2023 Part C and Part D Program Audit and Enforcement Report

Medicare Parts C and D Oversight and Enforcement Group
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Table of Contents

FOREWORD

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) in the Centers for Medicare & Medicaid Services (CMS) Audit and Enforcement Report summarizes information from its annual Part C and Part D program audits and enforcement actions to encourage improvement in industry performance. We encourage Medicare Advantage Organizations (MAOs), prescription drug plans (PDPs), and Medicare Medicaid plans (MMPs), collectively referred to as "sponsors", to review this information with their compliance staff, compliance committee, and other pertinent staff with the intent of ensuring:

- enrollees have appropriate access to health care services and medications,
- sponsors are in compliance with selected federal requirements, and
- sponsors understand our audit process and have a means to provide us feedback.

In this report, you will gain greater insight into some of the noncompliance we cited in 2023 and some of the enforcement actions we imposed as a result of Part C and Part D oversight activities.

Note that information included in this report should not be used to draw broad conclusions about the significance of deficiencies or performance across the MA, Part D, or MMP programs. This report is not intended to reflect overall industry performance and should not be interpreted to mean that there are pervasive issues throughout the industry related to the noncompliance we identified.

Lastly, we continue to welcome sponsor feedback on the format and content of this report. Please submit comments to our Parts C and D audit mailbox: part_C_part_D_audit@cms.hhs.gov (include "Comments on the Part C and Part D Program Audit and Enforcement Report" in the subject line).

INTRODUCTION

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs administered by CMS provide health and prescription drug benefits to eligible individuals 65 years old and older, younger people with disabilities, and people with End Stage Renal Disease. CMS contracts with private companies, known as sponsors, to administer these benefits. Some of these sponsors may partner with CMS and the state(s) to integrate primary, acute, behavioral health care, and long-term services and supports for Medicare-Medicaid enrollees through the Medicare-Medicaid Financial Alignment Initiative.

MOEG conducts program audits of Medicare sponsors. Program audits are conducted at the parent organization level, meaning the data we collect includes all MA and PDP contracts between CMS and the controlling legal entity. Through program audits, we evaluate key provisions related to the delivery of health care services and medications to Medicare enrollees in the Parts C and D programs.

Audited sponsors may be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action. CMS' enforcement authorities allow us to impose Civil Money Penalties (CMPs), intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and for-cause contract terminations. This report contains a summary of the noncompliance identified during 2023 program audits, as well as enforcement actions resulting from program audits and additional CMS oversight activities.

2023 PART C AND PART D PROGRAM AUDIT LANDSCAPE

CMS conducted program audits of 25 parent organizations covering approximately 3.05 million beneficiaries enrolled in the Part C and Part D programs. CMS primarily focused on small-to-medium sized organizations in 2023 due to covering approximately 89 percent of beneficiaries enrolled in the Part C and Part D programs in 2021 and 2022.

In 2023, our reviews covered:

- 69 MAPD contracts
    - 31 of these contracts offering special needs plans
- 14 PDP-only contracts
- one 1876 Cost plan
- 4 MMP contracts

PART C AND PART D PROGRAM AUDIT SCOPE

The 2023 program audits evaluated sponsor compliance in the following program areas based on the contract types offered by the audited sponsors:

Program Areas Reviewed	Description
Compliance Program Effectiveness (CPE)	• Assess whether an MAO has the foundation and structure in place for an effective Compliance Program, including controls to prevent, detect, and correct noncompliance with program requirements.
Part D Formulary and Benefit Administration (FA)	• Review samples of Part D denied claims to determine how the sponsor applied utilization management edits such as prior authorizations, step therapy, and quantity limits at the point of sale. • Review how claims for non-formulary drugs are processed, and whether all enrollees eligible for a transition fill are afforded the full transition benefit.
Part D Coverage Determinations, Appeals, and Grievances (CDAG)	• Review compliance with timeframes for processing drug coverage requests and whether these requests were processed in accordance with 42 CFR 423 Subpart M. • Review how a plan administers its Drug Management Program.
Part C Organization Determinations, Appeals, and Grievances (ODAG)	• Review compliance with timeframes for processing service requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M.
SNP Care Coordination (SNPCC)	• Review timeliness of Health Risk Assessment (HRA) completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.
Medicare-Medicaid Plan Service Authorization Requests, Appeals and Grievances (MMP-SARAG)	• Review compliance with timeframes for processing service authorization requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M and the applicable three-way contract.
Medicare-Medicaid Plan Care Coordination (MMPCC)	• Review timeliness of Health Risk Assessment (HRA) completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.

