2021 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

EXECUTIVE SUMMARY

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) within the Centers for Medicare & Medicaid Services (CMS) is responsible for conducting program audits of Medicare Advantage Organizations (MAOs), prescription drug plans (PDPs), and Medicare-Medicaid plans (MMPs), collectively referred to as "sponsors" throughout this report. Regular and consistent auditing of these sponsors provides measurable benefits by:

- Ensuring enrollees have appropriate access to health care services and medications,
- Verifying sponsors' adherence to selected aspects of their contracts with CMS, and
- Soliciting feedback from the sponsor community and external stakeholders on potential audit improvements.

This 2021 Part C and D Program Audit and Enforcement Report contains pertinent analyses and information sponsors and other stakeholders can review to continue improving performance within their respective organizations. We update the report each year to share data from the most recently completed year of audits and enforcement activities, and to provide information about the initiatives we have undertaken to advance the transparency, accuracy, and reliability of program audits.

Because we adjusted our 2020 audit strategy to account for the challenges presented by the COVID-19 public health emergency (PHE), this report does not contain any year-to-year comparisons between the audits.[1] In addition, data 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. We caution against reading too much into the data contained in the report without having a full understanding of the audit program, including how improvements made to audit processes each year may affect audit scores irrespective of actual audit performance. Reported data are not intended to reflect overall industry performance or that widespread or persistent issues exist in the program areas audited.

[1] For additional information on how COVID-19 affected our program audits in 2020, see the Health Plan Management System (HPMS) memo titled, "Reprioritization of PACE, Medicare Parts C and D Program, and Risk Adjustment Data Validation (RADV) Audit Activities," dated March 30, 2020 (https://www.cms.gov/files/document/covid-19-programauditsradv-memo.pdf).

Highlights

➢ 2021 Audit Results

The data analyses resulting from the 2021 program audits show the following:

- Overall audit scores:
  - The average overall audit score was 0.44.
- Average audit scores by audited program areas:

Program Area	Average Score
Compliance Program Effectiveness	0.07
Part D Formulary and Benefit Administration	0.33
Part D Coverage Determinations, Appeals, and Grievances	0.30
Part C Organization Determinations, Appeals, and Grievances	0.60
Special Needs Plans-Model of Care	1.73
MMP-Service Authorization Requests, Appeals, and Grievances	0.83
MMP-Care Coordination and Quality Improvement Program Effectiveness	2.50

➢ Enforcement Actions

- We imposed 16 civil money penalties (CMPs) totaling $1,043,953 and sanctioned 13 sponsors based on 2021 referrals.

➢ Report Improvements

This report contains two new sections, *Program Audit Insights and 2022 Process Improvements* and *Insights from the Enforcement Process*. These sections were developed in response to stakeholder feedback and to provide the industry more information related to our overall program audit and enforcement experience. We hope that sharing this information will help sponsors focus their internal monitoring and auditing efforts to improve their operations. We welcome comments on these sections. 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.

The Medicare Parts C and D Oversight and Enforcement Group (MOEG), which is in the Center for Medicare (CM), conducts program audits to evaluate sponsors' delivery of health care services and medications to Medicare enrollees in the Part C, Part D, and Medicare-Medicaid plan (MMP) programs. When program audits identify non-compliance requiring corrective action, sponsors are required to undergo validation audits to ensure correction of cited deficiencies. In addition to conducting program audits, we develop, maintain, and oversee the requirement for each sponsor to implement an effective compliance program. 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 summarizes our audit-related activities, including the scope of audits for the 2021 audit year. It also discusses the current audit landscape, results of data analyses from the 2021 audits, and a summary of enforcement activities. Finally, there are text boxes entitled "Sponsor Tips," and two new sections that offer program audit and enforcement insights. Stakeholders should consider all information presented in this report when considering how to improve their internal compliance and operations, and in preparation for future audit activities.

AUDIT SCOPE

In order to conduct a comprehensive audit of a sponsor's operation and to maximize agency resources, we conduct program audits at the parent organization level. The 2021 program audits evaluated sponsor compliance in the following program areas based on the contract types offered by the audited sponsors:

- Compliance Program Effectiveness (CPE)
- Part D Formulary and Benefit Administration (FA)
- Part D Coverage Determinations, Appeals, and Grievances (CDAG)
- Part C Organization Determinations, Appeals, and Grievances (ODAG)
- Special Needs Plan-Model of Care (SNP-MOC)
- Medicare-Medicaid Plan Service Authorization Requests, Appeals and Grievances (MMP-SARAG)
- Medicare-Medicaid Plan Care Coordination and Quality Improvement Program Effectiveness (MMP-CCQIPE)

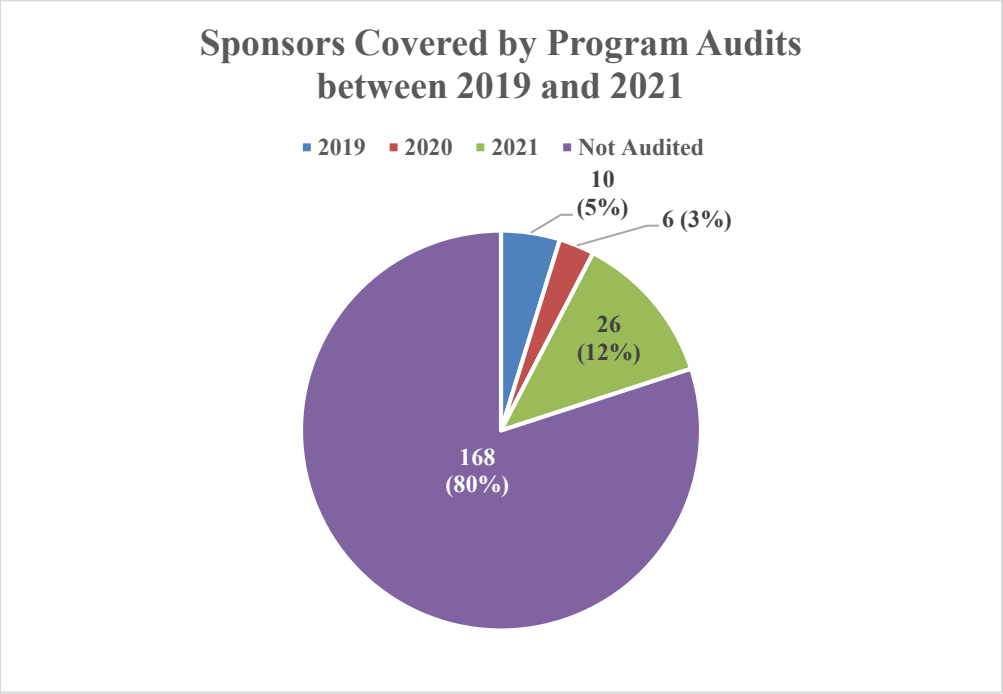
We audited each sponsor in all program areas applicable to its operation. For example, if a sponsor did not operate a SNP plan, then we did not conduct a SNP-MOC audit. Likewise, we would not apply the ODAG protocol to a standalone PDP since it does not offer the MA benefit.

CURRENT PROGRAM AUDIT LANDSCAPE

The figures below show the progress of program audits on Parts C and D by percentage of sponsors audited and by enrollment. These figures are based on data as of January 2022, and include coordinated care plan (CCP) contracts, private fee-for-service (PFFS) contracts, demonstration contracts, and standalone PDP contracts. Sponsors offering 1876 contracts are also included, provided that the sponsors do not operate only 1876 contracts. Figures 1 and 2 represent only those sponsors (and associated enrollments) that still operate Medicare contracts in 2022.

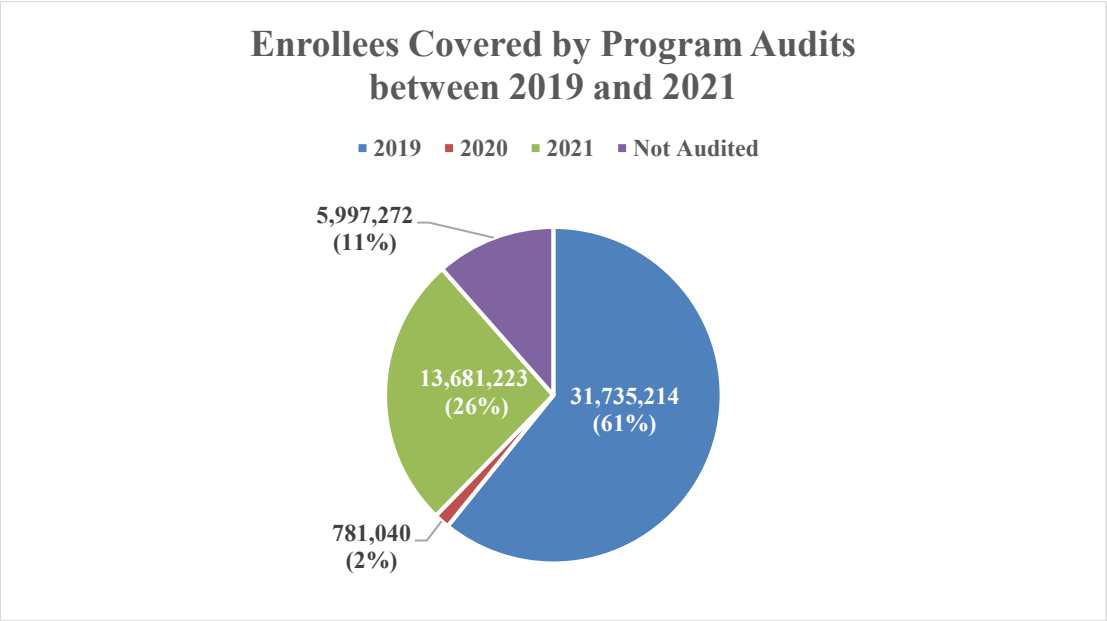
We do not audit a large number of sponsors each year, but within a three-year period, the sponsors we audit typically represent about 95 percent of the enrollment of the Medicare Advantage and Part D programs. We conducted a relatively small number of scheduled program audits in 2020 due to the PHE. However, we audited a much larger number of sponsors in 2021, bringing the total number of currently-active sponsors audited between 2019 and 2021 to 42, or approximately 20 percent of the sponsors with currently active Medicare contracts. Note that we actually conducted 13 separate audits in 2019, but are only reporting on 10 audits in Figure 1 because three of the sponsors we audited in 2019 are no longer active as unique sponsors. Also, while we conducted 27 audits in 2021, we only audited 26 separate sponsors as shown in Figure 1, because one sponsor had its contracts divided into two separate audits.

