DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C1-22-06
Baltimore, Maryland 21244-1850

Program Compliance and Oversight Group

November 19, 2010

VIA:
FEDERAL EXPRESS DELIVERY
EMAIL (Scott.R.Kelley@healthnet.com)
AND FACSIMILE: (818-676-8004)

Mr. Scott R. Kelly
Chief Government Programs Officer
Health Net, Inc.
21650 Oxnard St., 23rd Floor
Woodland Hills, CA 91367
Phone: 818-676-7620

Re: Notice of Immediate Imposition of Intermediate Sanctions (Suspension of Enrollment and Marketing) For All Medicare Advantage/Prescription Drug Contracts and All Standalone Prescription Drug Plan Contracts

Dear Mr. Kelly:

The Centers for Medicare & Medicaid Services (CMS) hereby informs Health Net, Inc. (Health Net) of its decision to immediately impose intermediate sanctions on contract numbers H0351, H0562, H5439, H5520, H6815 and S5678 pursuant to 42 C.F.R. § 422.752 and 42 C.F.R. § 423.756.

These intermediate sanctions will consist of the suspension of enrollment of Medicare beneficiaries (42 C.F.R. § 422.750(a)(1), 42 C.F.R. § 423.750(a)(1)) and the suspension of all marketing activities to Medicare beneficiaries (42 C.F.R. § 422.750(a)(3), 42 C.F.R. § 423.750(a)(3)). CMS is imposing these intermediate sanctions immediately, effective November 19, 2010 at 11:59 p.m., pursuant to 42 C.F.R. § 423.756(d)(2), because it has determined that Health Net's conduct poses a serious threat to the health and safety of Medicare beneficiaries. Pursuant to 42 C.F.R. § 422.756(d)(3) and 42 C.F.R. § 423.756(d)(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.

As the parent organization for entities that hold five Part C Medicare Advantage (MA-PD) contracts and one Part D Prescription Drug Plan (PDP) contract insuring more than 659,000 members in all 50 states, Health Net has been entrusted to provide Medicare beneficiaries with access to essential Medicare services, including prescription drug benefits. Health Net has demonstrated to CMS that it is significantly impaired with respect to its ability to maintain and administer a prescription drug formulary in accordance with CMS requirements, which is central to the responsibilities of MA-PD and PDP plans. Health Net's failures in the area of formulary and benefits administration have impacted its enrollees in different ways, in many cases to the detriment of their health and safety.

The severity of Health Net's conduct is magnified by the fact that 62% of its members are Low Income Subsidy (LIS) beneficiaries who are likely unable to afford to buy medication that is not covered by their insurance.

I. Prescription Drug Program Requirements – Access to and Provision of Benefits

Medicare Part D Prescription Drug Program requirements apply both to stand-alone PDP sponsors (i.e., organizations that offer Part D-only plans) and to Part C MA plans that include prescription drug benefits (MA-PD). Sponsors of these plans are required to enter into a contract with CMS by which the sponsor agrees to comply with a number of requirements based upon statute, regulations and program instructions. A Part D sponsor's central mission is to provide Medicare beneficiaries with prescription medications within a framework of Medicare requirements that provide a Part D sponsor's enrollees with a number of beneficiary protections.

Each Part D sponsor maintains a drug formulary, or list of prescription medications, covered by the Part D 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. (42 C.F.R. § 423.120(b)(2)(iv); Medicare Prescription Drug Benefit Manual, Pub.100-18, ch. 6 § 30.2. A Part D sponsor can change its formulary mid-year, but must obtain prior CMS approval and must notify its enrollees of any changes, including any changes in cost-sharing amounts for formulary drugs (42 C.F.R. §§ 423.120(b)(4)-(6); Medicare Prescription Drug Benefit Manual, Pub.100-18, ch. 6 § 30.3). CMS' formulary review and approval process includes a review of the Part D sponsor's proposed use of drug utilization management processes to adjudicate Medicare prescription drug claims (Part D claims), including the use of prior authorization (PA) or step therapy (ST) requirements (42 C.F.R. § 423.272(b)(2); Medicare Prescription Drug Benefit Manual, Pub.100-18,ch. 6 § 30.2).

