The 2014 Part C and Part D Program Audit and Enforcement Report

October 13, 2015

Issued By:

The Medicare Parts C & D Oversight and Enforcement Group

This report is published online at:
http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits.html

Table of Contents

EXECUTIVE SUMMARY

The Medicare Parts C & D Oversight and Enforcement Group (MOEG) within the Center for Medicare (CM) conducts program audits to evaluate sponsors' delivery of health care services and medications to Medicare beneficiaries enrolled in the Medicare Advantage and Prescription Drug Plans. Between 2010 and 2014, 49% of the sponsors, covering 96% of enrolled beneficiaries were audited, completing our first cycle.

Throughout this five-year period, we have worked closely with the industry to help sponsors improve their performance. We saw some of the largest improvements in audit scores from 2013 to 2014. The overall audit score improved by 27% from 2.20 in 2013 to 1.61 in 2014 (the lower the audit score the better the performance). A list of audit scores for each sponsor is on the CMS website. In addition to improvements in the overall audit score, each program area audited also improved significantly. Although the Coverage Determination, Appeals, and Grievances (CDAG) area was the worst performance area last year, it showed the largest improvement. The audit score for CDAG improved by approximately 37% from 4.89 in 2013 to 3.10 in 2014. Organization Determinations, Appeals, and Grievances (ODAG), was the next poorest performing area, but improved by almost 5%. The other two major audit areas of Formulary Administration (FA) and Compliance Program Effectiveness (CPE) improved significantly from 2013 to 2014, with audit score reductions of 27% and 24% respectively.

Additionally, when separating out the audit performance of Sponsors with high Part C and Part D Star Ratings (those with an overall Star Rating of 4.5 and above), they showed even greater improvement in audit scores between 2013 and 2014. High Star Ratings sponsors improved their overall audit scores from 2.22 in 2013 to 1.00 in 2014, a 55% improvement. They also reduced audit scores much more than the rest of the sponsors on the four specific audit areas mentioned above. They improved CDAG scores by 64%, ODAG by 29%, FA by 56%, and CPE by 72%

The attention and focus that sponsors are giving to their compliance with program requirements, is a result of the collaborative efforts between CMS and the industry. Over the last several years, the performance of the industry has improved as the audit process transformed. We have undertaken a variety of activities to engage sponsors around the audit process. We solicited feedback on the protocols used for auditing, the process for conducting the audits, and the topics to be audited. As a result, we have made the process transparent. We post our protocols for each subject area on the CMS website. This allows sponsors to understand what will be audited and affords them the opportunity to conduct self-audits in advance of CMS.

We use every opportunity to educate sponsors on requirements through dedicated CMS Audit and Enforcement Conferences and presentations given at industry-hosted conferences. Memos have also been released that outline common findings from audits, the common causes of those problems, and recommendations for solutions. Sponsors are also able to submit specific

questions to either of our two public facing mailboxes, where we provide technical assistance on thousands of inquiries each year.

In concert with sponsors improving their performance, CMS also focused on process improvement and streamlined various audit steps. From 2013 to 2014, the following improvements were realized:

- The time to issue a final audit report was reduced by 32% (a 66-day reduction).
- The amount of time for a sponsor to issue a corrective action plan to CMS was reduced by 36% (an 88-day reduction).
- The time to close out an audit was reduced by 27% (116-day reduction).
- The issuance of Civil Money Penalties (CMP) occurred in 64% fewer days, on average 57 days instead of 159 days.
- Clarified our policy guidance and interpretation where industry suggested our guidance was unclear.

In general, program audits give CMS reasonable assurance that sponsors deliver benefits in accordance with the terms of their contract and plan benefit package. However, we also have authority to take enforcement actions, up to and including termination, if warranted, for findings that involve direct beneficiary harm or the potential to result in such harm. In fact, 46 enforcement actions were issued in 2014 and the beginning of 2015 (based on 2013 and 2014 audits). This included 5 sanctions and 41 CMPs (totaling $7.8 million). A detailed chart is in the report.

In summary, through the joint efforts of CMS and Sponsors, significant improvement in audit performance and the audit process is underway. While we need continued progress, evidence shows movement in the right direction. The following report will provide more detail about results of the 2014 audits and enforcement activities, initiatives undertaken in 2014, and planned improvements for the 2015 audit process.

INTRODUCTION

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs provide health care and prescription drug benefits for eligible individuals aged 65 years and older and eligible individuals with disabilities. CMS contracts with private companies, referred to as "sponsors," to provide health care and prescription drug benefits to beneficiaries.

The Medicare Parts C & D Oversight and Enforcement Group within the Center for Medicare performs program audits to evaluate sponsors' delivery of health care services and medications to Medicare beneficiaries enrolled in the Part C and Part D programs. MOEG has undertaken a number of activities to engage sponsors in continually working to improve their performance.

In addition to program audits, we also develop, maintain, and oversee the requirements for sponsors to have an effective compliance program implemented within their organization, including compliance with key fraud and abuse program initiatives. We have 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. In addition, validations are conducted to ensure that sponsors correct all deficiencies: (1) identified during program audits or, (2) that were the basis for intermediate sanctions. Lastly, we serve 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 report will summarize activities for the 2014 audit year, as well as, describe the scope of audits and the audit selection process, the current audit landscape, the audit lifecycle, process improvements implemented, results of 2014 audits, and enforcement activities.

AUDIT SCOPE & SPONSOR SELECTION

In order to conduct a comprehensive audit of a sponsor's operation and maximize Agency resources, program audits in 2014, as well as in prior years, occur 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 2014 audits. The audits evaluated sponsor compliance in the following program areas:

- 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)
- Special Needs Plans Model of Care (SNP MOC)

Sponsors have all program areas audited when possible, unless a protocol was not applicable to their operation. For example, if a sponsor does not operate a SNP plan, the SNP MOC protocol

is not applicable. Likewise, a standalone PDP does not have the ODAG protocol applied, since they do not offer a MA benefit.

In addition to determining the topics we will audit each year, we also determine the selection of sponsors for audits. Sponsor selection for audit relies on a number of sources, the primary one being the risk assessment MOEG conducts each year. This risk assessment is data driven and utilizes STAR ratings data, past performance data, plan reported data, and other operational information (e.g., large enrollment growth in a short period of time, large-scale formulary changes, changing PBMs, etc.). We then assign a weight and a score to each measure for each organization and calculate six risk scores: one overall risk score and one risk score for each program area we audit. This list is used to select high risk, as well as, low risk sponsors for audit each year.

Other factors that come into play in the selection process include audit referrals (from Regional Offices and/or Central Office), sponsors that appear on our Low Performing Icon (LPI) list, sponsors not audited in the last 3 years, and High Star Ratings plans (those with an overall Star Rating of 4.5 and above).

CURRENT AND PROJECTED PROGRAM AUDIT LANDSCAPE

The figures below show the progress of program audit operations on the Parts C and D industry each year by enrollment and parent organization. These data were based on enrollment and parent organization data as of June 2015 and include 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 2015 totals are 41 million beneficiaries (Figure 2) and 203 unique parent organizations (Figure 3). Some parent organizations audited between 2010 and 2014 are no longer in existence due to a merger, acquisition, or termination. As a result, the number of parent organizations represented in Figure 3 may not reflect the actual number audited since 2010.

Figure 2

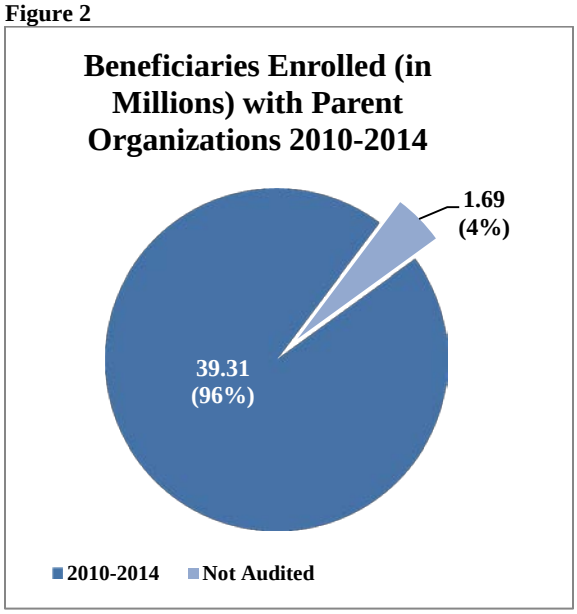


Figure 3

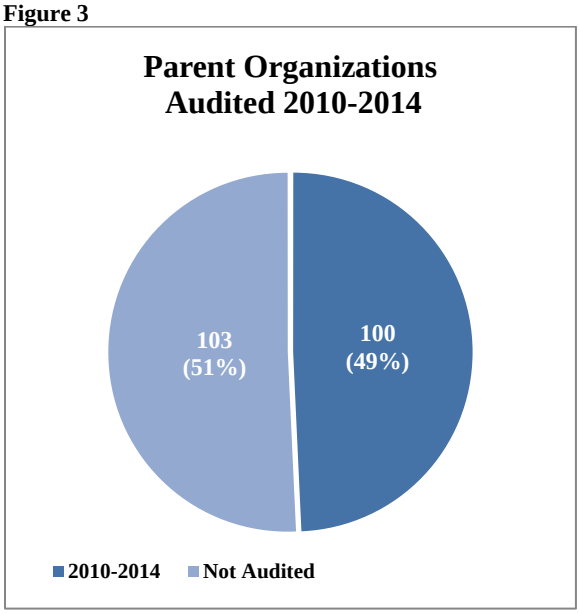


Figure 2 and 3 Summary:

- Since 2010, audited sponsors account for 96% of the total Medicare Advantage, other Medicare managed care health plans, and Prescription Drug Programs' enrollment.
- The variance between the percentage of parent organizations audited and the percentage of enrollment audited reflects MOEG's effort to audit sponsors with the largest enrollment in order to ensure the greatest number of beneficiaries are appropriately receiving services.

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

The figures below provide a view of the current audit status of all audits from 2010 through the end of 2014 by enrollment (Figure 4) and by parent organization (Figure 5) through the various phases of the audit process. These charts are based on data that are current as of June 30, 2015.

Figure 4

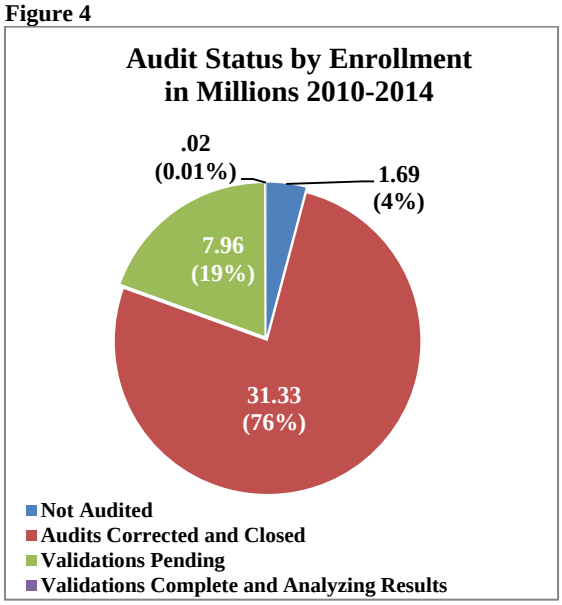
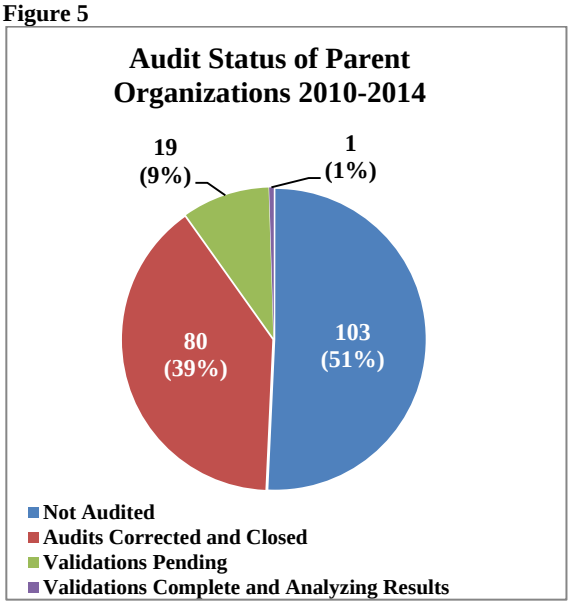


Figure 5



Note: The total percentages in Figures 4 and 5 do not equal exactly 100 due to rounding.

- Approximately 76% of all beneficiaries are enrolled in a plan that CMS has reasonable assurance is operating in compliance with the audited program areas (i.e., Corrected and Closed). In our 2013 Annual Report, this figure was 70% of total enrollment.
- While 51% of the existing 2015 parent organizations have not undergone an audit, this accounts for only 4% of the total enrollment in the MA and Part D programs, the same percentage as in 2013.

AUDIT LIFECYCLE

The lifecycle of an audit begins the day a start notice goes to the sponsor and concludes with the sponsor's receipt of an audit closeout letter. Previously, as the audit cycle was first implemented and the process refined, timeframes were often extended. We heard concerns from the industry about the length of the audit cycle. As a result, one of our primary goals in 2014 was to reduce the audit lifecycle to less than one year. Table 1 below shows achievement of this goal through a reduction in the overall audit lifecycle from 437 days to 321 days, a 27% decrease in the total number of days. The table and chart on the following page show the evolution and improvements of the average audit lifecycles from 2011-2014.

