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 26, 2016

Mr. Michael Turrell
Chief Executive Officer
Ultimate Health Plans, Inc.
1244 Mariner Blvd
Spring Hill, FL 34609

Re: Notice of Imposition of Immediate Intermediate Sanctions (Suspension of Enrollment and Marketing) for Medicare Advantage-Prescription Drug Contract Number: H2962

Dear Mr. Turrell,

Pursuant to 42 C.F.R. §§ 422.756 and 423.756, the Centers for Medicare & Medicaid Services (CMS) is providing notice to Ultimate Health Plans, Inc. (UHP), that CMS has made a determination to immediately impose intermediate sanctions on the following Medicare Advantage-Prescription Drug Contract Number: H2962.

These intermediate sanctions will consist of the suspension of enrollment of Medicare beneficiaries into UHP's contracts (42 C.F.R. §§ 422.750(a)(1) and 423.750(a)(1)), and the suspension of all marketing activities to Medicare beneficiaries (42 C.F.R. §§ 422.750(a)(3) and 423.750(a)(3)). CMS is imposing these intermediate sanctions immediately, effective February 26, 2016, at 11:59 p.m. EST, pursuant to 42 C.F.R. §§ 422.756(c)(2) and 423.756(c)(2), because it has determined that UHP's conduct poses a serious threat to the health and safety of Medicare beneficiaries. Pursuant to 42 C.F.R. §§ 422.756(c)(3) and 423.756(c)(3), the intermediate marketing and enrollment sanctions will remain in effect until CMS is satisfied that the deficiencies upon which the determination was based have been corrected and are not likely to recur. CMS will provide UHP with detailed instructions regarding the marketing and enrollment suspensions in a separate communication.

A Medicare Advantage organization and Prescription Drug Plan sponsor's central mission is to provide Medicare enrollees with medical services and prescription drug benefits within a framework of Medicare requirements that provide enrollees with a number of protections. CMS has determined that UHP substantially failed to provide its enrollees with services and benefits in accordance with CMS requirements.

**Summary of Noncompliance**

CMS conducted an audit of UHP's Medicare operations from October 26, 2015 through November 9, 2015. During the audit, CMS conducted reviews of numerous operational areas to determine if UHP is following CMS rules, regulations, and guidelines. CMS auditors concluded that UHP substantially failed to comply with CMS requirements regarding Parts C and Part D organization/coverage determinations, appeals and grievances; Part D formulary and benefit administration; and compliance program effectiveness in violation of 42 C.F.R. Part 422, Subparts K and M and 42 C.F.R. 423, Subparts C, K, and M. CMS found that UHP's failures in these areas were widespread and systemic. Violations resulted in enrollees experiencing delays or denials in receiving medical services and prescription drugs, and increased out of pocket costs for medical services and prescription drugs.

UHP lacks the organizational structure necessary to manage operations effectively and ensure beneficiaries receive covered medications and access to necessary medical services. The plan failed to provide appropriate oversight of their first tier, downstream-related entities (FDRs). In addition, UHP's Compliance Officer did not obtain monitoring reports that were to be submitted by the FDRs and failed to ensure the resolution of compliance issues.

According to UHP, most of the audit deficiencies resulted from the plan's limited resources and the fact that the plan had insufficient staff dedicated to the compliance function. UHP failed to complete a formalized risk assessment and identify high-risk compliance areas for focused auditing and monitoring. The Compliance Officer also served as the Operations Officer, which limited the time available for this individual to devote to compliance efforts. Similarly, the Medical Director was employed by UHP and concurrently with a separate physician group. Consequently, there was no senior-level staff member devoted to overseeing the organization's clinical decision making processes. The CMS audit revealed enrollees were subjected to an inappropriate clinical decision making process and were improperly denied access to medications and necessary medical services.