Prior authorization is a utilization management technique used by Part D sponsors (as well as by commercial and other health insurers) that requires enrollees to obtain prior approval from the Part D sponsor for coverage of certain prescriptions prior to being

prescribed the medication. Part D sponsor enrollees can find out if prior authorization is required for a prescription by 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 FDA and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.

Step therapy is a utilization management technique used by Part D sponsors (as well as commercial and other health insurers) to ensure that when an enrollee begins drug therapy for a medical condition, the first drug chosen is the most cost-effective and safest drug, and other more costly or risky drugs are only prescribed if they prove to be clinically necessary. The goal of ST is to control costs and minimize clinical risks.

Nonetheless, CMS has designated six drug classes in which Medicare beneficiaries must have ***uninterrupted access*** to all or substantially all of the drugs in that class. These are drugs that are typically critical to the health and safety of the population for whom they are prescribed. Therefore, Part D sponsors are not permitted to require PA or ST for members stabilized on drugs from the following "protected classes" (PA and ST are never allowed for antiretrovirals) (Medicare Prescription Drug Benefit Manual, Pub.100-18, ch. 6§ 30.2.5). The protected classes include:

- Antidepressants (e.g., fluoxetine, venlafaxine, sertraline) used for treating depression;
- Antipsychotics (e.g., Risperdal, Zyprexa, Seroquel) used for treating psychiatric disorders;
- Anticonvulsants (e.g., divalproex, Lyrica, carbamazepine) used for preventing or reducing seizures;
- Antiretrovirals used for the treatment of HIV and AIDS;
- Antineoplastics used for the treatment of cancers; and
- Immunosuppressants used to prevent the rejection of transplants.

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 scenario is particularly likely to affect full-benefit dual eligible (i.e., Medicare and Medicaid) beneficiaries 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 (42 C.F.R. § 423.120(b)(3); Medicare Prescription Drug Benefit Manual, Pub.100-18, ch. 6, § 30.4).

Part D sponsors must have systems capabilities that allow them to provide a one time, temporary supply of non-formulary Part D drugs (including Part D drugs that are on a sponsor's formulary but require PA or ST under a sponsor's utilization management rules) in order to accommodate the immediate needs of an enrollee, as well as to allow the sponsor and/or the enrollee sufficient time to work out with the prescriber an

appropriate transition to a therapeutically equivalent medication or the completion of an exception request to maintain coverage of an existing drug based on medical necessity. (42 C.F.R. § 423.120(b)(3); Medicare Prescription Drug Benefit Manual, Pub.100-18 ch. 6 § 30.4).

II. Legal Basis for Immediate Imposition of Marketing and Enrollment Sanctions

CMS has determined that Health Net's compliance deficiencies, as described in detail herein, provide a sufficient basis for the immediate imposition of intermediate sanctions (42 C.F.R. § 422.752(b) ; 42 C.F.R. § 423.752(b)). CMS has determined that:

- Health Net substantially failed to carry out the terms of its MA Organization and Prescription Drug Plan contracts with CMS (42 C.F.R. § 422.510(a)(1); 42 C.F.R. § 423.509(a)(1)).

- Health Net is carrying out its contracts with CMS in a manner that is inconsistent with the effective and efficient implementation of the program (42 C.F.R. § 422.510(a)(2); 42 C.F.R. § 423.509(a)(2)).

- Health Net failed to comply with the requirements in subpart M of Part 423 related to appeals and grievances (42 C.F.R. § 422.510(a)(6); 42 C.F.R. § 423.509(a)(6)).

Further, CMS has determined that Health Net's conduct poses a serious threat to the health and safety of its enrollees which justifies making this sanction effective on November 19, as specified by CMS, pursuant to the authority provided by 42 C.F.R. § 423.756(d)(2).

