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

May 29, 2026

Mr. Rick Grindrod
President & CEO
Provider Partners Health Plans
8820 Columbia 100 Parkway - Suite 430
Columbia, MD 21045

Re: Notice of Imposition of Intermediate Sanction (Suspension of Enrollment) for Medicare Advantage-Prescription Drug Plan Contract Number: H8067

Dear Mr. Grindrod:

Pursuant to 42 C.F.R. §§ 422.756 and 423.756, the Centers for Medicare & Medicaid Services (CMS) hereby informs Provider Partners Health Plans ("PPHP") of its determination to impose an intermediate sanction on the following Medicare Advantage-Prescription Drug Plan (MA-PD) Contract: H8067.

The intermediate sanction will consist of the suspension of enrollment of Medicare beneficiaries into PPHP plans (42 C.F.R. §§ 422.750(a)(1) and 423.750(a)(1)). CMS is imposing this intermediate sanction effective June 14, 2026 pursuant to 42 C.F.R. §§ 422.756(c)(1) and 423.756(c)(1). The intermediate enrollment sanction 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 PPHP with detailed instructions regarding the enrollment suspension in a separate communication.

Summary of Noncompliance

This notice imposes an intermediate sanction on PPHP for substantial noncompliance with Medicare Part C requirements around the operation of its Institutional Special Needs Plan (I-SNP). In 2026, CMS became aware that PPHP lost all contractual relationships with its long-term care facilities at the end of 2025 in violation of its Medicare Advantage contract and applicable federal regulations under 42 C.F.R. Part 422. Rather than reporting the network changes to CMS, PPHP sent notices to its enrollees incorrectly attributing the loss of coverage to a loss of Special Needs status and subsequently involuntarily disenrolled approximately 29 beneficiaries on that basis.

PPHP's failures to comply with Medicare Advantage requirements were substantial and have resulted in PPHP no longer substantially meeting the applicable conditions of 42 C.F.R. Part 422 necessary to operate a facility-based I-SNP. As a result, CMS is imposing an enrollment suspension pursuant to 42 C.F.R. § 422.752(b).

Provider Network, Enrollee Notifications, Disenrollment, and Contracting Requirements

I-SNPs are specifically designed to serve beneficiaries who reside in or are expected to reside for 90 days or more in an institutional setting such as a nursing home or long-term care facility or otherwise require an institutional level of care. Facility-Based (FI) I-SNPs are a specialized type of Medicare Advantage plan designed exclusively for institutionalized individuals. To ensure that enrollees have consistent access to care, FI-SNPs are required to either own or contract with at least one institution in every county within their service area and must maintain a direct ownership or contractual relationship with each institutional facility that serves their enrollees. *See* Definition of an FI-SNP 42 C.F.R. § 422.2. This ensures that the plan's network is built around the very settings where its members live and receive care.

Per Chapter 4, Section 110.1.2.2 of the Medicare Managed Care Manual, when an MA organization decides to terminate a contract with a provider, it must notify its CMS Account Manager at least 90 days in advance of any significant, no-cause provider contract termination. Furthermore, to ensure enrollees' awareness of network changes that may impact their access to covered services, 42 C.F.R. § 422.111(e) requires that an MA organization must notify affected enrollees of any contracted provider termination in accordance with the provider termination notice requirements established under § 422.2267(e)(12). When providing notice of a provider termination to enrollees, MA organizations may not mislead, confuse, or provide materially inaccurate information. MA organizations must ensure their statements and the terminology used in communications activities and materials adhere to CMS requirements under 42 C.F.R. § 422.2262.

In addition, consistent with Section 1851(e)(4) of the Social Security Act, CMS's regulations at 42 C.F.R. § 422.62(b)(23) provide that individuals affected by a significant change in a plan's provider network are eligible for a Special Enrollment Period (SEP). Per Section 1882(s)(3)(B)(ii) of the Social Security Act, this SEP comes with Guaranteed Issue (GI) rights, meaning that affected enrollees may obtain a Medigap (Medicare Supplement) policy without being subject to medical underwriting, which is significant financial and coverage protection.

Per 42 C.F.R. § 422.74(a), an MA organization may not disenroll an individual from any MA plan it offers, or request or encourage an individual to disenroll except in limited circumstances. One of those circumstances is that an MA organization can disenroll when individuals enrolled in an MA special needs plan no longer meet the special needs status of that plan. *See* 42 C.F.R. §422.74(b)(2)(iv). However, there is no basis to involuntarily disenroll an individual enrolled in an MA plan due to a significant change in the network.