Figure 1



Sponsors audited in 2021 covered 26 percent of the Part C and Part D enrollment. Audited sponsors from 2019 through 2021 represent approximately 89 percent of all Part C and Part D enrollment. While this number is somewhat lower than the 95 percent we typically reach within a three-year period, it is nonetheless a significant achievement considering the degree to which audits were reprioritized in 2020 in response to the public health emergency.

Figure 2*



***These enrollment data are summed by sponsor at the contract level. All contracts active in 2022 that are associated with sponsors that were audited in 2019 through 2021 are reflected in this chart.**

Figure 3 shows the percentage of Medicare enrollees in each state or territory that were covered by the program audits conducted in 2021. The largest percentage of enrollees covered in any one state or territory was Puerto Rico with just over 72 percent (note that these enrollment data are at the plan level, whereas all other figures reporting on enrollment in this report are at the contract level). Figure 4 depicts the percentage of plans in each state or territory that were included in the 2021 program audits. The largest percentage of plans audited in any of these states or territories was also in Puerto Rico, where approximately 24 percent of plans were audited.

Figure 3

Percentage of Enrollees in Each State Included in 2021 Program Audits

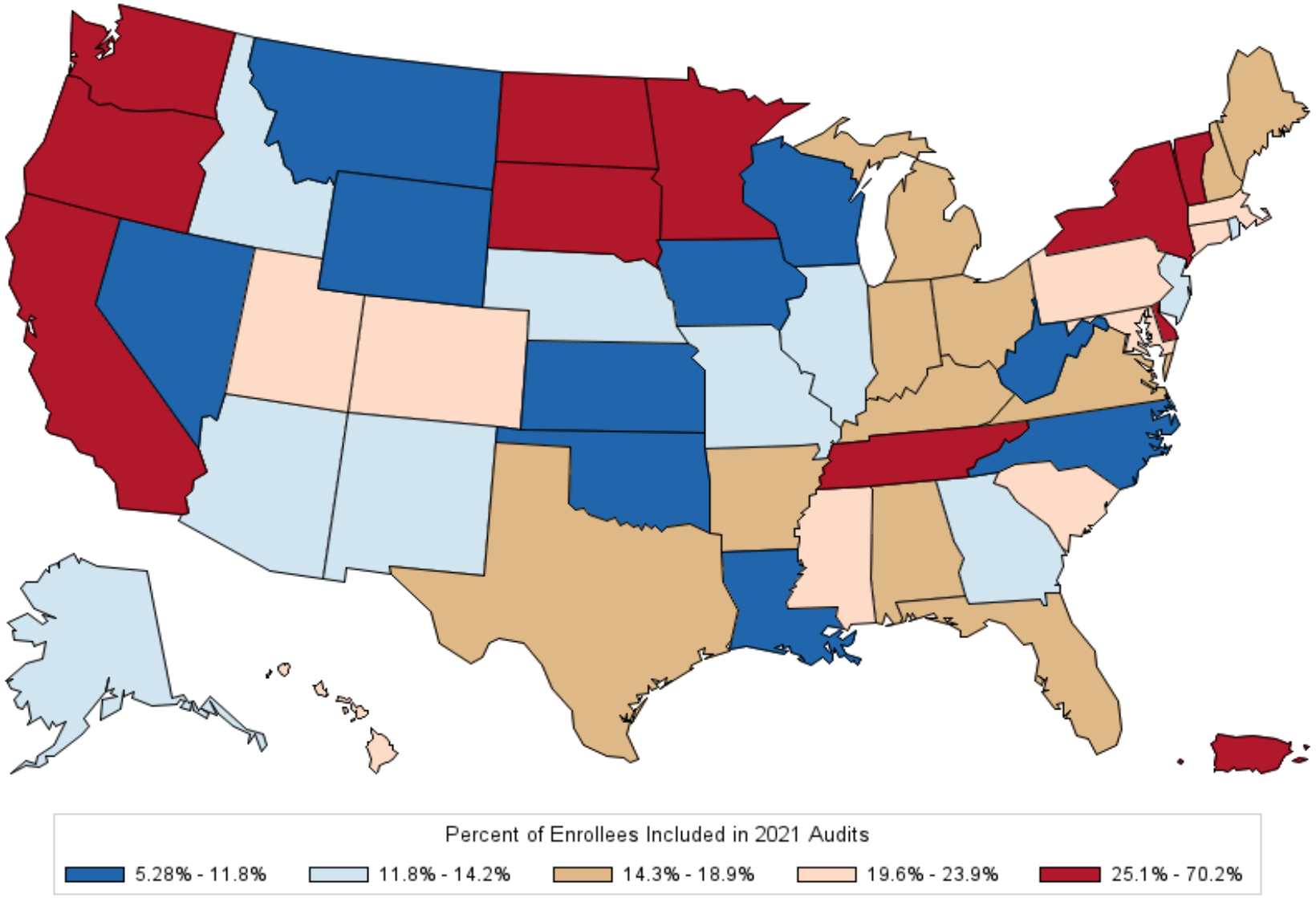
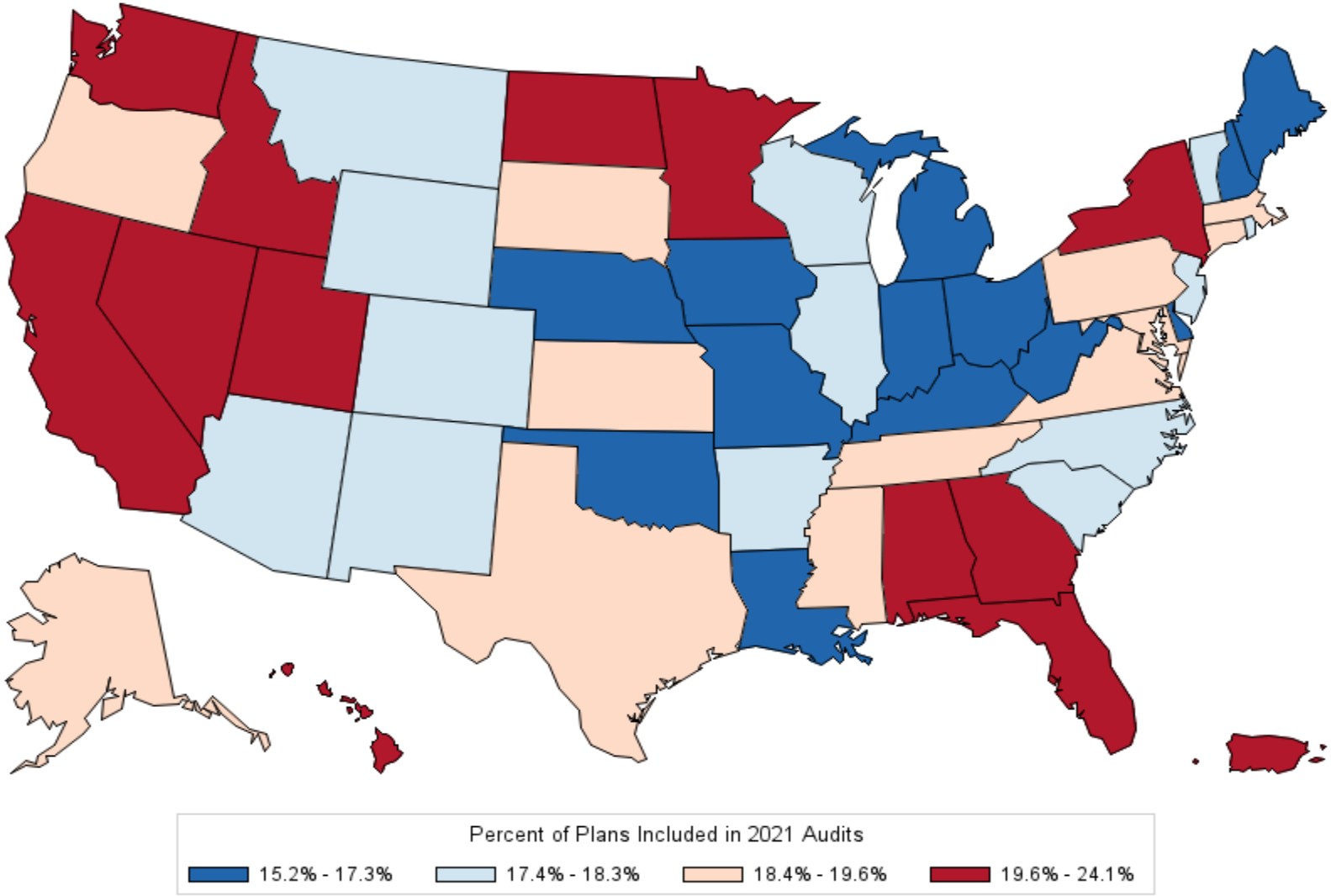


Figure 4

Percentage of Plans in Each State Included in 2021 Program Audits



AUDIT LIFECYCLE

The lifecycle of an audit begins the day a sponsor receives an engagement letter and typically concludes with the sponsor's receipt of an audit closeout letter. [2] In total, there are four distinct phases of the program audit process, as shown in Figure 5.