III. Decision to Immediately Impose Intermediate Sanctions

CMS has imposed these sanctions as a result of Health Net's intractable failure to provide its enrollees with prescription drug benefits in conformance with applicable law, the terms of its contract and CMS guidance. Health Net's deficient administration of its prescription drug program exposes Health Net enrollees to imminent and serious health risks. CMS has found that Health Net has continually subjected its enrollees to impermissible hurdles in their attempts to obtain needed, and in some cases, life sustaining, prescription medications. Therefore, CMS is compelled to immediately impose marketing and enrollment sanctions.

CMS has determined that Health Net has committed the following violations:

- Failed to follow CMS requirements regarding transition supplies of prescription drugs, including failing to provide for the appropriate transition

of new enrollees and existing beneficiaries prescribed Part D drugs that are not on Health Net's formulary in violation of Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch.6 §§ 30.4, 30.4.1.

- Improperly applied prior authorization requirements on existing beneficiaries and new enrollees who are actively taking drugs within a protected class in violation of Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch.6, § 30.2.5.

- Failed to provide timely and appropriate point-of-service claims adjudication in violation of 42 C.F.R. § 423.505(b)(17).

- Applied quantity limits (including those for protected class drugs) that were not approved by CMS in violation of 42 C.F.R. § 423.104(a), § 423.120(b)(2), and Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 6 §§ 30.2, 30.2.5; ch. 7 § 60.6.

- Improperly applied step therapy and prior authorization criteria in point-of-service edits, in violation of 42 C.F.R. § 423.104(a), § 423.120(b)(2), and Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 6 § 30.2.; ch. 7 § 60.6.

- Improperly rejected prescriptions at the point of service as non-formulary when in fact, the drugs are on Health Net's formulary, in violation of 42 C.F.R. § 423.104(a), § 423.120(b)(2), and Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 6 § 30.2.2.

- Improperly processed coverage determination requests, including, among other errors, automatically approving coverage determination requests if Health Net is otherwise unable to make a determination within a self-imposed deadline, failed to review the determinations manually for appropriateness, and approved requests for drugs that are not covered under Medicare Part D in violation of 42 C.F.R. §§ 423.566, 423.568, 423.572, Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch.18 §§ 40.2, 40.3.4and 130.1.

- Failed to auto-forward coverage determinations to the Independent Review Entity (IRE) in violation of 42 C.F.R. § 423.568(e) and Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch.18 § 40.4.

- Failed to timely process redetermination requests in violation of 42 C.F.R. § 423.590 and Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 18 §§ 70.7 and 70.8.1.

- Failed to establish an effective Part C and D Compliance Program in violation of 42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504(b)(4)(vi) and

Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 9.

These numerous violations of law have continued for a significant period of time. Despite extensive communication with CMS about these serious compliance issues, Health Net has been wholly unable to satisfactorily address these serious deficiencies and to deliver services in a manner consistent with its obligations to CMS and to the Medicare beneficiaries. Accordingly, the circumstances demand the imposition of marketing and enrollment sanctions until the violations can be cured with reasonable assurance that they will not recur.

A. History of Non-Compliance

Health Net has been under CMS scrutiny for the past several years because of a track record of serious compliance deficiencies in the operation and administration of its Part C and Part D contracts. This is the second time that CMS has imposed intermediate sanctions on Health Net for critical program deficiencies. Specifically, in 2008 CMS imposed marketing and enrollment sanctions on Health Net for numerous violations of enrollment requirements. More recently, non-compliance with program requirements has caused CMS to issue Health Net 13 Notices of Non-Compliance and one Warning Letter at the parent organizational level and 23 Notices of Non-Compliance and three Warning Letters at the contract level in the nine months between January and September 2010. In addition, Health Net was denied monthly LIS re-assignees in February 2010 for the remainder of contract year 2010 and annual re-assignees for contract year 2011 because of its persistent non-compliance with requirements regarding the processing of prescription drugs at the point of service, the failure to provide new beneficiaries with appropriate transition drugs; and the failure to provide beneficiaries access to protected class medications when authorization expires or doses change.

