The 2013 Part C and Part D Program Annual Audit and Enforcement Report

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Issued By:

The Medicare Parts C & D Oversight and Enforcement Group

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INTRODUCTION

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs provide health and prescription drug benefits for eligible individuals aged 65 years and older and eligible individuals with disabilities. CMS contracts with private companies, henceforth referred to as "sponsors," to provide health and prescription drug benefits to beneficiaries enrolled in Medicare Advantage (MA) plans, Medicare Advantage Prescription Drug Plans (MA-PDs), other Medicare managed care health plans, and standalone Prescription Drug Plans (PDPs).

The sponsors who participate in the Part C and Part D programs operate in a capitated environment that protects CMS from inappropriate spending on healthcare services and medications by allowing these sponsors to manage an enrollee's care through structured access to services and medications. However, the Part C and Part D programs have several protections that are built into the design of the benefit to ensure the health and safety of our beneficiary population. This makes the administration of a Part C or Part D plan different than commercial insurance. Program experience has demonstrated that certain organizations fail to recognize the need to establish distinct policies, procedures and systems to comply with specific Part C and Part D program requirements, which can result in inappropriate denials or delays in medically necessary items and services to enrollees. There is also the incentive to inappropriately deny or delay access to services or medications in an attempt to keep costs on health care services low.

The Medicare Parts C and D Oversight and Enforcement Group (MOEG), is one of the groups within the Centers for Medicare (CM), that evaluates sponsors' delivery of health care services to Medicare beneficiaries. MOEG strengthens the Medicare program's integrity by conducting a variety of oversight activities, primarily Part C and Part D program audits. Program audits evaluate sponsors' compliance with a number of core program requirements, key among those are the sponsors' ability to provide beneficiaries with access to medically necessary services and prescription drugs. MOEG also develops, maintains and oversees the requirements for sponsors to have an effective compliance program implemented within their organization so that sponsors may effectively monitor compliance with MA and Part D program requirements, including compliance with key fraud and abuse program initiatives. MOEG has 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. MOEG performs validations to ensure that sponsors correct all deficiencies: (1) identified during program audits or, (2) that were the basis for intermediate sanctions. Finally, MOEG serves 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 is the second annual report produced by MOEG, in which we provide a brief overview of the Part C and Part D program audit and enforcement processes, a current and projected snapshot of the program audit landscape, a summary of the program audit and enforcement activities in

2013, and other highlights and noteworthy developments in MOEG's operations since the issuance of our 2012 annual report.

Program audits are one way that CMS is reasonably assured that sponsors deliver benefits in accordance with the terms of their contract and plan benefit package. The program audits are designed to detect instances when sponsors are inappropriately denying services to beneficiaries and require sponsors to correct identified deficiencies and provide outreach to adversely affected beneficiaries. Audit findings involving direct beneficiary harm or the potential to result in such harm are referred by the Division of Audit Operations (DAO) for an independent evaluation to determine if conditions warrant the imposition of enforcement actions up to and including contract termination. This evaluation is conducted by the Division of Compliance Enforcement (DCE) and is separate from the audit process. This comprehensive approach to auditing, including validating correction of deficiencies and referring sponsors with egregious findings, ensures the integrity of the Part C and Part D programs and protects the health and safety of Medicare beneficiaries.

CMS expects all sponsors to carefully and routinely assess risks to their organization, as well as monitor and audit their operations to ensure compliance with CMS requirements. Sponsors should review this Annual Report with their compliance staff, compliance committee, senior leadership and other affected stakeholders, and utilize the information in this report, along with CMS audit protocols and Best Practices, Common Findings HPMS memos to enhance their compliance with CMS requirements and improve audit outcomes.

AUDIT SCOPE & TERMINOLOGY

In order to conduct a comprehensive audit of a sponsor's operation and maximize Agency resources, program audits were conducted 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 audit. The audits evaluated sponsor compliance in the following program areas[1]:

- Part D Formulary and Benefit Administration (FA)
- Part D Coverage Determinations, Appeals, and Grievances (CDAG)
- Part C Organization Determinations, Appeals, and Grievances (ODAG)
- Compliance Program Effectiveness (CPE)
- Part C and Part D Outbound Enrollment Verification Calls (OEV)
- Special Needs Plans Model of Care (SNP MOC) (Pilot Year)

Sponsors were audited in all program areas when possible, unless the protocol did not apply to their operation. For example, not all sponsors operate SNP plans, so SNP MOC would not be tested or a sponsor that is a standalone PDP would not be subjected to the ODAG protocol, as they do not offer an MA benefit. Additionally, when CMS introduces a new protocol, such as

[1] Each program area was divided into sub-areas, referred to as "elements," which tested specific requirements under each program area. A full list of program areas and elements is found in Appendix A.

with the SNP MOC in 2013, the first year is considered a pilot and the sponsor is not given a formal score for that audit area, nor is their performance in that program area factored into their overall audit score.

While each program area audit protocol has distinct and detailed methods of evaluation that are followed closely by CMS' audit teams, each protocol follows roughly the same high level audit procedures to detect non-compliant conditions. For example, sponsors submit data universes which are analyzed and used to select samples prior to the audit. CMS reviews each of these sample cases either via webinar or on-site during the audit. CMS conducts a thorough review of a sponsor's data systems, operations, and documentation while reviewing sample cases, and interviews the sponsor's staff and management personnel.

The following terminology is helpful to know as we proceed in describing our audit process and discussing our audit results:

- **Condition** – an instance of non-compliance detected during the audit that resulted from a sponsor's incorrect policies, systems, operations, or lack of internal controls. Conditions are recorded as Observations, Corrective Action Required (CAR), or Immediate Corrective Action Required (ICAR).
- **Observation**: an instance of non-compliance detected during the audit that appears to be limited to a single case or is clearly not systemic in nature. An observation does not require the development and submission of a corrective action plan, but is discussed with the sponsor in an effort to prevent compliance problems in the future.
- **Corrective Action Required (CAR)** – an instance of non-compliance that demands that the sponsor correct the detected condition. The sponsor is given 7 days from the date of the issuance of the final report to provide a corrective action plan (CAP). Once CMS accepts the CAP, the sponsor is given 90 days to implement the plan to correct the non-compliant condition.
- **Immediate Corrective Action Required (ICAR)** – an instance of non-compliance that demands that the sponsor correct the detected condition immediately. This occurs when the condition causes significant beneficiary harm, which is defined as policies, procedures, systems, and/or operations that may result in beneficiaries not receiving medical services or prescription drugs. The sponsor has three days from the issuance of the ICAR notice to remediate the condition and provide proof of correction. ICARs are issued in the following program areas: FA, CDAG, ODAG, and CPE.

AUDIT PLANNING AND STAFFING

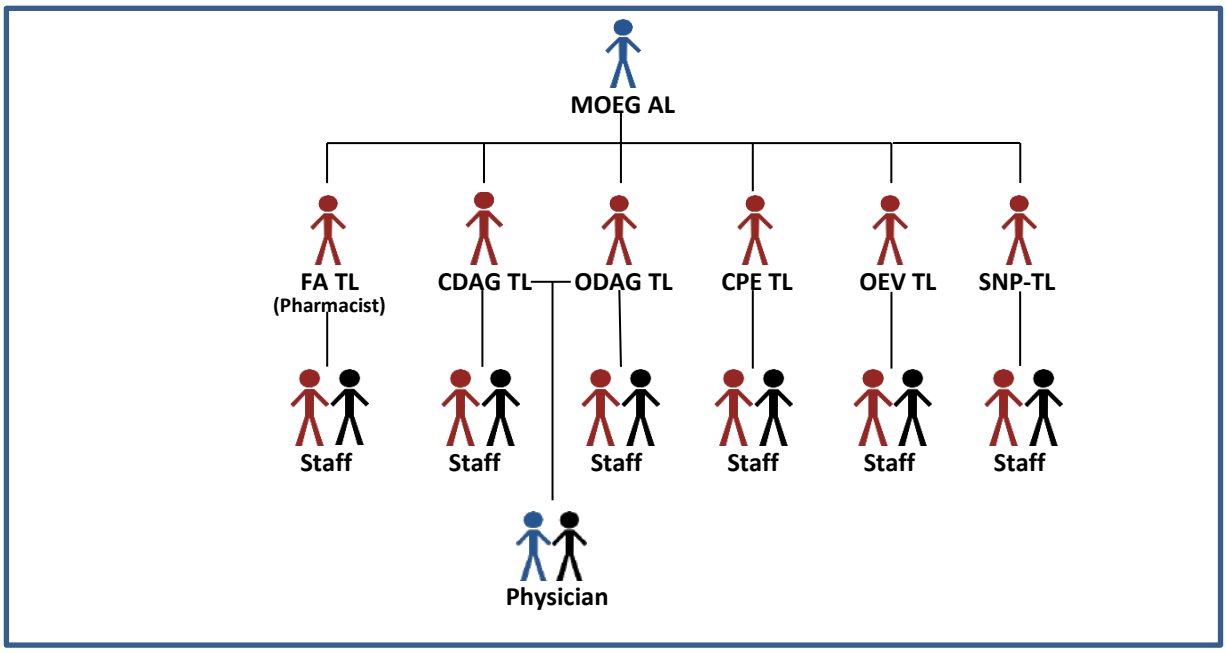
Each year MOEG works in collaboration with the CMS Regional Offices (ROs) to develop and execute the Part C and Part D program audits. MOEG established an Audit Executive Committee to engage management from both CO and ROs in the planning and execution of the Part C and Part D program audit strategy. The Division of Analysis, Policy and Strategy (DAPS) within MOEG is tasked with developing CMS' Part C and Part D audit strategy. Together MOEG and the ROs, with input from Parts C and Part D operations and policy experts, identify program areas that need continued focus; discuss possible new program areas or vulnerabilities for audits to target; propose process improvements to existing methods of evaluation and/or risk

assessment methodology; and determine how best to staff and execute audits through a mix of contractor, MOEG, and RO staff based on competing resources.

MOEG utilizes internal staff resources, resources from the ROs and also oversees and manages two audit support contracts to execute Part C and Part D program audits and validations each year.

The 2013 audit teams generally consisted of the following structure:

Figure 1: General Audit Team Structure



Legend

AL = Audit Lead
TL = Team Lead (generally either RO or contractor staff)
Staff = Additional Team Member to help perform and complete the audit

= CO Employee = RO Employee = Contractor Audit Support Staff

In 2013, only the Audit Lead and the Compliance Program Effectiveness team traveled onsite to assess the sponsor's compliance. The remainder of the audit was accomplished via webinar technology. This resulted in significant savings of both monetary and human resources by reducing travel costs and staff downtime spent while traveling. It also reduced the burden on sponsors, who no longer had to accommodate a large audit team onsite. The contractor audit support staff assisted the Team Leads by accessing and referencing plan benefit information during the real-time webinar reviews; documenting the sample case results; populating and maintaining all the audit work papers; and compiling the draft and final audit reports.

SPONSOR SELECTION FOR AUDIT

MOEG utilized a data-driven risk assessment to generate a risk score and subsequent ranking for all sponsors (at the parent organization level) as the primary means for audit selection. The risk assessment compiled various performance data for all contracts within a parent organization from March 2012 through October 2012 and calculated a sponsor's overall parent organization risk score by weighting each contract (under that parent organization) by its enrollment. The lower (i.e., poorer) the risk score, the higher the risk. Sponsors were arrayed in order of risk (highest to lowest) and were then selected for audit based on one of 4 risk classifications:

- **High Risk** – sponsors in the highest risk quartile of the Risk Assessment.
- **High Star** – a limited number of sponsors with 2013 Star Ratings greater than or equal to 4.5 stars
- **Low Performing Icons (LPI) –** all sponsors with Part C or D summary star ratings of less than 3 stars for at least 3 consecutive years.
- **Sponsors not audited in past 3 years**

Sponsors that are in the High Star category are selected to identify industry best practices, but it also assists CMS in refining our risk assessment methodology (i.e., do higher star plans perform better than high risk plans). Please note that MOEG also conducts Ad Hoc audits and audits based on referrals from CMS Central Office components and ROs. These audits are conducted as a direct response to emerging indicators of noncompliance and are separate and apart from the risk assessment process discussed above. CMS may use existing audit protocols or even develop new protocols specific to the areas of concern. Each year a few audit slots are held in reserve to accommodate ad hoc audits or audit referrals.

AUDIT LIFECYCLE

The lifecycle of an audit begins the day a start notice is issued to the sponsor and concludes with the sponsor's receipt of an audit closeout letter. Improvements continue to be made to the efficiency of the audit lifecycle by streamlining processes to reduce the overall length of the cycle and by responding to sponsor feedback with respect to processes. The table on the following page shows the evolution of the average audit lifecycles from 2011-2013, and where improvements have been made.

