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

January 17, 2025

Ms. Vinod Mohan
Sr. Vice President, Medicare
Molina Healthcare, Inc.
200 Ocean Gate
Long Beach, CA 90802

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug Contract Numbers: H5628, H5810, H5823, H5926, H7678, H8176, and H9955

Dear Ms. Mohan:

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 Molina Healthcare, Inc. (Molina), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$67,976** for Medicare Advantage-Prescription Drug (MA-PD) Contract Numbers H5628, H5810, H5823, H5926, H7678, H8176, and H9955.

An MA-PD organization's[1] primary responsibility is to provide Medicare enrollees with medical services and prescription drug benefits in accordance with Medicare requirements. CMS has determined that Molina failed to meet that responsibility.

Summary of Noncompliance

In 2023, CMS conducted an audit of Molina's 2021 Medicare financial information. In financial audit reports issued on July 28, 2023, and August 18, 2023, CMS auditors reported that Molina failed to comply with Medicare requirements. First, Molina failed to comply with requirements related to Part D coordination of benefits and low-income subsidy (LIS) requirements in violation of 42 C.F.R. Part 423, Subparts J and P. More specifically, auditors found that in 2021, Molina failed to reprocess prescription drug claims in accordance with enrollee's LIS levels within 45 days of receiving complete information regarding the enrollees LIS status.

In addition, auditors reported that Molina failed to comply with Medicare requirements related to Part C maximum out-of-pocket (MOOP) limit requirements in violation of 42 C.F.R. Part 422, Subpart C. More specifically, auditors found that in 2021, Molina charged enrollees more than the annual Part C MOOP limits.

[1] Referenced collectively as "plan sponsor".

Molina's failure to comply with Part C and Part D requirements adversely affected (or had the substantial likelihood of adversely affecting) enrollees because they may have experienced increased out-of-pocket costs.

Part D Coordination of Benefits and Low-Income Subsidy (LIS) Requirements
42 C.F.R. §§ 423.466(a) and 423.800(d)-(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 § 423.800(d)-(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 § 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 Coordination of Benefits and Low-Income Subsidy (LIS) Requirements

CMS determined that Molina failed to comply with Part D coordination of benefits and LIS requirements by failing to process retroactive adjustments to cost sharing for LIS individuals and issue any resulting refunds within 45 days of the receipt of complete information regarding the claims adjustment. More specifically, due to an ineffective adjustment process, retroactive adjustments to prescription drug event (PDE) records were not reprocessed automatically after revised LIS level changes were received. As a result, enrollees were overcharged for Part D drugs. Molina's failure to comply with LIS requirements violates 42 C.F.R. §§ 423.466(a) and 423.800(e).

Part C Maximum Out-of-Pocket Limit Requirements *(42 C.F.R. §§ 422.100(f)(4) and (5) and Health Plan Management System (HPMS) Memo, Final Contract Year 2021 Part C Benefits Review and Evaluation, April 8, 2020)*

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 Molina failed to comply with MOOP requirements by failing to track enrollee out-of-pocket spending and charging enrollees more than annual MOOP limits. More specifically, when 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 for the manual claims. As a result, enrollees were charged amounts in excess of their annual MOOP limit. Molina'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) 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 has failed substantially to carry out 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 Molina 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 C and 42 C.F.R. Part 423, Subparts J and P. Molina's violations of Part C and Part D 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

Molina 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. Molina must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by March 19, 2025[2]. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Molina disagrees. Molina 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.

[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.

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 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 Molina 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 March 20, 2025. Molina 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 Molina 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 Molina 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
Micheal Taylor, CMS/OPOLE
Joaquin Clinton-Clemens, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/DCE