



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

*for*

*Group Hospitalization and Medical Services, Inc. (District of Columbia)*

*March 3, 2023*

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## **I. EXECUTIVE SUMMARY**

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### **Background**

Group Hospitalization and Medical Services, Inc. (GHMSI) is a health insurance issuer that offered qualified health plans (QHPs) in the individual market State-Based Exchange (SBE) in District of Columbia (DC) during the 2016 benefit year. GHMSI submitted its final restated 2016 benefit year data in the October 2018 Enrollment and Payment Data Workbook (EPDW). The issuer received a total of \$388,254.42 in advance payments of the premium tax credit (APTC) from the Centers for Medicare and Medicaid Services (CMS) and reported a total of \$28,570,054.48 in premiums for its 2016 benefit year individual market plans.

This report is an assessment, conducted in coordination with the SBE, of GHMSI's compliance with the APTC program established in sections 1401 and 1412 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) enacted on March 23, 2010, and further amended and revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) enacted on March 30, 2010 (collectively referred to throughout as PPACA), and implementing regulations. This report also details the results of the assessment of premiums for information purposes only.

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

Under title 45 of the Code of Federal Regulations (CFR) sections [155.1210](#) and [156.480](#), the Department of Health and Human Services (HHS) may audit<sup>1</sup> issuers that offer a QHP in the individual market through an Exchange to assess the degree of compliance with the APTC program requirements. HHS designates the CMS to conduct these audits and to achieve the following objectives:

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

This audit is part of CMS's program to validate the enrollment and payment data reported in the final 2016 EPDW submitted by the issuer, and to analyze controls and policies of selected issuers pursuant to the authority defined in 45 CFR §§ 155.1210 and 156.480.

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

The findings and observations are documented below. If CMS found an instance of issuer non-compliance with APTC program requirements that requires correction to the APTC reported in the final EPDW, then CMS classified it as a *finding*. If CMS found a deviation from CMS or Exchange requirements that we are calling to the attention of management for purposes of improving compliance in future program years, but that does not require correction to payment, then CMS categorized it as an *observation*.

## **Results of Review**

CMS identified one (1) finding and five (5) observations for GHMSI. The net APTC financial impact of the one (1) finding is an understatement of \$53.23 in APTC in the final EPDW and therefore a payment due to GHMSI of \$53.23 in APTC. The net premium impact of the five (5) observations is an understatement of \$618,015.79 in premiums in the final EPDW. The finding and observations include the following:

### **Finding:**

1. Inclusion of incorrectly prorated APTC payment data for one (1) subscriber in the Payment Desk Audit File.

### **Observations:**

1. Differences in premium amounts identified in the comparison of the issuer's data included in the October 2018 EPDW submitted by GHMSI to a Payment Desk Audit File containing subscriber level data from GHMSI's systems;
2. Inclusion of enrollment and premium data in the Payment Desk Audit File for one (1) subscriber with coverage that was not effectuated in the issuer's systems;
3. Inclusion of full month or incorrectly prorated premium data for nine (9) duplicate subscribers in the Payment Desk Audit File;
4. Inclusion of incorrectly prorated premium data for forty (40) subscribers in the Payment Desk Audit File; and
5. Inclusion of incorrect premium amounts that were less than the APTC amounts for five (5) subscribers in the Payment Desk Audit File.

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

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

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### **A. Background**

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

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

#### **Interim Payment Process**

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

For the 2016 benefit year, the interim payment process required SBE issuer submitters, including issuers in DC, to self-report enrollment and payment data on a monthly basis, including any adjustments to previous months’ requests, via manual submission of an EPDW, and to attest to the accuracy of the data. SBE issuer submitters were required to calculate the QHP enrollment and payment amounts and to submit that information in the EPDW using their internal source data.

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

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

CMS conducted an SBE payment close-out process for the 2016 benefit year in which CMS compared the EPDW data against the policy-level reporting (PLR) data submitted by the SBE. The PLR data was based on the monthly submissions that SBEs sent to the Internal Revenue Service (IRS) for reporting purposes and contained cumulative individual market enrollment APTC data. CMS requested that SBEs append an additional field for the QHP ID for each policy and separately submit the data to CMS for this purpose. CMS asked SBEs or SBE issuers to explain any outlier discrepancies between EPDW and PLR data and to re-submit the EPDW, if necessary, or to verify that payment data was accurate despite discrepancies with PLR data.

