2022 Part C and Part D Program Audit and Enforcement Report

Medicare Parts C and D Oversight and Enforcement Group
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FOREWORD

The Medicare Parts C and D Oversight and Enforcement Group (MOEG) in the Centers for Medicare & Medicaid Services (CMS) has historically released an annual report summarizing information from its annual Part C and Part D program audits and enforcement actions to encourage improvement in industry performance. These data and analyses provided year-to-year comparisons of audit scores for Medicare Advantage Organizations (MAOs), prescription drug plans (PDPs), and Medicare-Medicaid plans (MMPs), collectively referred to as "sponsors." We encouraged sponsors to review this information with their compliance staff, compliance committee, and other pertinent staff with the intent of ensuring:

- enrollees have appropriate access to health care services and medications,
- sponsors are in compliance with selected federal requirements, and
- sponsors understood our audit process and had a means to provide us feedback.

We also used this report to solicit feedback from our stakeholders about the types of information we could include in the report to further drive improvement. The feedback we received helped us realize that the information we were sharing wasn't as helpful as it could be, and sponsors want us to provide more specifics about the types of noncompliance we see and the reasons for it. We listened to your feedback and revised the report accordingly. In this report, you will gain greater insight into the noncompliance we cited in 2022 and the enforcement actions that resulted from these oversight activities.

Note that information included in this report should not be used to draw broad conclusions about the significance of deficiencies or performance across the MA, Part D, or MMP programs. This report is not intended to reflect overall industry performance and should not be interpreted to mean that there are pervasive issues throughout the industry related to the noncompliance we identified.

Lastly, we continue to welcome sponsor feedback on the changes made to this report. Please submit comments to our Parts C and D audit mailbox: part_C_part_D_audit@cms.hhs.gov (include "Comments on the Part C and Part D Program Audit and Enforcement Report" in the subject line).

INTRODUCTION

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs administered by CMS provide health and prescription drug benefits to eligible individuals 65 years old and older, younger people with disabilities, and people with End Stage Renal Disease. CMS contracts with private companies, known as sponsors, to administer these benefits. Some of these sponsors may partner with CMS and the state(s) to integrate primary, acute, behavioral health care, and long-term services and supports for Medicare-Medicaid enrollees through the Medicare-Medicaid Financial Alignment Initiative.

MOEG conducts program audits of Medicare sponsors including Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), and Medicare-Medicaid Plans (MMPs). Program audits are conducted at the parent organization level, meaning the data we collect includes all MA and PDP contracts between CMS and the controlling legal entity. Through program audits, we evaluate key provisions related to the delivery of health care services and medications to Medicare enrollees in the Parts C and D programs.

Audited sponsors may be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action. CMS' enforcement authorities allow us to impose Civil Money Penalties (CMPs), intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and for-cause contract terminations. This report contains a summary of the noncompliance identified during 2022 program audits, as well as enforcement actions that were imposed as a result of program audits and additional CMS oversight activities.

PART C AND PART D PROGRAM AUDIT LANDSCAPE

In 2022, CMS conducted 26 program audits across 25 separate parent organizations (herein after referred to as sponsors) covering approximately 33.6 million, or 63 percent, of beneficiaries enrolled in the Part C and Part D programs.

Although we did not audit a large number of parent organizations in 2022, our reviews covered 291, or 29 percent, of total Part C and Part D contracts, including:

- 263 MAPD contracts
  - 146 of these contracts offering special needs plans
- 16 PDP-only contracts
- one 1876 Cost plan
- 11 MMP contracts

PART C AND PART D PROGRAM AUDIT SCOPE

The 2022 program audits evaluated sponsor compliance in the following program areas based on the contract types offered by the audited sponsors:

