



2017 Part C and Part D Program Audit and Enforcement Report

**Medicare Parts C and D Oversight
and Enforcement Group
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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. Regular and consistent auditing of these organizations (referred to as sponsors) 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 Program Audit and Enforcement Report emphasizes pertinent analyses and information sponsors and other stakeholders can adopt to continue improving performance within their respective organizations. Furthermore, the report conveys the initiatives undertaken by CMS to advance the transparency, accuracy, and reliability of the entire audit cycle. Highlights of this year's report include:

➤ **Audit Landscape**

The sponsors audited by CMS in 2017, which was the third year of the current audit cycle, cover approximately 16% of beneficiaries enrolled in the MA and Prescription Drug programs. This brings the total percent of beneficiaries covered in the current audit cycle to 93%.

➤ **Audit Innovations and Process Improvements**

CMS continually engages in efforts to improve audits by soliciting sponsor feedback on our audit protocols and processes. The feedback led to CMS making the following enhancements in 2017:

- Releasing the 2017 audit protocols for two public comment periods;
- Utilizing Program Audit Consistency Teams (PACTs) to review and consistently classify conditions of non-compliance in a streamlined manner;
- Reducing burden placed on sponsors undergoing an audit by:
 - Basing the audit review periods for Part D Coverage Determinations, Appeals, and Grievances and Part C Organization Determinations, Appeals, and Grievances on the size of a sponsor's enrollment; and
 - Streamlining the Compliance Program Effectiveness audit protocol to evaluate a sponsor's Medicare compliance program through its demonstration of prevention, detection, and correction activities.

➤ **Summary of 2017 Audit Results and Analyses**

The data analyses resulting from the 2017 program audits show the following:

- Changes in overall audit scores from 2016 to 2017:
 - The average overall audit score decreased from 1.22 in 2016 to 1.10 in 2017
- Changes in audit scores by program area from 2016 to 2017:
 - Average program area scores decreased from 2016 to 2017 in four of the five individual program areas
- Identification of the most commonly cited conditions of non-compliance in 2017:
 - The common conditions lists feature two conditions that were never previously among the most common conditions
 - Sponsor failed to identify and process enrollee complaints and disputes as grievances
 - Sponsor failed to reimburse enrollees within 60 days of making favorable reimbursement reconsiderations
- Identification of the most commonly cited Immediate Corrective Action Required (ICAR) conditions in 2017:
 - Of the five conditions listed, two were in the program area of Coverage Determinations, Appeals, and Grievances, two were in the program area of Organization Determinations, Appeals and, Grievances, and one was in the program area of Part D Formulary and Benefit Administration

➤ **Audit Enforcement Actions**

CMS provides information about the sponsors that received an enforcement action resulting from violations discovered during monitoring and audits conducted by CMS. CMS summarizes the number and types of enforcement actions taken, such as Civil Money Penalties (CMPs) and intermediate sanctions, the basis for those actions, the amounts of the CMPs, and the number of violations included in CMPs. For instance, CMS imposed 24 CMPs totaling \$2.9 million and three intermediate sanctions against sponsors for non-compliance identified in 2017. For program audits, CMS also presents year-to-year analyses of the number and amounts of CMPs imposed, shows correlations between audit conditions and enforcement violations, and identifies the average number of CMP violations by program area. For example, there was one more CMP imposed for 2017 program audits compared to 2016 (i.e., 18 in 2017 vs. 17 in 2016).

As part of our commitment to industry-wide improvement, we continue to refine and improve our audit processes and audit tools. We recognize the importance of collaboration and clear communication with sponsors and external stakeholders to assist the industry with its own process improvement initiatives.

Our fundamental mission is to ensure enrollees have adequate access to health care services and medications. Through improving the operational activities encompassed in MA and PDP program audits, we remain committed to achieving that goal.

INTRODUCTION

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

MOEG, which is in the Center for Medicare (CM), conducts program audits to evaluate sponsors' delivery of health care services and medications to Medicare beneficiaries enrolled in the Part C and Part D programs. When program audits identify systemic non-compliance, sponsors are required to undergo validation audits to ensure correction of cited deficiencies. In addition to conducting program audits, MOEG also develops, maintains, and oversees the requirement for each sponsor to have an effective compliance program implemented within its organization, including compliance with key fraud and abuse program initiatives. CMS' enforcement authorities allow us to impose CMPs, intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and for-cause contract terminations.

This report summarizes MOEG's audit-related activities, including the scope of audits and the audit selection process, for the 2017 audit year. It also discusses the current audit landscape, audit process improvements, results of data analyses from 2017 audits, the most common conditions found during audits, and a summary of enforcement activities.

In several areas of the report, there are text boxes entitled "Sponsor Tips." These tips provide information on how a sponsor can use the information in that section of the report to inform its own compliance and audit activities.

AUDIT SCOPE AND SPONSOR SELECTION

In order to conduct a comprehensive audit of a sponsor's operation and to maximize Agency resources, CMS conducts program audits at the parent organization level. The 2017 program audits evaluated 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)

Each sponsor was audited in all program areas, unless a protocol was not applicable to its operation. For example, if a sponsor did not operate a SNP plan, then a SNP-MOC audit was not performed. Likewise, a standalone PDP would not have the ODAG protocol applied, since it does not offer the MA benefit.

In addition, CMS piloted protocols for the following program areas:

- Medication Therapy Management
- Medicare-Medicaid Plan (MMP) Service Authorization Requests, Appeals and Grievances (SARAG)
- Medicare-Medicaid Plan (MMP) Care Coordination and Quality Improvement Program Effectiveness (CCQIPE)

Since these program areas were pilots, the results of these audits are excluded from this report.

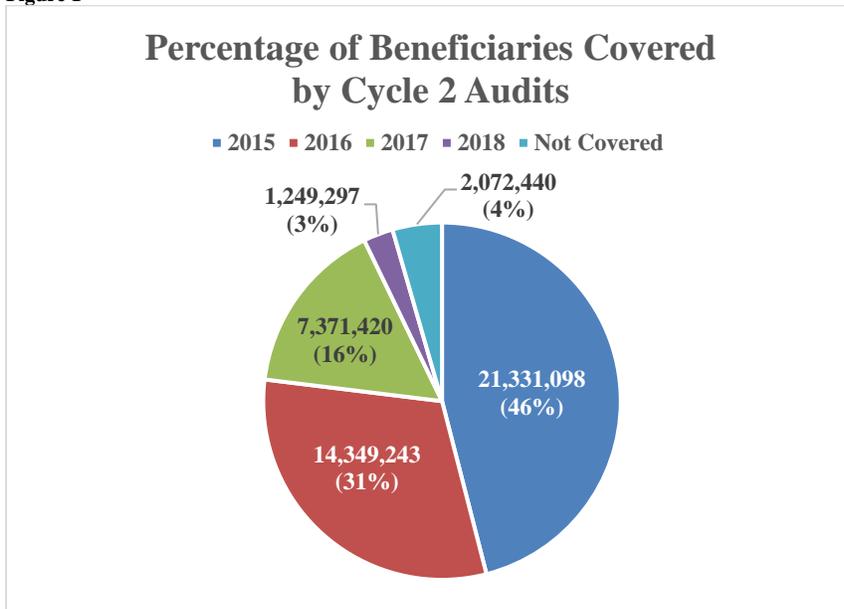
Sponsor selection for audit relies on a number of sources, including the yearly risk assessment. The risk assessment is data-driven and uses various data related to the Medicare Parts C and D programs, as well as other operational information (e.g., large enrollment growth in a short period of time) to identify the level of risk of each sponsor.

Other factors in the selection process include audit referrals (from Regional Offices and/or Central Office) and whether a given sponsor underwent a program audit in the current audit cycle. Consequently, some of the sponsors selected for audit in a given year may not always be the highest-risk, as calculated by the risk assessment.

CURRENT PROGRAM AUDIT LANDSCAPE

The figures below show the progress of program audits on Parts C and D by enrollment and percentage of sponsors audited. These figures are based on enrollment and parent organization data as of February and March 2018 and include all coordinated care plans (CCPs), private fee-for-service (PFFS) plans, 1876 cost plans, standalone prescription drug plans (PDPs), and employer group waiver plans (800 series).

Figure 1*



* These enrollment data are summed by parent organization at the contract level. All contracts active in 2018 that are associated with sponsors that were audited in 2017 are reflected in this chart.

The sponsors audited in 2017 account for 16% (i.e., roughly 7.37 million beneficiaries) of the total MA, other Medicare managed care health plan, and PDP enrollment (Figure 1).

Approximately 93% of all Part C and Part D enrollees were covered in part by auditing sponsors with a large number of enrollees during the first three years of this audit cycle. This number will increase to approximately 96% once 2018 program audits are complete.

While the sponsors audited from 2015 to 2017 represent 93% of all enrollment, they represent 42% of the sponsors with currently active Medicare contracts. By the end of 2018, the final year of the second audit cycle, this number will increase to roughly 59% (Figure 2). Over time, some audited sponsors have been acquired by other organizations or have terminated their Medicare contracts. Figures 1 and 2 represent only those organizations (and associated enrollments) that still operate Medicare contracts. For instance, while Figure 2 shows 16 sponsors being audited in 2015, in reality we actually audited 22. In addition, while we conducted 39 audits in 2017, Figure 2 reflects 34 sponsors because two sponsors audited in 2017 are no longer in operation, one

sponsor was subject to both a routine and a focused audit, and one sponsor had its contracts audited in three separate audits. The number of separate parent organizations audited in 2017 was 36.

Figure 2

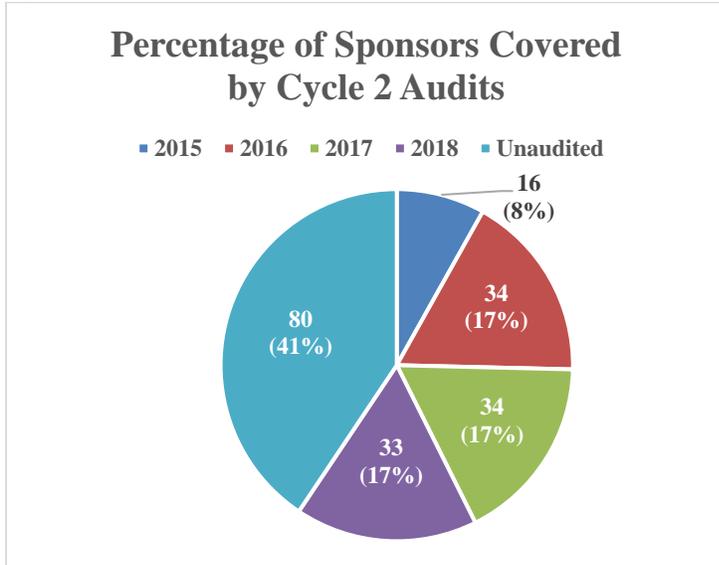


Figure 3 on the following page shows the percentage of Medicare beneficiaries in each state that were covered by the program audits conducted in 2017. The largest percentage of enrollees audited in any one state or territory was approximately 33% (note that these enrollment data are at the plan level, whereas all other figures (e.g., Figure 1) reporting on enrollment in this document are at the contract level). Figure 4 on page 9 depicts the percentage of plans in each state included in 2017 program audits.

AUDIT LIFECYCLE

The lifecycle of an audit begins the day a sponsor receives an engagement letter and concludes with the sponsor's receipt of an audit closeout letter. The average amount of time to complete various post-audit fieldwork activities is below in Table 1.

