

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1301 Young Street, Suite 106-900  
Dallas, TX 75202



## **Drug & Health Plan Operations**

---

February 18, 2026

### **CORRECTIVE ACTION PLAN REQUEST**

Contract ID: H3814, H5995, H6743, H7006

Parent Organization Name: ATRIO Health Plans

Legal Entity Name: ATRIO HEALTH PLANS

Tony Allotta  
Medicare Compliance Officer  
550 Hawthorne Ave SE #140, Salem  
Salem, OR 97301

VIA EMAIL: [tony.allotta@atriohp.com](mailto:tony.allotta@atriohp.com)

Subject: Corrective Action Plan for failure to timely and accurately pay contracted and non-contracted Part C providers and failure to protect enrollees from financial liability

Dear Tony Allotta:

The Centers for Medicare & Medicaid Services (CMS) is issuing this request for a Corrective Action Plan (CAP) to Atrio Health Plans, which operate(s) the Medicare Advantage Prescription Drug Plan (MA-PD) Contract IDs listed above, regarding your organization's failure to comply with CMS requirements regarding timely and correct payments to non-contracted providers, timely payments to contracted providers, and timely and correct direct member reimbursement (DMR) claims, as well as the failure to ensure enrollee financial protections.

As a result of your organization's pervasive failure to comply with CMS regulations, CMS directs your organization to take corrective action to address the identified areas of non-compliance.

Your organization is non-compliant with the following:

- 42 C.F.R. § 422.214(a)(1), which states that any non-contracted provider (other than those defined in section 1861(u) of the Social Security Act) must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.
- 42 C.F.R. § 422.568(c), which requires the MA organization to process requests for payment according to the "prompt payment" provisions set forth in 42 C.F.R. § 422.520.
- 42 C.F.R. § 422.520(a)(1), which requires that the contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-

service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

- 42 C.F.R. § 422.520(a)(3), which states that all other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.
- 42 C.F.R. § 422.520(b), which states that contracts or other written agreements between MA organizations and providers must contain a prompt payment provision (the terms of which are developed and agreed to by both the MA organization and the relevant provider) and requires the MA organization to pay contracted providers under the terms of the contract between the MA organization and the provider.
- 42 C.F.R. § 422.132, which provides that MA enrollees are entitled to the protections specified in § 422.504(g).
- 42 C.F.R. § 422.504(g), which requires MA organizations to adopt and maintain arrangements satisfactory to CMS to protect enrollees from incurring liability for payment of any fees that are the legal obligation of the MA organization, and to indemnify the enrollee for payment of such fees for services furnished by non-contracted providers.
- 42 C.F.R. § 422.504(a)(16), which requires MA organizations to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services.

Your organization is out of compliance with these Part C requirements because your organization did not: (1) ensure that non-contracted provider clean claims were paid within the required CMS timeframes; (2) pay contracted providers under the prompt payment terms of your contracts with the providers; (3) pay DMR and non-contracted providers the correct original Medicare amounts; (4) protect enrollees who received services from incurring liability for incorrect cost sharing amounts; (5) indemnify impacted enrollees; and (6) maintain sufficient administrative and management capabilities to implement compliant financial activities.

On March 4, 2024, your organization reported to CMS that you identified issues spanning from January 1, through March 1, 2024, with your delegated entity, Allymar. Allymar is responsible for your claims processing, which includes the processing and payment for contracted and non-contracted provider claims. Allymar failed to process non-contracted provider clean claims within 30 days.

On May 23, 2024, your organization reported to CMS that Allymar also failed to process all other claims from non-contracted providers or requests for reimbursements to enrollees within 60 calendar days from the date of the request. Allymar also reported that it failed to process claims from contracted providers under the terms of the contract between your organization and the contracted providers. Finally, some of the DMR and non-contracted provider claims that your organization paid were not the correct original Medicare amounts. The root cause of these failures was inadequate testing, management, and oversight of your new claims processing vendor, Allymar.

On October 16, 2024, your organization reported to CMS that these issues impacted 36,985 enrollees and 2,153 providers for claims received from January 1 through April 26, 2024. On October 29, 2024, you stated that 19,004 non-contracted provider claims totaling \$7,906,108.18 were over 30 days old, 342 DMR claims totaling \$113,471.96 were between 31-60 days old, and 97 DMR claims totaling \$69,672.61 were over 60 days old. On February 10, 2025, after numerous requests from CMS, you reported the following 2024 data regarding contracted provider claims:

- 249,247 contracted provider clean claims totaling \$99,165,997 were 31-60 days old
- 235,407 contracted provider clean claims totaling \$93,479,166 were 61-90 days old
- 157,579 contracted provider clean claims totaling \$63,983,650 were 91-120 days old
- 135,776 contracted provider clean claims totaling \$56,031,151 were 121-180 days old
- 16,955 contracted provider clean claims totaling \$9,752,449 were over 180 days old
- 613 contracted provider non-clean claims totaling \$1,866,958 were 31-60 days old
- 700 contracted provider non-clean claims totaling \$633,334 were 61-90 days old
- 625 contracted provider non-clean claims totaling \$351,074 were 91-120 days old
- 517 contracted provider non-clean claims totaling \$434,037 were 121-180 days old

CMS requested information from your organization several times regarding the number of impacted contracted provider claims and corresponding financial impact, but you failed to provide this information completely and timely. Additionally, CMS discovered that enrollees impacted by these untimely claim payments received discouraging communication from their providers regarding your organization, had providers refuse services, received delayed treatments and screenings from providers, and experienced financial hardships due to delayed or incorrect contracted and/or non-contracted provider claims payments and DMR claims processing. Your organization failed to protect your enrollees who received services from incurring liability for incorrect cost sharing and failed to indemnify impacted enrollees.

To correct these issues, your organization notified CMS during meetings in April and October 2024 that you have taken the following steps:

- Created a corrective action plan (CAP) and issued it to Allymar on April 8, 2024.
- Implemented daily communications with Allymar.
- Transitioned responsibility of the provider payments from Allymar to your previous vendor, RAM Technologies, Inc, on May 13, 2024.
- Ensured all outstanding clean claims from non-contracted providers were paid by August 30, 2024
- Ensured that, beginning October 1, 2024, all DMR claims are paid in accordance with CMS requirements.
- Consistently conducted internal reviews of processed claims and denied claims.

Although your organization took the steps outlined above, on November 5, 2024, your organization reported to CMS that providers were still not being paid in accordance with CMS requirements. CMS requested additional information regarding this issue from March 2024 through November 2024. The responses received from your organization were inconsistent, unclear, and incomplete. To date, you have not provided CMS with consistent information regarding the total number of impacted enrollees or the number of impacted claims or providers. As of the date of this letter, this matter continues to be unresolved by your organization.

As noted above, CMS requests that your organization develop and implement a detailed CAP. This CAP

should address the actions listed below. This CAP should also include other actions your organization identifies as necessary to correct this problem and prevent it from reoccurring. CMS expects your organization to develop a process for auditing its claims payment for accuracy and timeliness, which should include:

- Verification of the accuracy of the claims payments contracted providers are issued.
- Verification of the accuracy of the claims payments non-contracted providers are issued.
- Verification that claims are paid timely in accordance with CMS requirements.
- Verification that enrollees are not held financially liable for incorrect cost sharing amounts.
- Monitoring of casework, internal grievance reports, and claims appeals.
- Regular submission of biweekly claims status reports to CMS, demonstrating a continuous reduction in aged claims payment backlog with no setbacks.

CMS is issuing this compliance notice pursuant to 42 C.F.R. §§ 422.504(m)(3)(iii) and 422.510(c), which require CMS to afford an organization at least 30 calendar days to develop and implement a CAP to correct deficiencies before taking steps to terminate an organization's Medicare contract. Therefore, by March 20, 2026, please send a timeline for implementing each element of the CAP to your CMS Account Manager. In addition, please include in the CAP the specific time period for which your organization anticipates correcting the deficiencies. CMS expects that the correction timeline will be no longer than necessary and will reflect an appropriate level of urgency in resolving this matter.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of the review of any application for new or expanded Medicare contracts your organization may submit. CMS determines this instance of non-compliance a Part C issue. CMS considers your organization's efforts in self-reporting information concerning the non-compliant activity as a mitigating factor in determining the severity of this notice.

CMS has the authority to impose sanctions, penalties, and other enforcement actions as described in federal regulations at 42 C.F.R. Part 422 Subpart O. CMS also has the authority to terminate a contract per 42 C.F.R. § 422.510. Should your organization fail to develop, implement, or complete its CAP, CMS may consider intermediate sanctions (e.g., suspension of marketing and enrollment activities), civil money penalties, or termination of your organization's contracts.

If you have any questions about this notice, please contact your CMS Account Manager Toni Duplain at: (214) 767-4433, or [toni.duplain2@cms.hhs.gov](mailto:toni.duplain2@cms.hhs.gov).

Sincerely,



Jeremy C. Willard, Director  
Division of Surveillance, Compliance & Marketing  
Medicare Drug & Health Plan Contract Administration Group  
Centers for Medicare and Medicaid Services

CC via email:

Toni Duplain, CMS  
[COMPLIANCE LEAD 1], CMS Baltimore

[SME name, if involved in letter], CMS  
Christine Reinhard, Theresa Wachter, CMS