Program Areas Reviewed	Description
Compliance Program Effectiveness (CPE)	• Assess whether an MAO has the foundation and structure in place for an effective Compliance Program, including controls to prevent, detect, and correct noncompliance with program requirements.
Part D Formulary and Benefit Administration (FA)	• Review samples of Part D denied claims to determine how the sponsor applied utilization management edits such as prior authorizations, step therapy, and quantity limits at the point of sale. • Review how claims for non-formulary drugs are processed, and whether all enrollees eligible for a transition fill are afforded the full transition benefit.
Part D Coverage Determinations, Appeals, and Grievances (CDAG)	• Review compliance with timeframes for processing drug coverage requests and whether these requests were processed in accordance with 42 CFR 423 Subpart M. • Review how a plan administers its Drug Management Program.
Part C Organization Determinations, Appeals, and Grievances (ODAG)	• Review compliance with timeframes for processing service requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M.
SNP Care Coordination (SNPCC), *if applicable*	• Review timeliness of Health Risk Assessment (HRA) completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.
Medicare-Medicaid Plan Service Authorization Requests, Appeals and Grievances (MMP-SARAG)	• Review compliance with timeframes for processing service authorization requests and post-service claims, and whether these requests/claims were processed in accordance with 42 CFR 422 Subpart M and the applicable three-way contract.
Medicare-Medicaid Plan Care Coordination (MMPCC)	• Review timeliness of Health Risk Assessment (HRA) completion. • Assess whether the completed HRAs include a comprehensive assessment of enrollees' needs, and whether the individualized care plans are designed to address needs identified in the HRA.

We audited each sponsor in all program areas applicable to its operation. For example, if a sponsor did not operate a Special Needs Plan (SNP), then we did not conduct a SNPCC audit. Likewise, we would not apply the ODAG protocol to a standalone PDP since it does not offer the MA benefit.

PART C AND PART D PROGRAM AUDIT INSIGHTS

Program audits provide valuable insight into sponsor operations specific to audited requirements. Below we have outlined some of the generalized noncompliance we identified during our 2022 program audits by program area, and some of the reasons sponsors provided when asked why the noncompliance occurred. This is not an exhaustive list of all findings, and we still expect all sponsors to carefully and routinely assess all risks to their organizations and monitor and audit their operations to ensure compliance with CMS requirements.

Compliance Program Effectiveness (CPE)

- Compliance issues were not quickly addressed and corrected.
  - Compliance procedures weren't explicit in instructing users when to initiate corrective action in response to identified issues.
  - Corrective action plans fell short of addressing the root cause of the noncompliance and, therefore, did not remediate the noncompliance as intended.

SPONSOR TIP: *Sponsors can evaluate current work instructions for clarity, make updates as necessary, and support their expectations around prevention, detection, and correction of noncompliance with supplemental training within their organizations.*

- Systems for monitoring, auditing, and identifying compliance risks weren't comprehensive or current.
  - Sponsors may have established and implemented effective oversight within their own organizations but did not include monitoring and auditing of activities performed by their delegated entities.
  - Sponsors did not align their oversight of Part B timeliness with updated CMS requirements, therefore noncompliance was not detected.

SPONSOR TIP: *Sponsors should ensure timely updates to their auditing and monitoring plans in accordance with updates to CMS regulations.*

Formulary Administration (FA)

- Sponsors applied utilization management (UM) edits that were not part of their CMS-approved formulary.
  - Sponsors forgot to review prior authorization approval edits for existing enrollees in their adjudication system when they were setting up their new formulary for the upcoming plan year. When these edits were carried over into the new plan year, the edits were more restrictive than the updated formulary.
  - Coding edits in a sponsor's adjudication system did not allow for an extended day supply up to the Food and Drug Administration (FDA) approved duration for certain drugs.

- Approved prior authorization requests were inappropriately effectuated in Sponsors' systems.
    - Authorizations were not configured to effectuate at the same Generic Product Identifier (GPI) level for drugs where the clinical criteria are the same across dosage forms.
    - Overrides of opioid naïve edits for enrollees who were not opioid naïve were not applied to all opioids on the formulary.
- Enrollees were denied their full transition benefit under Medicare Part D.
    - Incorrect transition timeframes that were coded into systems shortened the transition period for continuing enrollees to receive medications that were removed from the formulary.
    - Data entry errors caused systems to apply incorrect transition of care start dates.
    - Hard-coding transition effective dates prevented sponsors from updating enrollee transition effective dates when necessary.
    - Medically-Accepted Indication (MAI) edits were inappropriately applied to transition eligible medications for continuing enrollees when MAI information was provided with related coverage determination requests.