Table 1 Average Days Elapsed After Audit Start Notice Issued, 2011-2013

Audit Activity	2011	2012	2013*	Difference between 2011 vs 2012	Difference between 2012 vs 2013	Difference between 2011 vs 2013
Entrance Conference	**21**	**27**	**32**	**+6**	**+5**	**+11**
Exit Conference	**26**	**42**	**44**	**+16**	**+2**	**+18**
Draft Report Issued	**240**	**148**	**129**	**-92**	**-19**	**-111**
Final Report Issued	**267**	**174**	**153**	**-93**	**-21**	**-114**
Sponsor Submits Corrective Action Plan (CAP)	**357**	**263**	**166**	**-94**	**-97**	**-191**
Validation Reviews Conducted	**497**	**408**	**316**	**-89**	**-92**	**-181**
Audit Closeout Letter Issued	**498**	**358**	**326**	**-140**	**-32**	**-172**

***Based on 2013 audits conducted after standardized conditions were finalized on 8/2/2013. No audit reports for 2013 were issued prior to this date.**

Table 1 Summary:

Table 1 shows the average days elapsed after the audit start notice was issued for three years, 2011 - 2013. The average number of days that an entrance conference is held has increased in response to industry feedback that more time is needed between the audit start notice and the actual start of the audit. This provides sponsors additional time to prepare for the audit and pull necessary documentation. The average time necessary to deliver the draft and final reports in 2012 was reduced by 38% and 35% respectively, from 2011. In 2013 there was an additional 8 percentage point reduction in report issuance for both the draft and final reports. This was achieved by streamlining the audit report drafting and issuance processes.

The delivery of a timely audit report is critical to the audit lifecycle because a sponsor needs documentation to share with their organization and leadership to create change and focus resources on correcting deficiencies. If a sponsor can focus their resources and submit a successful corrective action plan (CAP), it will expedite their release from audit. Those responses are reviewed and validated to ensure that the conditions of non-compliance identified during the audit are fixed. The time required for the validation process varies by sponsor, but on average it took approximately 150 days in 2013 (i.e., 316 days – 166 days) from receipt of the CAP to: review the CAP, determine if it was acceptable, and conduct the validation exercises. While the timeframe to complete this part of the audit lifecycle was shorter in 2012 than in 2013, (i.e., 145 days versus 150 days, respectively), the data in Table 1 show that the CAP was not even submitted in 2012 until 263 days after issuance of the start notice. In 2013, this timeframe improved significantly, and CAPs were able to be submitted only 166 days after the issuance of the start notice, a 37% reduction.

Table 1 also shows that the average duration of the entire audit process is typically 1 year, due largely to the amount of effort involved for the sponsor to correct their deficiencies and the thorough validation exercises CMS undertakes to ensure sponsors correct all deficiencies

discovered during the audit. For example, a sponsor audited in 2012 will likely not enter the validation phase of the audit process until sometime in 2013. As previously mentioned, program audits are one of the most comprehensive vehicles CMS utilizes to obtain reasonable assurance that sponsors are operating in compliance with CMS program requirements. This assurance is not achieved until the audit process is concluded and the sponsor is released from audit.

Figure 2 and Figure 3 Summary:
The figures below provide a view of the current audit status of all audits from 2010 through 2014 by enrollment (Figure 2) and by parent organization (Figure 3) through the various phases of the audit process.

Figure 2

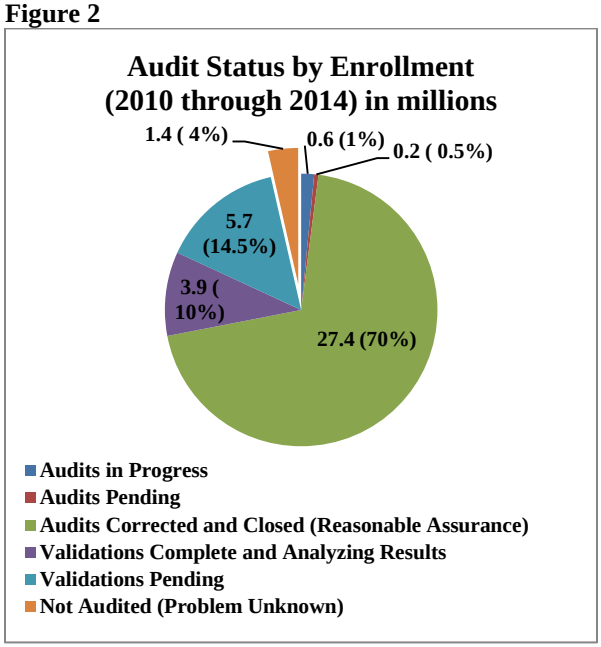
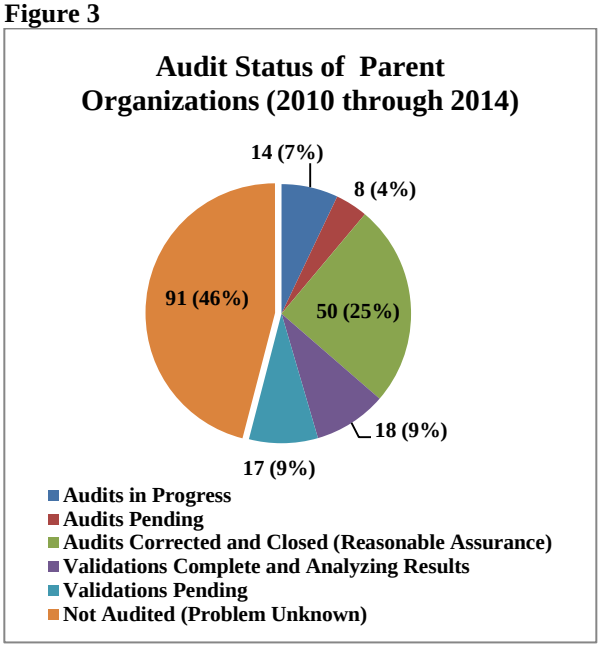


Figure 3



- Approximately 70% of all beneficiaries are enrolled in a plan that CMS has reasonable assurance is operating in compliance with the audited program areas (i.e., Closed and Corrected). In our 2012 Annual Report, this figure was 73% of total enrollment. From the release of our 2012 Annual Report to our 2013 Annual Report (approximately 17 months), total enrollment increased by 7% in MA and Part D. Therefore, the total number of beneficiaries in audited plans in the Closed and Corrected phase has actually increased by 700,000.
- While 46% of the existing 2014 parent organizations have not been audited, this accounts for only 4% of the total enrollment in the MA and Part D programs, down from 7% in 2012.
- 85% of sponsors audited in 2012 are in the Corrected and Closed phase and the remaining 15% are in the Validation phase (data not shown in figure above);
- 52% of sponsors audited in 2013 are in the Validation Pending phase, while the remaining 48% are in the Validation Complete phase (data not shown in figure above).
- All of the 2014 audited sponsors fall into the categories of Audit in Progress, Audit Pending, or Validation Pending buckets (data not shown in figure above).

- All sponsors audited in 2010, 2011 are in the Corrected and Closed phase of their audit (data not shown in figure above).

AUDIT INNOVATIONS AND PROCESS IMPROVEMENT

In order to continuously improve, MOEG evaluates the audit process and solicits feedback from sponsors, other industry stakeholders and trade associations, audit staff, RO staff, and subject matter experts in the Center for Medicare. As a result of our evaluation and the feedback received, the following improvements and innovations were implemented in 2013:

- Sponsors were selected for audit from a variety of performance pools (not only "High-risk" sponsors). At the conclusion of each audit year, the correlation between audit scores and risk scores are analyzed to enhance the predictive value of the risk assessment in selecting appropriate sponsors for audit. Major changes to the risk assessment were implemented for 2014. (Please see *Plans for the 2014 Audit Process* in this report for more information.)
- The 2012 Agent Broker program area was limited in 2013 to Outbound Enrollment Verification, as there were few findings in the remainder of the Agent Broker protocol and an extensive amount of non-audit related oversight was being conducted in this area.
- In 2013, the auditing of Special Needs Plans Model of Care (SNP MOC) was piloted to test sponsors' compliance with the implementation of their own CMS approved MOC. Note that sponsors do not receive a formal audit score for protocols that are in their first year of use. This allows sponsors time to understand CMS' expectations with respect to performance, conduct internal auditing prior to a CMS audit, and for CMS to identify and correct any possible vulnerabilities or gaps in the new protocol.
- In 2013, CMS posted the 2012 audit scores and audit status on the Compliance and Audits webpage. The webpage will be updated to include the audit scores and status annually. This information provides a view of a sponsor's audit results in contrast to the rest of the audited sponsors. The results are located at: http://cms.hhs.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Program-Audit-Results.html
- The 2012-2014 audit protocols and 2012-2013 Best Practices and Common Findings memos are also posted on the Compliance and Audits Website.
- In 2013, CMS incorporated the audit scoring methodology into the Part C and Part D Star Ratings and Past Performance Assessment.
- In 2013, MOEG implemented a 2-week audit review period to conduct all webinars and the compliance program review. This approach has lessened the burden on sponsors' compliance staff and allows more flexibility for CMS and the sponsors to conduct a thorough review.
- MOEG has implemented the first phase of its HPMS audit module in 2013 to automate the engagement letter process and will be working to automate the entire audit process in HPMS by 2015.

The following 2012 innovations and improvements continued to be enhanced in 2013:

- The ICAR process has been formalized.
- Imposing enforcement actions as a direct consequence of audit deficiencies that adversely affected (or had the substantial likelihood of adversely affecting) beneficiaries.

- Refining and shortening the time required for the report writing/issuing process.
- Utilizing and expanding the use of webinar technology in the audit process.
- Comparing sponsor performance on the audits through a condition focused scoring methodology as opposed to the previous pass/fail method, which did not allow for such comparison.

CURRENT AND PROJECTED PROGRAM AUDIT LANDSCAPE

MOEG began its program audit operation in 2010, with a goal to audit every sponsor in the Part C and Part D programs within a reasonable time period. The figures below show the progress of program audit operations on the Part C and Part D industry each year by enrollment and parent organization. These data were based on enrollment and parent organization data as of June 2014 and includes 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). The 2014 totals were 39.2 million beneficiaries (Figure 4) and 198 unique parent organizations (Figure 5). Some parent organizations audited between 2010 and 2013 are no longer in existence due to a merger, acquisition, or termination. As a result, the number of parent organizations represented in Figure 5 may not reflect the actual number audited each year.

Figure 4

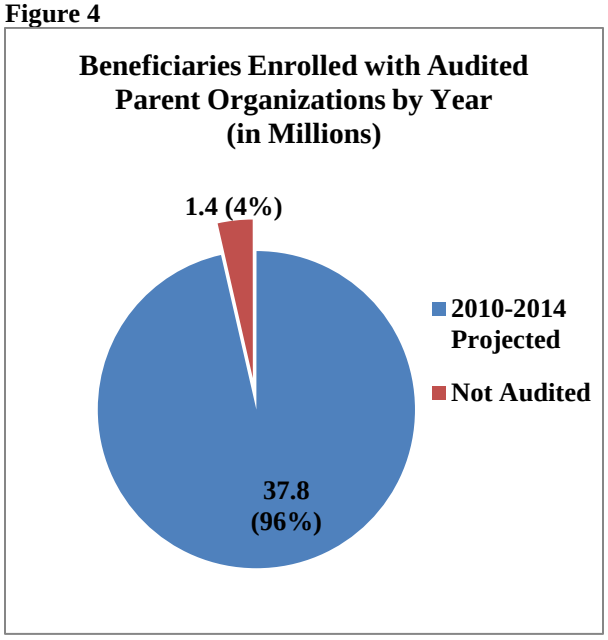


Figure 5

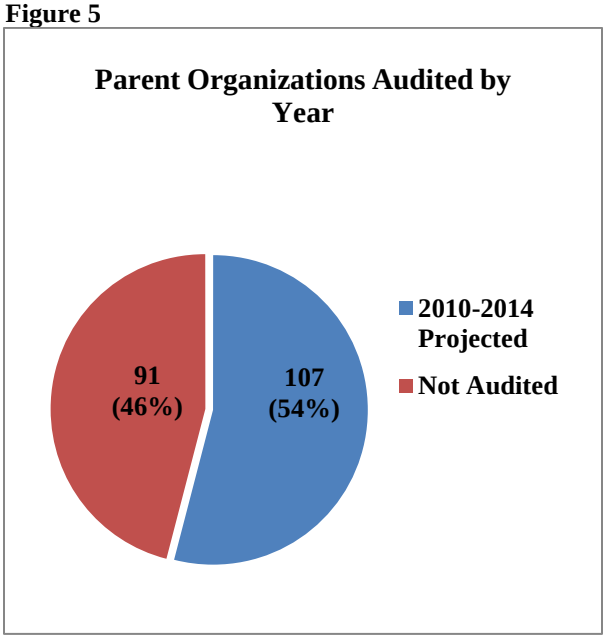


Figure 4 and 5 Summary:

- The variance between the percentage of parent organizations audited and the percentage of enrollment audited reflects MOEG's focused effort to audit sponsors with the largest enrollment in order to ensure that sponsors who impact the most beneficiaries are appropriately providing services to their enrollees.
- Since 2010, sponsors that account for 96% of the total Medicare Advantage, other Medicare managed care health plans and Prescription Drug Programs' enrollment will have been audited by the end of 2014.

