



# **2015 Part C and Part D Program Audit and Enforcement Report**

**Medicare Parts C and D Oversight  
and Enforcement Group  
September 6, 2016**

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## 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 (MA) and Prescription Drug Plan (PDP) organizations. Through rigorous auditing of these organizations (referred to as sponsors), MOEG provides measurable benefits by:

- Ensuring enrollees have adequate access to health care services and medications;
- Verifying sponsors' adherence to selected aspects of their contract with CMS;
- Providing a forum to share audit results and trends; and
- Soliciting feedback from the sponsor community and external stakeholders on potential audit improvements.

Each year, the Annual Audit and Enforcement Report emphasizes pertinent analyses and information sponsors and other stakeholders can adopt to improve performance continually within their respective organizations. Furthermore, the report serves to convey the initiatives undertaken to advance the transparency, accuracy, and reliability of the entire audit cycle. Highlights of this year's report include:

### ➤ **Audit Scope, Sponsor Selection & Audit Strategy**

This section of the report includes the rationale for CMS' selection of sponsors for audit; includes a summary of audit topics reviewed in the previous audit cycle; and CMS' audit progress by percentage of plans audited and beneficiary enrollment. In 2015, CMS audited sponsors that cover 48% of beneficiaries enrolled in the MA and Prescription Drug programs.

### ➤ **Audit Innovations and Process Improvements**

CMS continually engages in efforts to improve audit processes through solicitation of sponsor feedback on audit protocols and processes. This year's report focuses on improvements attained relative to the following:

- Reduction in average number of days between engagement letter and audit closeout;
- Implementation of Program Audit Consistency Teams (PACTs) focused on improving consistency in audit findings classification across audited entities, and instituting a feedback mechanism to determine if common audit findings warrant a clarification to CMS policy;
- Publication of CMS' audit protocols earlier in the audit cycle for sponsor review and understanding of CMS' planned areas of audit focus; and
- Improvements in audit protocols to allow for more specificity in cases evaluated, and timelier and streamlined sponsor documentation submission to CMS.

➤ **Summary of 2015 Audit Results and Analyses**

CMS presents the results of its analysis of data emerging from the 2015 audits. A few key points of interest include:

- Analysis of general year-over-year change in overall audit scores and specific program area audit scores. While overall scores and select program area scores remained relatively flat, we noted particular improvement in the Compliance Program area, with a 33% average score reduction from 2014.
- Over the course of cycle one and into cycle two, CMS has seen improved performance from audited sponsors. The average number of conditions cited per sponsor has fallen from 38 in 2012 to 27 in 2015.
- Specific, new analyses were initiated to study potential correlations between factors such as plan size, plan demographics, and program experience to audit performance. The results of analyses were mixed – there was not any particular correlation between plan size and plan demographics on audit performance; however, there was a positive correlation between plan experience and audit performance.

New this year is a list of the common conditions identified in each program audit area for sponsor assessment of applicability to their own individual operation and possible inclusion in their respective internal audit process.

➤ **Audit Enforcement Actions**

CMS also summarizes the types of enforcement actions taken, such as Civil Monetary Penalties (CMPs) and Intermediate Sanctions, presents year-to-year analyses of differing types of enforcement actions by program area; correlations between audit conditions and enforcement violations; and average number of CMP violations by program area.

As we continue to make strides in our audit processes and ensuing results, we remain vigilant in the successful implementation of improvements to our audit processes. We also recognize the importance of collaboration and clear communication of program requirements and audit results to sponsors and external stakeholders to further assist the industry in their own process improvement initiatives.

Our fundamental mission is to ensure enrollees have adequate access to health care services and medications. Through our diligent attention to improving the entire spectrum of activities encompassed in MA and PDP program audits, we remain committed to the persistent attainment of that goal.

## **INTRODUCTION**

The Medicare Advantage (MA or Part C) and Prescription Drug (Part D) programs provide health care and prescription drug benefits for eligible individuals aged 65 years and older and eligible individuals with disabilities. CMS contracts with private companies, referred to as “sponsors,” to provide health care and prescription drug benefits to beneficiaries.

The Medicare Parts C and D Oversight and Enforcement Group within the Center for Medicare performs program audits to evaluate sponsors’ delivery of health care services and medications to Medicare beneficiaries enrolled in the Part C and Part D programs. In addition to program audits, we also develop, maintain, and oversee the requirements for sponsors to have an effective compliance program implemented within their organization, including compliance with key fraud and abuse program initiatives. We have responsibility for utilizing CMS’ enforcement authorities, including the imposition of civil money penalties, intermediate sanctions (suspension of payment, enrollment and/or marketing activities), and for-cause contract terminations. Validations are also conducted to ensure that sponsors correct all deficiencies: (1) identified during program audits, or (2) that were the basis for intermediate sanctions. Lastly, we serve as the Center for Medicare’s liaison to the Center for Program Integrity in matters concerning fraud, waste, and abuse in the Part C and Part D programs.

This report summarizes activities for the 2015 audit year, as well as describes the scope of audits and the audit selection process. It will also discuss the current audit landscape, audit process improvements implemented, results of analyses of data from 2015 audits, the most common conditions found during audits, and a summary of enforcement activities.

New for 2015, in several areas of the report there are text boxes entitled “Sponsor Tips.” These tips provide information on how a sponsor can utilize the information in that section of the report to inform their own compliance and audit activities.

## **AUDIT SCOPE AND SPONSOR SELECTION**

In order to conduct a comprehensive audit of a sponsor’s operation and maximize Agency resources, program audits occur at the parent organization level. Therefore, all MA, MA-PD and PDP contracts owned and operated by the sponsor were included in the scope of the 2015 audits. The audits evaluate sponsor compliance in the following program areas:

- 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 Plans Model of Care (SNP-MOC)

Sponsors have all program areas audited, unless a protocol is not applicable to their operation. For example, if a sponsor does not operate a SNP plan, then a SNP-MOC audit is not performed. Likewise, a standalone PDP does not have the ODAG protocol applied, since they do not offer the MA benefit.

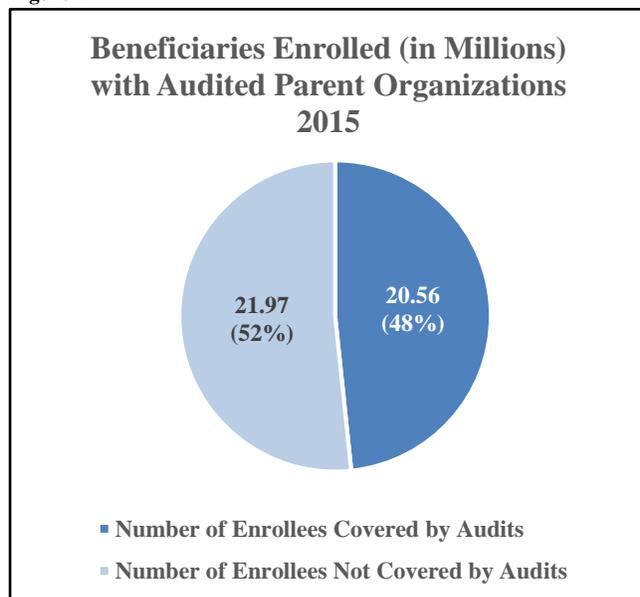
In addition to determining the topics to audit each year, we also determine the selection of sponsors for audits. Sponsor selection for audit relies on a number of sources, the primary one being the risk assessment conducted each year. This risk assessment is data driven and utilizes Medicare Advantage and Part D Star Ratings data, past performance data, plan reported data, and other operational information (e.g., large enrollment growth in a short period of time, large-scale formulary changes, changing Pharmacy Benefit Managers (PBMs), etc.). We then assign a weight and a score to each measure for each organization and calculate six risk scores: one overall risk score and one risk score for each program area we audit. In 2015, encounter data compiled by the Medicare Plan Payment Group (MPPG), are incorporated into the risk assessment.

Other factors that come into play in the selection process include audit referrals (from Regional Offices and/or Central Office), sponsors with a Low Performing Icon (LPI), and sponsors not audited in the last 3 years. Consequently, some of the sponsors selected for audit in a given year may not always be the highest risk as calculated by our risk assessment. For instance, if all of the highest risk sponsors had been audited in the previous two years, they would be unlikely to be audited again in year three.

## CURRENT PROGRAM AUDIT LANDSCAPE

The figures below show the progress of program audits on Parts C and D by enrollment and by the percentage of plans audited. These figures were based on enrollment and parent organization data as of April 2016 and include all coordinated care plans (CCPs), private fee-for-service (PFFS) plans, 1876 cost plans, stand-alone prescription drug plans (PDPs), and employer group waiver plans (800 series).

Figure 1



In 2015, audited sponsors account for 48% (i.e., roughly 20.5 million beneficiaries) of the total MA, other Medicare managed care health plans, and PDPs' enrollment (Figure 1).

By auditing sponsors that cover such a large number of enrollees during the first year of this audit cycle, we are positioned to reach 96-98% of total enrollment over the course of this audit cycle, and may be able to reach that figure in a shorter period than in cycle one.

Figure 2 on the following page shows the percentage of Medicare beneficiaries in each state that were covered by the program audits conducted in 2015. No single state had fewer than 30% of its beneficiaries covered, and one state had 74.8% of its beneficiaries covered by 2015 program audits. Figure 3 on page 8 depicts the percentage of plans in each state included in 2015 program audits. No state had fewer than 42.7% of its plans audited, and in one state 52.8% of the plans were audited.

Figure 2

### Percentage of Medicare Enrollees in Each State Included in 2015 Program Audits

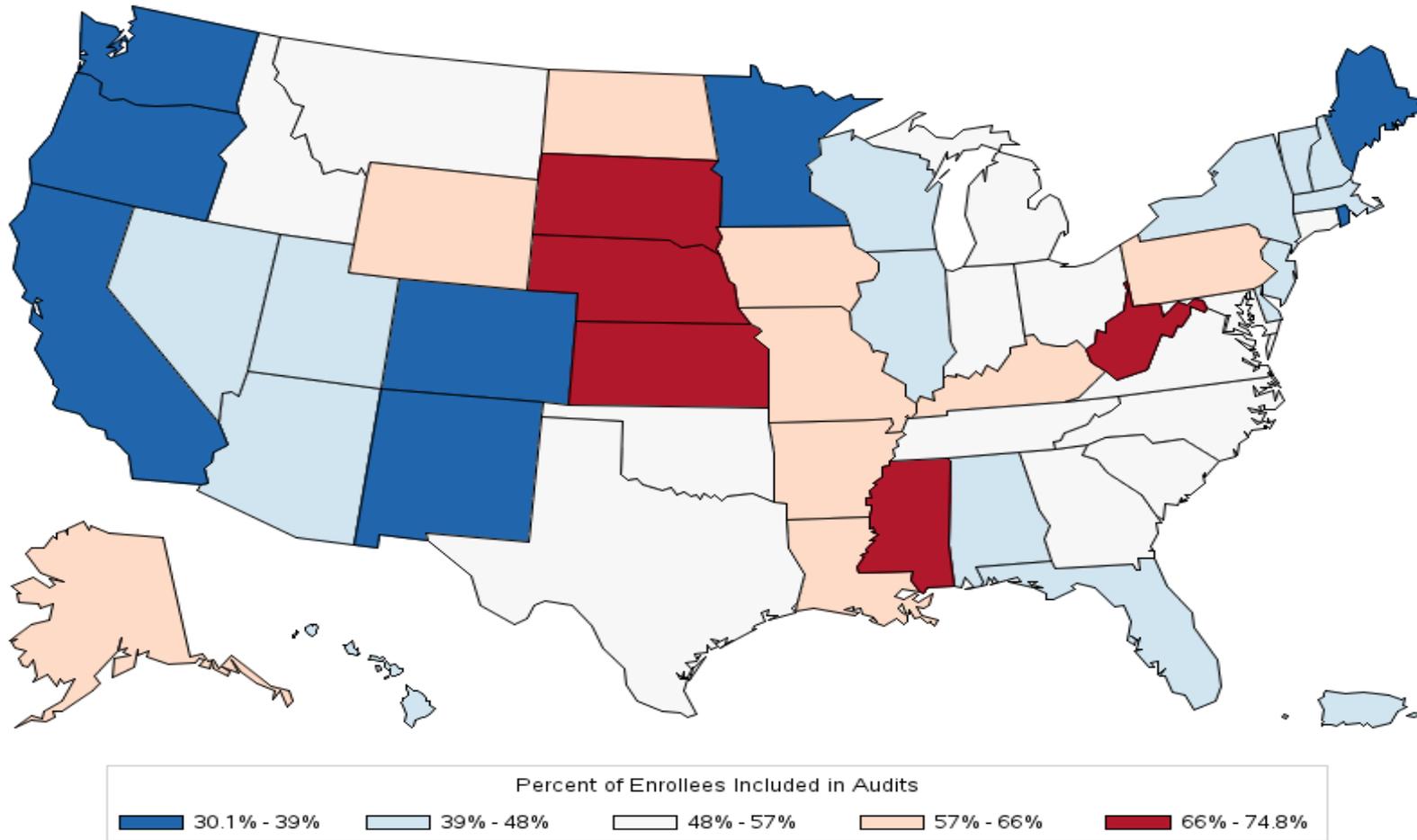
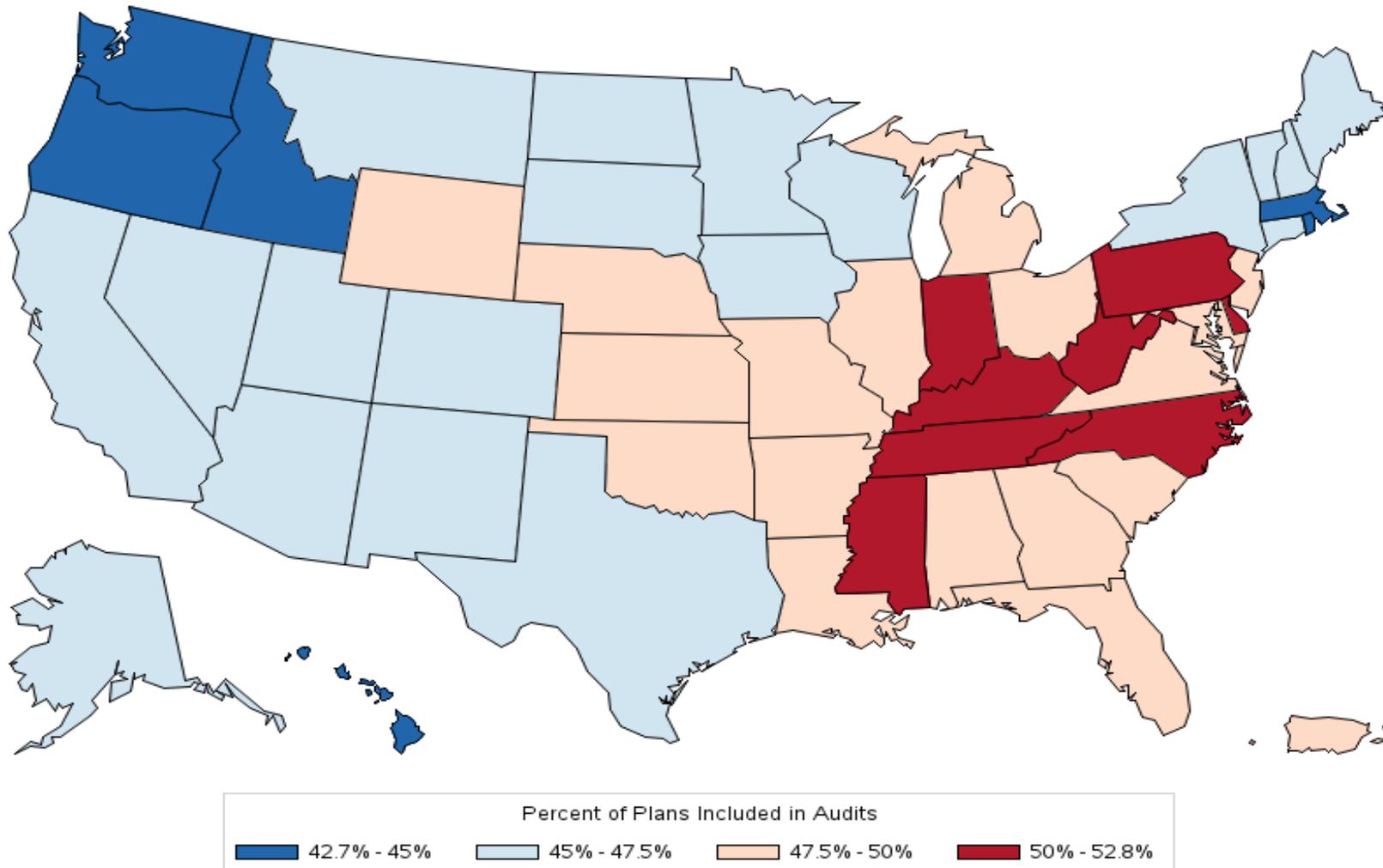