SPONSOR TIP: *Sponsors can tailor their monitoring of rejected claims to identify patterns that may be indicative of errors in the set-up of system edits.*

Coverage Determinations, Appeals, and Grievances (CDAG)

- Sponsors did not meet the timeframes for making redetermination decisions.
    - Staff were not properly trained on the process for taking extensions or the appropriate method and/or timeframe for communicating decisions when an extension was taken.
    - Staff did not follow established procedures for providing notification once a decision was made.
- Approved exception requests were not effectuated through the end of the plan year.
    - Quality control processes did not sufficiently identify and resolve manual errors.

SPONSOR TIP: *Sponsors can refer to the compliance standards in our protocols to learn more about how CMS assesses timeliness requirements during our Part C and Part D program audits.*

Organization Determinations, Appeals, and Grievances (ODAG)/Medicare Medicaid Plan – Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)

- Sponsors did not provide timely notice of their decisions for requests for service/items and/or resolution of grievances.

    - Training did not ensure staff understood the timeframe requirements for processing standard and expedited pre-service requests.
    - Workflow management systems did not alert staff to aging requests because of coding errors.
    - Staff inappropriately provided verbal notice of decisions to enrollees when written notice was required.
    - Sponsor did not maintain adequate staffing levels to ensure requests were processed timely.
    - Staff did not adhere to established internal processes designed to ensure timely resolution of grievances.
    - Staff did not identify and process requests for services/items or reconsiderations that were included in grievances.
- Denial notices were insufficient.
    - Sponsor used standardized denial rationales that were not specific to the service requested, including situations where system logic truncated denial rationales or included clinical references that enrollees could not understand.
    - Links referenced in the denial notices did not direct non-contract providers to the waiver of liability forms.

SPONSOR TIP: *Sponsors should ensure periodic system updates do not cause unexpected errors that hinder compliance with CMS notification requirements.*

Special Needs Plans Care Coordination (SNPCC)/Medicare-Medicaid Plan Care Coordination (MMPCC)

- Sponsors did not complete initial Health Risk Assessments (HRAs) and/or annual HRAs timely.
    - Sponsor did not follow its protocols for completing HRAs.
    - Systems did not accurately capture or track when HRAs were due to be completed and/or updated.
- Individualized Care Plans (ICPs) did not meet the needs of the enrollees and/or did not contain measurable outcomes.
    - Sponsor did not conduct oversight of the quality of ICPs.
    - Sponsor misinterpreted requirements related to including interventions and measurable outcomes in ICPs.
    - Staff training did not ensure measurable outcomes were included within the ICP.
- ICPs were not reviewed and/or revised when enrollees health status changed.
    - Care management system logic did not incorporate responses from enrollee HRAs into ICPs, and was not configured to alert the care team to update ICPs when changes to enrollee needs were identified.
    - Interdisciplinary Care Team (ICT) members were not trained to review and/or revise ICPs according to the approved Model of Care.

    - Staff did not follow the established enrollee risk stratification processes designed to ensure timely review and/or updates of ICPs.
- ICT did not effectively coordinate enrollee care.
    - Sponsor did not establish ICTs for enrollees with fair to excellent health.
    - Inadequate staffing impacted consistent ICT meetings.