We audited each sponsor in all program areas applicable to its operation. For example, if a sponsor did not operate a Special Needs Plan (SNP), then we did not conduct a SNPCC audit. Likewise, we would not apply the ODAG protocol to a standalone PDP since it does not offer the MA benefit.

PART C AND PART D PROGRAM AUDIT INSIGHTS

Program audits provide valuable insight into sponsor operations specific to audited requirements. Below we have outlined some of the generalized noncompliance we identified during our 2023 program audits by program area, and some of the reasons sponsors provided when asked why the noncompliance occurred. This is not an exhaustive list of all findings, and we still expect all sponsors to carefully and routinely assess all risks to their organizations and monitor and audit their operations to ensure compliance with CMS requirements.

Compliance Program Effectiveness (CPE)

- Compliance issues were not tracked, addressed, and corrected.
  - Compliance departments were not aware of internal auditing and monitoring results.
  - Turnover within the organization interfered with planned oversight activities.

SPONSOR TIP: *Sponsors should have clear procedures for timely communication of auditing and monitoring results to their Compliance Department.*

Formulary Administration (FA)

- Claims were inappropriately rejected at point of sale.
  - Enrollee eligibility files were not updated timely to reflect active coverage.
- Prior authorization edits for new starts were not configured correctly to recognize enrollees with prior claims history of the medication.

SPONSOR TIP: *Sponsors should tailor their monitoring of rejected claims to identify patterns that may be indicative of errors in their systems.*

Coverage Determinations, Appeals, and Grievances (CDAG)

- Coverage requests were misclassified and processed only as grievances.
  - Staff did not recognize complaints about access to, or cost of, medications as coverage requests.
- Dismissal notice templates were not updated to include the reason for the dismissal, the right to request the Sponsor vacate the dismissal, or the right to request redetermination of the dismissal.

SPONSOR TIP: *Sponsors should ensure that they are referencing the most current CMS Guidance and regulatory requirements when processing coverage requests.*

Organization Determinations, Appeals, and Grievances (ODAG)/Medicare Medicaid Plan – Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)

- Requests were not processed timely.
  - Challenges with implementing new systems resulted in processing delays.
  - Sponsors experienced increased workloads and staffing shortages.
  - Established procedures were not fully understood and/or followed.
- Requests were inappropriately dismissed.
  - Outreach for necessary clinical information was not conducted prior to dismissing requests.
  - Misrouted requests were dismissed rather than sent to the appropriate department.
- Notifications were incorrect or incomplete.
  - Dismissal notification templates did not contain enrollees' right to request the Sponsor vacate its dismissal.
  - Non-contracted providers received remittance advices that did not include a direct link to the waiver of liability form.
  - Reasons for denial were not specific to requested services.

SPONSOR TIP: *Sponsors' oversight processes should focus on both content and timeliness of notifications, including specific criteria applied to reach medical necessity determinations.*

Special Needs Plans Care Coordination (SNPCC)/Medicare-Medicaid Plan Care Coordination (MMPCC)

- Individualized care plans (ICPs) were inconsistent with Sponsors' approved models of care or were not updated timely.
  - ICPs were not comprehensive or did not account for changes in health risk assessments, the health status, or care transitions of enrollees.
  - Communication around care coordination was ineffective across care settings during transitions.

SPONSOR TIP: *Communication inclusive of all members of Interdisciplinary Care Teams helps support effective care management programs.*

TIPS FOR A BETTER PART C AND PART D PROGRAM AUDIT EXPERIENCE

More information about the program audit process is outlined in the program audit process overview document located on our website (https://www.cms.gov/files/document/program-audit-process-overview.pdf). CMS is offering the following suggestions to improve the overall program audit experience:

- CMS utilizes Zoom for program audit webinars. Please ensure all participating sponsor and delegated entity personnel are familiar with Zoom. Please also ensure that sponsor and delegated entity systems are compatible with Zoom. Conducting a practice session internally or requesting a webinar test from the auditor-in-charge may be helpful to ensure potential participants can access Zoom and share their system screens.
- Having personnel join webinars at least five minutes prior to the start will allow for a timely start and assist in addressing access delays, etc.
- If the sponsor uses delegated entities, having these entities on standby so they can join quickly to avoid long delays.
- Preparing the presenting team to quickly locate documentation that may be requested (examples of documentation can be found in the file CDAG_ODAG_SARAG_Guidance.pdf within HPMS Submission Materials).
- Read and become familiar with the Program Audit Process Overview Document. This document will provide answers to most questions you will have upon receiving the engagement letter.
- Review the HPMS User Guide. This user guide provides helpful information on how to use HPMS throughout the program audit.
- To avoid invalid data submission conditions, sponsors should use the time allotted for universe submissions to accurately compile the requested data according to the universe instructions and perform an internal quality review before it is submitted to auditors. Sponsors should always contact their program audit team leads for clarification about populating record layouts. Sponsors may also submit inquiries to our audit mailbox at part_c_part_d_audit@cms.hhs.gov.

