

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

May 1, 2026

Mr. Thomas Doran
President
Highmark Health Plan
120 Fifth Ave Suite 3032
Pittsburgh, PA 15222

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug, Prescription Drug Contract Numbers: H3384, H3916, H3957, H5106, H5526, and H8166

Dear Mr. Doran:

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 Highmark Health Plan (Highmark Health) that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **\$10,458** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers H3384, H3916, H3957, H5106, H5526 and H8166.

An MA-PD organization's¹ primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that Highmark Health failed to meet that responsibility.

Summary of Noncompliance

In 2024, CMS conducted an audit of Highmark Health's 2022 Medicare financial information. In a financial audit report issued on July 15, 2024, CMS auditors reported that Highmark Health failed to comply with Medicare requirements. First, Highmark Health failed to comply with requirements related to Part D coordination of benefits and low-income subsidy (LIS) in violation of 42 C.F.R. Part 423, Subparts J and P. In addition, Highmark Health failed to comply with requirements related to Part C cost sharing in violation of 42 C.F.R. Part 422, Subpart F. As a result, auditors found that Highmark Health overcharged enrollees for Part D medications and Part C medical services. Highmark Health's failure to comply with Medicare Part C and D requirements adversely affected (or had the substantial likelihood of adversely affecting) enrollees because they may have experienced increased out-of-pocket costs.

¹ Referenced as "plan sponsor"

Part D Low Income Subsidy and Claims Adjustment Requirements (42 C.F.R. §§ 423.466(a) and 423.800(b - (e)))

Medicare Part D Prescription Drug Program requirements apply to stand-alone Prescription Drug Plan sponsors, Medicare Cost Plans, and Medicare Advantage organizations that offer Part D prescription drug benefits. Sponsors that offer these plans are required to enter into agreements with CMS by which the sponsors agree to comply with a number of statutory, regulatory, and sub-regulatory requirements.

Pursuant to 42 C.F.R. § 423.800, CMS notifies the sponsor offering the Part D plan of an individual's eligibility for a subsidy and the amount of the subsidy. Pursuant to 42 C.F.R. § 423.800 (b)-(e), a sponsor must process prescription drug claims in accordance with the LIS enrollees' subsidy amount to ensure LIS enrollees are charged appropriate cost sharing for Part D drugs. In addition, pursuant to 42 C.F.R. § 423.466(a), whenever a sponsor receives information that necessitates a retroactive claims adjustment, the sponsor must process the adjustment and issue refunds or recovery notices within 45 days of the sponsor's receipt of complete information regarding claims adjustment.

Violation Related to Part D Low Income Subsidy and Claims Adjustment Requirements

CMS determined that Highmark Health failed to process retroactive adjustments to cost sharing for LIS individuals, after receiving complete information regarding LIS eligibility updates, and issue any resulting refunds within the applicable timeframes. In 2023, Highmark Health acquired contracts, H5526 and H3384. Prior to this acquisition, there was a failure with data transfers between those contracts' enrollment platform and its pharmacy benefit manager (PBM). This technical breakdown caused low-income cost sharing levels to fail to load correctly in the PBM's system, resulting in incorrect copay calculations for affected Medicare beneficiaries. Highmark Health's failure to comply with LIS requirements violates 42 C.F.R. §§ 423.466(a) and 423.800(e).

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. 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 Highmark Health failed to comply with cost sharing requirements by charging incorrect cost sharing amounts. More specifically, Highmark Health's claims processing system contained a coding error where a specific facility class code was omitted from the system logic. As a result, when claims were submitted from affected facilities, the system incorrectly applied per-admission copays to multiple claim lines, rather than applying the correct per-admission cost-sharing amount as specified in the Plan's CMS-approved Evidence of Coverage (EOC). In some cases, Highmark Health did not ensure enrollees were refunded until after the financial audit, which was approximately several years after the costs incurred. This failure to comply with cost sharing requirements violates 42 C.F.R. §422.270(b).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. §§ 422.752 (c)(1)(i) and 423.752(c)(1)(i), CMS may impose a CMP for any determination made under 42 C.F.R. §§ 422.510 (a)(1) and 423.509(a)(1). Specifically, CMS may issue a CMP if a MA-PD or PDP has failed substantially to follow Medicare requirements according to its contract. Pursuant to 42 C.F.R. §§ 422.760(b)(2) and 423.760(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 Highmark Health failed substantially to carry out the terms of its contract (42 C.F.R. §§ 422.510(a)(1) and 423.509(a)(1)) by substantially failing to comply with requirements at 42 C.F.R. Part 422, Subpart F and Part 423, Subparts J and P. Highmark Health's violations of Part C and D requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP.

Right to Request a Hearing

Highmark Health 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. Highmark Health must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by July 1, 2026.² The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Highmark Health disagrees. Highmark Health must also specify the basis for each contention that the finding or conclusion of law is incorrect.

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

² 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.

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 for additional guidance on filing the appeal.

A copy of the hearing request should also be sent 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

If Highmark Health 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. Highmark Health 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.

Impact of CMP

Further failures by Highmark Health 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 Highmark Health 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
Scott Labrecque, CMS/ OPOLE
Timothy Lape, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/
DCE