Table 1: Average Days Elapsed after Engagement Letter Issued 2011-2014

Audit Activity	2011	2012	2013*	2014*	Difference between 2011 and 2014	Difference between 2013 and 2014
Entrance Conference	21	27	28	28	7	0
Exit Conference	26	42	42	43	17	1
Draft Report Issued	240	148	181	113	-127	-68
Final Report Issued	267	174	208	142	-125	-66
Sponsor Submits Corrective Action Plan	357	263	242	154	-203	-88
Validation Reviews Conducted	497	434	411	310	-187	-101
Audit Closed	498	612	437	321	-177	-116

***The figures in this table use data from audits closed as of June 30, 2015.**

Figure 1

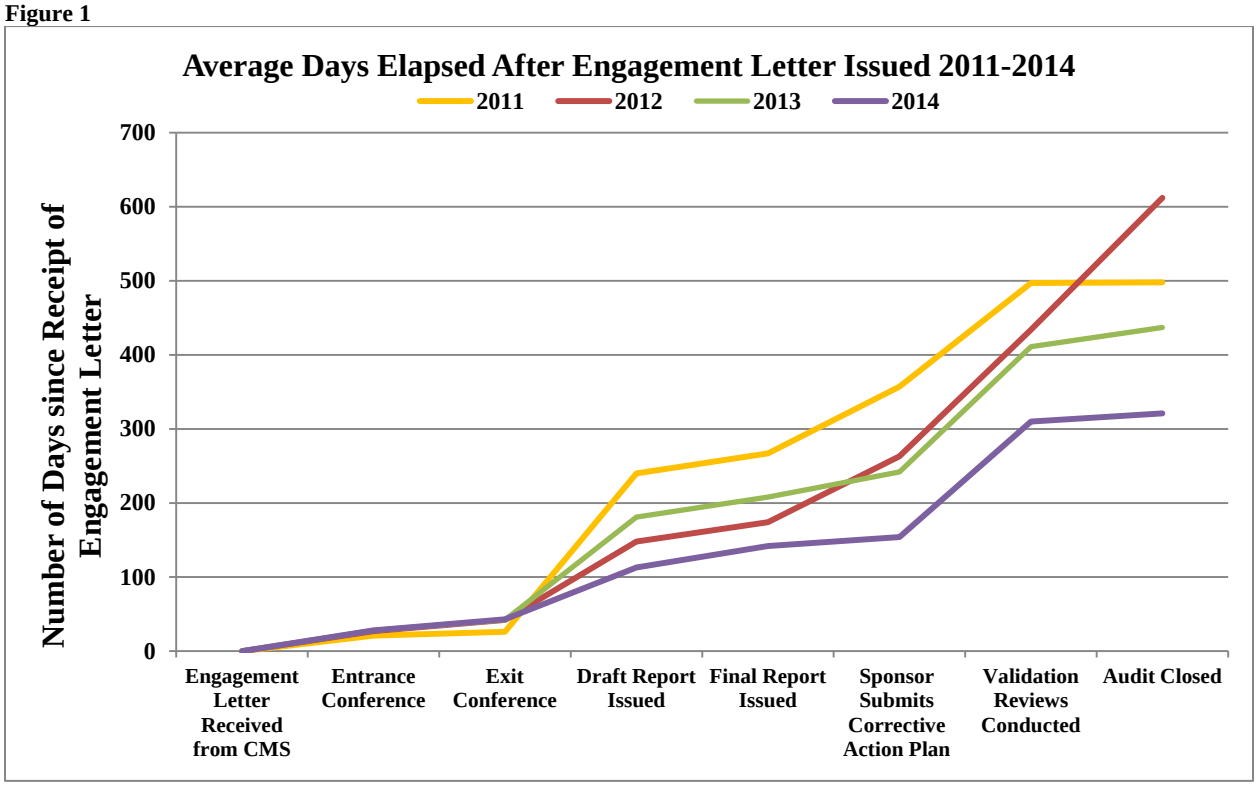


Table 1 and Figure 1 Summary:

Table 1 and Figure 1 show the average days elapsed after the issuance of the audit start notice for four years, 2011-2014. 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. In 2014, the reduction in the issuance of the draft report was 68 days and the reduction in the issuance of the final report was 66 days in comparison to 2013, representing a 38% and 32% reduction, respectively.

If a sponsor is able to more quickly focus its resources and submit a successful corrective action plan (CAP), it will expedite its release from audit. The CAPs are reviewed and validated to ensure that the conditions of non-compliance identified during the audit will be fixed. Sponsors submitted these corrective action plans 88 days sooner than in 2013, representing a 36% reduction.

Table 1 and Figure 1 also show that the average duration of the entire audit process was less than one year in 2014 for the first time since the redesign of the audit process. The timing for audit closeout is dependent largely on the amount of effort involved for the sponsor to correct its deficiencies and for CMS to validate those corrections. 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.

2014 AUDIT INNOVATIONS AND PROCESS IMPROVEMENTS

MOEG is looking for opportunities to continuously improve our processes and better support and educate our sponsors and external stakeholders. To assist us in this effort, we solicit feedback throughout the year on all our documentation, processes, and procedures. As a result, we made the following changes and improvements in 2014:

- While sponsors must submit an immediate corrective action plan within 72 hours of notification of any immediate corrective action required (ICARs) found during audit, the validations of these ICARs now occur with CAR validations, instead of being conducted separately. This creates better efficiencies for testing for both sponsors and CMS.
- CMS began conducting the timeliness tests for CDAG and ODAG at the universe level, thereby better capturing a sponsor's actual performance and not the performance of a targeted sample of cases.
- CMS enhanced automated features within the audit module in HPMS and introduced new functionality. The audit module now allows sponsors to obtain the engagement letter, audit protocols, universe templates, and audit reports, exchange files, and submit sample documentation via HPMS. It also allows CMS to generate the draft and final audit reports in HPMS.

AUDIT RESULTS AND TRENDING

In 2014, the audit scoring system generated an audit score for each sponsor based on the number and severity of non-compliant conditions detected. In this scoring system, a lower score represents better performance on the audit. Because the calculated audit score uses the number of non-compliant conditions discovered, the maximum audit score is unlimited. In addition, the weights are applied to ensure that conditions that have the greatest potential to impact beneficiary access to care have a greater impact on the overall score. The audit score assigns 0 points to observations, 1 point to each corrective action required (CAR), 2 points to each ICAR, and divides the sum of these points by the number of audit elements tested. The following is the formula for calculating the audit score:

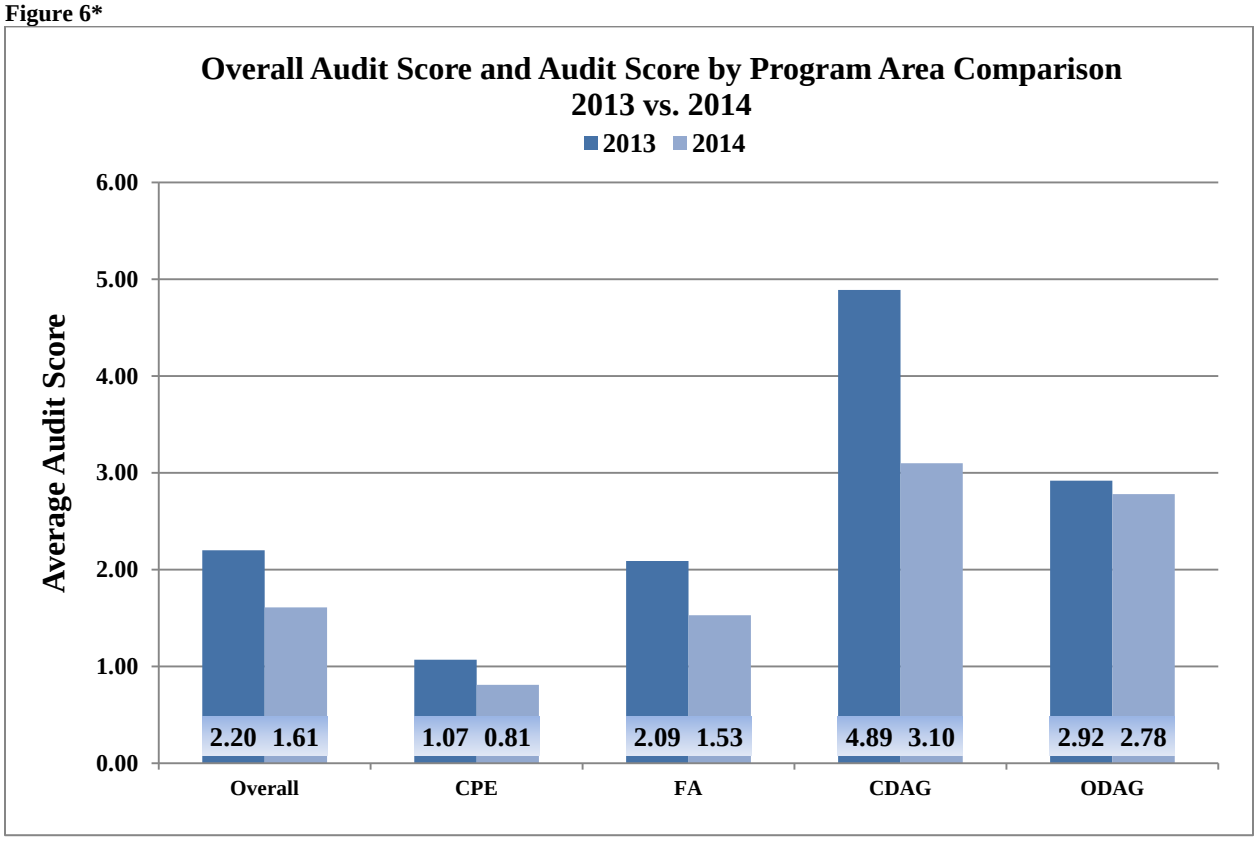
Audit score = (# CARs) + (# of ICARs X 2) / # of audited elements tested

Calculations produce an overall audit score, as well as, a score for each program area. As previously mentioned, not all sponsors audited in 2014 had each program area audited. This scoring system quantifies a sponsor's performance and allows comparisons of scores across the industry. The next several figures compare scores between 2013 and 2014; looks at scores based on the timing of the audits during the year, and displays overall and program area specific audit scores for sponsors audited in 2014.

Comparison of 2013 and 2014 Audit Results

The figure below shows the average sponsor score in each program area audited in 2013 compared to the 2014 scores. The scores in 2014 are lower (better performance) than in 2013, showing improvement in each of the program areas. The program area demonstrating the greatest improvement was CDAG, in which sponsors reduced their audit score by 37%.

Figure 6*

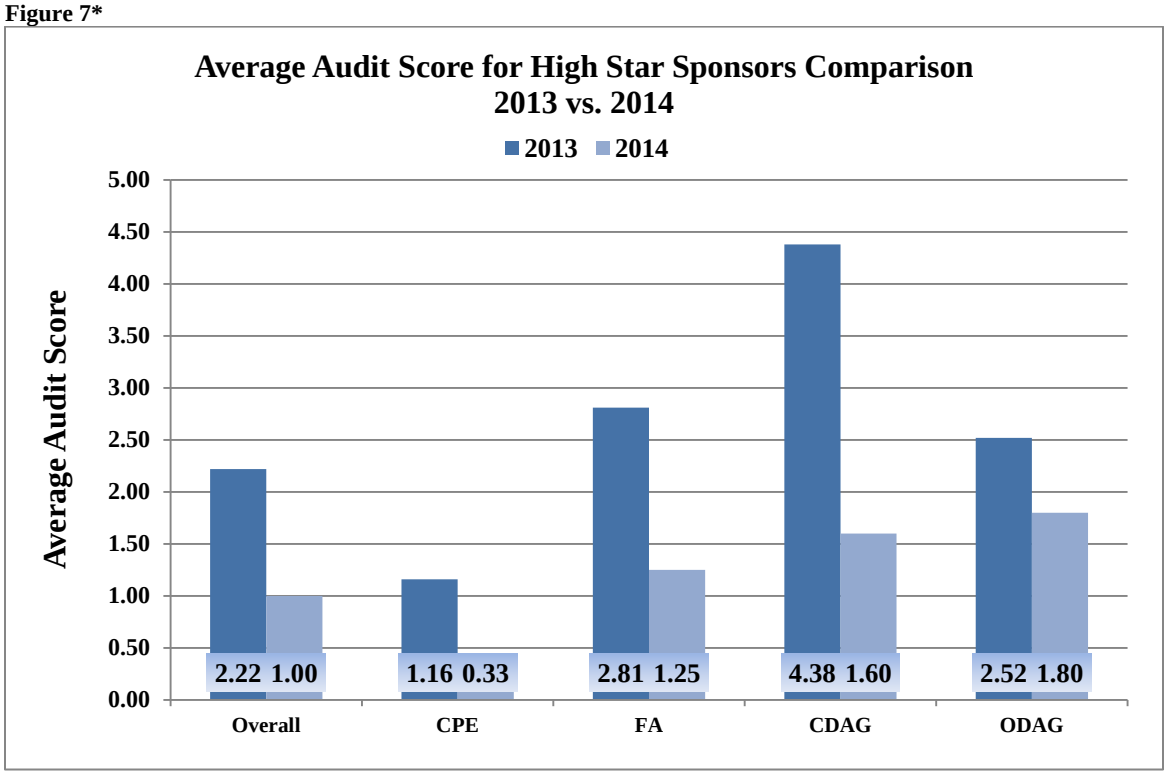


*** A lower audit score represents better audit performance. SNP MOC is not featured in this graph because it was a pilot program area in 2013, and audit scores were not calculated.**

Comparison of 2013 and 2014 Audit Scores for High Star Sponsors

Figure 7 compares the average overall and specific program area audit scores for the High Star sponsors audited. High Star sponsor's audit scores decreased (i.e., improved) markedly from 2013 to 2014.

Figure 7*

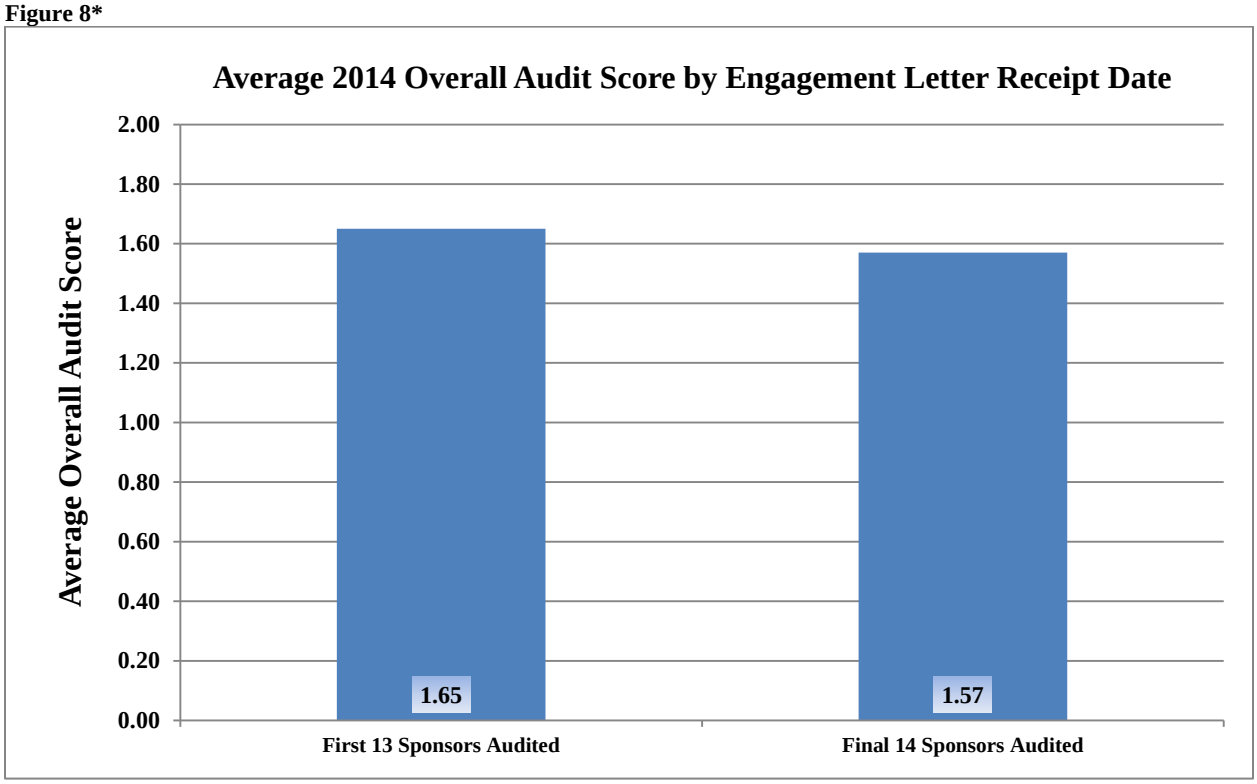


*** A lower audit score represents better audit performance. SNP MOC is not featured in this graph because it was a pilot program area in 2013, and audit scores were not calculated. In 2014, none of the High Star plans audited had a SNP plan. CMS audited 7 High Star sponsors in 2013 and 5 High Star sponsors in 2014.**

Comparison of 2014 Audit Scores by Engagement Letter Receipt Date

Sponsors raised concerns to CMS that those sponsors that are audited in the first part of the year are disadvantaged compared to those sponsors audited later in the year. Sponsors speculated that having more time to familiarize themselves with protocols and more time to program their systems to report data, led to better audit results. To determine if there was any merit to this claim, we conducted an analysis comparing the performance of the first 13 sponsors audited (based on engagement letter receipt date) to the last 14 sponsors audited. Figure 8 depicts the average overall performance of those two cohorts of sponsors audited in 2014. While there is variance between the scores of the sponsors in these two groups, it is small and is not indicative of any inherent advantage or disadvantage in the timing of an audit.