Description of Noncompliance

During 2025, PPHP experienced a significant breakdown in its facility network. A group of facilities declined to renew or enter into contracts with PPHP, and then PPHP chose to terminate contracts with another group of facilities. The combined effect left PPHP operating without any contracted facilities, a fundamental requirement for FI-SNP operation. Rather than notifying CMS of this network failure and working through the appropriate regulatory process, PPHP took a series of improper actions that harmed its enrollees.

Instead of reporting the network changes to CMS for evaluation of network adequacy and beneficiary impact, PPHP sent notices to its enrollees incorrectly stating that the beneficiaries had lost their Special Needs status. In actuality, the enrollees remained institutionalized and continued residing in the same long-term care facilities. As a result of these notices, some enrollees voluntarily enrolled into other plans. However, for a remaining 29 enrollees, PPHP involuntarily disenrolled them, incorrectly citing loss of Special Needs status even though the enrollees had not lost their Special Needs status. These enrollees did not receive the correct SEP for a significant change in the plan's provider network which would have provided GI rights under federal law.

Since contract H8067 no longer has any network facilities, beneficiaries should not be permitted to enroll in this contract. In order to protect Medicare beneficiaries, CMS is imposing an enrollment suspension pursuant to 42 C.F.R. § 422.752(b). If PPHP does not obtain a network facility in each of the counties within contract H8067 service area in 30 days, CMS will move to terminate contract H8067.

Violations of Provider Network, Enrollee Notification, Disenrollment, and Contracting Requirements

CMS determined that PPHP has substantially failed the following requirements related to provider network, enrollee notification, disenrollment, and contracting requirements.

1. PPHP failed to maintain contracted long-term care facilities as required for FI-SNP operation. Certain facilities declined to enter into contracts with PPHP, while PPHP itself chose to terminate agreements with others. The result is that PPHP currently has no contracted facilities remaining in its network. PPHP's failure to comply with FI-SNP contract and provider network requirements violates 42 C.F.R. §§ 422.2 and 422.112 (a)(1)(i).

2. PPHP failed to notify CMS of the provider network change. More specifically, CMS was unable to evaluate the significance of the network change, assess beneficiary impact, and determine the appropriate course of action, including whether a provider termination SEP should have been made available to affected enrollees. PPHP's failure to timely report these network changes impaired CMS oversight of applicable provider network and beneficiary protection requirements under 42 C.F.R. Part 422, including requirements described in Chapter 4, Section 110.1.2.2 of the Medicare Managed Care Manual.

3. PPHP did not provide enrollees with adequate advance notice of the facility contract terminations. PPHP incorrectly interpreted CMS provider termination notice

requirements and relied on the facility to lead enrollee notification efforts. The notice sent by the facility did not include all of the required information including the appropriate SEP rights. PPHP's failure to comply with enrollee notification requirements violates 42 C.F.R. §§ 422.111(e) and 422.2267(e)(12).

4. PPHP sent inaccurate and misleading notices to beneficiaries. PPHP incorrectly sent the loss of Special Needs status notice to enrollees. In addition, PHHP sent incorrect disenrollment notices to 29 enrollees informing them that they would be disenrolled due to loss of Special Needs status. These notices were factually inaccurate and misleading, as the enrollees did not lose their Special Needs status. PPHP's failure to comply with enrollee notification requirements violates 42 C.F.R. § 422.2262.

5. PPHP inappropriately disenrolled individuals from its MA plan. PPHP involuntarily disenrolled approximately 29 beneficiaries citing "loss of Special Needs status." However, these beneficiaries did not lose their institutionalized status and continued to reside in long-term care facilities. PPHP's failure to comply with disenrollment requirements violates 42 CFR §§ 422.74(a).

6. PPHP did not offer enrollees the correct SEP. More specifically, PPHP did not provide enrollees with the appropriate SEP for a significant change in a plan's provider network which provided GI rights. PPHP's failure to comply with SEP requirements violate sections 1882(s)(3)(B)(ii) and 1851(e)(4) of the Social Security Act; 42 C.F.R. § 422.62(b).

Legal Basis for the Imposition of Intermediate Sanctions

Pursuant to 42 C.F.R. § 422.752(b), CMS may impose an intermediate sanction (enrollment suspension) (42 C.F.R. § 422.750(a)(1) and (3)), for any of the bases listed in 42 C.F.R. § 422.510(a). Specifically, CMS may impose an intermediate sanction if CMS determines an MA organization has failed substantially to carry out its contract (42 C.F.R. § 422.510(a)(1)) and no longer substantially meets the applicable conditions of 42 C.F.R. Part 422 (42 C.F.R. § 422.510(a)(3)).

