DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Cost Plans

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DATE: December 12, 2010

SUBJECT: 2012 Application Cycle Past Performance Review Methodology

Each year the Centers for Medicare & Medicaid Services (CMS) conducts a comprehensive review of the past performance of Medicare Advantage Organizations (MAO), Medicare Prescription Drug Plan (PDP) Sponsors, and Cost plans. The review is a tool CMS uses to evaluate the performance of all Medicare contractors, evaluations that may also identify organizations with performance so impaired that CMS would prohibit the organization from further expanding its Medicare operations. Specifically, Sections 42 C.F.R. §422.502(b) and §423.503(b) of the regulations governing the Medicare Advantage and Prescription Drug programs authorize CMS to deny an organization's application either to offer Medicare benefits under a new contract or in an expanded service area during the subsequent contract year if a review of an organization's past performance finds that the organization has been out of compliance with any requirement.

CMS has long held the authority to deny applications based on past performance (even if the applicant otherwise meets all application requirements). In the final regulation published on April 10, 2010 entitled "Medicare Program: Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program" (CMS-4085-F), we clarified that our review for this purpose would be limited to the fourteen months leading up to the submission of a new application. Commenters on this provision in the regulation requested that CMS release the methodology used to determine whether an organization's performance is sufficiently non-compliant to form the basis for a CMS decision to deny an application. The purpose of this memorandum is to clearly describe the Past Performance Assessment Review methodology in its current form, as it is to be implemented for the 2012 application cycle. The detailed methodology is provided in the attachment.

We have established a performance assessment methodology that is quantitative in nature, rigorous, and systematic. Because we recognize that most organizations make mistakes from time to time, the methodology serves to identify extreme performance outliers, when they exist. Such outliers would be organizations whose performance is very poor compared to the rest of industry, which can be the result of an organization's non-compliance in a number of operational areas or in a single area that represents a very high risk to CMS.

Importantly, all of the information and data used by CMS to calculate the past performance assessment results is already known by organizations at the time we perform the analysis each year. We expect MA organizations, PDP sponsors, and Cost plans to monitor their own performance throughout the year. Organizations that perform continuous self-review, particularly in the context of the methodology described here, can use the results of such assessments as a basis for taking appropriate corrective action and to periodically evaluate the likelihood that CMS will not permit further expansions of the organization's Medicare line of business due to a finding of impaired performance.

CMS is pleased to release our Past Performance Assessment Review Methodology for the 2012 Application Cycle. We are committed to ensuring that CMS contracts with only the strongest and best performing Medicare Advantage Organizations and Prescription Drug Plan Sponsors. The Past Performance Assessment Review enables us, in a systematic and rigorous way, to understand the performance levels of all contracting organizations and to identify organizations that should focus on their current book of business before further expanding. We strongly encourage organizations to use this document in conjunction with their on-going performance self-review activities to bolster their own monitoring efforts.

We intend to update this methodology each year to reflect new sources of information. As we incorporate additional data or performance categories, we will adjust the weights and cut-offs accordingly. As we do so, we will publish revised versions of the methodology, either through our manual chapters or in memo form.

If you have any questions, please contact Jennifer Shapiro, Director, Division of Benefit Purchasing and Monitoring at Jennifer.Shapiro@cms.hhs.gov or 410-786-7407.

Attachment:
2012 Application Cycle Past Performance Assessment
Review Methodology

This methodology below describes in detail the approach CMS uses to evaluate the performance of all Medicare C and D contractors, evaluations that may also identify organizations with performance so impaired that CMS would prohibit the organization from further expanding its Medicare operations.

Review Period

CMS clarified in its April 15, 2010 final Part C and D regulations that we limit our performance review each year to the 14-month period leading up to the annual application submission deadline. (As a practical matter, we count the entire calendar month in which applications are due as the 14th month.) The specific 14-month performance period that will be assessed for the 2012 Application Review Cycle is January 1, 2010 through February 28, 2011.

For an instance of non-compliance to be considered in the review, the non-compliance or poor performance must have either occurred *or* been identified during the 14 month period. Thus, we may include in our analysis non-compliance that occurred in prior years but did not come to light or was not addressed until sometime during the review period. Likewise, if the problem occurred during the 14-month period but it was not identified until, for instance, the month following the end of the review period but before we finalize our results, we include the matter in our assessment.