Figure 8*



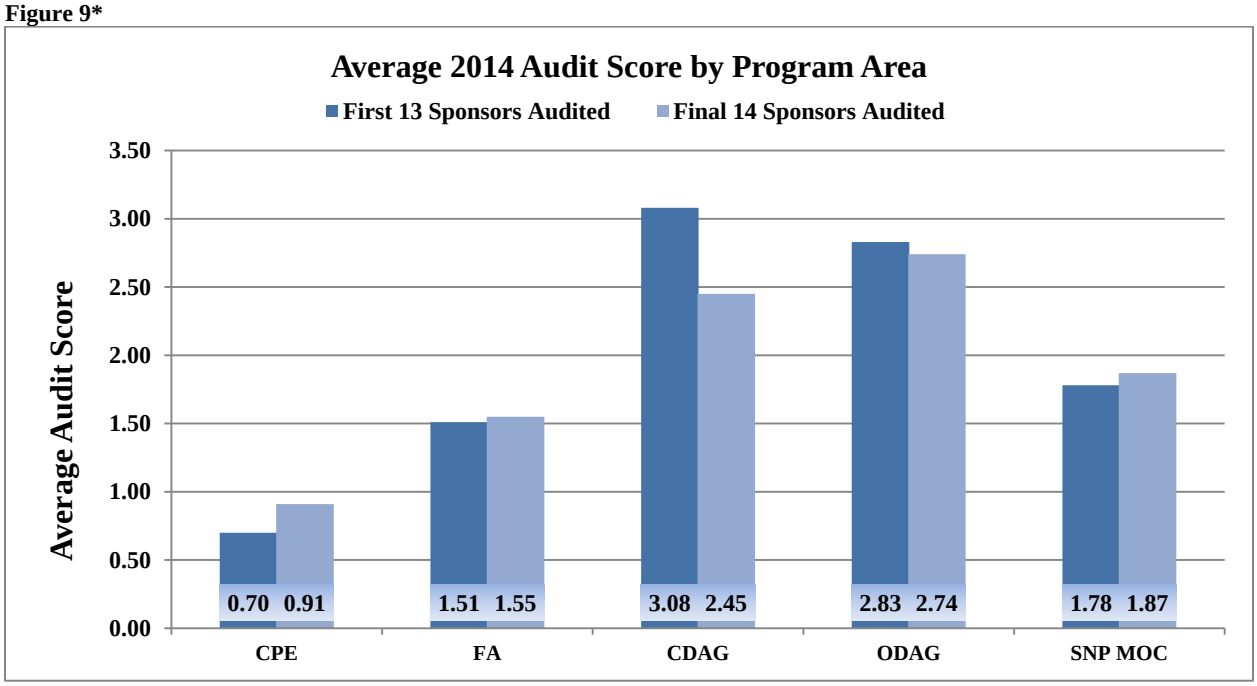
***A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited in 2014.**

In general, the same holds true for the five individual program areas in which CMS conducted audits in 2014. Figure 9 shows the 2014 audit results broken down by program area and by the two groups of sponsors. Figures 10-15 show the overall and program area audit scores arrayed by receipt date of the engagement letter for sponsors audited in 2014. The two lines on each chart indicate the average score for the first 13 sponsors and final 14 sponsors audited.

We previously noted that sponsors achieved the greatest improvement in the area of CDAG from 2013 to 2014, yet this is the one area that had the most variance between the first and second cohort with respect to 2014 performance. With the removal of one outlier (with a score of 12.33) from the first half of the sponsors audited, this group averaged a score of 3.08 in CDAG compared to 2.45 for the last half of the sponsors audited.

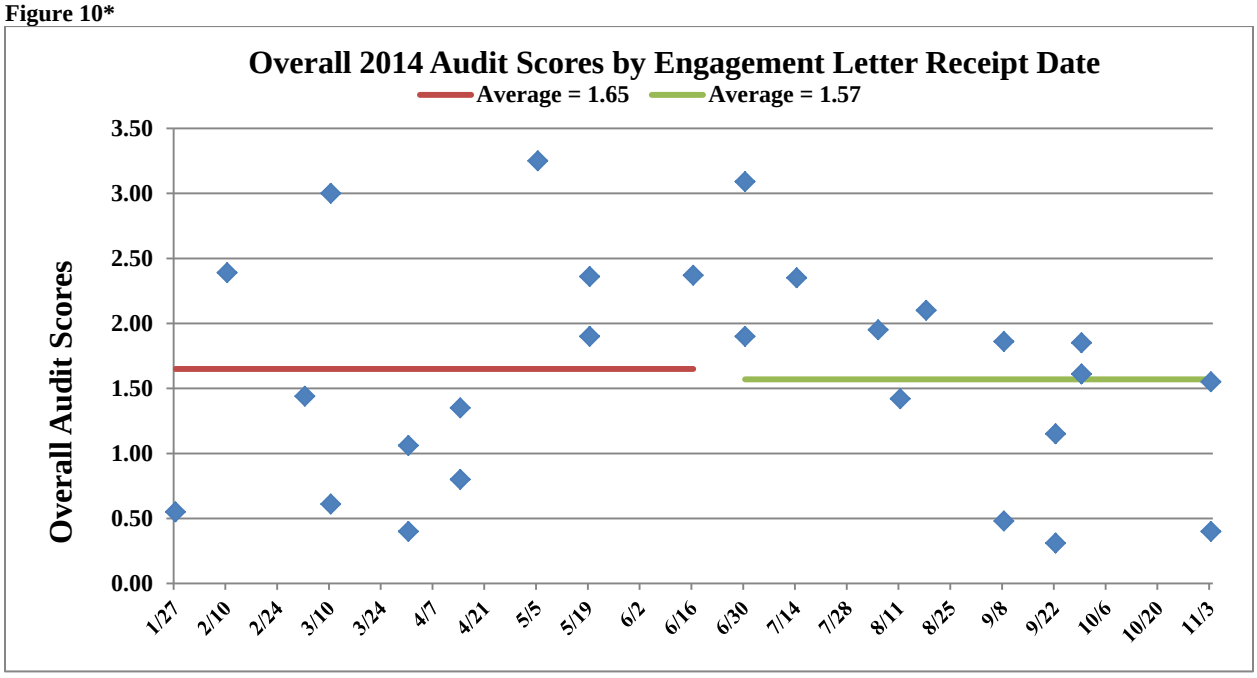
However, the first half of sponsors audited scored better than the second half of the sponsors audited in FA, CPE and SNP MOC (see Figure 9 below). Figures 10-15 below further reiterate that there is no association between the order in which the sponsor is audited and the audit score.

Figure 9*



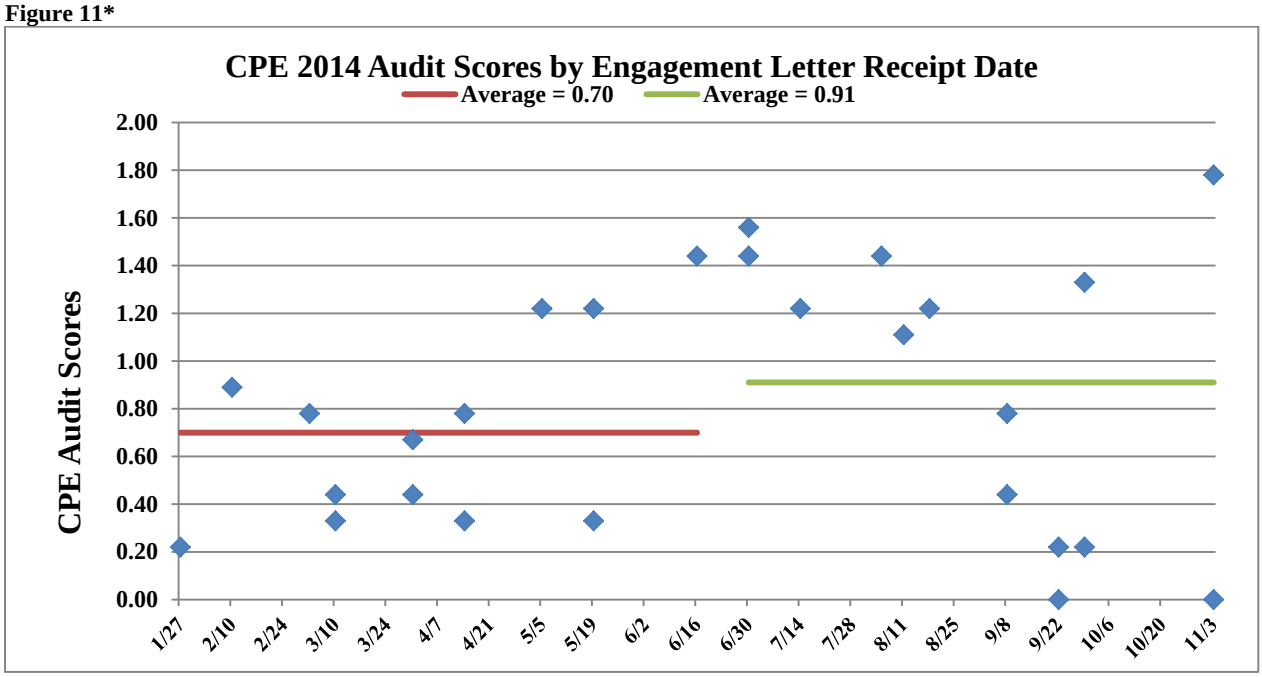
***A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited in 2014. Outlier removed for CDAG.**

Figure 10*



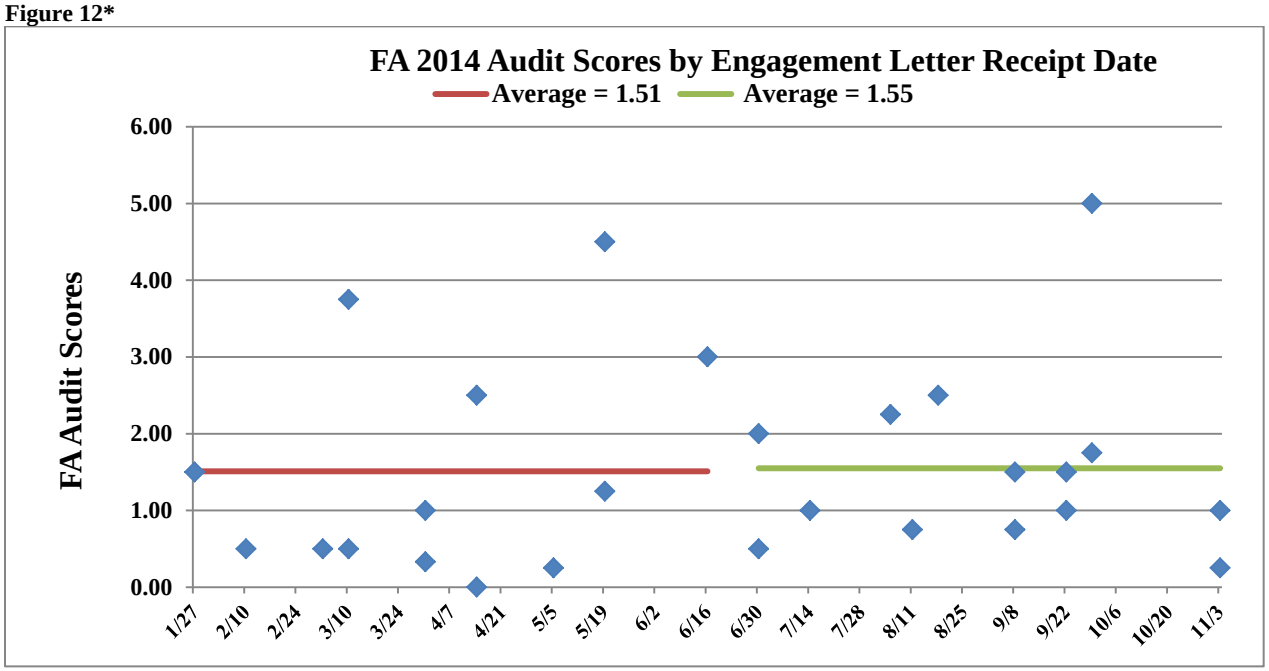
***A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited in 2014.**

Figure 11*



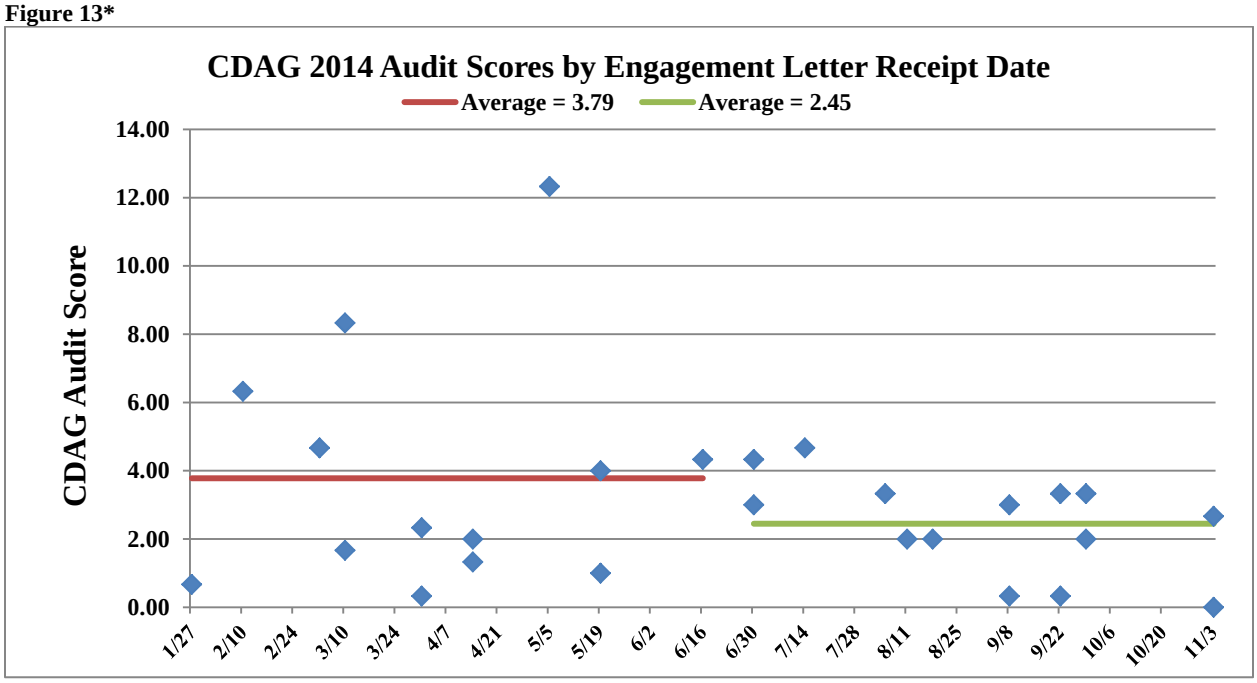
***A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited for the CPE program area in 2014.**

