DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850

Notice of Corrective Action Failure to Comply

Date of Notice: FULL DATE

CONTACT NAME
JOB TITLE
CE NAME
ADDRESS 1
ADDRESS 2
CITY, ST ZIP

Re: Corrective Action Number **XXXXX**

Dear TITLE LASTNAME:

On (month, day, year), the Department of Health and Human Services (HHS), National Standards Group (NSG) within the Centers for Medicare & Medicaid Services' (CMS) opened a corrective action based on the violations discovered during the **<Covered Entity Name>** 2017 assessment.

Unhappy Path 1 – CAP Not Submitted
As part of the corrective action process, <**Covered Entity Name**> was required to submit a corrective action plan (CAP) by (month, day, year). To date, we have not received a CAP from <**Covered Entity Name**>.

Unhappy Path 2 – CAP Requirements Not Met
As part of the corrective action process, <**Covered Entity Name**> submitted a corrective action plan (CAP) that included its milestones and plan to correct the applicable violations, as well as an expected completion date. To date, <**Covered Entity Name**> has not completed the CAP to the agreed terms, or has not provided the requested files or documentation for re-testing.

As a result, we will propose that a Civil Money Penalty (CMP) be imposed on <**Covered Entity Name**>. This action is being taken in accordance with 45 C.F.R. Part 160, Subpart C, section 312, and Subpart D, section 402.

In accordance with 45 C.F.R. Part 160, Subpart D, section 408, 410, and 412, <**Covered Entity Name**> may provide written evidence of mitigating factors, affirmative defenses, and/or a written evidence in support of a CMP waiver with respect to the violations cited in the corrective action. Written evidence must be provided within 30 days of this letter, (month, day, year). All submitted evidence will be reviewed and a determination will be made as to whether it is sufficient. If no such written evidence is received by (month, day, year), or it is determined to be

insufficient, <**Covered Entity Name**> will be notified of the proposed CMP in a Notice of Proposed Determination.

If you have any questions about this letter, please contact (contact name) at contact_name@cms.hhs.gov, or 555-555-5555. When contacting this office, please include the corrective action number located at the top of this letter.

Sincerely,
Michael Cimmino, Director
National Standards Group
Office of Burden Reduction and Health Informatics

cc:
Contact Name

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information, unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-XXXX (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **[10 hours]** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Kevin Stewart at kevin.stewart@cms.hhs.gov .