Plan Types

The past performance assessment is conducted at the contract level. Program for all-Inclusive Care for the Elderly (PACE) organizations and performance related to contracts exclusively offering products into which only employer group or union members may enroll currently are not included in the assessment. MA-PD organizations receive both a C and D score. Unless otherwise noted, the methodology presented below is identical for both the Part C and Part D reviews. For program management purposes, we integrate the final separate C and D scores to compile an overall summary score for MA-PD organizations.

Performance Categories and Negative Performance Points

For the 2012 Application Cycle, we have established 11 distinct performance categories. We carefully analyze the performance of all contracts in each performance category and assign "negative points" to contracts with poor performance in that category. The number of potential negative points corresponds to the risk to the program and our beneficiaries from deficient performance in that particular area.

The 11 performance categories that are included in the review for the 2012 application cycle include:

1. **Compliance Letters** (i.e., Notices of Non-Compliance, Warning Letters, and Corrective Action Plans (CAPs))
2. **Performance Metrics** (i.e., the plan performance ratings, sometimes called "star ratings" developed each year and published on the Medicare.gov website)
3. **Multiple Ad Hoc Corrective Action Plans (CAPs)** (i.e., findings of egregious violations that were discovered outside of the audit process, such as through beneficiary complaints)

4. **Ad Hoc CAPs with Beneficiary Impact** (i.e., CAPs where the compliance violation hindered health or drug access or imposed a financial burden on plan members)
5. **Financial Watch List** (i.e., organizations with financial solvency problems)
6. **One-Third Financial Audits** (i.e., organizations with adverse audit opinions or disclaimed audit reports stemming from a CMS One-Third Financial Audit)
7. **Performance Audits** (i.e., significant findings, in number or scope, as described in a performance audit report)
8. **Exclusions** (i.e., exclusion from: receiving auto-enrollees, appearing in Medicare & You, having certain formulary update opportunities, or participating in the Online Enrollment Center)
9. **Enforcement Actions** (i.e., intermediate sanctions and civil money penalties imposed or in place during the performance period)
10. **Terminations** (i.e., requests by an organization to rescind a contract with CMS after the annual non-renewal deadline or after the annual marketing and enrollment period has begun, mutual terminations to be effective mid-year, or terminations initiated by CMS)
11. **Outstanding Compliance Concerns Not Otherwise Captured** (i.e., compliance and enforcement actions largely developed but not yet formally issued by CMS)

Detailed Information

1. Compliance Letters

When CMS learns of a performance problem, we issue a compliance notice to the responsible organization. These notices serve to document the problem and, in some instances, request details on how the organization intends to address the problem. There are three key notice types: Notices of Non-Compliance (NONC), Warning Letters, and Ad Hoc Corrective Action Plan (CAP) Requests.

Notices of Non-Compliance are used to document small or isolated problems. Warning Letters are issued either when an organization has already received a NONC, yet the problem persists, or for a first offense for larger or more concerning problems. Unlike NONCs, these letters contain warning language about the potential consequences to the organization should the non-compliant performance continue. We also occasionally issue a Warning Letter with a request for a Business Plan when CMS determines that a plan of action is needed from the organization. The last type of letter, the CAP request, is reserved for persistent problems or very serious concerns that need in-depth and continued monitoring by CMS.

An outlier in this category is defined as an organization that is one of the worst performing organizations, based on a weighted distribution of the number and types of compliance letters received (or for conduct that occurred and for which letters will soon be issued) during the performance period across all organizations (including those that received no letters during the period, but excluding contracts otherwise not included in this analysis, such as PACE contracts). Specifically, a weighted score is calculated for each contract; the following table (Table 1) indicates the weights to be assigned for each type of letter or compliance event.