Table 1

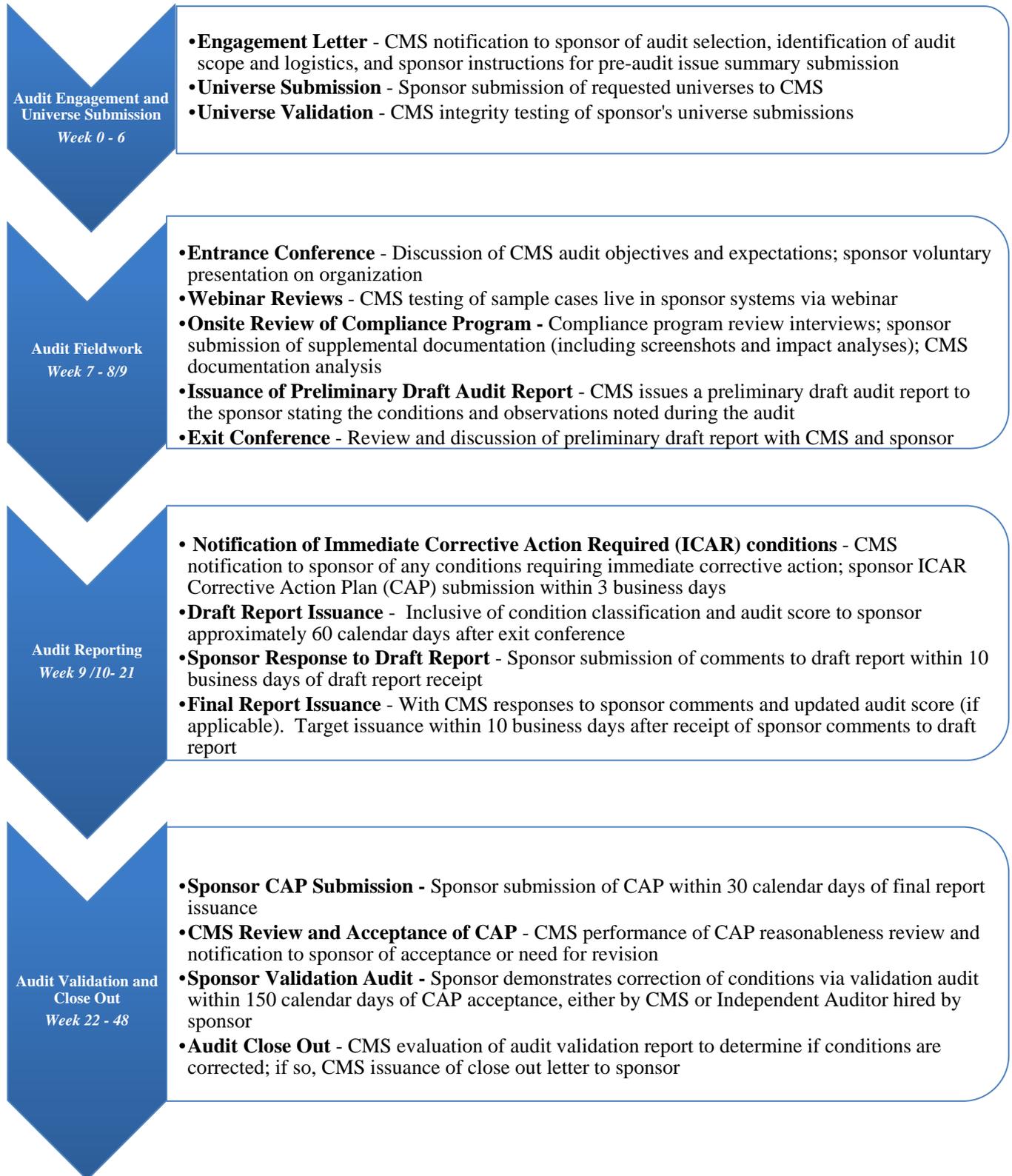
Audit Phase	2016	2017	Change
Average Time between Exit Conference and ICAR Email (in days)	27	31	4
Average Time between Exit Conference and Draft Audit Report (in days)	101	62	-39
Average Time between Exit Conference and Final Audit Report (in days)	129	88	-41
Average Time between Final Audit Report and Audit Closeout (in days)	278*	TBD	TBD

*Based on 36 of 37 audits conducted in 2016.

As shown in Table 1 above, the average amount of time that elapsed between the Exit Conference and the issuance of the final audit reports decreased by 41 days – or nearly six weeks – from 2016 to 2017. We anticipate further improvements in the future as we continue to refine and improve this process. However, the duration of the validation process and audit closeout is now largely dependent on the sponsor due to the use of independent auditors to perform audit validations.

Figure 5 on the following page provides an overview of each stage of the 2017 audit process and the estimated timeframe for completion of each stage.

Figure 5



2017 AUDIT INNOVATIONS AND PROCESS IMPROVEMENTS

Gathering feedback from sponsors and external stakeholders is key to improving program audit documentation, processes, and procedures and allows for better education and support. Recent feedback resulted in the following improvements:

- A streamlined audit submission checklist for sponsors that accounted for all audit deliverables prior to fieldwork.
- Limited submission of all audit-related documentation to the Health Plan Management System (HPMS) and eliminated the need to submit universes via an external Secure File Transfer Protocol.
- Scaled the audit review period for CDAG and ODAG based on a sponsor's enrollment size to reduce the burden associated with submitting universes.
- Updated the CPE protocol. In particular, eliminated employee interviews, moved all tracer reviews to the onsite portion of fieldwork, added a third week to conduct the CPE review when subject to the MMP pilot protocols, provided flexibility in the presentation of tracer samples, and allowed sponsors more time to prepare for tracer presentations. These changes promoted more outcome-based results and reduced the burden on sponsors.
- Refined application of mitigating factors associated with sponsor-disclosed issues of noncompliance.
- Increased consistency in reporting of program audit results via continued implementation of Program Audit Consistency Teams (PACTs).
- Continued classifying conditions in accordance with publicly released definitions of ICARs, CARs, and observations released via a HPMS memo in November 2015.
- Formalized the issuance of preliminary draft audit reports via HPMS prior to the onsite exit conference.
- Used fully integrated audio/video webinar technology (WebEx) during audits to manage and secure online participation.
- Allowed sponsors more time to submit supporting documentation, namely root cause analyses and impact analyses.
- Held a listening session with the industry to solicit feedback on the independent validation audit process.

SPONSOR TIP: Is your organization undergoing a program audit? Do you think you will undergo an audit in the near future? The audit protocols are valuable resources for audit preparation and detail the process for audits. Sponsors are encouraged to perform mock audits, including generating universes. Mock audits will not only help you prepare for an actual CMS audit, but may help you improve your operations by identifying areas that are problematic or otherwise non-compliant with CMS regulations.

AUDIT RESULTS AND TRENDING

An audit score for each sponsor is 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, we weight conditions to ensure that those conditions that have a greater 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), 1 point to each invalid data submission (IDS), and 2 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:

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

Calculations produce an overall audit score, as well as a score for each program area. As previously mentioned, not all sponsors audited in 2017 had every program area audited. The score quantifies a sponsor's performance and allows comparisons across sponsors. The figures on the following pages compare scores between 2016 and 2017 and display overall and program-area specific audit scores for sponsors audited in 2017.

Comparison of 2016 and 2017 Audit Results

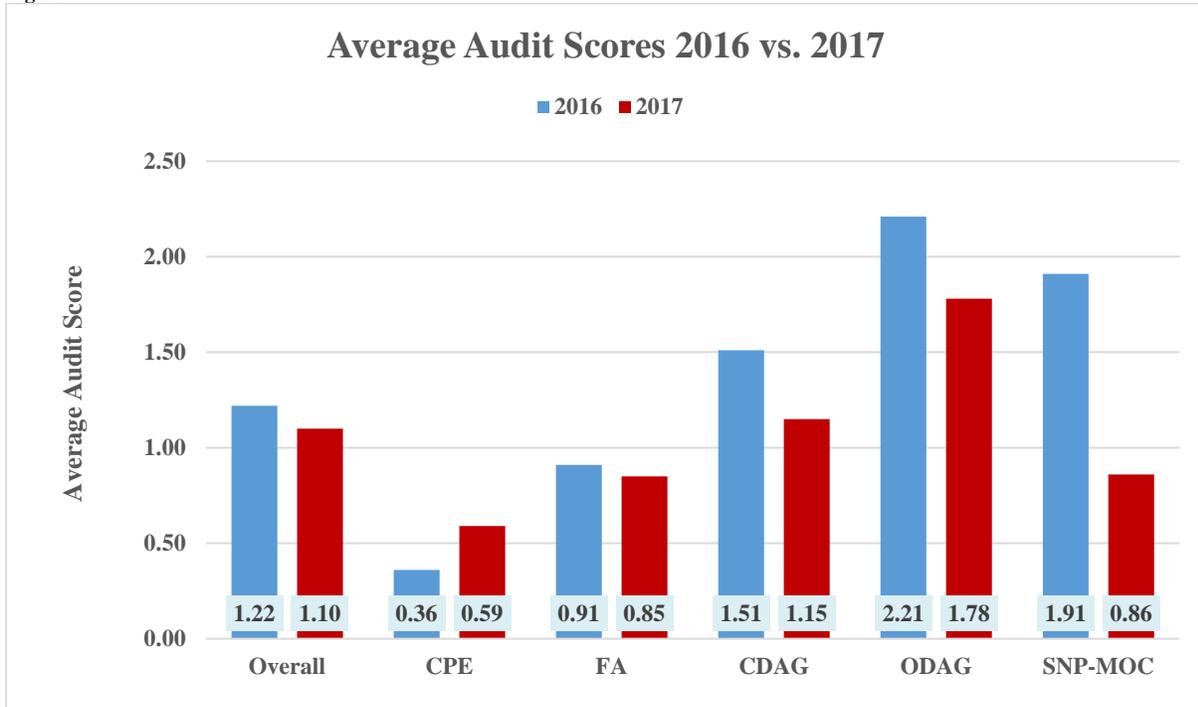
Figure 6 depicts the average audit score in each program area audited in 2016 compared to 2017 scores. The overall scores in 2017 are better than 2016, as are the scores in every individual program area except CPE.

The program area with the largest average score improvement from 2016 to 2017 was SNP-MOC, where the average score improved by more than 50% (from 1.91 in 2016 to .86 in 2017).

Over the course of almost two audit cycles, sponsors' performance continues to improve. The average number of conditions cited per audit in 2012 was 38 and was down to an average of just over 12 per audit in 2017.

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 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 CMS audit.

Figure 6*

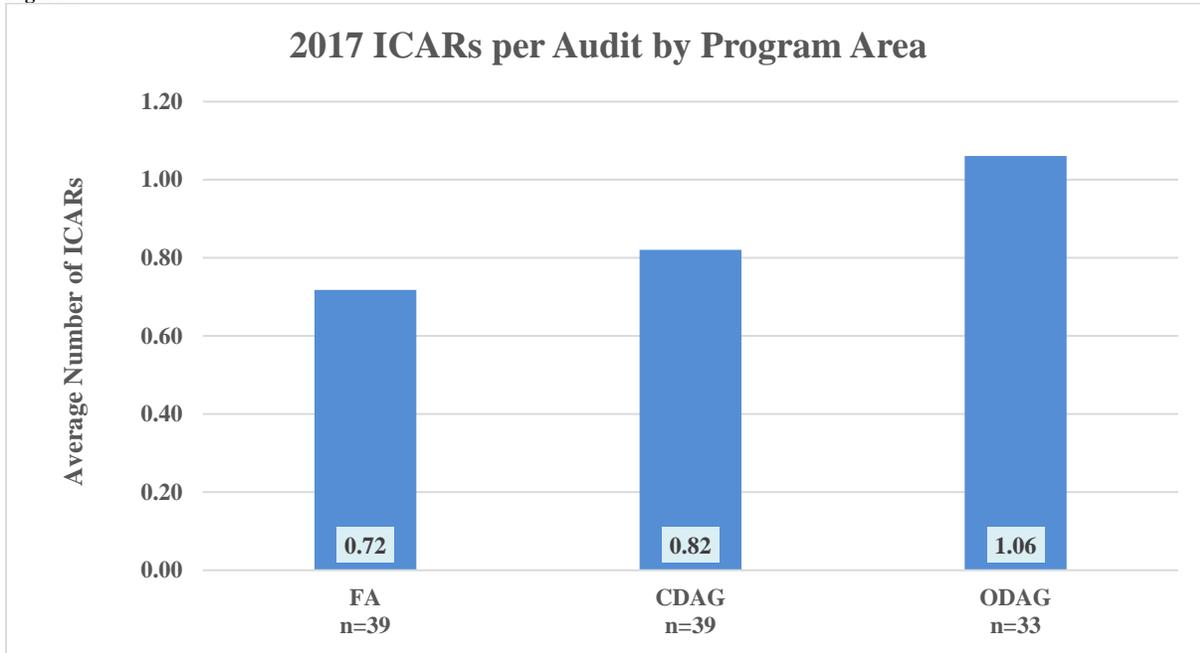


* Audit scores are analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.

ICARs by Program Area 2017

Figure 7 displays the average number of ICARs cited per audit by program area in 2017. All ICARs were cited in FA, CDAG, and ODAG. In total, 28 ICARs were cited in FA, 32 ICARs were cited in CDAG, and 35 ICARs were cited in ODAG. The number of ICARs cited in the audits we conducted in 2017 ranged from 0 to 7.