Although not separately displayed, we have audited all of the sponsors with the highest risk based on our current risk assesment tools.

AUDIT RESULTS AND TRENDING

In 2013, CMS utilized a scoring system that generated an audit score for every sponsor based on the number and severity of non-compliant conditions detected in a sponsor's operations. In this scoring system, a lower score represents better performance on the audit. Because the audit score is generated based on the number of non-compliant conditions discovered, the maximum audit score is unlimited. Also, the scoring system is weighted to ensure that conditions that have the potential to impact beneficiary access to care have a greater impact on the overall score. The audit score is calculated by assigning 0 points to observations, 1 point to each CAR, 2 points to each ICAR, and dividing the sum of these points by the number of audit elements tested. The following is the formula for calculating the audit score:

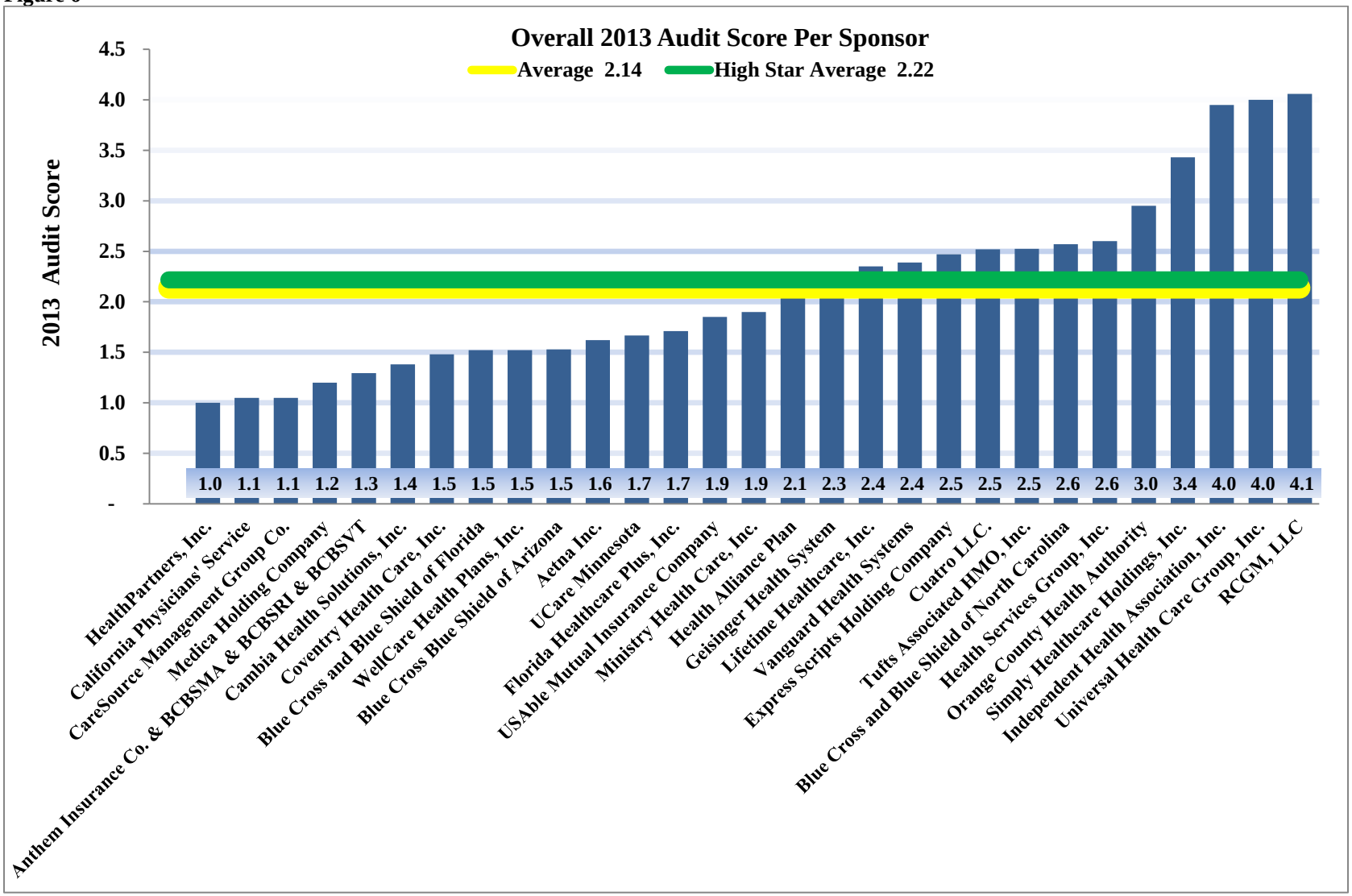
Audit score = (# CARs) + (# of ICARs X 2) / # of audited elements tested

In 2013, an overall audit score was calculated as well as an audit score for each program area. Performance in a particular program area may be better or worse than the overall audit score. As previously mentioned, not all 29 sponsors were audited in each program area. For example if a sponsor did not have operations in a program area (e.g., a sponsor was a standalone PDP), this would eliminate the need for Part C audit protocols. This scoring system quantifies a sponsor's performance and allows both CMS and the sponsors to compare their scores to other sponsors in the industry. The next several figures provide details about the 2013 program audit scores, how these scores compare to the 2013 risk assessment, and how 2013 scores compare to 2012 scores.

2013 Program Audit Scores:

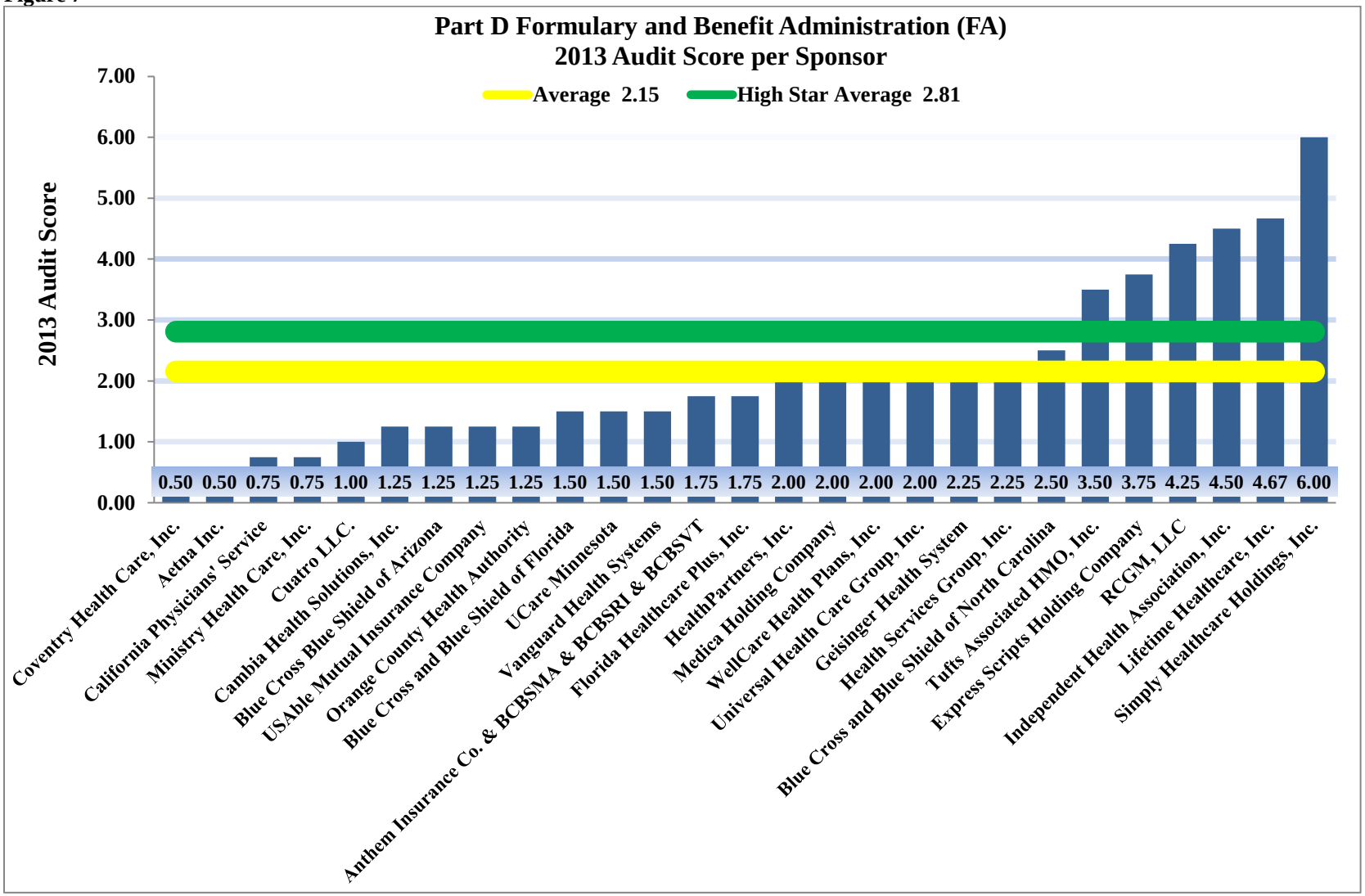
The figures (pages 13-18) array the overall and individual program area 2013 audit scores from three different perspectives. First, the audit scores are arrayed from best to worst score (i.e., lowest score to highest score) moving from left to right across the graph. Second, the average audit score across all audited sponsors is represented by the yellow line in each graph. Finally, the green line represents the average audit score for audited sponsors with a high star rating (4.5-5 stars). In general there was little to no difference between the high star average score and the overall average score.

Figure 6*



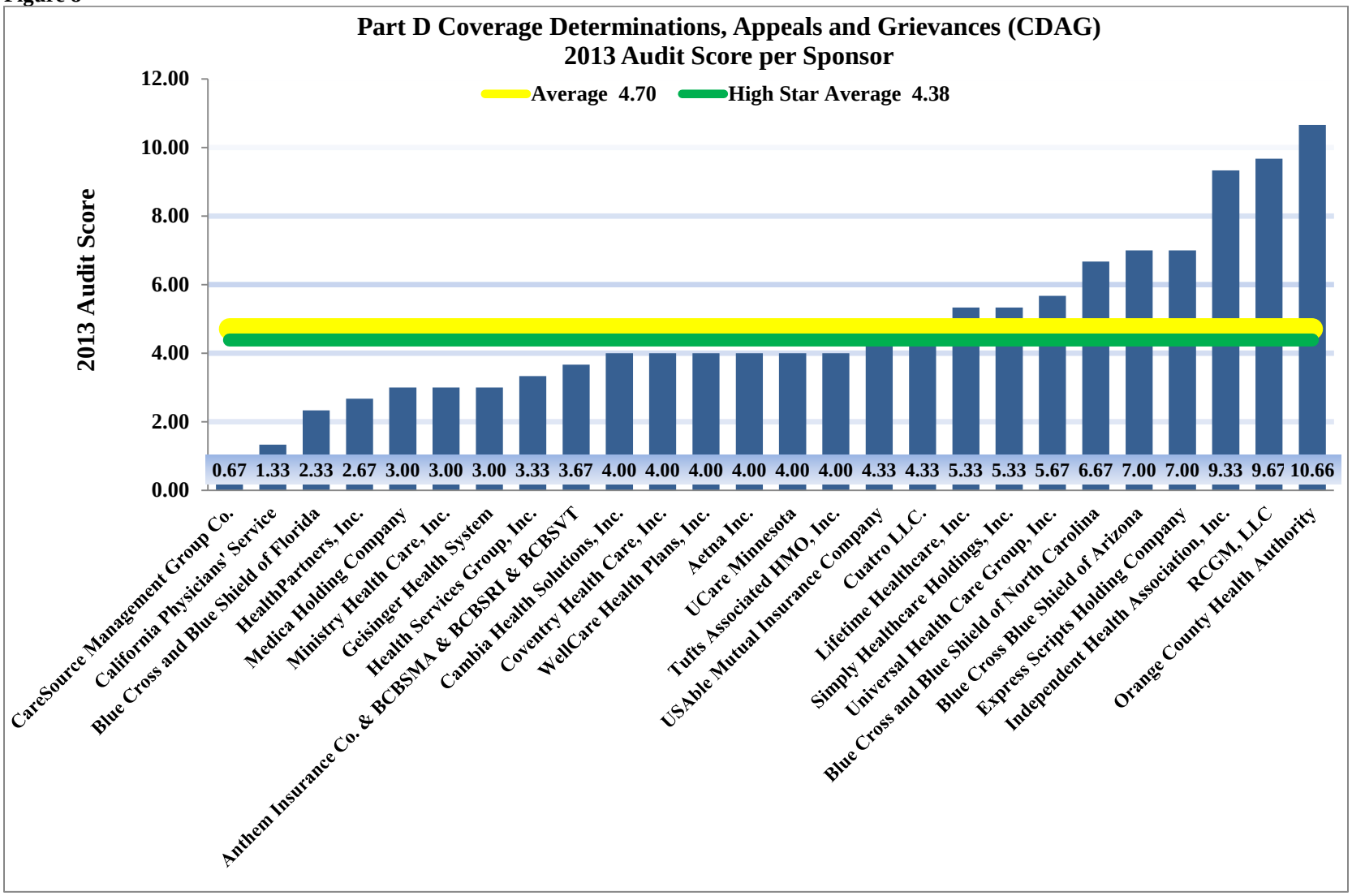
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2013. The high star average is an unweighted score across those sponsors with a star rating of 4.5 or greater.**