Table 1: Weights for Each Compliance Letter Type

Compliance Letter Type	**Weight**	**Rationale for Weight**
Notice of Non-Compliance	1	Mildest type of letter. Does not contain specific language regarding further compliance escalation or other consequences should the behavior/non-compliance continue.
Warning Letter	3	Formal communication that describes the consequences of continued non-compliance; weighted 3 times greater than notices of non-compliance.
Warning Letter with a Business Plan	4	The matter is serious enough to warrant a written response from the organization but not significant enough to warrant a CAP.
CAP – Targeted audit	1	Occasionally, CMS conducts targeted audits of a specific performance area among a set of particularly at-risk organizations. Since relatively few contracts are audited in such a manner, this category warrants a low weight. If there is at least one deficiency identified during an audit, a total weight of 1 is assigned *(not 1 per deficiency)*.
CAP – Ad hoc compliance event	6	Ad hoc CAPs represent the most serious form of compliance notice. Rated at twice the weight of warning letters because the issuance of this type of letter indicates continuing and/or severe, systemic problems.

Example: if a contract received one notice of non-compliance (weight = 1), two warning letters (weight = 3 each, total 6), and an ad hoc CAP (weight = 6), the contract's score would be 13.

After a Compliance Letter score has been calculated for each contract, we then rank the contracts in descending order from highest to lowest score (in the case of the Part D analysis, separately for MA-PD contracts and PDPs). Next, we identify the value (score) at the 90th percentile point and the 80th percentile point.

All contracts with a weighted score at or above the 90th percentile point receive 2 negative performance points in the Compliance Letter category. All contracts with a weighted score at or above the 80th percentile point, but less than the 90th percentile point, receive 1 negative performance point in this category. All other contracts receive 0 negative performance points for the Compliance Letter category.

The Health Plan Management System (HPMS) serves as CMS' definitive system of record for all such compliance notices. Each time a letter is issued the CMS issuing office enters key data elements into HPMS and uploads a copy of the letter. To obtain these data, we extract this information from HPMS. This ensures a complete and accurate data set. All letters issued during the performance period (or shortly after the performance period to the extent that the non-compliance occurred during the performance period) are included in the extract and analysis.[1]

[1] The only exception is to exclude ad hoc CAPs where the basis of the CAP is the forthcoming expiration of a PDP licensure waiver. These CAPs are issued in anticipation of the expiration of a sponsor's CMS-granted licensure waiver at the end of the current contract year. They provide sponsors with the notice required by regulation that, should the sponsor not obtain a state-granted risk bearing license, CMS would be required to non-renew all or a portion of that organization's PDP sponsor contract at the end of the contract year. Since these CAPs concern anticipated, rather than actual, non-compliance, they will not be included in any evaluation of an organization's Part D contract performance.

2. Performance Metrics

The most current "plan ratings" data as of the end of the 14-month performance period developed by CMS and posted on the Medicare.gov website are used for this analysis. As of the date of this memo, the most recent sponsor quality and performance metrics were calculated in accordance with the CY 2011 Technical Notes (separately available for Part C and Part D) made available to the public on the CMS website at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage. An outlier in this category is defined as any contract that received an overall summary score of 2.5 stars or below. The overall summary score summarizes a contract's performance across domains and underlying individual measures.

For Part D, there are currently four domains: Drug Plan Customer Service; Drug Plan Member Complaints and Medicare Audit Findings; Member Experience with Drug Plan; and Drug Pricing and Patient Safety. All told, there are 17 individual measures assigned among the four Part D domains. For Part C, there are five domains: Staying Healthy: Screenings, Tests and Vaccines; Managing Chronic (long-term) Conditions; Ratings of Health Plan Responsiveness and Care; Health Plan Members' Complaints and Appeals; and Health Plan's Telephone Customer Service. All together, there are 36 individual measures assigned among the five Part C domains.

A summary score is calculated separately for Part C measures and for Part D measures. Each summary score rating is based on an average of the individual measures, with consistent good performance recognized with a higher rating. While ratings of individual measures fall along a 5-star range with no half-star values, summary score ratings include half-stars to provide more differentiation among contracts.

A score of 2.5 stars or below was chosen as the outlier level because a score of "three stars" on any given individual measure is considered an indicator of adequate performance. Therefore a summary score falling below 3 stars indicates poor or "negative outlier" performance.

All outlier contracts in this category receive 2 negative performance points.