CMS implemented new protocols to conduct its 2022 Part C and Part D program audits (https://www.cms.gov/files/zip/final-protocols-medicare-part-c-and-part-d-program-audits-and-industry-wide-part-c-timeliness.zip) and continued to use these protocols in 2023. Prior to their implementation, CMS conducted a three-part training series to prepare organizations for the use of these protocols. Recordings of these trainings can be found at: https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives. CMS also shared a user group resource document that was updated in 2023 to provide further clarification on the protocols (see: https://www.cms.gov/files/document/user-group-resource-document-2023.pdf).

Sponsors can use our program audit protocols and the abovementioned tools to conduct mock audits, including generating and validating universes, to help prepare for program audits. This practice will assist organizations and their delegated entities with data preparation and universe submissions. In addition, mock audits may assist sponsors in identifying operational vulnerabilities or areas of noncompliance prior to a program audit.

ENFORCEMENT ACTIONS

CMS has the authority to impose Civil Money Penalties (CMPs), intermediate sanctions, and for-cause terminations against MA plans, PDPs, MMPs, and cost plans. MOEG is the group responsible for imposing these types of enforcement actions when a sponsor is substantially noncompliant with CMS' Medicare Parts C and D program requirements. Sponsors may appeal all enforcement actions either to the Departmental Appeals Board (for CMPs) or to a CMS hearing officer (for intermediate sanctions and terminations).

All enforcement actions are posted on the Part C and Part D Compliance and Audits website at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-. All information contained in referrals that involve suspected fraud, waste, and abuse is referred to the Center for Program Integrity.

We imposed various enforcement actions in calendar year 2023 and early 2024 due to referrals of violations discovered during program audits and other oversight activities conducted by CMS. These other oversight activities include financial audits (also known as one-third financial audits), routine monitoring activities (i.e., medical loss ratio and dual eligible special needs plan integration) and ad-hoc monitoring activities. This section of the report details enforcement actions imposed, the basis for those actions, and provides additional information about the sponsors that were sanctioned and/or received a CMP, as well as the amounts of the CMPs issued. It also contains insights and lessons learned from reviewing enforcement action referrals.

CIVIL MONEY PENALTIES

It is customary for program audits, unresolved issues in program audit validations, and one-third financial audits to be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action, as described in 42 CFR. Parts 422 and 423, Subpart O. This evaluation is separate from the audit process and is not conducted by the audit team. Audited sponsors that have been referred will receive notification from MOEG's Division of Compliance Enforcement (DCE) for matters related to enforcement actions. To access the current CMP methodology, go to https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D- Compliance-and-Audits/Downloads/2019CMPMethodology06212019.pdf.

CMPs Imposed

DCE imposed CMP actions on sponsors for the following referrals received in 2023: (1) 2023 program audits; (2) 2022 program audit validations; and (3) 2020 one-third financial audits.

Table 1: CMPs IMPOSED BASED ON 2023 PROGRAM AUDIT REFERRALS

Date of Imposition	Sponsor Name	CMP Amount
03/21/2024	CareSource Ohio, Inc.	$27,898
03/21/2024	USAble Mutual Insurance Company	$5,336
03/21/2024	Capital District Physicians' Health Plan, Inc.	$17,864
03/21/2024	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$7,424
03/21/2024	California Physicians' Service	$30,160
03/21/2024	Astiva Health, Inc.	$6,380
03/21/2024	Village Senior Services Corporation	$10,208

Table 2: CMP IMPOSED BASED ON 2022 PROGRAM AUDIT VALIDATION REFERRALS

Date of Imposition	Sponsor Name	CMP Amount
12/06/2023	UCare Minnesota	$13,224

Table 3: CMPs IMPOSED BASED ON ONE-THIRD FINANCIAL AUDIT REFERRALS

Date of Imposition	Sponsor Name	CMP Amount
08/07/2023	Moda Health Plan, Inc.	$5,800
08/07/2023	EmblemHealth, Inc.	$19,024
08/07/2023	Aultman Health Foundation	$162,632
11/02/2023	AvMed, Inc.	$5,336
11/02/2023	Blue Cross & Blue Shield of Rhode Island	$24,940
11/02/2023	Centene Corporation	$49,764
11/02/2023	Medica Holding Company	$62,060

Type of CMP Violations

CMPs are imposed for several different violations of the Parts C and D regulations. There were nineteen specific violations cited in the fifteen CMPs. Table 4 shows a breakdown of the nineteen violations cited in those notices.

