CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Part C and Part D Program Audit and Enforcement Report

Medicare Parts C and D Oversight and Enforcement Group

This report is also published online at: https://www.cms.gov/medicare/audits-compliance/part-c-d/program-audits

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Background

The Centers for Medicare & Medicaid Services (CMS) contracts with private companies, known as Sponsors, to administer Medicare Advantage (Part C) and Prescription Drug (Part D) benefits to eligible individuals age 65 or older, younger individuals with disabilities, and individuals with End Stage Renal Disease. The Medicare Parts C and D Oversight and Enforcement Group (MOEG), within CMS, is responsible for overseeing Sponsor compliance with Medicare program requirements through a combination of program audits and enforcement activities. Each year, MOEG conducts program audits of a subset of Sponsors to evaluate compliance with key contract provisions related to the delivery of health care services and prescription drug benefits to Medicare enrollees. These audits also assess whether Sponsors have implemented effective compliance controls to prevent, detect, and correct noncompliance related to beneficiary access, coverage determinations, appeals, grievances, and care coordination.

Program audit results, along with information and findings obtained through other CMS oversight activities, may be referred for an independent evaluation to determine whether a Sponsor's noncompliance warrants an enforcement action. MOEG's Division of Compliance Enforcement (DCE) has authority to impose Civil Money Penalties (CMPs), intermediate sanctions, and for-cause contract terminations on behalf of CMS when a Sponsor is substantially noncompliant with Medicare Parts C and D requirements.

Although 2025 was not a typical audit year, CMS still gained important insights through its oversight, audit, and enforcement work. This report reviews how CMS updated its oversight process, highlights operational challenges found in audits and enforcement assessments, and shares lessons that Sponsors can use to lower compliance risks and enhance outcomes for beneficiaries.

Pause. Reflect. Elevate: How CMS Improved Oversight

A bid protest impacted CMS' program audit season and reduced the volume of program audits CMS could conduct in 2025. The reduction gave CMS time to improve the audits, including identifying and eliminating unnecessary burden and making changes that strengthen audit operations and increase beneficiary protection.

Integrating Compliance Program Effectiveness Reviews

CMS used one of its program audits in 2025 to pilot a revised approach to reviewing compliance program effectiveness (CPE) by integrating compliance discussions into the operational program areas under review. Instead of relying on separate tracer reviews to audit CPE as a standalone element, CMS conducted targeted discussions with the compliance officer before and after audit fieldwork to better understand how the organization identified, monitored, and corrected compliance risks within the audited program areas. This approach provided greater operational context during the audit and allowed CMS to more directly evaluate how the compliance program functioned in practice, including how the organization responded to identified issues and oversaw delegated entities and internal controls.

Even in the revised approach, CMS needed to collect a Compliance Oversight Activities (COA) universe prior to fieldwork because, in general, this information provides important insight into where organizations have already identified risks and concentrated their monitoring and oversight activities. By reviewing the COA data alongside audit findings, CMS was able to have more focused discussions with the compliance officer regarding the effectiveness of existing oversight activities, root causes of noncompliance, and opportunities to strengthen internal controls and compliance strategies.

The updated approach also increased collaboration between CMS and the Sponsor's compliance team during fieldwork. The compliance officer was incorporated into the audit discussions for each program area as they occurred in real time, which better positioned the compliance officer to understand operational concerns as they emerged, and evaluate whether existing monitoring activities were effective at identifying and preventing similar issues. CMS found that these discussions helped the organization more quickly assess compliance risks, refine oversight activities, and focus corrective actions on operational areas most likely to affect beneficiaries.

