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

November 30, 2022

Mr. Bruce Broussard
Chief Executive Officer
Humana, Inc.
500 West Main Street
6th Floor - Humana Tower
Louisville, KY 40202

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage-Prescription Drug and Prescription Drug Plan Contract Numbers: H0028, H0292, H0473, H1019, H1036, H1468, H1951, H3533, H4007, H4141, H4461, H5216, H5525, H5619, H5970, H6622, H7284, H7621, H8087, H8908, H9070, R0110, R0865, R1390, R3392, R4182, R4845, R5495, R7220, S5552, S5884

Dear Mr. Broussard:

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 Humana, Inc. (Humana) that CMS has made a determination to impose a civil money penalty (CMP) in the amount of **$131,660** for Medicare Advantage-Prescription Drug (MA-PD) and Prescription Drug Plan (PDP) Contract Numbers H0028, H0292, H0473, H1019, H1036, H1468, H1951, H3533, H4007, H4141, H4461, H5216, H5525, H5619, H5970, H6622, H7284, H7621, H8087, H8908, H9070, R0110, R0865, R1390, R3392, R4182, R4845, R5495, R7220, S5552, and S5884.

An MA-PD and PDP 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 Humana failed to meet that responsibility.

Summary of Noncompliance

In 2021, CMS conducted an audit of Humana's 2019 Medicare financial information. In financial audit reports issued on July 16, 2021, CMS auditors reported that Humana failed to comply with Medicare requirements related to Part D gross covered drug costs and True Out-of-Pocket (TrOOP) accumulators in violation of 42 C.F.R. Part 423, Subparts B and J; Part D retroactive claims adjustment in violation of 42 C.F.R. Part 423, Subpart J; and Part C cost sharing in violation of 42 C.F.R. Part 422, Subpart F. More specifically, auditors found that

[1] Referenced collectively as "plan sponsor".

Humana overcharged enrollees for Part D medications and Part C services. Humana's failures adversely affected (or had the substantial likelihood of adversely affecting) enrollees because they may have experienced increased out-of-pocket costs.

Part D Gross Covered Drug Costs and TrOOP Accumulator Requirements *(42 C.F.R. §423.104(d); Medicare Prescription Drug Benefit Manual, Chapter 14, Section 50.8; 42 CFR §423.464(f)(2); and 80 FR 7934)*

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. Plan 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.

Gross covered drug costs and TrOOP expenses factor into a beneficiary's movement through the various standard prescription drug benefit phases, such as the deductible phase, initial coverage limit, coverage gap, and catastrophic phase. Pursuant to 42 C.F.R. §423.104(d), a plan sponsor must track a beneficiary's gross covered drug costs and TrOOP and correctly apply these costs to the benefit limits to correctly position the beneficiary in the benefit and provide the catastrophic level of coverage at the appropriate time. When a beneficiary transfers enrollment between plan sponsors during the coverage year, the enrollee's gross covered drug costs and TrOOP must be transferred between plans and applied by the subsequent plan in its administration of the Part D benefit.

Violation Related to Part D Gross Covered Drug Costs and TrOOP Accumulators

CMS determined that Humana failed to comply with Part D gross covered drug costs and TrOOP accumulator requirements by failing to accurately track these accumulators for beneficiaries with multiple member IDs.[2] This issue occurred because Humana had a manual process for identifying beneficiaries with multiple member IDs and, as a result, failed to identify all beneficiaries in this situation when adjudicating claims. This caused TrOOP and gross covered drug cost data to be tracked separately for each member ID. As a result, the beneficiary did not progress correctly through the benefit phases and paid incorrect amounts for Part D prescription drugs. Humana then failed to ensure that refunds were provided to enrollees who overpaid. This is in violation of 42 C.F.R. § 422.104(d).

Part D Retroactive Claims Adjustment Requirement *(42 C.F.R. §423.466(a))*

Pursuant to 42 C.F.R. §423.466(a), when a plan sponsor receives information that necessitates retroactive Part D claims adjustment, the plan sponsor must process the adjustment and issue a refund to the beneficiary within 45 days of the plan sponsor's receipt of such information.

[2] A beneficiary may have more than one member ID for different reasons, including enrollment changes.

Violation Related to Part D Retroactive Claims Adjustment Requirement

CMS determined that Humana failed to comply with the Part D retroactive claims adjustment requirement by failing to process an adjustment to the cost-sharing for some prescription drugs after receiving updated information from other plan sponsors, CMS or the State that necessitated retroactive claims adjustments. This issue occurred because when Humana received updated information about a beneficiary, Humana used a manual method for listing beneficiaries whose claims needed to be adjusted.[3] As a result of this manual method, Humana missed some beneficiaries that required adjustment and those beneficiaries' claims for prescription drugs were not re-adjudicated. In some cases, beneficiaries overpaid for prescription drugs and were not refunded within the applicable timeframes. This is in violation of 42 C.F.R. § 423.466(a).

Part C Cost Sharing Requirements *(42 C.F.R. §§ 422.111(b), 422.254, and 422.270; Chapter 4, Section 50 of the Medicare Managed Care Manual (IOM Pub. 100-16))*

Every year, a plan sponsor must submit to CMS an aggregate monthly bid amount which must include a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of the deductibles, coinsurance, and copayments. When the bid is approved by CMS the plan sponsor must provide to each enrollee a description of the benefits offered under a plan, including the applicable cost-sharing for the benefits (see 42 C.F.R. § 422.111(b)). The plan sponsor must not charge an enrollee a different amount from what was approved in the bid and disclosed to the enrollee for that benefit. Pursuant to 42 C.F.R. §422.270(b), if the plan sponsor charges amounts in excess of the agreed upon cost-sharing, then the plan sponsor must agree to refund all amounts incorrectly collected from its Medicare enrollees.

Violation Related to Part C Cost Sharing

CMS determined that Humana failed to comply with cost sharing requirements by charging incorrect coinsurance amounts. More specifically, Humana's contract with a particular physical therapy provider required the plan to pay them 65% of Medicare Allowable. However, Humana erroneously applied the non-contracted reimbursement rate (i.e., 100% of Medicare Allowable). This caused claims to the provider to be overpaid which resulted in enrollees being overcharged for their coinsurance. Humana did not have evidence whether enrollees received refunds for potential overpayments. This failure violates 42 C.F.R. §422.270(b).

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 or PDP 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.

[3] An example of information that would necessitate retroactive claims adjustment is notification from CMS of a beneficiary gaining retroactive eligibility to the Low-Income Subsidy.

CMS has determined that Humana 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 F and Part 423, Subparts B and J. Humana's violations of Part C and Part D requirements directly adversely affected (or had the substantial likelihood of adversely affecting) enrollees.

Right to Request a Hearing

Humana 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. Humana must send a request for a hearing to the Departmental Appeals Board (DAB) office listed below by January 30, 2023. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which Humana disagrees. Humana 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 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 Humana 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 January 31, 2023. Humana 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 Humana 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 Humana 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: Judith Flynn, CMS/OPOLE
Raymond Swisher, CMS/OPOLE
Joseph Sanchez, CMS/OPOLE
Kane Kunard, CMS/OPOLE
Kevin Stansbury, CMS/MOEG/DCE