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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

MEDICARE PARTS C AND D OVERSIGHT AND ENFORCEMENT GROUP

March 22, 2022

Mr. Thomas Wilfong
Medicare Senior Vice President
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Re: Notice of Imposition of Civil Money Penalty for Medicare-Medicaid Plan Contract Numbers: H8677, H5280, H8046, H2533, H7844, and H8197

Dear Mr. Wilfong:

Pursuant to Section 5.3.13 of the Cal MediConnect (California) contract, Section 5.3.14 of the Healthy Connections Prime (South Carolina) contract, Section 5.3.14 of the Medicare-Medicaid Alignment Initiative (Illinois) contract, Section 5.3.14 of the Michigan MI Health Link contract, Section 5.3.14 of the MyCare Ohio contract, Section 5.3.17 of the Texas Dual Eligible Integrated Care Demonstration Project contract, and 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 Molina Healthcare, Inc. (Molina), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$43,884** for Medicare-Medicaid Plan (MMP) Contract Numbers H8677, H5280, H8046, H2533, H7844, and H8197.

An MMP organization's 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

CMS conducted an audit of Molina's Medicare operations from August 30, 2021 through September 17, 2021. In a program audit report issued on February 2, 2022, CMS auditors reported that Molina failed to comply with Medicare requirements related to Medicare-Medicaid service authorization requests, appeals, and grievances in violation of 42 C.F.R. Part 422, Subpart M; Section 2.11.5.6.2 of the Cal MediConnect (California) contract; Section 2.8.3 of the Healthy Connections Prime (South Carolina) contract; Section 2.9.4 of the Medicare-Medicaid Alignment Initiative (Illinois) contract; Sections 2.8.3.6.2 of the Michigan MI Health Link contract, Sections 2.8.4.5.2 of the MyCare Ohio contract, Sections 2.8.3.7.2 of the Texas Dual Eligible Integrated Care Demonstration Project contract. One (1) failure was systemic and

adversely affected, or had the substantial likelihood of adversely affecting, enrollees. The enrollees experienced, or likely experienced, delayed access to covered benefits and/or untimely appeal rights.

CMS reviews audit findings individually to determine if an enforceable violation has occurred warranting a CMP. CMPs are calculated and imposed when a finding of non-compliance adversely affected or had a substantial likelihood of adversely affecting enrollees. The determination to impose a CMP on a specific finding does not correlate with the MMP's overall audit performance.

Medicare-Medicaid Service Authorization Requests, Appeals, and Grievances Requirements
(*42 C.F.R. Part 422, Subpart M; Cal MediConnect contract, Section 2.11.5.6.2; Healthy Connections Prime (South Carolina), Section 2.8.3; Medicare-Medicaid Alignment Initiative (Illinois), Section 2.9.4; Michigan MI Health Link contract, Section 2.8.3.6.2; MyCare Ohio contract, Section 2.8.4.5.2; Texas Dual Eligible Integrated Care Demonstration Project contract, Section 2.8.3.7.2.*)

A service authorization request is when an enrollee, provider, or legal representative of a deceased enrollee requests coverage for an item or service with a Medicare-Medicaid Plan (MMP). There are different decision-making timeframes for the review of service authorization requests. For standard service authorization requests, the MMP must provide notice of the decision no later than fourteen (14) calendar days after receipt of the request for service. If requests are expedited, an MMP is required to notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request for an expedited service authorization request. Failure to provide enrollees and/or their providers notice within the required timeframes, can result in enrollees failing to receive the approved services, or delays with accessing services and/or appeal rights.

Violation related to Medicare-Medicaid Service Authorization Requests, Appeals, and Grievances

CMS determined that Molina failed to notify enrollees of its decisions within required timeframes for expedited service authorization requests. As a result, there is a substantial likelihood that those enrollees with approved services were impeded from obtaining medically necessary services while others with denied services were delayed timely appeal rights. This failure violates 42 CFR § 422.572(a); Cal MediConnect contract, Section 2.11.5.6.2; Healthy Connections Prime (South Carolina), Section 2.8.3; Medicare-Medicaid Alignment Initiative (Illinois), Section 2.9.4; Michigan MI Health Link contract, Section 2.8.3.6.2; MyCare Ohio contract, Section 2.8.4.5.2; Texas Dual Eligible Integrated Care Demonstration Project contract, Section 2.8.3.7.2.

Basis for Civil Money Penalty

Pursuant to Cal MediConnect contract, Section 5.3.13.2.1; Healthy Connections Prime (South Carolina), Section 5.3.14.4.1; Medicare-Medicaid Alignment Initiative (Illinois), Section 5.3.14.2.1; Michigan MI Health Link contract, Section 5.3.14.4.1; MyCare Ohio contract,

Section 5.3.14.2.2; Texas Dual Eligible Integrated Care Demonstration Project contract, Section 5.3.17.4.1; and 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 Medicare-Medicaid Plan 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 Molina failed substantially:

- To carry out the terms of its contract with CMS (42 C.F.R. § 422.510(a)(1));
- To comply with the requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 422.510(a)(4)(ii));
- To comply with federal regulatory requirements related to Cal MediConnect (California) contract with CMS (Section 5.3.13.1.6);
- To comply with federal regulatory requirements related to Healthy Connections Prime (South Carolina) contract with CMS (Section 5.3.14.3.6);
- To comply with federal regulatory requirements related to Medicare-Medicaid Alignment Initiative (Illinois) contract with CMS (Section 5.3.14.1.6);
- To comply with federal regulatory requirements related to Michigan MI Health Link with CMS contract (Section 5.3.14.3.6);
- To comply with federal regulatory requirements related to MyCare Ohio contract with CMS (Section 5.3.14.1.6); and
- To comply with federal regulatory requirements related to Texas Dual Eligible Integrated Care Demonstration Project contract with CMS (Section 5.3.17.3.6).

Molina's violation of Part C 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

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 May 23, 2022.[1] 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:

[1] 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 60th day falls on a weekend or holiday, therefore the date reflected in the notice is the next regular business day for you to submit your request.

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 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 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 May 24, 2022. Molina 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 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: Laura Coleman, CMS/ OPOLE
Michael Moore, CMS/OPOLE
Tamara McCloy, CMS/OPOLE
Mortez Williams, CMS/OPOLE
Raymond Swisher, CMS/OPOLE
Judith Flynn, CMS/OPOLE
Brenda Suiter, CMS/OPOLE
Doreen Gagliano, CMS/ OPOLE
April Forsythe, CMS/ OPOLE
Erica Dimes, CMS/OPOLE
Ayana Busby-Jackson, CMS/OPOLE
Stephanie Arriaga, CMS/OPOLE
Estavan, Carter III, CMS/OPOLE
Chad Johnson, CMS/OPOLE
Jeri Fears, CMS/OPOLE
Kevin Stansbury, CMS/CM/MOEG/DCE