2024 Part C and Part D Program Audit and Enforcement Report

Medicare Parts C and D Oversight and Enforcement Group
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FOREWORD

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) in the Centers for Medicare & Medicaid Services (CMS) Audit and Enforcement Report summarizes information from its annual Part C and Part D program audits and enforcement actions to encourage improvement in industry performance. CMS encourages Medicare Advantage Organizations (MAOs), prescription drug plans (PDPs), and Medicare Medicaid plans (MMPs), collectively referred to as "sponsors", to review this information with their compliance staff, compliance committee, and other pertinent staff with the intent of ensuring:

- enrollees have appropriate access to health care services and medications,
- sponsors are in compliance with selected federal requirements, and
- sponsors understand the audit process and have a means to provide CMS feedback.

In this report, you will gain greater insight into some of the noncompliance CMS cited in 2024 and some of the enforcement actions imposed as a result of Part C and Part D oversight activities.

Note that information included in this report should not be used to draw broad conclusions about the significance of deficiencies or performance across the MA, Part D, or MMP programs. This report is not intended to reflect overall industry performance and should not be interpreted to mean that there are pervasive issues throughout the industry related to the noncompliance we identified.

Lastly, CMS continues to welcome sponsor feedback on the format and content of this report. Please submit comments to the Parts C and D audit mailbox: part_C_part_D_audit@cms.hhs.gov (include "Comments on the Part C and Part D Program Audit and Enforcement Report" in the subject line).

INTRODUCTION

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

MOEG conducts program audits of Medicare sponsors. Program audits are conducted at the parent organization level, meaning the data collected includes all MA and PDP contracts between CMS and the controlling legal entity. Through program audits, CMS evaluates key provisions related to the delivery of health care services and medications to Medicare enrollees in the Parts C and D programs.

Audited sponsors may be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action. CMS' enforcement authorities allow MOEG to impose Civil Money Penalties (CMPs), intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and for-cause contract terminations. This report contains a summary of the noncompliance identified during 2024 program audits, as well as enforcement actions resulting from program audits and additional CMS oversight activities.

2024 PART C AND PART D PROGRAM AUDIT LANDSCAPE

CMS conducted 39 total program audits of 36 parent organizations in 2024: 19 of the audits were routine (i.e., full-scope program audits) and the remaining 20 were focused audits (i.e., limited program areas were audited).

The routine audits covered:

- 181 MAPD contracts
    - 103 of these contracts offering special needs plans
- 10 PDP-only contracts
- One 1876 Cost plan
- 12 MMP contracts
- 14,932,384 Medicare beneficiaries

The focused audits covered an additional 290 MA/MAPD contracts and nearly 24.3 million Part C beneficiaries. In total, 2024 program audits covered 494 contracts, 87.6% of the total Medicare Part C population, and 68.8% of the total Medicare Parts C and D population.[1]

[1] Enrollment numbers as of July, 2024.

PART C AND PART D PROGRAM AUDIT SCOPE

Routine 2024 program audits evaluated sponsor compliance in the following program areas based on the contract types offered by the audited sponsors:

Program Areas Reviewed	Description
Compliance Program Effectiveness (CPE)	• Assess whether an MAO has the foundation and structure in place for an effective Compliance Program, including controls to prevent, detect, and correct noncompliance with program requirements.
Part D Formulary and Benefit Administration (FA)	• Review samples of Part D denied claims to determine how the sponsor applied utilization management (UM) edits such as prior authorizations, step therapy, and quantity limits at the point of sale. • Review how claims for non-formulary drugs are processed, and whether all enrollees eligible for a transition fill are afforded the full transition benefit.
Part D Coverage Determinations, Appeals, and Grievances (CDAG)	• Review compliance with timeframes for processing drug coverage requests and whether these requests were processed in accordance with 42 CFR 423 Subpart M.
Part C Organization Determinations, Appeals, and Grievances (ODAG)	• Review compliance with timeframes for processing service requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M.
SNP Care Coordination (SNPCC)	• Review timeliness of Health Risk Assessment (HRA) completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.
Medicare-Medicaid Plan Service Authorization Requests, Appeals and Grievances (MMP-SARAG)	• Review compliance with timeframes for processing service authorization requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M and the applicable three-way contract.
Medicare-Medicaid Plan Care Coordination (MMPCC)	• Review timeliness of HRA completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.