Figure 7*



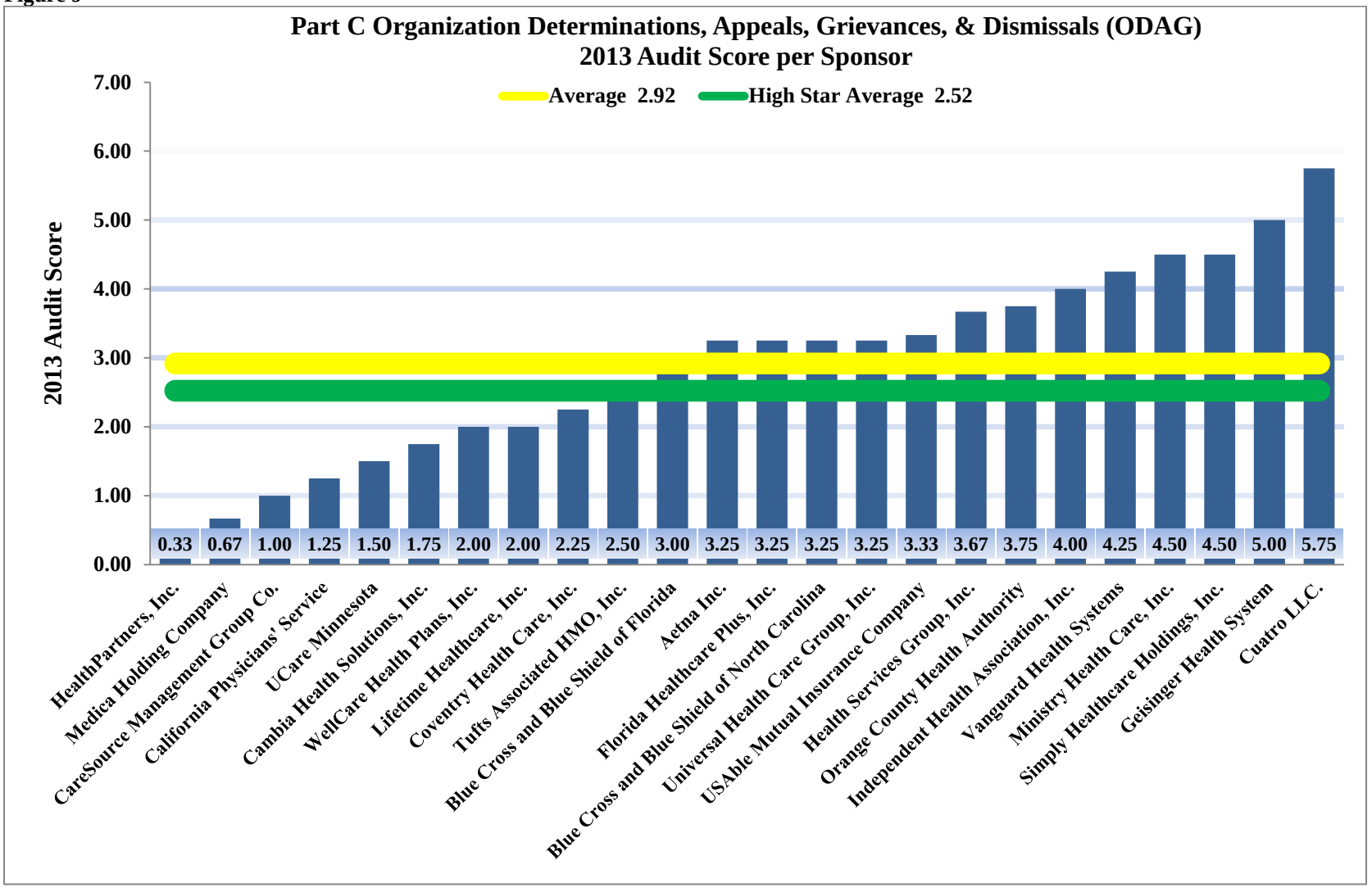
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the FA program area in 2013. The high star average is an unweighted score across those sponsors audited for FA with a star rating of 4.5 or greater.**

Figure 8*



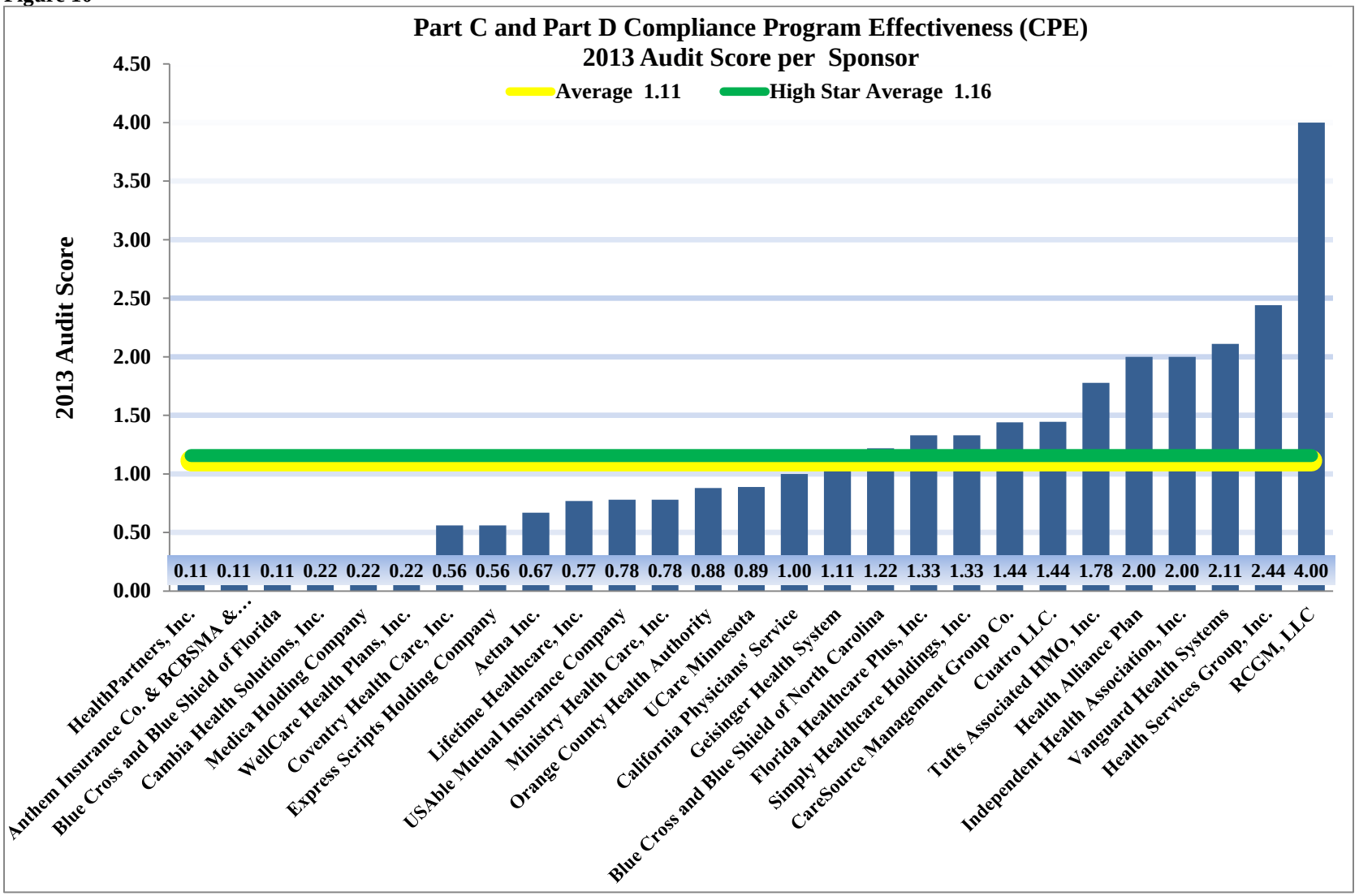
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CDAG program area in 2013. The high star average is an unweighted score across those sponsors audited for CDAG with a star rating of 4.5 or greater.**

Figure 9*



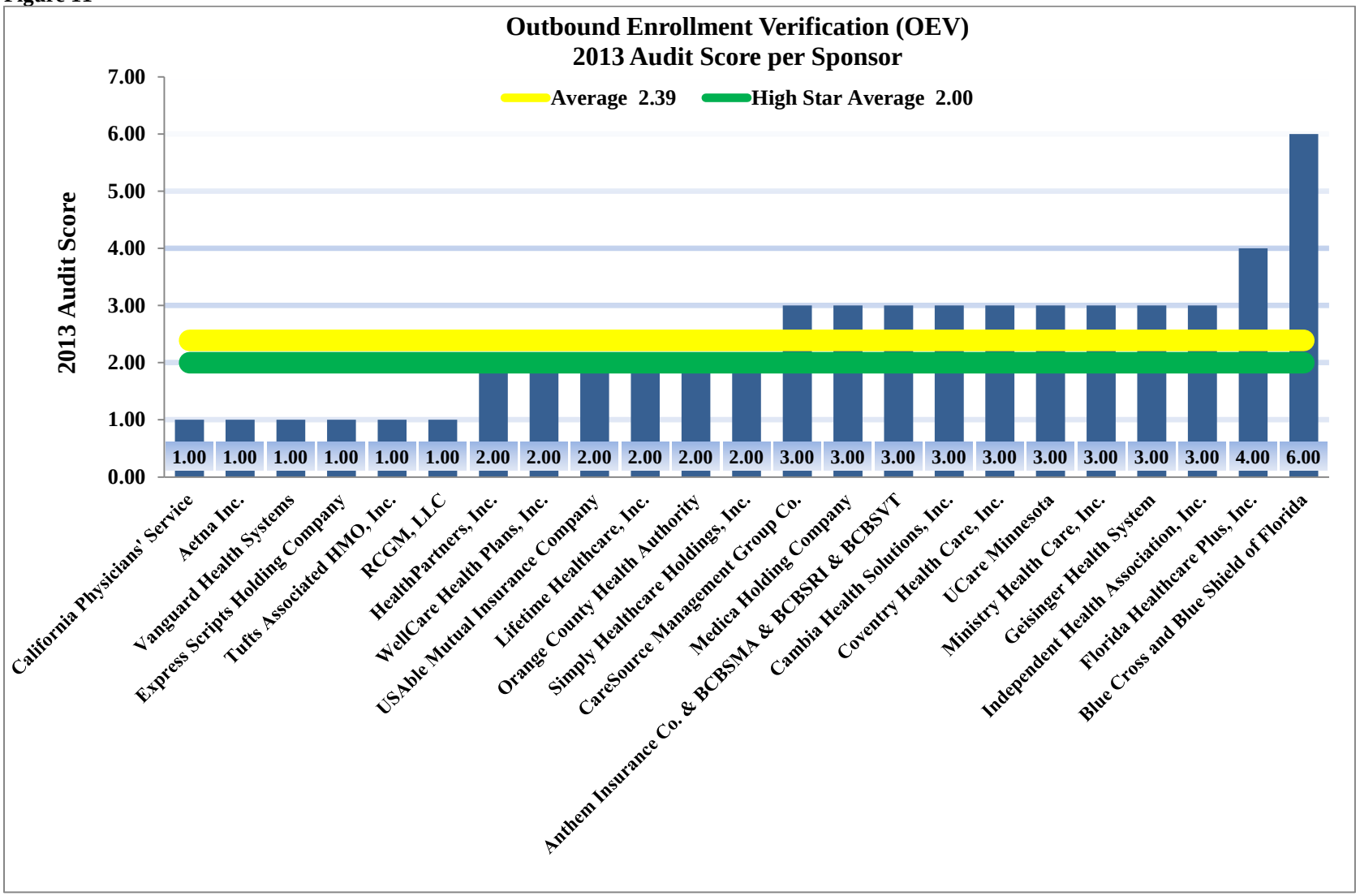
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the ODAG program area in 2013. The high star average is an unweighted score across those sponsors audited for ODAG with a star rating of 4.5 or greater.**

