

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601



Drug & Health Plan Operations Group (DHPO)

CORRECTIVE ACTION PLAN (CAP) REQUEST

February 13, 2023

Contract IDs: H2593, H3240, H3447, H3655, H4346, H5422, H5817, H7200, H8432, H9525, H9886, R5941

Ms. Michelle Turano
Vice President, Medicare Compliance
Elevance Health, Inc.
4200 W. Cypress Street
Tampa, FL 33607

VIA EMAIL: MedicareCO@anthem.com

RE: Corrective Action Plan (CAP) for failure to follow administrative appeals process for non-contracted providers

Dear Ms. Turano:

The Centers for Medicare & Medicaid Services (“CMS”) is issuing this determination for a Corrective Action Plan (“CAP”) to ELEVANCE HEALTH, INC. (“Elevance”), which operates the contract IDs listed above. This determination relates to Elevance’s failure to follow the CMS Medicare Advantage (“MA”) administrative appeals process which grants non-contracted providers the right to appeal adverse payment determinations which are reopened and revised on post-payment review. Accordingly, CMS directs Elevance to take corrective action to address the identified areas of non-compliance.

On July 1, 2019, Amerigroup, whose parent organization is Elevance, initiated a post-payment audit of claims for presumptive and definitive urine drug testing (“UDT”) services submitted by Aegis Sciences Corporation (“Aegis”), a non-contracted clinical laboratory. In a letter dated May 19, 2020, Amerigroup notified Aegis that all 50 claims in the audit sample were found to be deficient which, through extrapolation, resulted in an overpayment determination of \$1,606,913.08. The audit result letter provided Aegis 15 days to submit a rebuttal statement but

did not include information on the MA administrative appeals process. Aegis, through a letter dated May 27, 2020, disputed Amerigroup's findings, the overpayment determination, and requested information on its appeal rights. Amerigroup's response, dated June 10, 2020, stated, "[g]iven Aegis's primarily non-participating status with Amerigroup, there is not a formal appeals process." Amerigroup reiterated this position in subsequent letters, including, on October 29, 2020, when Amerigroup stated it "does not consider the overpayment determination on previously paid claims reopenings under applicable law . . . [because] reopenings [only] occur if the plan changes a previously binding determination it made on a [pre-service] request for coverage" Amerigroup continued to refuse to process Aegis' appeal requests until CMS intervened in May 2022.

The federal regulations at 42 C.F.R., Part 422, Subpart M, create an administrative process for MA enrollees and non-contracted providers to appeal certain adverse plan determinations. Included in this administrative appeal structure, by incorporation of portions of Part 405 (*see* §§ 422.562(d)(1) (non-conflicting administrative review regulations of Part 405 apply to Subpart M) and 422.616(a) (inclusion of reopening procedures of Part 405 to Subpart M)), is the right for qualified parties to appeal post-payment review decisions that result in revised payment determinations. MA organizations are required to inform parties in writing of the right to appeal revised adverse determinations. § 405.982.

In this case, Elevance: (1) failed to inform Aegis of its right to appeal 50 revised adverse payment determinations, as required by 42 C.F.R. § 405.982; (2) obstructed Aegis' right to appeal 50 revised adverse payment determinations, pursuant to §§ 422.578 and 422.616(d), by repeatedly furnishing erroneous information on the MA appeals process over the course of two years; (3) failed to adjudicate Aegis' repeated appeal requests in accordance with the timeframes established at § 422.590; and (4) failed to forward the untimely appeal decisions to the Part C Independent Review Entity ("IRE"), pursuant to 42 C.F.R. § 422.590(d).

The above findings support a determination by CMS that Elevance failed to comply with the requirements at 42 C.F.R., Part 422, Subpart M.

CMS requests that Elevance implement a detailed Corrective Action Plan (CAP). As part of this CAP, Elevance should address the actions listed below, plus any other additional items that Elevance identifies as necessary to correct this problem and prevent it from reoccurring. Because of the complexity and sensitivity of this matter, CMS will review materials and intermediary implementation steps throughout the process. Further, our engagement throughout this process will provide CMS with the information we need to eventually close the CAP.

- Provide to CMS confirmation that Elevance is providing appeals rights to non-contracted providers subject to post-payment reviews that result in revised payment determinations. This should include a review of all 2022 post-payment reviews performed by Elevance on non-contracted provider claims to determine whether appeals rights were provided appropriately, with a summary provided to CMS.

- Completely revise policies and procedures related to the right for non-contracted providers to appeal revised post-payment determinations, to conduct requested reconsiderations, and to forward cases to the Part C IRE for additional review as required, reflecting current CMS guidance and effective quality assurance processes.

By March 15, 2023, please send a timeline for implementing each element of Elevance's CAP to your Regional Office account managers, Albert Licup (albert.licup@cms.hhs.gov) and Elizabeth Smith (elizabeth.smith@cms.hhs.gov). CMS is issuing this compliance notice pursuant to 42 C.F.R. § 423.509(c), which requires CMS to afford an account at least 30 days to develop and implement a corrective action plan to correct deficiencies before taking steps to terminate a account's Medicare contract. While CMS is not obligated to grant a greater than 30-day cure period, we acknowledge that an extended period may be appropriate, depending on the nature of the correction required. CMS advises that, for any part of its timeline scheduled to be completed in more than 30 days, Elevance provide a justification of the need for that additional time. CMS expects that the correction timeline will be no longer than absolutely necessary and will reflect an appropriate level of urgency in resolving this matter.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. CMS deems this instance of non-compliance a Part C issue. CMS notes that we are issuing this compliance notice based exclusively on information that we obtained from sources other than your organization's self-disclosure.

CMS has the authority to impose sanctions, penalties and other enforcement actions as described in Federal regulations at 42 C.F.R., Part 423, Subpart O. Should your organization fail to develop, implement or complete its CAP, CMS may consider the imposition of intermediate sanctions (e.g., suspension of marketing and enrollment activities) or civil money penalties.

If you have any questions regarding this letter, please contact your Regional Office account managers, Albert Licup, at (312) 353-9847 or albert.licup@cms.hhs.gov, and Elizabeth Smith, at (312) 886-0792 or elizabeth.smith@cms.hhs.gov.

Sincerely,

Raymond Swisher
Deputy Group Director
Centers for Medicare & Medicaid Services
Drug & Health Plans Operations— CHI-KC Group

cc via email:

Christine Reinhard, CMS Baltimore

Thomas Plumley, CMS Baltimore

Adams Solola, Acting Division Director, DHPO, CMS Chicago

Albert Licup, CMS Chicago

Elizabeth Smith, CMS Chicago