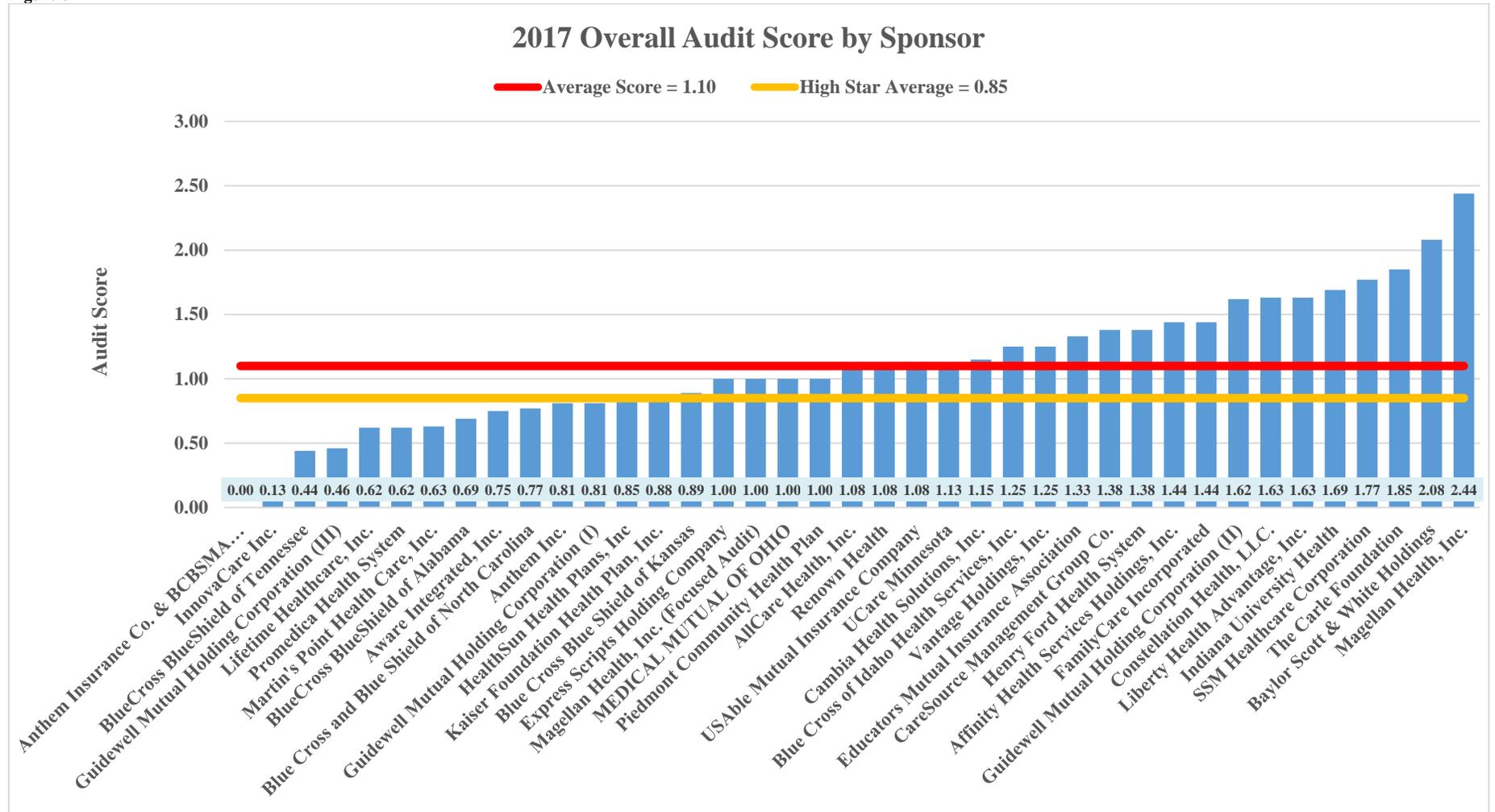
Figure 7



2017 Program Audit Scores

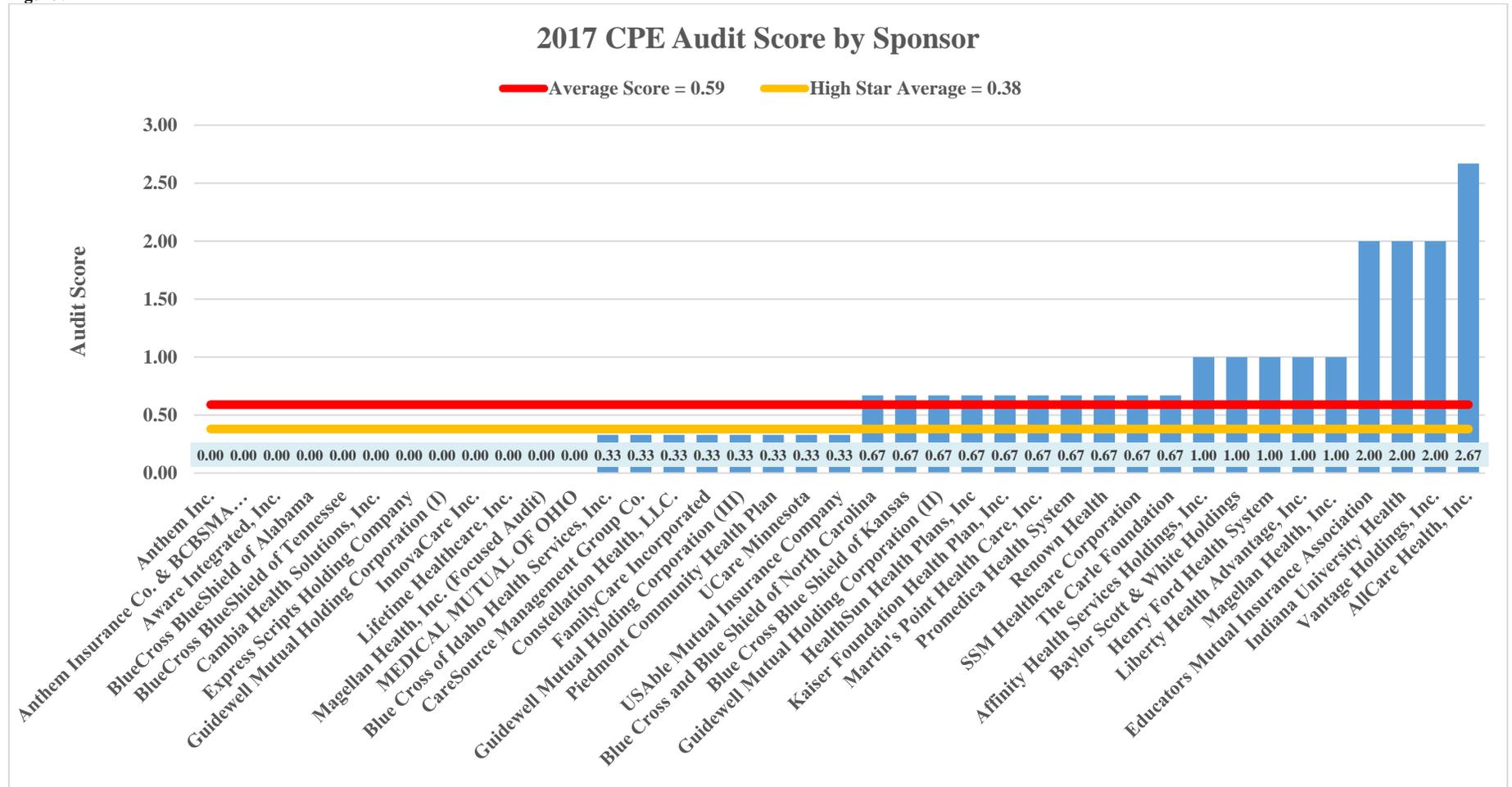
Figures 8-13 array the overall and individual program area audit scores. The audit scores are displayed from best to worst score (i.e., lowest score to highest score) moving from left to right across the graph. The red line in each graph represents the average audit score across all audited sponsors. The orange line represents the average audit score across all High-Star sponsors audited, both overall and for each individual program area. High-Star sponsors are those sponsors that had a weighted (by enrollment) Star Rating average of 4.5 or better across all of their contracts.

Figure 8*



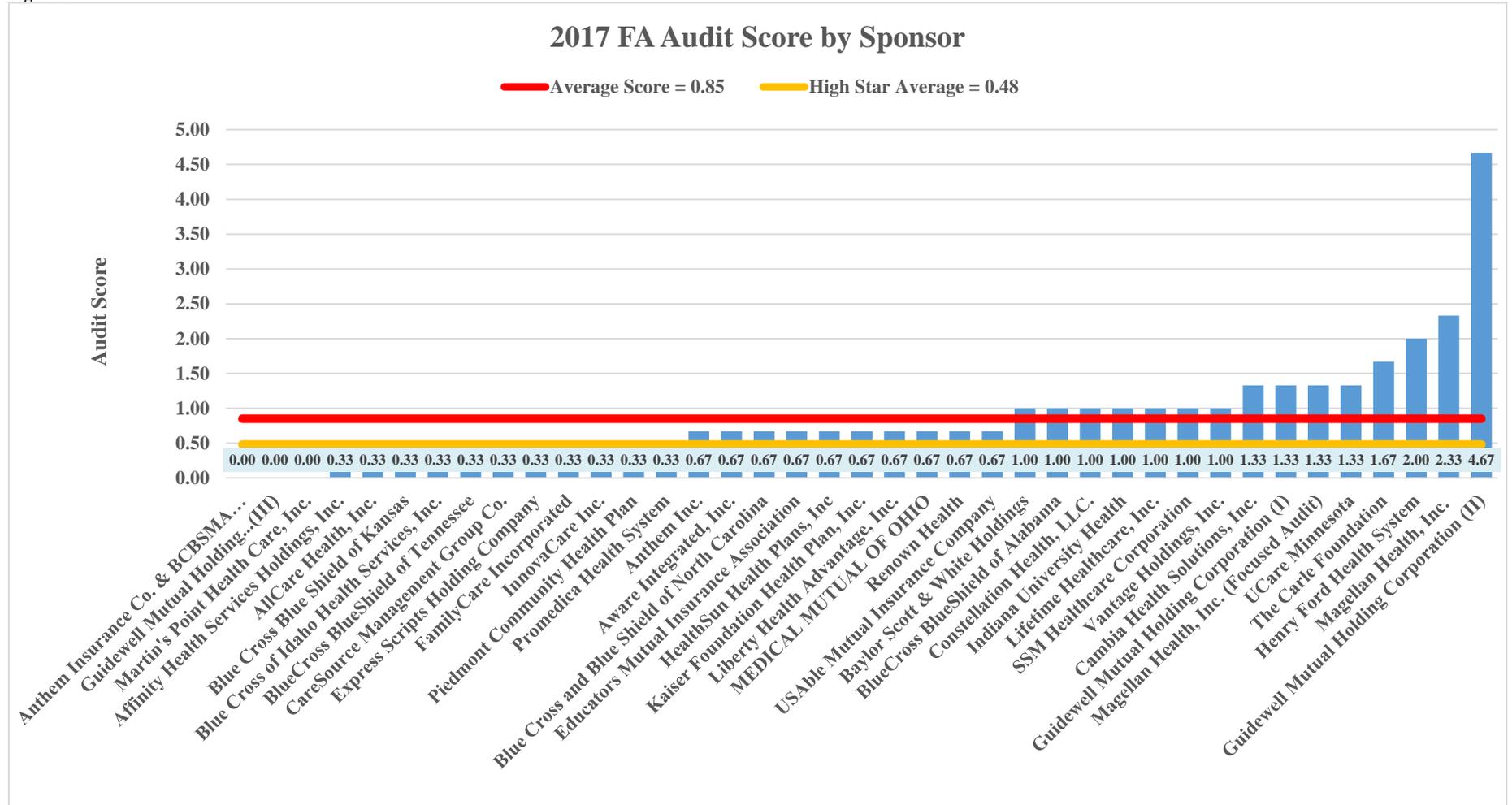
*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2017.

Figure 9*



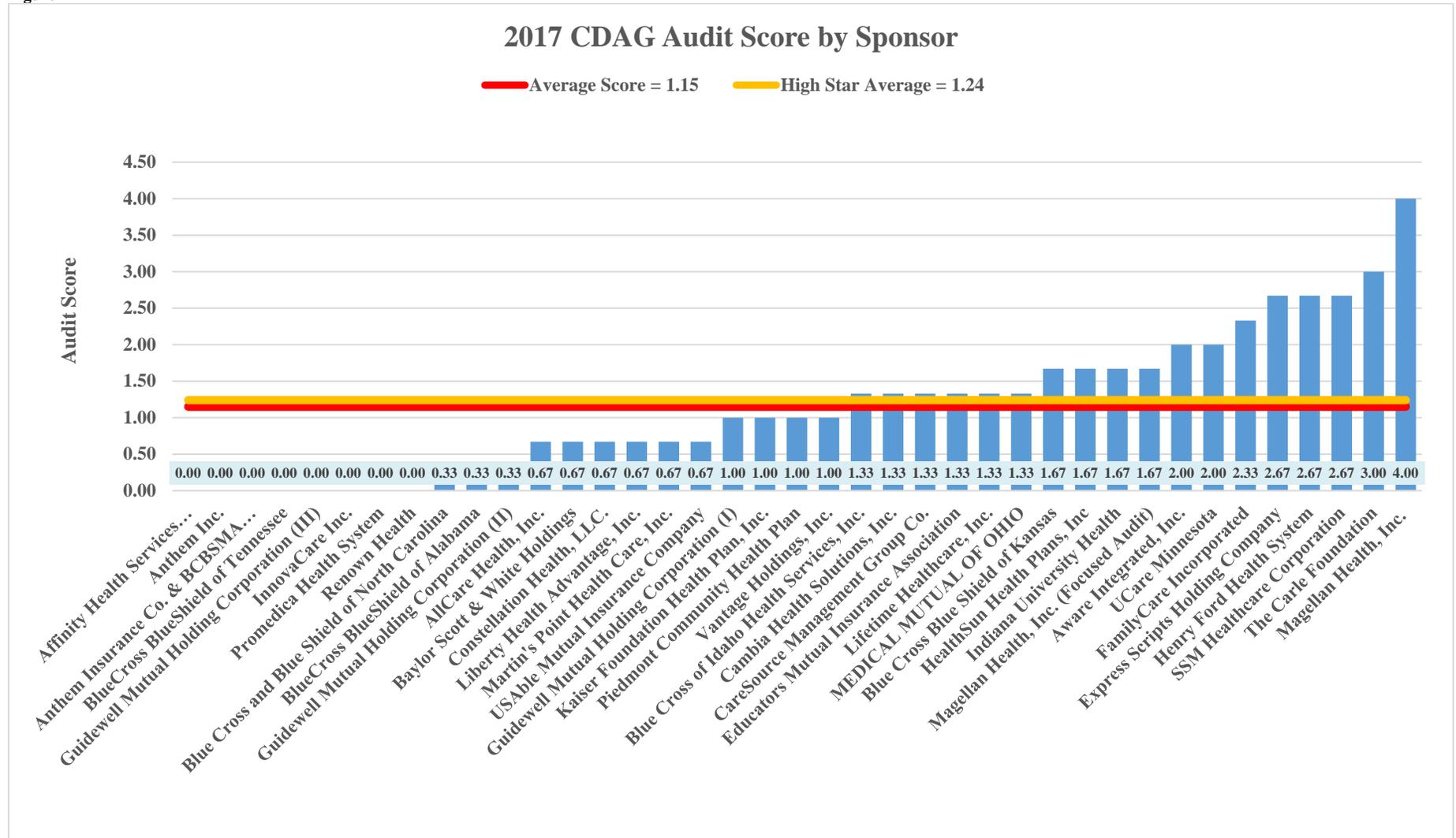
*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CPE program area in 2017.

