DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

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TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, Cost Plans, Employer-Direct and Employer-Only Contracts, and Medicare-Medicaid Plans

FROM: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

Kathryn A. Coleman, Director
Medicare Drug & Health Plan Contract Administration Group

SUBJECT: 2020 Application Cycle Past Performance Review Methodology Draft

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.[1] The review is a tool CMS uses to evaluate the performance of all Medicare contractors; these evaluations may also identify organizations with performance so impaired that CMS would prohibit the organization from further expanding its Medicare operations. Specifically, pursuant to 42 C.F.R. § 422.502(b) and § 423.503(b), CMS may 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). Since 2010 we have published our methodology for determining whether an organization's performance is sufficiently non-compliant to form the basis for a CMS decision to deny an application. The methodology is constructed to identify true or "extreme" outliers. While being identified as an outlier in any performance area

[1] We note that CMS applies the past performance review methodology to Medicare-Medicaid plans (MMPs) differently than to MAOs, PDP Sponsors, Cost Plans, and Employer Contracts. For more guidance on the applicability of the past performance methodology to MMPs in States implementing Capitated Financial Alignment Demonstrations in 2015, please refer to our January 13, 2014 HPMS guidance memorandum entitled, "Organizations Interested in Participating as Medicare-Medicaid Plans in States Seeking to Implement Capitated Financial Alignment Demonstrations in 2015" (see http://www.cms.gov/Medicare-Medicaid- Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination- Office/FinancialAlignmentInitiative/Downloads/2015_NewApplicantGuidance.pdf) and our January 14, 2014 guidance memorandum, "Capitated Financial Alignment Demonstration Medicare-Medicaid Plan Annual Requirements and Timeline for CY 2015" (see http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare- and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/2015_CurrentMMPAnnualRequirements.pdf). These documents describe the current applicability of the past performance methodology to all MMPs.

should be a cause for concern and should spark improvement initiatives by the MA organization or Part D sponsor, we established a much higher threshold for identifying those organizations with performance problems significant or extreme enough for us to deny 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. Such organizations must focus on their existing books of business before contemplating further expansion.

The purpose of this memorandum is to publish the draft 2020 Past Performance Assessment Review methodology, provided in the attachment. We welcome comments on the proposed changes.

The methodology remains largely unchanged from last year, with minor updates made to better clarify the effects of mergers and acquisitions in the context of the methodology as well as align the language in the methodology with the recently implemented regulation which changes our performance review each year to the 12-month period leading up to and including the month of the annual application submission deadline.

The more significant proposed changes to the methodology document for CY 2020 relate to the treatment of Civil Money Penalties (CMPs) in the Enforcement Actions Category. First, we plan to make clear the distinction between CMPs imposed based on non-compliance with Part C requirements and those based on Part D non-compliance. The methodology, until now, has never differentiated between assigning negative performance points on the basis of Part C, Part D, or Parts C and D designations when it comes to the assessment of points for the purposes of CMPs. CMS recognizes that there are instances in which certain CMPs may only affect a sponsor's Part C or Part D lines of business. To better address these types of situations, CMS has revised the manner in which CMPs will be assessed points. Going forward, each CMP will be assigned a Part C, Part D, or Parts C and D designation and it will be calculated toward the relevant Part C or Part D analysis.

Second, CMS is also considering updating the negative past performance point values assigned to CMPs to ensure that they are given the appropriate weight within the methodology. CMS is exploring the possibility of raising the one negative performance point that is currently assessed for each CMP to two negative performance points. CMS believes that this approach will be more representative of the severity of CMPs within the methodology. There is historical precedent for this action. Under former methodologies, CMPs used to be worth either one or two negative past performance points depending on the dollar amount that was assessed. Higher CMPs received the 2 point designation while lower CMPs received the one point designation. CMS would appreciate any comments sponsors have on this topic.

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.

Please submit any comments on the draft methodology to PartD_Monitoring@cms.hhs.gov by November 9, 2018. If you have any questions, please contact Michael Neuman at Michael.Neuman@cms.hhs.gov or 410-786-7069. Thank you.