**Part C and Part D Organization/Coverage Determination, Appeal, and Grievance Relevant Requirements**
*(42 C.F.R. Part 422, Subpart M; 42 C.F.R. Part 423, Subpart M; IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 18; IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 13)*

Medicare enrollees have the right to contact their plan sponsor to express general dissatisfaction with the operations, activities, or behavior of the plan sponsor or to make a specific complaint about the denial of coverage for drugs or services to which the enrollee believes he or she is entitled. Sponsors are required to classify general complaints about services, benefits, or the sponsor's operations or activities as grievances. Sponsors are required to classify complaints about coverage for drugs or services as organization determinations (Part C – medical services) or coverage determinations (Part D – drug benefits). It is critical for a sponsor to properly classify each complaint as a grievance or an organization/coverage determination or both. Improper classification of an organization or coverage determination denies an enrollee the

applicable due process and appeal rights and may delay an enrollee's access to medically necessary or life-sustaining services or drugs.

The enrollee, the enrollee's representative, or the enrollee's treating physician or prescriber may make a request for an organization determination or coverage determination. The first level of review is the organization determination or coverage determination, which is conducted by the plan sponsor, and the point at which beneficiaries or their physicians submit justification for the benefit.

If the organization or coverage determination is adverse (not in favor of the beneficiary), the beneficiary has the right to file an appeal. The first level of the appeal – called a reconsideration (Part C) or redetermination (Part D) – is handled by the plan sponsor and must be conducted by a physician who was not involved in the organization determination or coverage determination decision. The second level of appeal is made to an independent review entity (IRE) contracted by CMS.

There are different decision making timeframes for the review of organization determinations, coverage determinations, and appeals. CMS has a beneficiary protection process in place that requires plans to forward coverage determinations and appeals to the IRE when the plan has missed the applicable adjudication timeframe.

**Violations Related to Part C and Part D Organization/Coverage Determinations, Appeals and Grievances**

CMS identified serious violations of Parts C and Part D organization/coverage determination, appeal, and grievance requirements that resulted in UHP's enrollees experiencing inappropriate delays and denials of medical services and medications. In addition, enrollees received inaccurate and/or incomplete information from UHP, and experienced inappropriate and untimely resolution of their coverage requests and grievances.

UHP's violations include:

1. Failure to notify enrollees and/or providers, of its decisions within CMS required timeframes for standard and expedited coverage and organization determinations and expedited redeterminations. UHP did not have a process in place to notify enrollees when a request for coverage was issued, in cases where the request came from a provider. As a result, enrollees may have experienced a delay in obtaining access to medical care and prescribed medications. This is in violation of 42 C.F.R. §§ 422.568(b), 422.572(a), 423.568(b), 423.590(d), 423.572(a); IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Sections 40 and 50; and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 40, 50 and 70.

2. Failure to effectuate decisions within CMS required timeframes for expedited coverage and organization determinations. UHP did not track the dates and times requests were received, and instead started the clock on adjudication timeframes whenever staff began working on the request. As a result, enrollees may have

experienced a delay in obtaining access to medical care and prescribed medications. This is in violation of 42 C.F.R. §§ 422.572(a) and 423.572(a); IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Section 50; and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 50 and 130.

3. Failure to auto-forward coverage determinations and redeterminations to the Independent Review Entity (IRE) for review and disposition. UHP was unfamiliar with CMS' requirement to forward coverage requests to the IRE when a decision was not made timely. Untimely coverage request cases were never auto-forwarded to the IRE. As a result, enrollees were denied or delayed in receiving IRE review. This is in violation of 42 C.F.R. §§ 423.568(h), 423.572(d), 423.578(c), 423.590(c), 423.590(e); and IOM Pub. 100-18, Medicare Prescription Drug Manual, Chapter 18, Sections 40.4, 50.6, 70.7.1., 70.8.2, and 70.10.

4. Misclassified organization/coverage determinations, appeals and grievances.

    a. UHP failed to properly classify complaints regarding co-payments and medical service authorizations as organization determinations. As a result, enrollee complaints were adjudicated inappropriately, which enrollees likely experienced delays in receiving coverage decisions and/or were not provided with an opportunity to appeal an adverse decision. This is in violation of 42 CFR §§ 422.564(b) and 422.566(b); and IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Sections 10 and 20.

    b. UHP had no process for identifying requests received within 60 days of a denial as an appeal. As a result, enrollees were denied a second-level review and IRE appeal rights that are associated with an adverse redetermination. This is in violation of 42 CFR § 423.580; and IOM Pub.100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 30 and 70.