Utilizing Desk Reviews

CMS also piloted desk reviews in 2025 to evaluate whether certain audit activities could be conducted more efficiently while maintaining meaningful oversight. The pilot was designed to reduce administrative burden associated with live case reviews during webinars and provide auditors sufficient time to review documentation before discussing the cases with Sponsors. CMS found that advanced review of case documentation allowed auditors to identify questions and potential concerns earlier in the process. Sponsors also had additional time to gather documentation, coordinate with delegated entities, and ensure appropriate subject matter experts participated in discussions. The desk review approach resulted in more focused discussions during fieldwork, reduced time spent locating documentation during webinars, and allowed both CMS and Sponsors to spend more time evaluating substantive compliance issues rather than exchanging documents. CMS also found that providing discussion topics and questions in advance improved transparency and allowed organizations to respond more effectively to potential concerns. By shifting document review outside of live audit sessions, CMS was able to dedicate fieldwork discussions to understanding operational processes, evaluating compliance risks, and discussing corrective actions. This approach supported CMS' broader goal of reducing burden while maintaining effective oversight of beneficiary protections.

TIPS FOR DESK REVIEWS

- Carefully review the samples and requested documentation.
- Check to ensure all aspects of the requested documentation are included in the case file, and point out to CMS when a requested document is not available to avoid a question later on.
- Include large PDFs in a ZIP file for ease of uploading to HPMS.
- Review any follow-up questions from the audit team prior to the webinar to ensure appropriate staff is on the call.

Streamlining Validation of Audit Findings

Historically, CMS required all conditions needing correction to be validated through a full validation audit conducted either by CMS or an independent auditor hired by the Sponsor. These validation audits typically involved the submission of new universes and additional sample testing to verify correction. In 2025, CMS piloted a more flexible and streamlined validation approach that evaluated the nature, scope, and root cause of identified noncompliance to determine the level of validation necessary. For conditions that could be readily verified—such as updates to written notice templates or system configuration changes—CMS confirmed correction through webinars or targeted documentation review rather than requiring a full validation audit. This updated approach reduced overall administrative burden, allowed CMS to focus validation resources on more complex conditions, and reduced average audit closure timelines from 219 days to 150 days.

What CMS Learned from Program Audits

The 2025 program audits gave CMS valuable insights into Sponsor operational practices and compliance concerns that affect Medicare beneficiaries. This section outlines key lessons from those audits, discusses their significance for both beneficiaries and organizations, and suggests strategies Sponsors should consider to avoid noncompliance.

Lesson 1: Small Data Errors Can Become Beneficiary Access Issues

Some of the findings identified during 2025 audits stemmed from enrollment processing errors, system configuration issues, or changes that were not fully tested before implementation. While these issues often began as small data discrepancies or technical failures, they frequently affected beneficiaries' ability to access medications, services, or approved benefits.

Examples

Enrollment and Eligibility Processing

- Coverage was inadvertently deactivated when members moved between plan benefit packages.
- Weekend eligibility file processing temporarily terminated active coverage.
- Manual enrollment updates resulted in incorrect eligibility information.
- Transition-eligible enrollees were denied medications because systems relied on prior enrollment dates instead of current enrollment effective dates.

System Configuration and Change Management

- Duplicate logic in a prior authorization system failed after system updates, causing appeals to process incorrectly.
- System edits caused approved coverage requests to be unavailable for the full plan year.
- Auto-generation of care plans failed due to technical issues, requiring manual intervention and incomplete documentation.
- Vendor mailing processes did not align with CMS timeliness requirements following system changes.

Why It Matters

When critical data is inaccurate or system changes are not functioning as intended, beneficiaries may experience claim rejections, delayed access to medications or services, inappropriate cost sharing, or disruptions in care. These issues can also create administrative burdens for beneficiaries, providers, and Sponsors while increasing compliance risk.

SPONSOR TIPS

- Validate enrollment and eligibility updates before implementation.
- Test system changes before deployment and after implementation.
- Reconcile data across systems following updates or transitions.
- Monitor rejected claims, denied requests, and unusual processing trends for signs of underlying system issues.

Lesson 2: Delegation Does Not Transfer Accountability

Sponsors are allowed to contract with first-tier, downstream, or related entities (FDRs) to process Part D and Part C benefits on the sponsors' behalf. The value of relying on FDRs can include specialized expertise, additional resources, and faster decision-making. However, Sponsors that relied on FDRs experienced compliance challenges when oversight processes, communications, or operational controls were not fully aligned.