Figure 3

### Percentage of Medicare Plans in Each State Included in 2015 Program Audits



## AUDIT LIFECYCLE

The lifecycle of an audit begins the day an engagement letter is sent to the sponsor and concludes with the sponsor's receipt of an audit closeout letter. Because of concerns from the industry about the length of the audit cycle, we have worked to reduce the audit lifecycle, as shown in Table 1 below. In 2015, we issued audit closeout letters 82 days earlier on average than in 2013, a 17% reduction, despite starting week one of the audit two weeks later to allow sponsors more time to submit universes to CMS. CMS issued draft and final audit reports 52 days and 34 days earlier, respectively than in 2013. CMS approved corrective action plans for instances of non-compliance 27 days earlier in 2015 than in 2013.

Table 1

Audit Phase	2013	2015	Difference between 2013 and 2015
Draft Report Issued	181	129	-52
Final Report Issued	208	174	-34
Corrective Action Plan(s) Approved	263	236	-27
Audit Closeout Letter Issued	475	393	-82

Table 2 on the following page provides an overview of what each stage of the audit process entails, as well as the estimated timeframe to take to complete each stage of the audit process.

Table 2

<p><b>Audit Engagement and Universe Submission</b> <i>Week 0 - 6</i></p>	<ul style="list-style-type: none"><li>• <b>Engagement Letter</b> - CMS notification to Sponsor of audit selection; identification of audit scope and logistics; and Sponsor instructions for pre-audit issue summary submission</li><li>• <b>Universe Submission</b> - Sponsor submission of requested universes to CMS</li><li>• <b>Universe Validation</b> - CMS integrity testing of Sponsor's universe submissions</li></ul>
<p><b>Audit Fieldwork</b> <i>Week 7 - 8</i></p>	<ul style="list-style-type: none"><li>• <b>Entrance Conference</b> - Discussion of CMS audit objectives and expectations; Sponsor voluntary presentation on organization</li><li>• <b>Webinar Reviews (week 7)</b> - CMS testing of sample cases live in Sponsor systems via webinar</li><li>• <b>Onsite Review of Compliance Program (week 8)</b> - Compliance program review interviews; Sponsor submission of supplemental documentation (including screenshots and impact analyses); CMS documentation analysis</li><li>• <b>Issuance of Preliminary Draft Audit Report</b> - CMS issues a preliminary draft audit report to the Sponsor stating the conditions, observations, and best practices noted during the audit</li><li>• <b>Exit Conference</b> - Review and discussion of preliminary draft report with CMS and Sponsor</li></ul>
<p><b>Audit Reporting</b> <i>Week 9 - 21</i></p>	<ul style="list-style-type: none"><li>• <b>Immediate Corrective Action Required (ICAR) Email</b> - CMS notification to Sponsor of any findings requiring immediate corrective action; Sponsor ICAR Corrective Action Plan (CAP) submission within 3 business days</li><li>• <b>Draft Report Issuance</b> - Inclusive of condition classification and audit score to Sponsor approximately 60 calendar days after exit conference</li><li>• <b>Sponsor Response to Draft Report</b> - Sponsor submission of comments to draft report within 10 business days of draft report receipt</li><li>• <b>Final Report Issuance</b> - With CMS response to Sponsor comments and updated audit score (if applicable). Target issuance within 10 business days after receipt of Sponsor comments to draft report</li></ul>
<p><b>Audit Validation and Close Out</b> <i>Week 22 - 48</i></p>	<ul style="list-style-type: none"><li>• <b>Sponsor CAP Submission</b> - Sponsor submission of CAP within 30 calendar days of final report issuance</li><li>• <b>CMS Review and Acceptance of CAP</b> - CMS performance of CAP reasonableness review and notification to Sponsor of acceptance or need for revision</li><li>• <b>Sponsor Demonstration of Condition Correction</b> - Sponsor demonstration of condition correction within 150 calendar days of CAP acceptance, either by CMS or Independent Auditor hired by Sponsor</li><li>• <b>Sponsor Attestation Submission</b> - Sponsor CEO attestation submission to CMS that all conditions corrected and not likely to recur</li><li>• <b>CMS Audit Close Out</b> - CMS evaluation of attestation and audit validation report to determine if conditions are corrected; if so, CMS issuance of close out letter to Sponsor</li></ul>

## 2015 AUDIT INNOVATIONS AND PROCESS IMPROVEMENTS

In looking for opportunities to continuously improve processes and better support and educate sponsors and external stakeholders, we solicit feedback throughout the year on all of our documentation, processes, and procedures. As a result, the following changes and improvements were made in 2015:

- If sponsors were unable to provide an accurate universe to CMS after three attempts, conditions for inaccurate universe submissions were issued. This new policy highlights the need to keep audit timelines on track by limiting the number of opportunities sponsors are provided to submit universes, and the importance of sponsors' ability to track and consolidate data from both in-house operations and the operations of delegated entities.
- Program Audit Consistency Teams (PACTs) were established, consisting of Division of Audit Operations, Division of Analysis, Policy and Strategy, and Regional Office co-leads, as well as all team leads for a given program area. The PACTs meet after every audit to discuss audit findings, classify those findings, and work to ensure consistency across all audits. The PACTs also note policies or guidance that may need clarification to provide a feedback loop to Central Office subject matter experts for future guidance updates.
- To break out the different types of cases evaluated during the audit, additional record layouts for the 2015 CDAG and ODAG protocols were created. Sponsors reported this made their internal auditing and monitoring much easier, and they are better able to reproduce results similar to CMS auditors.
- The 2016 audit protocols were issued in October of 2015, giving sponsors more time to familiarize themselves with CMS' expectations and adjust their systems and operations accordingly in advance of a potential 2016 audit.

**SPONSOR TIP:** Is your organization undergoing a program audit? Do you think you may be audited in the near future? MOEG's audit protocols are valuable resources for audit preparation and detail how we perform audits. We encourage sponsors to perform practice audits, including practicing universe pulls, and calculating scores as we do. Practice audits will not only help prepare you for an actual CMS audit, but may help you to improve your operations, by exposing areas that are problematic or otherwise non-compliant with CMS regulations. Because audit findings may impact Medicare Advantage and Part D Star Ratings, we encourage routine self-audits to improve operations.

## AUDIT RESULTS AND TRENDING

CMS developed an audit scoring system in 2012. The audit scoring system generates a score for each sponsor based on the number and severity 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 the greatest impact on beneficiary access to care have a greater impact on the overall score. The audit score assigns 0 points to observations, 1 point to each corrective action required (CAR), and 2 points to each immediate corrective action required (ICAR), then the sum of these points is divided by the number of audit elements tested. The following is the formula for calculating the audit score:

$$\text{Audit score} = (\# \text{ CARs}) + (\# \text{ of ICARs} \times 2) / \# \text{ of audited elements tested}$$

Calculations produce an overall audit score, as well as a score for each program area. As previously mentioned, not all sponsors audited in 2015 had every program area audited. This scoring system quantifies a sponsor's performance and allows comparisons of scores across the industry. The next several figures compare scores between 2014 and 2015, evaluate if audit scores changed based on the timing of the audits during the year, and display overall and program-area specific audit scores for sponsors audited in 2015.

### Comparison of 2014 and 2015 Audit Results

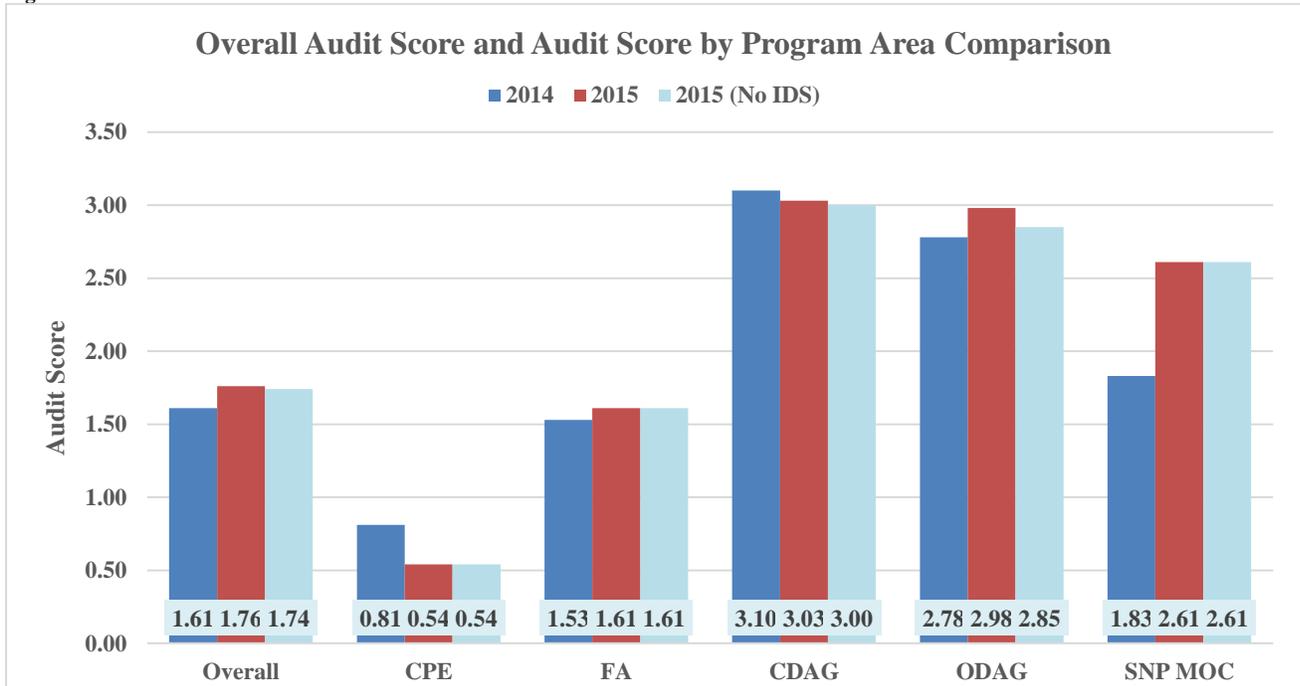
Figure 4 depicts the average audit score in each program area audited in 2014 compared to the 2015 scores, calculated with and without the conditions cited for inaccurate data submissions (IDS) (i.e., "2015 No IDS" in the figure below). The citing of IDS conditions began in 2015, so we wanted to show their impact on overall and program area scores. The overall scores in 2015 are similar to the overall scores in 2014, as are the scores in FA, CDAG and ODAG. In total, there are 5 audits where IDS conditions were cited. Specifically, 4 audits were affected only in ODAG, and one audit was affected in both CDAG and ODAG. There were no conditions cited relating to inaccurate universe submissions in CPE, FA or SNP-MOC.

**SPONSOR TIP:** If you utilize delegated entities to perform any of the functions CMS currently includes 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 universe data from delegated entities and ensure their accuracy to prepare for a future audit and to ensure compliance with CMS requirements. As we stated in the previous sponsor tip, because audits can have an impact on Star Ratings, it is important that both your organization and any delegated entities are prepared for all aspects of a CMS audit.