Figure 5

[2] Occasionally, we may choose not to require a sponsor to undergo validation activities to demonstrate correction of any deficiencies discovered during the audit, for instance if a sponsor decides to terminate its contract the year following the audit.

AUDIT RESULTS

The audit score for each sponsor is based on the number and types of non-compliant conditions detected during the audit. In this scoring system, a lower score represents better performance on the audit. Because the calculated audit score uses the number of non-compliant conditions discovered, the maximum audit score is unlimited. In addition, conditions are weighted to ensure that those conditions that have a greater impact on enrollee access to care have a greater impact on the overall score. The audit score assigns zero points to observations, one point to each corrective action required (CAR), one point to each invalid data submission (IDS), and two points to each immediate corrective action required (ICAR). We then divide the sum of these points by the number of audit elements tested. The formula for calculating the audit score is:

Audit score = ((# CARs + # IDSs) + (# of ICARs x 2)) / # of audited elements

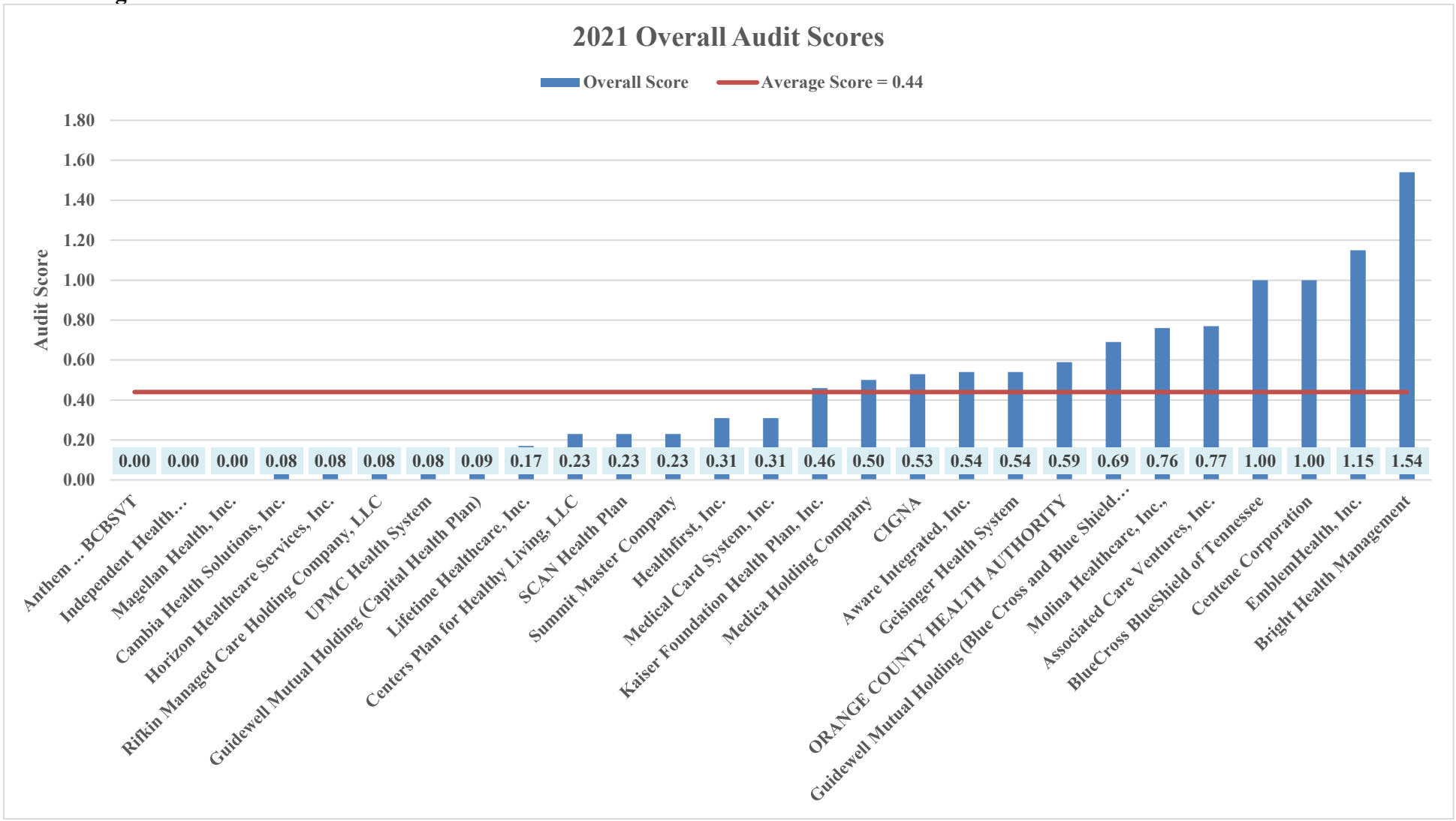
We calculate a score for each audited program area and an overall audit score. The score generally quantifies a sponsor's performance and allows comparisons across sponsors audited in a given year. The figures on the following pages display overall and program-area-specific audit scores for sponsors audited in 2021.

We caution against reading too much into the data contained in the report without having a full understanding of the audit program, including how improvements made to audit processes each year may affect audit scores irrespective of actual audit performance. Specifically, data 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.

Program Audit Scores

Figures 6 through 13 array the overall and individual program area audit scores for each program area. The audit scores are displayed from best (lowest) to worst (highest) score moving from left to right across the graph. The line in each graph represents the average audit score across all audited sponsors.