5. Failure to ensure the clinical accuracy of Part D coverage determinations and Part C organization determinations and appeals involving medical necessity. UHP did not employ a Medical Director responsible for ensuring the clinical accuracy of requests involving medical necessity. As a result, coverage requests were adjudicated through an inappropriate clinical decision-making process and enrollees were improperly denied access to care and prescribed medications when they met the indications cited in applicable National or Local Coverage Determinations. This is in violation of 42 CFR §§ 42 CFR § 423.562(a)(5) and 422.562(a)(4); and IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Section 10.2, Paragraph 3.

6. Failure to conduct sufficient outreach to providers or enrollees to obtain additional information necessary to make an appropriate clinical decision.

    a. UHP's oversight was inadequate to ensure its policies and procedures regarding outreach to providers and beneficiaries were properly implemented, and determinations were made based on accurate and thorough supporting

documentation. As a result, enrollees were inappropriately denied and experienced delays in access to care. This is in violation of 42 C.F.R. § 422.566; and IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Sections 70.7.1 and 70.7.2, and Chapter 4, Section 110.4.

b. Also, UHP failed to request required clinical information via its prior authorization form. As a result, enrollees were deprived of the ability to initiate a complete prior authorization request and ultimately denied access to necessary medications. This is in violation of 42 C.F.R. §§ 42 CFR § 423.566(a), 423.578, and 423.586; and IOM Pub.100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Section 10, 30 and 70.

7. Failure to comply with cost-sharing requirements. UHP failed to implement its policy to waive co-payments for facility-to-facility ambulance transfers, as indicated in its Evidence of Coverage. As a result, enrollees were charged a co-payment for facility-to-facility transfer via ambulance of $3,500. These inappropriate charges may have resulted in enrollee financial harm. This is in violation of 42 CFR § 422.270(b); and IOM Pub.100-16, Medicare Managed Care Manual, Chapter 4, Section 180.

8. Inappropriate denials of service to enrollees and/or payments to providers. As a result, enrollees were denied access to covered medical benefits and may have experienced financial harm. This is in violation of 42 CFR § 422.101(a) and (b); and IOM Pub. 100-16, Medicare Managed Care Manual, Chapter 13, Sections 10.2 and 10.4.1.

9. Failure to fully investigate and appropriately address all issues identified in grievances. UHP lacked effective processes for maintaining adequate documentation, communicating with enrollees, and researching the status of enrollees' requests. As a result, grievances were not resolved and the lack of investigation created the potential for a delay or denial in access to care and/or a financial hardship. This is in violation of 42 C.F.R. § 423.564(a); and IOM Pub.100-18 Medicare Prescription Drug Benefit Manual, Chapter 18, Section 20.

10. Approval letters did not accurately or fully explain the conditions of approval for Part D medications. UHP approval letters did not define applicable quantity limits, step therapy, and prior authorization criteria. As a result, enrollees may have experienced delays of access to the requested medications because they did not understand the criteria for approval. This is in violation of 42 CFR §§ 423.568(e), 423.572(c)(1), and 423.590(h); and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 40, 50, and 70.

11. Denial letters did not include an adequate rationale and/or contained incorrect information specific to the denial.

a. UHP denial letters either lacked information that was provided with the original request, were incomplete or included language that pertained only to providers. As a result, enrollees may not have understood the reason their requests were denied and their ability to file an adequate appeal could be impaired and result in delay or denial of care and/or financial hardship. This is in violation of 42 CFR § 422.568(d); and IOM Pub.100-16, Medicare Managed Care Manual, Chapter 13, Section 40.

b. In addition, enrollee denial letters included language that was inconsistent with formulary criteria, inaccurately described criteria required for approval, referenced incorrect medication, and recommended inappropriate formulary alternatives. This is in violation of 42 CFR § 423.568(g), 423.572(c)(2), 423.590(g); and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 18, Sections 40, 50, and 70.