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

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

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

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

## **C. Objectives**

The objectives of this audit are to:

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

## **D. Scope and Methodology**

CMS selected GHMSI for an audit to assess the issuer's compliance with 45 CFR §§ 155.1210, 156.460 and 156.480. CMS evaluated GHMSI's activities related to the 2016 benefit year (January 1, 2016, through December 31, 2016) individual market data reported in the final EPDW submitted in October 2018 by the issuer to CMS to support APTC payments and premium amounts.

CMS sent GHMSI an electronic letter on December 19, 2019, to notify them of the scope of this audit. CMS's audit contractor sent a follow-up letter to GHMSI on December 20, 2019, that identified data requirements required to conduct the audit. CMS's audit contractor reviewed the audit data file submitted by GHMSI, as well as the final 2016 EPDW submitted by the issuer to CMS and the PLR data submitted by the SBE to CMS, and used CMS's audit procedures to assess compliance with APTC program rules and regulations<sup>2</sup>.

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

- Validations of the Payment Desk Audit File<sup>2</sup> data submitted to CMS:
  - EPDW Validations: Review and comparison of the issuer's final submitted 2016 EPDW to the Payment Desk Audit File from the issuer's systems.
  - Unreconciled Subscribers Review: Review and comparison of the subscribers reported in the Payment Desk Audit File to the subscribers included in the SBE's PLR data to determine if the subscribers existed and their coverage was effectuated in the issuer's system (i.e., the amount the subscriber is responsible to pay toward the first month's total premium amount has been paid in full by the subscriber).
  - Duplicate Exchange-assigned Subscriber IDs Check: Review of the Payment Desk Audit File containing subscriber level data from the issuer's systems to verify that duplicate Exchange-assigned subscriber IDs (i.e., Exchange-assigned subscriber IDs that were reported in the file twice in the same month with full month or incorrectly prorated payment data) were not reported in the file.
  - Proration Check: Review of the Payment Desk Audit File to verify that the subscribers' premium and APTC amounts reported in the file for partial months of enrollment were appropriately prorated, if applicable (i.e., if the issuer applied proration for the 2016 benefit year).
  - Premium Less than APTC Validation: Review of the Payment Desk Audit File to verify that the subscribers' premium amounts reported in the file were not less than the APTC amounts reported in the file.
  - Coverage Days Validation: Review of the Payment Desk Audit File to verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems.
- Validations on samples of issuer's systems data:
  - Forty-five (45) Subscribers Sample Review: Review and comparison of the coverage periods, premium and APTC amounts from the issuer's systems to the corresponding data included in the SBE's PLR data for a selected sample of forty-five (45) subscribers.
  - Fifteen (15) Subscribers Sample Review: Analysis and review of data and documentation from the issuer's systems to verify effectuation and the appropriate application of premium and APTC amounts to policies for a selected sample of fifteen (15) subscribers.
- Policy and Procedure Review: Review of issuer APTC policies and procedures for completeness and clarity.

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

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

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

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

#### **EPDW Validations**

No findings and one (1) observation resulted from the comparison of the final 2016 EPDW submitted by the issuer to GHMSI's Payment Desk Audit File. Please refer to Observation No. 1 included in section IV for details on the observation.

#### **Unreconciled Subscribers Review**

No findings and one (1) observation resulted from the review of GHMSI's Payment Desk Audit File to determine if the subscribers reported in the file existed and their coverage was effectuated in the issuer's systems. Please refer to Observation No. 2 included in section IV for details on the observation.

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

No findings and one (1) observation resulted from the review of GHMSI's Payment Desk Audit File to verify that duplicate Exchange-assigned subscriber IDs were not reported in the file. Please refer to Observation No. 3 included in section IV for details on the observation.

#### **Proration Check**

One (1) finding and one (1) observation resulted from the review of GHMSI's Payment Desk Audit File to verify that correctly prorated payment data, if applicable, was reported in the file. Please refer to Finding No. 1 and Observation No. 4 included in section IV for details on the finding and observation.

