

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

March 31, 2014

VIA EMAIL: (Paul.Tufano@ibx.com)

Paul Tufano
Exec VP, General Counsel & President of Government Markets
Independence Blue Cross
1901 Market Street, 45th floor
Philadelphia, PA 19103
Phone: 215-241-3825

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage - Prescription Drug Plan Contract Numbers: H3156, H3909, H3952, S2321, S6875

Dear Mr. Tufano:

Pursuant to 42 C.F.R. §422.752(c)(1), §422.756(e), §422.760(b), §423.752(c)(1), §423.756(e), and §423.760(b), the Centers for Medicare & Medicaid Services (CMS) is providing notice to Independence Blue Cross (IBC), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **\$50,000** for violations in Medicare Advantage - Prescription Drug Plan (MA-PD) contract numbers H3156, H3909, H3952, S2321, S6875.

CMS has determined that IBC failed to process enrollments and disenrollments in accordance with CMS requirements. A Medicare Advantage and Prescription Drug Plan sponsor's central mission is to provide Medicare beneficiaries with medical services and prescription drug benefits within a framework of Medicare requirements that provide plan enrollees with a number of protections. Successful processing of enrollment and disenrollment transactions is essential to providing beneficiaries with timely health services and benefits without interruption.

Relevant Enrollment Requirements

To receive Part C and Part D benefits, Medicare beneficiaries elect to enroll in a MA-PD offered by an organization that contracts with CMS. An MA-PD sponsor must timely process an individual's enrollment request in accordance with CMS enrollment guidelines. *See* 42 C.F.R. §§ 422.60(e), 423.32(c). Additionally, the sponsor has the responsibility to coordinate enrollment and disenrollment transactions in a manner consistent with guidelines as specified by 42 C.F.R. §§ 422.60, 422.66, 422.74, 423.32, 423.36, and 423.44. This includes assigning individuals to their elected plans, transmitting enrollment data to CMS and maintaining accurate information on beneficiaries' eligibility.

Any failure of a MA-PD's data systems to accurately reflect the correct enrollment or disenrollment of a beneficiary may result in inaccurate records of the beneficiaries' enrollment history. Fixing these records in the MA-PD's and CMS's systems may cause a series of cascading issues for beneficiaries. For example, once the beneficiaries' records have been corrected, they may incur retroactive costs, such as higher premiums and higher co-insurance/co-pays for services or prescription medications. These are costs that the beneficiaries may not have been aware of while utilizing the MA-PD's services. In addition, correcting the beneficiaries' records may result in late enrollment penalties (LEP) for beneficiaries, given that there could be a break in prescription drug coverage for a continuous period of at least 63 days or longer. *See* 42 C.F.R. §§ 423.286(d)(3) and 423.46(a). Ultimately, the longer the beneficiaries' records remain incorrect, the harder it becomes to fix the issues for beneficiaries and the more problems arise.

History of Noncompliance

IBC has had ongoing significant issues related to their ability to process enrollments and disenrollments as required in 42 C.F.R. §§422.60, 422.66(b), 422.74, 423.32, 423.36, and 423.44. On February 27, 2009, IBC disclosed enrollment reconciliation discrepancies between CMS' enrollment system (MARx) and IBC's internal enrollment systems. Throughout 2009, CMS assisted IBC with the correction of enrollment reconciliation efforts. However, IBC's continued failure to properly reconcile its enrollment data resulted in CMS issuing an Ad Hoc Corrective Action Plan on February 3, 2010, and also advised IBC that continued failures to comply with CMS requirements regarding continued deficiencies might form the basis for the imposition of applicable remedies available under law, including intermediate sanctions, penalties, or other contract or enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

IBC enrollment information was closely monitored by CMS during the corrective action timeframe. After IBC reported three consecutive months of compliant enrollment records, CMS released IBC from the Corrective Action Plan on April 11, 2011.

However, in October 2012, IBC hired an independent consultant to perform analysis of its enrollment/disenrollment reconciliation process. At the conclusion of the analysis in June 2013, IBC determined that numerous enrollment discrepancies had occurred between IBC and CMS systems.

Deficiencies Related to Enrollment and Disenrollment

IBC failed to process enrollment and disenrollment requests in accordance with CMS enrollment guidelines. This is a violation of 42 C.F.R. §§ 422.60, 422.66, 422.74, 423.32, 423.36, 423.44, and 423.46(b). As a result of this violation, IBC reported that:

- Beneficiaries are incorrectly enrolled in two (2) separate plans during concurrent/overlapping timeframes.
- Beneficiaries are incorrectly enrolled in IBC's medical only plan and another Part D prescription drug plan.

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- IBC's internal reconciliation system for enrollment and disenrollment were not consistent with the CMS's enrollment system (MARx). Therefore, in some cases, beneficiaries are listed as enrolled in IBC but not in MARx. In other cases, beneficiaries are listed as being disenrolled in IBC but were not disenrolled in MARx.
- Beneficiaries, who relocated outside the plan service area, were never disenrolled by IBC. Therefore, correcting these disenrollments may result in access to care issues and uncovered months for Part D coverage.
- Beneficiaries who must be retroactively disenrolled from IBC may incur a late enrollment penalty.
- IBC failed to properly report to CMS information received on beneficiaries' creditable prescription drug coverage months, and as a result, beneficiaries may incur a late enrollment penalty.

Due to IBC failures to properly report and reconcile its enrollments and disenrollments, IBC reported on August 23, 2013 that 223 beneficiaries' enrollment records are incorrect. In some cases, enrollment records have been incorrect since at least 2007. Correcting these errors may result in numerous issues for these beneficiaries, including but not limited to Late Enrollment Penalties, retroactive costs, and beneficiary confusion about coverage as IBC and CMS work to correct IBCs records.

Basis for Civil Money Penalty

Without waiver of any other claim, whether known or unknown, this action is based solely on your organization's failure to process enrollment and disenrollment requests in accordance with CMS enrollment and disenrollment guidelines (self-reported to CMS on August 23 2013), in violation of 42 C.F.R. §§ 422.60(e), 422.66(b), 423.32 (c) and (d) and 423.36. 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).

CMS has determined that the failure by your organization to process enrollment or disenrollment requests accurately and timely is a deficiency which directly adversely affected or had the substantial likelihood of adversely affecting these enrollees. These deficiencies have the potential to disrupt enrollees' access to prescription medications and health benefits and/or cause undue financial hardship as a result of inaccurate enrollment/disenrollment data.

Right to Request a Hearing

IBC may request a hearing to appeal CMS's determination in accordance with the procedures outlined in 42 C.F.R. §§ 422 and 423, Subpart T. IBC 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 June 2, 2014. 42 C.F.R. §§ 422.1006, 423.1006, 422.1020 and 423.1020. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which IBC disagrees. IBC must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

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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
MAIL STOP: C1-22-06
Baltimore, MD 21244
Email: Michael.Dibella@cms.hhs.gov

If IBC 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 3, 2014. IBC may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS.

Please note that further failures by IBC 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 IBC 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: James McCaslin, ARA/CMHPO/Region III
Tamara McCloy, Branch Manager/CMHPO/Region III
Kevin Berna, Account Manager/CMHPO/Region III