**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 sponsors that offer prescription drug benefits. Sponsors of these plans (Part D Sponsors) are required to enter into an agreement with CMS by which the sponsor agrees to comply with a number of requirements based upon statute, regulations, and program instructions.

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

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. A Part D sponsor can change its formulary mid-year, but in order to do so must first obtain prior CMS approval, and then notify its enrollees of any changes, in addition to changes in cost-sharing amounts for formulary drugs. The CMS formulary review and approval process includes a review of the Part D sponsor's proposed drug utilization management processes to adjudicate Medicare prescription drug claims (Part D claims).

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

Prior authorization is a utilization management technique used by Part D sponsors (as well as commercial and other health insurers) that requires enrollees to obtain approval from the sponsor for coverage of certain prescriptions prior to being dispensed the medication. Part D enrollees can find out if prior authorization is required for a prescription by asking their physician or

checking their plan's formulary (which is available online). 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. A quantity limit may be placed on a medication as a safety edit based on FDA maximum daily dose limits. Quantity limits may also be placed on a drug for dosage optimization, which helps to contain costs.

In addition, Part D sponsors (as well as commercial and other health insurers) use step therapy to ensure that when enrollees begin drug therapy for a medical condition, the first drug chosen is cost-effective and safe and other more costly or risky drugs are only prescribed if they prove to be 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) and IOM Pub.100-18, Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4)*

Additionally, a Part D sponsor must provide for an appropriate transition process for enrollees prescribed any Part D drugs that are not on its formulary in certain designated situations. A Part D Sponsor's transition process must address situations in which an individual brings a prescription for a drug that is not on the formulary to a participating pharmacy. This may be particularly true for full-benefit dual eligible (i.e., Medicare and Medicaid) enrollees who are auto-enrolled in a plan and do not make an affirmative choice based on review of a plan's benefit relative to their existing medication needs. Part D sponsors must have systems capabilities that allow them to provide a one-time, temporary supply of a non-formulary Part D drug (including Part D drugs that are on a sponsor's formulary but require prior authorization or quantity limits under a sponsor's utilization management rules). In the long-term care setting, the temporary supply of non-formulary Part D drugs must be for at least 91 days, and may be up to at least 98 days, consistent with the dispensing increment, with refills provided, if needed. The transition process is designed to accommodate the immediate needs of an enrollee, as well as to allow the sponsor and/or the enrollee sufficient time to work out an appropriate switch to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity reasons.

**Violations Related to Formulary & Benefit Administration**

CMS identified violations of Part D formulary and benefit administration requirements that resulted in UHP's enrollees experiencing inappropriate denials of coverage at the point of sale.

UHP's violations include:

12. Failure to resolve claims that rejected for invalid National Provider Identifier with pharmacies within one business day. UHP had no formal process to communicate with the pharmacies to resolve these rejection issues within 1 day. As a result,

enrollees experienced inappropriate denials of coverage at the point of sale and were delayed access to prescription. This is in violation of 42 CFR § 423.120(c)(5).

13. Failure to properly administer its CMS-approved formulary by applying unapproved quantity limits. UHP entered quantity limits that could not be met by the medication strength/dosage form available. As a result, enrollees received less than the appropriate quantity of certain medications, experienced inappropriate denials of coverage at the point of sale and were delayed access to prescription. This is in violation of §§ 423.104(a) and 423.120(b)(2); and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30 and Chapter 7, Sections 20 and 60.

14. Failure to properly administer its CMS-approved formulary by applying unapproved prior authorization edits. UHP programmed a certain drug with a prior authorization requirement while adding another drug into its system and had no process for ensuring medications with prior authorization requirements were properly adjudicated. As a result, enrollees experienced inappropriate denials of coverage at the point of sale and were delayed access to prescription. This is in violation of 42 CFR § 423.120(b)(2); and IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.

