

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



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**MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP**

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May 1, 2026

Mr. Jim Parker  
Chief Executive Officer  
Group 1001  
250 South Northwest Highway, Suite 302  
Park Ridge, IL 60068

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug  
Contract Numbers: H3071, H5454, H6379, H6672, and H9589

Dear Mr. Parker:

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 Group 1001, that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **\$84,190** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers: H3071, H5454, H6379, H6672, and H9589.

An MA-PD organization's<sup>1</sup> primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that Group 1001 failed to meet that responsibility.

**Summary of Noncompliance**

In 2024, CMS conducted an audit of Group 1001's 2022 Medicare financial information. In financial audit report issued on June 12, 2024, CMS auditors reported that Group 1001 failed to comply with Medicare requirements related to Part C cost sharing and Part C maximum out-of-pocket (MOOP) limits in violation of 42 C.F.R. Part 422, Subparts C and F. More specifically, auditors found that in 2022, Group 1001 overcharged enrollees for Part C medical services and charged enrollees more than the annual Part C MOOP limits. Group 1001'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.

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<sup>1</sup> Referenced 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. A plan sponsor is also required to ensure uniform levels of cost-sharing throughout its service area or, where applicable, a segment of its service area (see 42 C.F.R. 422.100(d)(2)). 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 Group 1001 failed to comply with cost sharing requirements by charging incorrect copayment and coinsurance amounts. Group 1001 experienced multiple systemic claims processing configuration errors that resulted in incorrect payment methodologies and non-compliance with Medicare requirements. There were three root causes that contributed to this issue.

- First, Group 1001 failed to ensure accurate loading of contracted provider payment rates into its claims processing system.
- Second, Group 1001 established multiple payment rates for a single contract based on how individual providers were credentialed within the group. However, its claims processing system had a limitation that prevented it from handling more than one rate for a single contract.
- Finally, Group 1001 mistakenly enrolled beneficiaries into incorrect plans causing claims to be processed under the wrong plan. When these claims were reprocessed, they were not flagged as duplicate claims.

As a result, enrollees were overcharged copayments and coinsurance amounts for various Part C services. Group 1001 did not ensure enrollees were refunded until after the issue was identified on audit, which was several years after the incurred costs. Group 1001's failure to comply with cost sharing requirements violates 42 C.F.R. §§ 422.100(d)(2) and 422.270(b).

**Part C Maximum Out-of-Pocket Limit Requirements** (42 C.F.R. §§ 422.100(f)(4) and (5))

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 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 Group 1001 failed to comply with MOOP requirements by failing to track enrollee out-of-pocket spending and charging enrollees more than the annual MOOP limit. There were two root causes that contributed to this issue.

- First, Group 1001's system configuration error caused the out-of-pocket maximum tracking system to incorrectly use claim service dates instead of the current processing date when determining annual MOOP accumulations.
- Second, Group 1001 failed to combine different types of payments (e.g., copays, coinsurance, and deductibles) toward enrollee out-of-pocket maximums due to an issue with system configuration. Instead, these payments were being tracked in two separate locations that did not integrate with each other.

As a result, enrollees paid amounts over their annual MOOP limit. Group 1001'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 Group 1001 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. Group 1001'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**

Group 1001 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. Group 1001 must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by July 1, 2026<sup>2</sup>. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Group 1001 disagrees. Group 1001 must also specify the basis for each contention that the finding or conclusion of law is incorrect.

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<sup>2</sup> 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.

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:

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](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](mailto:kevin.stansbury@cms.hhs.gov)

If Group 1001 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 July 2, 2026. Group 1001 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 Group 1001 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 Group 1001 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  
Avalon Gordon, CMS/OPOLE  
Kevin Stansbury, CMS/CM/MOEG/DCE