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

January 17, 2025

Ms. Aimee Dailey
President Medicare Programs
Elevance Health, Inc.
5800 Northampton Blvd
Norfolk, VA 23502

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug Contract Numbers: H1894, H1947, H2593, H3240, H3447, H3536, H3655, H4036, H4346, H5422, H5471, H5828, H5854, H8432, H8552, H8849, H9065, and H9525

Dear Ms. Dailey:

Pursuant to 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 Elevance Health, Inc. (Elevance), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$149,060** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers: H1894, H1947, H2593, H3240, H3447, H3536, H3655, H4036, H4346, H5422, H5471, H5828, H5854, H8432, H8552, H8849, H9065, and H9525.

An MA-PD 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 Elevance failed to meet that responsibility.

Summary of Noncompliance

In 2023, CMS conducted an audit of Elevance's 2021 Medicare financial information. In financial audit reports issued on May 24, 2023, June 15, 2023, and June 21, 2023, CMS auditors reported that Elevance failed to comply with Medicare requirements related to Part C cost sharing and Part C maximum out-of-pocket (MOOP) limit requirements in violation of 42 C.F.R. Part 422, Subparts C and F. More specifically, auditors found that in 2021, Elevance overcharged enrollees for Part C medical services and charged enrollees more than the annual Part C MOOP limits. Elevance's failure to comply with Medicare Part C requirements adversely affected (or had the substantial likelihood of adversely affecting) enrollees because they may have experienced increased out-of-pocket costs.

[1] Referenced collectively as "plan sponsor".

Part C Cost Sharing Requirements *(42 C.F.R. §§ 422.111(b), 422.254, and 422.270; and Chapter 4, Section 50 of the Medicare Managed Care Manual (IOM Pub. 100-16))*

Every year, a plan sponsor must submit to CMS an aggregate monthly bid amount which must include a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of the deductibles, coinsurance, and copayments. When the bid is approved by CMS the plan sponsor must provide to each enrollee a description of the benefits offered under a plan, including the applicable cost-sharing for the benefits (see 42 C.F.R. § 422.111(b)). The plan sponsor must not charge an enrollee a different amount from what was approved in the bid and disclosed to the enrollee for that benefit. Pursuant to 42 C.F.R. § 422.270(b), if the plan sponsor charges amounts in excess of the agreed upon cost-sharing, then the plan sponsor must agree to refund all amounts incorrectly collected from its Medicare enrollees.

Violation Related to Part C Cost Sharing Requirements

CMS determined that Elevance failed to comply with cost sharing requirements by charging incorrect coinsurance amounts. More specifically:

- Elevance calculated enrollee cost sharing amounts based on 100% of the Medicare physician fee schedule instead of 85% of the fee schedule due to a system configuration error. As a result, provider claims were paid incorrectly, and enrollees were overcharged for their coinsurance[2].
- Elevance lab claims were processed at a higher carrier priced fee schedule rate instead of at the clinical lab fee schedule rate, as a result of a system configuration issue. As a result, provider claims were paid incorrectly, and enrollees were overcharged for their coinsurance[3].
- Elevance's claims processing system was not configured to correctly recognize the provider specialty for telehealth claims. As a result, enrollees were charged a $40 copay for telehealth services instead of a $0 copay, as specified in their benefits[4].

In all of these situations, Elevance did not ensure enrollees were refunded until after the financial audit, which was approximately two to three years after the incurred costs. Elevance's failure to comply with cost sharing requirements violates 42 C.F.R. § 422.270(b).

Part C Maximum Out-of-Pocket Limit Requirements *(42 C.F.R. §§ 422.100(f)(4) and (5) and Health Plan Management System (HPMS) Memo, Final Contract Year 2021 Part C Benefits Review and Evaluation, April 8, 2020)*

Medicare Advantage (MA) organizations must have an enrollee in-network MOOP amount for basic benefits that is no greater than the annual limit calculated by CMS. In addition, MA Preferred Provider Organization (PPO) plans must also establish a combined MOOP amount for

[2] This violation affects contracts H3447, H3655, and H4036.
[3] This violation affects contracts H1894, H1947, H2593, H3240, H3447, H3536, H3655, H4036, H4346, H5422, H5471, H5828, H5854, H8432, H8849, H9065, and H9525.
[4] This violation affects contracts H3447, H3536, H3655, H4036, H5422, H5854, H8432, H8552, H9065, and H9525.

basic benefits that are provided in-network and out-of-network. MA organizations are responsible for tracking out-of-pocket spending accrued by their enrollees and must alert enrollees and contracted providers when the plan's MOOP amounts are reached. MA organizations must not charge an enrollee in excess of MOOP limits.

Violation Related to Part C Maximum Out-of-Pocket Limit Requirements

CMS determined that Elevance failed to comply with MOOP requirements by failing to track enrollee out-of-pocket spending and charging enrollees more than the annual MOOP limit. More specifically, the plan incorrectly configured its system to apply the 2022 plan year MOOP limit of $7,300 instead of the 2021 plan year MOOP limit of $6,950. As a result, enrollees paid amounts in excess of their annual MOOP limit[5]. Elevance's failure to comply with MOOP limit requirements violates 42 C.F.R. §§ 422.100(f)(4) and (5).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 422.752(c)(1)(i), CMS may impose a CMP for any determination made under 42 C.F.R. § 422.510(a)(1). Specifically, CMS may issue a CMP if a MA-PD has failed substantially to carry out its contract. Pursuant to 42 C.F.R. § 422.760(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 Elevance failed substantially to carry out the terms of its contract (42 C.F.R.§ 422.510(a)(1)) by substantially failing to comply with requirements at 42 C.F.R. Part 422, Subparts C and F. Elevance's violations of Part C requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrant the imposition of a CMP.

Right to Request a Hearing

Elevance 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. Elevance must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by March 19, 2025[6]. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Elevance disagrees. Elevance 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:

[5] This violation affects contracts H5854.
[6] 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.

Civil Remedies Division
Department of Health and Human Services
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
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C1-22-06
Email: kevin.stansbury@cms.hhs.gov

If Elevance 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 March 20, 2025. Elevance 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 call or email the enforcement contact provided in the email notification.

Impact of CMP

Further failures by Elevance 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 Elevance 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
Adams Solola, CMS/OPOLE
Kenvin Ivory-Kennedy, CMS/OPOLE
Nicholas Rodriguez, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/DCE