

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**

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October 24, 2013

**VIA:**  
**EMAIL ([mfn@centene.com](mailto:mfn@centene.com))**

Michael F. Neidorff  
Chief Executive Officer  
Centene Corporation  
7700 Forsyth Boulevard  
St. Louis, MO 63105  
Phone: 314-505-6331

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage - Prescription Drug Plan Contracts: Superior Health Plan, Inc. (H5294) and Managed Health Services Wisconsin (H8189)

Dear Mr. Neidorff:

Pursuant to 42 C.F.R. §422.752(c)(1), §422.756(f), §422.760(b), §423.752(c)(1), §423.756(f), and §423.760(b), 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 \$25,710 for violations in Medicare Advantage - Prescription Drug Plan (MA-PD) contract numbers H5294 and H8189.

**Basis for Civil Money Penalty**

This action is based on your organization's failure to provide accurate benefit and coverage information to enrollees in the combined Contract Year 2013 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents, in violation of 42 C.F.R. §422.64, §422.111, §423.48, and §423.128. As a result, CMS has determined that your organization is carrying out its contract in a manner "inconsistent with the effective and efficient implementation of this part." See 42 C.F.R. §422.510(a)(2) and §423.509(a)(2).

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. Since 2009, CMS has clearly informed plans about the importance of accuracy in these documents and noted that plans would be subject to penalties for lateness and inaccuracy. Fifteen (15) sponsors have been assessed civil money penalties for inaccurate documents since 2010. On May 31, 2012, CMS released the standardized Annual Notice of Change (ANOC) and

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Evidence of Coverage (EOC) model letters, including the standardized Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) templates.

On January 08, 2013, CMS issued a notice reminding organizations that CMS conducts an annual analysis of the accuracy of ANOC/EOC documents. Organizations are required to ensure their ANOC/EOCs are accurate and mail errata sheets if inaccuracies are identified. Based on the information provided by your organization, CMS concluded that 1,834 members in Centene's contract number H5294 and 737 members in Centene's contract number H8189 were not provided accurate ANOC/EOC materials.

Based on the information provided by your organization, CMS determined that the following incorrect statements were made in the ANOC/EOC documents:

- Centene incorrectly stated that beneficiaries do not have a coverage gap.
- Centene incorrectly stated the limit for the Initial Coverage Stage as \$4,750. The correct limit is \$2,970.

CMS has determined that the failure by your organization to mail accurate ANOC/EOC documents to Medicare enrollees is a deficiency which directly adversely affected or had the substantial likelihood of adversely affecting these enrollees. Centene failed to provide Medicare enrollees with vital information about their benefits and cost-sharing that would have allowed them to make fully informed choices concerning their Medicare health care and prescription drug options during the 2013 Medicare Annual Open Enrollment Period.

### **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 written request for a hearing to the Departmental Appeals Board office listed below within 60 calendar days from receipt of this notice, or by December 24, 2013. 42 C.F.R. §§ 422.1006, 423.1006, 422.1020, and 423.1020. The request for a hearing must identify the specific issues and the findings of fact and 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 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:

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Michael Dibella, Acting Director, Division of Compliance Enforcement  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
MAIL STOP: C1-22-06  
Baltimore, MD 21244  
Email: [mike.dibella@cms.hhs.gov](mailto:mike.dibella@cms.hhs.gov)  
FAX: 410-786-6301

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 December 26, 2013. Centene may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS.

Please note that any further failures by Centene to comply with these or any other CMS requirements may subject your organization to other applicable remedies available under law, including 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 Centene 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: Janice Snyder, CMS/CMHPO/Region X  
Roya Rezai, CMS/CMHPO/Region X  
Brenda Suiter, CMS/CMHPO/Region X