Figure 4 below also shows sponsors reduced their average CPE score by 33% from 2014 to 2015. This could be due, in part, to the revised CPE audit protocol utilized in 2015.

Over the course of the audits, sponsors' performance continues to improve. The average number of conditions cited per audit in 2012 was 38 and is now down to an average of 27 per audit in 2015.

Figure 4\*

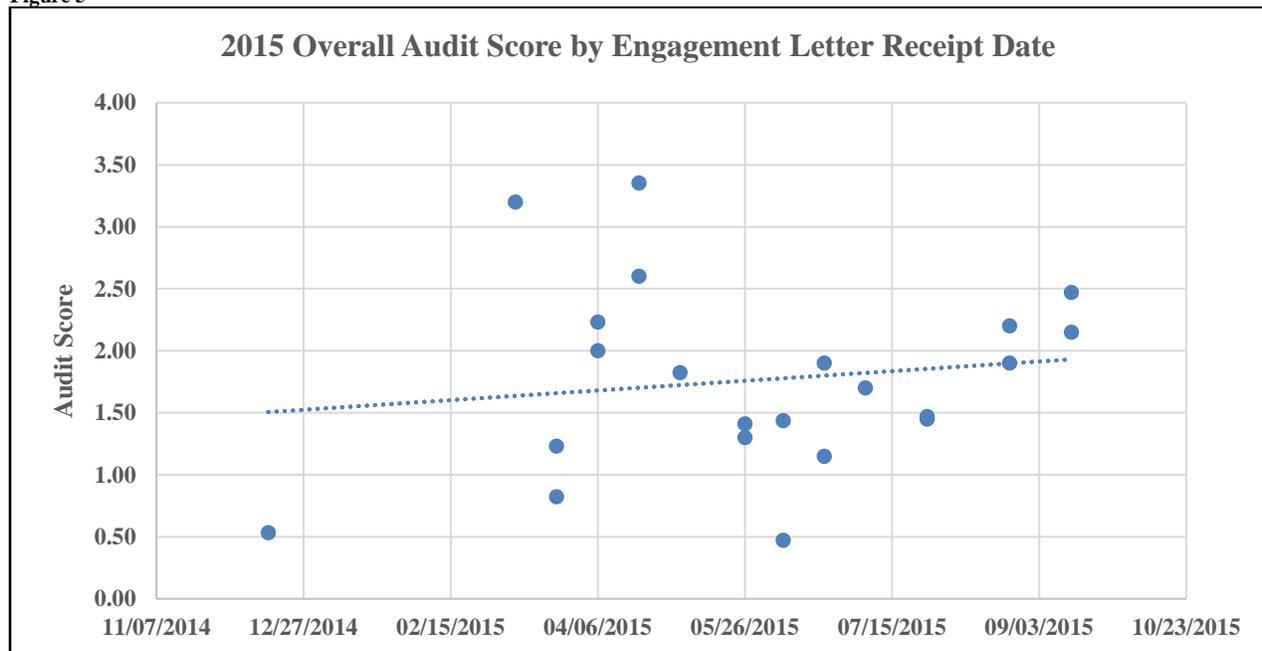


\* A lower audit score represents better audit performance. If the “2015” and “2015 (No IDS)” scores are the same for a given program area, it means no inaccurate universe conditions were cited in that program area in 2015.

### Comparison of 2015 Overall Audit Scores by Engagement Letter Receipt Date

Sponsors previously raised concerns that organizations audited during the first part of the calendar year are disadvantaged compared to sponsors audited later in the year. Sponsors hypothesized that having more time to familiarize themselves with protocols and more time to program their systems to report data led to better audit results. This was first analyzed using 2014 audit data, which showed that there is no meaningful advantage or disadvantage associated with the timing of the audit over the course of the year. The 2015 overall audit scores sponsors achieved were consistent across the 2015 audit year, as indicated by the slope of the trend line superimposed on the scatterplot in Figure 5.

Figure 5\*

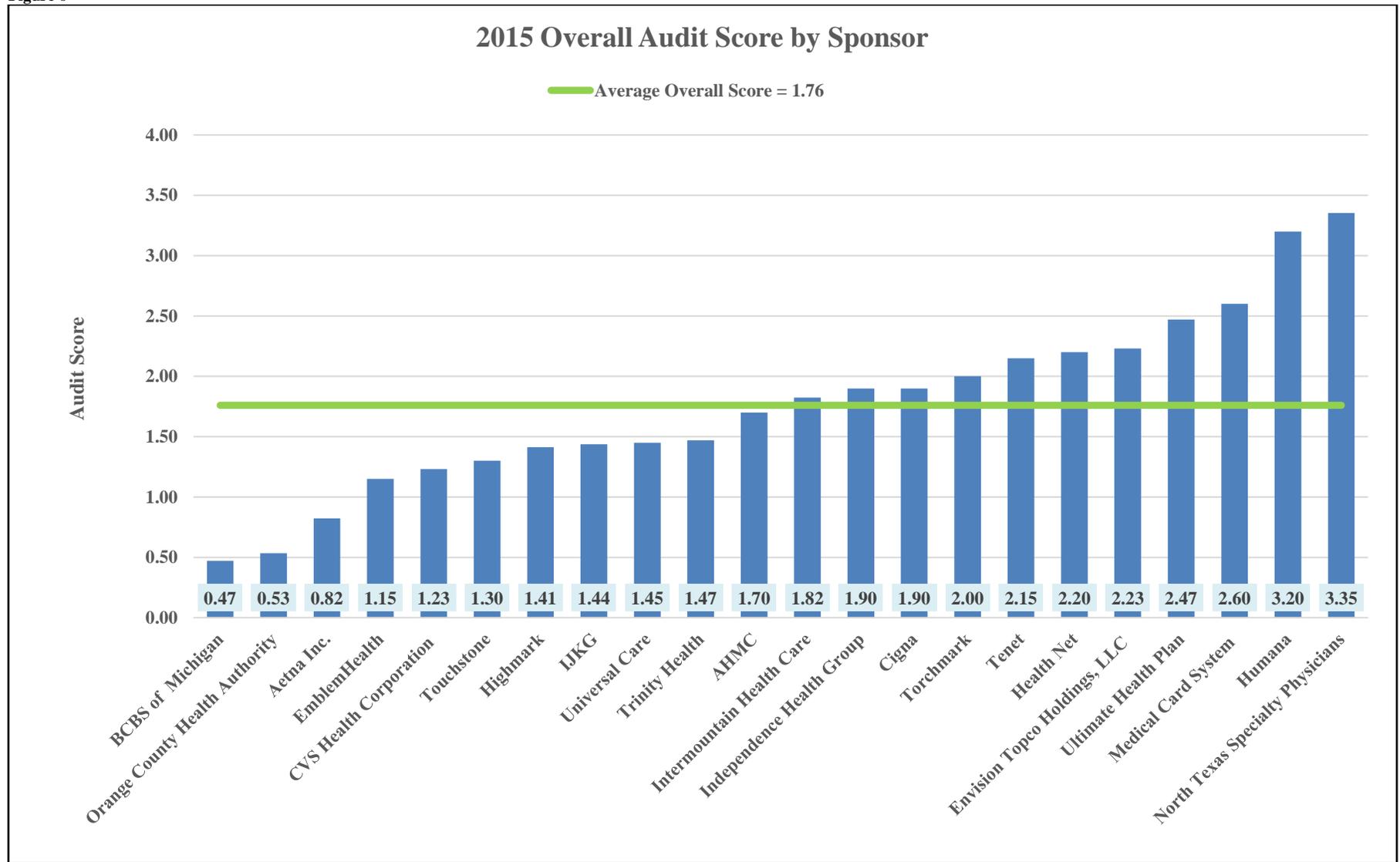


\*A lower audit score represents better audit performance.

### 2015 Program Audit Scores

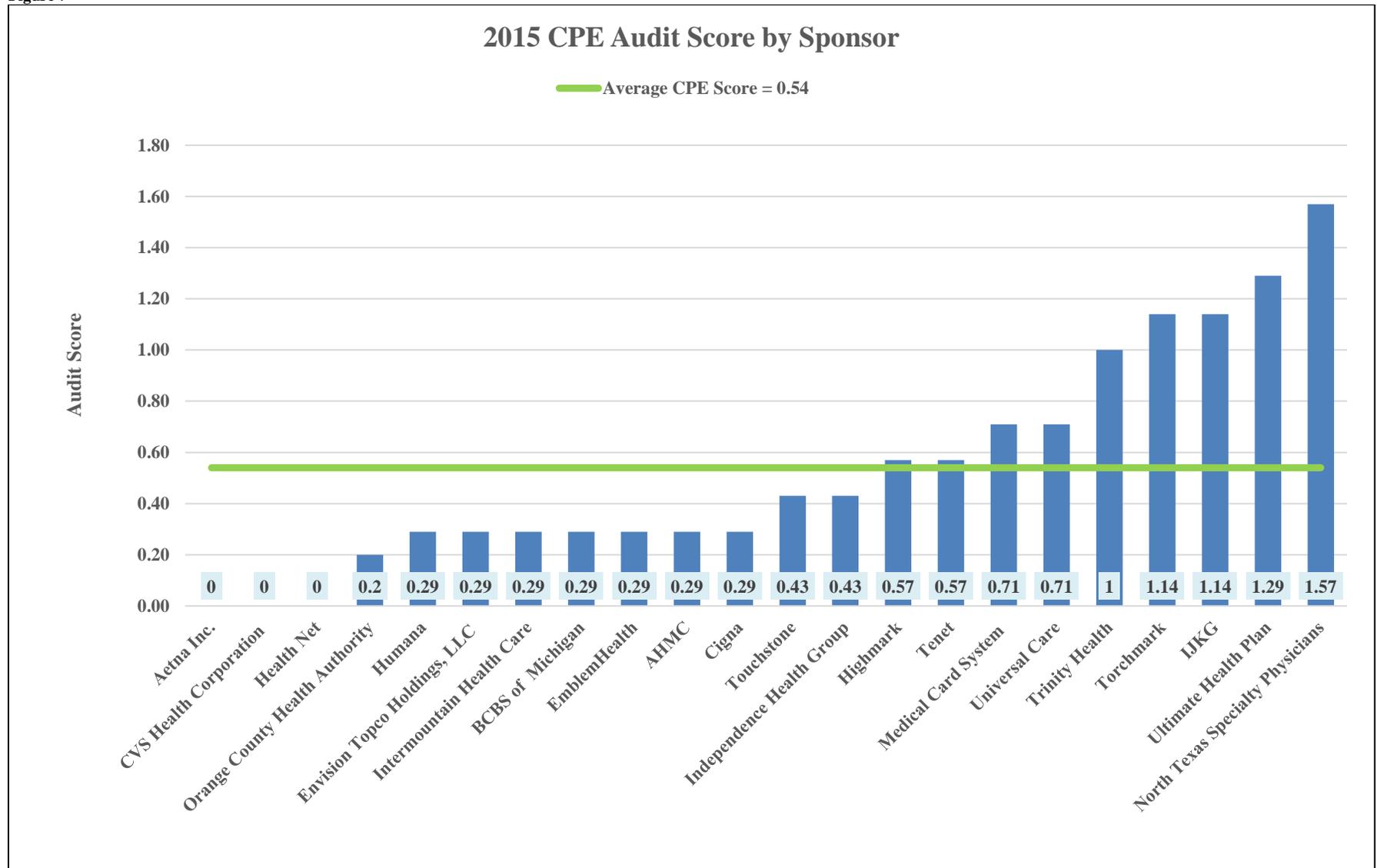
Figures 6-11 array the overall and individual program area audit scores from two different perspectives. First, the audit scores are arrayed from best to worst score (i.e., lowest score to highest score) moving from left to right across the graph. Second, the green line in each graph represents the average audit score across all audited sponsors.

Figure 6\*



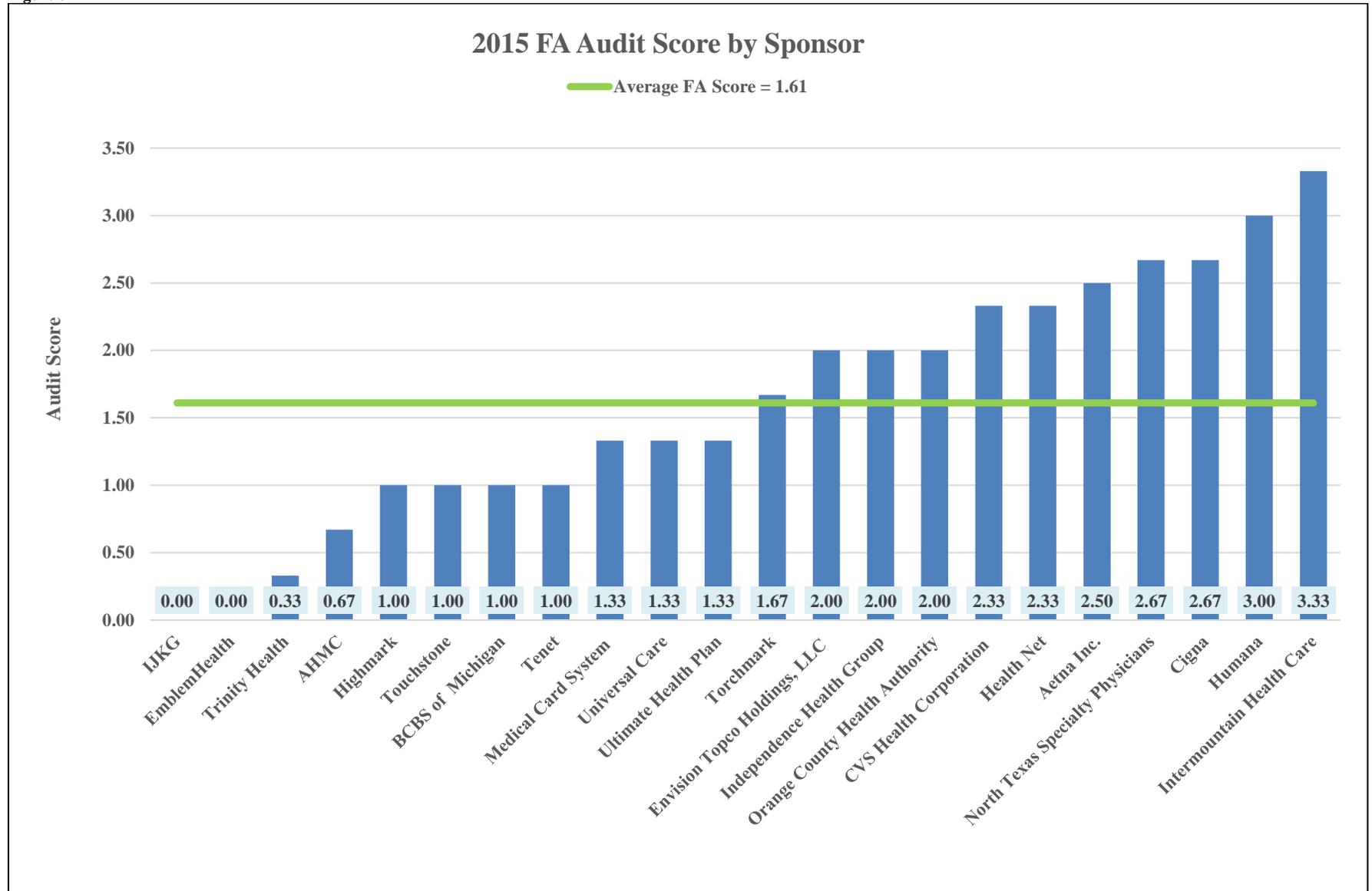
\*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2015.