Examples

- Utilization management edits were applied inconsistently with approved benefit designs.
- Decisions from delegated entities were not always consistent with Medicare coverage requirements and/or the Sponsor's approved plan benefit package.
- Claims processing vendors contributed to untimely notifications and/or payments.
- Required notice updates, such as the new 65-day appeal timeframe, were not implemented consistently across multiple systems and delegated entities.
- Dismissal notices omitted required language regarding vacating dismissals and requesting reconsideration.
- Quality-of-care grievance resolution letters incorrectly included Medicare appeal rights.
- Extension notices failed to explain the reason for extending a decision timeframe.

Why It Matters

Effective oversight of delegated entities is critical to ensuring beneficiaries receive timely and accurate coverage decisions. When delegated entities do not consistently administer benefits in accordance with Sponsor requirements and CMS rules, beneficiaries may face delays in accessing medically necessary medications, receive incorrect coverage decisions, or experience confusion regarding available benefits and treatment options.

SPONSOR TIPS

- Validate vendor system edits.
- Monitor delegated entity performance.
- Test denial notices or messaging across platforms.

Lesson 3: Coverage Decisions Must Be Based on Complete Information

Coverage decisions are only as effective as the information used to make them. Auditors identified situations where relevant clinical documentation or enrollee-specific information was not fully considered, increasing the risk of inappropriate coverage determinations and delays in access to care.

Examples

- Appeals submitted by different prescribers were processed as second coverage determinations instead of redeterminations.
- Duplicate logic failures caused redeterminations to be processed incorrectly.
- Coverage decisions were made without considering all available enrollee information.

Why It Matters

Beneficiaries rely on Sponsors to make timely and accurate coverage decisions. When decisions are based on incomplete information, beneficiaries may face delays or disruption in receiving needed services, uncertainty about their coverage, and additional effort and burden to obtain care through the appeals process.

SPONSOR TIPS

- Review denial trends.
- Audit medical necessity decisions.
- Ensure reviewers have complete clinical documentation relevant to the request so decisions aren't made to deny necessary services based only on abbreviated summaries of medical records.

Lesson 4: Effective Care Coordination Requires More than Documentation

Auditors identified instances where care coordination activities did not fully reflect an enrollee's individual needs or incorporate all available clinical information. These findings demonstrated that compliance with documentation requirements alone does not ensure effective care coordination. Rather, effective care coordination requires a comprehensive understanding of an enrollee's health needs and the active use of available information to identify risks, coordinate services, and address beneficiary needs.

Examples

- Individualized Care Plans (ICPs) did not address specific beneficiary needs such as chronic conditions that required coordination and intervention.
- Evidence of Interdisciplinary Care Team coordination was missing.
- Organizations failed to implement care plans when needs were identified.
- Care plans were not consistently developed or individualized when beneficiaries could not be reached.

Why It Matters

When available information is not fully incorporated into care planning, opportunities to coordinate care and address beneficiary risks may be missed. Effective care coordination relies on using available information to identify needs, monitor risks, and coordinate services. When care planning activities are not fully informed by an enrollee's circumstances, gaps in care, unmet needs, and missed opportunities to improve health outcomes may result.

SPONSOR TIPS

- Audit ICP quality.
- Monitor for quality and timely completion of Health Risk Assessments (HRAs).
- Use available clinical data when enrollee participation in HRAs and ICPs is limited.

What CMS Learned from Enforcement Evaluations

Program audits are used to spot compliance risks, while enforcement evaluations reveal the consequences when these risks lead to harm for beneficiaries. Enforcement evaluations aren't just triggered by referrals from program audits; DCE also receives referrals for noncompliance found during routine monitoring and financial audits administered by CMS' Office of Financial Management.

Lesson 5: Beneficiary Financial Protections and Access to Benefits Depend on Strong System Controls

System configuration issues, data synchronization failures, and payment integrity weaknesses can lead to beneficiaries either being charged more than they owe for covered services or prescription drugs or not receiving coverage for benefits at all. Often, these errors are not due to a misunderstanding of CMS requirements, but a breakdown in operational controls, system testing, or ongoing monitoring.