B. On-Site Audit of Health Net in August 2010

As a result of CMS' concerns about Health Net's administration of its Part C and D contracts, CMS conducted an on-site audit of Health Net in August 2010. At that time, CMS discovered glaring violations of CMS requirements with respect to Health Net's administration of its prescription drug formulary. Health Net's failures to properly manage its formulary have impacted its enrollees with respect to transition of drug coverage, prescription drug formulary adjudication and coverage determination and redetermination processes.

Issues of access to care and prescription medication can readily result in a potentially dangerous decline in medical status in this vulnerable population, many of whom suffer from chronic and disabling health conditions. CMS has expressed its grave concerns over Health Net's formulary and benefit administration, and the dangers that the lack of access to prescription medications poses to the health and safety of Medicare beneficiaries. Since the audit, CMS has given Health Net numerous opportunities to

demonstrate that it has addressed and corrected these deficiencies. Unfortunately, Health Net has utterly failed to do so.

Failure to Comply with CMS Transition Policy

Health Net has experienced massive failures with respect to supplying new and existing enrollees with required transition supplies of prescription drugs. Under federal regulations and CMS rules, Health Net is required to have system capabilities that, during the first 90 days of coverage, allow a one-time temporary supply of non-formulary drugs to enrollees who have not meaningfully transitioned to a formulary drug at the time they request a refill. 42 C.F.R. §423.120(b)(3); Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 6 §§30.4, 30.4.1. The purpose of the temporary fill is to allow the sponsor and/or the enrollee sufficient time to work with the prescribing physician an appropriate transition to a therapeutically equivalent medication within the formulary or to complete an exception request.

During the on-site audit, CMS auditors learned that Health Net did not effectuate a meaningful transition for enrollees who were affected by a formulary change between contract year 2009 and contract year 2010. While Health Net's transition policy stated that affected enrollees would either be transitioned to a formulary drug prior to the beginning of the contract year or be provided a transition fill at the beginning of the contract year, the documentation reviewed by the auditors demonstrated that Health Net failed to ensure that a meaningful transition occurred. Health Net did not program its systems to identify affected enrollees and thus transition-eligible fills were rejected at the point-of-service. The auditors reported that Health Net failed to perform adequate oversight and testing of its claims system to ensure that claims were processing in accordance with its stated transition policy. Health Net officials told CMS during the audit exit conference that they were unaware of this failure until the CMS audit.

The auditors also identified errors in Health Net's processing of transition-eligible claims for new enrollees. The auditors reviewed files provided by Health Net and concluded that, on a widespread basis, Health Net rejected claims that should have been eligible for transition fill during the first 90 days of 2010. Health Net was unable to identify the cause of this error during the audit.

After the audit concluded, Health Net confirmed for CMS that it substantially failed to comply with transition policy requirements during CY 2010. In an October 17, 2010 email to CMS, Health Net stated that between January 1, 2010 and August 22, 2010, it failed to properly comply with transition requirements resulting in 127,258 improperly rejected claims for 89,832 new and existing Health Net enrollees.

Improper Adjudication of CMS Approved Part D Formulary

Health Net is required to provide benefits by means of point-of-service systems to adjudicate drug claims in a timely and efficient manner. 42 C.F.R. § 423.505(b)(17). During the audit, CMS found that a number of drugs on Health Net's CMS-approved

formulary were being improperly denied by Health Net. Despite their inclusion on the approved formulary, Health Net records reviewed by the auditors indicated that the drugs were rejecting at point-of-service. Health Net reported that these rejections were the result of system coding errors. The affected drugs included Protonix (for acid reflux), Wellbutrin (for depression), Crestor (for high cholesterol), Flector (for pain), Mirapex (for Parkinson's disease), and hydrocodone/APAP (for pain). Health Net provided files containing claims rejections for these drugs. Based on the data within these files, thousands of beneficiaries experienced pharmacy rejections due to these errors.