Figure 10*



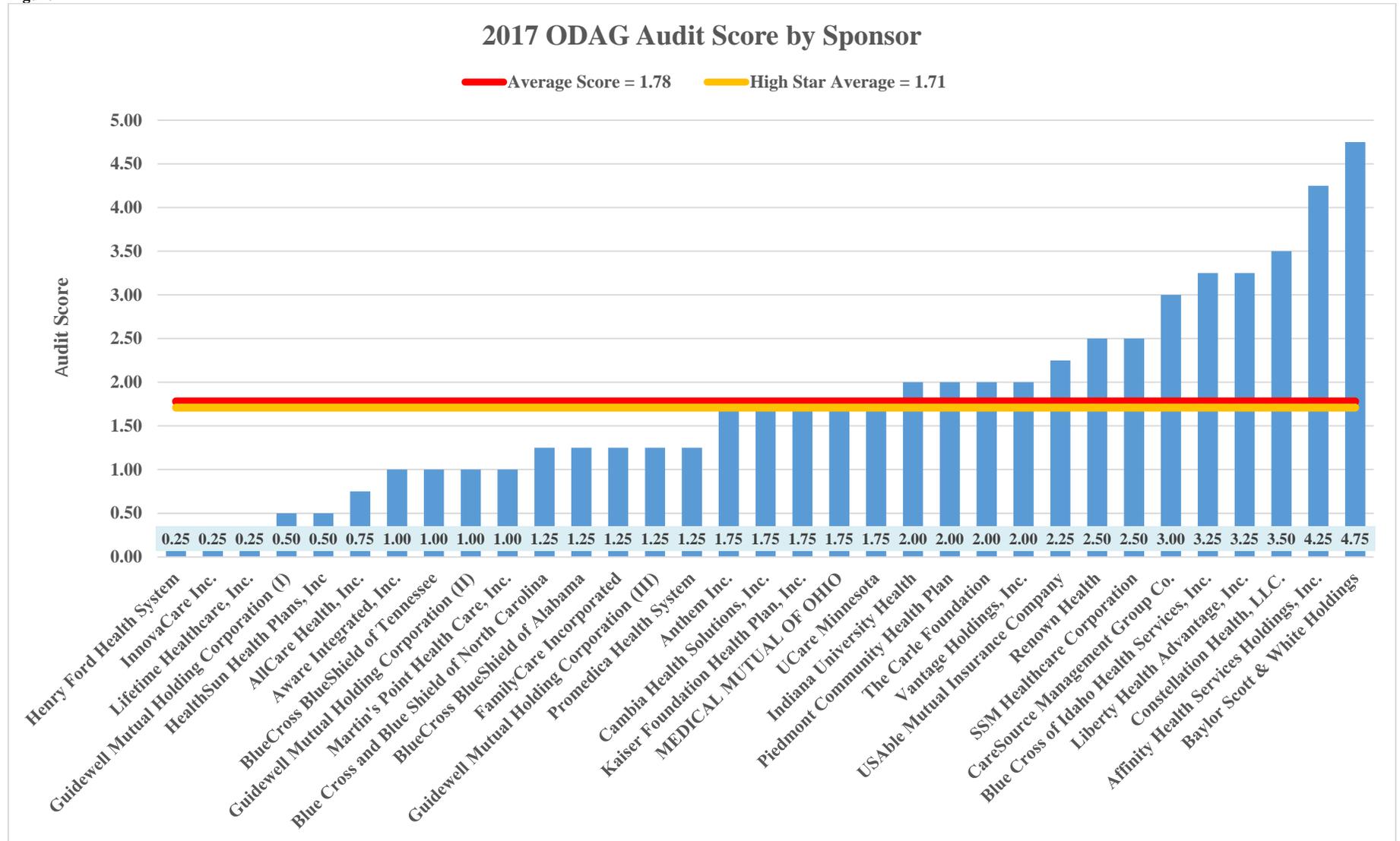
*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the FA program area in 2017.

Figure 11*



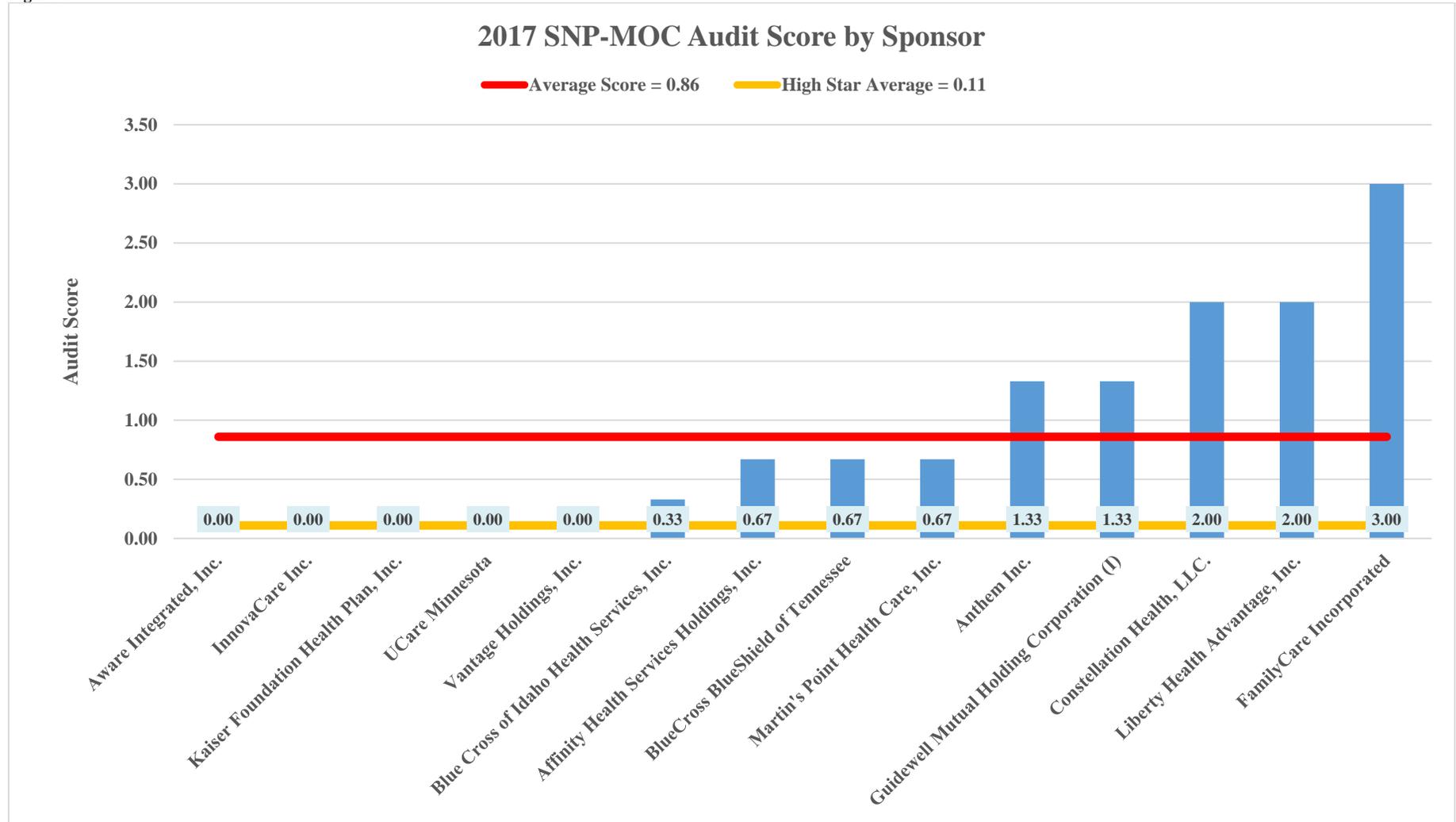
*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CDAG program area in 2017.

Figure 12*



*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 2017.

Figure 13*

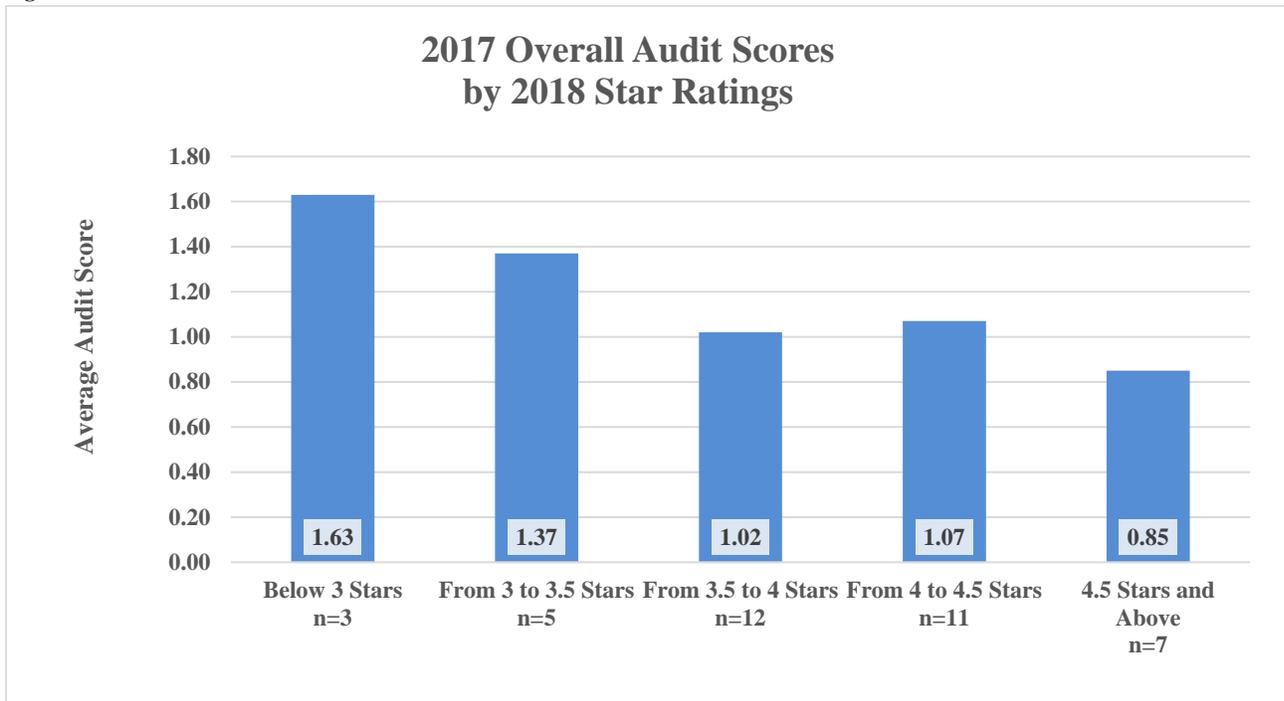


*A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the SNP-MOC program area in 2017. Note that only three High-Star sponsors were audited for SNP-MOC in 2017.

2017 Overall Audit Scores Compared to 2018 Star Ratings Data

Figure 14 compares the 2017 average overall audit score and a sponsor's 2018 Star Rating. Sponsors may receive a Star Rating between one and five, with five being the best rating. Sponsors fall into one of five Star Rating ranges, and then the average overall audit score for sponsors in that range is calculated. This figure demonstrates that sponsors with the highest Star Ratings (i.e., greater than 4.5), among those audited in 2017, perform better than those with average or low Star Ratings. This is the first year where there is a more direct trend in the relationship between audit scores and Star Ratings. Although program audits and Star Ratings evaluate different aspects of sponsors' operations and delivery of the benefit, both are valuable indicators of performance.