Examples

Maximum Out-of-Pocket (MOOP) Limits and Impact to Cost-Sharing

- Beneficiary cost-sharing accumulations were not accurately tracked across systems, causing some enrollees to continue being charged cost sharing after reaching their MOOP limit.
- Delays in sharing or updating cost-sharing information across claims platforms resulted in beneficiaries being charged amounts in excess of their MOOP limits according to their plan's benefit.

Claims Processing and Payment Integrity

- Claims and provider payment systems used incorrect payment methodologies, benefit configurations, or provider information, resulting in inaccurate payments and beneficiary cost-sharing amounts.
- Claims systems did not consistently identify duplicate services, resulting in duplicate payments and inappropriate beneficiary cost sharing.

Eligibility and Subsidy Processing

- Changes to beneficiary eligibility were not processed accurately, resulting in claims being adjudicated under incorrect benefit or cost-sharing information.
- Claims affected by retroactive Low-Income Subsidy (LIS) status changes were not consistently reprocessed, resulting in beneficiaries being charged incorrect amounts.

Why It Matters

Beneficiaries rely on Sponsors to accurately administer benefits and apply financial protections as intended. When system controls fail, beneficiaries may experience inappropriate cost sharing, delayed refunds, or other financial burdens that can affect access to care and confidence in their coverage. Because these issues often impact large numbers of enrollees before they are detected, financial harm was one of the most common factors associated with increased enforcement severity during the reporting period.

SPONSOR TIPS

- Validate cost-sharing calculations and payment methodologies before implementation.
- Regularly test controls related to MOOP, LIS, and other beneficiary financial protections.
- Reconcile data across systems following updates, transitions, or vendor changes.
- Monitor for duplicate charges, overpayments, and refund timeliness.
- Establish automated controls to identify and correct discrepancies before they affect beneficiaries.

Lesson 6: An Effective System for Routine Monitoring and Identification of Compliance Risks Can Help Avoid Penalties

In addition to the system breakdowns discussed in Lesson 5, when a Sponsor does not have effective prevention and detection controls in place and CMS identifies an issue on audit, there is an increased risk of financial penalties. Alternatively, when analyzing an issue for a CMP, CMS will take into consideration whether a Sponsor's monitoring and auditing identified the failure and whether the Sponsor promptly responded to fix the issues to ensure that impacted beneficiaries were remediated.

Examples

- Beneficiaries were overcharged cost sharing for services due to various system configuration errors that were not detected and, therefore, beneficiaries were not appropriately refunded.
- Beneficiaries' claims were inappropriately rejected and, because Sponsors were not monitoring denied claims, beneficiaries did not have timely access to their medications that are used to treat acute conditions that require immediate treatment.

Why It Matters

CMS will consider a Sponsor's good faith effort to monitor its complex organization. Employing a robust auditing and monitoring program to oversee its intricate network of systems, down-stream entities and benefit structures reflect that good faith effort and ensure compliance with CMS requirements.

SPONSOR TIPS

- Evaluate operational processes from the beneficiary's perspective to identify potential downstream impacts.
- Incorporate financial impact reviews into compliance monitoring activities.
- Prioritize remediation when issues affect beneficiary access or cost sharing.
- Ensure corrective actions address root causes rather than isolated symptoms.

On the Horizon

CMS' interoperability and prior authorization work is moving oversight toward **faster decisions, better data, and reduced duplication**. Beginning in 2026, Sponsors must send prior authorization decisions within **72 hours for expedited requests** and **7 calendar days for standard requests**. For Part C and Part D program audits, compliance officers should be ready to show that their organizations can monitor and validate these updated prior authorization timeframes, identify delayed cases, and confirm that operational workflows, delegated entities, and systems are aligned to meet the new requirements.

CMS has also indicated it is updating audit protocols to make greater use of existing CMS data, which should reduce duplicative data collection but may increase the importance of ensuring data submitted to CMS is accurate, complete, and reconcilable to internal systems.