SPONSOR TIP: *Effective oversight of care coordination can be supported by robust documentation and clear communication.*

TIPS FOR A BETTER PART C AND PART D PROGRAM AUDIT EXPERIENCE

More information about the program audit process is outlined in the annual overview document located on our website (https://www.cms.gov/files/document/2023-program-audit-process-overview.pdf). CMS is offering the following suggestions to improve the overall program audit experience for sponsors:

- CMS utilizes Zoom for program audit webinars. Please ensure all participating sponsor and delegated entity personnel are familiar with Zoom. Please also ensure that sponsor and delegated entity systems are compatible with Zoom. Conducting a practice session internally or requesting a webinar test from the auditor-in-charge may be helpful to ensure potential participants can access Zoom and share their system screens.
- Most program areas are reviewed via webinar. The individual most familiar with the audit area's processes should be the spokesperson/driver of the webinar.
- Having personnel join webinars at least five minutes prior to the start will allow for a timely start and assist in addressing access delays, etc.
- If the sponsor uses delegated entities, having these entities on standby so they can join quickly to avoid long delays.
- Preparing the presenting team to quickly locate documentation that may be requested (examples of documentation can be found in the file CDAG_ODAG_SARAG_Guidance.pdf within HPMS Submission Materials).
- Read and become familiar with the Program Audit Process Overview Document. This document will provide answers to most questions you will have upon receiving the engagement letter.
- Review the HPMS User Guide. This user guide provides helpful information on how to use HPMS throughout the program audit.
- In order to avoid multiple submissions of universes and invalid data submission conditions, sponsors should use the time allotted for universe submissions to accurately compile the requested data according to the universe instructions, field descriptions, and requested universe timeframes, as well as perform an internal quality review before it is submitted to auditors. Sponsors should always contact their program audit team leads for clarification about populating record layouts. Sponsors may also submit inquiries to our audit mailbox at part_c_part_d_audit@cms.hhs.gov.

CMS also implemented new protocols to conduct its 2022 Part C and Part D program audits (https://www.cms.gov/files/zip/final-protocols-medicare-part-c-and-part-d-program-audits-and-industry-wide-part-c-timeliness.zip). Prior to their implementation, CMS conducted a three-part training series to prepare organizations for the use of these protocols. Recordings of these trainings can be found at: https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.

Finally, CMS shared a user group resource document that provided further clarification on the protocols. In February 2023, CMS updated this document to account for questions received from sponsors audited in 2022 and from program audit mailbox submissions relative to the new protocols. The resource document can be found on our Program Audit webpage (https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/programaudits), or by clicking on the following link: https://www.cms.gov/files/document/user-group-resource-document-2023.pdf.

Sponsors can use our program audit protocols and the abovementioned tools to conduct mock audits, including generating and validating universes, to help prepare for program audits. This practice will assist organizations and their delegated entities with data preparation and universe submissions. In addition, mock audits may assist sponsors in identifying operational vulnerabilities or areas of noncompliance prior to a program audit.

ENFORCEMENT ACTIONS

CMS has the authority to impose Civil Money Penalties (CMPs), intermediate sanctions, and for-cause terminations against MA plans, PDPs, MMPs, and cost plans. MOEG is the group responsible for imposing these types of enforcement actions when a sponsor is substantially noncompliant with CMS' Medicare Parts C and D program requirements. Sponsors may appeal all enforcement actions either to the Departmental Appeals Board (for CMPs) or to a CMS hearing officer (for intermediate sanctions and terminations).

All enforcement actions are posted on the Part C and Part D Compliance and Audits website at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-. All information contained in referrals that involve suspected fraud, waste, and abuse is referred to the Center for Program Integrity.

We imposed various enforcement actions in calendar year 2022 and early 2023 due to referrals of violations discovered during program audits and other monitoring efforts conducted by CMS. These other monitoring efforts include: financial audits (also known as one-third financial audits), routine monitoring activities (i.e., medical loss ratio (MLR) and dual eligible special needs plan (D-SNP) integration) and ad-hoc monitoring activities. This section of the report details the number of enforcement actions imposed, the basis for those actions, and provides additional information about the sponsors that were sanctioned and/or received a CMP, as well as the amounts of the CMPs issued. It also contains insights and lessons learned from reviewing enforcement action referrals.