Figure 14*

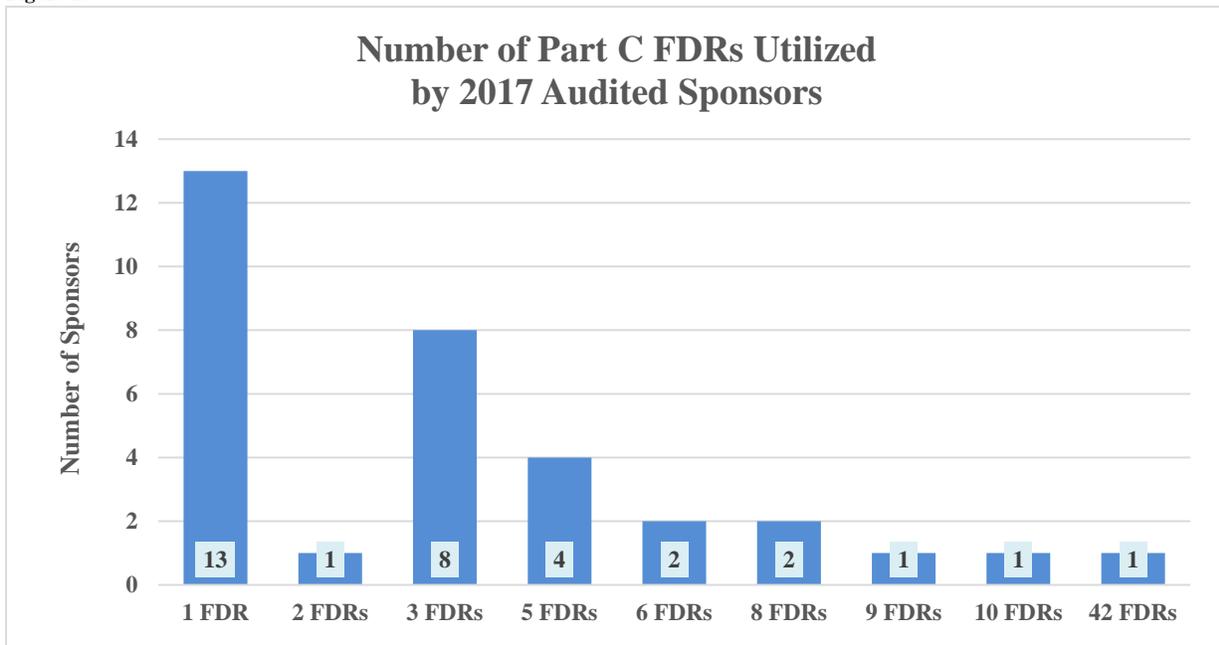


*Audit and Star Rating scores are analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance. One sponsor audited in 2017 did not have any contract with an associated Star Rating and is therefore excluded from this chart.

Number of Part C FDRs Utilized by Sponsors Audited in 2017

Figure 15 shows a detailed distribution of the numbers of FDRs used by the sponsors audited in 2017. The average number of Part C FDRs across all sponsors audited for ODAG in 2017 was 4.48, and the number of Part C FDRs ranged from 1 to 42. The sponsors utilizing 9, 10, and 42 Part C FDRs were among the largest audited in 2017 in terms of enrollment size. Note that Figure 15 and Figure 16 only represent FDRs that administer, process, or adjudicate claims on behalf of sponsors, as was the case in last year's report.

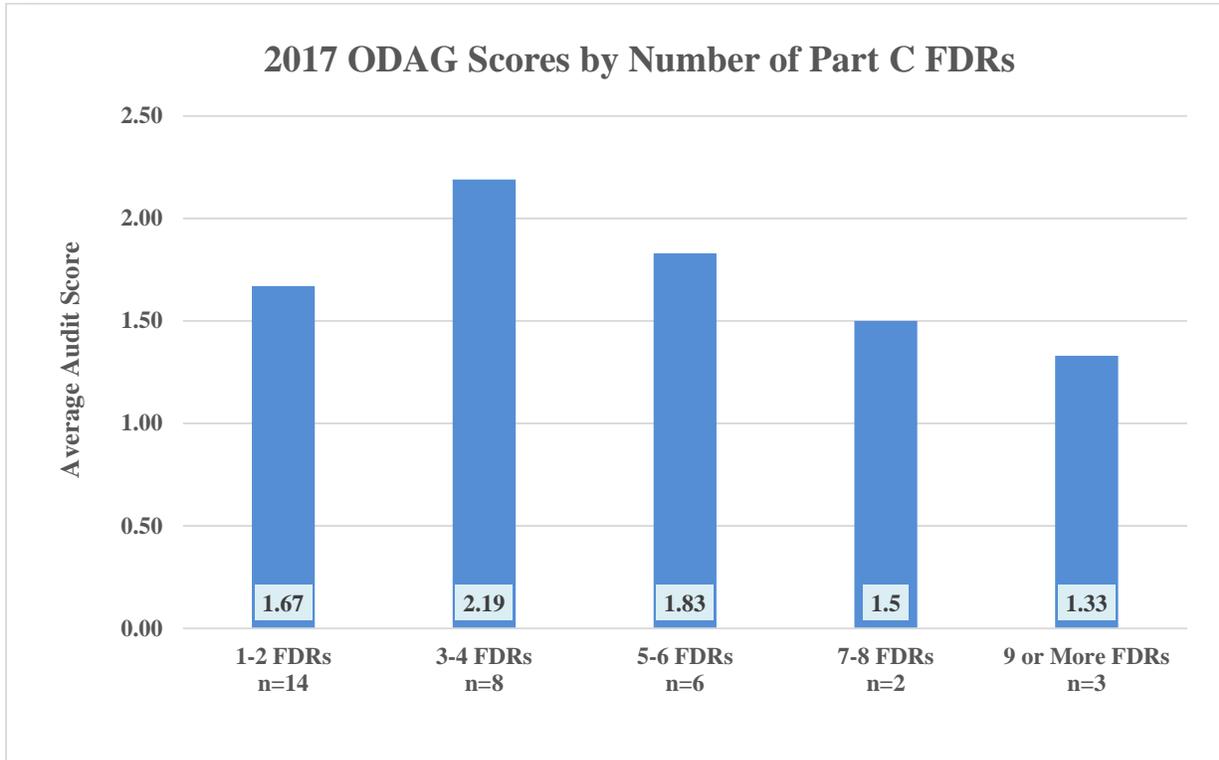
Figure 15



2017 Audit Scores by Number of Part C First Tier, Downstream, and Related Entities (FDRs)

Figure 16 displays average ODAG audit scores broken into five groups depending on the number of Part C FDRs the audited sponsors utilized. These results do not show a clear relationship between the number of Part C FDRs the sponsors we audited in 2017 utilized and their ODAG audit scores.

Figure 16*

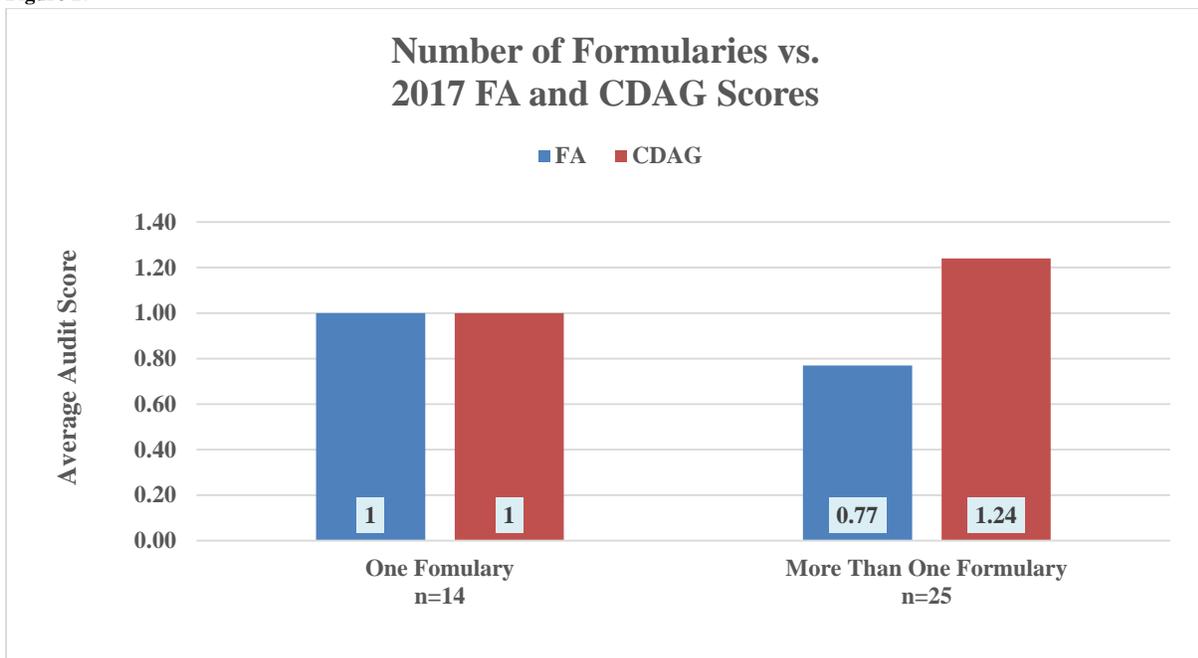


* Audit scores are analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance. Several of the audits conducted in 2017 did not involve ODAG.

2017 FA and CDAG Scores by Number of Formularies

Figure 17 displays the average 2017 FA and CDAG scores across audited sponsors broken into two groups: those that operate one formulary, and those that operate more than one formulary. In the latter group, the number of formularies used ranged from 2 to 12. In contrast to our 2016 audits, sponsors operating more than one formulary fared better in FA than those that operated only one. The results in CDAG were consistent with those from our audits last year. Sponsors operating only one formulary fared better on audit than those operating more than one. The average number of formularies used across all sponsors audited in 2017 was 2.72. This number was similar to 2016, where the average number of formularies used by the sponsors audited was 2.65. There was little correlation between the years of program experience of sponsors audited in 2017 and the number of formularies utilized. However, there was a positive correlation between the enrollment size of sponsors audited in 2017 and the number of formularies those sponsors utilized.

Figure 17*

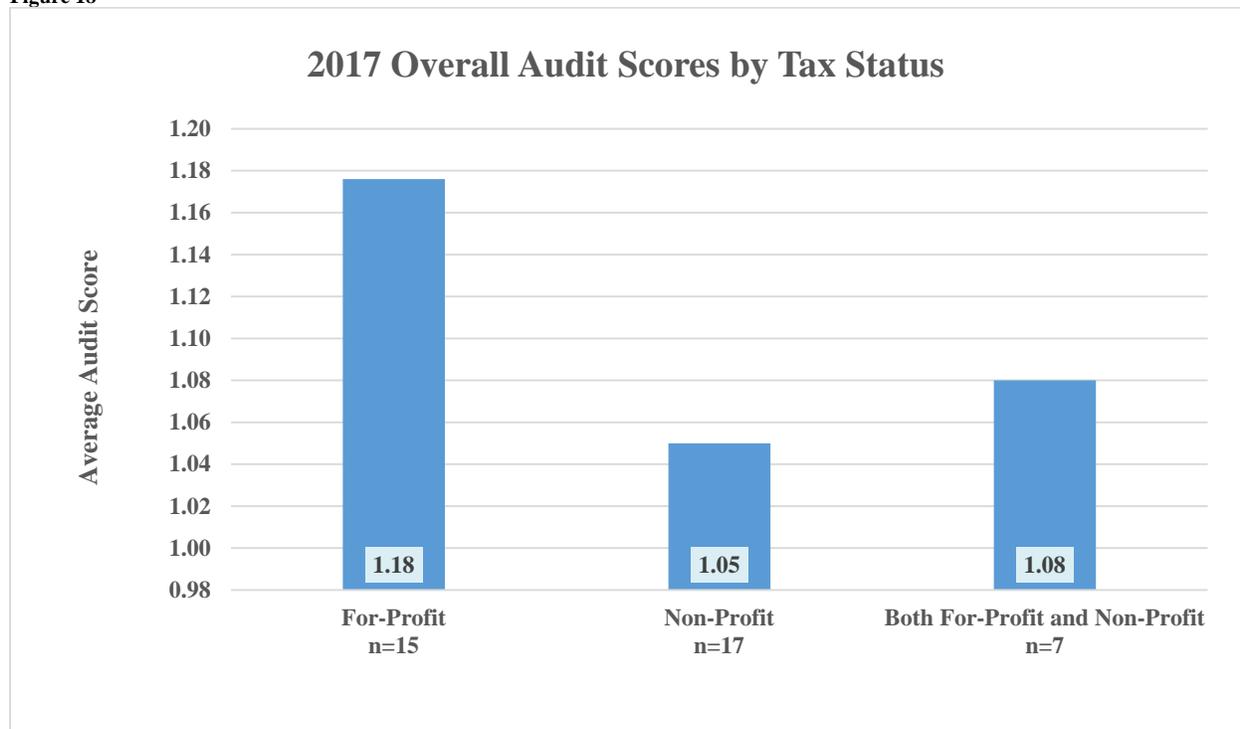


* Audit scores are analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each group. A lower audit score represents better audit performance.