Figure 6*

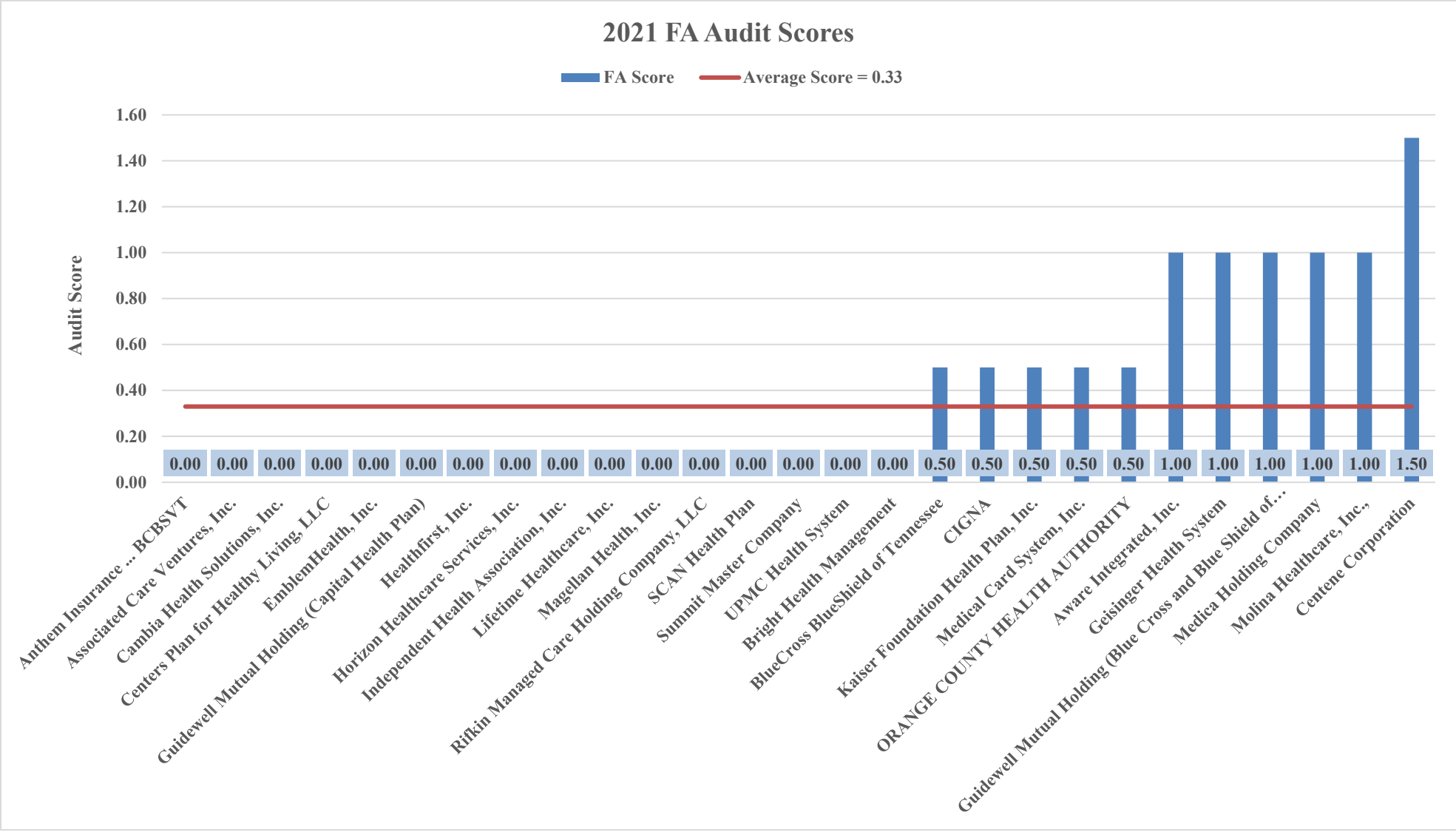


***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2021.**

Figure 7*

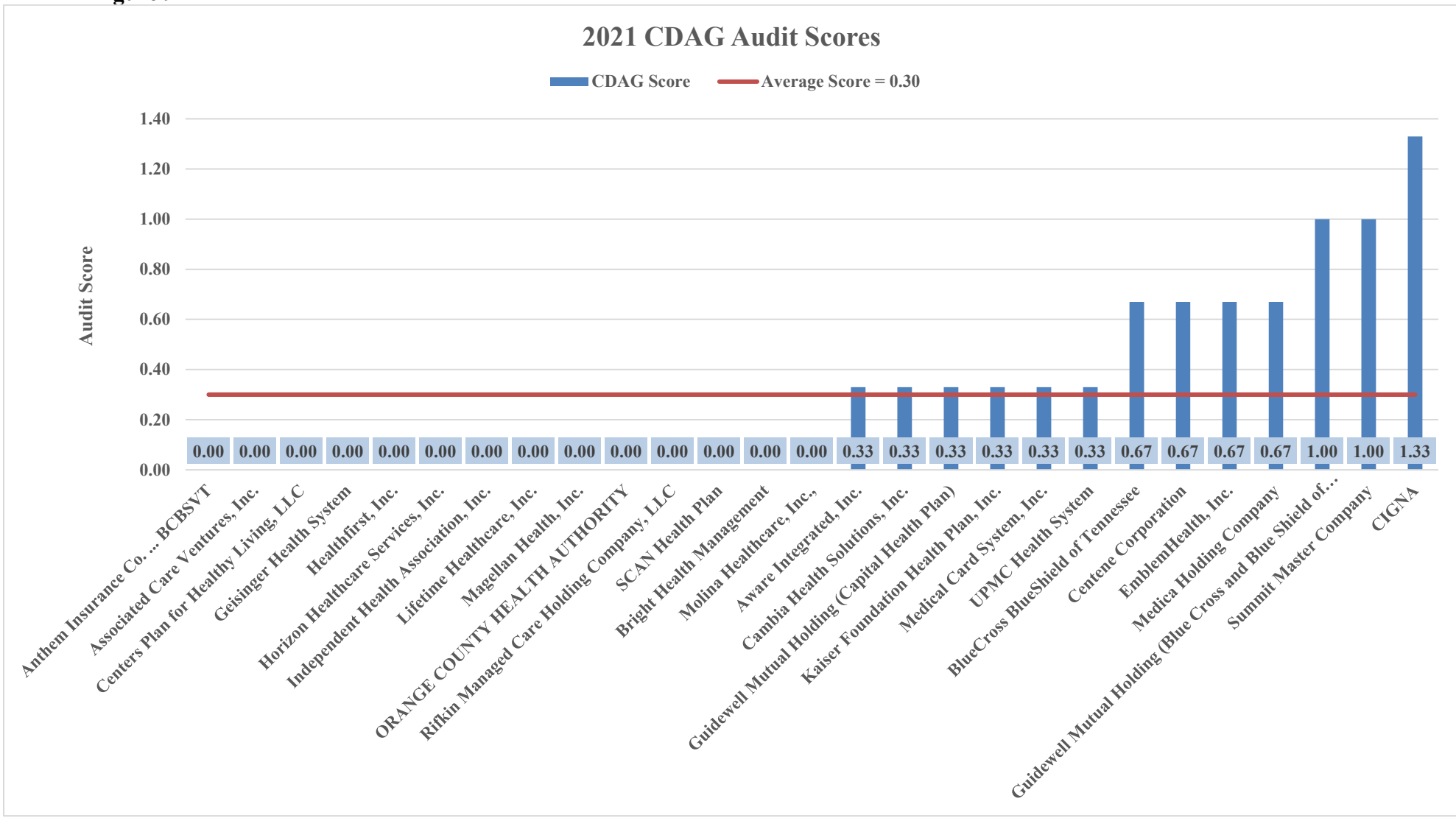
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CPE program area in 2021.**

Figure 8*



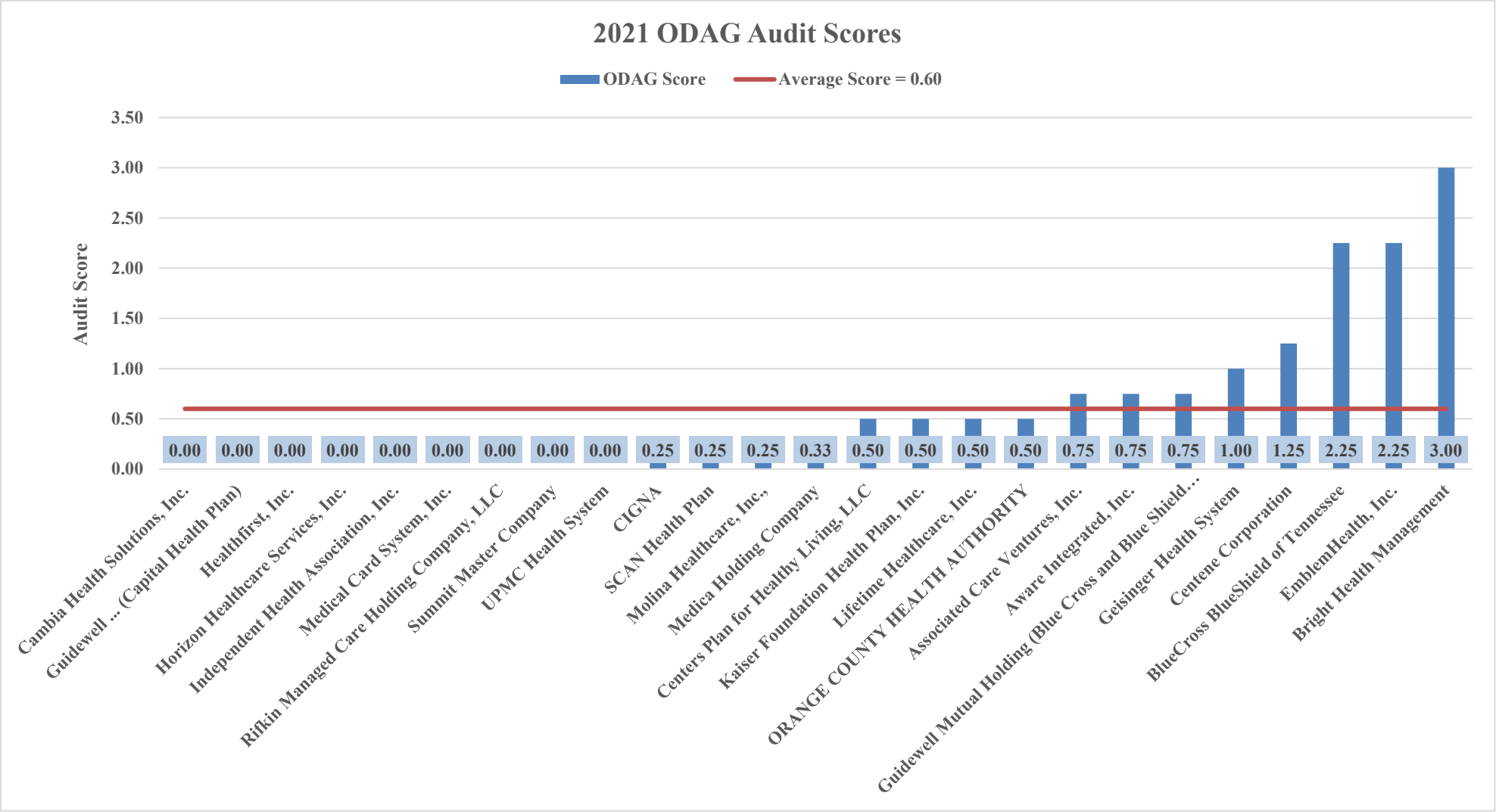
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the FA program area in 2021.**

