DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500
Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP

April 1, 2025

Mr. Michael Carson
Chief Executive Officer, Medicare
Centene Corporation
7700 Forsyth Boulevard
Clayton, MO 63105

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug and Prescription Drug Plan Contract Numbers H0022, H0351, H0562, H0908, H1032, H1395, H1416, H1664, H1774, H2117, H2128, H2491, H2915, H3561, H4868, H5087, H5294, H5439, H5590, H6815, H7323, H8189, H9630, H9900, S4802

Dear Mr. Carson:

Pursuant to Section 5.3.14 of the MyCare (Ohio) contract and 42 C.F.R. §§ 422.752(c)(1), 422.760(c), 423.752(c)(1), and 423.760(c), the Centers for Medicare & Medicaid Services (CMS) is providing notice to Centene Corporation (Centene), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$20,648** for Medicare-Medicaid Plan (MMP) Contract Number H0022 and Medicare Advantage-Prescription Drug (MA-PD) and Prescription Drug Plan (PDP) Contract Numbers H0022, H0351, H0562, H0908, H1032, H1395, H1416, H1664, H1774, H2117, H2128, H2491, H2915, H3561, H4868, H5087, H5294, H5439, H5590, H6815, H7323, H8189, H9630, H9900, and S4802.

An MMP, MA-PD and PDP organization's[1] primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that Centene failed to meet that responsibility.

Summary of Noncompliance

CMS conducted an audit of Centene's Medicare operations from May 6, 2024 through May 24, 2024. In a program audit report issued on September 9, 2024, CMS auditors reported that Centene failed to comply Medicare requirements related to Part D coverage determinations, appeals, and grievances in violation of 42 C.F.R. Part 423, Subpart M.[2]

[1] Referenced collectively as "plan sponsor".
[2] Per Appendix D, "Part D Addendum", of the MyCare (Ohio) contract, MMPs must comply with Part D requirements including those in 42 C.F.R. Part 423, Subpart M.

One (1) failure was systemic and adversely affected, or had the substantial likelihood of adversely affecting enrollees because the enrollees experienced delayed access to medications or appeal rights, paid out-of-pocket costs for medications, or never received medications.

CMS reviews audit findings individually to determine if an enforceable violation has occurred warranting a CMP. CMPs are calculated and imposed when a finding of non-compliance adversely affected or had a substantial likelihood of adversely affecting enrollees. The determination to impose a CMP on a specific finding does not correlate with the plan sponsor's overall audit performance.

Part D Coverage Determinations, Appeals, and Grievances Relevant Requirements
(42 C.F.R. Part 423, Subpart M)

A Medicare enrollee has the right to contact his or her plan sponsor to express general dissatisfaction with the plan sponsor's operations, activities, or behavior, or to make a specific complaint about the denial of coverage for Part D drugs which the enrollee believes he or she is entitled to receive. Plan sponsors are required to classify general complaints about benefits or the plan sponsor's operations or activities as grievances. Plan sponsors are required to classify complaints about coverage for drugs and payment as Part D coverage determinations. It is critical for a plan sponsor to properly classify each complaint as a grievance, coverage determination/appeal, or both. Improper classification may result in enrollees not receiving the required level of review and/or experiencing delayed access to medically necessary or life-sustaining drugs.

A Part D coverage determination is any determination made by the plan sponsor, or its delegated entity, with respect to a decision about whether to provide or pay for a drug that an enrollee believes may be covered by the plan sponsor, including a decision related to a Part D drug that is not on the plan's formulary, determined not to be medically necessary, furnished by an out-of-network pharmacy, or otherwise excluded under section 1862(a) of the Social Security Act if applied to Medicare Part D.

An enrollee, enrollee's representative, or enrollee's treating physician or prescriber may make a request for a coverage determination. If the coverage determination is adverse (i.e., not in favor of the enrollee), the enrollee has the right to file an appeal. The first level of appeal - called a redetermination – is handled by the plan sponsor and must be conducted by a person who was not involved in the coverage determination decision. The second level of appeal is made to an independent review entity (IRE) that contracts with CMS. If the sponsor does not issue the reconsideration decision timely, the decision is considered to be unfavorable to the enrollee and must be automatically sent to the IRE.