Figure 7\*



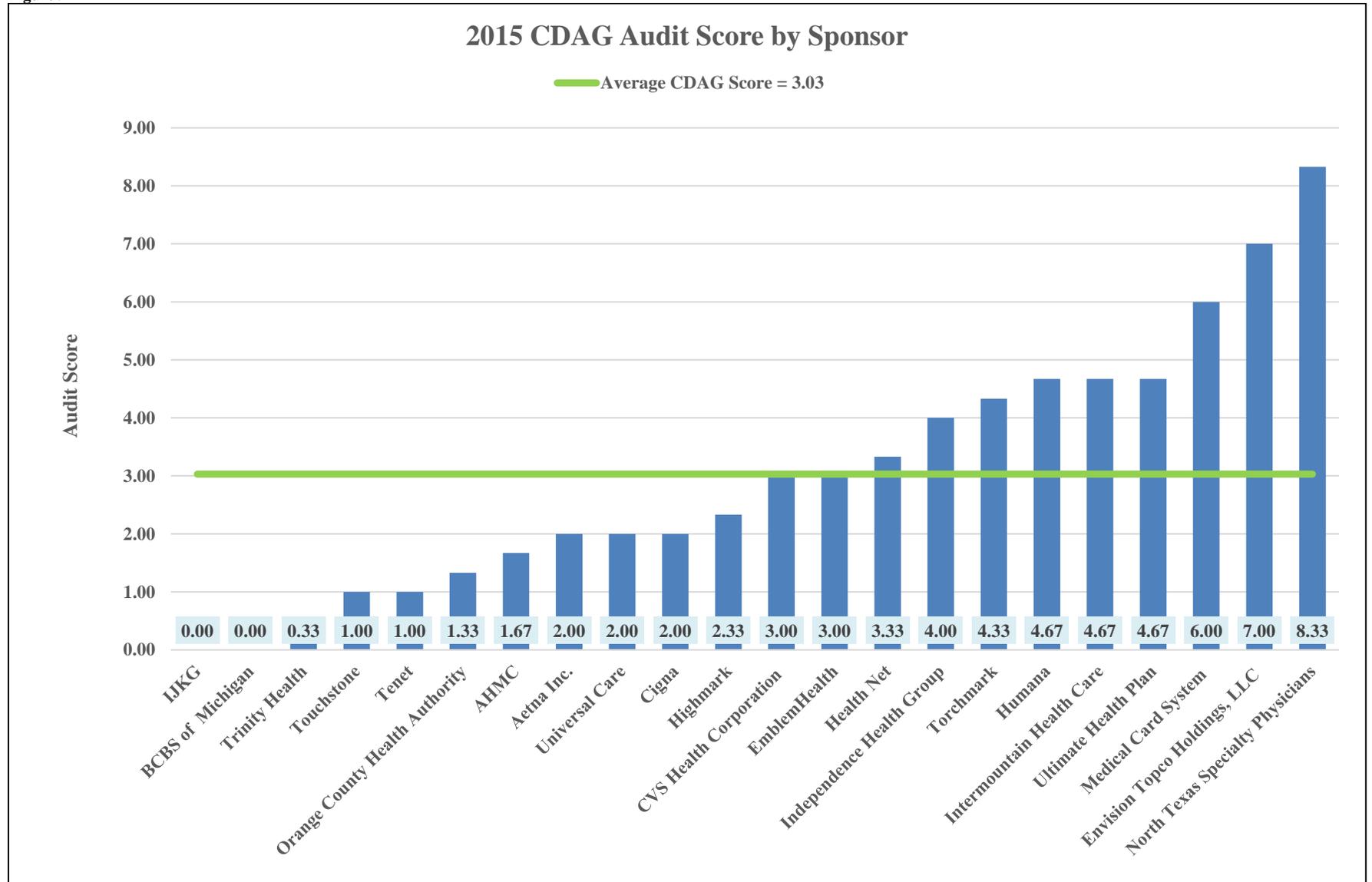
\*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CPE program area in 2015.

Figure 8\*



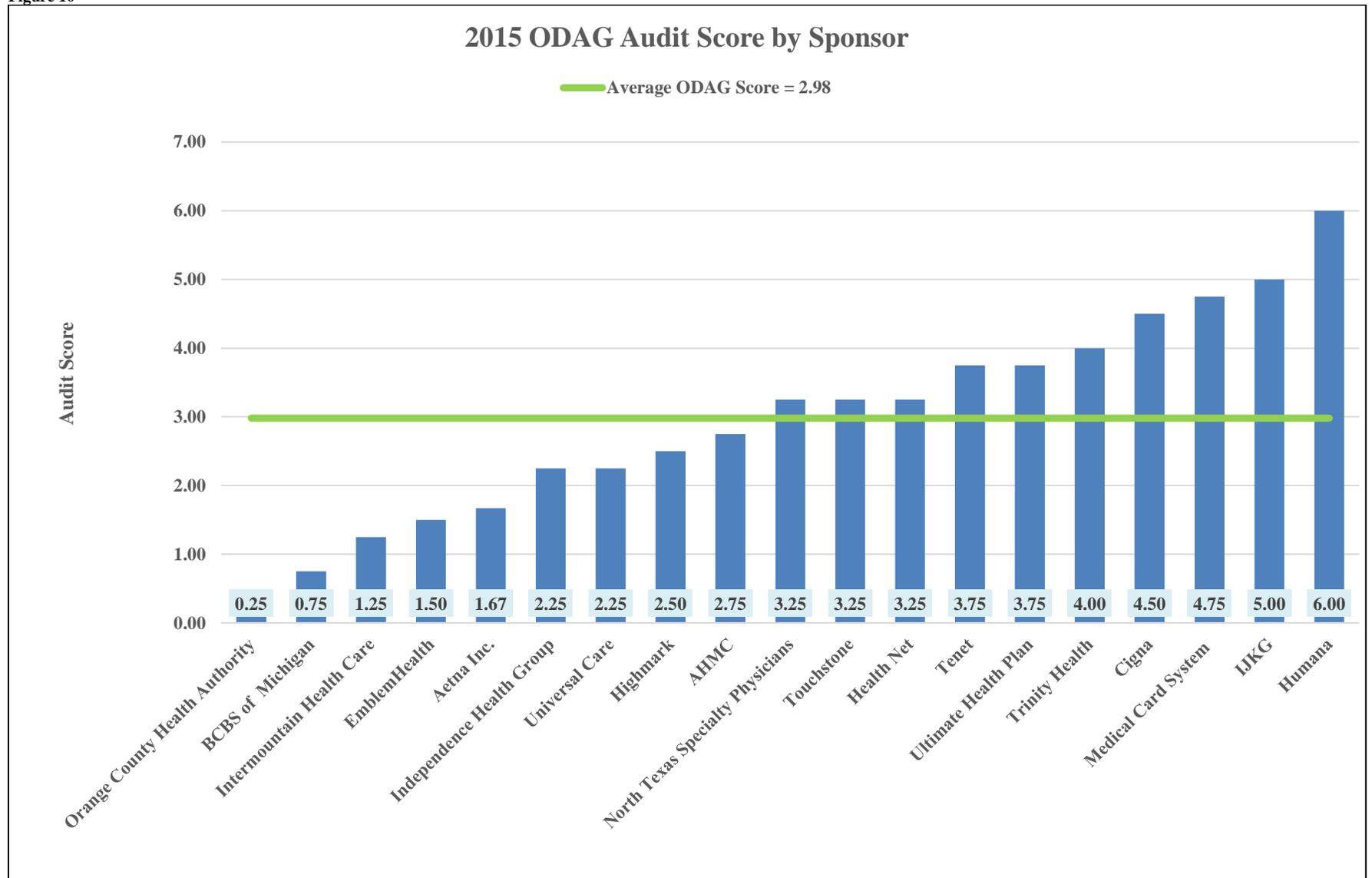
\*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the FA program area in 2015.

Figure 9\*



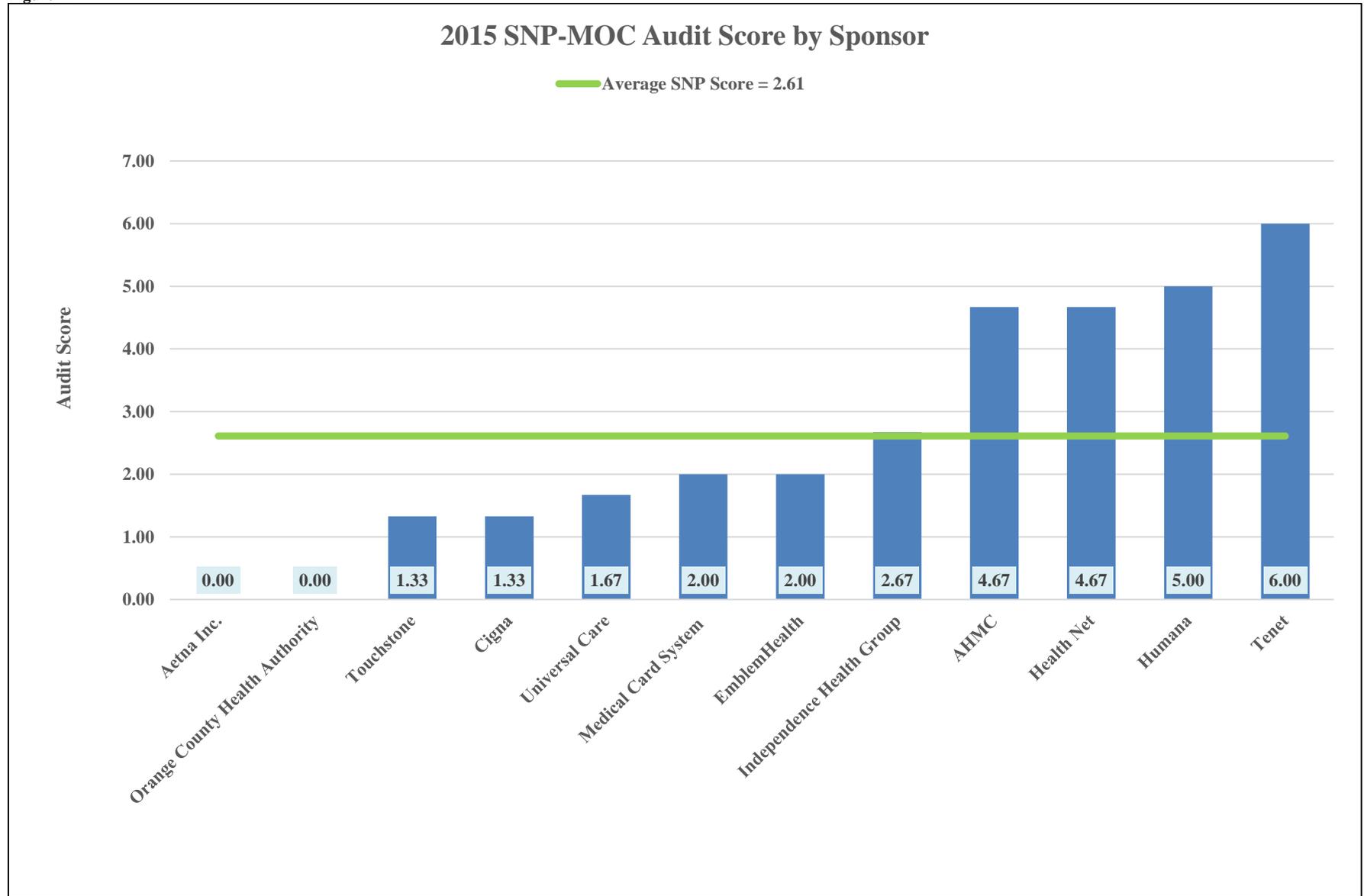
\*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CDAG program area in 2015.

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 2015.