Figure 9*



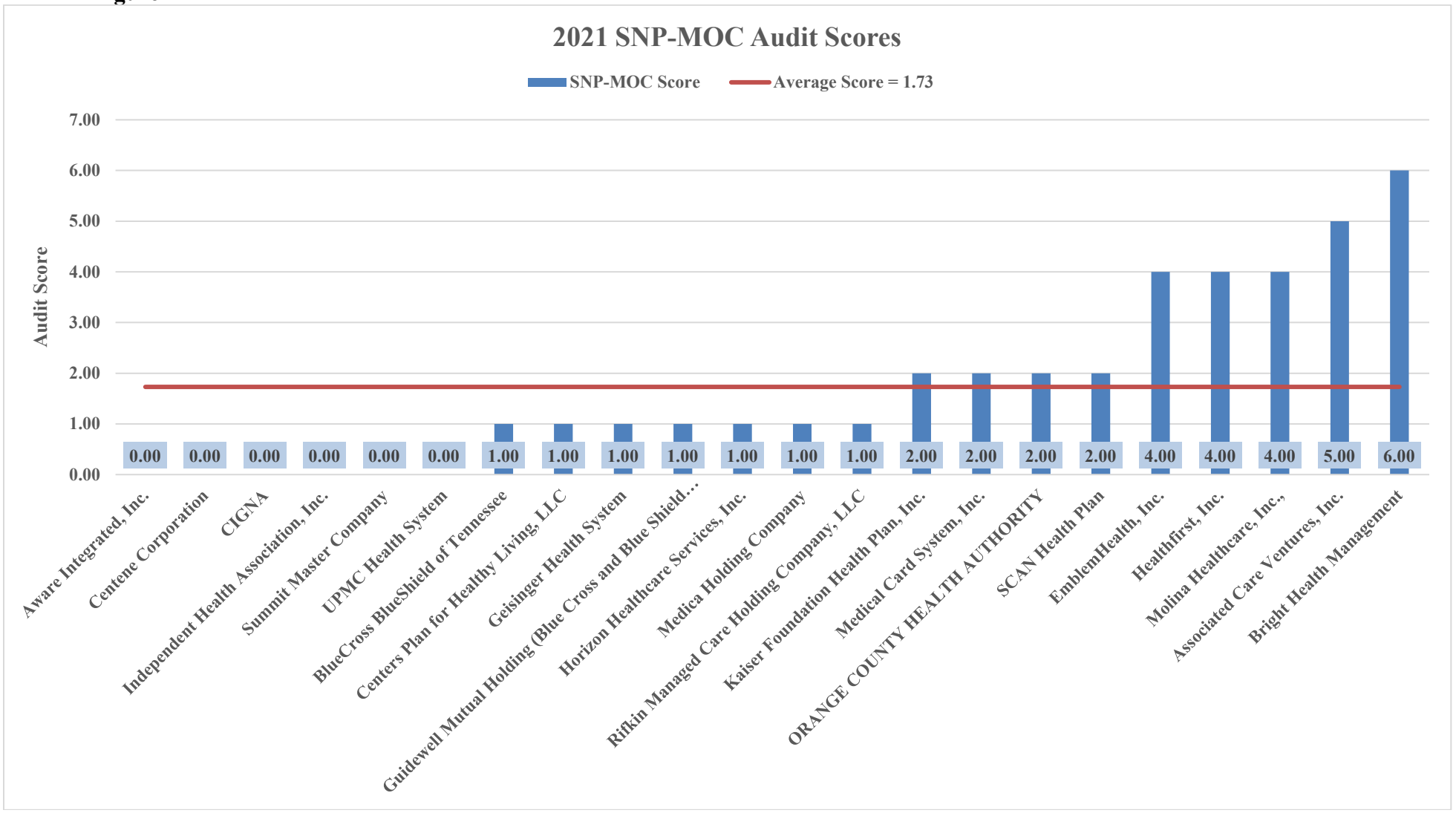
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CDAG program area in 2021.**

Figure 10*



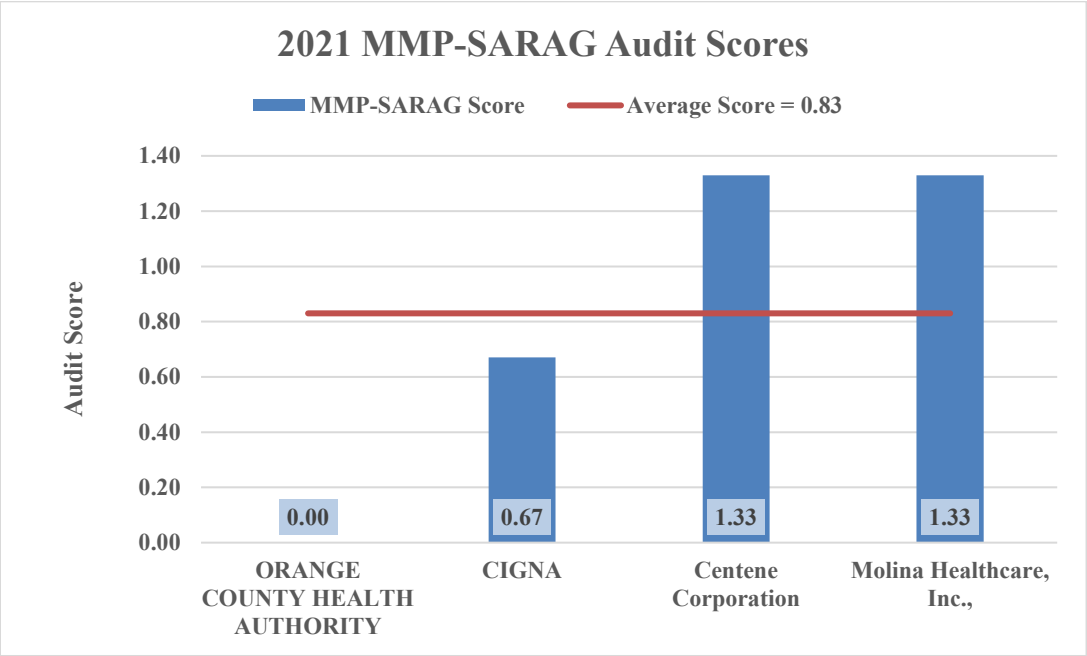
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the ODAG program area in 2021.**

Figure 11*



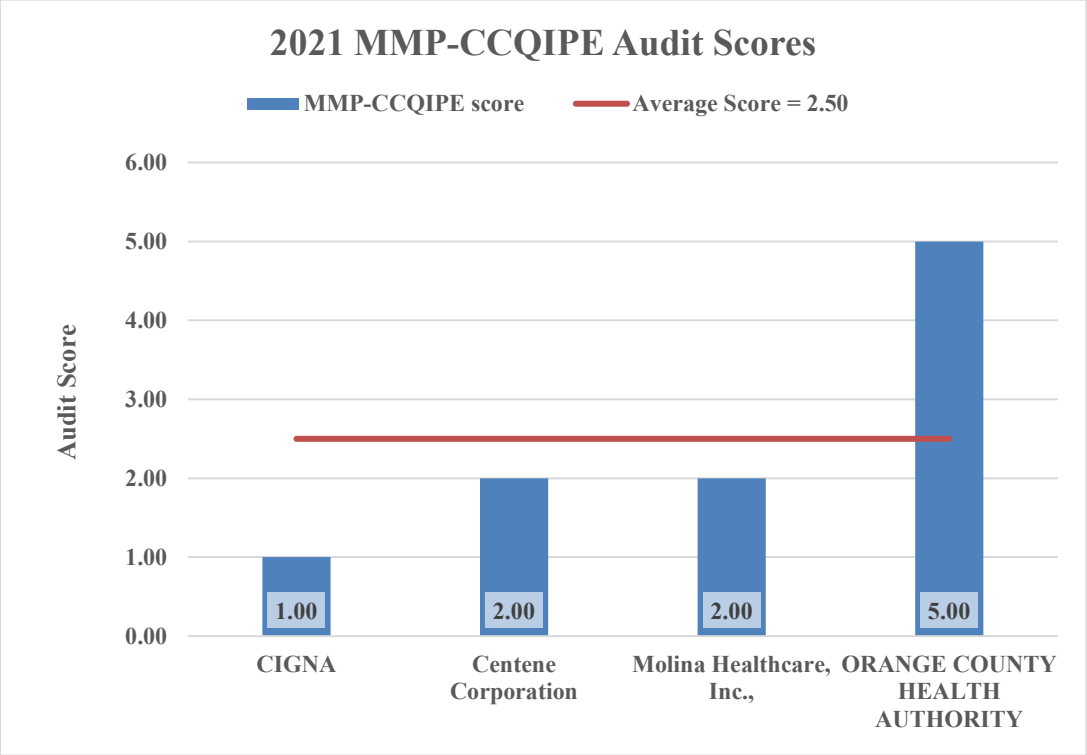
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the SNP-MOC program area in 2021.**

Figure 12*



***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the MMP-SARAG program area in 2021.**

Figure 13*



***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the MMP-CCQIPE program area in 2021.**

Table 1 shows 2021 audit results broken down by both program area and the enrollment size of the sponsors we audited. The three enrollment bands used in the table correspond to those used to determine how many months of data we collect for certain audited program areas, such as CDAG and ODAG. Small sponsors have 50,000 or fewer enrollees, medium sponsors have between 50,000 and 250,000 enrollees, and large sponsors have over 250,000 enrollees. Table 2 provides an overview of the number and percentage of audits that had no conditions of non-compliance in 2021, broken down by program area.