Figure 12*



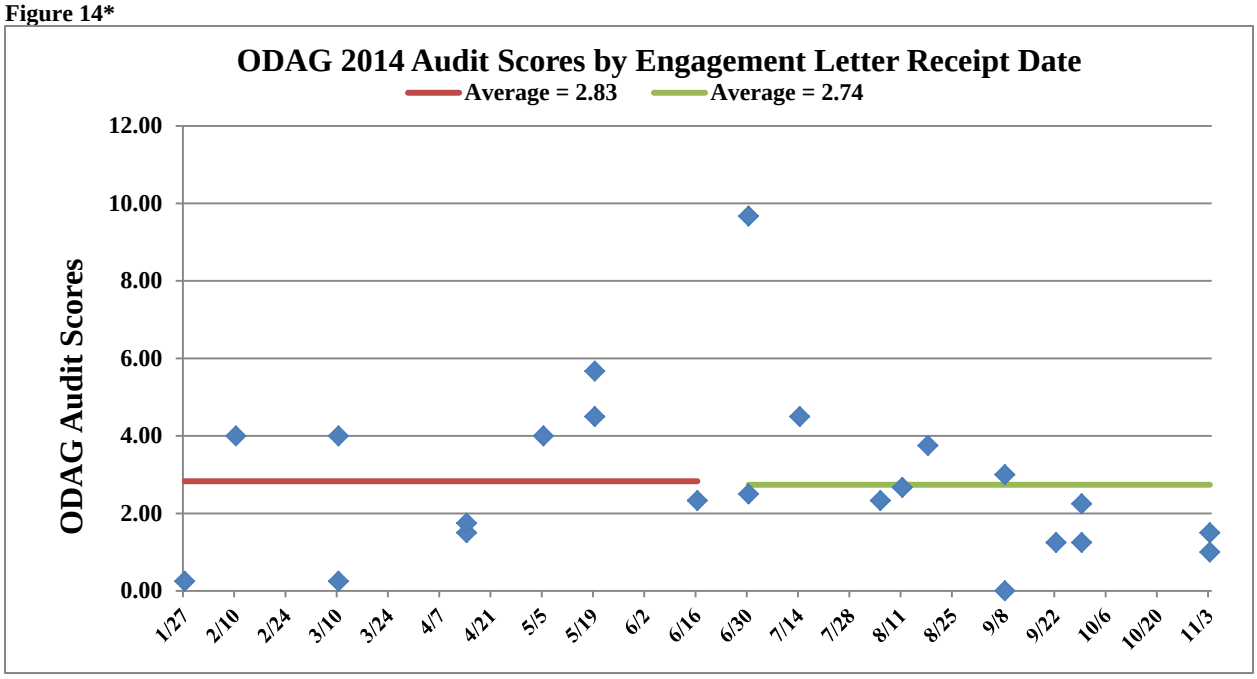
*** A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited for the FA program area in 2014.**

Figure 13*



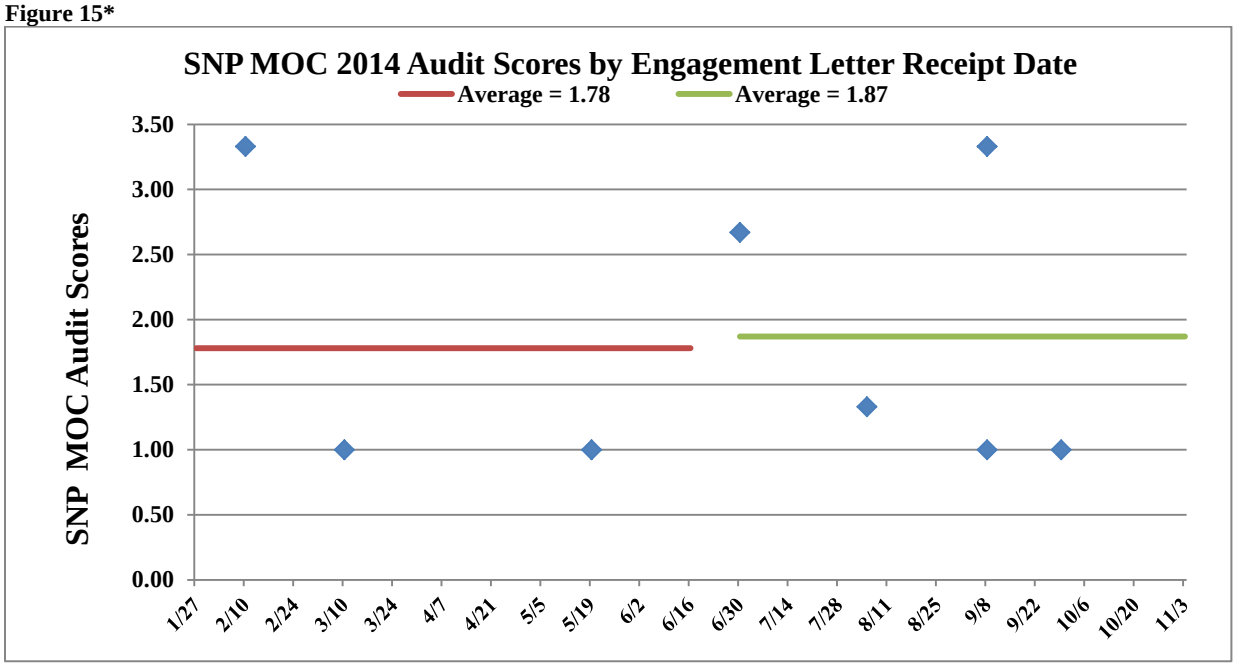
*** A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited for the CDAG program area in 2014.**

Figure 14*



*** A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited for the ODAG program area in 2014.**

Figure 15*

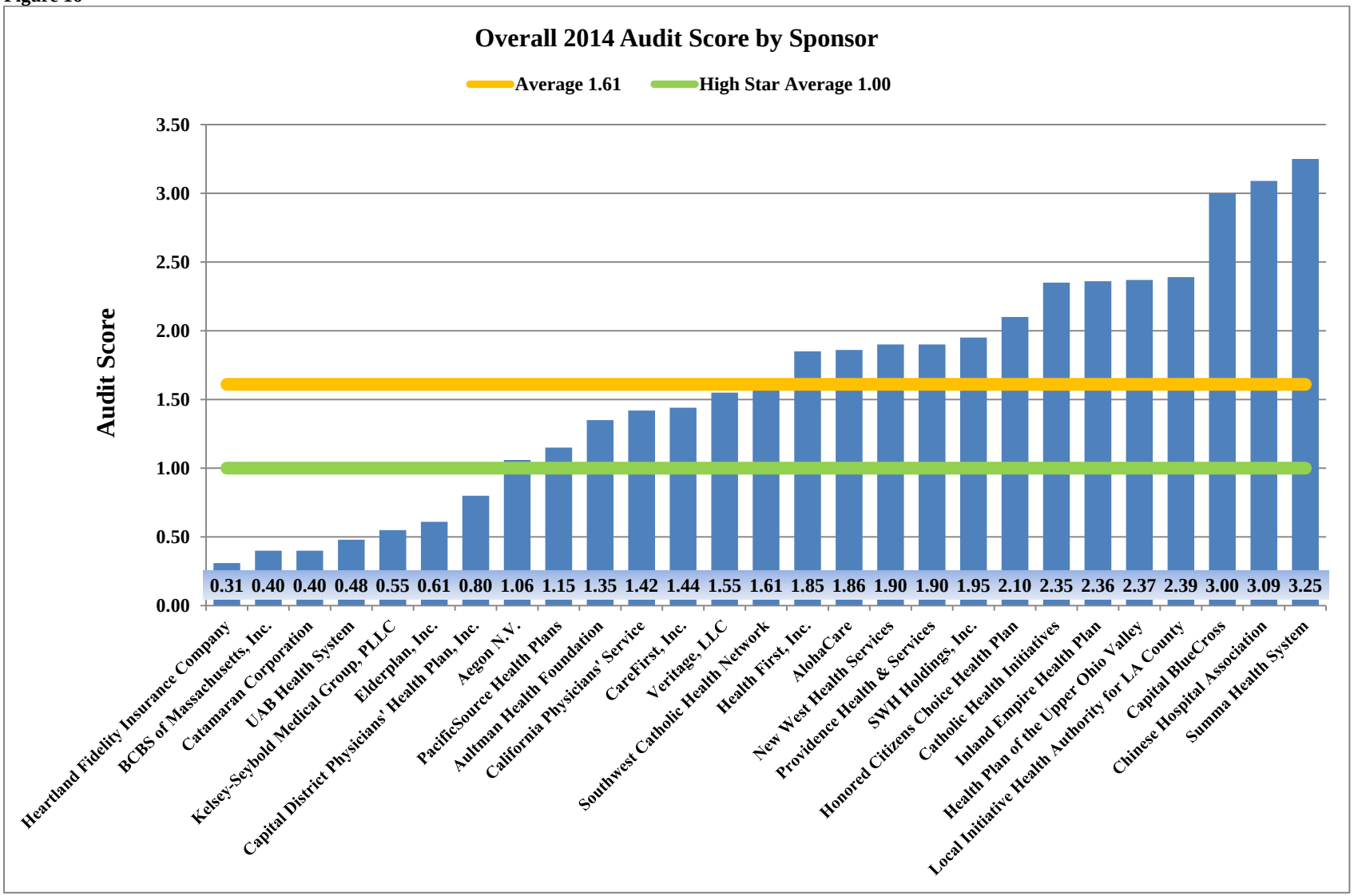


*** A lower audit score represents better audit performance. The average audit score is an unweighted score for the two groups of sponsors audited for the SNP MOC program area in 2014.**

2014 Program Audit Scores

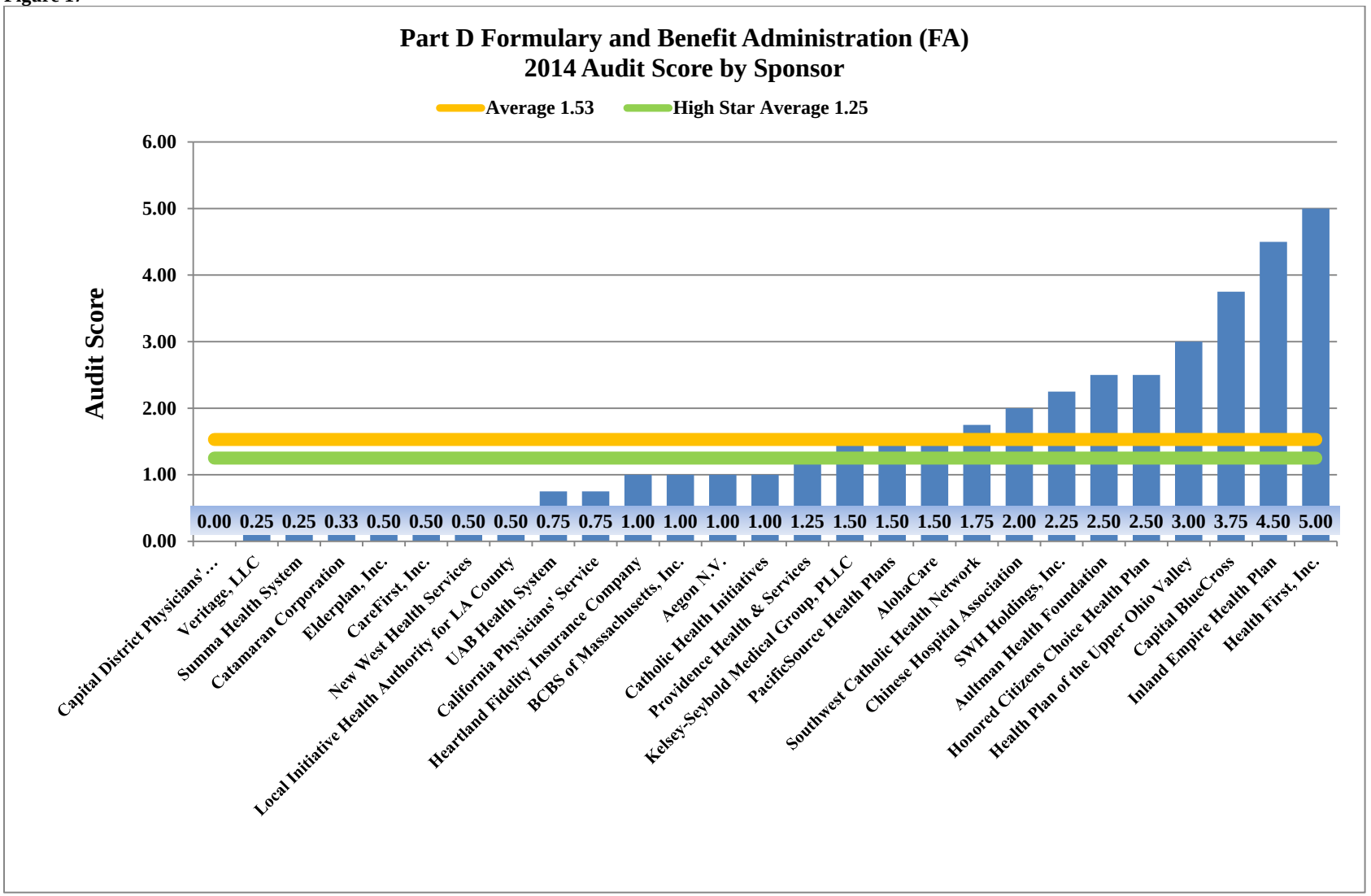
Figures 16-21 array the overall and individual program area 2014 audit scores from three different perspectives. First, the audit scores are arrayed from best to worst score (i.e., lowest score to highest score) moving from left to right across the graph. Second, the orange line in each graph represents the average audit score across all audited sponsors. Finally, the green line represents the average audit score for audited sponsors with a high Star Rating (4.5-5 stars).