CMS has determined that PPHP's: (1) failure to maintain an in-network facility; (2) failure to properly notify CMS of the provider network terminations; (3) failure to properly notify enrollees of a provider network termination; (4) failure to provide enrollees with the correct SEP; and (5) improper involuntary disenrollment of enrollees for an incorrect basis, collectively constitutes a substantial failure to carry out its contractual obligations under § 422.510(a)(1). In addition, since PPHP's contract H8067 does not have any facilities in its network, which is a material condition for the definition and operation of a FI-SNP, contract H8067 no longer substantially meets the applicable conditions of 42 C.F.R. Part 422, satisfying § 422.510(a)(3).

Therefore, after considering the seriousness of the noncompliance, CMS has determined that enrollment suspension is necessary and proportionate to protect enrollees and the integrity of the Medicare Advantage program.

CMS further determined that lesser administrative interventions would be insufficient to protect beneficiaries given the complete absence of contracted institutional facilities and the issuance of

materially inaccurate beneficiary communications. PPHP's noncompliance provides a sufficient basis for the imposition of an intermediate sanction (enrollment suspension) (42 C.F.R. § 422.752(b)).

Corrective Action Steps

Pursuant to 42 C.F.R. § 422.756(c)(3) the sanction will remain in effect until CMS is satisfied that the deficiencies that are the basis for the sanction determination have been corrected and are not likely to recur. In addition, pursuant to 42 C.F.R. § 422.510(c)(1), this notice provides a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan.

In order to meet the condition of corrective action, PPHP has 30 calendar days to demonstrate to CMS that contract H8067 either owns or contracts with at least one institution for each county in the plan's service area (*See* Definition of FI-SNP at 42 C.F.R. § 422.2). PPHP has previously indicated that it does not intend to pursue facility contracts. Should PPHP fail to demonstrate compliance within 30 calendar days, CMS will initiate a for-cause termination of contract H8067 pursuant to 42 C.F.R. § 422.510.

Opportunity to Respond to Notice

Pursuant to 42 C.F.R. §§ 422.756(a)(2) and 423.756(a)(2), PPHP has 10 calendar days after the receipt of this notice to provide a written rebuttal, by June 9, 2026. Please note that CMS considers receipt as the day after the notice is sent by fax, email, or overnight mail or in this case May 30, 2026. If you choose to submit a rebuttal, please send it to the attention of Kevin Stansbury at the email address noted below. Note that rebuttal is not an appeal and the sanction imposed pursuant to this letter is not stayed pending a rebuttal submission.

Right to Request a Hearing

PPHP 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 423.650-668. Pursuant to 42 C.F.R. §§ 422.756(b) and 423.756(b), your written request for a hearing must be filed within 15 calendar days after the receipt of this notice, by June 15, 2026.[1] Please note, however, a request for a hearing will not delay the effective date of the sanction.

The request for a hearing must be sent to CMS electronically to the CMS Office of Hearings (OH). OH utilizes an electronic filing and case management system, the Office of Hearings Case and Document Management System ("OH CDMS").

PPHP should complete the one-time OH CDMS registration process as soon as possible after receiving this notice, even if PPHP is unsure whether it will appeal CMS's imposition of an intermediate sanction. After the registration process is complete, PPHP must then file its request for a hearing within the time frame set forth above.

[1] Since the 15th day, June 14, 2026, falls on a weekend or holiday, the date reflected in the notice is the next regular business day for you to submit your request.

Registration information (including how to add an outside representative/law firm to participate in the appeal), filing instructions and general information may be found on the OH webpage at https://www.cms.gov/medicare/regulations-guidance/cms-hearing-officer/hearing-officer-electronic-filing . Follow the OH CDMS External Registration Manual for step-by-step instructions regarding registration and the OH CDMS Hearing Officer User Manual for appeal filing instructions.[2]

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
Email: kevin.stansbury@cms.hhs.gov

CMS will consider the date the Office of Hearings receives the request via the CDMS as the date of receipt of the request(s). The request for a hearing must include the name, fax number, and email address of the contact within PPHP (or an attorney who has a letter of authorization to represent the organization) with whom CMS should communicate regarding the hearing request.

PPHP 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.

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

Sincerely,

/s/

John A. Scott
Director
Medicare Parts C and D Oversight and Enforcement Group

cc: Kevin Stansbury, CMS/CM/MOEG/DCE
Erica Sontag, CMS/CM/MCAG
Mark McMullen, CMS/CM/MEAG
Ashley Hashem, CMS/OPOLE
Verna Hicks, CMS/OPOLE
Scott Spilky, CMS/OPOLE

[2] If technical assistance is required, please contact the OH CDMS Help Desk at 1-833-783-8255 or by email at helpdesk_ohcdms@cms.hhs.gov. The hours of operation are Monday–Friday (excluding federal holidays) from 7:00 a.m. to 8:00 p.m. Eastern Time.