Table 4: TYPES OF VIOLATIONS INCLUDED IN 2023 CMPs

Violation Type	Number of Violations	Source of Referral
Inappropriate cost sharing for Part C services/Part D medications	8	One-third financial audit
Inappropriate denials/delays of Part D medications/Part C Services	4	Program audit
Misclassification of Part D coverage requests	2	Program audit/validation
Non-Contract Provider Denial Notice Appeal Rights	2	Program audit
Inappropriate Dismissals	2	Program audit
Inappropriate Part D Premiums	1	One-third financial audit

Penalty Calculation

The amount of the CMP does not automatically reflect the overall performance of a sponsor. Rather, the amount of a CMP mostly depends on the number of enrollees impacted by certain violations. The type of contract(s) involved, and the nature and scope of the violation(s) also factor into the total CMP amount a sponsor receives. We apply a standard CMP amount for each deficiency cited in a CMP notice, based on either a per-enrollee or a per-determination basis. CMPs imposed on a per-enrollee basis have a quantifiable number of enrollees that have been adversely affected (or have the substantial likelihood of being adversely affected) by a deficiency. CMPs imposed on a per-determination basis either do not have a quantifiable number of enrollees that have been affected or are explicitly stated as a per-determination penalty in statute. Out of the nineteen violations included in the fifteen CMP actions:

- Eighteen violations were calculated on a per-enrollee basis; and
- One violation was calculated on a per-determination basis.

Consistent with the CMP Methodology, CMS relied on available data and mitigating information to determine if a sponsor's deficiency either directly adversely affected or had the substantial likelihood of adversely affecting an enrollee.

Aggravating Factors

A sponsor's CMP is increased if aggravating factors apply to certain deficiencies. The standard penalty for a deficiency may increase if the violation involved the following:

- Drugs that are used to treat acute conditions that require immediate treatment,
- Enrollees were not provided access to their inappropriately denied medical services or medications,

- Expedited cases,
- Financial impact over $100,
- Annual Notice of Change (ANOC) documents: ANOC/errata documents were not mailed by Dec. 31, and/or
- A history of prior offense.

Out of the nineteen violations, we applied an aggravating factor penalty to twelve violations. The total aggravating factor penalties amounted to $63,568, which is fourteen percent of the total CMP amount of $448,050 imposed for 2023 referrals.

INTERMEDIATE SANCTIONS

Intermediate sanctions can either suspend a sponsor's ability to market to and accept new Part C or Part D enrollees or to receive payment for new enrollees. Intermediate sanctions remain in place until the deficiencies which formed the basis of the sanction are corrected and are not likely to recur. In 2023, some of the intermediate sanctions CMS imposed were for failures to meet Medical Loss Ratio requirements and Duals Special Needs Plans integration requirements.

Medical Loss Ratio – Enrollment Suspensions

Sponsors are required to spend at least 85 percent of premium dollars on beneficiary medical care, also known as the Medical Loss Ratio (MLR). Sponsors are also required to report an MLR each year for each of their contracts. When an organization fails for three consecutive years to meet the 85 percent threshold, CMS is statutorily required to suspend that organization's ability to accept new enrollments into the noncompliant contract for the contract year following submission of the report. Sponsors subject to MLR sanctions must demonstrate that it has achieved an MLR of at least 85 percent, and CMS will allow the sponsor to resume accepting enrollments that become effective on or after the following contract year. Table 5 lists the sponsors that were under sanction for MLR failures during 2023.

Table 5: SPONSORS UNDER SANCTION FOR MLR FAILURES DURING 2023

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
09/20/2022	01/01/2023	UnitedHealthcare Plan of the River Valley, Inc.	Enrollment Suspension	Effective 01/01/2024

** Suspensions based on MLR failures prevent enrollments for applications submitted for coverage effective the following plan year.*

Dual-Special Needs Plans – Enrollment Sanction

Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and a Medicaid state plan. D-SNPs must meet one or more of the following criteria for the integration of Medicare and Medicaid benefits:

- Meets the additional requirements in its contracts with the State Medicaid agency;
- Is a highly integrated dual eligible special needs plan; or

- Is a fully integrated dual eligible special needs plan.

Certain D-SNPs are placed under an enrollment sanction because the specific D-SNP plan benefit package (PBP) failed to meet the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a dual special needs plan at 42 C.F.R. § 422.2. More specifically, the state Medicaid contracts associated with these PBPs are not yet executed, which is required for designation as a Highly Integrated or Fully Integrated D-SNP. Once the state executes the Medicaid contract, CMS will lift the sanction. Table 6 lists the sponsors that were under sanction for D-SNP failures during plan year 2023.