3. Multiple Ad Hoc CAPs

Using the dataset developed for the Compliance Letter category, we identify all contracts that received more than one ad hoc compliance CAP during the performance period (or shortly after the performance period to the extent that the non-compliance occurred during the performance period). Ad hoc compliance CAPs are relatively rare and are typically issued only when other forms of intervention have failed to correct a problem and/or the problem was especially egregious. Receiving more than one such CAP during a performance period is a powerful indication of ongoing performance problems. All contracts meeting the criteria in this category receive 1 negative performance point.

4. Ad Hoc CAPs with Beneficiary Impact

Ad hoc compliance CAPs can be issued for numerous reasons. Some CAPs are directly related to the services received by enrolled beneficiaries while others are not. An example of a CAP we previously issued that does not have significant immediate beneficiary impact concerns late reporting of financial information to CMS. In contrast, an example of a CAP where there is beneficiary impact concerns proper administration of the organization's beneficiary call center. Other CAP topics that are associated with beneficiary impact and are therefore counted under this category include: 4RX data submissions to CMS, enrollment and disenrollment processing, application of correct low income subsidy (LIS) status for plan members, volume of member complaints logged into CMS' Complaints Tracking Module (CTM), failure to provide appropriate Part D drugs, processing of member appeals and grievances, marketing abuses, overall failure to appropriately administer the Part D benefit, execution of benefit coverage determinations, and formulary administration.

We extract from HPMS each individual CAP issued during the performance period (or shortly thereafter for conduct that occurred during the performance period) and assess it to determine whether the root cause behind the CAP request had a direct beneficiary impact. Because organizations that have experienced such problems represent more of a performance risk, all contracts meeting the criteria in this category receive 1 negative performance point *for each issued CAP* that had beneficiary impact.

5. Financial Watch List

Organizations with actual or potential financial solvency problems are carefully monitored by CMS. These organizations are tracked on a Financial Watch List. An entity is placed on the watch list when:

1. The entity has a negative net worth (liabilities greater than assets), or
2. A negative net income (net loss) is reported and the amount of that loss is greater than half of the entity's total net worth.

Entities on the watch list are required to report financial data quarterly to CMS. Entities are only removed when, upon review of an independently audited annual report, CMS determines that neither Item 1 nor Item 2 apply to the organization.

Because CMS has a responsibility to ensure our contractors have sufficient funds to allow them to pay providers and otherwise maintain operations, contracts on the Financial Watch List at the time the analysis is conducted receive 1 negative performance point.

6. One-Third Financial Audits

Sections 1857(d)(1) and 1860D-12(b)(3)(C) of the Social Security Act require the Secretary to provide for an annual audit of the financial records of at least one-third of all active MAOs and PDPs. All contracts that receive **adverse** audit opinions or **disclaimed** audit reports during the 14 month performance period receive 1 negative performance point. The auditor issues a ***disclaimed*** audit report when it could not form, and consequently refuses to present, an opinion on management's assertion (i.e., the auditor tried to audit an entity but could not complete the work to issue an opinion because of circumstances created by the audited organization). The auditor issues an ***adverse*** audit report when it determines that the financial data is materially misstated (i.e., the information contained is materially incorrect, unreliable, and inaccurate).

These types of audit reports signal a lack of internal controls over the sponsoring organization's operations and/or a serious failure by the sponsoring organization to devote the necessary resources to respond to the auditor's request for documentation. The scope of the one-third financial audits includes: 1) Solvency, 2) Related-Party Transactions, 3) Non Benefit Expense, 4) Part D Costs and Payments (TROOP, Direct and Indirect Remuneration), and 5) Direct Medical.

7. Performance Audits

Each year, CMS conducts audits of select Part C and D sponsors' performance under their Medicare contracts. CMS selects sponsors for audit by conducting a risk assessment of all Part C and D organizations. The assessment combines a number of factors, including each organization's compliance history, enrollment levels, and the rate of growth of plan enrollment, to produce a list of sponsors whose potentially poor program operations present a significant risk to the overall strength of the entire Part C and D programs in meeting the healthcare needs of Medicare beneficiaries.

Generally, significant performance audit (including compliance audit) findings form the basis for other categories of compliance and enforcement actions already described in this memorandum. This category is intended to ensure that audit findings that do not otherwise rise to the level of a compliance or enforcement action are still considered as part of a contract's overall past performance.