2017 Overall Audit Scores by Tax Status

Figure 18 depicts the 2017 average overall 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 seven sponsors operated both for-profit and non-profit subsidiaries. Those sponsors operating only non-profit contracts fared on average better than those operating only for-profit contracts or a combination of non-profit and for-profit contracts.

Figure 18*



*Audit scores are analyzed at the sponsor (parent organization) level. The tax status was 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.

2017 Overall Audit Scores by Program Experience

Figure 19 breaks the 2017 average overall audit scores into three categories, depending on how long a sponsor has had an active Medicare contract. A sponsor’s earliest effective contract date was used to determine the length of program experience. For example, if a sponsor has one contract dating back to 2005 and five contracts dating back to 2015, they were included in the “Between 5 and 15 Years” category below. The audit scores for sponsors operating Medicare contracts from five to 15 years and over 15 years were similar. The sponsors offering Medicare contracts for fewer than five years had somewhat higher audit scores than the other two groups of sponsors (i.e., 1.34 vs. 1.07 and 1.10). This difference may be explained by experienced sponsors being more familiar with CMS’ requirements and having more time to operationalize them. In some cases, sponsors may have had the benefit of undergoing previous program audits, giving them an opportunity to remediate deficiencies discovered during those audits.

Figure 19*

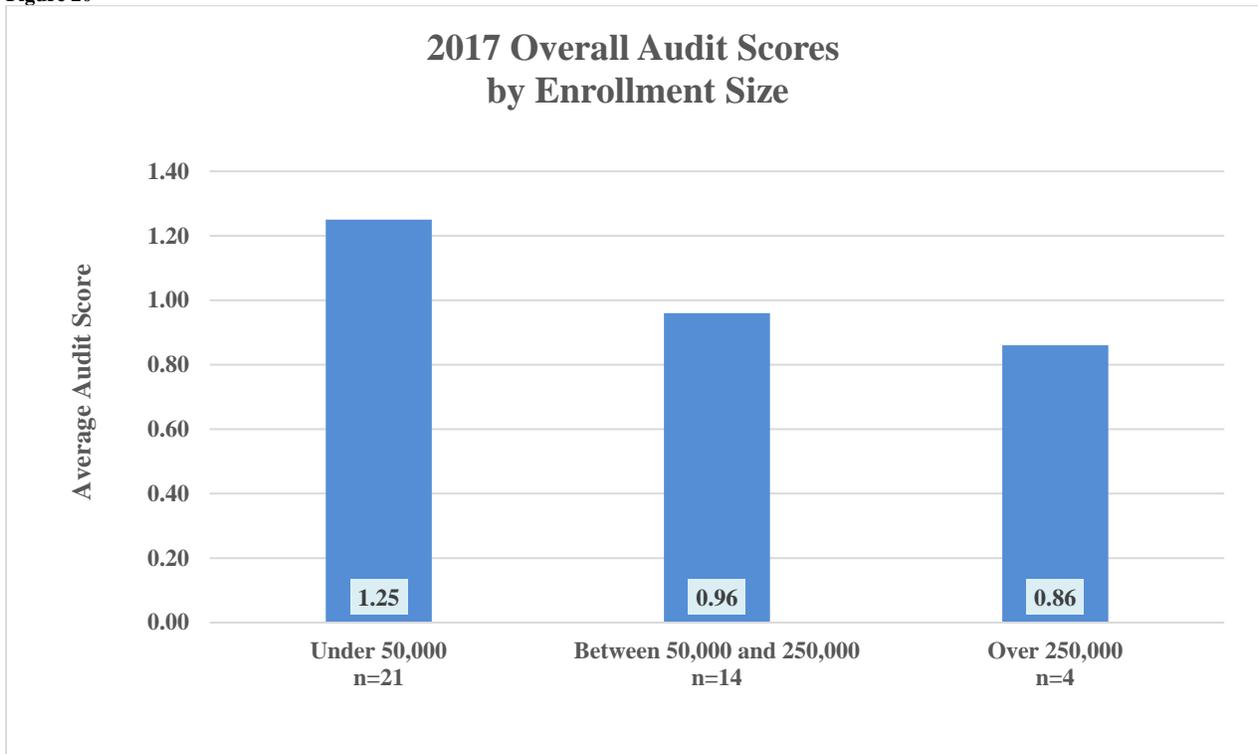


* Audit scores are analyzed at the sponsor (parent organization) level. The length of time a sponsor has offered Medicare contracts is based on the contract a sponsor has with the earliest effective date. The average audit score is an unweighted score across all audited sponsors within each group. A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

2017 Overall Audit Scores by Enrollment Size

Figure 20 displays 2017 average overall audit scores by the size of enrollment for a given sponsor. In 2017, there was, on average, an inverse relationship between enrollment size and audit performance. The larger a sponsor's enrollment, the better their performance on audit. However, this was not a consistent trend. In 2015, medium-sized sponsors fared on average the worst, but in 2016 medium-sized sponsors on average fared the best.

Figure 20*



* Audit scores are 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.

2017 MOST COMMON CONDITIONS

Tables 2-6 on pages 30-32 list the five most commonly cited conditions in 2017 in each of the five program areas. Several conditions have been a Top-5 condition in each of the common conditions lists since 2011.

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 appearing in your audit report.

In 2017, CMS conducted 39 audits in the CPE, FA and CDAG, 33 in ODAG program areas, and 14 in SNP-MOC. The percentage of sponsors affected using these respective numbers is calculated as the denominator for each given program area.

CPE Most Common Conditions:

Table 2

CPE Condition Language	Percent of 2017 Audits Affected
Sponsor did not review Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for any new employee, temporary employee, volunteer, consultant, or governing body member prior to hiring or contracting and monthly thereafter.	31%
Sponsor did not establish, implement, and provide timely and effective compliance and fraud, waste and abuse (FWA) training and education for its employees, including the CEO, senior administrators and managers and for its governing body members involved in the administration or delivery of Parts C and D benefits.	26%
Sponsor did not provide evidence that it audits, or otherwise measures, the effectiveness of the compliance program at least annually and that the results are shared with the governing body.	18%
Sponsor did not have an effective system to monitor first tier, downstream and related entities' (FDRs') compliance with Medicare program requirements.	10%
Sponsor did not establish and implement a formal risk assessment and an effective system for routine monitoring and auditing of identified compliance risks.	10%

FA Most Common Conditions:

Table 3

FA Condition Language	Percent of 2017 Audits Affected
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices.	67%
Sponsor improperly effectuated prior authorizations or exception requests.	23%
Sponsor failed to properly administer the CMS transition policy.	18%
Sponsor failed to properly administer its CMS-approved formulary by applying unapproved quantity limits.	18%
Sponsor failed to properly post its CMS-approved formulary on its website.	8%

CDAG Most Common Conditions:

Table 4

CDAG Condition Language	Percent of 2017 Audits Affected
Sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.	64%
Sponsor failed to identify and process enrollee complaints and disputes as grievances.*	28%
Sponsor's 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.	23%
Sponsor did not take appropriate actions, including full investigations, and/or appropriately addressing all issues raised by grievance.	21%
Sponsor did not auto-forward coverage determinations and/or redeterminations (standard and/or expedited) that exceeded the CMS required timeframe to the Independent Review Entity (IRE) for review and disposition.	18%

*This condition has not appeared previously in a common conditions list.

ODAG Most Common Conditions:

Table 5

ODAG Condition Language	Percent of 2017 Audits Affected
Sponsor did not fully investigate and/or take actions to appropriately address all issues raised in grievances.	48%
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.	45%
Sponsor did not include in its denial letters adequate rationales, correct/complete information specific to denials, or language easily understandable to enrollees.	42%
Sponsor failed to correctly determine whether the issues in enrollees' complaints met the definition of inquiries, grievances, organization determinations, appeals, or a combination of the preceding and, therefore did not resolve the complaints or disputes through the appropriate procedures.	36%
Sponsor failed to reimburse enrollees within 60 days of making favorable reimbursement reconsiderations.*	30%

*This condition has not appeared previously in a common conditions list.

SNP-MOC Most Common Conditions:

Table 6

SNP-MOC Condition Language	Percent of 2017 Audits Affected
Sponsor did not conduct comprehensive annual reassessments to enrollees within 1 year of initial assessment or within 1 year of previous Health Risk Assessment (HRA), or as often as the health of enrollees require.	36%
Sponsor did not show documentation of interdisciplinary care team (ICT) coordination of member care.	36%
Sponsor did not develop Individualized Care Plans (ICP) for enrollees.	36%
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 enrollees.	29%
Sponsor did not provide evidence that it conducted initial Health Risk Assessments (HRAs) of enrollees.	14%

Most Common ICAR Conditions from 2017 Audits

Table 7 below displays the conditions that were cited as ICARs the most in 2017. Of the five conditions listed, two were in CDAG, one was in FA, and two were in ODAG.

Table 7

Number of ICAR Citations	Condition Language	Program Area
22	Sponsor misclassified coverage determination or redetermination requests as grievances and/or customer service inquiries.	CDAG
12	Sponsor failed to properly administer its CMS-approved formulary by applying unapproved utilization management practices.	FA
5	Sponsor did not auto-forward coverage determinations and/or redeterminations (standard and/or expedited) that exceeded the CMS required timeframe to the Independent Review Entity (IRE) for review and disposition.	CDAG
4	Sponsor did not demonstrate sufficient outreach to providers or enrollees to obtain additional information necessary to make appropriate clinical decisions.	ODAG
4	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.	ODAG

ENFORCEMENT ACTIONS

In 2017, CMS 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 Civil Money Penalty (CMP), as well as the amounts of the CMPs issued. The first part of this section focuses on the enforcement actions imposed based on all referrals received in calendar year 2017 and early 2018 due to non-compliance detected in 2017. These referrals encompass actions for violations from 2017 program audits, as well as violations discovered through other audits or monitoring efforts. The second part of this section focuses more specifically on data from enforcement actions imposed for 2017 program audit violations.

General Enforcement Background

CMS has the authority to impose CMPs, intermediate sanctions, and for-cause terminations against MA plans, PDPs, PACE Organizations, and Cost Plans. MOEG is the group responsible for imposing these types of enforcement actions when a sponsor is substantially noncompliant with CMS' contract requirements, such as the Medicare Parts C and D and PACE 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, clearance is obtained from the Office of General Counsel within the Department of Health and Human Services, the Office of Inspector General, and the Department of Justice. All enforcement actions are also posted on the Part C and Part D Compliance and Audits website.¹ All information contained in referrals that involve suspected fraud, waste and abuse are referred to the Center for Program Integrity for investigation.

2017 Process Improvements

During 2017, we implemented the first-ever published CMP Methodology, which became final on December 15, 2016.² In addition, numerous other enhancements to increase transparency related to the enforcement referral evaluation process were implemented. Affected sponsors received more timely notification upon receipt of a referral for a potential enforcement action. Sponsors were also given more timely notification if CMS decided not to take an enforcement action against them. Lastly, sponsors subject to a CMP received a more detailed written explanation of the calculation of their penalty.

Furthermore, in 2017 efforts to engage with sponsors throughout the evaluation process improved to ensure enforcement actions used data that accurately reflected the impact of violations on beneficiaries. To that end, there were increased efforts to reach out to sponsors during the analysis phase to obtain additional and/or mitigating data and to verify findings when necessary. With respect to program audits, sponsors were also told that their comments to the draft audit report were taken into consideration during the enforcement phase and were strongly encouraged to fully evaluate discovered non-compliance and provide any additional information while still in the audit phase.

I. ENFORCEMENT ACTIONS IMPOSED BASED ON 2017 REFERRALS

This section provides information on enforcement actions taken in calendar year 2017 and early 2018 due to non-compliance detected by CMS in 2017. There were 24 CMPs and 3 intermediate sanctions imposed against sponsors because of non-compliance identified in 2017. However, there were no for-cause terminations because of non-compliance in 2017.

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. In 2017, there were 93 referrals; approximately 38% were due to non-compliance detected through the Medicare Parts C and D program audits. The other bases for enforcement action referrals in 2017 include:

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

² The CMP Methodology is on our enforcement action website in the above footnote.