CIVIL MONEY PENALTIES

It is customary for program audits and one-third financial audits to be referred for an independent evaluation to determine whether noncompliance discovered during the audit warrants an enforcement action, as described in 42 CFR. Parts 422 and 423, Subpart O. This evaluation is separate from the audit process and is not conducted by the audit team. Audited sponsors that have been referred will receive notification from MOEG's Division of Compliance Enforcement (DCE) for matters related to enforcement actions. To access the current CMP methodology, go to https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2019CMPMethodology06212019.pdf.

Program audits accounted for 53 percent of the total enforcement referrals received in 2022. Table 1 shows the sponsors that received a CMP based on 2022 program audit referrals.

Table 1: CMPs IMPOSED BASED ON 2022 PROGRAM AUDIT REFERRALS

Date of Imposition	Sponsor Name	Enrollment*	CMP Amount
03/16/2023	Imperial Health Plan of California	6,391	$39,208
03/16/2023	Independence Health Group, Inc.	21,716	$6,032
03/16/2023	Intermountain Health Care, Inc.	44,095	$17,980

** Enrollment reflects actual contracts included in the CMP versus the entire sponsor*

One-third financial audits accounted for 25 percent of the total enforcement referrals received in 2022. Table 2 shows the sponsors that received a CMP based on this type of audit referral.

Table 2: CMPs IMPOSED BASED ON ONE-THIRD FINANCIAL AUDIT REFERRALS

Date of Imposition	Sponsor Name	Enrollment*	CMP Amount
11/30/2022	Elevance Health	1,175,979	$38,512
11/30/2022	Humana Inc.	2,281,640	$131,660
11/30/2022	Kaiser Foundation Health Plan, Inc.	1,713,761	$27,260

** Enrollment reflects actual contracts included in the CMP versus the entire sponsor*

The amount of the CMP does not automatically reflect the overall performance of a sponsor. Rather, the amount of a CMP mostly depends on the number of enrollees impacted by certain violations. The type of contract(s) involved and the nature and scope of the violation(s) also factor into the total CMP amount a sponsor receives. We apply a standard CMP amount for each deficiency cited in a CMP notice, based on either a per-enrollee or a per-determination basis. CMPs imposed on a per-enrollee basis have a quantifiable number of enrollees that have been adversely affected (or have the substantial likelihood of being adversely affected) by a deficiency, while CMPs imposed on a per-determination basis do not. There were nine specific violations cited in the six CMPs imposed based on 2022 referrals:

- Eight violations were calculated on a per-enrollee basis
- One violation was calculated on a per-determination basis

Type of CMP Violations

We take actions on a number of different violations of the Parts C and D regulations. Table 3 shows a breakdown of the nine violations cited in the six CMP notices.

Table 3: TYPES OF VIOLATIONS INCLUDED IN 2022 CMPs

Violation Type	Number of Violations	Source of Referral
Inappropriate cost sharing for Part D medications	3	One-third financial audit
Inappropriate denials of Part D medications at the Point of Sale	2	Program audit
Inappropriate cost sharing for Part C items and services	1	One-third financial audit
Inappropriate Part D Premiums	1	One-third financial audit
Inappropriate denials of Part D coverage determinations	1	Program audit
Failure to hold enrollees harmless for plan directed care	1	Program audit

Aggravating Factors

A sponsor's CMP is increased if aggravating factors apply to certain deficiencies. The standard penalty for a deficiency may increase if the violation involved the following:

- Drugs that are used to treat acute conditions that require immediate treatment,
- Enrollees were not provided access to their inappropriately denied medical services or medications,
- Expedited cases,
- Financial impact over $100,
- Annual Notice of Change (ANOC) documents: ANOC/errata documents were not mailed by Dec. 31, and/or
- A history of prior offense.

Out of the nine violations, we applied an aggravating factor penalty to six violations because of the following:

- Enrollees were not provided access to their inappropriately denied medical services or medications;
- Enrollees incurred inappropriate out-of-pocket expenses exceeding $100; and
- Enrollees were delayed or denied drugs that are used to treat acute conditions that require immediate treatment.

The total aggravating factor penalties amounted to $24,244, which is nine percent of the total CMP amount of $260,652 imposed for 2022 referrals.