Figure 11\*

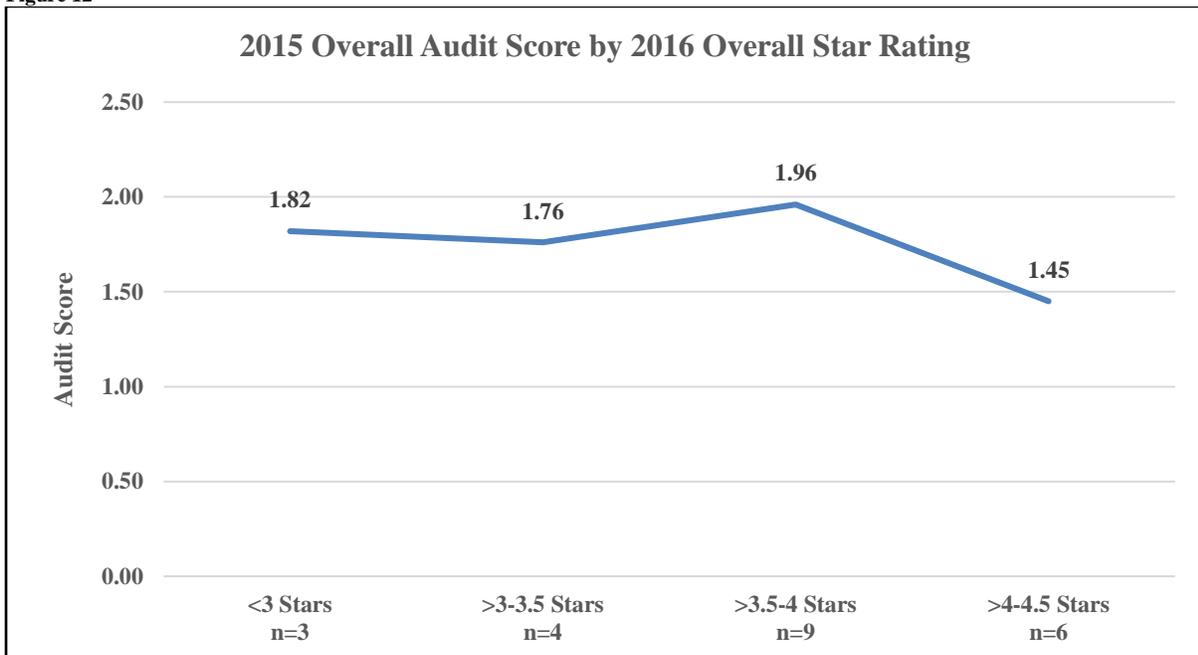


\*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the SNP-MOC program area in 2015.

### 2015 Overall Audit Scores Compared to 2016 Star Rating Data

Figure 12 compares the average audit score from 2015 and an organization's 2016 Star Rating. Sponsors may receive a Star Rating between 1 and 5, five being the best rating. Sponsors are grouped into one of four Star Rating ranges, and then the average overall audit score for plans in that group is calculated. This figure demonstrates that sponsors with the highest Star Ratings (i.e., between 4 and 4.5) among those audited in 2015 performed better than those with average or low Star Ratings. However, the lack of a stronger inverse relationship suggests that program audits reveal unique information about sponsor performance and compliance that other data do not show. This may be because we do not have access to the same amount of CDAG and ODAG data for all sponsors to use in the Star Rating. While Star Ratings remain a valuable measure of quality and beneficiary experience, they evaluate different aspects of sponsors' operations and delivery of the benefit. Therefore, both Star Ratings and audit scores are valuable measures.

Figure 12\*

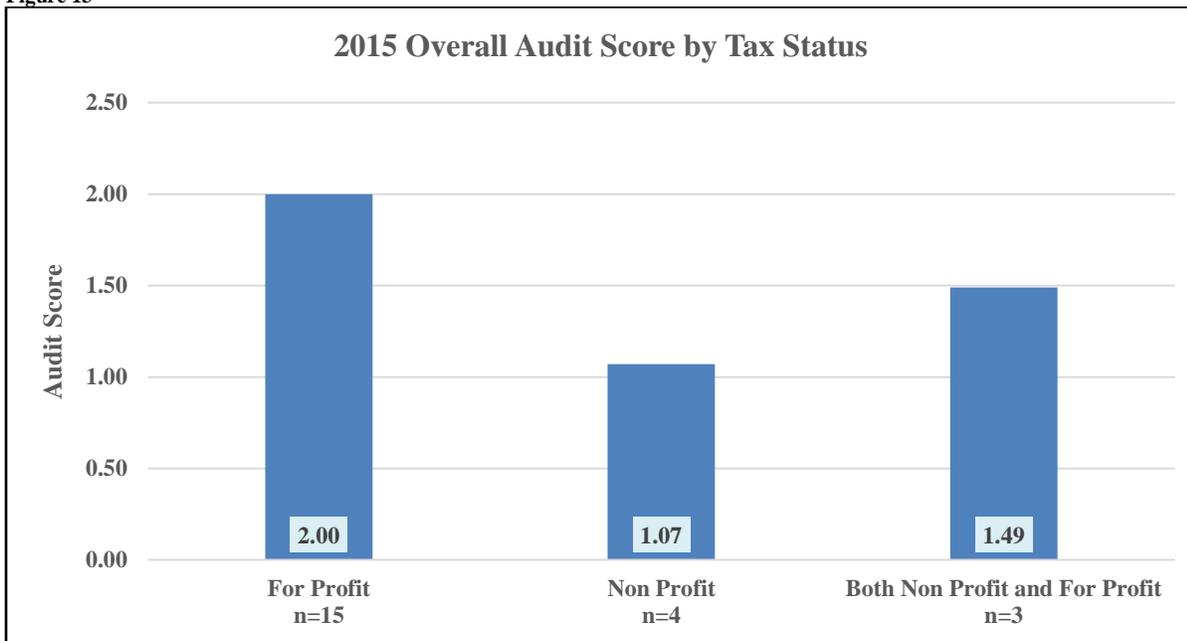


\*Audit and Star Rating scores were analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance.

### 2015 Overall Audit Scores by Tax Status

Figure 13 depicts the 2015 overall average audit scores by tax status (non-profit vs. for-profit), assigned at the contract level. Sponsors were grouped into each category based on all of their offerings under their parent organization, which could include both for-profit and non-profit contracts. The majority of sponsors were either classified as for-profit or as non-profit, but not both. Only three sponsors operated both for-profit and non-profit subsidiaries. Those sponsors with only a non-profit tax status had better overall average audit scores, as was the case in both 2013 and 2014.

Figure 13\*

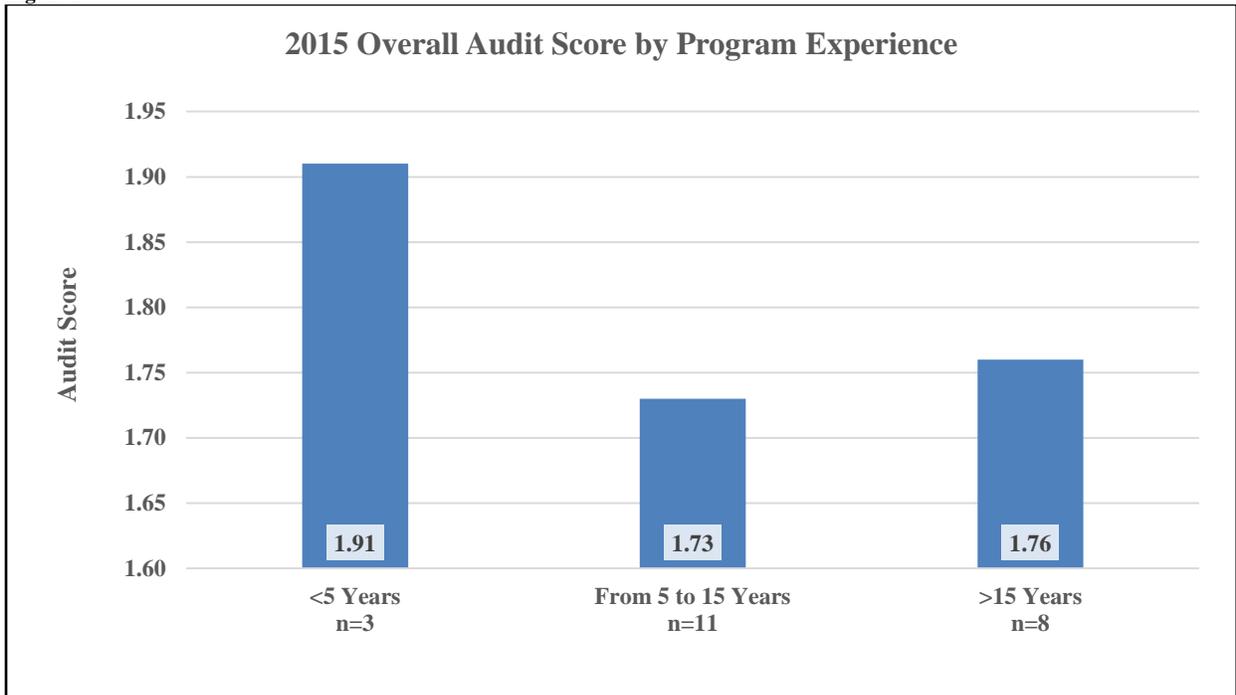


\*Audit scores were analyzed at the sponsor (parent organization) level. The tax status is assigned at the contract level; both for-profit and non-profit contracts can exist under a single parent organization. The average audit score is an unweighted score across all audited sponsors within each tax status group. A lower audit score represents better audit performance.

### 2015 Overall Audit Scores by Program Experience

Figure 14 breaks down the 2015 overall audit scores into three categories, depending on how long a sponsor has had an active Medicare contract, based on a sponsor’s earliest effective contract. For example, if a sponsor has one contract dating back to 2005 and 5 contracts dating back to 2015, they were included in the “5 to 15 years” category below. The audit scores for sponsors operating Medicare contracts from 5 to 15 years and over 15 years are consistent. The sponsors offering Medicare contracts for fewer than 5 years had somewhat higher scores than the other two groups of sponsors (i.e., 1.91 vs. 1.73 and 1.76). There are a number of possible reasons for this difference. It may be that more experienced sponsors have had more time to familiarize themselves with regulatory guidance, operationalize that guidance and, in some cases, may have had the benefit of undergoing previous program audits, giving them an opportunity to remediate deficiencies discovered during those audits.

Figure 14\*

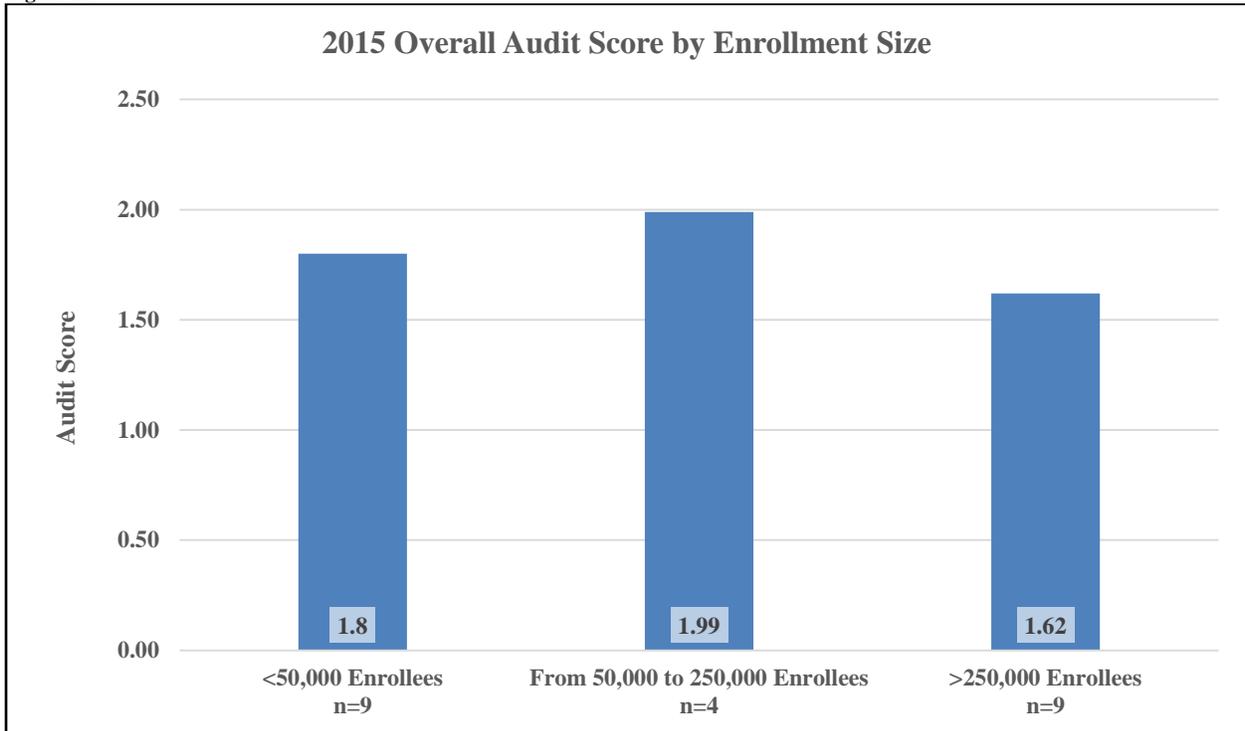


\* Audit scores were analyzed at the sponsor (parent organization) level. The length of time a sponsor has offered a Medicare contract is based on the contract a sponsor has with the earliest effective date. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.

### 2015 Overall Audit Scores by Enrollment Size

Figure 15 displays 2015 overall audit scores by the size of a sponsor’s enrollment. While there is not a significant difference in any of the three groups, larger sponsors did perform slightly better than smaller and medium-sized sponsors.