**Compliance Program Relevant Requirements**
*(42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 9; IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21)*

Sponsors are required to adopt and implement an effective compliance program, which must include measures that prevent, detect and correct non-compliance with CMS' program requirements. An effective compliance infrastructure is necessary for a sponsor to adequately monitor and oversee its operations as a whole. Serious issues of non-compliance often occur when a sponsor does not dedicate the resources to developing and maintaining an effective compliance program. Some of the most important requirements for an effective compliance program include, but are not limited to: involving the sponsor's senior leaders in issues of non-compliance; developing an effective system for routine monitoring and identifying of compliance risks; promptly responding to compliance issues as they are raised; investigating potential issues of non-compliance and correcting those problems; and monitoring and auditing first tier entities that contract with the sponsor to ensure that they are in compliance with CMS requirements.

**Violations Related to Compliance**

CMS' audit determined that UHP is in substantial violation of compliance program requirements.

UHP's violations include:

15. Failure to establish and implement a formal risk assessment and an effective system for routine monitoring and auditing of identified compliance risks. This is in

violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(F) and 423.504(b)(4)(vi)(F); IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21, Section 50; and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.

16. Failure to have adequate and appropriate resources dedicated to FDR audit activities. This is in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(F) and 423.504(b)(4)(vi)(F); IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21, Section 50; and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.

17. Failure to provide updates on results of monitoring, auditing, and compliance failures to senior leadership. This is in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(B) and 423.504(b)(4)(vi)(B); IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21, Section 50; and IOM Pub.100-18 Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.

18. Failure to receive regular reports of audit and monitoring results and the status of the effectiveness of corrective actions taken. This is in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(F) and 423.504(b)(4)(vi)(F); IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21, Section 50; and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.

19. Failure to maintain thorough documentation of all deficiencies identified and corrective actions taken. This is in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(G) and 423.504(b)(4)(vi)(G); IOM Pub. 100-16 Medicare Managed Care Manual, Chapter 21, Section 50; and IOM Pub. 100-18 Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.

UHP did not have the proper resources dedicated to the compliance function, which affected their ability to complete a formalized risk assessment, implement annual monitoring and auditing work plans, and ensure its operational areas complied with Medicare regulations. In addition to having insufficient staff, UHP did not demonstrate an understanding of CMS requirements for monitoring its FDRs and assumed its FDRs would independently comply with all applicable CMS requirements. The committee overseeing the compliance program was not aware of its responsibilities and requirements for reporting auditing and monitoring activities to its senior leadership. UHP's Compliance Officer was not able to effectively conduct any follow up of corrective action plans to ensure they were effective in fully addressing and resolving identified compliance issues.

**Basis for Intermediate Sanctions**

CMS has determined that UHP's deficiencies provide a sufficient basis for the imposition of intermediate sanctions (42 C.F.R. §§ 422.752(b) and 423.752(b)). UHP failed substantially:

- To carry out the terms of its contracts with CMS (42 C.F.R §§ 422.510(a)(1) and 423.509(a)(1));

- To comply with the requirements in 42 C.F.R. Parts 422 and 423 Subpart M related to grievances and appeals (42 C.F.R. §§ 422.510 (a)(4)(ii) and 423.509(a)(4)(ii));
- To comply with the Part D service access requirements in § 423.120 (42 C.F.R. § 423.509(a)(4)(iv)).

*UHP's Deficiencies Create a Serious Threat to Enrollee Health and Safety*

UHP's lack of fundamental oversight and monitoring, inadequate knowledge of basic Parts C & D requirements, along with an insufficient compliance infrastructure, place its Medicare beneficiaries at a high risk of harm. UHP's failures have a serious impact on beneficiaries' access to medical services and prescription medications and may increase beneficiary out-of-pocket costs. The nature of UHP's noncompliance provides sufficient basis for CMS to find the presence of a serious threat to enrollees' health and safety, supporting the immediate suspension of UHP's enrollment and marketing activities. Consequently, these sanctions are effective on February 26, 2016 at 11:59 p.m. EST, pursuant to the authority provided by 42 C.F.R. §§ 422.756(c)(2) and 423.756(c)(2).