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Attachment: 2020 Application Cycle Past Performance Assessment Review Methodology (Draft)

The methodology below describes in detail the approach CMS uses to evaluate the performance of all Medicare Part C and Part 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 regulations concerning the past performance methodology previously stated that we would review the 14-month period leading up to the annual application submission deadline. In its April 16, 2018 final Part C and Part D regulation at https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf#page=294 CMS revised the methodology to change our performance review each year to the 12-month period leading up to and including the month of the annual application submission deadline. Consequently, beginning for the first time with the 2020 application cycle, we will be reviewing the previous 12 months' performance, instead of 14. (As a practical matter, we count the entire calendar month in which applications are due as the 12th month.) The specific 12-month performance period that will be assessed for the 2020 application review cycle will be March 1, 2018 through February 28, 2019.[2]

For an instance of non-compliance to be considered in the review, the non-compliance or poor performance must have been documented by CMS (through the issuance of a letter, report, or other publication) during the 12-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.

In accordance with our regulations, in the absence of 12 months' performance history, we may deny an application based on a lack of information available to determine an applicant's capacity to comply with the requirements of the Part C or Part D programs (42 C.F.R. §§ 422.502(b)(2) and 423.503(b)(2)). Therefore, during the 2020 application cycle, organizations that commence their Part C and/or Part D operations in 2019 will not be permitted to expand their service areas or product types until they have accumulated at least 12 months of performance experience.

Importantly, these provisions only pertain to applying entities that currently operate Part C or Part D contract(s) but have done so for less than 12 months, and further, are unrelated (by virtue of being subsidiaries of the same parent) to any other contracting entity with at least 12 months' experience. So long as a contracting entity or another subsidiary of its parent organization has operated one or more Medicare contracts for the program for which the entity is submitting an application for the requisite period of time (i.e., only Part C experience may be counted for a Part C application; only Part D experience may be counted for a Part D application), applications for new contracts or service area expansions submitted by a current contracting entity will not be subject to denial for having less than 12 months experience. An example of an exception is when a parent organization without any contracts meeting the 12 month requirement purchases another contract that does meet the 12 month requirement. In such circumstances the parent and its existing

[2] Per 42 C.F.R. §§ 422.502(b)(3) and 423.503(b)(3), for organizations that have had a previous Medicare contract terminated or non-renewed by CMS within the 38 months preceding the application submission deadline, the applicable past performance review period will be extended to include that same 38-month period.

contracts are not waived from having to meet the 12 month requirement on their own. That is, purchasing a contracting entity that has operated in the Medicare program in excess of 12 months does not entitle the new parent organization to use that experience.

Plan Types

The past performance assessment is conducted at the contract level, and includes contracts that operated at any time during the performance period, even if the contract terminated or non-renewed prior to the end of the performance period.

With one exception, all contract types are included in the past performance review. Due to continuing variations in the Programs of All-Inclusive Care for the Elderly (PACE) regulations, PACE organizations remain excluded from this analysis. Medicare Advantage-Prescription Drug (MA-PD) organizations receive both a Part C and Part D score. Unless otherwise noted, the methodology presented below is identical for both the Part C and Part D reviews.

Performance Categories and Negative Performance Points

For the CY 2020 application review cycle, we have established 11 distinct performance categories. We carefully analyze the performance of all contracts in each performance category and assign "negative performance points" to contracts with poor performance in that category. The number of potential negative performance 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 CY 2020 application review cycle include:

- **Compliance Letters.** (i.e., Notices of Non-Compliance, Warning Letters, Warning Letters with Request for Business Plan, and Corrective Action Plans (CAPs))
- **Star Ratings.** (i.e., the plan performance ratings developed and calculated each year by CMS)
- **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)
- ***Ad Hoc* CAPs with Beneficiary Impact.** (i.e., CAPs where the compliance violation relates directly or indirectly to a beneficiary's experience with the services and protections the contracting organization is required to provide [e.g., denial of access to health care services or prescription drugs, charging of incorrect premiums or cost sharing])
- **Failure to Maintain Fiscally Sound Operation.** (i.e., organizations with financial solvency problems)
- **One-Third Financial Audits.** (i.e., organizations with adverse audit opinions or disclaimed audit reports stemming from a CMS One-Third Financial Audit)
- **Program Audits.** (i.e., poor audit results)
- **Exclusions.** (i.e., exclusion from: receiving auto-enrollees, appearing in Medicare & You, having certain formulary update opportunities, or participating in the Online Enrollment Center)