Figure 15\*

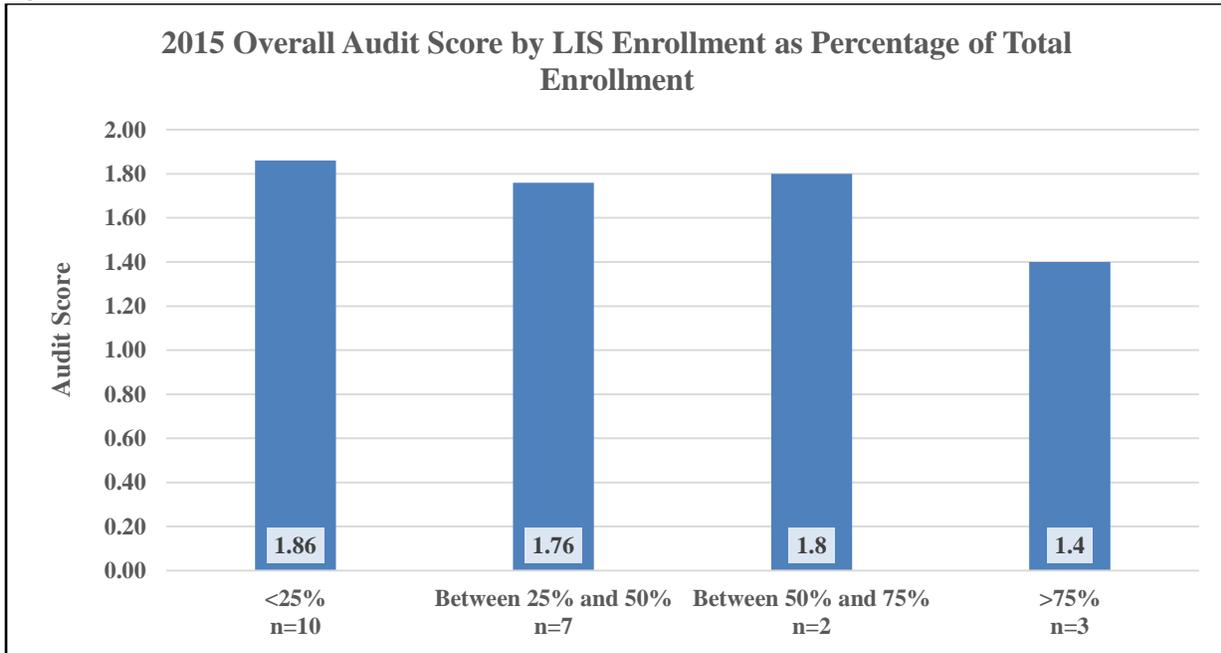


\* Audit scores were analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.

### 2015 Overall Audit Scores by Low Income Subsidy (LIS) Enrollment Percentage

Figure 16 compares average overall audit scores, broken down by the percentage of a sponsor's enrollment that is comprised of LIS beneficiaries. Most sponsors (17 out of 22) have overall enrollments comprised of fewer than 50% LIS beneficiaries, but five operate contracts where LIS beneficiaries are the majority. Across the first three groups of sponsors (i.e., <25%, between 25% and 50%, and between 50% and 75%) the average audit scores are consistent. The group with the lowest (i.e., best) average overall audit score is the group of sponsors with the largest percentage of LIS beneficiaries (up to 99% of total enrollment).

Figure 16\*



\* Audit scores were analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.

## 2015 MOST COMMON CONDITIONS

Tables 3-7 on pages 27-29 list the five most commonly cited conditions in 2015 in each of the five program areas. Several conditions have been a top-5 condition in each of the common conditions lists since 2011. On April 20, 2016, a memo was released through the Health Plan Management System (HPMS) titled “Job Aids Replace the Common Conditions, Best Practice Audit Memos.” These job aids were designed to assist sponsors with some common conditions repeatedly seen year after year. If a condition that a job aid addressed appears in Table 5 or 6, the condition is noted with an asterisk.

In 2015, 22 sponsors were audited for CPE, FA and CDAG, 19 were audited for ODAG, and 12 were audited for SNP-MOC. The percentage of sponsors affected in the tables was calculated from these numbers. That is, for CPE, FA and CDAG, all conditions are a percentage of 22 sponsors; for ODAG, all conditions are a percentage of 19 sponsors. For SNP-MOC, all conditions are a percentage of 12 sponsors. “Citation frequency” indicates the number of times a given condition has appeared in a common conditions list we have compiled (e.g., 4/6) since 2011, and all but the 2014 list were released via an HPMS memo to the industry. It is also important to note that ODAG and SNP-MOC became active as program areas in 2011 and 2013, respectively, and therefore were included in fewer memos. Consequently, all ODAG conditions are out of five, and all SNP-MOC conditions are out of three.

**SPONSOR TIP:** Please pay close attention to the common audit deficiencies listed by program area on the following pages. Understanding the failures of other organizations that operate in the Medicare Advantage and Prescription Drug programs can inform your internal auditing and monitoring efforts. Reviewing these common conditions can identify areas of potential weakness in your own operation. By evaluating your own organization’s compliance around these most common audit deficiencies, you may prevent them from being reflected in your audit report and negatively affecting your Star Ratings!

## CPE Most Common Conditions:

Table 3

Condition Language	Citation Frequency 2011-Present	Percentage of Sponsors Affected 2015
Sponsor did not have an effective system to monitor first tier, downstream related entities' (FDRs') compliance with Medicare program requirements.	3 out of 6	36.3%
Sponsor did not provide evidence that general compliance information was communicated to its first tier, downstream related entities (FDRs).	2 out of 6	27.2%
Sponsor did not have procedures to ensure that its first tier, downstream related entities (FDRs) are not excluded from participation in federal health care programs.	1 out of 6	27.2%
Sponsor's compliance officer or his/her designee does not provide updates on results of monitoring, auditing, and compliance failures (i.e. Notices of Noncompliance to formal enforcement actions) to: <ul style="list-style-type: none"> <li>•compliance committee,</li> <li>•senior executive/CEO,</li> <li>•senior leadership, and</li> <li>•governing body.</li> </ul>	3 out of 6	27.2%
Sponsor did not establish and implement a formal risk assessment and an effective system for routine monitoring and auditing of identified compliance risks.	3 out of 6	27.2%

## FA Most Common Conditions:

Table 4

Condition Language	Citation Frequency 2011-Present	Percentage of Sponsors Affected 2015
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.	6 out of 6	63.6%
Sponsor failed to properly administer the CMS transition policy.	6 out of 6	40.9%
Sponsor improperly effectuated prior authorizations or exception requests.	6 out of 6	40.9%
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved prior authorization edits.	3 out of 6	36.3%
Sponsor failed to properly post its CMS-approved formulary on its website.	1 out of 6	36.3%

## CDAG Most Common Conditions:

Table 5

Condition Language	Citation Frequency 2011-Present	Percentage of Sponsors Affected 2015
Denial letters did not include adequate rationales, contained incorrect/incomplete information specific to denials, or were written in a manner not easily understandable to enrollees.*	6 out of 6	68.1%
Sponsor did not appropriately auto-forward coverage determinations and/or redeterminations (standard and/or expedited) to the Independent Review Entity (IRE) for review and disposition within the CMS required timeframe.	4 out of 6	63.6%
Sponsor did not demonstrate sufficient outreach to prescribers or beneficiaries to obtain additional information necessary to make appropriate clinical decisions.*	6 out of 6	45.4%
Sponsor did not notify beneficiaries or their prescribers, as appropriate, of its decisions within 72 hours of receipt of expedited redetermination requests.	1 out of 6	45.4%
Sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.*	5 out of 6	31.8%

\*The job aids MOEG and the Medicare Enrollment and Appeals Group (MEAG) released via HPMS on April 20, 2016 address this condition.

## ODAG Most Common Conditions:

Table 6

Condition Language	Citation Frequency 2011-Present	Percentage of Sponsors Affected 2015
Sponsor did not notify enrollees and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited organization determination requests.	4 out of 5	57.9%
Denial letters did not include adequate rationales, contained incorrect/incomplete information specific to denials or were written in a manner not easily understandable to enrollees.*	5 out of 5	52.6%
Sponsor inappropriately denied services to beneficiaries and/or payments to providers for services rendered to beneficiaries.	2 out of 5	47.3%
Sponsor did not notify enrollees, and providers when appropriate, of its determinations within 72 hours of receipt of expedited reconsideration requests.	2 out of 5	36.8%
Sponsor did not demonstrate sufficient outreach to providers or to enrollees to obtain additional information necessary to make appropriate clinical decisions.*	5 out of 5	31.6%

\*The job aids MOEG and the Medicare Enrollment and Appeals Group (MEAG) released via HPMS on April 20, 2016 address this condition.

## SNP-MOC Most Common Conditions:

Table 7

Condition Language	Citation Frequency 2011-Present	Percentage of Sponsors Affected 2015
Sponsor did not administer comprehensive annual reassessments within 12 months of the last annual health risk assessments (HRAs).	2 out of 3	66.7%
Sponsor did not provide evidence that it developed individualized care plans (ICP) for beneficiaries.	3 out of 3	58.3%
Sponsor did not review and/or revise individualized care plans (ICPs) consistent with its model of care (MOC) or as warranted by changes in the health status or care transitions of beneficiaries.	1 out of 3	50%
Sponsor administered initial health risk assessments (HRAs) to beneficiaries more than 90 days after their enrollment.	2 out of 3	50%
Individualized care plans (ICPs) do not address issues identified in health risk assessments (HRA).	2 out of 3	41.7%

## **ENFORCEMENT ACTIONS**

In 2015, there were a number of enforcement action referrals based on both 2014 and 2015 audit results, as well as other compliance violations. This section details the number and types of violations, the basis for those actions, and provides additional information about sponsors who were sanctioned and the amount of Civil Money Penalties (CMPs) issued.

CMS has the authority to impose CMPs, intermediate sanctions, and for-cause terminations against Medicare Advantage Organizations, Prescription Drug Plans, PACE Organizations, and Cost Plans. The Division of Compliance Enforcement (DCE) in MOEG is responsible for imposing these types of enforcement actions when a sponsor is substantially non-compliant with CMS contract requirements. Sponsors that significantly failed to comply with Medicare Parts C and D requirements received an enforcement action. All enforcement actions may be appealed either to the Departmental Appeals Board (CMPs) or to a CMS hearing officer (intermediate sanctions and terminations).

DCE works closely with the Department of Health and Human Services Office of General Counsel, the Office of Inspector General, and the Department of Justice to clear all enforcement actions prior to issuance. Enforcement actions are publicly posted on the Part C and Part D Compliance and Audits website.<sup>1</sup> When referrals involve suspected fraud, waste, and abuse, the information is immediately referred to the Center for Program Integrity for investigation.

## **ENFORCEMENT ACTIONS IMPOSED BASED ON 2015 REFERRALS**

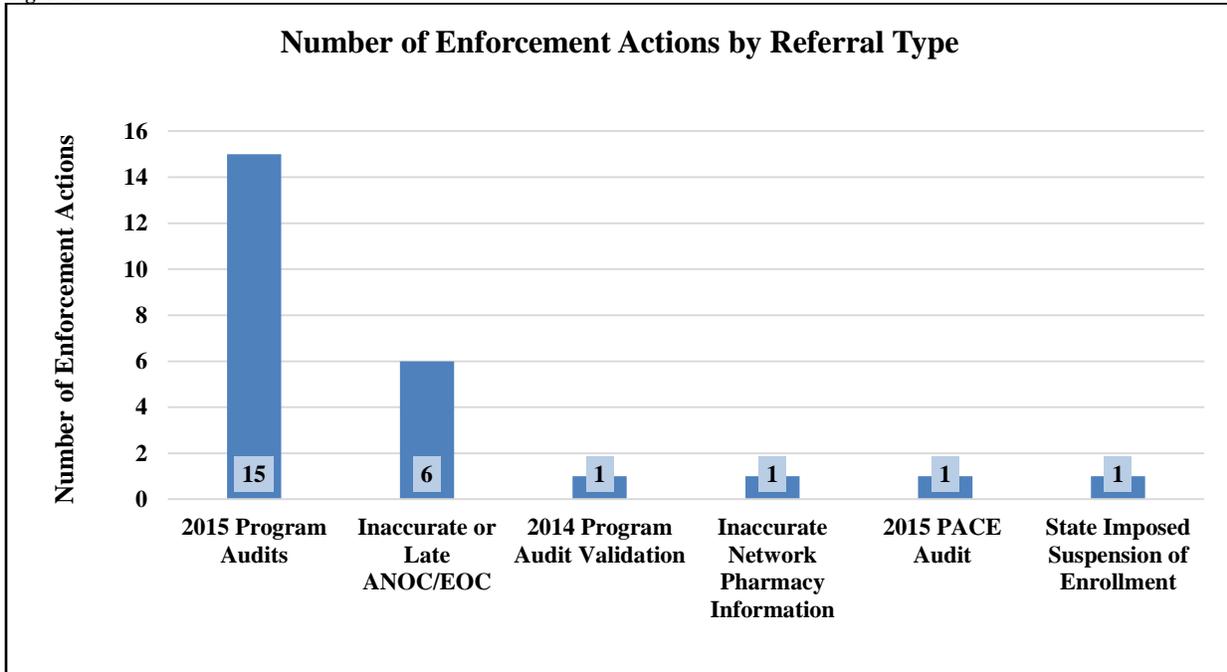
This section provides information on enforcement actions taken in calendar year 2015 or early 2016 due to non-compliance detected in 2015 program audits. DCE imposed 25 enforcement actions: 5 intermediate sanctions and 20 CMPs. There were no for-cause terminations in 2015.

Referrals of non-compliance are made for a variety of reasons. Approximately 60% of the referrals were for non-compliance found during program audits. Other non-compliance findings that commonly resulted in enforcement referrals include erroneous or late Annual Notice of Change/Evidence of Coverage documents (ANOC/EOC), PACE audit deficiencies, inaccurate pharmacy network directories, and state enforcement actions that affect an organization's ability to comply with CMS requirements. Figure 17 below displays the number of enforcement actions by referral type.