Sponsors should focus on three areas:

1. **Prior authorization readiness:** confirm systems can track expedited and standard requests, monitor timeliness, document denial reasons, and escalate cases before they exceed CMS timeframes.
2. **Data integrity and interoperability:** ensure prior authorization, appeals, claims, and encounter data are consistent across internal systems, delegated entities, and CMS data sources.
3. **Governance and monitoring:** use compliance oversight activities to test whether operational teams and FDRs are applying requirements consistently and correcting issues before they affect beneficiaries.

CMS will continue hosting quarterly compliance officer calls to share audit-identified compliance issues and promote discussion of best practices. Compliance officers should treat those calls as an opportunity to benchmark internal controls, ask operational questions, and adjust monitoring plans based on CMS' emerging areas of concern.

Quarterly Compliance Officer Call Remaining Dates

Appendix A: How CMS Evaluates Sponsor Performance

Effective compliance depends on more than policies and procedures. CMS' Part C and Part D program audits evaluate the operational processes that support beneficiary access to medications, medical services, appeals, grievances, and care coordination. The areas below represent the core functions CMS reviews to assess whether Sponsors have implemented effective controls to prevent, detect, and correct noncompliance.

Operational Areas Reviewed	Description
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.

Details about how CMS conducts its Part C and Part D program audits can be found on our webpage: https://www.cms.gov/medicare/audits-compliance/part-c-d where you can access an overview of the Program Audit Process and CMS' Medicare Part C and Part D Program Audit protocols.

Questions about the program audit process or audit protocols should be directed to: part_c_part_d_audit@cms.hhs.gov

Questions specific to Part C and Part D Compliance Policy should be directed to: parts_c_and_d_cp_guidelines@cms.hhs.gov

Appendix B: Civil Money Penalties

Using its published methodology[1], CMS imposed 14 Civil Money Penalties (CMPs) based on violations identified through program audits, financial audits, and other routine oversight activities conducted in 2025. Analysis of these actions identified several recurring operational themes, including beneficiary cost-sharing errors, payment integrity issues, eligibility processing failures, and breakdowns that affected beneficiary access to medications.

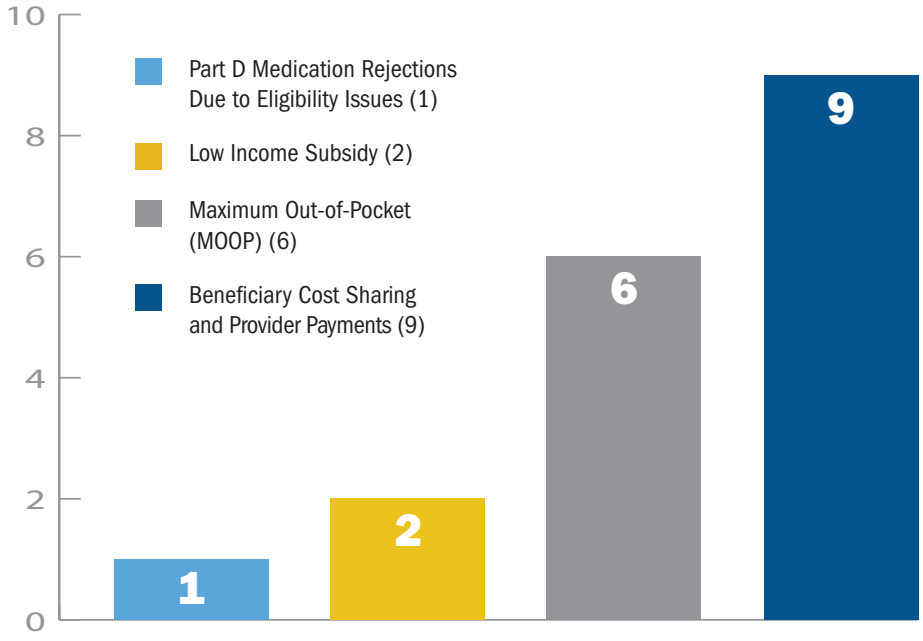
CMPs At-a-Glance

14	18	$1.54	21%
CMPs	Violations	Million	Aggravating Factors

Type of CMP Violations

The majority of violations involved beneficiary cost-sharing and payment integrity issues, followed by failures related to maximum out-of-pocket protections, low-income subsidy processing, and Part D eligibility determinations.

