

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, 15 New Sudbury St., Room 2325
Boston, MA 02203



Drug & Health Plan Operations

November 01, 2024

WARNING LETTER

Contract ID: H0876, H9414, H9876

Parent Organization Name: Commonwealth Care Alliance, Inc.

Legal Entity: Commonwealth Care Alliance Massachusetts, LLC., Commonwealth Care Alliance Rhode Island, LLC

Katherine Charron
Medicare Compliance Officer
30 Winter Street
Boston, MA 02108

VIA EMAIL: KCharron@commonwealthcare.org

Subject: Failure to Administer Approved Contract Year 2022 and 2023 Plan Benefits

Dear Katherine Charron:

The Centers for Medicare & Medicaid Services (CMS) is issuing this warning letter to Commonwealth Care Alliance, Inc., which operates the Medicare Advantage Prescription Drug Plan (MA-PD) contracts H0876 and H9876 (Commonwealth Care Alliance Rhode Island, LLC), and H9414 (Commonwealth Care Alliance Massachusetts, LLC) regarding your organization's failure to administer your contract year (CY) 2022 and 2023 plan benefits as approved by CMS. CMS issued a notice of non-compliance for a similar issue regarding Part D benefit administration on April 19, 2023.

Pursuant to 42 C.F.R. § 422.254(b), a Medicare Advantage (MA) organization must submit bids (and supplemental information specified by CMS) that reflect the features (e.g., premium amount, cost sharing) and projected cost estimates of each benefit package it expects to offer. For CY 2022 and 2023, MA organizations provided their bid information through two different submissions – a Bid Pricing Tool (BPT) and a Plan Benefit Package (PBP) – by June 7, 2021 (CY 2022) and June 6, 2022 (CY 2023), in accordance with the deadline established at 42 C.F.R. § 422.254(a)(1). In general, the PBP describes the structure of a proposed benefit package (e.g., co-pay amounts, deductibles) while the BPT describes the underlying basis used to calculate the price of the benefit package. The information in these submissions must combine to reflect a consistent benefit package.

Additionally, pursuant to 42 C.F.R. § 422.504(l), the MA organization's CEO, CFO, or another individual delegated the authority to sign on behalf of one of these officers, must submit a certification (referred to as the "benefit certification") that the information provided in each bid is accurate, complete, and truthful. Finally, § 422.504(i) states that the MA organization is responsible for the actions of all their first

tier, downstream, and related entities.

On May 18th, 2023, your organization notified CMS that you failed to ensure the CY 2022 and 2023 plan benefits administered by your claims vendor, Public Consulting Group (PCG), aligned with the CMS-approved bid. You identified this failure when CMS requested additional investigation following the receipt of an enrollee complaint through 1-800-MEDICARE regarding incorrect cost sharing. Once your organization became aware of the complaint, you identified that PCG inaccurately configured their systems for 135 different procedure codes, which resulted in the calculation of incorrect enrollee cost sharing amounts. Between January 4, 2022, and March 31, 2023, 253 enrollees, with a total of 595 claims, were charged incorrect cost sharing amounts. Of these 253 enrollees, 204 enrollees were overcharged (totaling \$17,652.79) and 66 enrollees were undercharged (totaling \$4,736.43). Seventeen of the 253 enrollees fell into both categories and were over and undercharged depending on the service. Your organization is out of compliance with Part C requirements because your organization failed to ensure that your CY 2022 and 2023 plan benefits were administered as approved by CMS.

CMS understands that your organization transitioned to a new claims vendor (Cognizant), effective April 1, 2023, and that your organization validated that the coinsurance configuration associated with your new vendor was accurate. In addition, your organization reported to CMS that you took the following remediation steps:

- Reprocessed the 595 impacted claims on October 24, 2023;
- Sent corrected Explanation of Benefits (EOB) documents to enrollees and Explanation of Payments (EOP) documents to providers by November 30, 2023;
- Reimbursed the provider when the cost sharing was overapplied, and asked the provider to reimburse the enrollee; and
- Attempted to collect underpayments as applicable.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of our review of any application for new or expanded Medicare contracts your organization may submit. CMS determines this instance of non-compliance a Part C issue. CMS notes that we are issuing this compliance notice based exclusively on information that we obtained from sources other than your organization's self-disclosure.

Your organization has been referred for enforcement action. CMS has the authority to impose sanctions, penalties, and other enforcement actions as described in federal regulations at 42 C.F.R. Part 422 Subpart O.

If you have any questions about this notice, please contact your CMS Account Manager Deborah O'Leary at: (615) 565-1282, or deborah.oleary@cms.hhs.gov.

Sincerely,



Adele Pietrantoni, Director
Division of Medicare Plan Management
Medicare Plan Management Group

CC via email:

Deborah O'Leary, Emily Chapple, Lizamarie Cintron, CMS
Theresa Wachter, CMS Baltimore