Program audit reports for the preceding year are provided by the Program Compliance and Oversight Group. Each audit report includes a final audit score reflecting the volume and seriousness of failed audit elements. Lower scores reflect worse performance. Contracts with audit scores in the worst 25th percentile, excluding those contracts subject to enforcement actions due to the audit findings, are assigned one negative performance point. Because not all sponsors are subject to performance audits and because the most serious findings would be addressed in other performance categories, the point value is relatively low.

8. Exclusions

Medicare offers contracts in good standing certain privileges. These include the display of the organization's marketing information on our web site and in publications, the ability to make certain programmatic updates during the course of a benefit year, and the automatic enrollment of some low income members who have not elected a prescription drug benefit plan and would otherwise be without coverage. Should an organization demonstrate poor performance, CMS may choose to exclude the organization from participation in one or more of these activities. The particular exclusion CMS might select would be tied to the nature of the organization's poor performance. The full list of privileges which could be suspended in such a manner includes:

- Medicare & You Handbook. Each fall, CMS issues Medicare & You Handbooks to all beneficiaries. The Handbook provides information about the different plan choices available to Medicare beneficiaries. Should an organization fail to complete its contracting activities in a timely manner (e.g., fail to sign a contract or have its bid or formulary approved), then we would prevent information related to the incomplete contract(s) from appearing in the Handbook. Should this occur during the performance period, the Medicare & You Handbook exclusions are noted in the performance review with 1 negative performance point. (There are other reasons why a contract may be excluded from appearing in the Handbook, such as the contracting organization being under a sanction, but to the extent those types of compliance problems are addressed via other performance categories, they are not considered as part of this category.)

- On-Line Enrollment Center (OEC). Most organizations are required to participate in CMS' On-Line Enrollment process, which enables Medicare beneficiaries to submit an enrollment application via the Medicare.gov website. There are a variety of OEC requirements organizations must fulfill, including downloading these enrollments from the website on a daily basis. Contracting organizations that fail to download these enrollments once or twice receive compliance letters for those contracts for which enrollments were not properly processed. Contracts for which organizations fail repeatedly to retrieve enrollments are excluded from participation in the OEC. Contracts that were excluded from the OEC for any length of time falling within the performance period receive 1 negative performance point.

- Formulary Update *(Part D only).* Prior to the start of the contract year CMS reviews and approves a formulary for each Part D plan. After the start of the plan year, Part D sponsors are allowed to submit updated formulary files to CMS that reflect formulary enhancements (e.g. addition of new drugs to the market) and CMS-approved negative formulary changes (e.g. brand deletion with generic addition, prior authorization addition, etc.). Should a sponsor submit an un-approvable monthly update formulary file (e.g. file is missing a protected class drug that is new to the market) the formulary update file will be denied. When this occurs, the sponsor may not implement any negative formulary changes for the contracts to which the formulary is attached until a new formulary update file is submitted and approved by CMS. CMS assigns 1 negative performance point to a contract when this occurs four or more times per calendar year during the performance period.

  Also with regard to formulary updates, organizations have a special opportunity to update newly approved formularies for the upcoming benefit year each August. On occasion, CMS will deny an organization the opportunity to update its new formulary during August due to serious problems CMS has had in working with the contract to receive an acceptable formulary. Should this be the case, CMS assigns 1 negative performance point to any contracts that lose their August update opportunity. (This could potentially be in addition to the 1 point described in the previous paragraph.)

- Low Income Subsidy (LIS) Reassignments/Auto-enrollees *(Part D only).* Each month, CMS auto-enrolls low income subsidy beneficiaries (who have not elected a Part D plan on their own) into a randomly selected plan whose premium is low enough to be covered in full by the subsidy amount (known as "benchmark" plans). Each fall, CMS reassigns members into new plans when the old plan's premium in the coming year will be above the benchmark amount. Should a contracting organization whose plans otherwise qualify for such auto-enrollments or reassignees demonstrate poor performance that would jeopardize its ability to accommodate these members, CMS suspends the contract's participation in the auto-enrollment/reassignment process until the problem is cured. Contracts with such a suspension during the performance period, but that subsequently cure their problems, making them eligible to resume receiving these enrollments by the end of the period, receive 2 negative performance points. Contracts that are under a suspension at the end of the performance period receive 3 negative performance points.