Figure 10*



***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 2013. The high star average is an unweighted score across those sponsors audited for CPE with a star rating of 4.5 or greater.**

Figure 11*

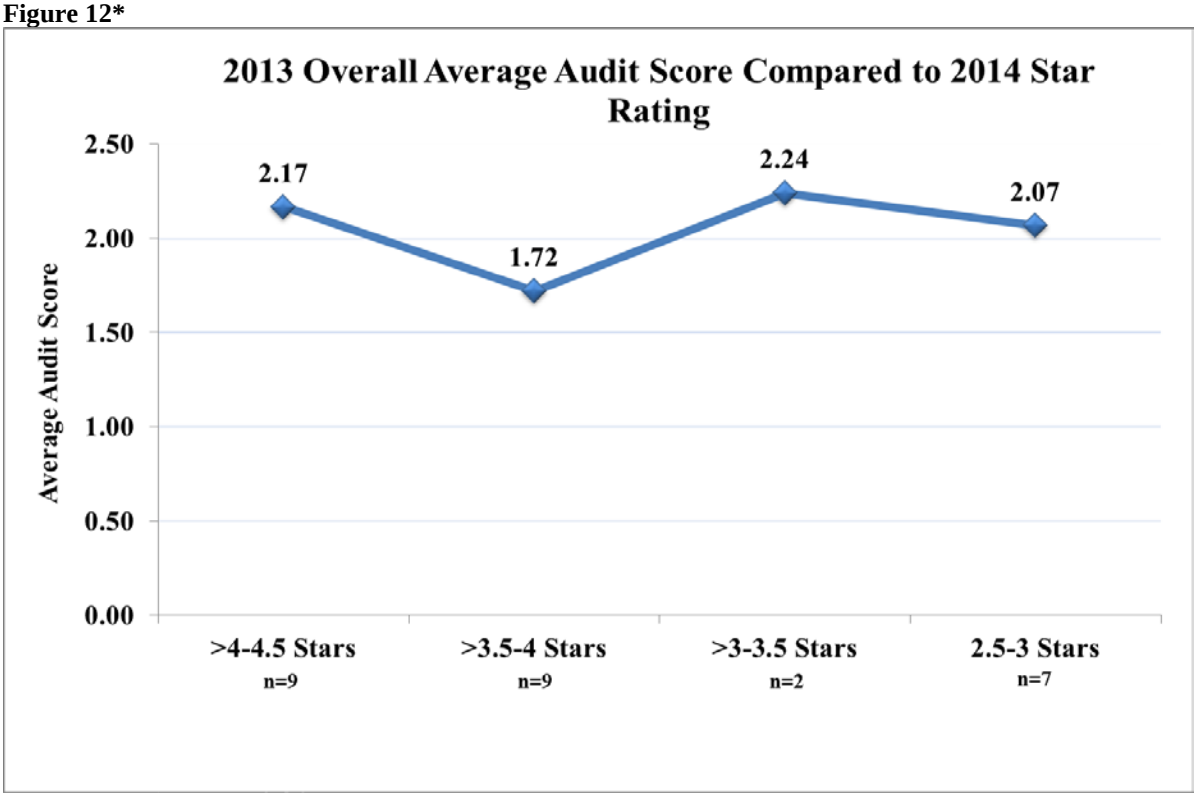


***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the OEV program area in 2013. The high star average is an unweighted score across those sponsors audited for OEV with a star rating of 4.5 or greater.**

Overall 2013 Audit Scores Compared to 2014 Star Rating Data

Figure 12 shows a comparison between 2013 overall average audit scores and Star Rating scores. Terminated or new Medicare sponsors were not assessed a 2014 Star Rating score and therefore were omitted from the analysis. Sponsors were grouped into one of 4 Star Rating ranges before the average of their audit scores were calculated. Sponsors may receive a Star Rating from 1 to 5, 5 being the best. In contrast, the audit score has no upper limit and the lower the audit score the better. We assumed originally that sponsors who received high Star Ratings would perform well on audits. However, this figure shows that there is no direct correlation between the Star Ratings and the actual audit performance of the sponsor. This disparate relationship suggests that program audits reveal unique information about plan performance and compliance that other data do not show. While Star Ratings remain a valuable measure of quality and beneficiary experience, they evaluate different aspects of the sponsors' operations and delivery of the benefit. Therefore, both Star Ratings and audit scores are valuable measures. Each measures different aspects of a sponsor's operation.

Figure 12*

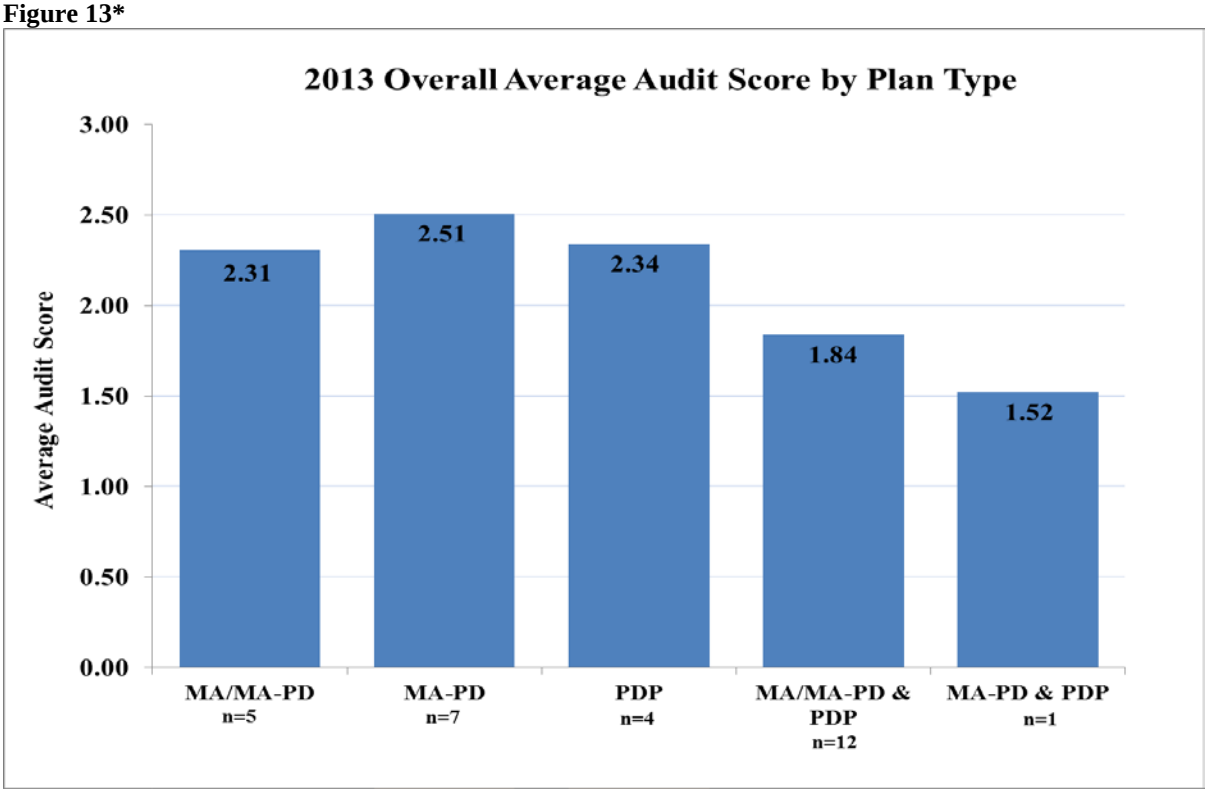


***Audit and star rating scores were analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance. A higher star rating represents better quality and performance.**

Overall 2013 Audit Scores by Organization Type

Figure 13 depicts the 2013 overall average audit score by plan type (e.g., PDP). The majority of the sponsors audited in 2013 offered MA-PDs, MA only and PDPs. Sponsors were grouped into each category based on all of their offerings under their parent organization. In other words, if a sponsor had 5 contracts under their parent organization, four of which were MA-PDs and one PDP, they would fall into the MA-PD & PDP category. The sponsor who fell into the MA-PD and PDP group had the lowest (i.e., best) audit score. CMS does not believe there is enough audit data to draw conclusions about sponsor performance based on this grouping, especially since there are multiple factors that could impact performance (i.e., does the sponsor offer Medicare only products, Medicare and Medicaid, or a mix of Medicare and commercial offerings, etc.)

Figure 13*

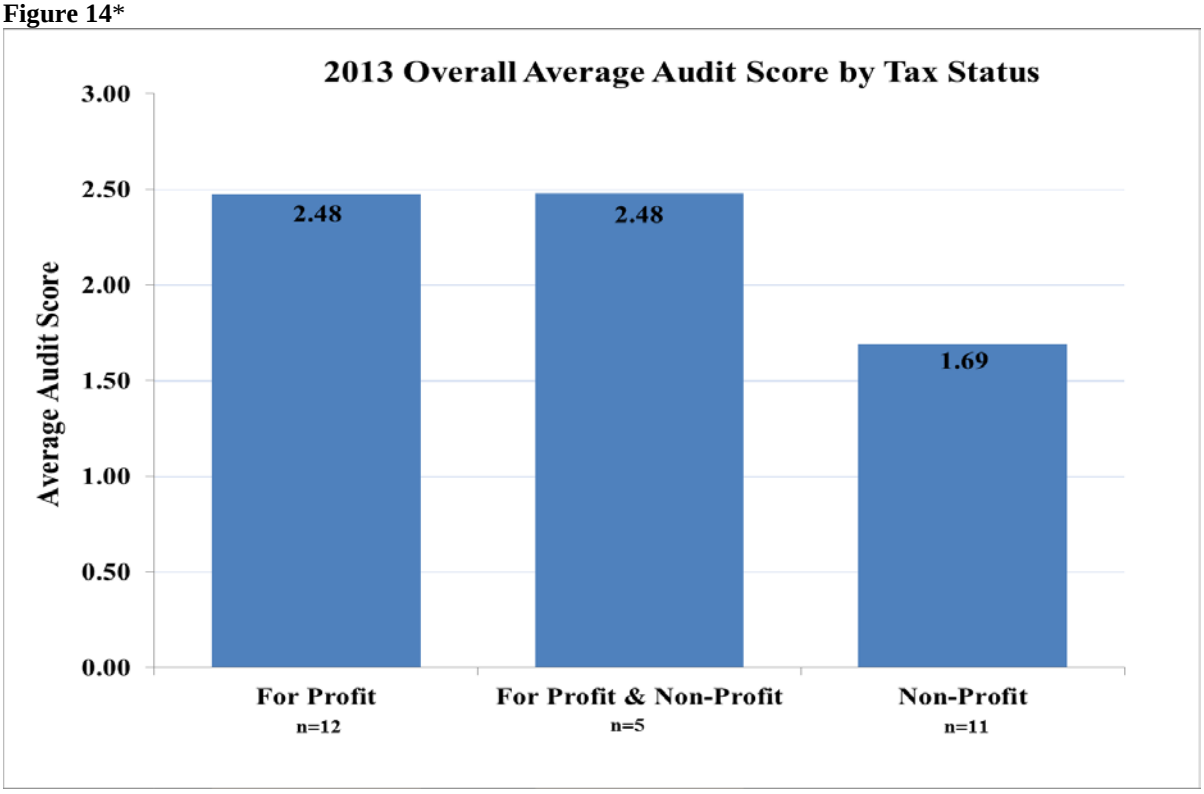


***Audit scores were analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each plan type group. A lower audit score represents better audit performance.**

Overall 2013 Audit Scores by Tax Status

Figure 14 depicts the 2013 overall average audit score by tax status (e.g., for profit). The tax status is 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. Sponsors without a tax status designation for their contracts were omitted. The majority of sponsors were either classified as for profit or as non-profit; only a few sponsors were operating both for and non-profit subsidiaries. Sponsors were almost evenly split between the profit only and non-profit only tax status grouping. Those with only a non-profit tax status had better overall average audit scores.