**Opportunity to Correct**

Pursuant to 42 C.F.R. §§ 422.756(c)(3) and 423.756(c)(3), the sanctions will remain in effect until CMS is satisfied that the deficiencies that are the basis for the sanctions determination have been corrected and are not likely to recur. UHP is solely responsible for the identification, development, and implementation of its Corrective Action Plan, and for demonstrating to CMS that the underlying deficiencies have been corrected and are not likely to recur. Attached to this notice is a Corrective Action Plan template with instructions for UHP to complete. UHP should submit its Corrective Action Plan to CMS within seven (7) calendar days from the date of receipt of this notice, or by March 4, 2016. If UHP needs additional time beyond seven (7) days to submit its Corrective Action Plan, contact your enforcement lead. Once UHP has fully implemented its Corrective Action Plan, it must submit to CMS an attestation from UHP's Chief Executive Officer, or most senior official, stating that UHP has corrected the deficiencies that are the basis for the sanction and they are not likely to recur.

**Hiring of an Independent Auditor**

Pursuant to 42 C.F.R. §§ 422.756(c)(3)(i) and 423.756(c)(3)(i), CMS is requiring UHP to hire an independent auditor to conduct a validation audit of all operational areas cited in this notice and to provide a written report to CMS. Upon completion of the validation audit, CMS will make a determination about whether the deficiencies that are the basis for the sanctions have been corrected and are not likely recur. CMS will send additional information about the use of an independent auditor in a separate communication.

**Opportunity to Respond to Notice**

Pursuant to 42 C.F.R. §§ 422.756(a)(2) and 423.756(a)(2), UHP has ten (10) calendar days from the date of receipt of this notice to provide a written rebuttal, or by March 8, 2016. Please note that CMS considers receipt as the day after the notice is sent by fax, email, or overnight mail or

in this case February 27, 2016. If you choose to submit a rebuttal, please send it to the attention of Vikki Ahern at the address noted below. Note that the sanctions imposed pursuant to this letter are not stayed pending a rebuttal submission.

**Right to Request a Hearing**

UHP may also request a hearing before a CMS hearing officer in accordance with the procedures outlined in 42 C.F.R. §§ 422.641-696 and 423.650-662. Pursuant to 42 C.F.R. §§ 422.756(b) and 423.756(b), a written request for a hearing must be received by CMS within fifteen (15) calendar days of receipt of this notice, or by March 13, 2016.[1] Please note, however, a request for a hearing will not delay the date specified by CMS when the sanctions become effective. Your hearing request will be considered officially filed on the date that it is mailed; accordingly, we recommend using an overnight traceable mail carrier.

The request for a hearing must be sent to the CMS Hearing Office at the following address:

Benjamin Cohen
CMS Hearing Officer
Office of Hearings
ATTN: HEARING REQUEST
Centers for Medicare & Medicaid Services
2520 Lord Baltimore Drive
Suite L
Mail Stop: LB-01-22
Baltimore, MD 21244-2670
Phone: 410-786-3169
Email: Benjamin.Cohen@cms.hhs.gov

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

Vikki Ahern
Acting Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C1-22-06
Email: vikki.ahern@cms.hhs.gov

CMS will consider the date the Office of Hearings receives the email or the date it receives the fax or traceable mail document, whichever is earlier, as the date of receipt of the request. The request for a hearing must include the name, fax number, and e-mail address of the contact within UHP (or an attorney who has a letter of authorization to represent the organization) with whom CMS should communicate regarding the hearing request.

[1] If the 15th day falls on a weekend or federal holiday, you have until the next regular business day to submit your request.

Please note that we are closely monitoring your organization and UHP may also be subject to other applicable remedies available under law, including the imposition of additional sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O. CMS will consider taking action to immediately terminate your contract if issues that pose a serious threat to the health and safety of Medicare beneficiaries are identified or left uncorrected.

If you have any questions about this notice, please call or email the enforcement contact provided in your email notification.

Sincerely,

/s/

Gerard J. Mulcahy
Director
Medicare Parts C and D Oversight and Enforcement Group

Enclosure:
Attachment A – Corrective Action Plan Template

cc: Gloria Parker, CMS/CMHPO/Region V
Michael Taylor, CMS/CMHPO/Region V
Lorraine Williams, CMS/CMHPO/Region V
Shannon Comage, CMS/CMHPO/Region V