9. Enforcement Actions

CMS imposes intermediate sanctions, such as a suspension of an organization's ability to market or enroll members in its plans, if an organization meets one or more of the bases for intermediate sanctions in 42 C.F.R. §422.752(a) and §423.752(a) or meets one or more of the bases for termination in 42 C.F.R. §422.510(a) and §423.509(a). Likewise, we have the authority to impose civil money penalties (CMPs) when an organization meets one or more of the bases for termination in 42 C.F.R. §422.510(a) and §423.509(a) and its violations have directly adversely affected or have the substantial likelihood of adversely affecting one or more enrollees. Because these enforcement actions are rare and significant, it is important that we capture these as distinct performance events for the purpose of this review.

Contracts under an intermediate sanction during the performance period but then released from the sanction prior to the end of the performance period receive 3 negative performance points for “immediate” sanctions (i.e., sanctions that become effective on a date specified by CMS and are based on conduct that poses a serious threat to a beneficiary’s health and safety) or 2 negative performance points for “regular” sanctions (i.e., sanctions that become effective 15 days after CMS issues notice of the sanction). Contracts under sanction at the conclusion of the performance period (or subsequent to the performance period if the conduct that formed the basis of the sanction occurred during the performance period) receive an additional 4 points, bringing the possible total to 7 negative performance points for immediate sanctions or 6 negative performance points for regular sanctions.

Because there may be drastic variations in the level of CMPs imposed by CMS depending on the scope and severity of the violation as well as the degree of adverse impact on beneficiaries, CMS designates contracts assessed more serious CMPs (>$50,000) with 2 negative performance points per CMP and those with lesser CMPs (≤$50,000) with 1 negative performance point per CMP.

Of note, both intermediate sanctions and CMPs are subject to potential appeals from the organization on which the sanction or CMP has been imposed. Should an organization win on appeal (thereby fully overturning the sanction or CMP), no points are assessed for CMS’ initial action. Should an appeal be underway at the time of the analysis, the points are counted during the appeals process. If necessary, we will retroactively remove the points and reconsider any decisions that were based on the original point values.[2]

10. Terminations

There are three types of contract terminations of concern to CMS: 1) CMS-imposed, 2) disruptive mutual, and 3) non-disruptive mutual.

CMS will impose a termination as a last resort when an organization meets one or more of the bases for termination in 42 C.F.R. §422.510(a) and §423.509(a) such that the organization substantially fails to comply with the terms of its contract, is carrying out its contract in a manner that is inconsistent with the effective and efficient implementation of the Medicare program, or no longer meets the requirement of the Medicare program for being a contracting organization. Under such circumstances, we assign 8 negative performance points to the terminated contract.

In past years, several organizations requested mutual contract terminations very late in the year based on financial solvency grounds or because their contracted provider networks, necessary to meet provider access requirements, had not been finalized in time for the start of the new benefit year. These are very serious problems and could have been grounds for CMS-imposed contract terminations had CMS not granted the organizations’ requests for a mutual contract termination. Such “disruptive terminations” are harmful to beneficiaries, show lack of good faith in contracting with CMS, and put stress on the Part C and D programs by providing less than the required 90-day notice to CMS to effectuate a smooth transition. Organizations that experienced such problems after marketing for the upcoming year begins on October 1, or at any time of the year in the case of a mid-year termination, are high-risk organizations. Therefore, these terminated contracts receive 4 negative performance points. As discussed below, the 4 points are ultimately assessed to the organization that held the terminated contract.

[2] If CMS denied an application based on an enforcement action that was later overturned on appeal, the latest date for a favorable decision to the applicant and a reversal of CMS’ decision to deny the application would be the established program-wide last date for signing contracts (typically in late summer).