In addition to the requirements listed above, 2024 audits represented CMS's first opportunity to assess compliance with some of the Part C UM requirements finalized in CMS-4201-F that MAOs were expected to implement as of January 1, 2024. Specifically, CMS assessed whether MAOs:

- Complied with national coverage determinations (NCDs), local coverage determinations (LCDs), and coverage and benefit conditions included in Traditional Medicare
- Used internal coverage criteria (ICC) when the MAO determined Medicare coverage criteria was not fully established
- Denied a service based on lack of medical necessity when it previously approved the service through prior authorization
- Used a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue when it expects to issue an adverse medical necessity decision
- Made internal coverage criteria publicly accessible, and
- Established a utilization management committee (UMC) to develop and review all utilization management policies and procedures.

The results of audits showed sponsors were working to implement these new requirements. CMS determined sponsors generally adhered to coverage criteria in applicable NCDs and LCDs, applied ICC to ensure consistent decision making for medically necessary services, conducted appropriate oversight of adverse decisions by appropriate physicians, and established UMCs in an effort to meet CMS requirements. Because this was the first year MAOs implemented these requirements, and the first opportunity CMS had to audit these new rules, CMS cautions readers to not draw conclusions about MAOs' performance based on the 2024 audit findings.

PART C AND PART D PROGRAM AUDIT INSIGHTS

Program audits provide valuable insight into sponsor operations specific to audited requirements. Below CMS has outlined some of the generalized noncompliance identified during 2024 program audits by program area, and some of the reasons sponsors provided when asked why the noncompliance occurred. This is not an exhaustive list of all findings, and CMS expects all sponsors to carefully and routinely assess all risks to their organizations and monitor and audit their operations to ensure compliance with CMS requirements.

Compliance Program Effectiveness (CPE)

- Compliance issues were not tracked, addressed, and corrected.
  - Internal routine monitoring processes did not detect untimely notifications to enrollees when a delegated entity misinterpreted regulatory requirements.

SPONSOR TIP: *Sponsors should implement routine monitoring to oversee their delegated entities in order to ensure CMS regulations are being followed.*

Formulary Administration (FA)

- Sponsors inappropriately limited access to covered Part D drugs on their CMS-approved formulary by applying unapproved edits, incorrectly effectuating authorizations, or improperly processing enrollment and eligibility.
  - Beneficiaries were inappropriately restricted to a single strength or dosage form when sponsors effectuated the approved medication in their systems.[2] This restricts enrollee access to medications and increases provider burden by requiring the submission of a new coverage request for the same medication.
  - Unintended quantity restrictions and/or inappropriate application of day supply limits on pre-packaged medications below the plan benefit allowance prevented enrollees from receiving the necessary prescribed quantity.
  - Inadvertent termination of enrollees when updating eligibility files prevented those enrollees from accessing necessary Part D medications.
- Sponsors did not provide temporary Part D transition supply allowances to eligible enrollees when medications were identified as non-formulary, removed from the formulary in a new year, and/or when utilization management requirements impacted an enrollee's continued use of medications:
  - Transition-eligible medications and/or transition supply notices were not provided due to improper coding logic. This restricts enrollee access to medications and prevents enrollees from understanding the steps needed to submit a coverage determination to obtain the medication, or switch to an alternate medication.
  - Enrollees with an established history of using a medication for Part D indications were prevented from receiving transition-eligible medications due to the application of inappropriate medically accepted indication edits.