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- **Enforcement Actions.** (i.e., intermediate sanctions and civil money penalties imposed or in place during the performance period)
- **Terminations and Non-Renewals.** (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)
- **Documented Significant Compliance Issues Awaiting Formal CMS Clearance.** (i.e., compliance and enforcement actions largely developed but not yet formally issued by CMS)

Detailed Information

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 (NONCs), Warning Letters, and *Ad Hoc* CAP Requests. NONCs 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 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.

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Compliance Letter Type	Weight	Rationale for Weight
CAP – a*d hoc* compliance event	6	*Ad hoc* CAPs represent the most serious form of compliance notice. Rated at twice the weight of a warning letter because the issuance of this type of letter indicates continuing and/or severe, systemic problems.

Example: if a contract received one NONC (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.[3,4]

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 (unless the letter is generated directly from HPMS, in which case the data elements are captured automatically). 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 are included in the extract and analysis.[5]

[3] For the 2019 application cycle (the 14 months between January 2017 and February 2018), Part D thresholds were as follows: 80th percentile – 4/ 90th percentile – 7 (MA-PDs); 80th percentile –6/90th percentile – 10.2 (PDPs). For Part C, the thresholds were: 80th percentile – 3/90th percentile – 5. This information is provided to assist organizations in monitoring their own performance. These percentile values are likely to change when re-calculated for the final 2020 application cycle performance period of March 2018 through February 2019.

[4] For Part C, in the event that the 90th percentile calculation results in a Compliance Letter score of less than 5, CMS will use a score of 5 as the minimum value for the assessment of two negative performance points. Likewise, in the event that the 80th percentile calculation results in a Compliance Letter score of less than 3, CMS will use a score of 3 as the minimum value for the assessment of one negative performance point.

[5] There are three exceptions. The first is that we 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. The second example is that we exclude *ad hoc* CAPs concerning an organization receiving a star rating of less than three stars for a specific year. Because this methodology includes a separate performance category specifically concerning low star ratings, it would be inappropriate to further include in our analysis CAPs issued as a result of the same problem. Finally, we exclude CAPs stemming from performance audits as these, by definition, are not "*ad hoc*" CAPs.

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Star Ratings. The most current MA and Part D Plan Star Ratings data as of the end of the 12-month performance period developed and calculated by CMS 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 2019 Technical Notes made available to the public on the CMS website at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.[6] An outlier in this category is defined as any contract that received a summary score for Part C or Part D of 2.5 stars or below. The 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; Member Complaints and Changes in the Drug Plan's Performance; Member Experience with Drug Plan; and Drug Pricing and Patient Safety. All told, there are 14 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; Member Experience with Health Plan; Member Complaints and Changes in the Health Plan's Performance; and Health Plan Customer Service. Altogether, there are 34 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 a weighted average of the individual measure stars, with outcomes and intermediate outcomes weighted 3 times as much as process measures, and patient experience and access measures weighted 1.5 times as much as process measures. Consistent good performance is 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 three stars indicates poor or "negative outlier" performance.

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

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. *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.

***Ad Hoc* CAPs with Beneficiary Impact.** *Ad hoc* compliance CAPs can be issued for numerous reasons. Some CAPs are related, directly or indirectly, to a beneficiary's experience with the services and protections the contracting organization is required to provide, while others are not. An example of a CAP we previously issued that does not present a threat to beneficiaries (and therefore no beneficiary impact as defined here) concerns late reporting of financial information to CMS. The non-compliance in this instance involves largely administrative aspects of the Medicare program that, while crucial to the overall administration of the Medicare program, do not relate to

[6] In the rare instance that a contract terminated mid-year and therefore does not have a calculated rating for the current year, we use the prior year's rating.

beneficiaries' day-to-day use of the Medicare benefit. 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 enrollees, volume of member complaints logged into CMS' Complaints Tracking Module (CTM), failure to provide appropriate Part D drugs, failure to apply safety edits when processing claims, processing of member appeals and grievances, marketing abuses, failure to provide accurate information about sponsor services, 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 and assess it to determine whether the non-compliance stated in the CAP request should be characterized as conduct that had a beneficiary impact.[7] 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.