Table 1

Program Area	2021 Average Audit Scores by Enrollment Band		
	<50K Enrollees	Between 50K and 250K Enrollees	>250K Enrollees
Overall	0.28	0.47	0.56
CPE	0.10	0.03	0.08
FA	0.07	0.42	0.63
CDAG	0.19	0.36	0.58
ODAG	0.29	0.64	0.56
SNP-MOC	1.80	1.89	1
MMP-SARAG	0	1.33	1
MMP-CCQIPE	5	2.00	1.50

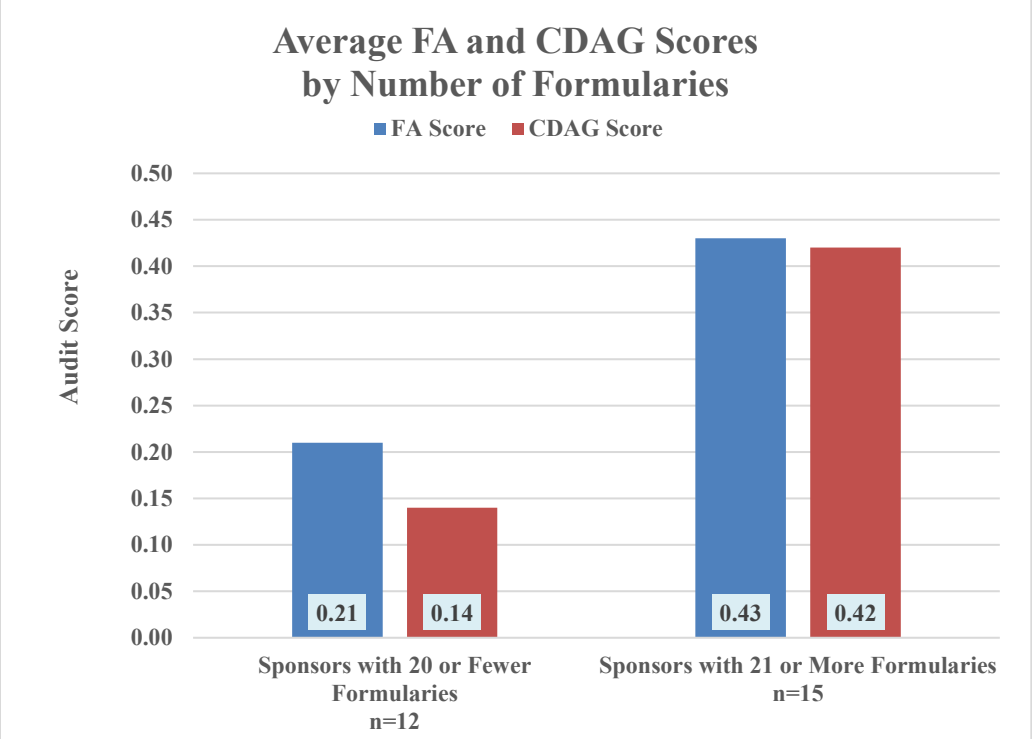
Table 2

Program Area	Number of Audits without Conditions (2021)	Percentage of Audits without Conditions (2021)
Overall	3	11.11%
CPE	23	85.19%
FA	16	59.26%
CDAG	14	51.85%
ODAG	9	36.00%
SNP-MOC	6	27.27%
MMP-SARAG	1	25.00%
MMP-CCQIPE	0	0.00%

FA and CDAG Scores by Number of Formularies

Figure 14 displays the average 2021 FA and CDAG scores respectively across audited sponsors broken into two groups: those that operate 20 or fewer formularies, which was the case in 12 of the 27 audits we conducted, and those that operate 21 or more formularies, which was the case in 15 of the 27 audits we conducted. In the former group, the number of formularies ranged from 2 to 19, and in the latter group the number of formularies ranged from 27 to 651. In both FA and CDAG, the average scores were lower for the group of sponsors operating 20 or fewer formularies as compared to the group of sponsors operating 21 or more formularies: 0.21 versus 0.43 in FA and 0.14 versus 0.42 in CDAG. However, performance in both groups of sponsors was strong in both program areas.

Figure 14*



*** The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.**

PROGRAM AUDIT INSIGHTS AND 2022 PROCESS IMPROVEMENTS

Program audits provide valuable insight into Medicare Advantage and Prescription Drug Plan sponsor operations. In this section, we provide information and recommendations sponsors should consider to help ensure non-compliance is prevented before it occurs or corrected if it exists. Sponsors should review this information with their compliance staff, compliance committee and other affected stakeholders.

Audit Insights

We expect all sponsors to carefully and routinely assess risks to their organization, and monitor and audit their operations to ensure compliance with CMS requirements. Sponsors can use our program audit protocols 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 non-compliance prior to a program audit. For example, vulnerabilities may include:

- transitioning to a new system or updates made to legacy systems
- a breakdown in communication between existing systems or interfaces that impact benefit eligibility, enrollment, or claims history
- untimely updates to training, policies and procedures to account for system updates
- incomplete, incorrect, or non-existent processes and policies
- incorrect mapping of denial codes and reasons, and enrollee liability amounts
- not recognizing when prior authorization or other utilization management standards have been met
- denial notices not populating applicable appeal rights
- a breakdown in Medicare Advantage Prescription Drug plan (MA-PD) coverage or care coordination, for example Part B versus Part D, coverage coordination or transitions in care settings
- System flags not triggering as intended, for example to alert teams to aging coverage requests, or when health risk assessments or care plans require updating

Other areas worthy of enhanced review include ensuring coordinated care aligns with approved models of care and ensuring thorough and clear interpretation of requirements found in the three-way agreements applicable to Medicare-Medicaid plans.

SPONSOR TIP: The success of any audit starts with the audited organization's ability to produce accurate data, universes, and supplemental documentation for review. We encourage sponsors to use the time allotted for universe submissions to accurately compile the requested data according to the universe instructions, field descriptions, and requested universe timeframes. Requested information should also be subject to internal quality review before it is submitted to auditors. Sponsors should not rely on guidance received during previous audits as it may no longer be applicable to current protocols. 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. When in doubt, reach out!!!

2022 Audit Process Improvements

On May 26, 2021, we announced that the audit protocols we will use to conduct the Medicare Part C and Part D Program Audits and collection of the Industry-Wide Part C Timeliness Monitoring Project (CMS-10717) were approved by the Office of Management and Budget (OMB 0938-1395 expires 05/31/2024).[3] These protocols represent a concerted effort to streamline and consolidate our data collection tools in an effort to reduce the overall burden on stakeholders. To assist stakeholders with the implementation of the new protocols, we hosted a training series in August 2021 to provide clarification on the operational and technical changes and to promote a uniform understanding of the audit scope and objective. The training series was recorded and is available here: https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.

On December 16, 2021, in the "2022 Program Audit Updates" memorandum issued via the Health Plan Management System, we also announced updates to condition of non-compliance classification definitions effective for 2022 program audits.

- Immediate Corrective Action Required (ICAR) – Audit findings that inappropriately delay, restrict or limit an enrollee's access to required medications and/or services are classified as ICARs. Generally, these are significant findings that require immediate action to mitigate impact on enrollees. The ICAR counts as two points in the audit scoring methodology.
- Corrective Action Required (CAR) – Audit findings that do not have an immediate impact on the enrollee's ability to request or receive medications and/or services, but are still significant are classified as CARs. The CAR counts as one point in the audit scoring methodology.
- Observation Requiring Corrective Action (ORCA) – Audit findings that are limited in scope, or otherwise mitigated, are classified as observations requiring corrective action. Generally, these findings are less significant, but require attention to ensure any enrollee impact is resolved and/or to prevent further non-compliance. Observations requiring corrective action do not count as points in the audit scoring methodology.
- Observation – Audit findings that are insignificant are classified as observations. Generally, these findings represent an anomaly and do not require corrective action. Observations do not count as points in the audit scoring methodology.

Although not listed in the memorandum, conditions resulting from Invalid Data Submissions (i.e., IDS conditions) will still be cited in 2022 when sponsors are unable to produce an accurate or complete universe within three attempts. Each IDS condition counts as one point in the audit scoring methodology.

[3] This collection request can be found at: https://www.cms.gov/files/zip/final-protocols-medicare-part-c-and-part-d-program-audits-and-industry-wide-part-c-timeliness.zip. Also see https://www.cms.gov/files/zip/2022-mmp-audit-protocols-and-data-requests.zip for a link to the 2022 MMP protocols.

SPONSOR TIP: If you use delegated entities to perform any of the functions currently included in a program audit, ensure you are able to collect and consolidate the relevant universe data accurately. When performing internal audits, sponsors should practice the submission of the comprehensive universe data from delegated entities and ensure their accuracy to prepare for a future audit and to ensure compliance with CMS requirements. It is important that both your organization and any delegated entities are prepared for all aspects of a program audit.