[2] This was also observed in the CDAG program area.

- Continuing enrollee claims history was not migrated in sponsors' systems preventing enrollees from receiving transition fills.

SPONSOR TIP: *CMS does not specify how sponsors effectuate individual medication coverage, and sponsors are responsible for determining the most appropriate methodology to ensure coverage for medication strengths and dosage forms subject to the same formulary criteria. For example, if a medication requires prior authorization, and that prior authorization requirement is the same for all doses of the medication; the sponsor should not limit the effectuation of the drug to a specific dosage. By limiting the effectuation, the prescriber may be forced to initiate a new coverage request to satisfy the same prior authorization requirement in order to adjust the dose as needed. Sponsors should consider whether effectuation of a drug should be done more broadly in situations where the formulary requirements do not change for different strengths or doses.*

Coverage Determinations, Appeals, and Grievances (CDAG)

- Coverage requests were misclassified or inappropriately dismissed resulting in enrollee delays in accessing medications.
  - Electronic prior authorization (ePA) configuration logic processed redetermination (appeal) requests as initial requests when ePA cases were submitted with different National Provider Identifiers (NPIs).
  - Internal processes for correctly classifying coverage requests were insufficient and/or not followed.
  - Valid requests for coverage were dismissed due to a misinterpretation of CMS guidance.
- Requests for coverage were inappropriately processed causing enrollees to experience delays in receiving necessary medications.
  - Clinical reviewers overlooked pertinent clinical information when considering coverage requests resulting in inappropriate decisions.

SPONSOR TIP: Sponsors should ensure they put appropriate safeguards in place to ensure they recognize and process coverage requests; including coverage requests that come in through electronic systems and/or the call center.

Organization Determinations, Appeals, and Grievances (ODAG)/Medicare Medicaid Plan – Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)

- Decision notifications were incorrect or incomplete which prevented enrollees and/or providers from appropriately advocating for services.
  - Dismissal notification templates did not contain enrollees' right to request the sponsor vacate its dismissal.
  - When cases were partially denied, notifications did not clearly specify what services, items or drugs were approved/denied.
- Requests for coverage were inappropriately delayed.

- Internal processes used to review coverage requests were insufficient to ensure enrollees were notified of decisions timely.
- Reviewers overlooked pertinent clinical information when processing coverage requests that indicated services should be approved.
- Coverage denials were inadvertently issued due to a system logic error.

SPONSOR TIP: *Sponsors should ensure an enrollee's medical history (for example, diagnoses, conditions, functional status,), physician recommendations, and clinical notes are considered prior to issuing an adverse medical necessity decision.*

Special Needs Plans Care Coordination (SNPCC)/Medicare-Medicaid Plan Care Coordination (MMPCC)

- Individualized care plans (ICPs) did not address all the results from enrollee HRAs and/or include measurable outcomes.
  - Results from the HRA were not carried over to the ICP as a starting point for prioritizing care and goal development.
  - Sponsor relied on a risk stratification system that categorizes enrollees according to their health status, rather than using the individualized results of the HRAs, to determine which conditions should be included in the ICP. This limits the conditions incorporated into the ICP and prevents the enrollee from determining which conditions they want to pursue as part of their care plan.

SPONSOR TIP: *Development of comprehensive ICPs includes identifying goals and objectives, including measurable outcomes, considering all results from the HRAs, while focused on conditions an enrollee chooses to pursue.*

TIPS FOR A BETTER PART C AND PART D PROGRAM AUDIT EXPERIENCE

CMS offers the following suggestions to improve the overall program audit experience. Thorough consideration of the tips below will help ensure a smoother audit process and reduce the likelihood of delays or complications during CMS program audits.