Mitigating Factors

Consistent with our approach in 2021, we considered other available evidence indicating that harm to enrollees was minimized when determining whether to move forward with a CMP for a particular violation or to remove enrollees from the CMP calculation. For example, if an enrollee received the requested drug on the same day after an inappropriate rejection occurred at the point of sale, we would exclude the enrollee from the total CMP calculation.

INTERMEDIATE SANCTIONS

Intermediate sanctions can either suspend a sponsor's ability to market to and accept new Part C or Part D enrollees or to receive payment for new enrollees. Intermediate sanctions remain in place until the deficiencies which formed the basis of the sanction are corrected and are not likely to recur. One sponsor remained under sanction because of an enrollment suspension from the state due to financial solvency concerns. This sponsor mutually terminated its contract with CMS during 2022.

The following table lists the sponsor that was under sanction for financial solvency issues during 2022.

Table 4: SPONSOR UNDER SANCTION FOR FINANCIAL INSOLVENCY DURING 2022

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
04/29/2021	04/30/2021	Golden State Medicare Health Plan	Enrollment Suspension	Mutually Terminated 08/01/2022

Statutory Enforcement Actions

Medical Loss Ratio – Enrollment Suspensions

Sponsors are required to spend at least 85 percent of premium dollars on beneficiary medical care, also known as the Medical Loss Ratio (MLR). Sponsors are also required to report an MLR each year for each of their contracts. When an organization fails for three consecutive years to meet the 85 percent threshold, CMS must suspend that organization's ability to accept new enrollments into the noncompliant contract for the contract year following submission of the report. Sponsors subject to MLR sanctions must demonstrate that it has achieved an MLR of at least 85 percent, and CMS will allow the sponsor to resume accepting enrollments that become effective on or after the following contract year. Table 5 lists the sponsors that were under sanction for MLR failures during 2022.

Table 5: SPONSORS UNDER SANCTION FOR MLR FAILURES DURING 2022

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
09/02/2021	01/01/2022	MMM Healthcare, LLC	Enrollment Suspension	Effective 01/01/2023
09/02/2021	01/01/2022	Triple-S Advantage, Inc.	Enrollment Suspension	Effective 01/01/2023
09/02/2021	01/01/2022	UnitedHealthcare of Arkansas, Inc. n/k/a UnitedHealthcare of the Midlands, Inc.	Enrollment Suspension	Effective 01/01/2023
09/02/2021	01/01/2022	UnitedHealthcare of New Mexico, Inc.	Enrollment Suspension	Effective 01/01/2023
09/02/2021	01/01/2022	UnitedHealthcare of the Midwest, Inc.	Enrollment Suspension	Effective 01/01/2023

Dual-Special Needs Plans – Enrollment Sanction

Dual Eligible Special Needs Plans (D-SNPs) enroll individuals who are entitled to both Medicare and a Medicaid state plan. D-SNPs must meet one or more of the following criteria for the integration of Medicare and Medicaid benefits:

- Meets the additional requirements in its contracts with the State Medicaid agency;
- Is a highly integrated dual eligible special needs plan; or
- Is a fully integrated dual eligible special needs plan.

Certain D-SNPs are placed under an enrollment sanction because the specific D-SNP plan benefit package (PBP) failed to meet the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a dual special needs plan at 42 C.F.R. § 422.2. More specifically, the state Medicaid contracts associated with these PBPs are not yet executed, which is required for designation as a Highly Integrated or Fully Integrated D-SNP. Once the state executes the Medicaid contract, CMS will lift the sanction. Table 6 lists the sponsors that were under sanction for D-SNP failures during plan year 2022.