ENFORCEMENT ACTIONS

In 2021, we imposed various enforcement actions resulting from violations discovered during audits and other monitoring efforts conducted by CMS. This section of the report details the number and types of 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. The first part of this section focuses on the enforcement actions imposed in calendar year 2021 and early 2022 due to referrals received by us in 2021. These referrals encompass actions for violations from Parts C and D program audits, financial audits (also known as "one-third" financial audits), routine monitoring activities (i.e., medical loss ratio (MLR), annual notice of change (ANOC), and dual eligible special needs plan (D-SNP) integration) and ad-hoc monitoring activities. The second part of this section focuses on enforcement process improvements and the lessons learned from reviewing enforcement action referrals.

General Enforcement Background

CMS has the authority to impose 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 non-compliant with CMS' program requirements, such as the 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).

Prior to issuing an enforcement action, we obtain clearance from the Office of General Counsel within the Department of Health and Human Services. In addition, for any CMPs, we obtain clearance from the Office of Inspector General and the Department of Justice. All enforcement actions are posted on the Part C and Part D Compliance and Audits website.[4] All information contained in referrals that involve suspected fraud, waste, and abuse is referred to the Center for Program Integrity.

ENFORCEMENT ACTIONS IMPOSED BASED ON 2021 REFERRALS

This section provides information on enforcement actions taken in calendar year 2021 and early 2022 due to referrals we received in 2021. For this time period, we issued 16 CMPs and seven intermediate sanctions against sponsors.

[4] https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-

Referrals were based on non-compliance detected through routine audits, ad-hoc audits, routine monitoring and surveillance activities, and the identification of significant instances of non-compliance both self-reported and discovered by CMS. We received 48 referrals separated into the following referral types:

- One-Third Financial Audit failures (40%)
- Medicare Parts C and D Program Audit failures (21%)
- Dual Eligible Special Needs Plan (D-SNP) Medicare-Medicaid Integration deficiencies (13%)
- Medical Loss Ratio (MLR) failures (10%)
- Inaccurate Annual Notice of Change (ANOC) (6%)
- Ad-hoc Parts C and D issues (4%)
- State suspension of enrollment due to financial solvency (4%)
- State suspension of enrollment due to licensure issues (2%)

Table 3 shows the referral details and displays the number of enforcement actions by referral type:

Table 3

Referral Type	Number of Referrals	Number of Referral Closeouts	Number of Referrals Under Review	Number of Enforcement Actions Taken
One-Third Financial Audits	19	11	0	8
Medicare Parts C and D Program Audits	10	4	0	6
Dual SNP (D-SNP) Integration	6	1	0	5
Medical Loss Ratio	5	0	0	5
Inaccurate Annual Notice of Change	3	3	0	0
State Suspension of Enrollment/Financial Solvency	2	0	0	2
State Suspension of Enrollment/Licensure	1	0	0	1
Enrollment Processing	1	0	0	1
Parts C and D Appeals & Grievances and Marketing	1	0	0	1[5]

CIVIL MONEY PENALTIES

We imposed 16 CMPs for referrals received in 2021 totaling $1,043,953 with an average of $65,247 per CMP.[6] The highest CMP imposed was $146,068, and the lowest CMP imposed was $9,328. The following table shows the sponsors that received a CMP based on 2021 referrals:

[5] Enforcement action taken only on Part D appeal violation.
[6] 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.

Table 4

Date of Imposition	Sponsor Name	Basis for Referral	Enrollment[7]	CMP Amount
12/06/2021	Group 1001	Enrollment Processing	294,435	$53,162
02/24/2022	California Physicians' Service	One-Third Financial Audit	40,913	$40,282
02/25/2022	Paramount Care, Inc.	One-Third Financial Audit	15,035	$146,068
02/25/2022	GlobalHealth, Inc.	One-Third Financial Audit	10,855	$26,182
02/25/2022	Network Health Insurance Corporation	One-Third Financial Audit	68,670	$11,236
02/25/2022	CareSource Ohio, Inc.	One-Third Financial Audit	3,948	$66,250
02/25/2022	Vibra Health Plan, Inc.	One-Third Financial Audit	6,604	$9,328
02/25/2022	Independence Health Group, Inc.	One-Third Financial Audit	103,764	$26,500
02/25/2022	CIGNA	One-Third Financial Audit	198,444	$126,988
03/22/2022	Guidewell Mutual Holding Corporation	2021 Program Audit	175,402	$52,258
03/22/2022	BlueCross BlueShield of Tennessee	2021 Program Audit	160,748	$142,676
03/22/2022	EmblemHealth, Inc.	2021 Program Audit	149,212	$106,325
03/22/2022	Centene Corporation	2021 Program Audit	5,104,326	$88,192
03/22/2022	CIGNA	2021 Program Audit	3,463,241	$85,436
03/22/2022	Molina Healthcare, Inc.	2021 Program Audit	69,244	$43,884
04/05/2022	Anthem Inc.	Part D Appeals	1,560,201	$19,186

The amount of the CMP does not automatically reflect the overall performance of a sponsor. As discussed below, the majority of CMPs depend on the number of enrollees impacted by certain violations. Consequently, the CMP amount may be higher for sponsors with larger enrollments or when a violation affected a high number of enrollees.

The type of contract(s) involved, as well as the nature and scope of the violation(s), determine 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, while CMPs imposed on a per-determination basis do not.

There were 23 specific violations cited in the 16 CMPs:[8]

- Nineteen violations were calculated on a per-enrollee basis resulting in $844,184
- Four violations were calculated on a per-determination basis resulting in $199,769

For CMPs taken as a result of 2021 referrals, Figure 15 and Figure 16 show the total number of violations and dollar amount of violations by calculation type:

[7] Enrollment reflects actual contracts included in the CMP versus the entire sponsor.
[8] These numbers include CMPs from program audits, financial audits, and enrollment and Part D appeal failures.

Figure 15

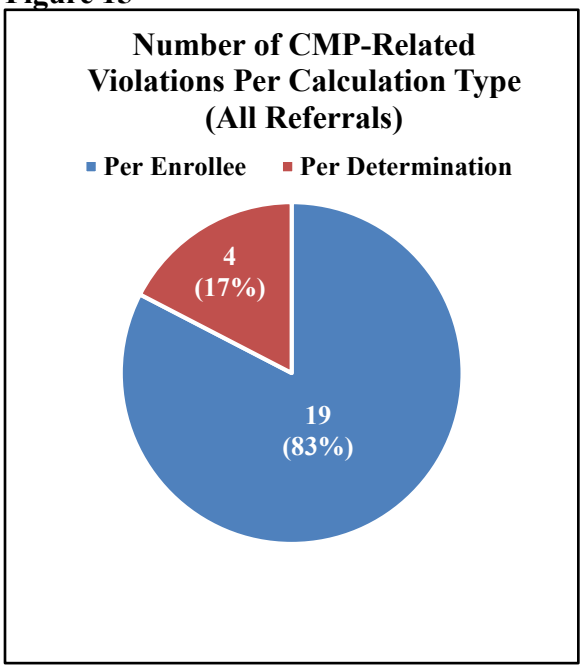
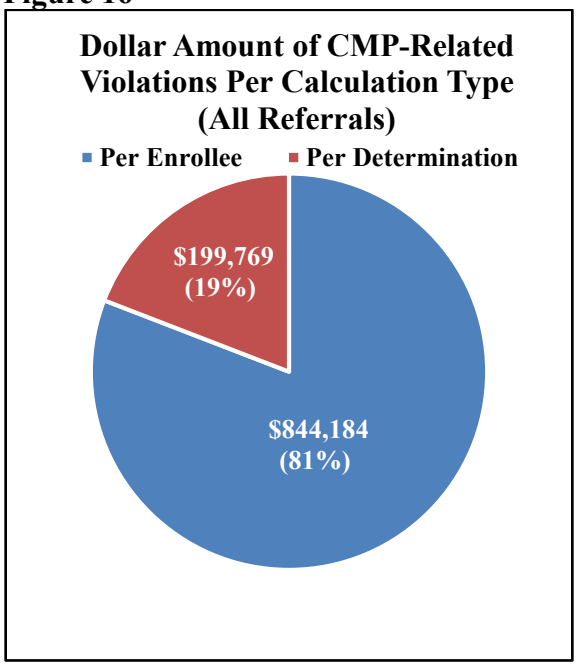


Figure 16



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 23 violations, we applied an aggravating factor penalty to 18 violations because of the following:

- Enrollees incurred inappropriate out-of-pocket expenses exceeding $100,
- Sponsor failed to notify enrollees of its expedited coverage decisions timely,
- Enrollees were delayed or denied drugs that are used to treat acute conditions that require immediate treatment, and
- Sponsor had a history of a prior offense.

The total aggravating factor penalties amounted to $121,508 which is 12 percent of the total CMP amount of $1,043,953 imposed for 2021 referrals.

Mitigating Factors
Consistent with our approach in 2020, we considered other available evidence indicating that harm to enrollees was minimized when determining whether to move forward with a CMP for a particular violation or to remove enrollees from the CMP calculation. For example, if an enrollee received the requested drug on the same day after an inappropriate rejection occurred at the point of sale, we would exclude the enrollee from the total CMP calculation.