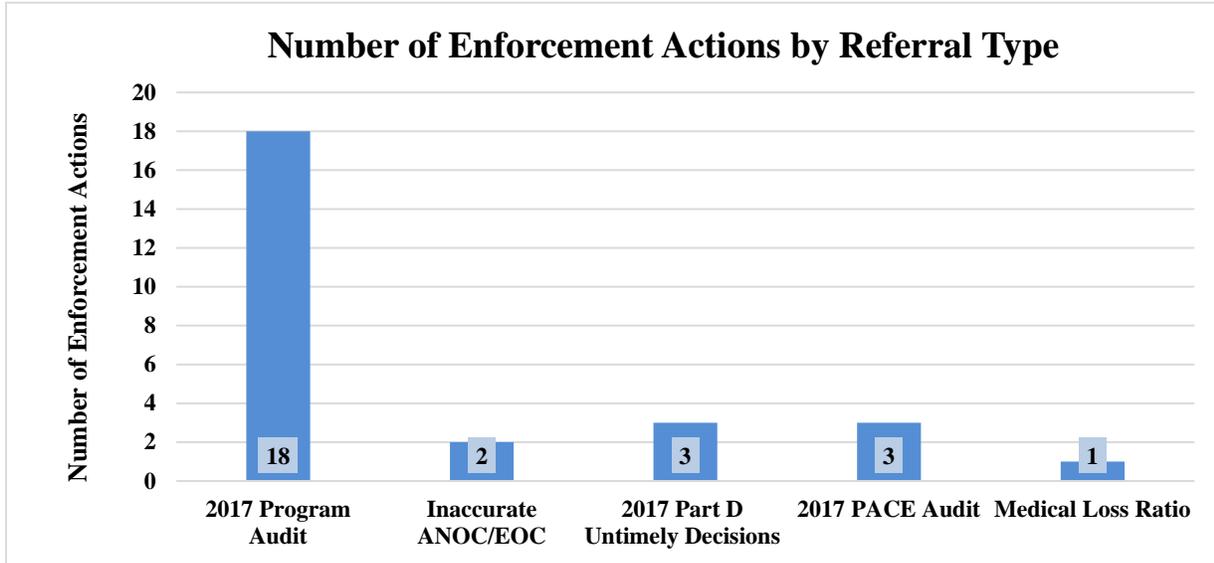
- Failure to send accurate and/or timely Annual Notice of Change/Evidence of Coverage (ANOC/EOC) found during routine monitoring activities (28%)
- Non-compliance found during One-Third Financial Audits (21%)
- Failure to make timely decisions related to Part D coverage determinations, appeals, and grievances identified through routine monitoring activities with the Independent Review Entity (9%)
- Non-compliance discovered through Program of All-Inclusive Care for the Elderly (PACE) audits (3%)
- Failure to maintain an adequate Medical Loss Ratio (MLR) for three consecutive years, as determined by reviews of self-disclosed MLR data (1%).

Table 8 shows the referral details, and Figure 21 displays the number of enforcement actions by referral type.

Table 8

Referral Type	# of Referrals	# of Referral Closeouts	# of Referrals Under Review	# of Enforcement Actions Taken
Medicare Parts C & D Program Audits	35	17	0	18
Annual Notice of Change/Evidence of Coverage	26	24	0	2
One-Third Financial Audits	20	12	8	0
Part D Untimely Decisions	8	5	0	3
Program of All-Inclusive Care for the Elderly	3	0	0	3
Medical Loss Ratio	1	0	0	1
Totals	93	58	8	27

Figure 21



CIVIL MONEY PENALTIES (CMPs)

CMPs imposed totaled \$2.9 million, with an average of \$120,899 per CMP. The highest CMP imposed was \$1,368,200 and the lowest CMP imposed was \$3,600. The following table shows the sponsors that received a CMP based on 2017 referrals:

Table 9

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
06/21/2017	Elderplan, Inc.	Inaccurate ANOC/EOC	\$132,000
06/21/2017	CHRISTUS Health Plan	Inaccurate ANOC/EOC	\$7,080
07/14/2017	Merit Health Insurance Company	2017 IRE Auto-Forward	\$59,600
09/13/2017	Express Scripts Holding Company	2017 Program Audit	\$213,000
09/18/2017	Premier Health Insuring Corporation	2017 IRE Auto-Forward	\$3,600
10/31/2017	Lifetime Healthcare, Inc.	2017 Program Audit	\$105,400
11/14/2017	USABLE Mutual Insurance Company	2017 Program Audit	\$67,500
11/14/2017	BlueCross BlueShield of Tennessee	2017 Program Audit	\$74,400
11/14/2017	Senior LIFE York, Inc.	2017 PACE Audit	\$37,396
11/27/2017	Affinity Health Plan, Inc.	2017 Program Audit	\$35,300
11/27/2017	Kaiser Foundation Health Plan, Inc.	2017 Program Audit	\$45,900
12/11/2017	Indiana University Health Plans, Inc.	2017 Program Audit	\$41,300
12/11/2017	Medical Mutual of Ohio	2017 Program Audit	\$222,300
12/11/2017	BlueCross BlueShield of Alabama	2017 Program Audit	\$27,000
12/21/2017	Baylor Scott and White Holdings	2017 Program Audit	\$39,300
12/21/2017	Vantage Health Plan, Inc.	2017 Program Audit	\$98,500
02/06/2018	Magellan Healthcare, Inc.	2017 Program Audit	\$1,368,200
02/06/2018	SSM Healthcare Corporation	2017 Program Audit	\$36,400

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
02/06/2018	Guidewell Mutual Holding Corporation (I)	2017 Program Audit	\$30,900
02/21/2018	Cambia Health Solutions, Inc.	2017 Program Audit	\$65,800
02/21/2018	Guidewell Mutual Holding Corporation (II)	2017 Program Audit	\$23,800
02/21/2018	Henry Ford Health System	2017 Program Audit	\$43,300
02/21/2018	UCare Minnesota	2017 Program Audit	\$61,500
03/14/2018	Magellan Healthcare, Inc.	2017 IRE Auto-Forward	\$62,100

The average CMP amount, broken down by enrollment size of the parent organization’s audited contracts, is as follows:³

- For organizations with < 10,000 enrollees, the average CMP was \$22,238
- For organizations with 10,000 – 50,000 enrollees, the average CMP was \$74,513
- For organizations with 50,000 – 200,000 enrollees, the average CMP was \$166,842
- For organizations with 200,000 or more enrollees, the average CMP was \$129,450

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 enrollment or when a violation affected a high number of enrollees.

The nature and scope of the violation(s) determined the total CMP a sponsor received. A standard CMP amount applies for each deficiency cited in a CMP notice, based on either a per-enrollee or a per-determination basis. A sponsor’s CMP is increased if aggravating factors apply to certain deficiencies:

- *Aggravating Factors:* The standard penalty for a deficiency for a contract may increase if the violation involved the following:
 - Drugs that are used to treat acute conditions that require immediate treatment;
 - Expedited cases;
 - Financial impact over \$100;
 - A prevalence of failed audit samples;
 - A Top-5 common condition; and/or
 - A history of prior offense.

Although specific mitigating factors were eliminated from the published CMP methodology, CMS did consider other available evidence indicating that harm to enrollees was minimized in

³ Organizations that received more than one CMP could be included in an enrollment band more than once.

determining whether to move forward with a CMP for a particular violation, or to remove beneficiaries from the CMP calculation. For example, if beneficiaries received the drug on the same day (after an initial rejection at the point of sale), those beneficiaries may have been excluded from the total CMP calculation. In addition, the CMP methodology established enrollment-based penalty caps per condition of non-compliance. Therefore, CMP totals per violation could not exceed certain established amounts.

There were 24 CMPs imposed for 57 specific violations:⁴

- 50 on a per-enrollee basis resulting in \$2,817,480 (97% of the total CMP amount).
- 7 on a per-determination basis resulting in \$84,096 (3% of the total CMP amount).

For CMPs taken in 2017 and early 2018, Figure 22 and Figure 23 show the total number of violations and dollar amount of violations by calculation type. Notably, in 2017 there were only seven violations penalized on a per-determination basis.

Figure 22

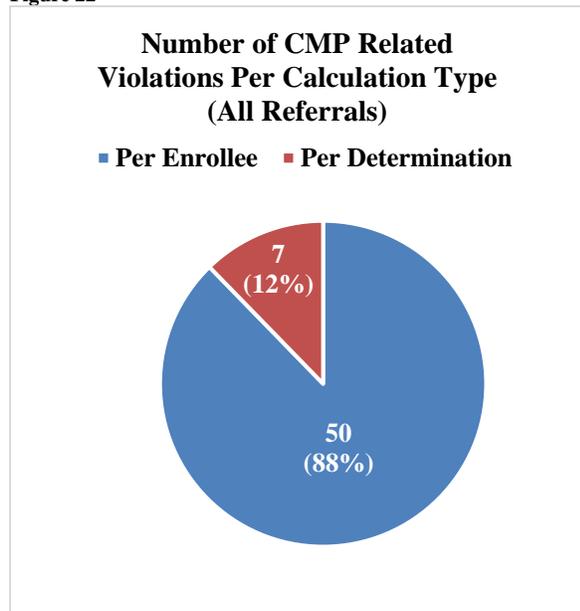
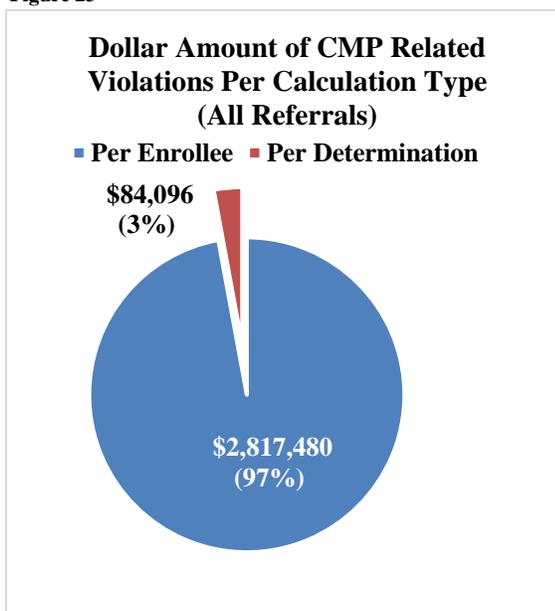


Figure 23



INTERMEDIATE SANCTIONS

Intermediate sanctions can either suspend a sponsor’s ability to market to and enroll new Parts C or D beneficiaries or to receive payment for new enrollees. For PACE Organizations, CMS’ sanction authority includes either suspending their ability to enroll eligible PACE participants or payment for new enrollees. In 2017, there were three

⁴ These numbers include CMPs from program audits, but also CMPs for late or erroneous ANOC/EOCs, untimely decisions related to Part D coverage determinations, appeals, and grievances, and Programs of All-inclusive Care for the Elderly administration failures that adversely affect an enrollee or have the substantial likelihood of adversely affecting an enrollee.

enrollment suspensions imposed. Two actions were imposed because of non-compliance discovered through 2017 PACE audits, and one action was imposed because of non-compliance with CMS’ Medical Loss Ratio (MLR) requirements. In 2017, one sponsor was released from intermediate marketing and enrollment sanctions imposed in 2016 because they were able to demonstrate correction of their deficiencies. The following sponsors and PACE organizations were under intermediate sanctions during 2017:

Table 10

Date of Imposition	Organization Name	Basis for Referral	Type of Intermediate Sanction	Date of Intermediate Sanction Release
01/21/2016	Cigna-HealthSpring	2015 Program Audit	Immediate Suspension of Enrollment & Marketing	06/16/2017
09/26/2017	USABLE Mutual Insurance Company (S5795)	Medical Loss Ratio	Enrollment Suspension	TBD
10/03/2017	Via Christi Healthcare Outreach for Elders, Inc.	2017 Focused PACE Audit	Enrollment Suspension	TBD
12/20/2017	Riverside Retirement Services, Inc.	2017 PACE Audit	Enrollment Suspension	TBD

CIGNA-HealthSpring corrected the operational deficiencies that were the basis for their sanctions and were able to demonstrate compliance by successfully passing validation exercises. Via Christi Hope and Riverside PACE remain under sanction. Both organizations are working to implement their corrective action plans. USABLE may be eligible for release from its sanction at the end of 2018 after it resubmits 2017 MLR data to CMS for review.

Independent Auditor Validation

Depending on the nature of the deficiencies, MA or PDP sponsors under intermediate sanctions may be required to select and hire an independent auditor to conduct a validation audit at the sponsor’s expense. The independent validation auditor audits the sponsor using CMS’ audit protocols, drafts a report that details the findings from their independent audit, and submits the report to CMS. The information gathered during the sanction monitoring process and the results of the independent audit validation are used to determine if the sponsor is released from intermediate sanctions. If there are serious concerns about the

ability of the sponsor to correct its deficiencies, CMS may choose to conduct its own validation of the sponsor’s corrective actions.