- Audit Preparation
  - The routine program audit process document available on the CMS website (https://www.cms.gov/files/document/program-audit-process-overview.pdf) outlines the four stages of a program audit. Review this document as it answers the most common questions that arise after receipt of an audit engagement letter.
  - Review and use the program audit protocols to conduct mock audits, including generating and validating universes. This practice will assist with data preparation and universe submissions. Additionally, mock audits may assist in identifying operational vulnerabilities or areas of noncompliance prior to a program audit.
  - The Health Plan Management System (HPMS) is used to conduct program audits and facilitate the transfer of audit information between CMS and sponsors. The Integrated Audit Module User Guide is available within the audit module in HPMS. Review this guide for information on using HPMS audit module throughout the audit process.
  - Sponsors should occasionally validate their contact information details in HPMS and ensure appropriate staff in the organization have access to the HPMS.
  - Review the User Group Resource Document on the CMS website for further clarification on the audit protocols (https://www.cms.gov/files/document/user-group-resource-document-2023.pdf).
- Information Technology
  - CMS is migrating from Zoom to Microsoft (MS) Teams for program audit webinars. Ensure all staff, including delegated entities, are familiar with Zoom and MS Teams and that your systems are compatible.
    - If needed, you may request a test webinar from the auditor-in-charge (AIC) to verify Zoom and/or MS Teams access and screen-sharing capabilities.
- Documentation Readiness
  - Prepare your team to quickly locate requested documentation. Examples of required documentation can be found in the file CDAG_ODAG_SARAG_Guidance.pdf file in HPMS Submission Materials).
- Best Practices during a Program Audit
  - Perform internal quality reviews to ensure data has been compiled according to program area record layout instructions before submitting universes to HPMS.
  - Proactively contact the program area team leads with any questions concerning record layout instructions.
  - Join webinars at least 5 minutes before start time to ensure beginning timely and address any technical issues.
  - When necessary, have delegated entities on standby to join webinars quickly to prevent delays.

ENFORCEMENT ACTIONS

CMS has the authority to impose Civil Money Penalties (CMPs), intermediate sanctions, and for-cause terminations against MA plans, PDPs, MMPs, and cost plans. MOEG is the group responsible for imposing these types of enforcement actions when a sponsor is substantially noncompliant with CMS' Medicare Parts C and D program requirements. Depending upon the type of enforcement action, sponsors may appeal actions either to the Departmental Appeals Board (CMPs) or to a CMS hearing officer (intermediate sanctions and terminations).

All enforcement actions based on violations discovered during program audit findings are posted on the Part C and Part D Compliance and Audits website at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-. Information contained in referrals that involve suspected fraud, waste, and abuse is referred to the Center for Program Integrity.

MOEG imposed various enforcement actions in calendar year 2024 and early 2025 due to referrals of violations discovered during program audits and other oversight activities conducted by CMS. These other oversight activities include financial audits (also known as one-third financial audits), routine monitoring activities (i.e., medical loss ratio and dual eligible special needs plan integration) and ad-hoc monitoring activities. This section of the report details enforcement actions imposed, the basis for those actions, and provides additional information about the sponsors that were sanctioned and/or received a CMP, as well as the amounts of the CMPs issued. It also contains insights and lessons learned from reviewing enforcement action referrals.

CIVIL MONEY PENALTIES

It is customary for program audits and one-third financial audits to be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action, as described in 42 CFR. Parts 422 and 423, Subpart O. This evaluation is separate from the audit process and is not conducted by the audit team. Audited sponsors that have been referred will receive notification from MOEG's Division of Compliance Enforcement (DCE) for matters related to enforcement actions. To access the current CMP methodology, go to https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/downloads/hpmsmemocmpmethodology06212019.pdf.