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<sup>1</sup> <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html>

Figure 17



### Civil Money Penalties (CMPs)

We imposed \$10.3 million in CMPs, with an average of \$516,163 per CMP. The highest CMP amount imposed was \$3,100,000, and the lowest amount imposed was \$30,000. The following chart shows the sponsors that received a CMP based on 2015 referrals:

Table 8

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
04/16/2015	Aetna Inc.	Inaccurate Network Pharmacy Information	\$1,000,000
07/09/2015	New West Health Services	2014 Program Audit Validation	\$204,200
07/13/2015	Atrio Health Plans	Inaccurate ANOC/EOC	\$69,405
07/13/2015	Fallon Community Health Plan	Inaccurate ANOC/EOC	\$52,045
07/14/2015	Indiana University Health Plans, Inc.	Inaccurate ANOC/EOC	\$101,675
07/14/2015	The Carle Foundation	Inaccurate ANOC/EOC	\$34,445
07/14/2015	UnitedHealthCare of New York, Inc.	Late ANOC/EOC	\$149,150
08/03/2015	Health Net of Arizona, Inc.	Inaccurate ANOC/EOC	\$227,450
11/19/2015	Envision Insurance Company	2015 Program Audit	\$2,596,700
11/20/2015	SilverScript Insurance Company (CVS Health Corporation)	2015 Program Audit	\$594,100
11/23/2015	Care N <sup>2</sup> Care Insurance Company, Inc. (North Texas Specialty Physicians)	2015 Program Audit	\$327,100

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
11/23/2015	SelectHealth, Inc. (Intermountain Health Care, Inc.)	2015 Program Audit	\$174,800
12/29/2015	Independence Health Group, Inc.	2015 Program Audit	\$206,400
12/29/2015	Humana, Inc.	2015 Program Audit	\$3,100,900
12/29/2015	Medical Card System, Inc.	2015 Program Audit	\$652,650
02/24/2016	Trinity Health	2015 Program Audit	\$30,000
02/24/2016	Universal Care, Inc.	2015 Program Audit	\$62,950
02/24/2016	AHMC Central Health Plan of California, Inc.	2015 Program Audit	\$153,850
02/29/2016	Tenet Healthcare Corporation	2015 Program Audit	\$127,200
02/29/2016	Health Net, Inc.	2015 Program Audit	\$458,250

The nature and scope of the violation(s) determined the total CMP a sponsor received. A standard CMP amount was calculated for each deficiency cited in a CMP notice, based on either a per-enrollee or a per-determination basis. CMS may have either increased or decreased a sponsor's CMP by applying aggravating or mitigating factors to certain deficiencies:

- *Aggravating Factors:* For example, the standard penalty for a deficiency for a contract may increase if the violation involved drugs where treatment should not be delayed, expedited cases, a prevalence of failed audit samples, the existence of a top-5 common findings condition, and/or a history of prior offense.
- *Mitigating Factors:* For example, the standard CMP amount for a violation may decrease if the beneficiary received the drug on the same day (after an initial rejection at the point of sale) or the enrollment based penalty cap per condition of non-compliance were reached.

There were 20 CMPs imposed for 83 violations<sup>2</sup>:

- 71 on a per-enrollee basis resulting in \$9,731,570 (94% of the total CMP amount).
- 12 on a per-determination basis resulting in \$591,700 (6% of the total CMP amount).

Figure 18 and Figure 19 show the total number of violations and dollar amount of violations by calculation type, including CMPs taken in 2015 and 2016 as a result of all referrals from CMS components and from 2015 program audits.

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<sup>2</sup> These numbers include CMPs from program audits, but also CMPs for late or erroneous ANOC/EOCs, PACE audit deficiencies, inaccurate pharmacy network directories, and state enforcement actions that affect an organization's ability to comply with CMS requirements. The figures on page 36 include only those CMPs related to program audits.

Figure 18

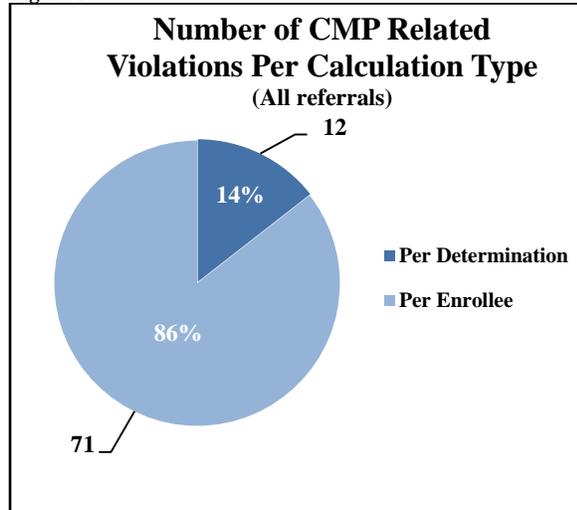
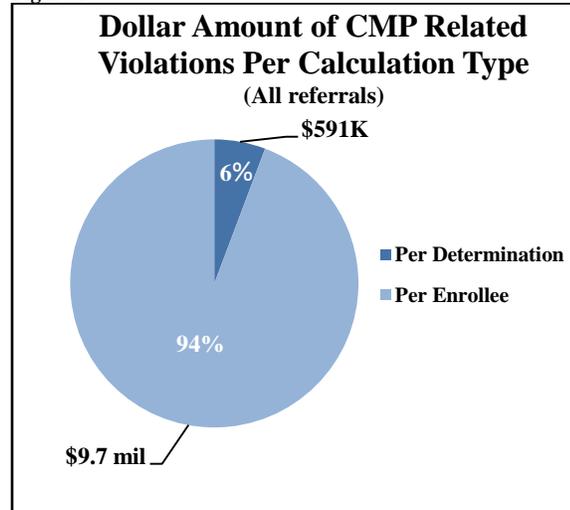


Figure 19



### Intermediate Sanctions

Intermediate sanctions suspend the sponsor’s ability to market to or enroll new beneficiaries, or to receive payment for new enrollees. CMS imposed the following five intermediate sanctions based on 2015 referrals:

Table 9

Date of Imposition	Organization Name	Basis for Referral	Type of Intermediate Sanction	Date the Limited Marketing & Enrollment Period (LMEP) Began	Date of Intermediate Sanction Release
03/12/2015	HealthPlus of Michigan	State Imposed Suspension of Enrollment	Immediate Suspension of Enrollment	Not Eligible	76 days – released 5/27/2015
07/17/2015	Torchmark Corporation	2015 Program Audit	Non-Immediate Suspension of Enrollment & Marketing	-----	265 days – released 4/7/2016
11/17/2015	Alexian Brothers Community Services	2015 Focused Audit Results	Immediate Suspension of Enrollment	Not Eligible	Unilateral termination effective 4/30/2016
01/21/2016	Cigna-HealthSpring	2015 Program Audit	Immediate Suspension of Enrollment & Marketing	-----	TBD
02/26/2016	Ultimate Health Plans, Inc.	2015 Program Audit	Immediate Suspension of Enrollment & Marketing	-----	TBD

HealthPlus of Michigan had two contracts placed under sanction. This sponsor elected not to renew one of the contracts (H1595), effective the end of calendar year 2015. Torchmark Corporation corrected the operational deficiencies that were the basis for their sanctions and were able to demonstrate operational compliance by successfully passing CMS-directed validation exercises. Alexian Brothers Community Services requested to unilaterally terminate PACE contract number H2609 and cease all operations by April 30, 2016. Although Alexian Brothers chose to end their contract with CMS, the enrollment sanction remained effective until the final date of the unilateral termination. CIGNA-HealthSpring and Ultimate Health Plans, Inc. are currently under intermediate enrollment and marketing sanctions and are working to remediate their deficiencies.

### **Independent Auditor Validation**

Each sponsor under intermediate sanctions is required to select and hire an independent auditor to conduct a validation audit at the sponsor's expense. CMS recommends sponsors hire an independent auditor early in the sanction process. The independent auditor will audit the sponsor using CMS' audit protocols, draft a report that details the findings from the audit, and submit the report to CMS. CMS will use information gathered during the sanction process and the results of the audit validation to determine whether the sponsor should be released from intermediate sanctions.

### **Limited Marketing and Enrollment Period**

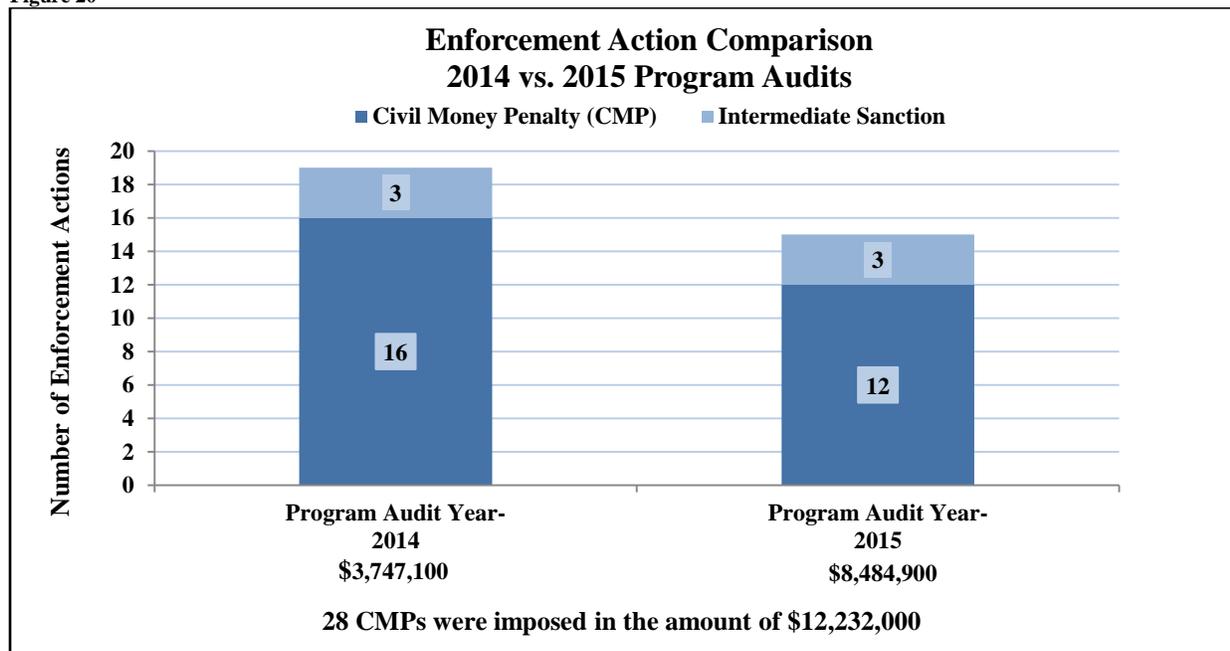
Sponsors under intermediate sanctions may request to engage in a test period of accepting enrollments or marketing for a limited period. CMS may grant the request when the sponsor has fully implemented its corrective action plan, demonstrated the effectiveness of the corrections through self-monitoring and regular status reporting to CMS, and attested to the correction of its deficiencies. Sponsors are also required to submit the Independent Auditors' validation audit work plan, which CMS will review and approve prior to granting the limited marketing and enrollment period.

## ENFORCEMENT ACTIONS RELATED SPECIFICALLY TO 2015 PROGRAM AUDITS

This section provides additional details on the enforcement actions taken related to the 2015 program audits and compares these enforcement actions to those from the 2014 program audits. For full details of the enforcement actions taken related to 2014 program audits, please see the 2014 Part C and Part D Program Annual Audit and Enforcement Report.

There were 23 organizations audited during 2015.<sup>3</sup> Of those 23, 15 (65%) received an enforcement action. Figure 20 compares the cumulative CMP amounts and types of enforcement actions imposed on sponsors for the 2014 and 2015 program audits.

Figure 20



Although more sponsors received CMPs based on results from the 2014 program audits, the total CMP amounts for 2015 audits are significantly higher. Despite providing best practices to assist sponsors for a number of years, CMS continues to see similar problems. Therefore, an aggravating factor/amount was added to the standard penalty in an effort to increase compliance. Improvements in the audit process were also made to obtain more accurate beneficiary impact data from sponsors.

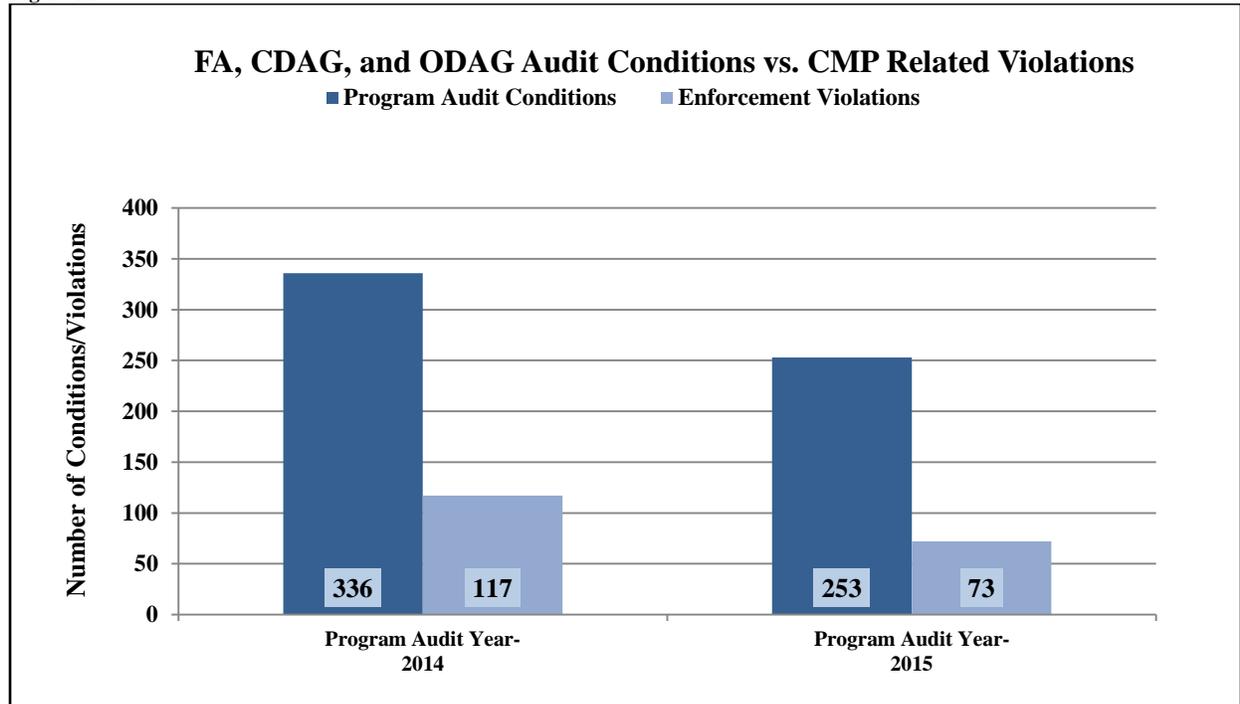
<sup>3</sup> In total, MOEG conducted 23 audits in 2015; however, only 22 were full scope, routine audits. All other sections of this report, besides the enforcement section, are based on and reference the 22 full-scope, routine audits. The enforcement section also includes one targeted audit that yielded results (in terms of audit scores, etc.) that are not comparable with those of the other 22.

