



CENTER FOR MEDICARE

**Information about Ad-hoc Corrective Action Plan (CAP) Requests
Qualifying Conditions**

- The ad-hoc CAP files posted at <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Part-C-and-Part-D-Compliance-Actions.html> contain ad-hoc CAP information that pertains to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), Employer/Union-Only Group Waiver Plans (EGWPs), Section 1876 Cost-Based Plans (Cost Plans), Program of All-inclusive Care for the Elderly (PACE) Plans, and Medicare-Medicaid Plans (MMPs) that operate under contract with CMS to provide Medicare services and prescription drugs to Medicare beneficiaries.
- In order to ensure compliance with Medicare program requirements, CMS oversees the operations of these organizations, in part, through day-to-day monitoring.
- When CMS determines that an organization does not comply with Medicare program requirements, the organization is directed to take all actions necessary to comply with Medicare program requirements. In some circumstances, this action takes the form of an ad-hoc corrective action plan (CAP) request letter from CMS. “Ad hoc” refers to CAPs issued by CMS that are not included in an audit report.
- Please refer to the ad-hoc CAP report “read-me” document for the technical data specifications. If you have any additional questions, please contact Linda Gousis at Linda.Gousis@cms.hhs.gov.