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

CENTERS for MEDICARE & MEDICAID SERVICES

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

November 19, 2010

VIA FEDERAL EXPRESS DELIVERY
EMAIL (tcarpenter@universalamerican.com)
AND FACSIMILE: (713) 893-6762

Mr. Theodore M. Carpenter, Jr.
President and CEO
Universal American Corporation
4888 Loop Central Drive
Suite 800
Houston, TX 77081
Phone Number: (713) 770-1131

Re: Notice of Imposition of Intermediate Sanctions (Suspension of Enrollment and Marketing) for All Medicare Advantage-Prescription Drug Contracts

Dear Mr. Carpenter:

Pursuant to 42 C.F.R. §§ 422.756(d) and 423.756(d), the Centers for Medicare & Medicaid Services (CMS) is hereby providing notice to Universal American Corporation (UAC) of the imposition of intermediate sanctions for all of UAC's Medicare Advantage-Prescription Drug contract numbers: H2775, H2816, H3333, H3706, H3708, H4506, H5301, H5378, H5421, H5656, H5909, H6169, and H8742. These intermediate sanctions will consist of the suspension of enrollment of Medicare beneficiaries (42 C.F.R. §§ 422.750(a)(1), 423.750(a)(1)) and the suspension of all marketing activities to Medicare beneficiaries (42 C.F.R. §§ 422.750(a)(3), 423.750(a)(3)). This determination to impose intermediate sanctions will be effective 15 calendar days after the date of this notice, or on December 5, 2010, and will remain in effect until CMS is satisfied that the deficiencies upon which the determination is based have been corrected and are not likely to recur. 42 C.F.R §§ 422.756(d)(3), 423.756(d)(3).

As the parent organization for thirteen (13) Medicare Advantage-Prescription Drug (MA-PD) contracts, UAC has been entrusted to provide Medicare beneficiaries with access to essential Medicare services. As such, UAC has the important responsibility to protect the interests not only of those beneficiaries enrolled in its Medicare Advantage plans, but also of those Medicare

beneficiaries to whom it markets its plans. CMS has determined that UAC has failed to meet this responsibility despite repeated notice and opportunity to cure and has placed the health and safety of Medicare beneficiaries at risk as a result.

Background on CMS Marketing Oversight

CMS is responsible for overseeing communications between Medicare Advantage (MA) organizations and beneficiaries enrolled in their plans. Because MA organizations are Medicare contractors, communications to beneficiaries must comply with various statutory and regulatory requirements as well as CMS marketing guidelines. In September 2008, CMS issued final regulations designed to protect Medicare beneficiaries from deceptive or high-pressured marketing tactics by private insurance companies and their agents, brokers, and plan representatives. Medicare Improvements for Patients and Providers Act (MIPPA) Sec. 103.

In an effort to ensure compliance with these marketing requirements and prohibitions, CMS initiated a comprehensive surveillance program that commenced in the Fall of 2008 for contract year 2009's Annual Election Period (AEP) and Open Enrollment Period (OEP). CMS' comprehensive surveillance program encompassed numerous surveillance activities including, among others, secret shopping of public marketing events and analysis of beneficiary complaint data. Each year CMS conducts marketing surveillance in the form of "secret shoppers" who attend public marketing events to make sure that the plan and its agents are accurately describing plan benefits, plan restrictions, and the premiums and cost sharing obligations of enrollees. "Shopping" public marketing events also affords CMS the opportunity to ensure that plans are not engaging in coercive or aggressive marketing tactics. In order to conduct this vital activity, CMS requires all plans to report all of their planned marketing events to CMS. 42 C.F.R. §§ 422.2274(d), 423.2274(d); Medicare Managed Care Manual, Pub. 100-16, Chapter 3, § 70.8.

CMS also uses a centralized complaints repository called Complaints Tracking Module (CTM). CMS Regional Office staff or 1-800-MEDICARE customer service representatives enter complaints into the CTM. A specific designation used in the CTM is "marketing misrepresentations." This designation was developed to capture complaints related to marketing violations or abuses that impacted beneficiaries' health care or prescription drug benefit decision-making processes.