CMPs Imposed

DCE imposed 14 CMP actions on sponsors for the following referrals received in 2024:

1. 2024 program audits; and
2. 2021 one-third financial audits[3]

Table 1: CMPs IMPOSED BASED ON 2024 PROGRAM AUDIT REFERRALS

Date of Imposition	Sponsor Name	CMP Amount
04/01/2025	Molina Healthcare, Inc.	$285,476
04/01/2025	Point32Health, Inc.	$55,796
04/01/2025	Aware Integrated, Inc.	$31,088
04/01/2025	BlueCross BlueShield of Tennessee, Inc.	$21,692
04/01/2025	Centene Corporation	$20,648
04/01/2025	Presbyterian Health Plan	$14,152
04/01/2025	Geisinger Health Plan	$5,800

Table 2: CMPs IMPOSED BASED ON ONE-THIRD FINANCIAL AUDIT REFERRALS

Date of Imposition	Sponsor Name	CMP Amount
01/17/2025	Centene Corporation	$2,000,000
01/17/2025	Elevance Health, Inc.	$149,060
01/17/2025	The Carle Foundation	$101,500
01/17/2025	Humana Inc.	$99,064
01/17/2025	Molina Healthcare, Inc.	$67,976
01/17/2025	Baylor Scott & White Holdings	$37,816
01/17/2025	Medco Containment Life and Medco Containment NY	$32,364

Type of CMP Violations

[3] CMS's Office of Financial Management audited sponsors' 2021 financial data during 2023 and sent enforcement referrals to DCE in 2024

CMPs are imposed for several different violations of the Parts C and D regulations. There were 18 specific violations cited in the fourteen CMPs. Table 4 shows a breakdown of the 18 violations cited in those notices.

Table 4: TYPES OF VIOLATIONS INCLUDED IN 2024 CMPs

Violation Type	Number of Violations	Source of Referral
Inappropriate cost sharing for Part C services/Part D medications	10	One-third financial audit
Inappropriate denials/delays of Part D medications	6	Program audit
Misclassification of Part D coverage requests	2	Program audit

Penalty Calculation

The amount of the CMP does not automatically reflect the overall performance of a sponsor. Rather, the amount of a CMP mostly depends on the number of enrollees impacted by certain violations. The type of contract(s) involved, and the nature and scope of the violation(s) also factor into the total CMP amount a sponsor receives. MOEG applies a standard CMP amount for each deficiency cited in a CMP notice, based on either a per-enrollee or a per-determination basis. CMPs imposed on a per-enrollee basis have a quantifiable number of enrollees that have been adversely affected (or have the substantial likelihood of being adversely affected) by a deficiency. CMPs imposed on a per-determination basis either do not have a quantifiable number of enrollees that have been affected or are explicitly stated as a per-determination penalty in statute. Out of the 18 violations included in the 14 CMP actions:

- Seventeen violations were calculated on a per-enrollee basis; and
- One violation was calculated on both per enrollee and per-determination basis.[4]

Consistent with the CMP Methodology, CMS relied on available data and mitigating information to determine if a sponsor's deficiency either directly adversely affected or had the substantial likelihood of adversely affecting an enrollee.

Aggravating Factors

A sponsor's CMP is increased if aggravating factors apply to certain deficiencies. The standard penalty for a deficiency may increase if the violation involved the following:

- Drugs that are used to treat acute conditions that require immediate treatment,
- Enrollees were not provided access to their inappropriately denied medical services or medications,
- Expedited cases,
- Financial impact over $100,
- Annual Notice of Change (ANOC) documents: ANOC/errata documents were not mailed by Dec. 31, and/or

[4] For one violation, part of the penalty was calculated using a per determination basis as specified in regulation, because the impacted contract was an 1876 cost plan contract.

- A history of prior offense.

Out of the 18 violations, an aggravating factor penalty was applied to 16 violations. The total aggravating factor penalties amounted to $713,632, which is 24% of the total CMP amount of $2,922,432 imposed for 2024 referrals.

INTERMEDIATE SANCTIONS

Intermediate sanctions can either suspend a sponsor's ability to market to and accept new Part C or Part D enrollees or to receive payment for new enrollees. Intermediate sanctions remain in place until the deficiencies which formed the basis of the sanction are corrected and are not likely to recur. In 2024, some of the intermediate sanctions CMS imposed were for failures to meet Medical Loss Ratio requirements and Dual Eligible Special Needs Plan integration requirements.