Failure to Maintain Fiscally Sound Operations. CMS requires all organizations to submit audited annual financial statements. Organizations whose audited annual financial statements fail to meet the requirements of 42 C.F.R. §§ 422.504(a)(14) and 423.505(b)(23) are carefully monitored by CMS. Specifically, organizations are required to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities). Because CMS has a responsibility to ensure our contractors have sufficient funds to allow them to pay providers and otherwise maintain operations, contracts CMS has determined have not met the requirements of 42 C.F.R. §§ 422.504(a)(14) or 423.505(b)(23) on their audited annual financial statements receive negative performance points. If the entity has had a negative net worth reported on the audited annual financial statements during the 12-month review period, the contract will receive two negative past performance points.

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 (including, but not limited to, data relating to Medicare utilization and costs, including allowable reinsurance and risk corridor costs as well as low income subsidies and other costs and computation of the bid per 42 C.F.R. §§ 422.503(d) and 423.504(d)) of at least one-third of all active MAOs and PDPs. For example, this may include procedures to test Prescription Drug Event (PDE) data, Direct and Indirect Remuneration (DIR) data, bid data, internal controls, etc. All contracts that receive adverse audit opinions or disclaimed audit reports during the 12 month performance period receive one 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

[7] CAPs indicate in the body of the letter if the issue was related to beneficiary experience.

includes: 1) Solvency, 2) Related-Party Transactions, 3) Non Benefit Expense, 4) Part D Costs and Payments (True Out-Of-Pocket, Direct and Indirect Remuneration), and 5) Direct Medical.

Program Audits. Each year, CMS conducts audits of select Part C and Part D sponsors to determine the level of performance under their Medicare contracts. At the conclusion of the audit, sponsors receive an audit score based on both the variety and severity of the conditions identified. For purposes of the Past Performance Assessment, a modified audit score is calculated by utilizing the audit results for each of the following program areas: Part D Formulary and Benefit Administration; Part D Coverage Determinations, Appeals, and Grievances (CDAG); Part C Organizational Determinations, Appeals, and Grievances (ODAG); and Compliance Program Effectiveness. We consider only these 4 core program areas for the modified past performance audit score because they are consistently audited each year and have limited changes to the audit protocols from year-to-year. The modified audit score is then calculated by taking the total number of audit points (determined based on both the number of unique conditions identified and the severity of those conditions) in these 4 areas and dividing those audit points by the total number of audit elements tested (again in the 4 core program areas) to arrive at the Past Performance Audit Score. A lower score is better than a higher score.

CMS has established a 75th percentile threshold to determine if a sponsor will receive a negative past performance point in this category. Sponsors exceeding the threshold will receive one negative performance point in this category. The threshold will be determined by utilizing cumulative data and establishing the 75th percentile as the threshold. (The date of issuance of the final audit report determines whether an organization's audit results are included in the 12-month performance period.)

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 beneficiaries 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 one 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.)
- **Online Enrollment Center (OEC).** Most organizations are required to participate in CMS' online 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 one negative performance point.

- **Formulary Update (Part D only).** Organizations have a special opportunity to update newly approved formularies for the upcoming benefit year each summer. On occasion, CMS will deny an organization the opportunity to update its new formulary during the summer due to serious problems CMS has had in working with the contract to receive an acceptable formulary. Should this be the case, CMS assigns one negative performance point to any contracts that lose their summer update opportunity.
- **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 beneficiaries into new plans for the coming year when their current 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 beneficiaries, 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 two negative performance points. Contracts that are under a suspension at the end of the performance period receive three negative performance points.