CMS is also concerned about agent/broker behavior in one-to-one settings with Medicare beneficiaries and has set up mechanisms to allow beneficiaries to register complaints. Beneficiaries with complaints about their health care plan are urged to call their plan directly so that the plan is given the opportunity to resolve any issues. To report issues that remain unresolved by their plan, Medicare suggests that beneficiaries call 1-800-MEDICARE. Complaints made to 1-800-MEDICARE are tracked through the CTM. CTM allows CMS to isolate all marketing-related grievances made by individual beneficiaries.

CMS further requires that plans conduct various ***internal*** checks to identify agents that misrepresent plan features. First, plans must conduct a pre-enrollment and Outbound

Enrollment Verification (OEV) call for each enrollment generated by agents and brokers. During this call, the plan representative is required to review all plan benefits, restrictions, and costs to ensure that the Medicare beneficiary fully understands all elements critical to his or her enrollment decision. *See* 42 CFR §§ 422.2272(b) and 423.2272 (b); Medicare Managed Care Manual, Pub 100-16, Chapter 3, § 70.6. In addition to OEV calls, plans should conduct internal reviews of agents by examining their own data concerning whether some agents have a large number of beneficiaries who either disenroll in the first 90 days after enrollment or who make the decision not to enroll based on the OEV calls. As part of an effective compliance plan, plans should investigate these agents and take appropriate corrective actions based on beneficiary response. Such corrective action could include imposing disciplinary measures like suspension or termination of the agent where appropriate.

Summary of Universal American's Non-Compliance

Marketing Violations

CMS is imposing these intermediate sanctions as a result of UAC's longstanding pattern of prohibited marketing practices targeted to highly vulnerable populations in violation of federal law, CMS guidelines, and UAC's contractual responsibilities to CMS. UAC's Medicare Advantage plans include, among other types of plans, two Special Needs Plans. Participants in Special Needs Plans are institutionalized individuals, dual eligible beneficiaries (subscribing to Medicaid and Medicare), and beneficiaries with severe or disabling chronic conditions. Typically these beneficiaries are low income individuals who in many cases cannot afford to buy their medication or to pay for health care providers who are not within their plan's formulary or network.

As set forth below, UAC has been a chronic poor performer with respect to CMS regulations. Specifically, validated beneficiary complaints have demonstrated the following regulatory violations which are indicative of UAC's failure to exercise appropriate agent/broker oversight:

- Agents/brokers enrolled beneficiaries in plans without their prior knowledge or consent in violation of 42 C.F.R. §§ 422.2272(b), 422.2268(e), 422.2268(o), 423.2272(b), 423.2268(e), 423.2268(o).

- Agents/brokers marketed through door-to-door solicitation, cold calls and other unsolicited means of direct contact in violation of 42 C.F.R. §§ 422.2268(d) and 423.2268(d).

- Agents/brokers misled or confused beneficiaries or misrepresented information regarding the plan, including type, network restrictions, scope of coverage, contents of plan formulary, identification of providers in network, and loss of traditional Medicare as a result of plan enrollment in violation of 42 C.F.R. §§ 422.2268(e) and 423.2268(e).

- Agents/brokers engaged in aggressive sales tactics and abusive behavior in violation of 42 C.F.R. §§ 422.2268(e) and 423.2268(e).

- Agents/brokers misrepresented the plan as endorsed by Medicare or as part of the government's Healthcare Reform or the Affordable Care Act in violation of 42 C.F.R. §§ 422.2268(e) and 423.2268(e).

Inadequate Oversight/Monitoring of Agents and Brokers

CMS has also determined from an on-site audit conducted from June 28 to July 2, 2010, that UAC had inadequate controls in place to monitor and oversee agent/broker conduct. More specifically, audit findings documented the following violations of Medicare regulations regarding oversight of agents/brokers:

- UAC's passing score for the agent/broker annual training was lower than CMS' minimum passing grade in violation of 42 C.F.R. §§ 422.2274(b)-(c) and 423.2274(b)-(c); Medicare Managed Care Manual, Pub. 100-16, Chapter 3, § 120.3.

- UAC did not test its agent/broker knowledge of specific details of the Medicare plans being sold to beneficiaries in violation of 42 C.F.R. §§ 422.2274(b)-(c) and 423.2274(b)-(c).

- UAC provided no evidence that its compliance department conducted a formal risk assessment. UAC did not conduct any data analysis of its information to identify agent/broker misrepresentation issues in violation of 42 C.F.R. §§ 422.503(b)(4)(ii) & (vi) and 423.504(b)(4)(ii) & (vi).