Medical Loss Ratio – Enrollment Suspensions

Sponsors are required to spend at least 85 percent of premium dollars on beneficiary medical care, also known as the Medical Loss Ratio (MLR). Sponsors are also required to report an MLR each year for each of their contracts. When an organization fails for three consecutive years to meet the 85 percent threshold, CMS is statutorily required to suspend that organization's ability to accept new enrollments into the noncompliant contract for the contract year following submission of the report. A sponsor subject to MLR sanctions must demonstrate that it has achieved an MLR of at least 85 percent, and CMS will allow the sponsor to resume accepting enrollments that become effective on or after the following contract year. Table 5 lists the sponsors that were under sanction for MLR failures during 2024.

Table 5: SPONSORS UNDER SANCTION FOR MLR FAILURES DURING 2024

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
09/19/2023	01/01/2024	Care Improvement Plus South Central Co.	Enrollment Suspension	Effective 01/01/2025
09/06/2024	01/01/2025	Wellcare of Missouri Health Insurance Company, Inc.	Enrollment Suspension	TBD

** Suspensions based on MLR failures prevent enrollments for applications submitted for coverage effective the following plan year.*

Dual-Special Needs Plan – Enrollment Sanctions

Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and a Medicaid state plan. D-SNPs must meet one or more of the following criteria for the integration of Medicare and Medicaid benefits:

- Meets the additional requirements in its contracts with the State Medicaid agency;
- Is a highly integrated dual eligible special needs plan; or
- Is a fully integrated dual eligible special needs plan.

Certain D-SNPs are placed under an enrollment sanction because the specific D-SNP plan benefit package (PBP) failed to meet the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a dual special needs plan at 42 C.F.R. § 422.2. More specifically, the state Medicaid contracts associated with these PBPs are not yet executed, which is required for designation as a Highly Integrated or Fully Integrated D-SNP. Once the state executes the Medicaid contract, CMS will lift the sanction. Table 6 lists the sponsors that were under sanction for D-SNP failures during plan year 2024.

Table 6: SPONSORS UNDER SANCTION IN 2024 FOR D-SNP INTEGRATION FAILURES

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
12/09/2020	01/01/2021	Visiting Nurse Association of Central New York	Enrollment Suspension	TBD
09/28/2021	01/01/2022	MVP HealthPlan, Inc. (MVP Health Care, Inc.)	Enrollment Suspension	TBD
10/05/2022	01/01/2023	Aetna Health Inc. (NY)	Enrollment Suspension	TBD
10/05/2022	01/01/2023	Excellus Health Plan Community Care, LLC.	Enrollment Suspension	TBD
10/05/2022	01/01/2023	iCircle Services of the Finger Lakes, Inc.	Enrollment Suspension	TBD
10/28/2024	01/01/2025	Humana WI Health Insurance Organization Insurance Corporation	Enrollment Suspension	02/04/2025

** Sanctions based on D-SNP Integration failures prevent enrollments for applications submitted for coverage effective the following plan year.*

INSIGHTS FROM THE ENFORCEMENT PROCESS

CMS continues to engage sponsors throughout the enforcement evaluation process to ensure enforcement actions are based on data that accurately reflect the impact of violations on enrollees. As in previous years, outreach was conducted to discuss and validate plan-submitted impact analyses. This process provides sponsors with additional opportunities to review the accuracy of their submissions provided during the audit process and explain the data in further detail. CMS also improved communication with sponsors about the status of their enforcement evaluation review, CMS' expectations while under intermediate sanctions, and the sanction validation process when applicable.

Lessons Learned for Sponsors

To help sponsors strengthen their overall compliance programs, and to benefit the program more broadly, some of the observations made during an analysis of 2024 enforcement referrals are provided below.