In addition, the beneficiary impact data are now validated for FA violations. This process ensures the accuracy and reliability of the information used to calculate per-enrollee penalties for FA violations. Additional areas of beneficiary impact data will be validated in the future.

### Program Audit CMPs

Most sponsors received CMPs for non-compliance in the program areas of FA, CDAG, and ODAG because their actions adversely affected (or had the substantial likelihood of adversely affecting) one or more enrollees. Figure 21 compares the number of conditions cited in FA, CDAG, and ODAG from 2014 and 2015 program audits to the number of violations that were included in the basis for taking CMPs. Thirty-five percent of conditions found in FA (39), CDAG (48), and ODAG (30) were cited in a CMP for 2014 program audits. Twenty-nine percent of FA (25), CDAG (27), and ODAG (21) conditions were cited in a CMP for 2015 program audits.

Figure 21



For 2015 program audits, CMPs were imposed for 73 violations:

- 9 on a per-determination basis resulting in \$387,500 (5% of the total CMP amount).
- 64 on a per-enrollee basis resulting in \$8,097,400 (95% of the total CMP amount).

Figure 22 shows the average number of CMP violations by program area for 2014 and 2015 program audits. On average, sponsors received about the same number of audit conditions in 2014 and 2015. The number of FA, CDAG, and ODAG violations slightly decreased in number between program audit years 2014 and 2015.

Figure 22

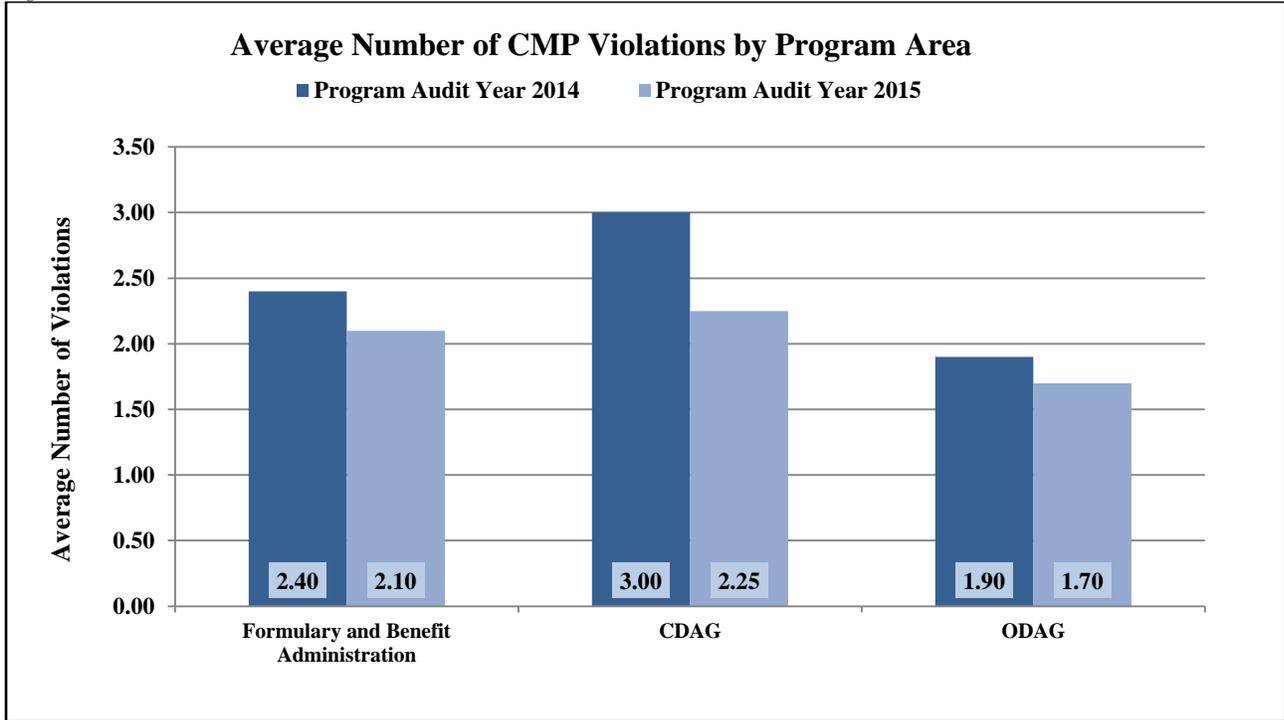


Figure 23 and Figure 24 show the total number of CMP related violations and cumulative CMP related violation dollar amounts by calculation type resulting from the 2015 program audits (CMPs resulting from other types of referrals are not included).

Figure 23

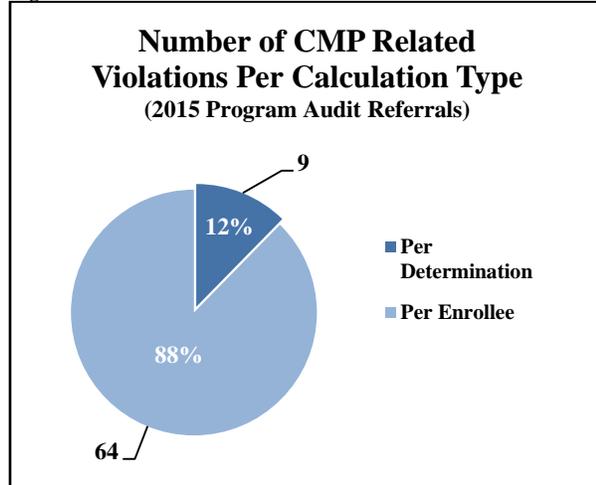
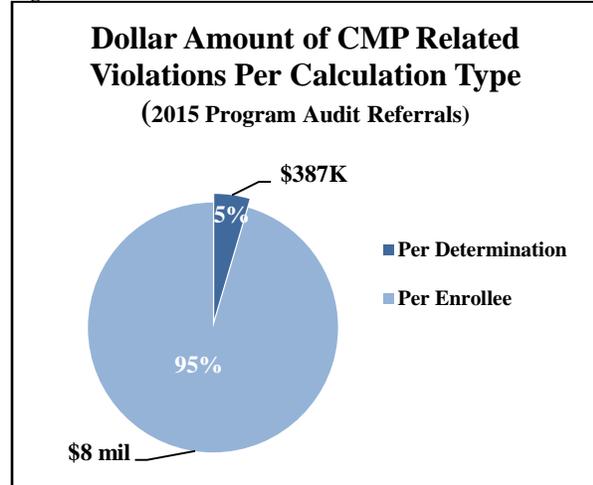


Figure 24

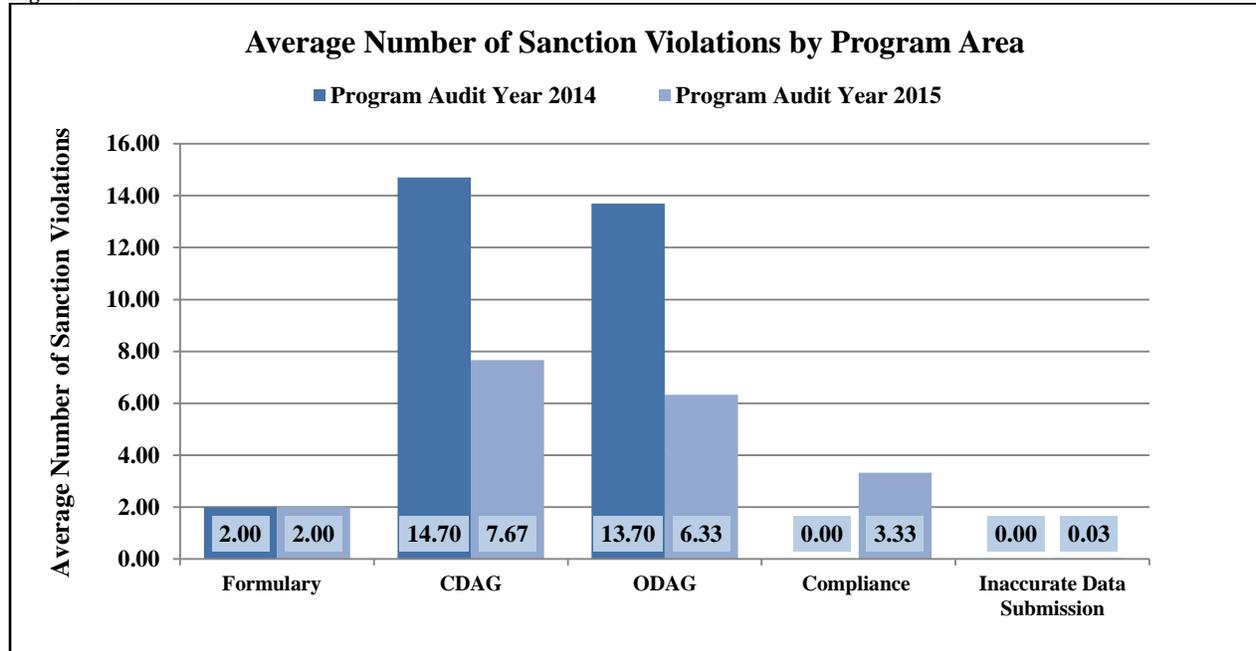


CMS also continued to reduce the timeframe for issuing CMPs by improving the referral process and the processes for analyzing enforcement cases. For program audit year 2015, the number of days between the final audit report and CMP issuance was 50 days. This number improved from 57 days in program audit year 2014, a 12% reduction.

### Program Audit Intermediate Sanctions

Intermediate sanctions for systemic operational failures in FA, CDAG, and ODAG were also issued. These actions protect current and future beneficiaries when there is evidence a sponsor has substantially failed to carry out the terms of its contract with CMS. Immediate intermediate sanctions are imposed if there is a serious threat or potential for a serious threat to an enrollee's health and safety, such as denying or delaying access to medications or services. Figure 25 shows the average number of sanction violations by program area for 2014 and 2015 audits.

Figure 25



For intermediate sanctions, the number of violations by program area remained the same for FA violations for the two years. However, there was a significant decrease in the number of CDAG and ODAG violations. Increased transparency of audit protocols, audit process improvements, CMS’ enforcement actions and sponsors’ responsiveness to CMS guidance have all helped to drive improvements in performance overall. There were no deficiencies related to compliance program effectiveness or inaccurate data submissions included in the intermediate sanctions taken for 2014 program audits.

## APPEALS

Sponsors have the right to appeal CMPs, intermediate sanctions, and termination actions by CMS. For CMPs, appeal requests must be filed no later than 60 days after receiving the CMP notice. If the sponsor does not appeal, the CMP is final and due for payment. For intermediate sanctions and terminations, appeals must be filed no later than 15 days after receiving the enforcement or termination notice. An appeal does not delay the imposition of the sanction, but it will delay the imposition of a termination unless there is imminent and serious risk to the health of the enrollees.

In 2015, two enforcement actions were appealed. One involved an intermediate sanction, and the other a CMP. The sponsor that challenged CMS’ decision to impose an intermediate sanction later rescinded its appeal and remains under sanction. The sponsor that filed the CMP appeal has since settled with CMS.

## **2016 AUDIT PROCESS IMPROVEMENTS**

Our primary goal in 2016 remains to enhance the consistency among audits and strengthen the expertise of audit teams. We believe that by continuing to build auditor expertise, we are better suited to collaborate with and provide technical assistance to the industry, and aid in improving performance. The following initiatives and process improvements were implemented in 2016 or are underway for 2017:

- Streamlined audit protocol and process documents by removing requests for extraneous detail that were collected in previous years but were not essential to complete the audit. This revision reduces burden on sponsors.
- Continued to strengthen the Program Audit Consistency Teams (PACTs) by more actively engaging with central office, regional office and contractor support staff. Recently, decision trees were developed for use by all PACT members in determining if a condition of non-compliance should be a CAR or an ICAR, or classified as an observation. These audit tools continue to refine our audit process and bolster CMS auditors' knowledge and consistency.
- Began development of MMP-specific protocols in 2016 to evaluate MMP-specific requirements in the processing of organization determinations, appeals and grievances as well as the specific requirements MMPs have around their Model of Care and Care Coordination. These protocols will be ready for use in 2017.
- Provided sponsors with a preliminary draft report prior to the exit conference. This report detailed the preliminary conditions, observations, and best practices noted during the audit, which enabled sponsors to take any necessary corrective actions more quickly.
- Transitioned to fully integrated audio/video webinar technology that allowed for a seamless review. In addition, it provided for more secure control over the audit webinar to protect sponsors' proprietary operations.
- Updated processes to solicit feedback about the audit. In 2016, a survey was issued following the final audit report, as opposed to the draft audit report, to allow sponsors the opportunity to provide CMS with feedback on the entirety of the audit process.

## **CONCLUSION**

We have greatly increased the level of transparency with respect to our audit materials, performance and results, including any enforcement actions. We believe that program audits and consequences of possible enforcement actions are continuing to drive improvements in the industry and are increasing sponsors' compliance with core program functions in the MA and Part D program. We hope that sponsors will utilize the information contained in this report to inform their internal auditing, monitoring and compliance activities. We look forward to continued collaboration with the industry and developing new approaches to assist with achieving compliance.