Number of Violations by Type Included in 2025 CMPs



[1] https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/downloads/hpmsmemocmpmethodology06212019.pdf

What Increased CMP Amounts?

CMP amounts are not intended to reflect a Sponsor's overall performance. Rather, CMS evaluates the impact of a violation on beneficiaries, including the number of affected enrollees, the nature and scope of the noncompliance, and the actual or potential harm that resulted.

Certain circumstances that CMS considers aggravating factors may increase the severity of a violation and lead to higher CMP amounts. In 2025, aggravating factors were most commonly associated with violations that resulted in significant financial harm to beneficiaries or limited access to medically necessary medications. In fact, 89 percent of violations identified in 2025 CMP actions involved enrollees who experienced financial harm greater than $100. One violation may also have multiple aggravating factors that impacted beneficiaries. For example, in one instance, a single violation was associated with two separate aggravating factors because the violation involved enrollees who were not provided access to their drugs that are used to treat acute conditions, and each factor resulted in individual penalty increases.

Aggravating Factors Associated with 2025 Violations

Operational failure type	Drugs that are used to treat acute conditions that require immediate treatment	Financial harm >$100	Enrollees were not provided access to their inappropriately denied medical services or medications
Maximum Out-of-Pocket	N/A	6 Instances	N/A
Low Income Subsidy	N/A	2 Instances	N/A
Beneficiary Cost Sharing and Provider Payments	N/A	9 Instances	N/A
Part D Medication Rejections Due to Eligibility Errors	1 Instance	N/A	1 Instance

Least Instances — Most Instances

Detailed CMP Actions

Information regarding individual CMP actions imposed based on 2025 referrals is provided in the table below.

CMPs Imposed Based on Referrals for Enforcement Action in 2025

Date of Imposition	Sponsor Name	CMP Amount
5/1/2026	CVS Health Corporation	$753,805
5/1/2026	Centene Corporation	$380,785
5/1/2026	Group 1001	$84,190
5/1/2026	USAble Mutual Insurance Company	$57,757
5/1/2026	Health Care Service Corporation	$50,437
5/1/2026	UnitedHealth Group, Inc.	$48,869
4/29/2026	Health First Shared Services, Inc.	$43,546
5/1/2026	Marshfield Clinic Health System, Inc.	$29,005
5/1/2026	ATRIO Health Plans	$21,847
5/1/2026	Devoted Health, Inc.	$18,668
5/1/2026	Memorial Hermann Health Plan	$16,676
5/1/2026	EmblemHealth, Inc.	$11,648
5/1/2026	California Physicians' Service	$10,988
5/1/2026	Highmark Health	$10,458

Appendix C: 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 not likely to recur. In 2025, some of the intermediate sanctions imposed were for failures to meet Medical Loss Ratio requirements, Dual Eligible Special Needs Plan integration requirements, or state-based financial solvency requirements.

Medical Loss Ratio—Enrollment Suspensions

Sponsors are required to spend at least 85 percent of premium dollars on enrollee medical care, also known as the Medical Loss Ratio (MLR). Additionally, Sponsors must annually report the MLR for each of their contracts. If an organization fails to meet the 85 percent threshold for three consecutive years, CMS is statutorily required to suspend that organization's ability to accept new enrollments into the noncompliant contract for the subsequent contract year. A Sponsor subject to MLR sanctions must demonstrate compliance by achieving an MLR of at least 85 percent; once this requirement is met, CMS will allow the Sponsor to resume accepting enrollments effective on or after the following contract year. The table below identifies the Sponsors that were under sanction for MLR failures during 2025.