Figure 16*



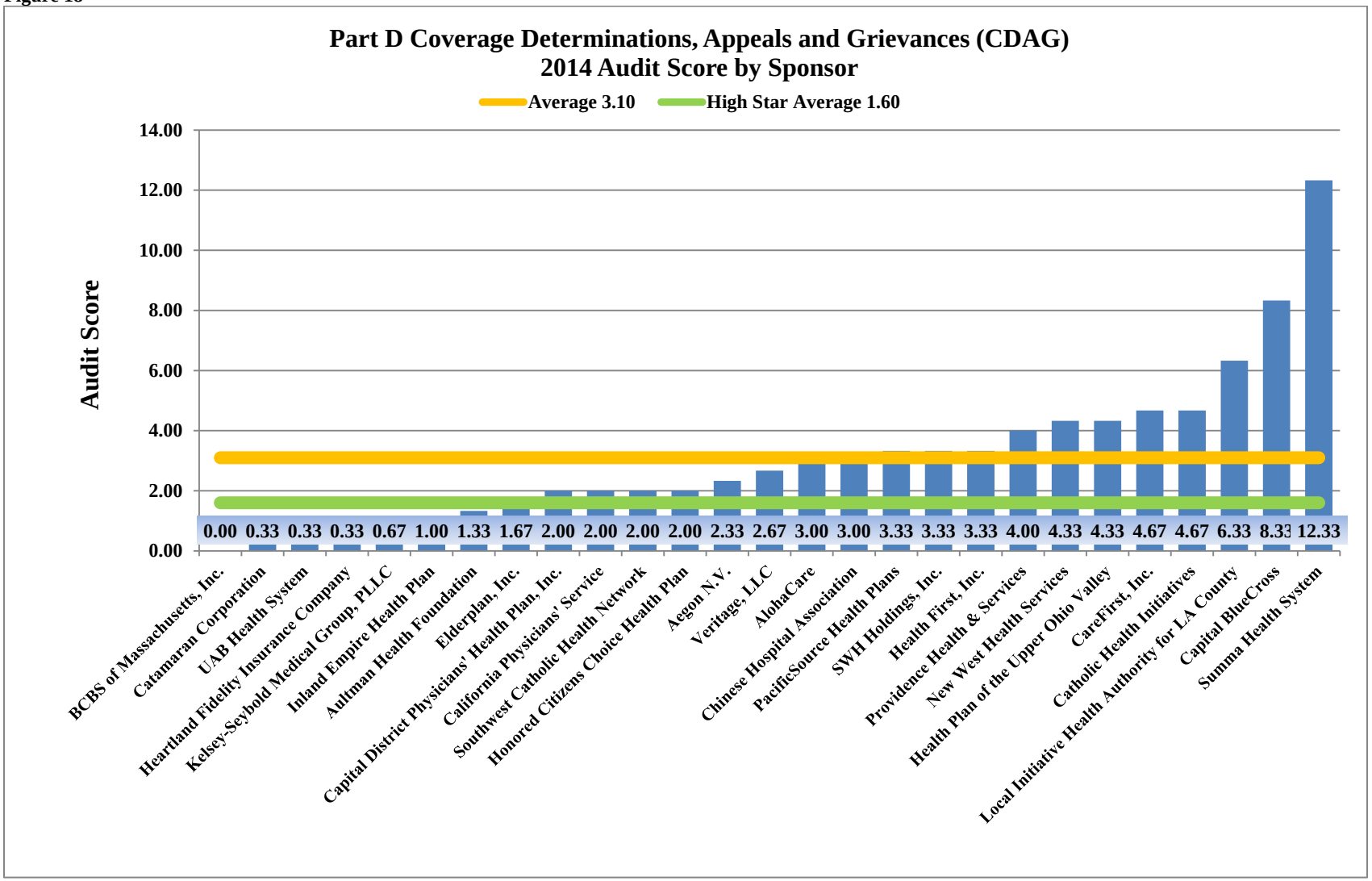
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited in 2014. The High Star average is an unweighted score across those sponsors with a STAR Rating of 4.5 or greater.**

Figure 17*



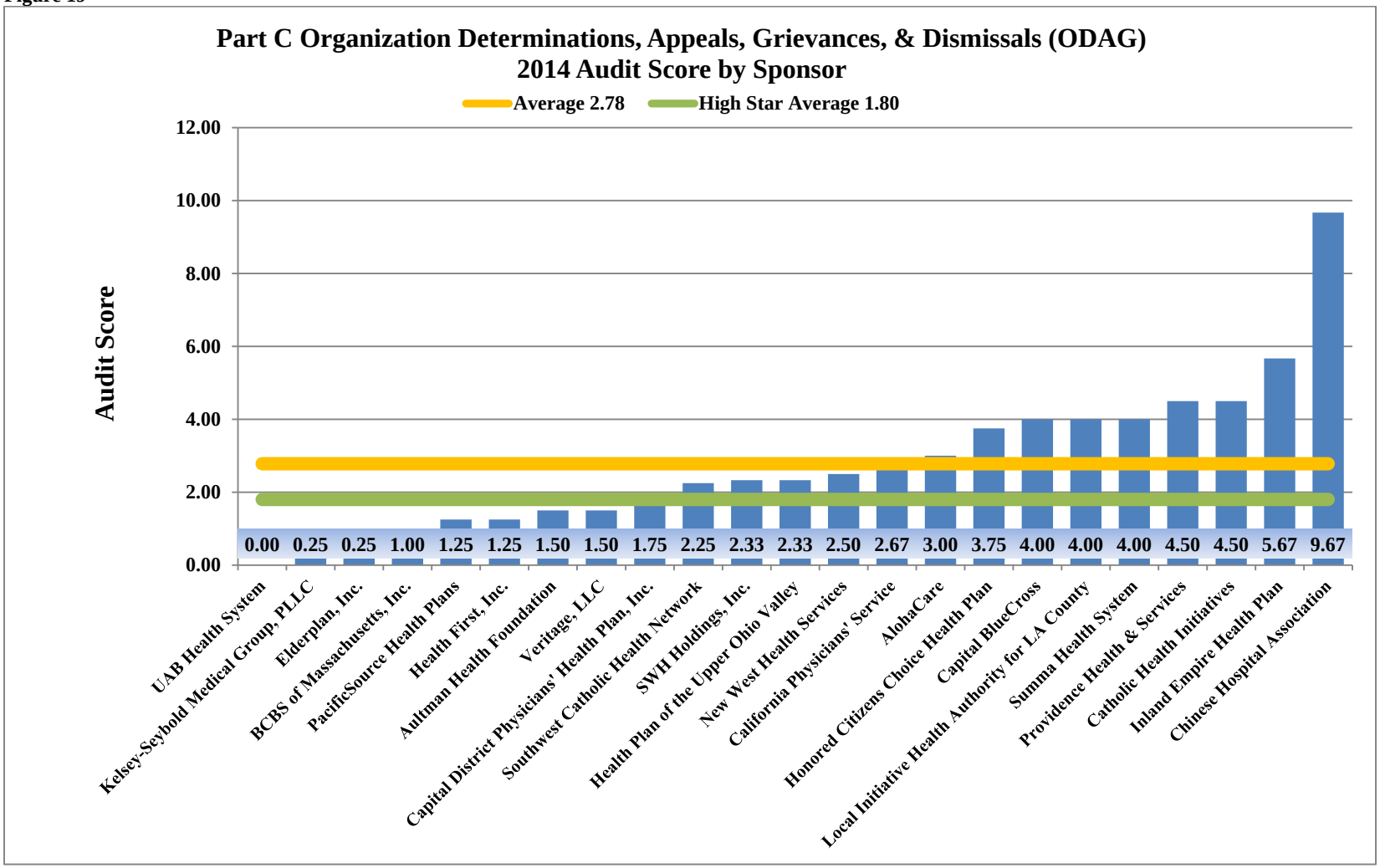
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the FA program area in 2014. The High Star average is an unweighted score across those sponsors audited for FA with a STAR Rating of 4.5 or greater.**

Figure 18*



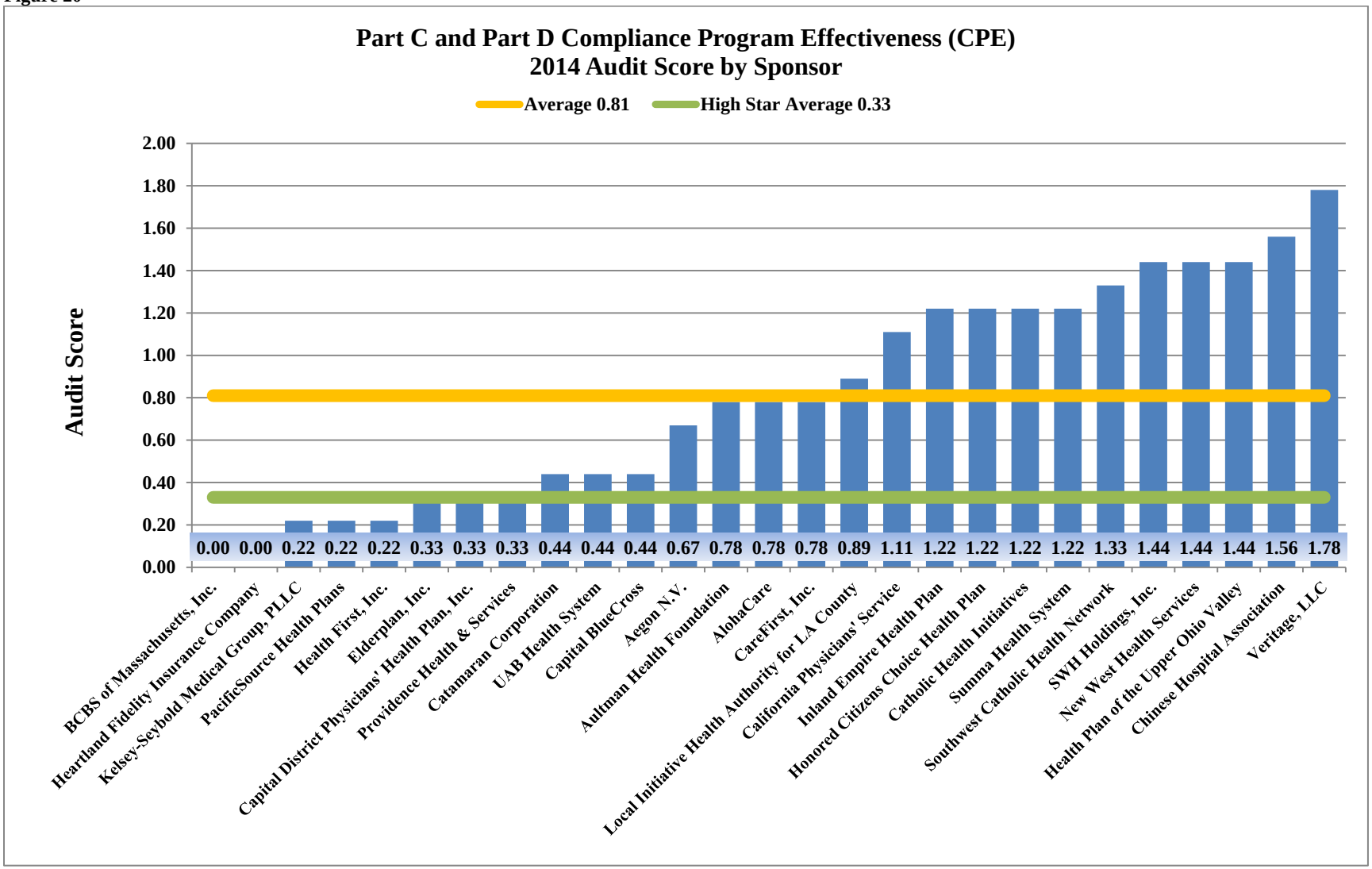
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the CDAG program area in 2014. The High Star average is an unweighted score across those sponsors audited for CDAG with a STAR Rating of 4.5 or greater. Note that the average CDAG audit score decreases to 2.74 when excluding the score for Summa Health System.**

Figure 19*



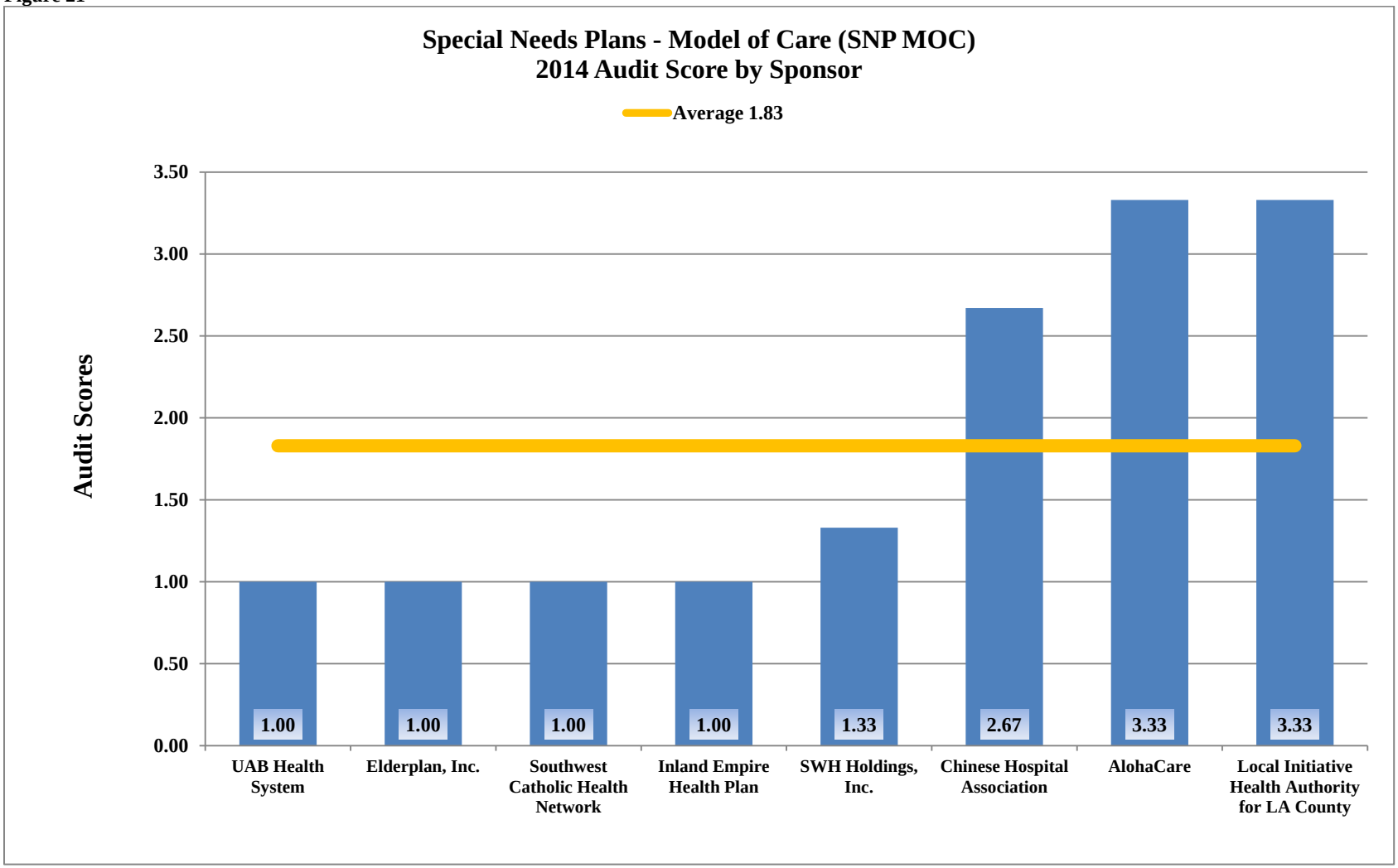
***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the ODAG program area in 2014. The High Star average is an unweighted score across those sponsors audited for ODAG with a STAR Rating of 4.5 or greater. Note that the average ODAG audit score decreases to 2.47 when excluding the score for Chinese Hospital Association.**

Figure 20*



***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 2014. The High Star average is an unweighted score across those sponsors audited for CPE with a STAR Rating of 4.5 or greater.**