Figure 14*

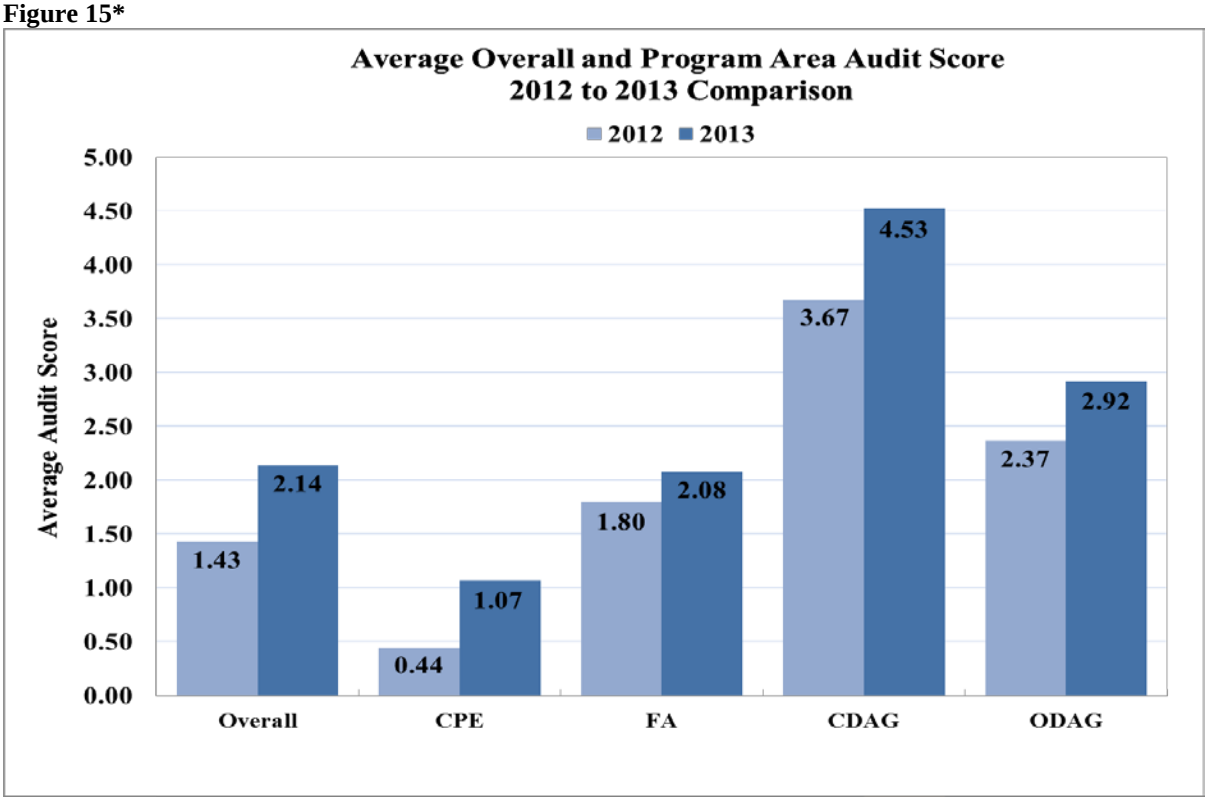


***Audit scores were analyzed at the sponsor (parent organization) level. The tax status is assigned at the contract level; both for profit and non-profit contracts can exist under a single parent organization. The average audit score is an unweighted score across all audited sponsors within each tax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

Comparison of 2012 and 2013 Audit Results*

The figure below shows the average sponsor score in each program area audited in 2012 compared to the 2013 scores.The scores in 2013 are higher than in 2012, however, in 2012 we developed the scoring methodology after most of the audits were conducted and retrospectively calculated the score from the audit results. In 2013 the scores were calculated based on newly developed standarized conditions and the formalized ICAR process, all of which had the potential to impact a sponsor's audit score, which may explain some of the increase between the two years of data. Consequently, CMS believes that the 2012 to 2013 scores have limited comparability and that additional years of audit data are needed before accurate trending can occur.

Figure 15*



***Note that several process improvements, such as standardized conditions, the audit scoring methodology and formalization of the ICAR process in 2012-13, impact the comparability of audit scores from 2012 to 2013. A lower audit score represents better audit performance.**

PLANS FOR 2014 AUDIT PROCESS

MOEG has undertaken the following initiatives and process improvements for 2014:

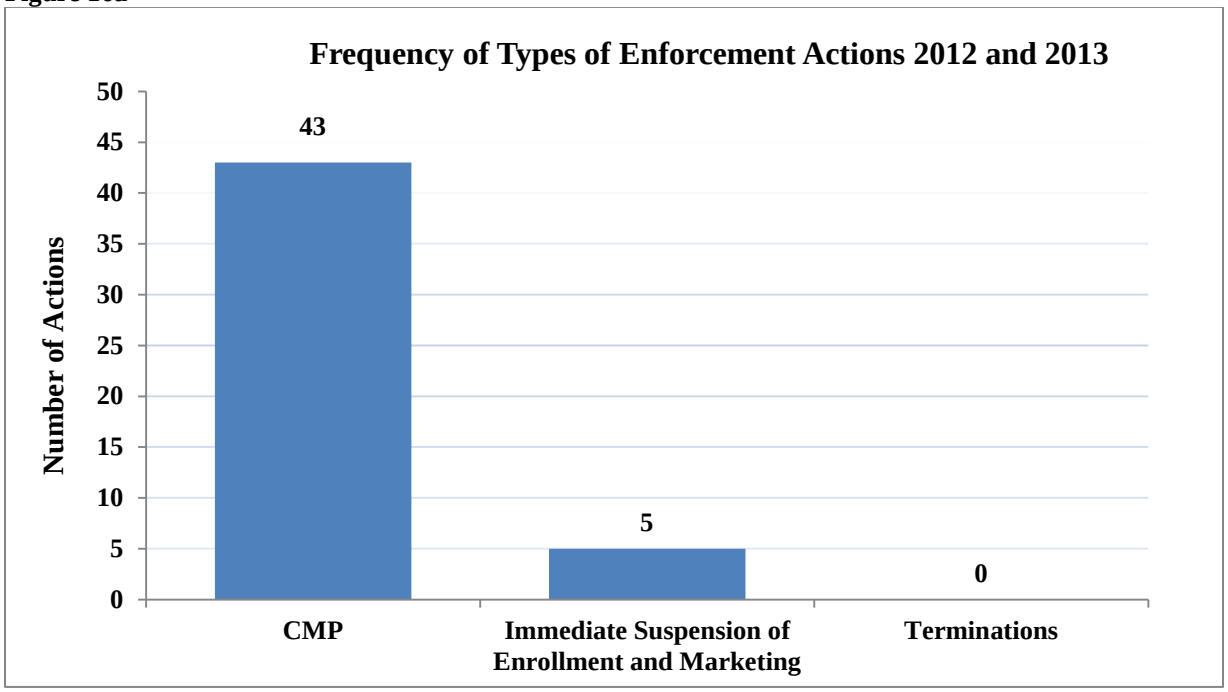
- Although sponsors are required to submit an immediate corrective action plan within 72 hours of notification of any ICARs identified during the audit, beginning with the 2014 audits, ICARs and CAR validations will be conducted simultaneously.
- Beginning in 2014, sponsors are afforded a total of seven (7) calendar days from the issuance of the final audit report to provide a corrective action plan. Sponsors are required to include a brief summary describing the process and give a timeframe for correction. Once submitted, CMS will review the corrective action plan(s). Once the corrective action plan for all CARs is accepted by CMS, the sponsor will have 90 calendar days from the date of acceptance of the corrective action plan to correct the findings noted in the report and conduct internal testing to validate the effectiveness of the corrective action.
- Beginning with audits conducted in 2014, the review of timeliness of determinations, appeals and grievances in both the CDAG and ODAG protocols will be conducted at the universe level.
- CMS continues in 2014 to automate the audit module in HPMS and implement functionality to generate the draft and final audit report in HPMS. The HPMS Audit module currently allows sponsors to obtain the engagement letter, audit protocols, universe templates, audit reports, exchange files, etc. and submit sample documentation via HPMS.
- CMS will continue to perform the CPE portion of the audit in the second week after all other program area audits have been completed. CMS received feedback from sponsors and audit teams that this approach worked more smoothly and allowed a sponsor's compliance officer to be present for a greater portion of the overall audit.
- The audit support contract was restructured to reduce the cost per audit and expand limited resources by streamlining the contractors' role and the staffing model used in 2013.
- CMS redesigned its risk assessment by pulling in more operational data that program experience has shown can have a greater impact on a sponsor's successful operations and ability to comply with our program requirements. The new risk assessment approach produces an overall risk score, but also individual risk scores for each of the program areas we audit. Data analysis will be conducted in 2014 and 2015 to refine this new model to identify measures that better predict how well a sponsor will perform on an audit. If CMS can move to this predictive modeling, it will further enhance our ability to target sponsors for audit, meaning a sponsor who is high risk in formulary, but low risk in CDAG, may only need to receive a formulary audit.

CMS ENFORCEMENT

CMS has authority to impose civil money penalties (CMPs), intermediate sanctions (i.e., suspension of marketing and enrollment activities), and terminate Medicare Advantage (MA) or Prescription Drug Plan (PDP) contracts. MOEG's Division of Compliance Enforcement (DCE) routinely evaluates cases involving substantial and/or repeated non-compliance to determine whether one of these "enforcement actions" is warranted. DCE works closely with the Office of General Counsel, Office of Inspector General, and the Department of Justice to clear all enforcement actions prior to issuance. All enforcement actions are publicly posted on the Part C and Part D Compliance and Audits website[2]. When issues involving fraud, waste, and abuse are detected, they are immediately referred to the Center for Program Integrity in CMS. The scope of the analyses under this section includes enforcement actions imposed in calendar year 2012 and 2013, as well as enforcement actions imposed in calendar year 2014 for 2013 program audits.

Figure 16a shows the cumulative number and type of enforcement actions imposed for 2012 and 2013 on Medicare Advantage Organizations, Prescription Drug Plans, and PACE organizations. Figures 16b and 16c show the number and type of enforcement actions imposed separately for 2012 and 2013.

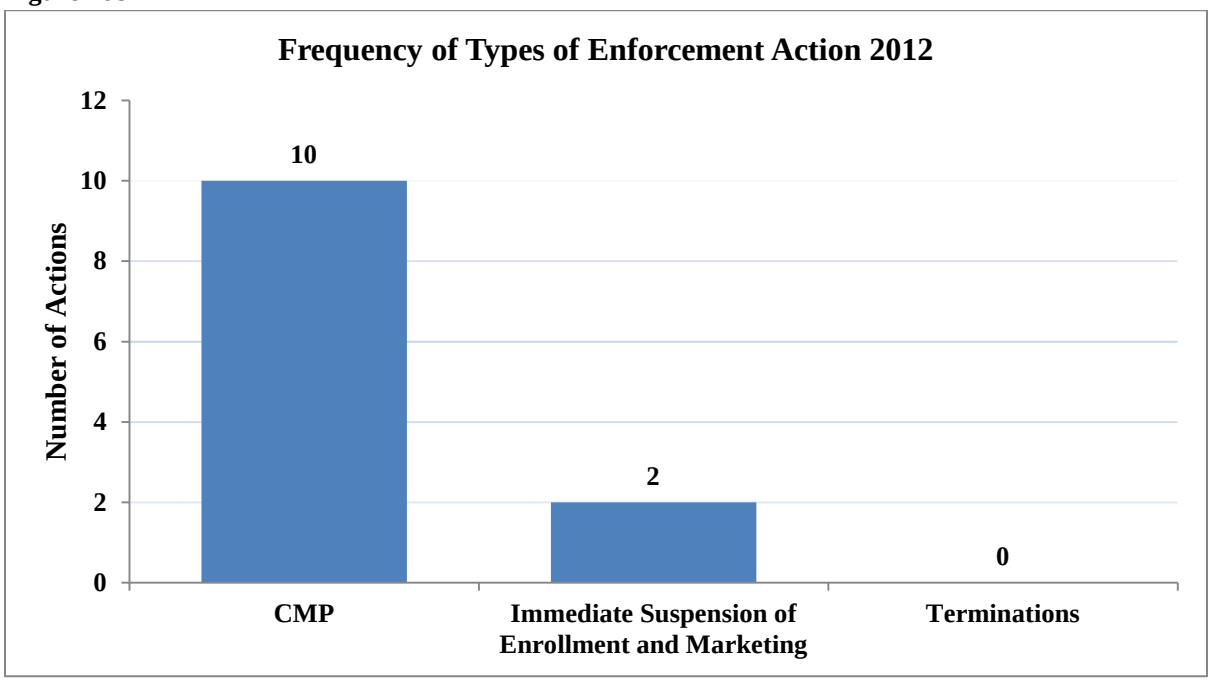
Figure 16a*



***Contract terminations do not include voluntary terminations or mutual terminations. A CMP is a civil monetary penalty.**