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

No findings and one (1) observation resulted from the review of GHMSI's Payment Desk Audit File to verify that subscribers were not reported in the file with premium amounts that were less than the APTC amounts. Please refer to Observation No. 5 included in section IV for details on the observation.

#### **Coverage Days Validation**

No findings or observations resulted from the review of GHMSI's Payment Desk Audit File to

verify that enrollments of five (5) days or fewer reported in the file were effectuated and had active coverage in the issuer's systems.

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

No findings or observations resulted from the review and comparison of the data from GHMSI's systems to the corresponding data included in the SBE's PLR data to determine accuracy of the reported enrollment months and the application of premium and APTC for a selected sample of forty-five (45) subscribers.

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

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

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

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

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#### IV. FINDINGS AND OBSERVATIONS

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A finding is an identification of an instance of issuer non-compliance with APTC program requirements that requires correction to payment. CMS's audit procedures identified one (1) finding, which resulted in a change to the APTC amounts reported in GHMSI's EPDW for individual market plans for the 2016 benefit year.

An observation is a deviation from CMS or Exchange requirements that we are calling to the attention of management for purposes of improving compliance in future program years but that does not require correction to payment. CMS's audit procedures identified five (5) observations, consisting of five (5) that resulted in a change to the premium amounts reported in GHMSI's EPDW for individual market plans for the 2016 benefit year.

In light of the one (1) finding and five (5) observations, the adjusted 2016 benefit year EPDW APTC and premium amounts for individual market plans are shown in the following table.

##### Recalculated EPDW for the 2016 Benefit Year

	APTC	Premium (Observations)
EPDW as Filed in October 2018	\$388,254.42	\$28,570,054.48
Observation No. 1 - EPDW Validations Adjustment	\$0.00	\$602,559.57
Observation No. 2 – Unreconciled Subscribers Review Adjustment	\$0.00	\$(497.11)
Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check Adjustment	\$0.00	\$262.78
Finding No. 1 and Observation No. 4 – Proration Check	\$53.23	\$1,292.86
Observation No. 5 – Premium Less Than APTC Validation Adjustment	\$0.00	\$14,397.87
EPDW As Recalculated	\$388,307.65	\$29,188,070.45

	APTC	Premium (Observations)
<b>Total Impact</b>	<b>\$53.23</b>	<b>\$618,015.97*</b>

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

The net financial impact of the one (1) finding is a payment due to GHMSI of \$53.23, consisting of APTC to be paid to GHMSI.

\*Note: The premium impact of the five (5) observations is an understatement of \$618,015.97 in premiums. The premium impact is noted for purposes of improving compliance in future program years.

For the one (1) finding and five (5) observations, CMS documented the criteria, cause, effect, corrective actions, and GHMSI's responses as seen in the charts below.

<b>Observation No. 1 – EPDW Validations</b>	
<b>Condition:</b>	<b>Premium Differences (Observation)</b> – For one (1) or more months of 2016 benefit year enrollment in nine (9) QHPs, the net “Total Premium Amount by QHP ID for effectuated enrollments” included in GHMSI’s EPDW was less than the total premium amount included in GHMSI’s Payment Desk Audit File, resulting in an understatement of \$602,559.57 in premiums. For the one (1) or more months of 2016 benefit year enrollment in nine (9) QHPs, the total net enrollment in the EPDW was understated by fourteen thousand, four hundred and ninety-two (14,492) enrollment groups and seventeen thousand, three hundred and twelve (17,312) members.
<b>Criteria:</b>	Pursuant to CMS guidance and EPDW submission requirements:  The “Total APTC amount by QHP ID for effectuated enrollments” submitted on the EPDW is the “total APTC toward the total premium amount for effectuated enrollments within a 16-digit QHP ID.”  The “Total premium amount by QHP ID for effectuated enrollments” submitted on the EPDW is the “total premium amount for the health coverage for all effectuated enrollments within that plan.”
<b>Cause:</b>	The issuer indicated that “the final, restated 2016-benefits year EPDW, submitted in September 2018 did not include two dental QHP IDS 78079DC0320001 and 78079DC0320002 and the submission was based on data available from November 2017 which did not fully reflect enrollment updates because of retroactive appeals. The Premium Amount/Enrollment Group/Member counts provided on the final, restated 2016-benefits year EPDW, reflect partial months of premium coverage due to policies termed for nonpayment, which are not reflected in the data submitted on the Payment Desk Audit File.”