Figure 21*

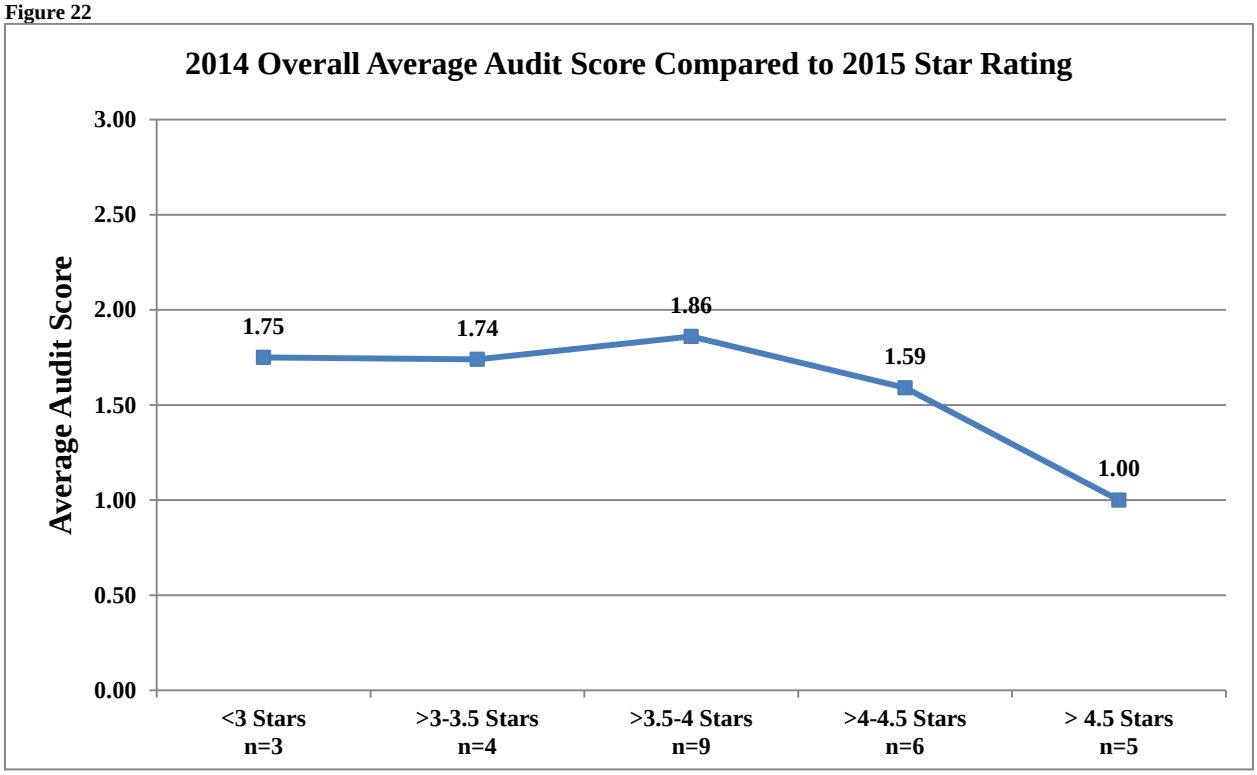


***A lower audit score represents better audit performance. The average audit score is an unweighted score across all sponsors audited for the SNP MOC program area in 2014. There is no High Star average for SNP MOC as no High Star sponsors were audited for this program area in 2014.**

Overall 2014 Audit Scores Compared to 2015 Star Rating Data

Figure 22 shows a comparison between 2014 overall average audit scores and 2015 Star Ratings scores. Sponsors were grouped into one of five Star Ratings ranges before the average audit score was calculated. Sponsors may receive a Star Rating between 1 and 5, 5 being the best. In contrast, the audit score has no upper limit, and the lower the audit score the better. This figure demonstrates that sponsors with the highest Star Ratings performed better than those with average or low Star Ratings. However, the lack of a stronger inverse relationship suggests that program audits reveal unique information about sponsor 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 operations and performance.

Figure 22

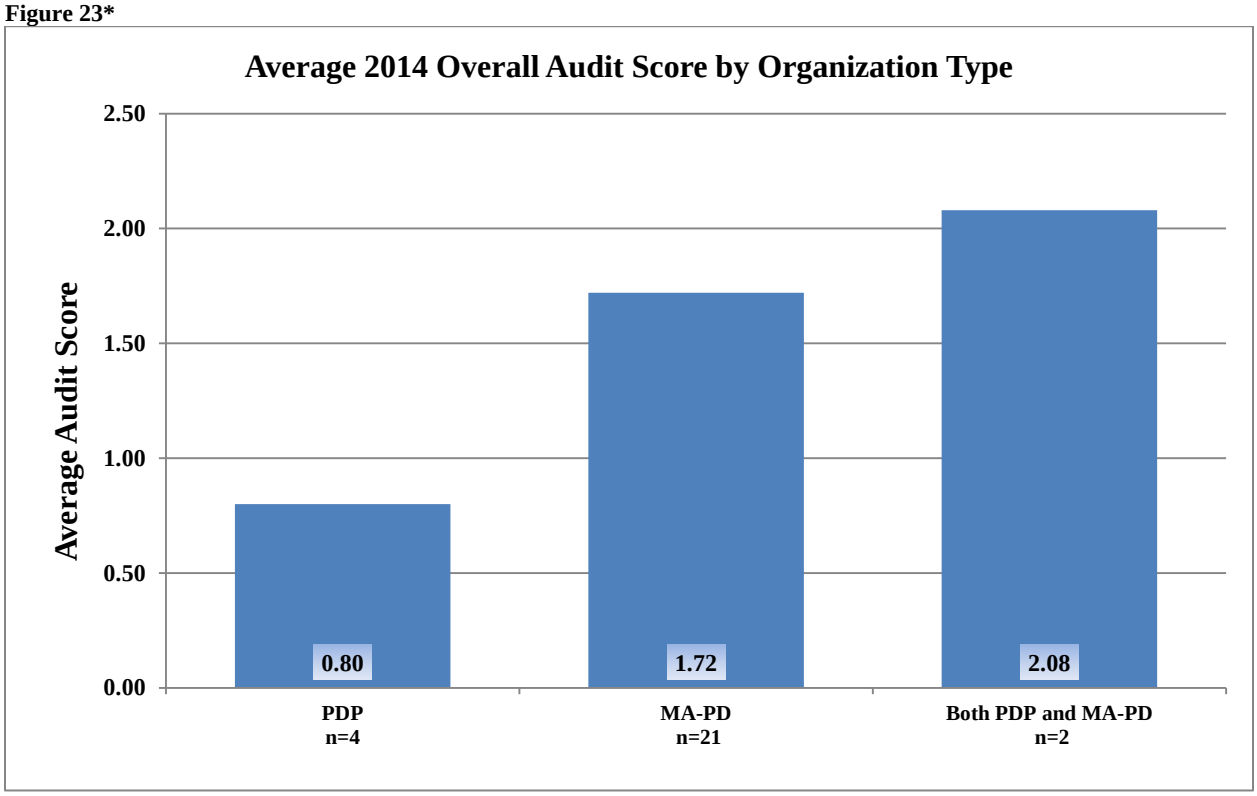


***Audit and Star Rating scores were analyzed at the sponsor (parent organization) level. A lower audit score represents better audit performance. A higher Star Rating represents better quality and performance.**

Overall 2014 Audit Scores by Organization Type

Figure 23 depicts the 2014 overall average audit score by plan type (e.g., PDP). The majority of the sponsors audited in 2014 offered MA-PDs. Sponsors were grouped into each category based on all of their offerings under their parent organization. For example, 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. Sponsors were only assigned to one category. PDP sponsors had the lowest (i.e., best) audit score. However, we do not believe there are 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 23*

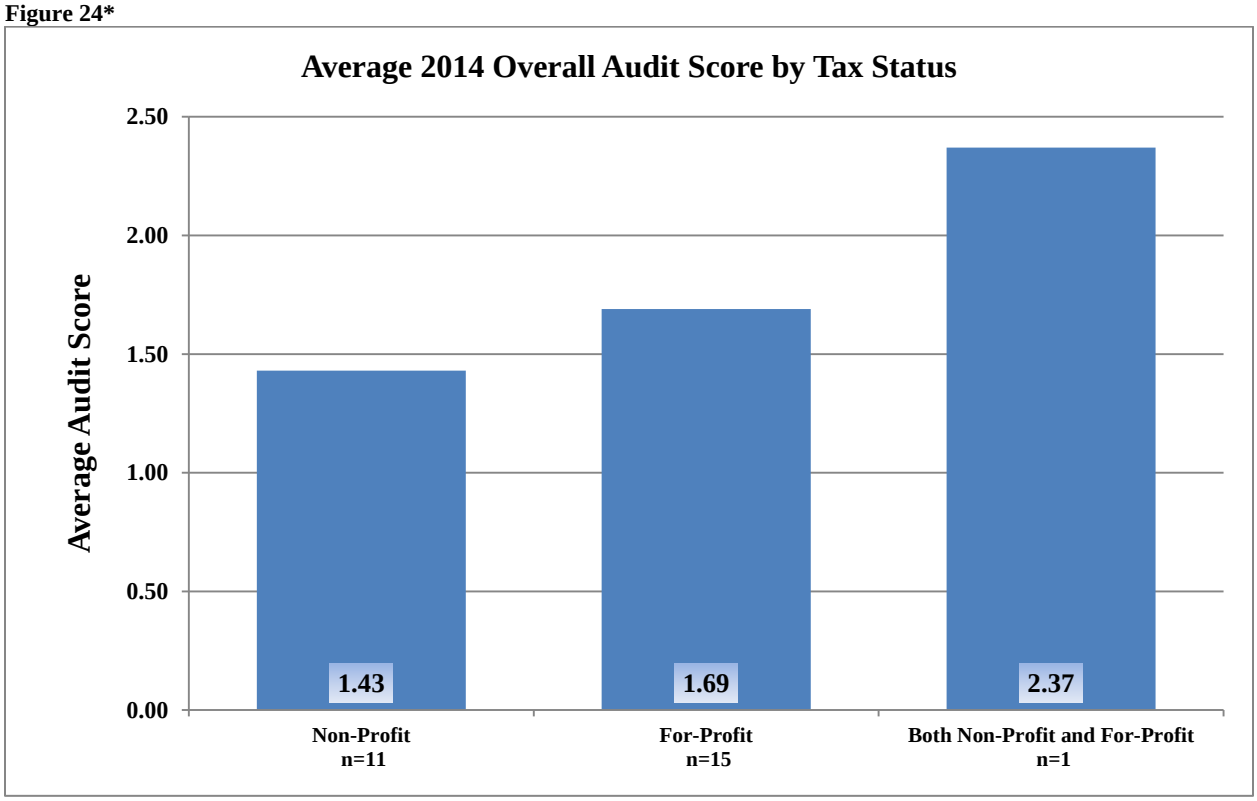


***Audit scores were analyzed at the sponsor (parent organization) level. The average audit score is an unweighted score across all audited sponsors within each plan type group. A lower audit score represents better audit performance.**

Overall 2014 Audit Scores by Tax Status

Figure 24 depicts the 2014 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. The majority of sponsors were either classified as for-profit or as non-profit; that is to say that all of their contracts were either for-profit or non-profit, but not both. Only one sponsor operated both for- and non-profit subsidiaries. Those with only a non-profit tax status had better overall average audit scores.

Figure 24*



***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.**

Overall Audit Performance

As seen above through various different lenses, audit performance has improved in 2014, especially compared to 2013. All subject areas audited improved between the two audit years. Sponsors who achieve 4 stars or higher on Star Ratings, tended to also score better on the audits. In addition, there is no meaningful difference between audit results of sponsors audited in the first part of the year versus the later part of the year. All of these findings demonstrate the industry is taking their responsiblitity for serving beneficiaries more seriously and implementing strategies that improve program compliance and access to care.

Audit Referrals

While CMS is encouraged to see that sponsors' performance improved, we did make a number of referrals to the Division of Compliance Enforcement based on non-compliance found during the program audits. In 2014, we took a number of enforcement actions, based on both 2013 and

2014 audit results and other compliance violations. The next section details the number and types of violations, the basis for those actions, provides additional information with respect to the amount of Civil Money Penalties issued, and provides information about sponsors that were sanctioned.

ENFORCEMENT ACTIONS

Sponsors that significantly failed to comply with Medicare Parts C and D requirements received an enforcement action. CMS has the authority to impose civil money penalties (CMPs), intermediate sanctions, and for-cause terminations against Medicare Advantage Organizations, Prescription Drug Plans, PACE Organizations and Cost Plans. The Division of Compliance Enforcement (DCE) in MOEG is responsible for imposing these types of enforcement actions when a sponsor is substantially non-compliant with CMS contract requirements. DCE routinely evaluates referrals of non-compliance to determine if an enforcement action is warranted. All enforcement actions may be appealed either to the Departmental Appeals Board (CMPs) or to a CMS hearing officer (intermediate sanctions and terminations).

DCE works closely with the Health and Human Services 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.[1] When referrals involve suspected fraud, waste, and abuse, the information is immediately referred to the Center for Program Integrity for investigation.

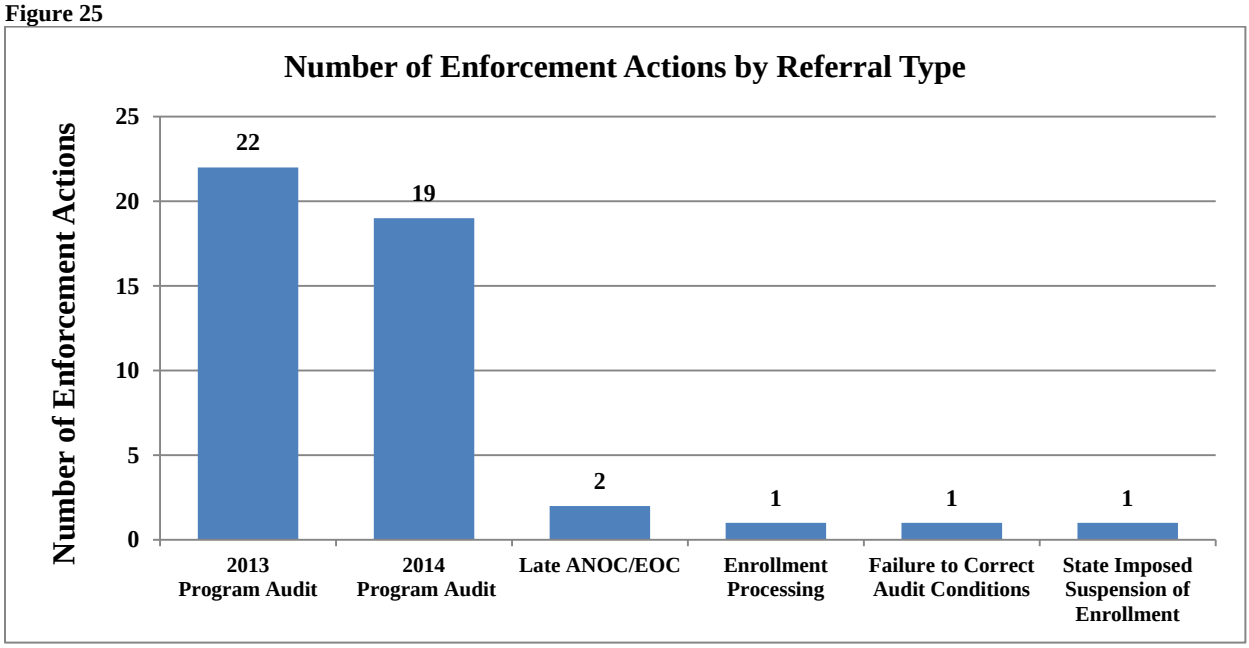
ENFORCEMENT ACTIONS IMPOSED IN 2014

This section provides information on all enforcement actions taken in calendar year 2014, as well as actions imposed in 2015 due to non-compliance detected in 2014 program audits. DCE imposed 46 enforcement actions: 5 intermediate sanctions and 41 CMPs. There were no for-cause terminations in 2014.

