

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. Matt Hocks
President
Security Health Plan of Wisconsin, Inc.
4800 West 57th Street
Sioux Falls, SD 57108

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug
Contract Number: H5211

Dear Mr. Hocks:

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 Security Health Plan of Wisconsin, Inc. (Security Health Plan WI), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **\$29,005** for Medicare Advantage-Prescription Drug (MA-PD) Contract Number H5211.

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 Security Health Plan WI failed to meet that responsibility.

Summary of Noncompliance

In 2024, CMS conducted an audit of Security Health Plan WI's 2022 Medicare financial information. In financial audit reports issued on September 10, 2024, CMS auditors reported that Security Health Plan WI 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, Security Health Plan WI overcharged enrollees for Part C medical services and charged enrollees more than the annual Part C MOOP limit. Security Health Plan WI'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.

¹ 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 the 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 Security Health Plan WI failed to comply with cost sharing requirements by charging incorrect coinsurance amounts. More specifically, Security Health Plan WI claims processing system could not detect duplicate services when they were billed by different providers on separate claims. As a result, some enrollees were charged cost sharing for the same service twice, and in other cases, there was a substantial likelihood that enrollees were charged twice. Security Health Plan WI did not ensure enrollees were refunded until after the issue was identified on audit, which was several years after the costs incurred. Security Health Plan WI'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 Security Health Plan WI failed to comply with MOOP requirements by failing to track enrollee out-of-pocket spending and charging enrollees more than annual MOOP limits. There were five root causes for this failure. First, when some claims were manually processed, the claims processors did not check to see whether enrollees had met their MOOP limits and did not factor those limits into the calculation of the enrollees' cost sharing. Second, in other cases, the claims system processor selected an incorrect benefit package that did not include the cost-sharing amounts in the enrollees' MOOP.

Third, there was a programming glitch during an update to the claims processing software which caused amounts for claims finalized between 07/12/23 – 08/29/23 to not apply to MOOP. Fourth, a systems timing issue occurred which affected how patient out-of-pocket costs were tracked. Finally, MOOP overages were missed during a manual review and beneficiaries were charged amounts exceeding their MOOP limit. Security Health Plan WI'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 Security Health Plan WI 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. Security Health Plan WI'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

Security Health Plan WI 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. Security Health Plan WI must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by July 1, 2026². The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Security Health Plan WI disagrees. Security Health Plan WI 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
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

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.

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 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

If Security Health Plan WI 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. Security Health Plan WI 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 Security Health Plan WI 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 Security Health Plan WI 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
Verna Hicks, CMS/OPOLE
Anthony Jordan, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/DCE