During the audit CMS also found that Health Net was applying impermissible quantity limits not approved by CMS to drugs listed on its formulary. For example, claims for the protected class drugs Cymbalta, and Risperdal Consta were being restricted to quantities lower than those on Health Net's approved formulary. Hundreds of beneficiaries experienced rejected claims at the pharmacy because of these errors.

The audit found that Health Net has also inappropriately applied step therapy and prior authorization criteria – not approved by CMS, as required – in point-of-service edits. Health Net's formulary benefits management tool is not consistent with CMS guidelines, as is required under federal regulations and CMS rules. 42 C.F.R. §§ 423.104(a); §423.120(b)(2); Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 6 § 30.2; ch. 7 § 60.6.

Improper rejection for drugs within the protected classes

CMS requirements prohibit Part D sponsors from applying PA or ST requirements to drugs from certain therapeutic classes for beneficiaries who are already taking the drug. Auditors found that Health Net's failure to comply with CMS formulary requirements had a significant impact on patient access to drugs within the classes of clinical concern. Health Net has failed to ensure that access for these drugs was uninterrupted. Health Net has had numerous problems in this area. For example:

- For new enrollees, Health Net did not have any mechanisms in place to help determine whether the enrollees were already taking drugs within the protected classes. As such, newly enrolled beneficiaries presenting prescriptions for protected class drugs were inappropriately subjected to PA and ST requirements.

- CMS expects that PA requirements will be applied for each drug regardless of strength or dosage form. In rare instances, sponsors may impose PA requirements at a drug strength or dosage level but only when approved by CMS. The audits found that Health Net had entered PA approvals for protected class drugs at the drug, strength, and dosage form level when PA requirements at that level had not been approved by CMS. Thus, when dose adjustments were necessary, enrollees were subjected to additional unnecessary and inappropriate PA requirements.

- Health Net inappropriately applied quantity limitations for protected class drugs including Cymbalta and Risperdal Consta.

- Health Net reported to CMS that they did not believe that the anticonvulsant Lyrica should be considered a protected class drug, even though it is, in fact, a protected class drug. Therefore, enrollees already established on Lyrica therapy were impermissibly required to receive prior approval for continuation of care with this protected class drug.

Coverage Determinations

Health Net has failed to properly process coverage determination requests from beneficiaries as is required under federal regulations and CMS rules. 42 C.F.R. §423.566, 568, 572; Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 1 §§40.2, 40.3.4, 130.1. Health Net's coverage determination policy is to automatically *approve* coverage determination requests if Health Net is otherwise unable to make a determination within a self-imposed deadline. These automatic approvals are not manually reviewed for clinical appropriateness or safety. By automatically approving determination requests and failing to review the determinations manually for appropriateness, Health Net has violated regulations and created potential health and safety risks for enrollees. In addition, Health Net's failure to follow CMS requirements has resulted in its dispensing of drugs to Medicare beneficiaries that are not even among the drugs covered by Medicare Part D. The audit revealed 256 such approvals.

Health Net has also failed to auto-forward coverage determinations to the Independent Review Entity (IRE). When a party makes a request for a drug benefit or payment, Health Net must notify the enrollee (and the prescribing physician or other prescriber involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the receipt of the request, or, for an expedited request, the physician's or other prescriber's supporting statement. 42 C.F.R. §§ 423.568(a), (b). If Health Net fails to notify the enrollee of its determination in the appropriate timeframe, the failure is deemed to constitute an adverse coverage determination. In that circumstance, Health Net must forward the enrollee's request to the IRE for independent review of the correctness of Health Net's coverage determination within 24 hours of the expiration of the adjudication timeframe 42 C.F.R. § 423.568(e); Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch.18 § 40.4. The IRE review is crucial because it provides the beneficiary with a neutral third party review of his request for coverage.

