

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**

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April 29, 2026

Mrs. Jamie Forrest  
President and Chief Operating Officer  
Health First Health Plans, Inc.  
6450 US Highway 1  
Rockledge, FL 32955

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug  
Contract Number: H1099

Dear Mrs. Forrest:

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 Health First Health Plans, Inc. (Health First), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **\$43,546** for Medicare Advantage-Prescription Drug Contract Number H1099.

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 Health First failed to meet that responsibility.

**Summary of Noncompliance**

CMS conducted an audit of Health First's Medicare operations from June 9, 2025, through June 20, 2025. In a program audit report issued on September 16, 2025, CMS auditors reported that Health First failed to comply with Medicare requirements related to Part D formulary and benefits administration in violation of 42 C.F.R. Part 423, Subpart C. One (1) failure was systemic and adversely affected, or had the substantial likelihood of adversely affecting, enrollees because the enrollees either experienced delayed access to medications, had to pay full cost to receive medications, or never received medications.

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 MA-PD's overall audit performance.

## **Part D Formulary and Benefit Administration Relevant 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.

### Qualified Prescription Drug Coverage

*(42 C.F.R. § 423.104; Chapter 5, Section 20.1 of the Medicare Prescription Drug Benefit Manual, (IOM Pub. 100-18))*

A Part D sponsor must provide its enrollees with qualified prescription drug coverage. Qualified prescription drug coverage, which consists of either standard or alternative prescription drug coverage, may be provided directly by the Part D sponsor or through arrangements with other entities.

### Formulary

*(42 C.F.R. §§ 423.120(b), 423.272(b)(2); 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 covered by the sponsor. 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. Except in limited circumstances, once CMS approves a sponsor's formulary, the sponsor cannot change the formulary unless it obtains CMS approval and subsequently notifies its enrollees of the changes.

### Utilization Management Techniques

*(42 C.F.R. §§ 423.120(b), 423.272(b)(2); Chapter 6, Section 30.2 of the Medicare Prescription Drug Benefit Manual (IOM Pub. 100-18); Health Plan Management System (HPMS) Memorandum "CMS Part D Utilization Management Policies and Requirements" dated October 22, 2010)*

Prior authorization is a utilization management technique used by Part D sponsors and other health insurers that requires enrollees to obtain approval from the sponsor for coverage of certain prescriptions prior to being dispensed the medication. Prior authorization guidelines are determined on a drug-by-drug basis and may be based on Food and Drug Administration (FDA) and manufacturer guidelines, medical literature, safety, appropriate use, and benefit design.

Quantity limits are another utilization management technique used by Part D sponsors. A sponsor may place a quantity limit on a drug for a number of reasons. For example, a quantity limit may be placed on a medication in order to ensure that the quantity and/or dosage does not exceed the maximum daily dose limits established by the FDA. Quantity limits may also be placed on a drug to optimize dosage, which helps to contain costs.

Part D sponsors and other health insurers use step therapy to ensure that the first drug prescribed for an enrollee who is beginning drug therapy is cost-effective and safe, and other more costly or risky drugs are prescribed only if clinically necessary. The goal of step therapy is to control costs and minimize clinical risks.

#### Transition of Coverage

(42 C.F.R. § 423.120(b)(3); Chapter 6, Section 30.4 of the Medicare Prescription Drug Benefit Manual (IOM Pub. 100-18))

A Part D sponsor must provide a one time, temporary supply (i.e. a “transition supply”) of a drug to enrollees who are within their first 90 days of coverage under a new plan and have a prescription for a Part D drug that is not on the plan’s formulary (including Part D drugs that are on a sponsor’s formulary but are subject to prior authorization, step therapy, or quantity limits in certain situations). The transition process is designed to accommodate the immediate needs of an enrollee, and to allow the sponsor and/or enrollee sufficient time to switch to a therapeutically equivalent medication or request an exception to maintain coverage of an existing drug.

#### **Violation Related to Part D Formulary and Benefit Administration Requirements**

CMS determined that Health First failed to properly administer the CMS transition policy. Specifically, for enrollees who had a break in coverage with Health First, the sponsor’s adjudication system should have calculated whether the enrollee was still within their first 90 days of coverage based on the enrollee’s *most recent* enrollment effective date. Instead, Health First’s system applied the enrollee’s *previous* enrollment effective date with the sponsor and did not recognize that the enrollee was entitled to a transition supply of medication. As a result, Health First inappropriately rejected medications that should have been approved for a transition supply and enrollees either experienced delayed access to medications, had to pay full cost to receive medications, or never received their medications. Health First’s failure to comply with Part D transition supply requirements violates 42 C.F.R. § 423.120(b)(3).

#### **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) and 423.509(a). Specifically, CMS may issue a CMP if an MA-PD plan sponsor has failed substantially to carry out its contract (42 C.F.R. §§ 422.510(a)(1) and 423.509(a)(1) and substantially failed to comply with the service access requirements in § 423.120 (42 C.F.R. § 423.509(a)(4)(iv)). 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 Health First failed substantially to carry out the terms of its contract with CMS (42 C.F.R. § 423.509(a)(1)) and substantially failed to comply with the service access requirements (42 C.F.R. § 423.509(a)(4)(iv)) because it substantially failed to comply with requirements related to the administration of the Part D transition policy at 42 C.F.R. § 423.120(b)(3). Health First’s violation of Part D 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**

Health First 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. Health First must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by June 29, 2026.<sup>1</sup> The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Health First disagrees. Health First 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

Please see [https://dab.efile.hhs.gov/appeals/to\\_crd\\_instructions](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](mailto:kevin.stansbury@cms.hhs.gov)

If Health First 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 June 30, 2026. Health First 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 Health First to provide its enrollees with Medicare benefits in accordance with CMS requirements may result in CMS imposing additional remedies available under law,

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<sup>1</sup> 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.

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 Health First 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  
Erick Bowen, CMS/OPOLE  
Ayn Phillips-Piquant, CMS/OPOLE  
Kevin Stansbury, CMS/CM/MOEG/DCE