Table 6: SPONSORS UNDER SANCTION FOR D-SNP FAILURES DURING 2022

Date of Sanction Letter	Effective Date of Sanction	Sponsor Name	Type of Intermediate Sanction	Date of Intermediate Sanction Release
12/09/2020	01/01/2021	UnitedHealthcare of New York, Inc.	Enrollment Suspension	TBD
12/09/2020	01/01/2021	Visiting Nurse Association of Central New York	Enrollment Suspension	TBD
09/28/2021	01/01/2022	MVP HealthPlan, Inc.	Enrollment Suspension	TBD
09/28/2021	01/01/2022	UnitedHealthcare Insurance Company	Enrollment Suspension	01/31/2022
09/28/2021	01/01/2022	Health Insurance Plan of Greater New York	Enrollment Suspension	Non-Renewal of PBP Effective 12/31/2022

INSIGHTS FROM THE ENFORCEMENT PROCESS

We continue to engage sponsors throughout the enforcement evaluation process to ensure enforcement actions are based on data that accurately reflects the impact of violations on enrollees. As in previous years, outreach was conducted to discuss and validate plan-submitted impact analyses. This process provides sponsors with additional opportunities to review the accuracy of their submissions provided during the audit process and explain the data in further detail. CMS also improved communication with sponsors about the status of their enforcement evaluation review, CMS' expectations while under intermediate sanctions, and the sanction validation process when applicable.

Lessons Learned for Sponsors

To help sponsors strengthen their overall compliance programs, and to benefit the program more broadly, we are summarizing some of the observations we made during our analysis of 2022 enforcement referrals.

- **Inappropriate cost sharing for Part D medications**
  Sponsors must ensure that enrollees are charged the correct cost sharing amounts for Part D medications. This includes having effective oversight over Part D claims that span multiple member identification numbers for the same beneficiary. CMS understands that beneficiary member identification numbers may change mid-year for various reasons. However, failing to consolidate claims for members with multiple ID numbers could result in inaccurate tracking of beneficiary True Out-of-Pocket (TrOOP) costs. Inaccurate

TrOOP costs impacts beneficiary progression through the benefit phases and their cost-sharing for Part D prescription drugs.

In addition, when a sponsor receives information that necessitates retroactive claims adjustment, it must process the adjustment and issue a refund to the beneficiary within 45 days of the sponsor's receipt of such information. This includes reprocessing prescription drug claims in accordance with enrollee's Low-income subsidy (LIS) levels within 45 days of receiving complete information regarding the enrollees LIS status. Failing to re-adjudicate prescription drug claims and adjust prescription drug event records after receiving updated information could result in enrollees being charged inappropriate cost sharing for their Part D drugs. We recommend sponsors develop and implement automated safeguards to alert sponsors to ongoing changes in LIS status.

- **Provider Payment Issues**
  CMS is finding issues during the one-third financial audits where sponsors are processing claims with incorrect provider payment amounts. Sponsors must ensure claims are paid in accordance with the contract provider's reimbursement contract terms or, for non-contract providers, the Medicare fee schedule. When providers are paid incorrect amounts, this can affect the cost sharing that the beneficiary pays. Sponsors should make efforts to monitor claims processing systems to confirm that they are properly programmed to process claims using the correct provider reimbursement information and confirm that staff are properly trained to process claims with the correct reimbursement rates when manual intervention is required. Most importantly, when the sponsor identifies incorrect payments to providers, it must ensure beneficiaries have not been overcharged for those services, and if beneficiaries have been overcharged, then they must be refunded overcharged amounts (see below).

- **Beneficiary Reimbursements**
  Sponsors must process claims with the correct beneficiary cost sharing amounts. We encourage sponsors to review their claims system programming to ensure claims are processed in accordance with the beneficiary's plan benefit design. In instances where claims are processed incorrectly and those claims are re-processed, many sponsors delegate the responsibility to reimburse beneficiaries for overpayments to providers. However, it is ultimately the sponsor's responsibility to ensure beneficiaries are refunded all amounts incorrectly collected, either through the provider or the sponsor directly. This responsibility may entail conducting outreach to providers to ensure that beneficiaries have been refunded any overcharges.

CONCLUSION

We hope sponsors will use the information in this report to inform their internal auditing, monitoring, and compliance activities. We continue to encourage your feedback on the contents of this report and look forward to continued collaboration with the sponsor community and their partners in developing new approaches to improve compliance.