

CY 2025



Part C and Part D Program Audit and Enforcement Report **At-a-Glance**

Medicare Parts C
and D Oversight and
Enforcement Group

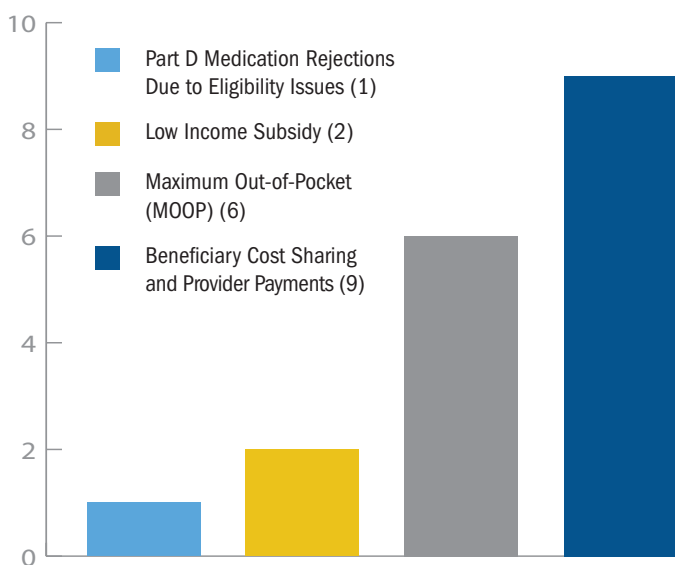
CMS continues to identify important operational and compliance risks through program audits, enforcement evaluations, and other oversight activities. The lessons observed throughout 2025 reinforce a common theme: many compliance failures stemmed from operational breakdowns rather than policy misunderstandings. Proactive compliance and robust operational controls are essential to prevent significant financial penalties and beneficiary impact.

Financial Cost of Non-compliance

CMS IMPOSED
\$1.54M
Across 14
enforcement
actions

INTERMEDIATE SANCTIONS
**Enrollment
Suspended**
MLR, D-SNP integration,
financial solvency

Top Enforcement Drivers



Top Aggravating Factors

Financial harm over \$100 or restricted access to medically necessary services.

Top Audit Findings

Data & Systems Errors

Minor inaccuracies in enrollment, eligibility, and benefits configuration cause inappropriate medication denials and incorrect cost-sharing.

Variability in Vendor Oversight

Sponsors remain fully accountable for FDR compliance failures—yet inconsistent oversight processes remain a top driver of cited noncompliance.

Incomplete Information

Coverage decisions made without considering all enrollee information or clinical documentation lead to inappropriate denials and delays.

On the Horizon: 2026

**QUARTERLY
COMPLIANCE
OFFICER CALL
REMAINING
DATES**



&



Faster Decisions in Part C

Prior authorization required within 72 hours (expedited) or 7 calendar days (standard).

Increased Data Scrutiny

CMS will rely more on existing data—accuracy, completeness, and integrity of submissions are more critical than ever.



QUESTIONS EVERY ORGANIZATION SHOULD BE ASKING:

- How confident are we that system changes, eligibility updates, and data transfers are validated before they affect beneficiaries?
- How do we verify that delegated entities are making decisions consistent with CMS requirements and our approved benefit designs?
- What controls ensure coverage decisions are based on complete clinical information?
- How do we measure whether care coordination activities are improving beneficiary outcomes?