<b>Observation No. 1 – EPDW Validations</b>	
<b>Effect:</b>	The premium differences resulted in a change to GHMSI’s final, restated 2016 benefit year EPDW data.
<b>Corrective Action Required:</b>	The premium impact of this observation is an understatement of \$602,559.57 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	CareFirst agrees with the noted observation and will use the information to improve compliance in future years.

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
<b>Condition:</b>	GHMSI overstated the 2016 benefit year premium amounts for one (1) subscriber in the Payment Desk Audit File by reporting enrollment and payment data for the subscriber with coverage that was not effectuated.
<b>Criteria:</b>	<p>Pursuant to District of Columbia SBE guidance, “carriers offering qualified health plan (QHP), including qualified dental plan (QDP), in the individual market on DC Health Link must adhere to binder payment policies set forth in the Carrier Integration Manual. The Carrier Integration Manual permits carriers to require binder payments to effectuate coverage, provided that carriers afford consumers 30 days to make the binder payment before the carrier is permitted to cancel coverage for nonpayment. This Bulletin clarifies that carriers offering individual market plans on DC Health Link must provide enrollees with at least 30 calendar days to make full payment on the binder payment before the carrier can cancel coverage. It also clarifies that this 30-day period begins on the date the coverage goes into effect.</p> <p>Carriers may set their own binder payment policies based on this guidance. However, carriers must apply their binder payment policies uniformly to all of their individual market consumers. Where this rule cannot be implemented--for example, for certain special enrollment periods that provide for retroactive enrollments and in particular cases that are processed outside the regular system--HBX will work directly with carriers to determine the date by which the binder payment must be made.”</p> <p>Additionally, pursuant to CMS guidance and EPDW submission requirements, the EPDW should include data for effectuated enrollments where an effectuated enrollment is described as “any enrollment in which the amount the enrollment group is responsible to</p>

<b>Observation No. 2 – Unreconciled Subscribers Review</b>	
	pay toward the total premium amount has been paid in full by the enrollment group.”
<b>Cause:</b>	The issuer indicated that the one (1) subscriber was enrolled under a different HIOS ID for 2016.
<b>Effect:</b>	The inclusion of the one (1) non-effectuated enrollment resulted in a change to GHMSI’s final, restated 2016 benefit year EPDW data.
<b>Corrective Action Required:</b>	The premium impact of this observation is an overstatement of \$497.11 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	CareFirst agrees with the noted observation and will use the information to improve compliance in future years.

<b>Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check</b>	
<b>Condition:</b>	GHMSI understated the 2016 benefit year premium amounts for nine (9) subscribers in the Payment Desk Audit File by reporting enrollment and full month or incorrectly prorated payment data for the subscribers more than once in the same month.
<b>Criteria:</b>	<p>Issuers cannot report full month enrollment data for the same subscriber twice within a month.</p> <p>Pursuant to 45 CFR § 155.240, Exchanges may establish one or more standard processes for premium calculation. Additionally, per the issuer’s policies and procedures, proration is calculated by dividing the APTC monthly amount by the number of days in the month and then multiplying that amount by the number of days billed during that month.</p>
<b>Cause:</b>	<p>The issuer indicated for eight (8) subscribers whose premium amounts were incorrectly prorated that the discrepancies were due to changes in member coverage when there was a “dependent birth or dependent removal.”</p> <p>The issuer indicated for one (1) subscriber whose full month of enrollment was reported twice for one month, that there was an “overlap in coverage and the subscriber only policy should have been terminated.”</p>

<b>Observation No. 3 – Duplicate Exchange-assigned Subscriber IDs Check</b>	
<b>Effect:</b>	The inclusion of the nine (9) duplicate subscribers resulted in a change to GHMSI's final, restated 2016 benefit year EPDW data.
<b>Corrective Action Required:</b>	The premium impact of this observation is an understatement of \$262.78 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	CareFirst agrees with the noted observation and will use the information to improve compliance in future years.