Table 6: SPONSORS UNDER SANCTION FOR PLAN YEAR 2023 D-SNP INTEGRATION FAILURES

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
12/09/2020	01/01/2021	UnitedHealth Group, Inc. (UnitedHealthcare of New York, Inc.)	Enrollment Suspension	01/19/2024
12/09/2020	01/01/2021	Visiting Nurse Association of Central New York	Enrollment Suspension	-
09/28/2021	01/01/2022	MVP HealthPlan, Inc. (MVP Health Care, Inc.)	Enrollment Suspension	-
10/05/2022	01/01/2023	Aetna Health Inc. (NY)	Enrollment Suspension	-
10/05/2022	01/01/2023	Capital District Physicians' Health Plan, Inc.	Enrollment Suspension	Non-Renewal of PBP Effective 12/31/2023
10/05/2022	01/01/2023	Senior Whole Health of New York, Inc.	Enrollment Suspension	04/18/2023
10/05/2022	01/01/2023	Excellus Health Plan Community Care, LLC.	Enrollment Suspension	-
10/05/2022	01/01/2023	iCircle Services of the Finger Lakes, Inc.	Enrollment Suspension	-
10/05/2022	01/01/2023	Healthfirst Health Plan, Inc.	Enrollment Suspension	12/13/2022 (sanction released prior to 2023 plan year)

** Sanctions based on D-SNP Integration failures prevent enrollments for applications submitted for coverage effective the following plan year.*

INSIGHTS FROM THE ENFORCEMENT PROCESS

We continue to engage sponsors throughout the enforcement evaluation process to ensure enforcement actions are based on data that accurately reflects the impact of violations on enrollees. As in previous years, outreach was conducted to discuss and validate plan-submitted impact analyses. This process provides sponsors with additional opportunities to review the accuracy of their submissions provided during the audit process and explain the data in further detail. CMS also improved communication with sponsors about the status of their enforcement evaluation review, CMS' expectations while under intermediate sanctions, and the sanction validation process when applicable.

Lessons Learned for Sponsors

To help sponsors strengthen their overall compliance programs, and to benefit the program more broadly, we are summarizing some of the observations we made during our analysis of 2023 enforcement referrals.

- **Part D Claims Processing**

  It is important for sponsors to ensure that Part D claims are processed using the correct beneficiary enrollment and eligibility information. This might involve transmitting enrollment and eligibility data to pharmacy benefit managers (PBMs) delegated to process Part D claims. The PBM needs to receive eligibility data that is timely and accurate. If a PBM receives untimely and inaccurate enrollment and eligibility data it could result in the incorrect processing of Part D claims by the PBM. Sponsors must ensure that they obtain the most current enrollment eligibility files directly from CMS and share them with its PBM frequently. Failing to ensure enrollee eligibility files are loaded into its PBM's system timely could result in enrollees being inappropriately rejected at the point of sale or overcharged for their medications.

- **Inappropriate cost sharing for Part C services**

  Sponsors must have effective oversight over its Part C claims processing system. Sponsors should conduct routine monitoring, perform system updates, and test system configurations to ensure claims are processed in accordance with each plan benefit design. CMS found instances where sponsors failed to update their claims processing systems and incorrectly priced provider payments. CMS also discovered that, due to system configuration errors, claims were processed with the incorrect cost sharing amounts. Plans should ensure that their claims processing systems are updated and configured correctly. Sponsors should also address any system limitations that prevent them from processing Part C claims appropriately. Incorrect claims processing system configurations can result in enrollees being charged incorrect cost sharing amounts.

- **Beneficiary Reimbursements**

  Sponsors must process claims with the correct beneficiary cost sharing amounts and appropriately track a beneficiaries' cost sharing through the year. We encourage sponsors to review their claims systems programming to ensure claims are processed in

accordance with the beneficiary's plan benefit design. In instances where claims are processed incorrectly and those claims are re-processed, many sponsors delegate the responsibility to reimburse beneficiaries for overpayments to providers. However, it is ultimately the sponsor's responsibility to ensure beneficiaries are refunded, either through the provider or the sponsor directly, all amounts incorrectly collected. This responsibility may entail conducting outreach to providers to ensure that beneficiaries have been refunded any overcharges.

CONCLUSION

We hope sponsors will use the information in this report to inform their internal auditing, monitoring, and compliance activities. We continue to encourage your feedback on the contents of this report and look forward to continued collaboration with the sponsor community and their partners in developing new approaches to improve compliance.