Type of CMP Violations
We take actions on a number of different violations of the Parts C and D regulations. The following table shows a breakdown of the 23 violations cited in the 16 CMP notices:

Table 5

Violation Type	Number of Violations
Inappropriate cost sharing for Part C items and services*	8
Failure to timely notify enrollees of decisions on Part C/MMP organization/service determinations and appeals (standard & expedited)	4
Failure to hold enrollees harmless for plan directed care*	3
Inappropriate denials of Part D coverage determinations	2
Failure to process enrollments timely and accurately	1
Inappropriate denials of Part C post-service organization determinations	1
Failure to initiate Part D coverage determinations	1
Failure to provide enrollees with a transition fill of Part D medications	1
Failure to send untimely adverse Part D appeals to the independent review entity	1
Failure to provide information on a timely basis to current and prospective enrollees when enrollees contacted customer service	1

***Additional information on these violations is discussed in the Lessons Learned section starting on page 30.**

INTERMEDIATE SANCTIONS

Intermediate sanctions can either suspend a sponsor's ability to market to and accept new Parts C or D enrollees or to receive payment for new enrollees. In 2021, we imposed 13 intermediate sanctions. Of the 13 sanctions, five actions were imposed because of non-compliance with CMS' requirements with respect to MLR. Three actions were imposed because of an enrollment suspension from the state, either due to financial solvency concerns or licensure issues. Five actions were imposed for failure to meet D-SNP Medicare-Medicaid integration requirements.

Intermediate sanctions remain in place until the deficiencies which formed the basis of the sanction are corrected and are not likely to recur. Out of the 13 intermediate sanctions imposed in 2021, three sponsors have corrected their deficiencies and returned to normal enrollment status.

Table 6 lists the sponsors that were sanctioned during 2021.

Table 6

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Basis for Referral	Type of Intermediate Sanction	Date of Intermediate Sanction Release
04/29/2021	04/30/2021	Golden State Medicare Health Plan	State Suspension/ Financial Solvency*	Enrollment Suspension	TBD
06/17/2021	06/17/2021	Imperial Insurance Companies, Inc. (H2793 – State of Arizona Only)	State Suspension/ Licensure*	Enrollment Suspension	10/05/2021
09/02/2021	01/01/2022	MMM Healthcare, LLC	Medical Loss Ratio	Enrollment Suspension	TBD
09/02/2021	01/01/2022	Triple-S Advantage, Inc.	Medical Loss Ratio	Enrollment Suspension	TBD
09/02/2021	01/01/2022	UnitedHealthcare of Arkansas, Inc	Medical Loss Ratio	Enrollment Suspension	TBD
09/02/2021	01/01/2022	UnitedHealthcare of New Mexico, Inc.	Medical Loss Ratio	Enrollment Suspension	TBD
09/02/2021	01/01/2022	UnitedHealthcare of the Midwest, Inc. (UnitedHealth Group, Inc.)	Medical Loss Ratio	Enrollment Suspension	TBD
09/28/2021	01/01/2022	UnitedHealthcare Insurance Company (UnitedHealth Group, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	01/31/2022
09/28/2021	01/01/2022	MVP HealthPlan, Inc. (MVP Health Care, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	TBD
09/28/2021	01/01/2022	UnitedHealthcare of New York, Inc. (UnitedHealth Group, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	TBD
09/28/2021	01/01/2022	Health Insurance Plan of Greater New York (EmblemHealth, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	TBD
09/28/2021	01/01/2022	Visiting Nurse Association of Central New York	D-SNP Integration Requirements	Enrollment Suspension	TBD
10/26/2021	10/26/2021	Eternal Health of Delaware, Inc.	State Suspension/ Financial Solvency*	Enrollment Suspension	12/02/2021

***Additional details on these violations are provided in the Lessons Learned section starting on page 30.**

In addition, there were six sponsors sanctioned in 2020 that remained under a sanction during 2021. Four sponsors corrected their deficiencies in 2021 and returned to normal enrollment status. Two sponsors remain under sanction as of the time of this report.

Table 7 lists the sponsors that were sanctioned during 2020.

Table 7

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Basis for Referral	Type of Intermediate Sanction	Date of Intermediate Sanction Release
07/02/2020	07/02/2020	Vitality Health Plan of California, Inc.	State Suspension/ Financial Solvency	Enrollment Suspension	01/04/2022
09/09/2020	01/01/2021	Blue Cross of Idaho Health Services, Inc.	Medical Loss Ratio	Enrollment Suspension	09/02/2021
12/09/2020	01/01/2021	Hamaspik of Rockland County, Inc. (Hamaspik, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	02/18/2021
12/09/2020	01/01/2021	New York City Health and Hospitals Corporation (MetroPlus Health Plan, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	08/13/2021
12/09/2020	01/01/2021	UnitedHealth Group, Inc. (UnitedHealthcare of New York, Inc.)	D-SNP Integration Requirements	Enrollment Suspension	TBD
12/09/2020	01/01/2021	Visiting Nurse Association of Central New York	D-SNP Integration Requirements	Enrollment Suspension	TBD

INSIGHTS FROM THE ENFORCEMENT PROCESS

This section includes insights from reviewing enforcement action referrals and implementing the enforcement process.

Increasing Transparency

We continue our efforts to engage with sponsors throughout the evaluation process to ensure enforcement actions use data that accurately reflect the impact of violations on enrollees. For example, we recognize the complexity involved in completing an impact analysis and developing methodologies for pulling the data. We also continue to conduct outreach with sponsors to discuss and validate plan-submitted impact analyses in order to provide those sponsors with additional

opportunities to review the accuracy of their submissions and explain the data in further detail.

In addition, we continue to implement and refine process improvements, such as:

- Affected sponsors received timely notice when being referred for a potential enforcement action, and the referral notices contained more information about the specific conditions or violations that were under review;
- Sponsors were given timely notice when we decided not to take enforcement actions;
- Sponsors subject to a CMP received a detailed, written explanation of the calculation of their penalty;
- We improved efforts to obtain additional and/or mitigating data from sponsors during the analysis phase and clarified findings when necessary;
- We strongly encouraged sponsors to fully evaluate discovered non-compliance and provide any additional information during the audit phase; and
- We considered sponsors' comments to the draft audit reports when evaluating referrals.

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 2021 enforcement referrals.

- **Medicare Parts C and D Plan-Directed Care**
  Sponsors are reminded that they can only hold their enrollees financially liable for the applicable cost-sharing when a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan (also known as "plan-directed care"). Claims processors should be properly trained and adhere to the established procedures for identifying plan-directed care before out-of-network claims are denied. This may include providing claims processing staff with increased training and/or job aids. There should also be sufficient oversight of denied claims, in particular, to ensure non-contract providers are given the appropriate appeal rights and waiver of liability statement in their denial notices.

- **Monitoring for Enrollee Overcharges**
  We recommend that sponsors improve their internal processes for monitoring and refunding (when appropriate) overcharges to enrollees by contracted and non-contracted providers. Improved monitoring and analysis of claims denials, co-pays/co-insurance coding, and provider payments (both contracted and non-contracted) could improve a sponsor's ability to identify overcharges that require correction. Sponsors must ensure that enrollees are not overcharged and, when they are, refunds are issued to enrollees for any incorrectly collected amounts. We may impose a CMP on sponsors when enrollees have been overcharged or there was a substantial likelihood that enrollees were overcharged.

- **Financial Solvency and Contracting Requirements**
  Sponsors must also be prepared financially to operate a MA-PD or PDP. Federal requirements do not preempt state authority in the areas of licensure and fiscal solvency. When sponsors are out of compliance with these requirements and are subject to state actions that limit their ability to accept new enrollees as a result, they are also out of compliance with CMS' requirement for contracted sponsors to accept new enrollments. When sponsors have been sanctioned by states with enrollment freezes, we will impose a parallel enrollment sanction on the affected MA or Part D contracts. When a sponsor satisfies the state requirements and the state lifts its enrollment freeze, we will also lift our enrollment sanction. If the sponsor is unable to meet state requirements and further action is taken to either revoke its license or declare it insolvent, we may take steps to terminate the contract.

  Being prepared, both financially and operationally, is imperative to running a viable MA-PD or PDP organization. Before a sponsor decides to contract with CMS to offer Medicare Advantage or prescription drug benefits, it should ensure that it has the proper resources and funding to offer adequate health and drug benefits for its enrollees. This includes providing sufficient scrutiny to actuarial, service area, and risk profile assumptions when developing and submitting bids to CMS each year. These assumptions should be objectively evaluated in conjunction with individual state financial requirements. In addition, any changes in ownership, novation agreements, and service area expansions should be fully vetted with CMS to ensure they are in compliance with CMS regulations.

CONCLUSION

We continue to strive for increased transparency in relation to audit materials, performance, findings, and enforcement actions. The focus on program audits (and the resulting consequences of possible enforcement actions) continues to drive improvements in the industry. The audits help increase sponsors' compliance with core program functions in the MA, Part D, and MMP programs. We hope sponsors will use the information in this report to inform their internal auditing, monitoring, and compliance activities. We encourage feedback and look forward to continued collaboration with the sponsor community and external stakeholders in developing new approaches to improve compliance.