During the audit, CMS discovered numerous cases that were not forwarded to the IRE. Since, then, despite requests from CMS, Health Net has failed to demonstrate its compliance with CMS rules and regulations regarding independent review of its coverage determinations.

Redeterminations

Health Net has failed to timely process redetermination requests. When Health Net makes a redetermination of a beneficiary request for coverage – either favorable to the beneficiary or adverse – it must notify the enrollee in writing of its redetermination. 42 C.F.R. § 423.590; Medicare Prescription Drug Benefit Manual, Pub. 100-18, ch. 18 §§70.7, 70.8.1. In addition, upon redetermination of a coverage request, Health Net is required to effectuate the decision as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it receives the request for a standard redetermination. 42 C.F.R. §423.636(a)(1). If Health Net, however, fails to provide the enrollee with a redetermination within the timeframes specified, the failure constitutes an adverse redetermination decision, and Health Net must forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. 42 C.F.R. §423.590(c).

During the audit, CMS discovered numerous cases that were not timely processed nor appropriately forwarded to the IRE. Additionally, CMS discovered that Health Net has had no clear process for the administration of redeterminations. In some cases, redeterminations were listed as "Partially Approved" or "Partially Denied" but Health Net could not explain the difference between the two categories. Accordingly, CMS believes that redeterminations are being labeled in an arbitrary manner.

In addition, CMS discovered redetermination cases in which Health Net reversed an earlier denial of coverage, but failed to effectuate the decision to provide the drugs in a timely manner, delaying beneficiary access to their prescription medication. Health Net has not consistently notified enrollees in a timely manner regarding the redetermination decisions. As with the untimely coverage determinations discussed above, Health Net has failed to forward adverse redeterminations to the IRE in a timely manner.

In the months following the audit, CMS requested that Health Net demonstrate that it has achieved compliance with CMS rules and regulations, but Health Net has failed to do so.

Ineffective Compliance Program

Health Net has failed to establish an effective part C and D Compliance Program. Under federal regulations, Health Net is required to establish an effective compliance program to prevent, detect and respond to noncompliance. 42 C.F.R. §422.503(b)(4)(vi); 42 C.F.R. § 423.504(b)(4)(vi). Chapter 9 of the Medicare Prescription Drug Benefit Manual provides guidance on the seven required elements of an effective compliance program. Health Net has a compliance program, but it is ineffective. It is deficient in six of the seven required elements. More specifically, Health Net lacks effective monitoring and oversight of its delegated entities. Nor has it implemented effective risk assessment, internal monitoring, or auditing programs to protect against non-compliance and potential fraud, waste and abuse. In addition, Health Net's governing body has failed to exercise the proper level of oversight and control over its compliance program.

It is the absence of an effective compliance program that has allowed the deficiencies discussed above, and which are the bases for this enforcement action, to occur. An effective compliance program is an indispensible tool in ensuring that Medicare Advantage companies and sponsors of Prescription Drug Programs meet their obligations to CMS and to the Medicare beneficiaries that they serve. Unfortunately, that did not occur in this case.

C. Health Net Has Failed to Take Advantage of Opportunities to Demonstrate Corrective Action

Since the August 2010 audit, Health Net has been given repeated notice of its severe deficiencies and many opportunities to cure, which it has wholly failed to do. CMS has communicated with Health Net's senior leadership via conference calls and emails; it has conveyed the grave nature of the violations and told Health Net that the problems must be resolved. The duration, nature and extent of Health Net's non-compliance with CMS requirements is a strong indicator that Health Net's compliance program has failed to adequately detect, prevent and respond to these compliance deficiencies. Health Net has failed to institute the kind of auditing, risk assessment, internal controls and oversight over its operations and delegated entities that are essential to implementing and maintaining effective compliance operations.