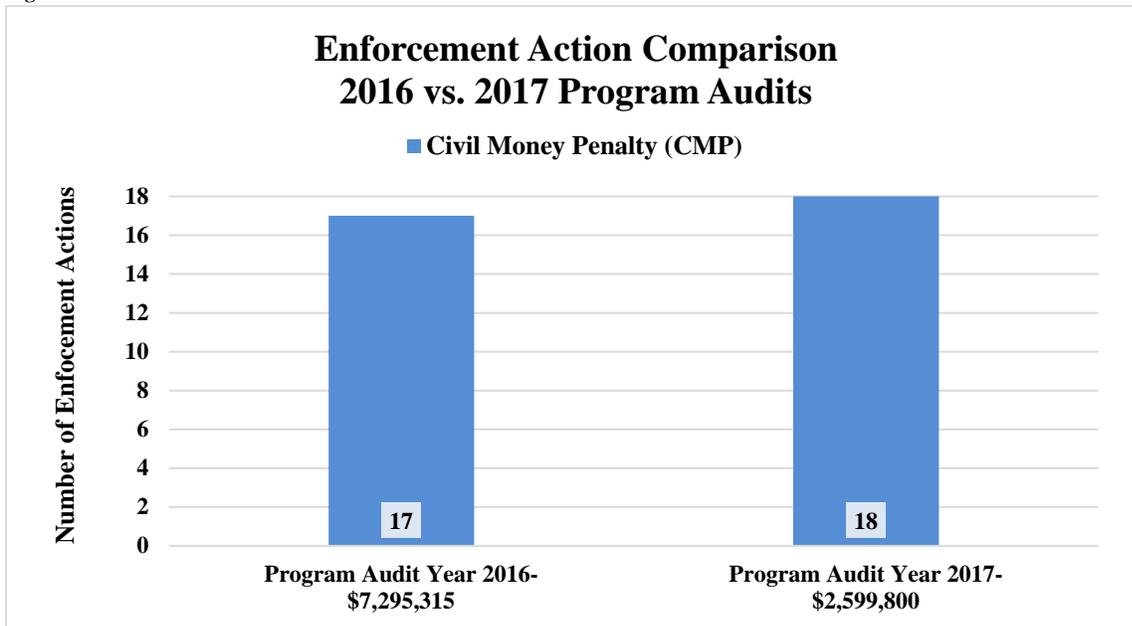
In contrast, PACE sponsors under intermediate sanctions must undergo and pass a CMS validation audit. For the two PACE sponsors currently subject to intermediate sanctions, CMS auditors will conduct the validation audit once the sponsors acquire enough clean data to validate correction of their deficiencies.

II. ENFORCEMENT ACTIONS RELATED SPECIFICALLY TO 2017 PROGRAM AUDITS

This section provides additional details regarding enforcement actions imposed as a result of 2017 program audits, and offers a comparison of those data to enforcement actions taken based on 2016 program audits. For full details of enforcement actions taken related to 2016 program audits, please see the 2016 Part C and Part D Program Audit and Enforcement Report.⁵

Of the 36 organizations audited during 2017, 17(47%) received an enforcement action. Figure 24 compares the cumulative CMP amounts and types of enforcement actions imposed on sponsors for 2016 and 2017 program audits.

Figure 24⁶



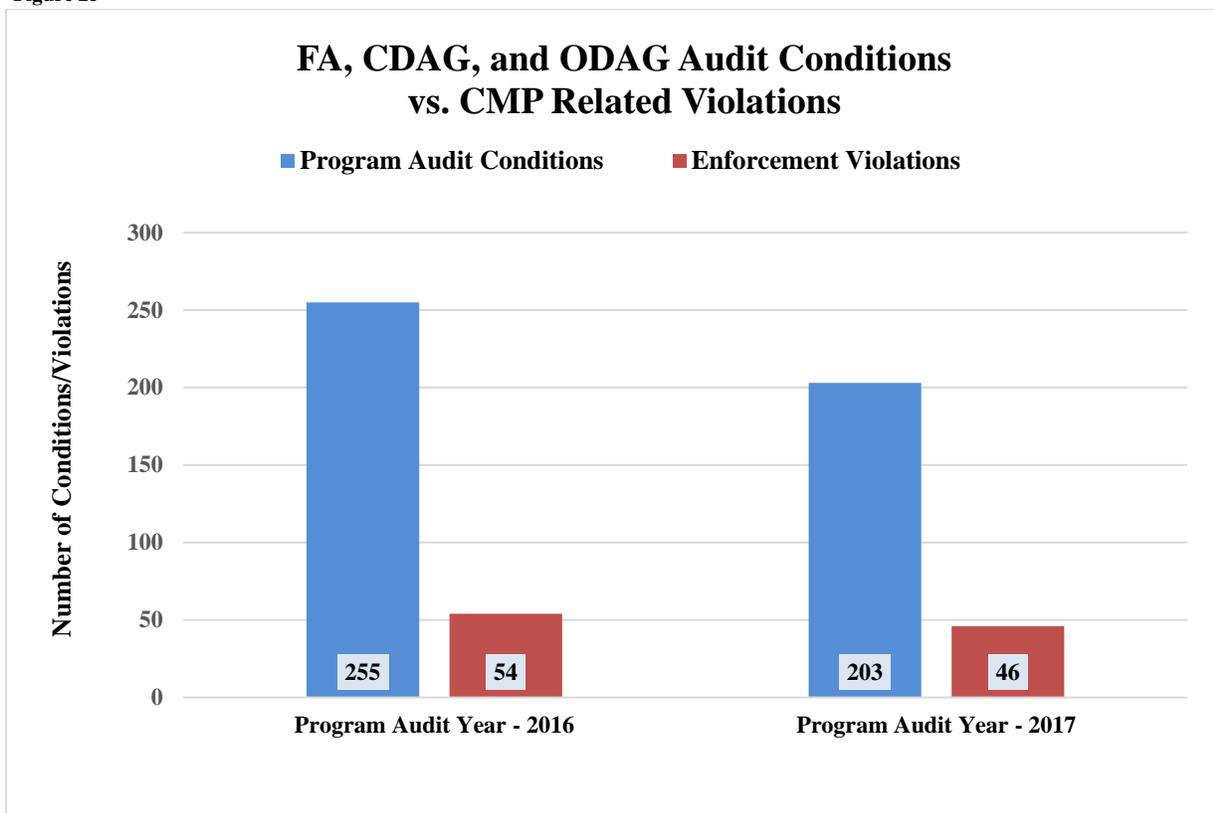
⁵ https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2016_Program_Audit_Enforcement_Report.pdf

⁶ The 18 CMPs were issued to 17 sponsors because one sponsor received two CMPs.

There was one more CMP imposed for 2017 program audits compared to 2016 (i.e., 18 in 2017 vs. 17 in 2016). However, in 2017, CMS conducted a larger number of full-scope program audits compared to 2016. While the issuance of CMPs slightly increased in 2017, the combined dollar amount of the CMPs decreased. This decrease was attributed to a smaller number of violations per CMP and the smaller enrollment size per sponsor (average enrollment size of sponsors receiving a CMP in 2017 was 241,890 compared to 656,650 in 2016).

Sponsors received CMPs for non-compliance in the program areas of FA, CDAG, and ODAG since violations in these areas adversely affected (or had the substantial likelihood of adversely affecting) one or more enrollees. Figure 25 compares the number of conditions cited in the audit reports for the areas of FA, CDAG, and ODAG to the number of violations that were included in CMPs for 2016 and 2017 program audits. There were 255 FA, CDAG, and ODAG conditions cited during the 2016 program audits. CMPs were imposed for 54 (or 21%) of the 255 conditions, specifically, (13) in FA, (19) in CDAG, and (22) in ODAG. There were 203 FA, CDAG, and ODAG conditions cited during the 2017 program audits. CMPs were imposed for 46 (or 23%) of the 203 conditions, specifically, (19) in FA, (15) in CDAG, and (12) in ODAG.

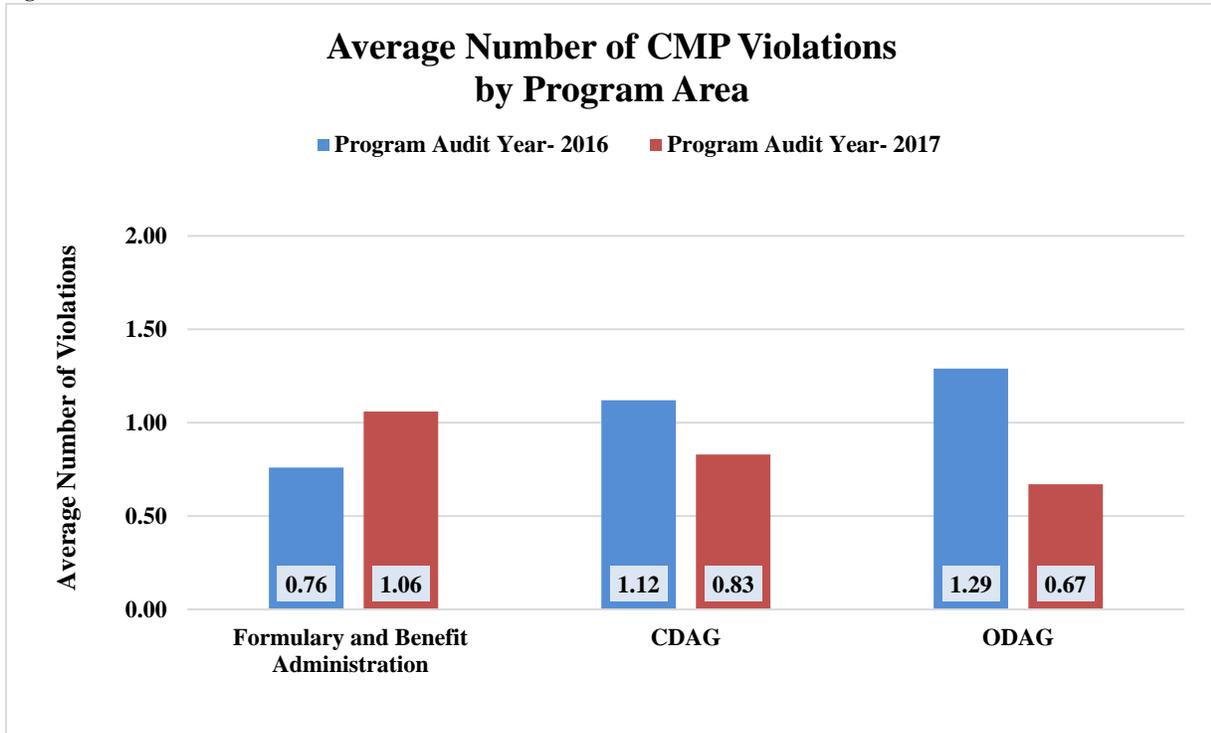
Figure 25



For 2017 program audits, 45 CMP violations were imposed on a per-enrollee basis (total CMP amount of \$2,553,100) and 6 CMP violations were imposed on a per-determination basis (total CMP amount of \$46,700).⁷

Figure 26 shows the average number of CMP violations by program area for 2016 and 2017 program audits. The number of FA violations increased and the number of CDAG and ODAG violations decreased between program audit years 2016 and 2017.

Figure 26



CMS also continues to work to reduce the time to issue CMPs. Improvement in the referral process and analysis of enforcement cases led to an 18% reduction in the number of days to issue a CMP following the date the referral was received (153 days in 2016 vs. 125 days in 2017).

PROGRAM AUDIT INTERMEDIATE SANCTIONS

There were no intermediate sanctions imposed because of 2017 program audits.

⁷ For sponsors that received a CMP based on noncompliance detected in both their MA-PD and Cost plan contracts, violations were calculated on both a per-enrollee and per-determination basis, depending on the applicable regulation. Specifically, 4 of the 6 per-determination penalties (and 4 of the total 51 violations) contained a mix of per-determination and per-enrollee penalty calculations.

2018 AUDIT PROCESS IMPROVEMENTS

The goal in 2018 is to continue enhancing the consistency among audits and strengthen the expertise of audit teams. All audit findings continue to undergo review and evaluation by program audit consistency teams to ensure a fair and consistent outcome across all audits. Through improved auditor expertise, we are better suited to collaborate with and provide technical assistance to our stakeholders, and aid in improving performance. The following is a list of initiatives and process improvements implemented this year:

- Suspended the Medication Therapy Management pilot protocol.
- Fully operationalized the two Medicare-Medicaid Plan (MMP)-specific protocols and expanded our audit plan to account for organizations that offer only MMP-type contracts.
- Reduced the scope of Part C and Part D Call Log universes collected for program audits.
- Extended audit fieldwork from two to three weeks to provide sponsors with additional time to respond to audit requests and prepare for the onsite Compliance Program Effectiveness (CPE) audit.
- Provided written supplemental guidance to audited sponsors prior to universe submissions to address frequently asked questions about protocols.
- Published a blank audit submission checklist on the program audit website for sponsors to use when conducting their own practice audits.
- Published additional information related to the validation audit and program audit closeout processes on our program audit website.
- Enhanced the validation audit process based on feedback received during a 2017 industry-attended listening session, as described in the Calendar Year 2019 Final Call Letter.
- Released the program audit data request documents for the first of two public comment periods in 2018 pursuant to the Paperwork Reduction Act (PRA), allowing stakeholders an opportunity to share with us questions and concerns they have related to our data collection requests for the next audit cycle.
- Posting our updated program audit protocols for the next audit cycle on our website.

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 and Part D 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 sponsors in developing new approaches to improve compliance.