Enforcement Actions. CMS may impose intermediate sanctions, such as a suspension of an organization's ability to market to or enroll beneficiaries, if an organization meets one or more of the bases for intermediate sanctions in 42 C.F.R. §§ 422.752(a) or 423.752(a), meets one or more of the bases for termination in 42 C.F.R. §§ 422.510(a) or 423.509(a), or meets other statutory criteria (e.g., failure to report an annual medical loss ratio of at least 85% for three consecutive years). Likewise, in addition to or in place of intermediate sanctions, CMS has 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) or 423.509(a) and its violations have directly adversely affected or had the substantial likelihood of adversely affecting one or more enrollees. Because these enforcement actions are contract determinations, 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 three 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 two negative performance points for "non-immediate" 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 receive an additional four points, bringing the possible total to seven negative

performance points for immediate sanctions or six negative performance points for non-immediate sanctions.

Regarding CMPs, we assess two negative performance points for each CMP imposed by CMS on a contract. Should an organization receive more than one CMP during the performance period, the contract receives two negative performance points for each distinct CMP. Each CMP will be assigned a Part C, Part D, or Parts C and D designation and will be calculated toward the relevant Part C and/or Part D analysis.

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 determination. 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.[8]

Terminations and Non-Renewals. There are three types of contract or partial 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) or 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 requirements of the Medicare program for being a contracting organization.

Under such circumstances, we assign eight negative performance points to the terminated contract. In some instances, CMS must terminate or non-renew an organization's contract in only a portion of its service area where it no longer meets the plan sponsor qualifications (e.g., organization is no longer licensed as a risk-bearing entity in a particular jurisdiction). CMS will assign four negative performance points to these contracts.

In past years, several organizations requested mutual contract terminations (for an entire contract or for a specific portion of the service area) 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 or service area reduction. Such "disruptive terminations" are harmful to beneficiaries, show lack of good faith in contracting with CMS, and put stress on the Part C and Part 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 beginning 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/reduced contracts receive four negative performance points. As discussed below, the four points are ultimately assessed to the organization that held the terminated contract.

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[8] 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 coverage, and has an effective termination date of the last day of the current contract year, December 31), then CMS assigns one 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 CMS-imposed partial termination	8 points 4 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)

Documented Significant Compliance Issues Awaiting Formal CMS Clearance. 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 only where CMS has identified non-compliance that supports the imposition of an intermediate sanction, civil money penalty, or termination, but the matter has not yet worked its way through CMS's internal enforcement clearance processes. In such a situation, 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 an instance, 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 this limited circumstance, CMS assigns negative performance points to open significant compliance concerns.

Specifically, organizations for which CMS has an enforcement action pending (e.g., suspension of marketing and enrollment activities or imposition of civil money penalty) receive two negative

performance points for pending sanctions or two points for pending CMPs. Organizations with a "Low Performing Icon" designation due to three consecutive years of poor star ratings receive three negative past performance points on the basis that the regulation states that such contracts are subject to termination (42 C.F.R. §§ 423.509(a)(13) and 422.510(a)(14)). In extremely limited circumstances where a termination is actively in process or 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 five negative performance points.

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

The results of the analyses described above are then compiled separately for Part C and Part D. 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 then 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 summarizes the negative performance points associated with each performance area.

For organizations offering MA-PD contracts, we identify actions as related exclusively to an organization's Part C, Part D, or Part C and D performance and count them toward the relevant Part C or Part D analysis. However, there are instances where the underlying performance is not exclusive to Part C or D, such as non-compliance with enrollment requirements and the failure to maintain fiscally sound operations. Also, there are situations where the penalty for poor performance affects an MA-PD organization's Part C and Part D operations, such as *Medicare & You* and Online Enrollment Center Exclusions and Intermediate Sanctions in the form of the suspension of enrollment and marketing activities. In other instances, we assign points that are based on the results of an evaluation of a combination of Part C and Part D performance, and the result cannot be separated into Part C and Part D findings after the evaluation is completed. Examples of this situation include One Third Financial Audit and Program Audit results. In these types of situations, where the performance upon which points are assigned cannot be established as exclusively related to Part C or Part D, we assign the calculated points to the MA-PD organization's Part C and Part D past performance scores.

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 one point for Compliance Letters and two points for Performance Metrics, and SXXXX received one point for Compliance Letters and one 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 one point for Compliance Letters,

two points for Performance Metrics, and one point for Formulary Exclusions for a total past performance score of four.