Health Net has continuously demonstrated its failure to comply with important Part D requirements that are critical to protecting the health and safety of its Medicare enrollees. This substantial noncompliance has resulted in significant impediments to enrollees' ability to promptly access needed Part D drugs, and places Health Net's current and future enrollees' health and safety at risk

IV. Opportunity to Respond to Notice

Pursuant to 42 C.F.R. §422.756(a)(2) and 42 C.F.R. §423.756(a)(2), Health Net has ten (10) calendar days from the date of receipt of this notice to provide a written rebuttal, or by November 30, 2010. Please note that CMS considers receipt as the day after the notice is sent by fax, e-mail, or overnight mail, or in this case, November 20, 2010. If you choose to submit a rebuttal, please send it to the attention of Brenda J. Tranchida at the address noted below. It should be noted that the sanctions imposed pursuant to this letter are not stayed pending a rebuttal submission.

V. Right to Request a Hearing

Health Net may also request a hearing before a CMS hearing officer in accordance with the procedures outlined in 42 C.F.R. §§423.650 through 662. Pursuant to 42 C.F.R. §422.756(b) and 42 C.F.R. §423.756(b), your written request for a hearing must be received by CMS within 15 calendar days of your receipt of this notice, or by December 6, 2010. Please note, however, a request for a hearing will not delay the date specified by

CMS when the sanction becomes effective.[1] Your hearing request will be considered officially filed on the date that it is mailed; accordingly, we recommend using an overnight traceable mail carrier.

Health Net must submit a request for a hearing to the following CMS official:

Brenda J. Tranchida
Director, Program Compliance and Oversight Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
MAIL STOP: C1-22-06
Baltimore, MD 21244
Email: brenda.tranchida@cms.hhs.gov
FAX: 410-786-6301

You must also send a courtesy copy of your request by e-mail to the CMS Hearing Officer on the date you mail your request. CMS will consider the date the Office of Hearings receives your e-mail or the date it receives the fax or traceable mail document, whichever is earlier, as the date of receipt of your request. Your request for a hearing must include the name, fax number and e-mail address of the contact within your organization (or the attorney who has a letter of authorization to represent your organization) with whom you wish us to communicate regarding the hearing request. 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 20244-2670
Phone: (410) 786-3169
E-Mail: Benjamin.Cohen@cms.hhs.gov

Please note that we are closely monitoring your organization and Health Net 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. Part 422, Subparts K and O and 42 C.F.R. Part 423, Subparts K and O. CMS believes these issues to be of such a serious nature that if left uncorrected, CMS will consider taking action to immediately terminate your contract.

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

If you have any questions about this determination, please do not hesitate to contact Trish Axt directly at (410) 786-0095 or trish.axt@cms.hhs.gov.

Sincerely,

/s/

Brenda J. Tranchida
Director
Program Compliance and Oversight Group

cc: Mr. Jonathan Blum, CMS/CM
Mr. Timothy Hill, CMS/CM
Ms. Cynthia Tudor, CMS/CM/MDBG
Ms. Jennifer Shapiro, CMS/CM/MDBG
Ms. Judith Geisler, CMS/CM/MDBG
Ms. Danielle Moon, CMS/CM/MCAG
Ms. Helaine Fingold, CMS/CM/MCAG
Mr. Randy Brauer, CMS/CM/MPPG
Mr. Michael Crochunis, CMS/CM/MEAG
Ms. Mary Wallace, CMS/OEABS
Mr. Peter Ashkenaz, CMS/OEABS
Mr. Greg Jones, CMS/OL
Mr. James Kerr, CMS/CMHPO
Mr. Paul Collura, CMS/CMHPO
Mr. John Spiegel, CMS/CPI
Ms. Bella Roytberg, CMS/CMHPO/Region
Ms. Cathy Smerker, CMS/CMHPO/Region
Ms. Carol Bennett, DHHS/OGC
Ms. Jill Abrams, DHHS/OGC
Ms. Janet Nolan, DHHS/OGC
Ms. Nancy Brown, DHHS/OIG/OCIG
Mr. Benjamin Cohen, CMS/OA
Ms. Trish Axt, CMS/CM/PCOG
Ms. Tawanda Holmes, CMS/CM/PCOG