Sponsors Under Sanction for MLR Failures During 2025

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
9/6/2024	1/1/2025	Wellcare of Missouri Health Insurance Company, Inc.	Enrollment Suspension	8/14/2025

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

Dual Eligible Special Needs Plan—Enrollment Sanctions

Dual Eligible Special Needs Plans (D-SNPs) serve individuals who are eligible for both Medicare and Medicaid, and are intended to promote coordination between the two programs. Sponsors offering a D-SNP must meet specified Medicare-Medicaid integration standards as a condition of continued enrollment. If a D-SNP did not meet the applicable integration requirements in 2025, CMS was required to impose enrollment sanctions on the affected plan benefit packages. In the cases listed in the table below, the organizations did not have fully executed state Medicaid contracts necessary to support their integration status. Most of the affected organizations subsequently obtained state approval of the required Medicaid contracts and were released from sanction. The following table summarizes the D-SNP enrollment sanctions that were in effect during plan year 2025.

Sponsors Subject to Enrollment Suspension in 2025 for D-SNP Integration Failures

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Contract and Plan Benefit Package	Date of Intermediate Sanction Release
12/9/2020	1/1/2021	Visiting Nurse Association of Central New York	H9066-001	9/17/2025
9/28/2021	1/1/2022	MVP HealthPlan, Inc. (MVP Health Care, Inc.)	H3305-035	Non-renewed Effective 12/31/2025
10/5/2022	1/1/2023	Aetna Health, Inc. (NY)	H3312-073	9/17/2025
10/5/2022	1/1/2023	Excellus Health Plan Community Care, LLC	H7524-002 H7524-004	9/17/2025
10/5/2022	1/1/2023	iCircle Services of the Finger Lakes, Inc.	H7813-001	9/17/2025

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

Financial Solvency—Enrollment Suspensions

State licensure and financial solvency laws require health plans to meet minimum financial requirements to operate. Medicare Advantage and Part D plans are also required by federal regulations to accept new enrollments unless otherwise permitted by CMS. When a state determines that a Sponsor's financial condition requires restrictions on new enrollments, CMS generally imposes parallel enrollment sanctions on the affected MA or Part D contracts. Once the Sponsor resolves the issues identified by the state and the state lifts its enrollment freeze, CMS lifts its enrollment sanction, as well. The table below lists the two Sponsors subject to sanction for financial solvency issues in 2025.

Sponsors Under Sanction in 2025 for Financial Solvency Issues

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
4/3/2025	4/3/2025	eternalHealth, Inc.	Enrollment Suspension	9/10/2025
9/29/2025	9/29/2025	Gold Kidney	Enrollment Suspension	12/15/2025

Appendix D: Audit Preparation Resources

Sponsors can take the following steps to help ensure a smoother audit process and reduce the likelihood of delays or complications during CMS program audits.

Audit Preparation

- Review the Program Audit Process Overview on the CMS website to understand the four stages of a program audit.
- Conduct mock audits using the program audit protocols, including generating and validating universes, to prepare data submissions and identify potential operational vulnerabilities.
- Review the Integrated Audit Module User Guide in HPMS to understand how to use the audit module throughout the audit process.
- Confirm that contact information in HPMS is accurate and ensure appropriate staff have access to the system.
- Review the User Group Resource Document for additional clarification on the audit protocols.

Information Technology Readiness

- Ensure staff and delegated entities are familiar with Microsoft Teams, as CMS uses this platform for audit webinars.
- If needed, request a test webinar from the Auditor-in-Charge (AIC) to confirm access and screen-sharing capabilities.

Documentation Readiness

- Prepare staff to quickly locate requested documentation during the audit.
- Review examples of required documentation in the CDAG_ODAG _Guidance.pdf file located in HPMS Submission Materials.

Best Practices During the Audit

- Conduct internal quality reviews to ensure universes are compiled according to program area record layout instructions before submitting them to HPMS.
- Contact program area team leads proactively with questions about record layout instructions.
- Join audit webinars at least five minutes early to ensure timely start and address any technical issues.
- Have delegated entities on standby when necessary so they can join webinars quickly and avoid delays.

Tips for Desk Reviews

- Carefully review the samples and requested documentation.
- Check to ensure all aspects of the requested documentation are included in the case file, and point out to CMS when a requested document is not available to avoid a question later.
- Include large PDFs in a ZIP file for ease of uploading to HPMS.
- Review any follow-up questions from the audit team prior to the webinar to ensure appropriate subject matter experts are on the call.