1. Part D Issues

A number of instances were found in which sponsors failed to cover Part D drugs due to inaccurate eligibility files. Sponsors must ensure accurate processing of Part D claims by maintaining correct beneficiary enrollment and eligibility information and overseeing the proper data transmission of those files to their Pharmacy Benefit Managers (PBMs). In addition, sponsors must ensure timely updates of eligibility data. In some cases, CMS audits found that, while sponsors corrected the eligibility data system issue, they failed to address the previously rejected claims. This left beneficiaries without access to necessary medications. CMS requires sponsors to fix the system-level eligibility issues and remediate the impact on affected beneficiaries.

One-third financial audits uncovered several instances where beneficiaries were overcharged for Part D drugs because low-income subsidy (LIS) levels were not reconciled in every instance as required. Sponsors must process retroactive adjustments to cost sharing for LIS individuals. There should be an effective adjustment process in place to ensure retroactive adjustments to prescription drug event (PDE) records are reprocessed automatically after LIS level changes are received to ensure enrollees do not overpay for their Part D drugs.

Program audits continue to detect that sponsors are not consistently identifying and initiating enrollee coverage requests when they are received as part of a grievance. Sponsors should make sure their staff are properly trained and implement oversight tools and processes to more quickly identify coverage requests and route them to the correct department so enrollees receive Part D medications timely.

Lastly, in one instance, beneficiaries were unable to receive medications despite having approved prior authorizations. This occurred because active authorization files were not properly transmitted to a new PBM. To prevent such issues, sponsors must ensure prior authorization data are loaded timely and accurately into PBM systems. Failure to maintain correct prior authorizations may result in inappropriate claim rejections at the point of sale. Sponsors are responsible for maintaining continuous medication access through the authorized period by ensuring proper file transmission between all systems.

2. Inappropriate cost sharing for Part C services

CMS found a high number of instances where sponsors were not appropriately tracking Maximum Out-of-Pocket (MOOP) limits which caused beneficiaries to pay more in cost-sharing than allowed. Sponsors must maintain sufficient oversight of their Part C claims processing systems to prevent excess charges beyond annual MOOP limits. This oversight should include:

- Monitoring beneficiary out-of-pocket spending;
- Ensuring correct MOOP limit programming;
- Tracking concurrent claims processing for the same member and benefit; and
- Verifying MOOP limits during manual claims processing.

In addition, CMS continues to detect sponsors overcharging beneficiaries due to processing claims incorrectly. Sponsors must maintain effective oversight of their Part C claims processing systems through routine monitoring, regular system updates, configuration testing and proper benefit design implementation. Recent audits revealed that sponsors failed to update systems appropriately, resulting in incorrect provider payments and cost-sharing amounts. Sponsors should address any system limitations that affect proper Part C claims processing to prevent beneficiary overcharges.

3. Beneficiary Reimbursements

When beneficiaries are overcharged for cost-sharing, sponsors must ensure beneficiaries are refunded any incorrectly collected amounts. When a sponsor reprocesses claims, CMS' expectation is that beneficiaries receive all refunded amounts. Even if claims are reprocessed quickly, CMS may impose penalties if an audit reveals beneficiaries have not received appropriate refunds.

While sponsors may delegate refund responsibilities to providers, the ultimate responsibility for ensuring beneficiaries receive refunds remains with the sponsor. This includes verifying that all incorrectly collected amounts are returned, whether through providers or direct sponsor payment. Sponsors must ensure providers are following proper refund procedures and sponsors may need to conduct provider outreach to confirm that beneficiaries were correctly refunded.

CONCLUSION

CMS hopes sponsors will use the information in this report to inform their internal auditing, monitoring, and compliance activities. CMS welcomes feedback on the contents of this report and looks forward to continued collaboration with the sponsor community and their partners in developing new approaches to improve compliance.