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Improving outcomes of Compliance Program Effectiveness audits

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Each year, the Centers for Medicare & Medicaid Services (CMS) conducts its rigorous Medicare program audits by carefully selecting a percentage of Medicare Advantage (MA) and Prescription Drug Plan (Part D) organizations for review.

As Plan sponsors know, the Compliance Program Effectiveness (CPE) audit, as a component of the annual program audit, is considered to be the most rigorous and demanding audit within the six individual program audits. Several factors contribute to this:

- The CPE audit requires significant resources from both operational and compliance areas to respond to the audit requirements.
- The CPE audit is the only individual program audit that is conducted on-site at the Plan sponsor's headquarters.
- Plan sponsors must provide live presentations to CMS auditors regarding targeted operational issues that CMS discovers in the CPE universes and supporting documentation.
- The CPE audit is a formidable and challenging endeavor.

In our experience helping Plan sponsors prepare for CMS audits, we take a historical approach in counseling sponsors regarding past findings of CPE audits. Simply put, those who don't know history are bound to repeat it. The case for this is based on the fact that CMS publishes annual audit reports that detail widespread, repetitive issues across the Medicare Part C and Part D programs.

In our research into CMS audit archives, we have studied and compiled CPE audit performance and CMS common findings from 2013 through 2016. The results demonstrate that even though CMS provides formal guidance in Chapter 21, findings in yearly audit reports and supplemental guidance through Health Plan Management System (HPMS) memos, certain issues continue to recur.

A look at recent CPE audit outcomes

In the last several years, overall program audit scores have shown improvements from an average high of 2.20 in 2013 to 1.22 in 2016. In tandem with this drop in overall scores (lower numbers indicate improvement), the average number of conditions has dropped from 38 in 2012 to under 18 in 2016. CMS findings suggest that newer sponsors (i.e., those that have offered Medicare contracts for five years or less) tend to score somewhat higher audit scores than more experienced sponsors. And, Plan sponsors who have not been audited in the last three to five years tend to struggle more with CPE audits.

CMS reasons that more experienced Plans have had the benefit of time on their side to familiarize themselves

with operational and compliance program regulatory guidance and time to build operations around that guidance. Established Plans have also experienced at least one CMS audit and multiple mock audits, which allows an opportunity to remediate deficiencies that should not recur.

The implications of these findings suggest that Plans that have not been audited in the last three to five years and young Plans in the market are susceptible to audit deficiencies. And, while audit scores have improved, there are areas of repeated deficiencies.