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

July 14, 2015

Mr. Jeffrey C. Ingrum
Chief Executive Officer
The Carle Foundation
301 S. Vine Street
Urbana, IL 61801

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug Contract Numbers: H1417 and H1737

Dear Mr. Ingrum:

Pursuant to 42 C.F.R. § 422.752(c)(1), § 422.760(b), § 423.752(c)(1), and § 423.760(b), the Centers for Medicare & Medicaid Services (CMS) is providing notice to The Carle Foundation (hereinafter referred to as "Sponsor"), that CMS has made a determination to impose a Civil Money Penalty (CMP) in the total amount of **$34,445** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers: H1417 (Health Alliance Medical Plans) and H1737 (Health Alliance-Midwest).

CMS has determined that Sponsor failed to provide clear and accurate benefit information to its enrollees in the combined Contract Year (CY) 2015 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents.

Summary of Noncompliance

Sponsor reported to CMS that 2,364 of its enrollees received inaccurate information about their 2015 benefits in Sponsor's CY 2015 ANOC and EOC documents. For contract H1417, Plan Benefit Packages (PBP) 003 and 004, 2,161 enrollees received an ANOC that did not include copayment amounts for out-of-network skilled nursing facility (SNF) benefits, when the costs for those benefits significantly increased between 2014 and 2015. Sponsor mailed an errata sheet correcting these omissions on December 5, 2014. This was 2 days before the open enrollment period ended, and therefore, affected the time in which enrollees could use the information to make a fully informed decision about their Medicare health care and prescription drug options for the 2015 plan benefit year.

For contract H1737-001, 203 enrollees received ANOC/EOC documents that contained numerous inaccuracies, many of which incorrectly conveyed lower-cost sharing and more extensive benefits under the plan. The most egregious inaccuracies included were:

- The ANOC incorrectly listed the maximum-out-of-pocket amount (MOOP) as $2,900, when the correct MOOP amount is $4,500.
- The ANOC incorrectly listed the copayment amounts for doctors' office visits as $10 per primary care doctor visit and $30 per specialist visit, when the correct copayment amounts are $20 per primary care visit and $50 per specialist visit.
- The ANOC incorrectly listed the copayment amount for inpatient hospital stays as $235 per day for days 1–8, when the correct copayment amount is $345 per day for days 1–5.
- The ANOC incorrectly listed the Part D prescription drug deductible as $20, when the correct information is a $70 deductible.
- The EOC incorrectly listed the copayment amount for inpatient hospital care as $270 per day for days 1–7, when the correct copayment amount is $345 per day for days 1–5.
- The EOC incorrectly listed the copayment amounts for physician/practitioner services as $15 per primary care doctor visit and $40 per specialist visit, when the correct copayment amounts are $20 per primary care visit and $50 per specialist.

Sponsor mailed two separate errata sheets correcting these inaccuracies on November 12, 2014. This was almost a month after the open enrollment period had started, and therefore, affected the time in which enrollees could use the information to make a fully informed decision about their Medicare health care and prescription drug options for the 2015 plan benefit year.

Relevant Disclosure and Information Dissemination Requirements

Pursuant to 42 C.F.R. § 422.111(a) and § 423.128(a), MA-PD Sponsors are required to ensure that members receive clear and accurate ANOC/EOC documents by September 30th of each year. The ANOC and EOC provide vital information to Medicare beneficiaries about their plan and permit beneficiaries to make informed choices concerning Medicare health care and prescription drug options for the upcoming plan year. Organizations are required to ensure their ANOC/EOCs are accurate and mail errata sheets if inaccuracies are identified. Since 2009, CMS has clearly informed plans about the importance of providing beneficiaries with accurate ANOC/EOC documents and noted that plans would be subject to penalties for inaccuracies.

Violations Related to Disclosure and Information Dissemination Requirements

CMS identified a violation of the disclosure and information dissemination requirements that had the substantial likelihood of adversely affecting Sponsor's enrollees. Sponsor's violation includes:

1. Failure to provide clear and accurate benefit information to its enrollees for the 2015 Medicare Open Enrollment Period. As a result, enrollees did not receive accurate benefit information to make fully informed choices concerning their Medicare coverage for the 2015 plan benefit year. This is in violation of 42 C.F.R. § 422.111(a) and 42 C.F.R. § 423.128(a).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 422.752(c)(1), § 422.760(b), § 423.752(c)(1), and § 423.760(b), CMS has determined that Sponsor's violations of Parts C and D requirements had the substantial likelihood of adversely affecting enrollees and warrants the imposition of a CMP. Sponsor is carrying out its contract in a manner that is "inconsistent with the effective and efficient implementation of this part." *See* 42 C.F.R. §422.510(a)(2) and §423.509(a)(2).

Right to Request a Hearing

Sponsor 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. Sponsor must send a written request for a hearing to the Departmental Appeals Board office listed below within 60 calendar days from receipt of this notice or by September 14, 2015. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Sponsor disagrees. Sponsor must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

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

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

Michael DiBella
Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C1-22-06
Email: Michael.Dibella@cms.hhs.gov

If Sponsor 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 September 15, 2015. Sponsor may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS. 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.

Please note that further failures by Sponsor may result in additional applicable remedies available under law, up to and including contract termination, the imposition of intermediate

sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

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

Sincerely,

/s/

Gerard J. Mulcahy
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Heather Lang, CMS/ CMHPO/Region V
Dolores Perteet, CMS/ CMHPO/Region V
Timothy Lape, CMS/CMHPO/Region V