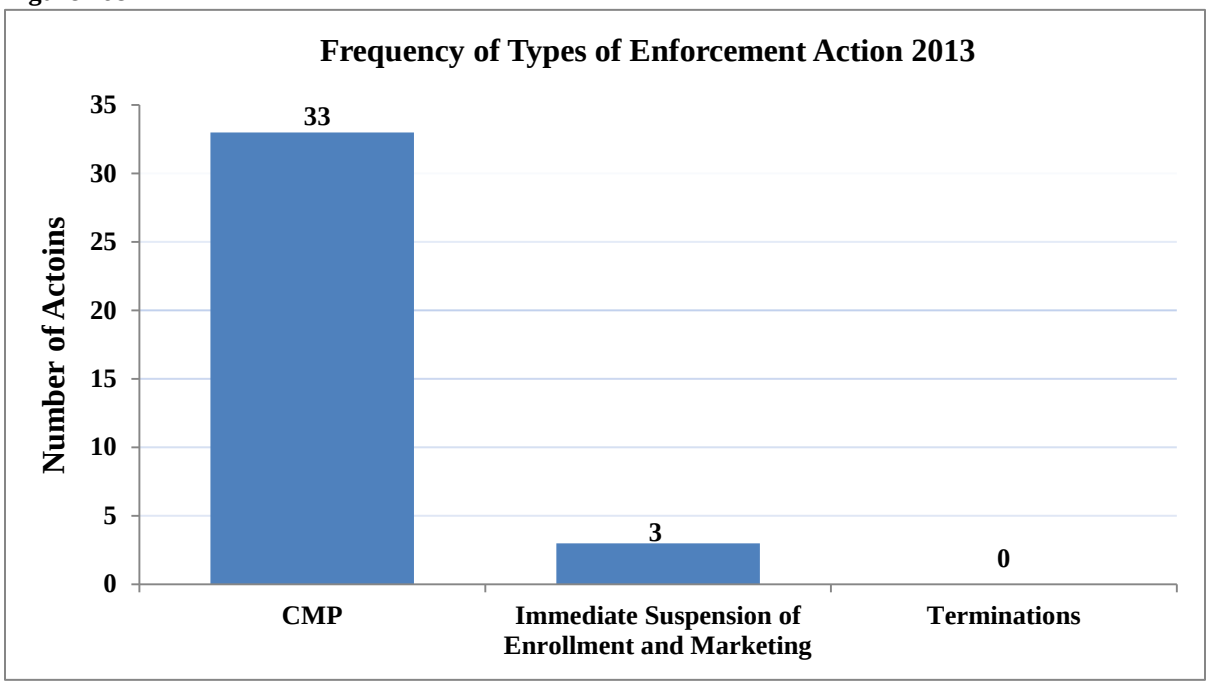
[2] http://cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Part-C-and-Part-D-Enforcement-Actions-.html

Figure 16b*



*** Contract terminations do not include voluntary terminations or mutual terminations. A CMP is a civil monetary penalty.**

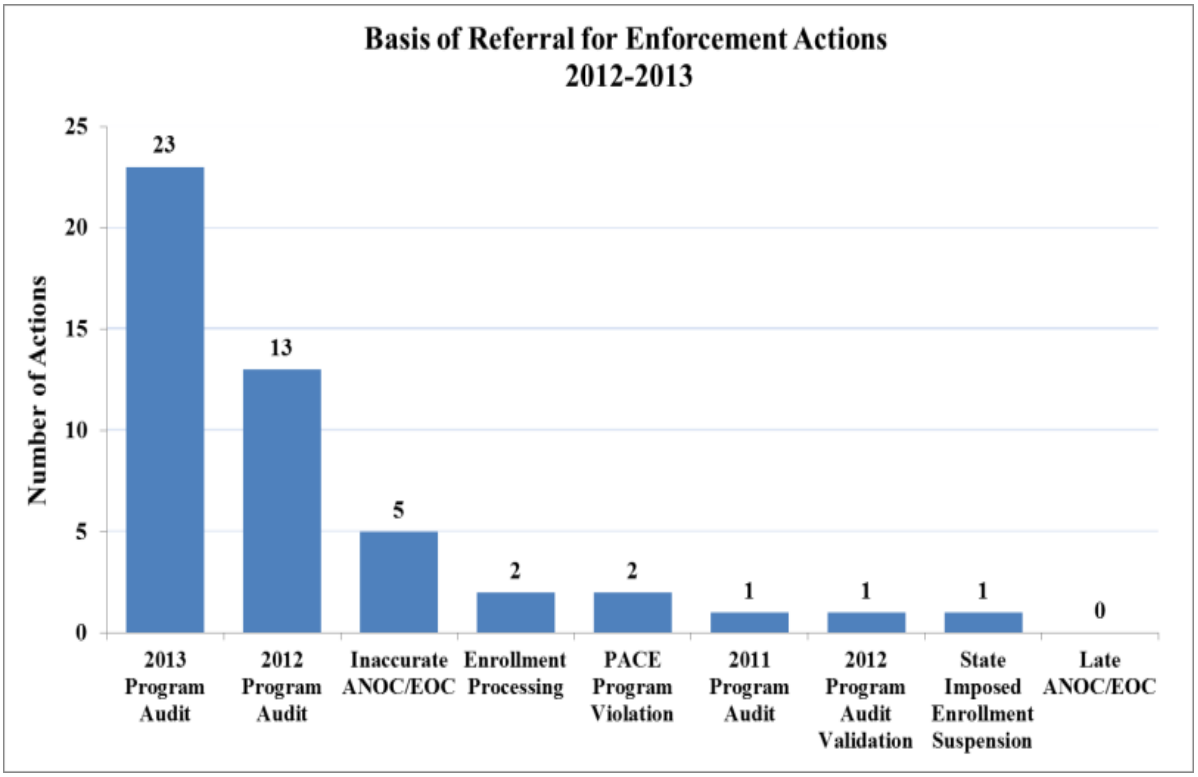
Figure 16c*



*** Contract terminations do not include voluntary terminations or mutual terminations. A CMP is a civil monetary penalty.**

Figure 17 shows the detailed reasons these sponsors were referred for enforcement action. (For a detailed list of all enforcement actions and the entity it impacted, please see Appendix B.)

Figure 17



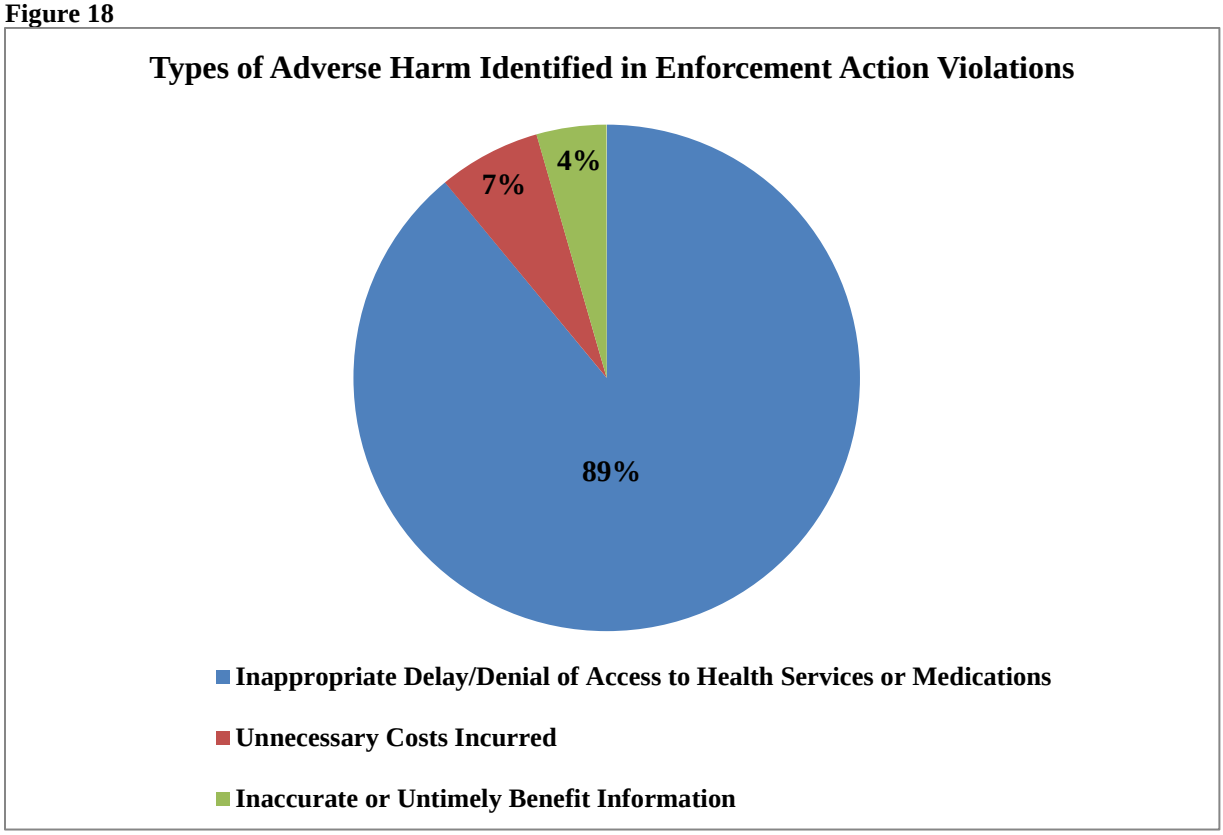
The largest contributor of enforcement action referrals are related to the CMS program audits. These referrals accounted for 38 of the 48 (79.2%) actions imposed by DCE. Other areas of non-compliance that resulted in enforcement actions related to errors in the Annual Notice of Change and Evidence of Coverage documents (10.4%), inaccurate enrollment processing (4.2%), PACE program violations (4.2%) and state imposed enrollment suspensions (2%). These referrals typically come from the ROs, and CMS Part C and Part D compliance divisions.

CMS imposes enforcement actions when a sponsor's actions violate Medicare requirements or adversely affected (or had the substantial likelihood of adversely affecting) enrollees. This usually involves one or more of the following types of harm:

1. Inappropriate delay or denial of access to health services or medications;
2. Unnecessary costs incurred by the beneficiary (i.e., incorrect premiums/cost-sharing);
3. Inaccurate or untimely benefit information necessary to make informed decisions.