Violation Related to Part D Coverage Determinations, Appeals, and Grievances

CMS determined that Centene failed to process coverage requests for Part D drugs. Specifically, when enrollees submitted coverage or appeal requests as part of a complaint, Centene did not initiate the request until a fax request form was returned from the prescriber.

In addition, Centene's staff did not consistently identify and initiate coverage or appeal requests when received with grievances. As a result, there is a substantial likelihood that enrollees did not receive their Part D drug timely or at all, paid more for the requested drug, or did not receive their appeal rights timely or at all. Centene's failure of Part D coverage determinations and appeal requirements violates 42 C.F.R. § 423.564(b).

Basis for Civil Money Penalty

Pursuant to Section 5.3.14.2.2 of the MyCare (Ohio) contract, 42 C.F.R. §§ 422.752 (c)(1)(i) and 423.752(c)(1)(i), CMS may impose a CMP for any determination made under 42 C.F.R. §§422.510 (a) and 423.509(a). Specifically, CMS may issue a CMP if a plan sponsor has failed substantially to carry out its contract. Pursuant to 42 C.F.R. §§422.760(b)(2) and 423.760(b)(2), a penalty may be imposed for each enrollee directly adversely affected (or with the substantial likelihood of being adversely affected) by the deficiency.

CMS has determined that Centene failed substantially:

- To carry out the terms of its contract with CMS (42 C.F.R. § 423.509(a)(1)).
- To comply with the requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 423.509(a)(4)(ii)).
- To comply with federal regulatory requirements related to MyCare (Ohio) contract with CMS (Section 5.3.14.1.6).

Centene's violations of Part D requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP.

Right to Request a Hearing

Centene may request a hearing to appeal CMS's determination in accordance with the procedures outlined in 42 C.F.R. Parts 422 and 423, Subpart T. Centene must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by June 2, 2025[3]. The request for hearing must identify the specific issues and the findings of fact or conclusions of law with which Centene disagrees. Centene must also specify the basis for each contention that the finding or conclusion of law is incorrect.

The request should be filed through the DAB E-File System (https://dab.efile.hhs.gov) unless the party is not able to file the documents electronically. If a party is unable to use DAB E-File, it must send appeal-related documents to the Civil Remedies Division using a postal or commercial delivery service at the following address:

Civil Remedies Division
Department of Health and Human Services

[3] Pursuant to 42 C.F.R. §§ 422.1020(a)(2) and 423.1020(a)(2), the plan sponsor must file an appeal within 60 calendar days of receiving the CMP notice. The 60th day falls on a weekend or holiday, therefore the date reflected in the notice is the next regular business day for you to submit your request.

Departmental Appeals Board
Medicare Appeals Council, MS 6132 330
Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

Please see https://dab.efile.hhs.gov/appeals/to_crd_instructions for additional guidance on filing the appeal.

A copy of the hearing request should also be emailed to CMS at the following address:

Kevin Stansbury
Director
Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
Email: kevin.stansbury@cms.hhs.gov

If Centene does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on June 2, 2025. Centene may choose to have the penalty deducted from its monthly payment or transfer the funds electronically. To notify CMS of your intent to make payment and for instructions on how to make payment, please email the enforcement contact provided in the email notification.

Impact of CMP

Further failures by Centene to provide its enrollees with Medicare benefits in accordance with CMS requirements may result in CMS imposing additional remedies available under law, including contract termination, intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

If Centene has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

John A. Scott
Director

Medicare Parts C and D Oversight and Enforcement Group
cc: Ashley Hashem, CMS/OPOLE
Michael Taylor, CMS/OPOLE
Verna Hicks, CMS/OPOLE

Kirsten Duval, CMS/OPOLE
Eric Hansen, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/DCE