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

February 24, 2017

Sharon Fletcher
President & CEO
Community Care HMO, Inc.
218 W 6th Street
Tulsa, OK 74119

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug
Contract Number: H3755

Dear Dr. Fletcher:

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 Community Care HMO, Inc. (Community Care), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$760,500** for Medicare Advantage-Prescription Drug (MA-PD) Contract Number H3755.

An MA-PD 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 Community Care failed to meet that responsibility.

Summary of Noncompliance

CMS conducted an audit of Community Care's Medicare operations from August 29, 2016 through September 9, 2016. In a program audit report issued on January 12, 2017, CMS auditors reported that Community Care failed to comply with Medicare requirements related to Part D formulary and benefit administration and coverage determinations, appeals, and grievances in violation of 42 C.F.R. Part 423, Subparts C and M. Community Care's failures in these areas were systemic and adversely affected, or had the substantial likelihood of adversely affecting, enrollees. The enrollees experienced, or likely experienced, delayed or denied access to covered benefits, increased out-of-pocket costs, and/or inadequate grievance or appeal rights.

Part D Formulary and Benefit Administration Requirements

Medicare Part D Prescription Drug Program requirements apply to stand-alone Prescription Drug Plan sponsors and to 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.

Formulary
(42 C.F.R. §§ 423.120(b)(2)(iv) and 423.120(b)(4)-(6); Chapter 6, Section 30.3 of the Medicare Prescription Drug Benefit Manual, (IOM Pub. 100-18))

Each Part D sponsor maintains a drug formulary or list of prescription medications and must cover those Part D drugs in accordance with requirements provided in 42 C.F.R. Part 423. A number of Medicare requirements govern how Part D sponsors create and manage their formularies. Each Part D sponsor is required to submit its formulary for review and approval by CMS on an annual basis. The formulary review and approval process includes reviewing the Part D sponsor's proposed drug utilization management processes to adjudicate Medicare Part D prescription drug claims. Once CMS approves a sponsor's formulary, the sponsor must administer the formulary as approved and cannot change the formulary unless it obtains CMS approval and subsequently notifies its enrollees of the changes.

Violations Related to Formulary & Benefit Administration

CMS determined that Community Care violated the following Part D formulary and benefit administration requirement:

1. Failure to properly administer its CMS-approved formulary by inappropriately rejecting covered Part D drugs. Community Care had a policy of rejecting prescriptions for formulary medications that were written by out-of-network providers. As a result, enrollees experienced inappropriate denials of coverage at the point of sale, and either were delayed access to the medications, never received the medications, or incurred increased out-of-pocket costs in order to receive the medications. This deficiency violates 42 CFR §§ 423.104(h), 423.120(b)(2), and 423.100; Chapter 6, Section 10.2 of the Medicare Prescription Drug Benefit Manual (IOM Pub. 100-18).

Part D Coverage Determination, Appeal, and Grievance Requirements
(42 C.F.R. Part 423, Subpart M; Chapter 18 of the Medicare Prescription Drug Benefit Manual (IOM Pub. 100-18))

A Medicare enrollee has the right to contact his or her plan sponsor to express general dissatisfaction with the sponsor's operations, activities, or behavior, or to make a specific complaint about the denial of coverage for drugs to which the enrollee believes he or she is entitled to receive. Sponsors are required to classify general complaints about benefits or the sponsor's operations or activities as grievances. Sponsors are required to classify complaints about coverage for drugs as coverage determinations or exception requests. It is critical for a sponsor to properly classify each complaint as a grievance, coverage determination/exception request, or both. Improper classification may result in enrollees not receiving the required level of review, and/or experiencing delayed access to medically necessary or life-sustaining drugs.

The first level of review is the coverage determination or exception request, which is conducted by the plan sponsor. The enrollee, the enrollee's representative, or the enrollee's treating physician or prescriber may make a request for a coverage determination or exception request. Once an exception is granted, the plan sponsor is prohibited from requiring the enrollee to request approval for a refill or new prescription to continue using the Part D prescription drug approved under the exceptions process for the remainder of the plan year, so long as the enrollee remains enrolled in the plan, the physician or other prescriber continues to prescribe the drug and it continues to be safe for treating the enrollee's condition.

Violations Related to Part D Coverage Determinations, Appeals, and Grievances

CMS determined that Community Care violated the following Part D coverage determination, appeal, and grievance requirement:

2. Failure to effectuate exception approvals through the end of the plan year. As a result, there was a substantial likelihood that enrollees were required to go through the exceptions process a second time in order to receive medications that were previously approved. This is in violation of 42 C.F.R. § 423.578(c)(3) and (4), and Chapter 18, Sections 30.2 and 130 of the Medicare Prescription Drug Benefit Manual (IOM Pub. 100-18).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 423.752(c)(1) and § 423.760(b), CMS has determined that Community Care's violations of Part D requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees and warrants the imposition of a CMP. Community Care failed substantially:

- To carry out the terms of its contract with CMS (42 C.F.R. § 423.509(a)(1));
- To comply with the Part D service access requirements in § 423.120 (42 C.F.R. § 423.509(a)(4)(iv)); and
- To comply with the requirements in Subpart M relating to grievances and appeals (42 C.F.R. § 423.509(a)(4)(ii)).

Right to Request a Hearing

Community Care 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. Community Care must send a written request for a hearing to the Departmental Appeals Board office listed below by April 26, 2017. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Community Care disagrees. Community Care must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

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

A copy of the hearing request should also be sent to CMS at the following address:

Kevin Stansbury
Acting 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 Community Care 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 April 27, 2017. Community Care 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

Please note, this action will factor into Community Care's Star Rating and Past Performance calculations. For Star Ratings, there will be a deduction of up to 40 points from the Beneficiary Access and Performance Problems measure. For Past Performance, your organization will receive one negative past performance point.

Further failures by Community Care 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 Community Care has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

Vikki Ahern
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Kevin Stansbury, CMS/CM/MOEG
Arthur Pagan, CMS/CMHPO/Region VI
April Forsythe, CMS/CMHPO/Region VI
Catherine Snow, CMS/CMHPO/Region VI