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	90th – 100th percentile: 2 points 80th – <90th 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
Failure to Maintain Fiscally Sound Operations	Negative Net Worth: 2 points
One-Third Financial Audits (Adverse Opinion or Disclaimed Results)	1 point
Program Audit	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 Non-Immediate: 2 points lifted/6 points ongoing 2 points per CMP
Terminations	CMS-Imposed: 8 points Disruptive Mutual: 4 points Non-Disruptive Mutual: 1 point
Documented Significant Compliance Issues Awaiting Formal CMS Clearance	1-5 points

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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 recent prior contracting history with CMS (i.e., a legal entity brand new to the Medicare program, or one with prior Medicare contract experience that precedes the 12-month review period). We determine whether that entity is held by a parent of other Part C or D contracting organizations or otherwise shares common control with another contracting organization through a determination of whether the applying contracting organization shares a "covered person" as described in 42 C.F.R. §§ 422.502(b)(4) and 423.503(b)(4) with another current contracting organization (e.g., overlapping board membership, shareholders, or partners). In these instances, it is reasonable in the absence of any recent actual contract performance by the applicant due to a lack of recent Part C or Part D participation, to impute to the applicant the performance of its sibling organizations as part of CMS' application evaluation. This approach prevents parent organizations with subsidiaries that are poor Part C or Part D performers, or the parties that otherwise control poor performing entities, from evading CMS' past performance review authority by creating new legal entities to submit Part C or Part D applications. It also forces organizations responsible for a poor past performance record to direct their attention away from acquiring new Medicare business when their focus should be on bringing their current Medicare contract performance up to an acceptable level. Should one or more of the sibling organizations have a high negative performance score, the application from the new legal entity will be denied.

Of note, we wish to clarify the impact of mergers and acquisitions on the past performance review and legal-entity summary result. If a parent organization with existing Part C and/or Part D lines of business purchases a contracting entity or the Part C and/or Part D contract of another parent organization that has negative performance points, the purchasing parent (upon a formal request to CMS) will be allotted a one-year grace period, calculated from the closing date of the purchase, before any negative performance by the purchased entity or contract will be imputed to the purchasing parent's existing entities. More specifically, negative performance points associated with the purchased entity will not be assigned to the purchasing entity during both the performance period in which the transaction closes and the entire succeeding period. In any event, the negative performance points earned by that contract during the review period will remain with that contract, and will be counted by CMS in response to any request for an expansion of that contract's service area.

Finally, with respect to contract consolidations and novations that may occur among contracts held within the same parent organization, we hold each legal entity responsible for the points earned by any of the contracts it held at any time during the review period. We do not apportion the performance based on the time each entity held a particular contract during a 12-month review period. The following example demonstrates this policy. ABC Health Plan holds MA-PD contract H1XXX and DEF Health Plan holds MA-PD contract H2XXX. Both legal entities are subsidiaries of the same parent organization. Effective January 1, prior to the mid-February application submission deadline, contract H1XXX is consolidated into contract H2XXX, with DEF Health Plan remaining as the contract holder of H2XXX. In that scenario, DEF Health Plan's performance during the 12-month review period of both H1XXX and H2XXX would be imputed to DEF Health Plan. The performance of H1XXX would also be imputed to ABC Health Plan for the same period.

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Negative Performance Point Thresholds

In determining those organizations that have significant performance problems, we established a contracting organization threshold of four negative performance points for Part C and five 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 one negative performance point indicates a contract's "outlier" status in an important performance area, we established four or five 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.

Communication of Results with Organizations

During the application review process, CMS will provide results 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. In 2011, 2013, 2014, and 2018, organizations whose applications had been denied on past performance grounds appealed the decisions, thus making CMS' Past Performance Methodology the subject of multiple appeals. Both the CMS Hearings Officer and the CMS Administrator upheld CMS' decisions to deny applications based on the appropriateness of this methodology, and CMS' correct application of the methodology to the application approval and denial process. Formal application 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 12 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, post the results in HPMS for plans to review, and communicate the potential of a denial to organizations with high negative scores that also submit Notices of Intent to Apply.

Public Posting of Past Performance Results

Once final, results of this analysis are posted on CMS' public website at:

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDComplianceActions.html

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