On the other hand, there are some instances where organizations encounter operational and/or financial difficulties, but partner with CMS in order to coordinate and effectuate a smooth transition for beneficiaries with adequate notice. For example, there are organizations that experience such difficulties but may have just missed CMS' non-renewal notification deadline. If the organization demonstrates adequate partnership with CMS, and the mutual termination is not considered immediately disruptive (i.e., occurs prior to the commencement of marketing on October 1, gives beneficiaries and CMS at least 90 days to effectuate a smooth transition to other Part D coverage, and has an effective termination date of the last day of the current contract year, December 31), then CMS assigns 1 negative performance point for such a "non-disruptive" mutual termination.

Table 2 summarizes the point value designations for the various termination types.

Table 2: Summary of Termination Scenarios

Termination Type	**Point Value**
CMS imposed termination	8 points
Mutual termination in all cases that are effective mid-year, and also where the termination is effective on December 31, but beneficiaries and CMS have less than 90 days' notice to effectuate a smooth transition or termination.	4 points (Disruptive)
Mid-year mutual terminations that are entered into *after* the non-renewal deadline but before October 1st, and where the termination date is December 31st. In these cases, CMS and beneficiaries have the full 90 days to effectuate a smooth transition.	1 point (Non-Disruptive)

11. Outstanding Compliance Concerns Not Otherwise Captured

Finally, we believe it is important that a thorough past performance analysis account for non-compliance that is a strong indicator of weaknesses in the organization's performance, but which is not otherwise captured in other areas of the past performance analysis. This situation arises where CMS has identified non-compliance that supports the imposition of an intermediate sanction or civil money penalty, but the matter has not yet worked its way through CMS's internal enforcement clearance processes. In these situations, CMS has already developed and verified the facts concerning the scope and severity of non-compliance and only the timing of the agency's internal enforcement processes (e.g., formal sign-off from senior CMS leadership or the issuance of a formal demand letter) is preventing the non-compliance from being included in the organization's past performance profile. In such instances, it is irresponsible for CMS not to account for the non-compliant conduct as part of our evaluation as to whether an organization is qualified to expand its Medicare business. Therefore, in limited circumstances, CMS assigns negative performance points to open significant compliance concerns.

Organizations for which CMS has an enforcement action pending (e.g., suspension of marketing and enrollment activities or imposition of civil money penalty) receive 2 negative performance points for pending sanctions or 1 point for pending CMPs. In extremely limited circumstances where CMS has identified recent and ongoing non-compliance that puts beneficiary health and safety at significant and immediate risk, CMS may assign up to 5 negative performance points.

Summary of Negative Point Values and Calculation of Contract-Level Scores

The results of the analyses described above are then compiled in separate Part C and Part D tracking spreadsheets. A contract is assigned the designated number of negative performance points in each category where it is deemed deficient according to the results of the analysis. Otherwise, the contract receives a score of 0 for the particular category. We sum the results across the performance categories to calculate a total negative performance score. Higher scores indicate evidence of performance problems across multiple and varied and/or high risk dimensions. Table 3 on the following page summarizes the negative performance points associated with each performance area.

Summarizing Results at the Contracting Organization (Legal Entity) Level

While the analyses described above are conducted at the contract level, it is necessary to summarize the results at the legal entity level. Frequently a contracting organization (i.e., a licensed, risk-bearing legal entity) holds multiple contracts with CMS. In turn, some parent organizations own numerous legal entities, each of which hold one or more CMS contracts. We summarize the contract-level performance results at the contracting organization level by assigning to a contracting organization the highest point value assessed for each performance area among all of the contracts held by that organization. The assigned scores for each performance area are then added to produce a total score for that contracting organization. For instance, "ABC Health Plan" holds two Medicare contracts, HXXXX and SXXXX. In reviewing ABC's Part D past performance we find that HXXXX received 1 point for Compliance Letters and 2 points for Performance Metrics, and SXXXX received 1 point for Compliance Letters and 1 point for Formulary Exclusions. To calculate the performance of ABC Health Plan as a whole, we assign that contracting organization the highest number of points any of its contracts received per performance category. In this example, ABC Health Plan would be assigned 1 point for Compliance Letters, 2 points for Performance Metrics, and 1 point for Formulary Exclusions for a total past performance score of 4.

Contracting organizations with high negative performance scores (according to the cut-offs described below) are checked to see if they are applying for an initial contract or a service area expansion. Such applications are denied.