<b>Finding No. 1 and Observation No. 4 – Proration Check</b>	
<b>Condition:</b>	GHMSI reported incorrectly prorated 2016 benefit year premium amounts for forty (40) subscribers, and incorrectly prorated 2016 benefit year APTC amounts for one (1) of those subscribers, in the Payment Desk Audit File.
<b>Criteria:</b>	Pursuant to 45 CFR § 155.240, Exchanges may establish one or more standard processes for premium calculation. Additionally, per the issuer's policies and procedures, proration is calculated by dividing the APTC monthly amount by the number of days in the month and then multiplying that amount by the number of days billed during that month.
<b>Cause:</b>	The issuer indicated that rates were manually pulled incorrectly in its system.
<b>Effect:</b>	The inclusion of the incorrectly prorated payment data for the forty (40) subscribers resulted in a change to GHMSI's final, restated 2016 benefit year EPDW data.
<b>Corrective Action Required:</b>	<p>The net financial impact of this finding is a payment due to GHMSI of \$53.23, consisting of APTC to be paid to GHMSI. GHMSI should confirm the financial impact by filling out Appendix 1.</p> <p>The premium impact of this observation is an understatement of \$1,292.86 in premiums. CMS notes this observation for purposes of improving compliance in future program years.</p>
<b>Management Response:</b>	CareFirst agrees with the noted finding and observation and will use the information to improve compliance in future years.

<b>Observation No. 5 – Premium Less than APTC Validation</b>	
<b>Condition:</b>	GHMSI reported 2016 benefit year premium amounts that were less than the APTC amounts for five (5) subscribers in the Payment Desk Audit File by understating the 2016 benefit year premium amounts for those subscribers.
<b>Criteria:</b>	Issuers cannot report an APTC amount that is more than the premium amount.
<b>Cause:</b>	The issuer indicated for one (1) subscriber that the “premium amount rate was incorrectly updated for the subscriber’s spouse” and noted for the other four (4) subscribers that there was an issue with providing the premium amount from their system. The issuer provided the correct premium amounts for review.
<b>Effect:</b>	The inclusion of the incorrect premium amounts for five (5) subscribers resulted in a change to GHMSI’s final, restated 2016 benefit year EPDW data.
<b>Corrective Action Required:</b>	The premium impact of this observation is an understatement of \$14,397.87 in premiums. CMS notes this observation for purposes of improving compliance in future program years.
<b>Management Response:</b>	CareFirst agrees with the noted observation and will use the information to improve compliance in future years.

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## **V. MANAGEMENT RESPONSES**

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

### **Agreement**

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

### **Disagreement**

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

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

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

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

Issuer HIOS ID: 78079

Issuer Name: Group Hospitalization and Medical Services, Inc. (GHMSI)

The undersigned Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other individual who can legally and financially bind this issuer has reviewed the information included in the audit report of the issuer's 2016 benefit year APTC program participation, resulting in a payment of \$53.23 to be paid to GHMSI and:

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

**OR**

(INITIAL) \_\_\_\_\_ Disagrees and requests a review of additional information that may impact the audit net adjustment amount resulting from the 2016 benefit year audit. If review is requested, CMS will consider this draft only a preliminary audit report. If the review option is selected, you must provide a written explanation with any additional documentation when you return this response within thirty (30) calendar days of the date of this draft audit report. CMS will review the written explanation and any supporting documentation to determine if the report can be amended in a mutually acceptable manner. If you and CMS are unable to come to a mutually acceptable result, your response to this report will be included in the final published audit report.

Signed: \_\_\_\_\_

(Signature of authorized person acting on behalf of the issuer)

Printed Name: Brian J. Keefe

(Print name of signature)

Title: SVP, Chief Accounting Officer

(Title of authorized person acting on behalf of the Issuer)

Telephone Number: 410-998-7494

(Direct Telephone Number)

Date: 4/25/2023

## Appendix 2 – Applicable Regulations

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

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

Regulation	Rules
<p><b>45 CFR § 156.460 - Reduction of enrollee's share of premium to account for advance payments of the premium tax credit</b></p>	<p><b>(a) Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.</b> A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—</p> <ul style="list-style-type: none"> <li>(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;</li> <li>(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and</li> <li>(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.</li> </ul>

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

### Appendix 3 – Glossary of Terms and Acronyms

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