentation of the corrective actions once taken. **(5)** ***Failure to comply with audit activities.*** If an issuer fails to comply with the audit activities set forth in this subsection in the manner and timeframes specified by HHS: **(i)** HHS will notify the issuer of reinsurance payments received that the issuer has not adequately substantiated; and **(ii)** HHS will notify the issuer that HHS may recoup any payments identified in paragraph (5)(i) of this section.
45 C.F.R. § 153.420 – Data Collection	**(a)** ***Data requirement.*** To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State. **(b)** ***Deadline for submission of data.*** An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.
45 C.F.R. § 153.700(a) – Distributed data environment	**(a)** ***Dedicated distributed data environments.*** For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a State, an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in the State, as applicable, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program.

Citation	Regulatory Text
45 C.F.R. § 153.710(a)-(d) – Data requirements	**(a)** ***Enrollment, claims, and encounter data.*** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. **(b)** ***Claims data*** All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer (or payment of cost sharing by the enrollee). **(c)** ***Claims data from capitated plans*****.** An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving. **(d)** ***Final dedicated distributed data environment report.*** Within 15 calendar days of the date of the final dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either: (1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with §153.700(a) for the benefit year specified in the report; or (2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report.
45 C.F.R. § 153.730 – Deadline for submission of data	A risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must submit data to be considered for risk adjustment payments and charges and reinsurance payments for the applicable benefit year by April

Citation	Regulatory Text
	30 of the year following the applicable benefit year or, if such date is not a business day, the next applicable business day.[31]

[31] Recognizing there are years when April 30 does not fall on a business day, 45 C.F.R. § 153.730 was amended to provide that when April 30 of the year following the applicable benefit year falls on a non-business day, the deadline for issuers to submit the required data would be the next applicable business day. See the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023; Final Rule, 87 FR 27208 at 27258 (May 6, 2022). When this occurred in prior benefit years, CMS exercised enforcement discretion to shift the deadline to the next applicable business day. See supra note 6.