Additionally, we identify applying contracting organizations with no prior contracting history with CMS (i.e., a legal entity brand new to the Medicare program). We determine whether that entity is held by a parent of other Part C or D contracting organizations. In these instances, it is reasonable in the absence of any actual contract performance by the subsidiary applicant, to impute to the applicant the performance of its sibling organizations as part of CMS' application evaluation. This approach prevents parent organizations whose subsidiaries are poor Part C or D performers from evading CMS' past performance review authority by creating new legal entities to submit Part C or D applications. Should one or more of the sibling organizations have a high negative performance score, the application from the new legal entity will be denied.

Table 3: Summary of Performance Areas and Negative Performance Points

Performance Area	**Negative Performance Points Value for Contracts Identified as Category Outlier or Meeting Category Criteria**
Compliance Letters	90^{th} – 100^{th} percentile: 2 points 80^{th} – <90^{th} percentile: 1 point
Performance Metrics	2 points
Multiple Ad Hoc CAPs	1 point
Ad Hoc CAPs with Beneficiary Impact	1 point per CAP with beneficiary impact
Financial Watch List	1 point
One-Third Financial Audits (Adverse Opinion or Disclaimed Results)	1 point
Performance audit (for findings not otherwise used to support compliance notices or enforcement actions)	1 point
Exclusions • Medicare & You Handbook • On-Line Enrollment Center • Formulary Update • LIS Reassignments/Auto-Enrollees	 1 point 1 point 1 point Subsequently lifted: 2 points Ongoing: 3 points
Enforcement Actions • Intermediate Sanctions • Civil Money Penalties (CMP)	 Immediate: 3 points lifted/7 points ongoing Regular: 2 points lifted/6 points ongoing CMP > $50,000: 2 points CMP ≤ $50,000: 1 point
Terminations	CMS-Imposed: 8 points Disruptive Mutual: 4 points Non-Disruptive Mutual: 1 point
Outstanding Compliance Concerns Not Otherwise Captured	1-2 points (up to 5 points in rare and limited circumstances)

Negative Performance Point Thresholds

In determining those organizations that have significant performance problems, we established a contracting organization threshold of 4 negative performance points for Part C and 5 negative performance points for Part D. The difference is due to a larger number of applicable categories where points may be accumulated by Part D sponsors (e.g., formulary or LIS specific categories). It is sufficient to reach the designated threshold for either the Part C or Part D analysis to be considered an overall poor performer.

These cut-offs were established to identify organizations that were outliers in at least one serious performance category (e.g. a current sanction) or in multiple performance categories. While even 1 negative performance point indicates a contract's "outlier" status in an important performance area, we established 4 or 5 points as the minimum total score for identifying those organizations with performance problems significant enough for us to take definitive action, such as denying expansion applications. This allows us to concentrate on those organizations that are either performance outliers in multiple categories or otherwise represent a high risk to the program. That said, we reserve the flexibility to increase the threshold values as necessary to account for shifts in the underlying performance categories and their associated point values to ensure that the analysis continues to identify true outliers.

While we use the individual C and D scores for purposes of approving or denying C and D applications, respectively, for program management purposes, we integrate the final separate C and D scores to compile an overall summary score for MA-PD organizations.

Communication of Results with Organizations

During the application review process, CMS Group Directors place phone calls to the affected organizations in advance of the issuance of the application Notices of Intent to Deny to provide applicants the opportunity to proactively withdraw their applications. Organizations that choose to pursue their applications receive a Denial Notice and have an opportunity to appeal the decision. Formal applications denials are made available to the public.

We have been asked in the past whether it would be possible to provide organizations with advance notice of their scores so that low performing organizations could opt not to submit applications in the first instance. Because our analysis is based on performance during the 14 months immediately prior to the submission of applications at the end of February, we cannot provide final scores any earlier. However, as stated previously, organizations should be conducting a continuous self-review of their performance and based on that analysis, can make business decisions about submitting applications given the risk that CMS may deny the application on past performance grounds. Additionally, we make every effort to calculate preliminary scores in the fall and communicate the potential of a denial to organizations with high negative scores that also submit Notices of Intent to Apply.