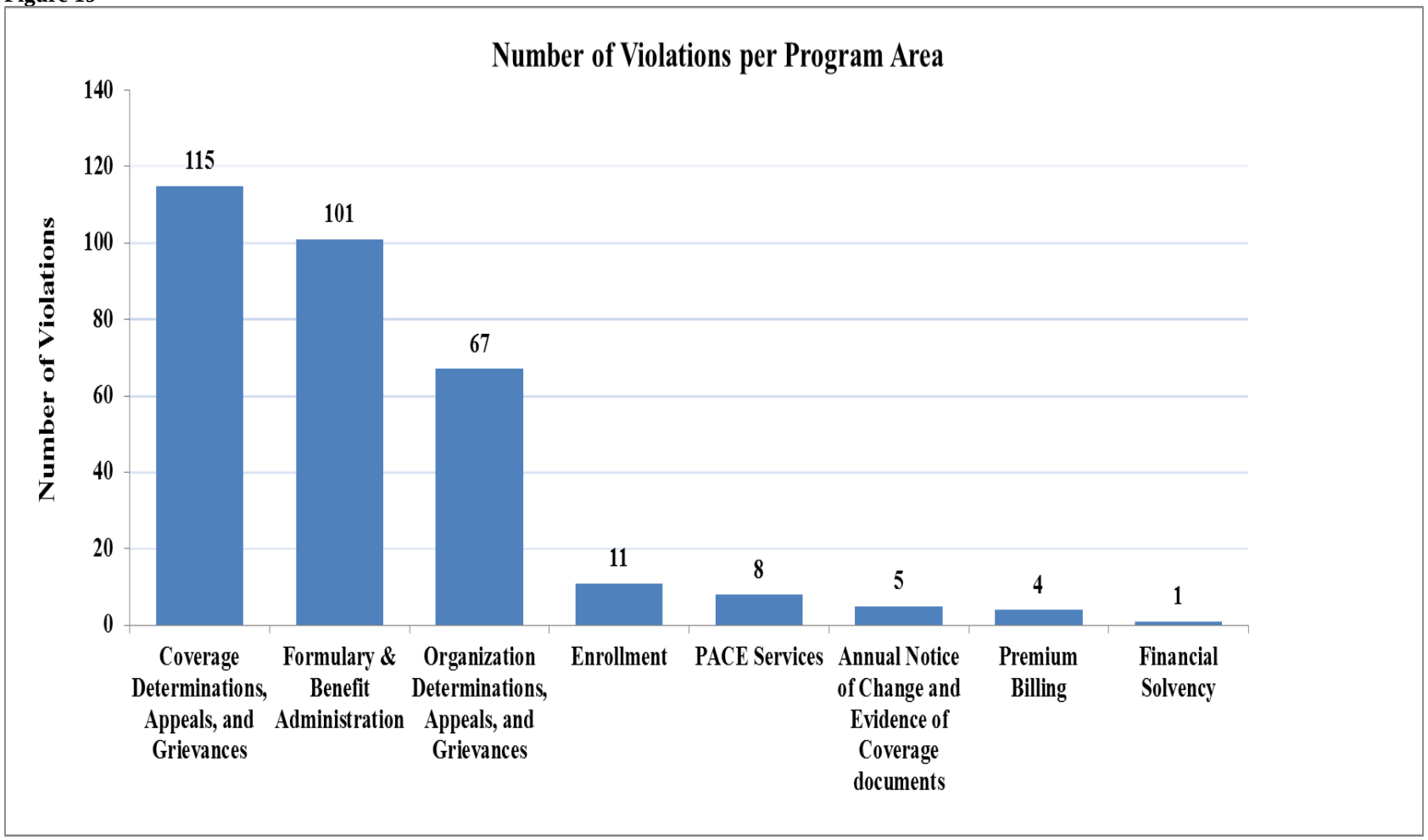
As shown below in Figure 18, most violations (89%) cited in enforcement actions resulted in inappropriate delays or denials of access to health services and medications for enrollees.

Figure 18



CMS identified various types of non-compliance that warranted enforcement actions and tracks the number of non-compliant organizations and the frequency of violations in a given program area. As one can see in Figure 19 (following page), the most frequent violations occurred in the areas of Part D Coverage Determinations, Appeals, and Grievances, Formulary and Benefit Administration, and Part C Organization Determinations, Appeals, and Grievances. This is due to the large number of enforcement referrals that result from audits, but also because these areas are the most likely to result in adverse consequences to an enrollee when a requirement is violated.

Figure 19


Number of Violations per Program Area
Number of Violations
140
120
100
80
60
40
20
0
115
101
67
11
8
5
4
1
Coverage Determinations, Appeals, and Grievances
Formulary & Benefit Administration
Organization Determinations, Appeals, and Grievances
Enrollment
PACE Services
Annual Notice of Change and Evidence of Coverage documents
Premium Billing
Financial Solvency

INTERMEDIATE SANCTIONS

Intermediate sanctions may be imposed by suspending an organization's ability to market, enroll, or receive payment for new enrollees. CMS imposed 5 intermediate sanctions for issues identified in 2012 and 2013.

Table 2 Intermediate Sanctions for Issues Identified in 2012 and 2013

Date of Imposition	Sponsor Name	Enrollment	Basis for Referral	Type of Sanctions Imposed	Duration
10/09/2012	MAPFRE Life Insurance Company	10,744	2012 Program Audit	Immediate Suspension of Enrollment and Marketing	N/A - Entered into Mutual Termination w/ CMS
11/19/2012	Universal Health Care Insurance Company, Inc.	69,220	State Imposed Suspension of Enrollment	Immediate Suspension of Enrollment	N/A - Entered into Mutual Termination w/ CMS
01/15/2013	Silverscript Insurance Company	4,194,327	Enrollment Processing	Immediate Suspension of Enrollment and Marketing	350 days – released as of 1/1/2014
04/23/2013	Smart Insurance Company (S0064)	77,198	2013 Program Audit	Immediate Suspension of Enrollment and Marketing	Sanctions Ongoing
01/24/14	Orange County Health Authority	15,636	2013 Program Audit	Immediate Suspension of Enrollment and Marketing	Sanctions Ongoing

Two of the five organizations decided to enter into a mutual termination of their contracts, which ended the sanctions. One organization corrected the operational deficiencies that were the bases for their sanctions and was able to demonstrate operational compliance by successfully passing CMS directed validation exercises. Smart Insurance Company and Orange County Health Authority remain under sanction and are in the process of correcting their operational deficiencies.

Since 2009, CMS has imposed 15 sanctions. The length of the sanction period ranged from 215 days to 637 days, with an average sanction period of 325 days. Five of the sanctions ended in termination or mutual termination.

CIVIL MONEY PENALTIES

CMS imposed 43 Civil Money Penalties (CMPs), totaling $8,360,005, on 39 different organizations for issues identified in 2012 and 2013. CMPs ranged from $21,800 to $2,175,000, resulting in an average CMP of $194,419.

APPENDICES

APPENDIX A PROGRAM AREAS AND ELEMENTS AUDITED IN 2013

PROGRAM AREA	ELEMENT
Part D Formulary and Benefit Administration	Formulary Administration
	Transition
	Pharmaceutical and Therapeutics (P&T) Committee
	Website Review
Part D Coverage Determinations, Appeals, and Grievances	Effectuation Timeliness
	Appropriateness of Clinical Decision Making & Compliance with Processing Requirements
	Grievances
Part C Organization Determinations, Appeals, Grievances, and Dismissals	Effectuation Timeliness
	Appropriateness of Clinical Decision Making & Compliance with Processing Requirements
	Grievances
	Dismissals
Part C and Part D Compliance Program Effectiveness	Written Policies, Procedures, and Standards of Conduct
	Compliance Officer, Compliance Committee, and High Level Oversight
	Effective Training and Education
	Effective Lines of Communication
	Enforcement of Well-Publicized Disciplinary Standards
	Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
	Procedures and Systems for Promptly Responding to Compliance Issues
	Effectiveness Measure
	Sponsor Accountability and Oversight of FDRs
Outbound Enrollment Verification	Outbound Enrollment Verification
Special Needs Plan – Model of Care	Population to be Served – Enrollment Verification
	Health Risk Assessment (HRA), Interdisciplinary Care Team (ICT), and Implementation of the Individualized Care Plan (ICP)
	Plan Performance Monitoring and Evaluation of the MOC

APPENDIX B

ENFORCEMENT ACTIONS IMPOSED FOR ISSUES IDENTIFIED IN 2012 AND 2013*

#	Date of Imposition	Sponsor Name	Enrollment at Time of Action	Basis for Referral	Type of Action Imposed	CMP Amount
1	06/19/2012	UnitedHealth Group, Inc.	7,181,659	2011 Program Audit	CMP	$2,175,000
2	10/09/2012	Care1st Health Plan	25,916	2012 Program Audit	CMP	$50,000
3	10/09/2012	MAPFRE Life Insurance Company	10,744	2012 Program Audit	Immediate Suspension of Enrollment and Marketing	N/A
4	10/09/2012	Triple-S Salud, Inc.	71,354	2012 Program Audit	CMP	$350,000
5	10/09/2012	Universal American Corp.	136,140	2012 Program Audit	CMP	$325,000
6	11/19/2012	Universal Health Care Insurance Company, Inc.	69,220	State Imposed Suspension of Enrollment	Immediate Suspension of Enrollment and Marketing	N/A
7	12/14/2012	Aveta Inc.	218,268	2012 Program Audit	CMP	$75,000
8	12/14/2012	Health Alliance Plan	46,040	2012 Program Audit	CMP	$75,000
9	12/14/2012	HealthSun Health Plans, Inc.	15,061	2012 Program Audit	CMP	$50,000
10	12/14/2012	Physician's United Plan	23,903	2012 Program Audit	CMP	$50,000
11	12/14/2012	Sterling Life Insurance Company	78,660	2012 Program Audit	CMP	$75,000
12	12/14/2012	The New York State Catholic Health Plan, Inc.	9,972	2012 Program Audit	CMP	$75,000
13	01/15/2013	Silverscript Insurance Company	4,194,327	Enrollment Processing	Immediate Suspension of Enrollment and Marketing	N/A
14	02/20/2013	Public Health Trust of Miami-Dade	2,105	2012 Program Audit	CMP	$175,000
15	04/03/2013	Centene Corporation	5,266	2012 Program Audit	CMP	$100,000
16	04/03/2013	Torchmark Corporation	251,974	2012 Program Audit	CMP	$150,000
17	04/23/2013	Smart Insurance Company	77,198	2013 Program Audit	Immediate Suspension of Enrollment and Marketing	N/A

#	Date of Imposition	Sponsor Name	Enrollment at Time of Action	Basis for Referral	Type of Action Imposed	CMP Amount
18	08/01/2013	Alexian Brothers Community Services	157	PACE	CMP	$25,000
19	08/01/2013	Silver Star Health Network	76	PACE	CMP	$25,000
20	10/24/2013	Centene Corporation	2,571	Inaccurate ANOC/EOC	CMP	$25,710
21	10/24/2013	HealthNet, Inc.	8,653	Inaccurate ANOC/EOC	CMP	$86,530
22	10/24/2013	Independence Blue Cross	9,589	Inaccurate ANOC/EOC	CMP	$47,945
23	10/24/2013	InnovaCare, Inc.	4,971	Inaccurate ANOC/EOC	CMP	$49,710
24	10/24/2013	Medical Card System, Inc.	2,341	Inaccurate ANOC/EOC	CMP	$23,410
25	11/21/2013	Health Alliance Plan	47,504	2012 Program Audit Validation	CMP	$423,200
26	01/24/2014	Orange County Health Authority	15,636	2013 Program Audit	Immediate Suspension of Enrollment and Marketing	N/A
27	03/31/2014	Independence Blue Cross	97,700	Enrollment Processing	CMP	$50,000
28	04/23/2014	Independent Health Association, Inc.	73,325	2013 Program Audit	CMP	$154,600
29	04/23/2014	Lifetime Healthcare, Inc.	140,853	2013 Program Audit	CMP	$447,450
30	04/23/2014	Simply Healthcare Holdings, Inc.	25,755	2013 Program Audit	CMP	$252,750
31	04/23/2014	UCare Minnesota	108,846	2013 Program Audit	CMP	$30,000
32	04/24/2014	Aetna	2,739,575	2013 Program Audit	CMP	$101,500
33	04/24/2014	Aetna	1,373,405	2013 Program Audit	CMP	$407,800
34	04/24/2014	Anthem Insurance, Co.	123,149	2013 Program Audit	CMP	$100,950
35	04/24/2014	Blue Cross Blue Shield of Arizona, Inc.	5,968	2013 Program Audit	CMP	$60,000
36	06/11/2014	Blue Cross Blue Shield of Florida, Inc.	158,210	2013 Program Audit	CMP	$176,000
37	06/11/2014	HealthPartners, Inc.	49,351	2013 Program Audit	CMP	$21,800
38	06/11/2014	Tufts Associated Health Maintenance Organization	112,204	2013 Program Audit	CMP	$137,700

#	Date of Imposition	Sponsor Name	Enrollment at Time of Action	Basis for Referral	Type of Action Imposed	CMP Amount
39	06/12/2014	Express Scripts Holding Company	2,703,570	2013 Program Audit	CMP	$334,300
40	06/12/2014	USAble Mutual Insurance	58,597	2013 Program Audit	CMP	$51,150
41	06/12/2014	WellCare Health Plans, Inc.	1,459,922	2013 Program Audit	CMP	$290,050
42	07/16/2014	Blue Cross Blue Shield of North Carolina, Inc.	219,303	2013 Program Audit	CMP	$290,250
43	07/16/2014	Cambia Health Solutions, Inc.	134,149	2013 Program Audit	CMP	$254,000
44	07/16/2014	Cuatro LLC	3,411	2013 Program Audit	CMP	$80,600
45	07/17/2014	Florida Healthcare	9,744	2013 Program Audit	CMP	$113,200
46	07/17/2014	Geisinger Health Solutions	69,001	2013 Program Audit	CMP	$180,400
47	07/17/2014	Health Services Group, Inc.	48,230	2013 Program Audit	CMP	$312,300
48	07/17/2014	Ministry Health Care, Inc.	56,564	2013 Program Audit	CMP	$81,700

***Includes enforcement actions imposed in calendar year 2012 and 2013, as well as enforcement actions imposed in calendar year 2014 for 2013 program audits.**