DCE receives referrals of non-compliance for a variety of reasons. More than 90 percent of the referrals came from the Division of Audit Operations (DAO) for non-compliance found in the operational areas of Part D Formulary and Benefit Administration, CDAG and ODAG. Other non-compliance that commonly resulted in enforcement referrals is erroneous or late Annual Notice of Change/Evidence of Coverage documents, failures in enrollment processing, and state enforcement actions that affect an organization's ability to comply with CMS requirements. Figure 25 below displays the number of enforcement actions by referral type.

[1] http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html

Figure 25



Civil Money Penalties (CMPs)

We imposed $7.8 million in CMPs, with an average of $190,390 per CMP. The highest CMP amount imposed was $689,800, and the lowest amount imposed was $20,700. As a reminder, this section provides information on all enforcement actions taken in calendar year 2014 (on 2013 and 2014 audits), as well as actions imposed in 2015 due to non-compliance detected in 2014 program audits. The following chart shows all the sponsors that received a CMP:

Table 2

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
03/31/2014	Independence Blue Cross	Enrollment Processing	$ 50,000
04/07/2014	Commonwealth Care Alliance, Inc.	Late ANOC/EOC	$ 49,510
04/07/2014	Florida Healthcare Plus, Inc.	Late ANOC/EOC	$ 40,890
04/23/2014	Independent Health Association, Inc.	2013 Program Audit	$ 154,600
04/23/2014	Lifetime Healthcare, Inc.	2013 Program Audit	$ 447,450
04/23/2014	Simply Healthcare Plans, Inc.	2013 Program Audit	$ 252,750
04/23/2014	UCare Minnesota	2013 Program Audit	$ 30,000
04/24/2014	Aetna Inc.	2013 Program Audit	$ 101,500
04/24/2014	Aetna Inc.	2013 Program Audit	$ 407,800
04/24/2014	Anthem Insurance Company & BCBSMA & BCBSRI & BCBSVT	2013 Program Audit	$ 100,950
04/24/2014	Blue Cross Blue Shield of Arizona, Inc	2013 Program Audit	$ 60,000
06/11/2014	Blue Cross Blue Shield of Florida, Inc	2013 Program Audit	$ 176,000
06/11/2014	HealthPartners, Inc.	2013 Program Audit	$ 21,800
06/11/2014	Tufts Associated HMO, Inc.	2013 Program Audit	$ 137,700

Date of Imposition	Organization Name	Basis for Referral	CMP Amount
06/12/2014	Express Scripts Medicare	2013 Program Audit	$ 334,300
06/12/2014	USAble Mutal Insurance Company	2013 Program Audit	$ 51,150
06/12/2014	WellCare Health Plans, Inc.	2013 Program Audit	$ 290,050
07/16/2014	Blue Cross Blue Shield of North Carolina	2013 Program Audit	$ 290,250
07/16/2014	Cambia Health Solutions, Inc.	2013 Program Audit	$ 254,000
07/16/2014	Cuatro LLC	2013 Program Audit	$ 80,600
07/17/2014	Florida Healthcare Plus, Inc.	2013 Program Audit	$ 113,200
07/17/2014	Geisinger Health System	2013 Program Audit	$ 180,400
07/17/2014	Moda Health Services	2013 Program Audit	$ 312,300
07/17/2014	Network Health Insurance Corporation	2013 Program Audit	$ 81,700
09/11/2014	Stonebridge Life Insurance Company	2014 Program Audit	$ 370,400
09/11/2014	Local Initiative Health Authority for L.A. County	2014 Program Audit	$ 234,850
09/11/2014	SilverScript Insurance Company	2014 Program Audit	$ 20,700
09/19/2014	Torchmark Corporation	Failure to correct audit conditions	$ 40,000
11/06/2014	Phoenix Health Plans, Inc.	2014 Program Audit	$ 146,600
11/06/2014	Aultman Health Foundation	2014 Program Audit	$ 93,700
01/07/2015	Providence Health Plan	2014 Program Audit	$ 164,600
01/29/2015	Health Plan of the Ohio Upper Valley	2014 Program Audit	$ 194,950
01/29/2015	Inland Empire Health Plan	2014 Program Audit	$ 256,950
01/29/2015	New West Health Services	2014 Program Audit	$ 349,800
01/29/2015	Senior Whole Health Holdings, Inc.	2014 Program Audit	$ 229,350
01/29/2015	SoundPath Health, Inc.	2014 Program Audit	$ 250,100
02/25/2015	Southwest Catholic Health Network	2014 Program Audit	$ 202,200
02/25/2015	Citizens Choice Health Plan	2014 Program Audit	$ 689,600
02/25/2015	AlohaCare	2014 Program Audit	$ 32,700
02/25/2015	PacificSource Community Health Plans	2014 Program Audit	$ 90,000
04/08/2015	Health First Health Plans, Inc.	2014 Program Audit	$ 420,600

CMP Calculation Methodology

In 2014, we piloted a CMP calculation methodology to establish a standard process for determining CMPs imposed on sponsors. Using this methodology ensured all sponsors were treated equally. The nature and scope of the violation(s) dictated the total CMP a sponsor received.

A standard CMP amount was calculated for each deficiency cited in a sponsor's CMP notice, on either a per-enrollee or per-determination basis. Additionally, Beneficiary Impact Analysis (BIA) information provided by sponsors was used to calculate per-enrollee standard penalty amounts.

DCE imposed CMPs for 273 violations:

- 104 on a per-determination basis resulting in $1,159,000 (15%) of the total CMP amount.
- 169 on a per-enrollee basis resulting in $6,647,000 (85%) of the total CMP amount.

Figure 26 and Figure 27 show the total number of violations and dollar amount of violations by calculation type for CMPs imposed in 2014 as well as actions taken in 2015 related to 2014 program audits.

Figure 26

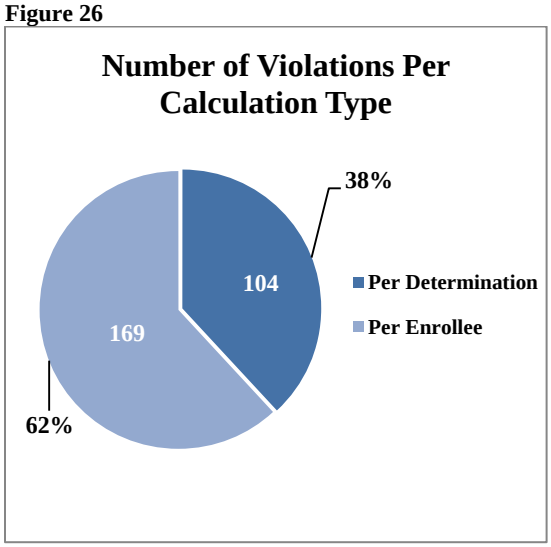
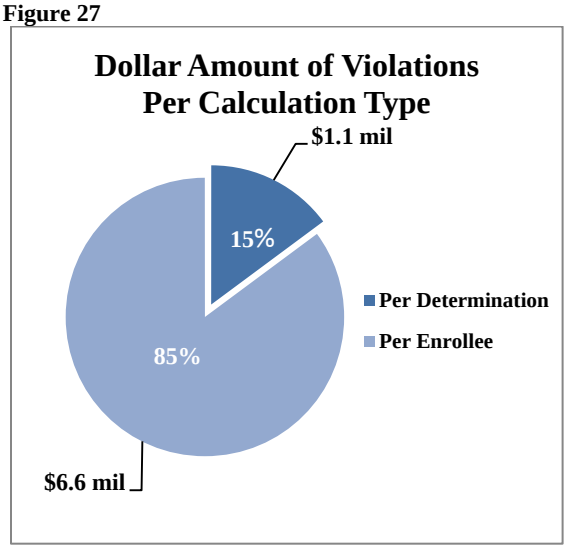


Figure 27



In addition, DCE may have either increased or decreased a sponsor's CMP amount for a deficiency by applying aggravating or mitigating factors:

- *Aggravating Factors:* For example, the standard penalty for a deficiency may increase if the violation involved drugs where treatment should not be delayed, expedited cases, a prevalence of failed audit samples, and/or a history of prior offense.

- *Mitigating Factors:* For example, the standard CMP amount for a violation may decrease if the beneficiary received the drug on the same day (after an initial rejection at the point of sale) or the standard penalty cap per condition of non-compliance was reached.

Intermediate Sanctions

Intermediate sanctions suspend a sponsor's ability to market, enroll, or receive payment for new enrollees. CMS imposed 5 intermediate sanctions in 2014:

Table 3

Date of Imposition	Organization Name	Basis for Referral	Type of Intermediate Sanction	Date the Limited Marketing & Enrollment Period Began	Date of Intermediate Sanction Release
01/24/2014	Orange County Health Authority	2013 Program Audit	Immediate Suspension of Enrollment & Marketing	11/01/2014	377 days – released 02/05/2015
05/28/2014	Capital Blue Cross	2014 Program Audit	Immediate Suspension of Enrollment and Marketing	12/01/2014	273 days – released 2/25/2015
08/11/2014	SummaCare, Inc.	2014 Program Audit	Immediate Suspension of Enrollment and Marketing	01/01/2015	226 days – released 3/25/2015
09/30/2014	Florida Healthcare Plus, Inc.	State Imposed Suspension of Enrollment	Immediate Suspension of Enrollment	N/A	Contract Terminated as of 12/31/2014
10/29/2014	Chinese Community Health Plan	2014 Program Audit	Immediate Suspension of Enrollment and Marketing	07/01/2015	316 days- released 9/10/2015

Four sponsors corrected the operational deficiencies that were the bases for their sanctions and were able to demonstrate operational compliance by successfully passing CMS-directed validation exercises. Florida Healthcare Plus, Inc. agreed to a termination by mutual consent. The average duration for intermediate sanctions (excluding Florida Health Plus, Inc.) was 298 days.

Intermediate Sanction Process Improvements

In 2014, two significant changes were made to the intermediate sanction process that modified the way sponsors experienced intermediate sanctions.

The first change was that sponsors under intermediate sanctions were required to hire an independent auditor to conduct a validation audit. The results of the validation audit, along with other information gathered during the sanction process, factor into making a determination about whether to release the sponsor from intermediate sanctions. Out of the five sponsors under intermediate sanctions in 2014, three sponsors had to hire an independent auditor to conduct a validation audit.

The second change forced sponsors under intermediate sanctions to engage in a test period of accepting enrollments or marketing for a limited time period. Granting of this limited marketing and enrollment period occurred when sponsors fully implemented their corrective action plans,

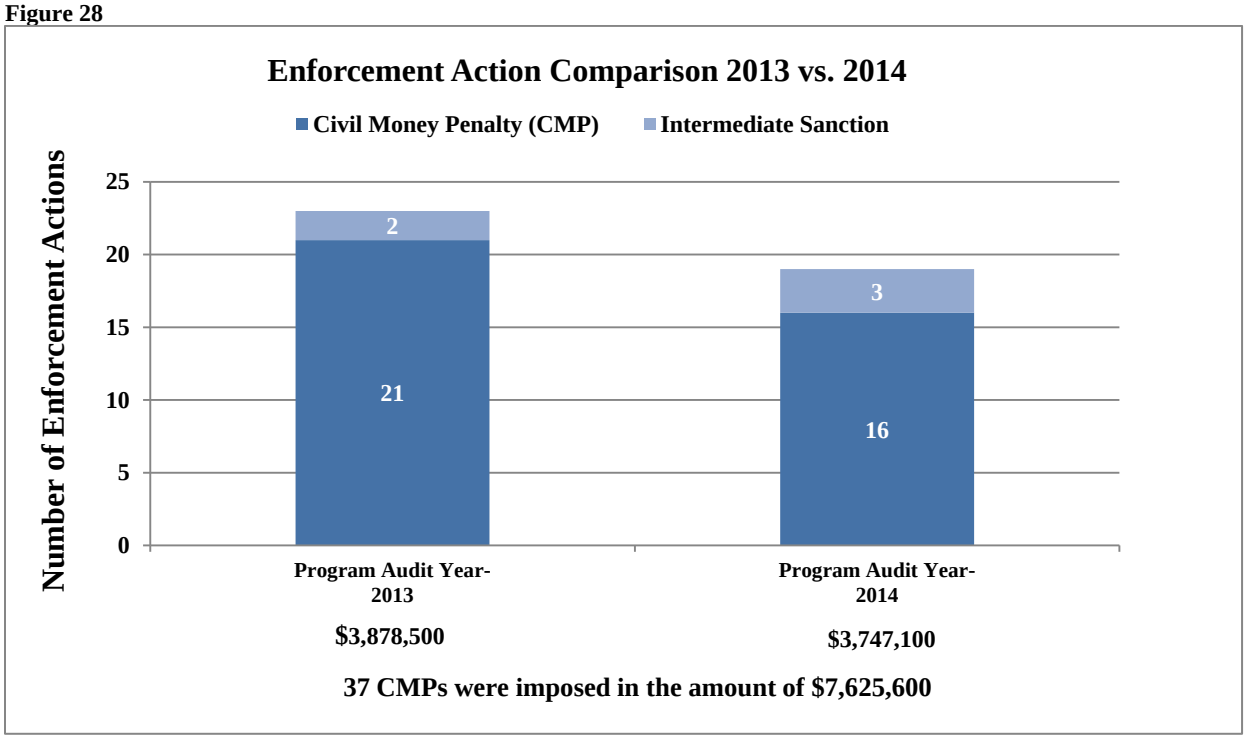
demonstrated the effectiveness of corrections through self-monitoring and regular status reporting to CMS, and attested to the correction of their deficiencies. Sponsors were also required to submit the independent auditors' validation audit work plan to be reviewed and approved prior to granting the limited marketing and enrollment period. Out of the five sponsors under intermediate sanctions in 2014, four sponsors were granted a limited marketing and enrollment period. The average duration of the limited marketing and enrollment period was 84 days.

ENFORCEMENT ACTIONS RELATED TO 2014 PROGRAM AUDITS

This section provides additional details on the enforcement actions taken related to the 2014 program audits. In addition, this section provides some comparisons between the data from 2014 and the data from enforcement actions taken related to the 2013 program audits. For full details of the enforcement actions taken related to 2013 program audits, however, please see the 2013 Part C and Part D Program Annual Audit and Enforcement Report.

DAO selected 27 sponsors for a program audit during 2014. Of those 27 sponsors, 19 (70%) received an enforcement action. Figure 28 compares the cumulative CMP amounts and types of enforcement actions imposed on MA-PDs and PDPs for 2013 and 2014 program audits.

Figure 28



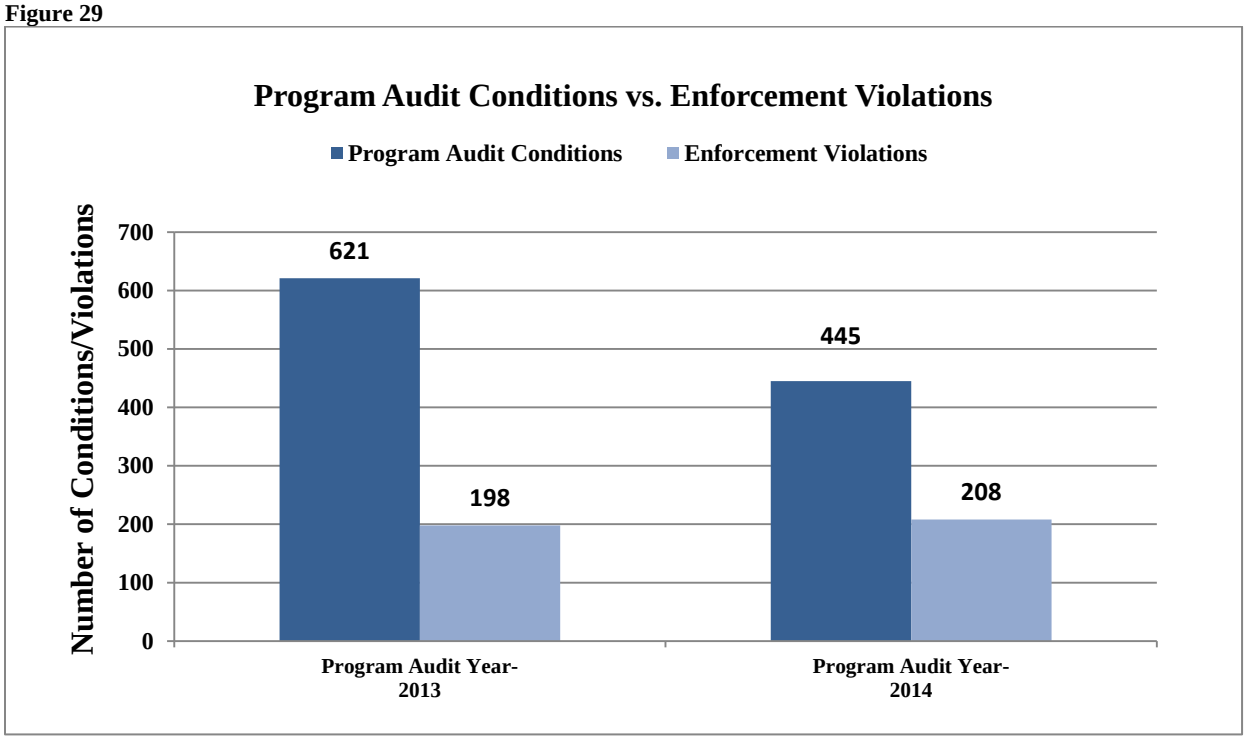
Although fewer sponsors received CMPs based on results from the 2014 program audits, the total CMP amounts for both years were roughly equal. This was due to improvements in the audit process to obtain more accurate beneficiary impact data from sponsors. Because of these improvements, more violations were imposed on a per-enrollee basis for 2014 program audits, resulting in a higher CMP amount per sponsor. We will continue to impose more per-enrollee

calculations for sponsors' violations in the future and plan to implement a process to validate the beneficiary impact data provided by sponsors.

Program Audit CMPs

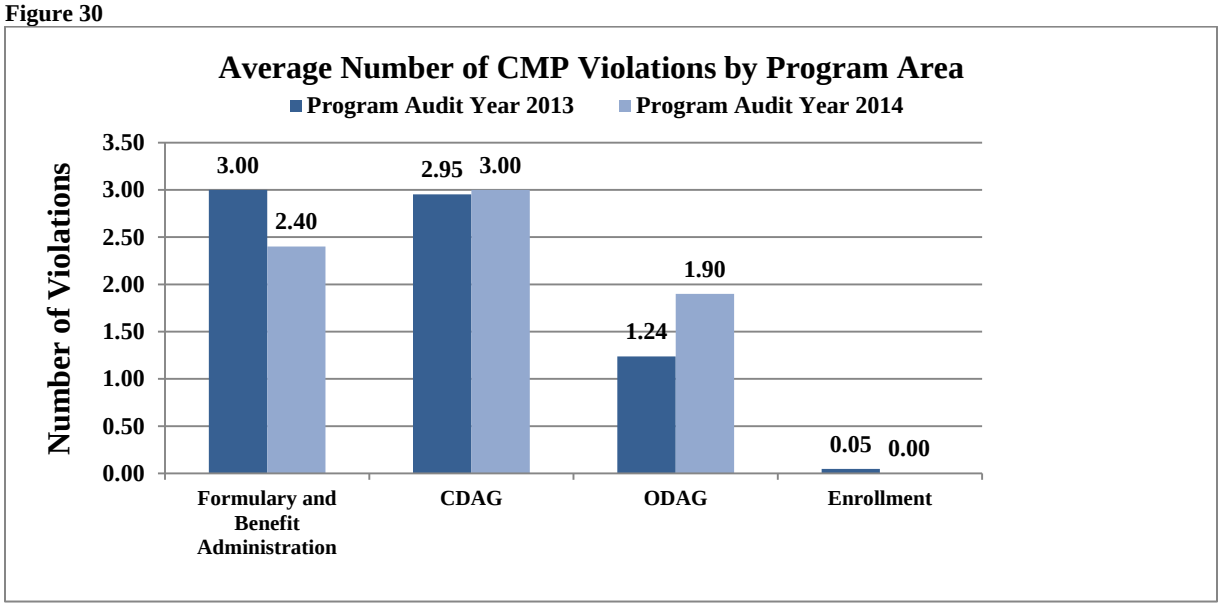
Most sponsors received CMPs for non-compliance in program areas Formulary administration, CDAG, and ODAG and their actions adversely affected (or had the substantial likelihood of adversely affecting) one or more enrollees. Figure 29 compares the number of conditions cited in FA, CDAG, and ODAG from 2013 and 2014 program audits to the number of violations that were included in the bases for taking enforcement actions.

Figure 29



Thirty-two percent of FA, CDAG, and ODAG conditions were cited in an enforcement action for 2013 program audits. Forty-seven percent of conditions found in FA, CDAG, and ODAG were cited in an enforcement action for 2014 program audits. Figure 30 shows the average number of CMP violations by program area for 2013 and 2014 program audits.

Figure 30



The number of violations by program area remained consistent between program audit year 2013 and 2014, with a slight decrease in the number of FA violations and a slight increase in the number of ODAG violations.

DCE imposed CMPs for 117 violations found during the 2014 program audits:

- 27 on a per-determination basis resulting in $314,000 (8%) of the total CMP amount.
- 90 on a per-enrollee basis resulting in $3,433,100 (92%) of the total CMP amount.

As stated above, CMS was able to obtain more beneficiary impact data from sponsors as a result of improvements in the audit process. This allowed DCE to increase the number of violations imposed on a per-enrollee basis. Figure 30 and Figure 31 show the total number of violations and cumulative violation dollar amounts by calculation type for 2014 program audits.

Figure 31

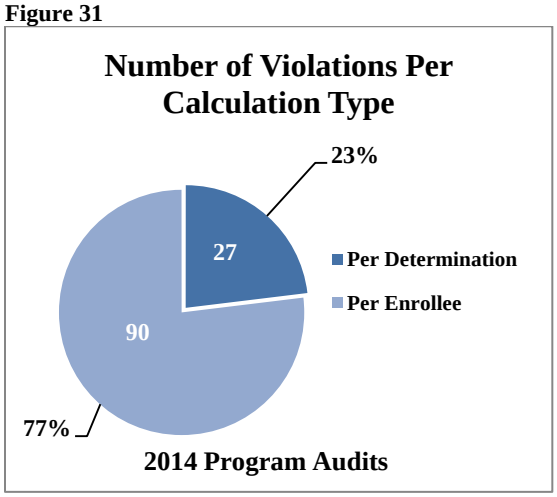
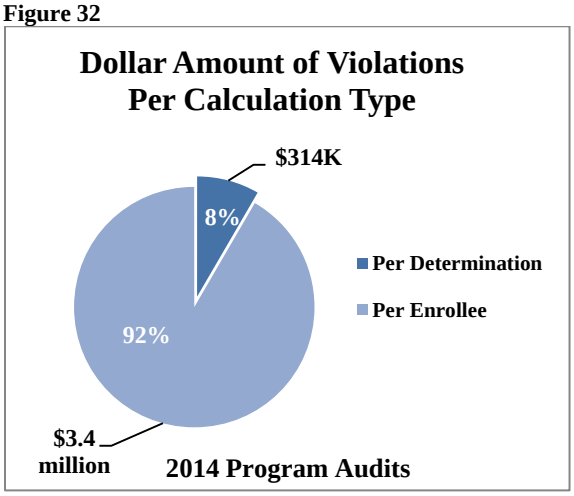


Figure 32

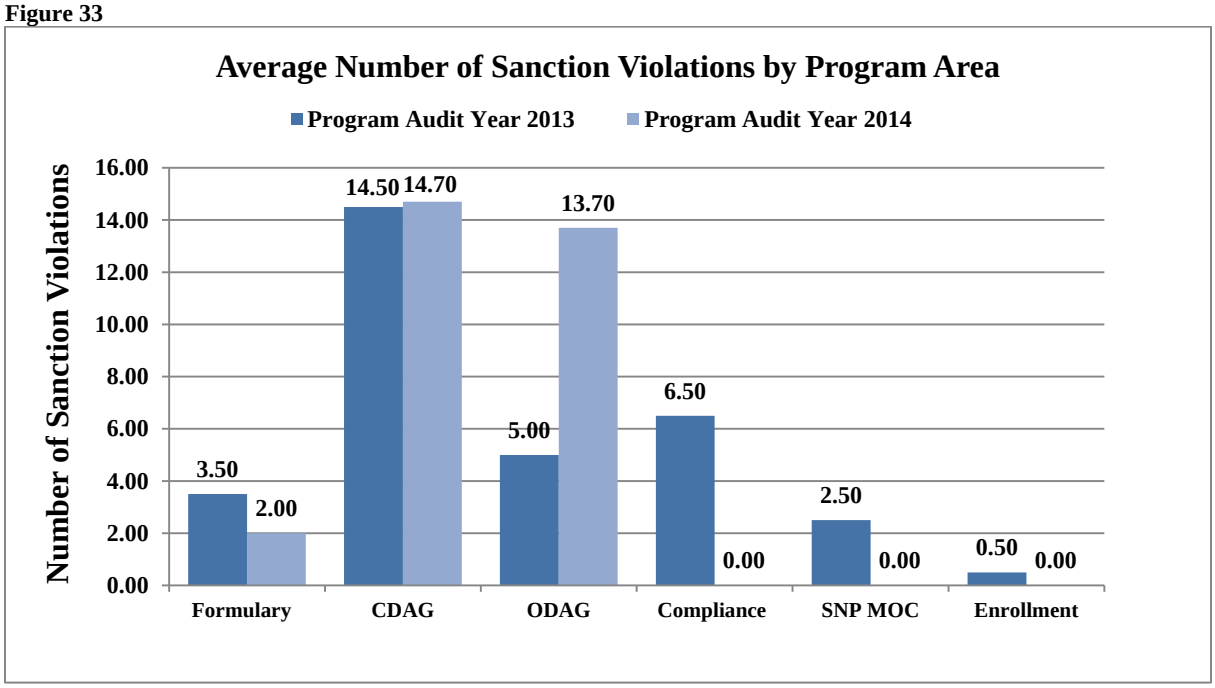


Also, the timeframe for CMP issuance was greatly reduced. For program audit year 2013, the number of days between the final audit report and CMP issuance was 159 days. This number improved to 57 days for program audit year 2014, a 64% reduction. This reduction was due to improvements in the referral process between DAO and DCE, as well as improvements with processes for analyzing enforcement cases.

Program Audit Intermediate Sanctions

Sponsors also received intermediate sanctions for systemic operational failures in FA, CDAG, and ODAG. These actions protect current and future beneficiaries when there is evidence the sponsor has substantially failed to carry out the terms of its contract with CMS. CMS will impose immediate intermediate sanctions if it finds that there is a serious threat or potential for a serious threat to an enrollee's health and safety, such as denying or delaying access to medications or services. Figure 33 shows the average number of sanction violations by program area for 2013 and 2014 audits.

Figure 33



For intermediate sanctions, the number of violations by program area remained similar for both FA and CDAG violations for the two years. However, there was a significant increase in the number of ODAG violations. This is likely due to improvements in the audit process in being able to identify the scope and size of sponsor ODAG failures. There were no sanctions taken in 2014 for compliance program, SNP MOC, or enrollment violations.

APPEALS

Sponsors have the right to appeal CMPs, intermediate sanctions and termination actions by CMS. For CMPs, sponsors must file their appeal no later than 60 days after receiving the CMP notice. If the sponsor does not appeal, the CMP is final and due for payment. For intermediate sanctions and terminations, sponsors must file their appeal no later than 15 days after receiving the enforcement or termination notice. An appeal does not delay the imposition of the sanction. However, an appeal will delay the imposition of a termination, unless there is imminent and serious risk to the health of the beneficiaries enrolled with the sponsor.

In 2014, CMS received one appeal that was later rescinded by the organization.

2015 AUDIT PROCESS IMPROVEMENTS

Our focus on continuous improvement extended into 2015. Our primary goal was to enhance the consistency among audits and strengthen the expertise of audit teams. We believe that by continuing to build auditor expertise, we are better suited to partner with and provide technical assistance to the industry, and aid in improving performance. The following initiatives and process improvements were in place for 2015

- In 2015, audit protocol and process documents were redesigned to include additional detail that had previously only been in the internal methods of evaluation, including information on self-identified and self-disclosed issues as well as the process to provide beneficiary impact analyses.
- In 2015, expanded the record layouts to allow sponsors to more easily recreate and conduct our universe timeliness tests for CDAG and ODAG. Incorporated a data dictionary into the record layouts defining what was expected for each field.
- In 2015, added two additional weeks from the date of receipt of the audit start notice to the date the audit began. This allowed sponsors one additional week to compile universes and one additional week for CMS to analyze and validate universes prior to selecting samples.
- Based on sponsor feedback in 2015, overhauled the CPE audit protocol that resulted in a large decrease in the volume of documentation requested in advance of each audit.
- In 2015, moved to a core team approach, meaning there is a dedicated team of individuals who act as team leads for one audit program area for the entire year.
- In addition to moving to core teams, CMS implemented Program Audit Consistency Teams (PACTs) for each audit program area (e.g., CDAG, FA, ODAG, etc.). The PACT comprises the core team for that program area, plus representatives from DAO and DAPS. The PACTs meet at least monthly to discuss audit findings and ensure consistency in the audit process. The PACTs also work to identify areas where CMS' policy may be vague or require updating and develop recommendations to policy components for updating industry guidance.

CONCLUSION

CMS has audited sponsors that represent all but a small number of enrollees in the MA and Part D programs. We have greatly increased the level of transparency with respect to our audit materials, the performance of our audits and the results of those audits, including any enforcement actions that may result. We believe that program audits and consequences of possible enforcement actions are continuing to drive improvements in the industry and are increasing sponsor's compliance with core program functions in the MA and Part D program. We look forward to continuing to collaborate with the industry and develop new approaches to assist with achieving compliance. In 2015, we are in a new cycle of auditing. We are planning to evaluate the sustainability of compliance as we audit sponsors that also underwent audit in the last cycle. We stay committed to transparency and improving the audit process and performance of the industry overall.