- UAC did not have appropriate internal controls to allow it proactively to take appropriate corrective or disciplinary actions such as retraining, suspending, or terminating agents, based upon results of internal monitoring in violation of 42 C.F.R. §§ 422.503(b)(4)(ii) & (vi), 423.504(b)(4)(ii) & (vi).

These deficiencies demonstrate that UAC has substantially failed to exercise appropriate oversight with respect to its agents and brokers engaged in the marketing and selling of Medicare products to beneficiaries which has allowed the misconduct and representation of agents and brokers to continue to the detriment of Medicare beneficiaries.

Compliance Program Deficiencies

During the on-site audit, CMS discovered compliance plan deficiencies under each of the required compliance plan elements (42 C.F.R. §§ 422.503(b)(4)(vi); § 423.504(b)(4)(vi)). Overall, UAC did not comply with any of the seven elements of an effective compliance program, yielding 26 noted deficiencies. UAC lacked processes to conduct internal auditing and

monitoring of business operations, including processes to oversee their first tier, downstream, or related entities' compliance (including its agents and brokers) with CMS program requirements. This is in direct violation of CMS regulatory and contract requirements and has contributed to UAC's failure to detect, correct, and prevent marketing violations, in compliance with CMS requirements and UAC's contract with CMS. The following are examples of confirmed deficiencies from CMS's on-site audit and are in direct violation of CMS requirements regarding compliance programs:

- UAC did not have up to date written policies, procedures, and standards of conduct in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(A) and 423.504(b)(4)(vi)(A).

- UAC did not screen its first tier, downstream, or related entities against the U.S. Department of Health and Human Services Office of Inspector General and U.S. General Services Administration excluded parties list systems in violation of 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

- UAC provided no evidence that its first tier, downstream, and related entities had access to its hotline number or mechanisms to report fraud, waste, and abuse in violation of 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

- UAC substantially failed to exercise appropriate oversight with respect to its agents and brokers engaged in the marketing and selling of Medicare products to beneficiaries in violation of 42 C.F.R. §§ 422.503(b)(4)(vi)(F) and 423.504(b)(4)(vi)(F).

UAC's failure to have an effective compliance plan in place directly affects its ability to exercise appropriate oversight and control with respect to its agents and brokers. These numerous marketing violations and compliance program deficiencies demonstrate that UAC has substantially failed to adhere to the regulatory and contractual requirements as cited above.

History of Non-Compliance

UAC has been under CMS scrutiny for marketing violations since November 2007. As discussed above, as part of its agent/broker monitoring, CMS "secret shops" public marketing activities to ensure that accurate information is dispensed to Medicare beneficiaries. Public marketing events are held during the Annual Election Period (AEP) and Open Enrollment Period (OEP) or October 1 through March 31 every year. In November 2007, CMS issued UAC three Corrective Action Plan (CAP) letters in one week for UAC's public marketing event activities. In spite of this, CMS determined that UAC's performance did not improve. UAC was again warned on December 23, 2008, by issuance of yet another Warning Letter for serious marketing violations which occurred during the 2008 AEP.

In 2009, UAC received a total of eight Notices of Non-Compliance and one Warning Letter for activities related to its public and private sales and marketing practices. Specifically:

- February 26, 2009: Notice of Non-Compliance regarding the release of 90,000 pieces of unapproved marketing materials to beneficiaries;

- March 5, 2009: Notice of Non-Compliance regarding failure to effectively educate agents. CMS noted that this failure to educate constituted the possibility that every enrollment by an agent into a 2009 Today's Options PPO (MA-Only) product could be categorized as a marketing misrepresentation;

- April 14, 2009: Notice of Non-Compliance for deficiencies in enrollment/disenrollment operations, verification call process, and timely response to beneficiary complaints and requests for assistance;

- June 19, 2009: Warning Letter for failing to report "a significant number" of marketing events as required by CMS's September 20, 2008 memorandum "*Submission of Sales Event Data for Medicare Advantage Organizations (MAOs) and Prescriptions Drug Plan Sponsors (PDPs)"*;

- September 14, 2009: Notice of Non-Compliance regarding sales agents using "bait and switch" techniques and sales agents not using the required Scope of Appointment Documentation Forms pursuant to the HPMS memorandum dated February 11, 2009;

- September 24, 2009: Notice of Non-Compliance for submitting incorrect compensation data for the 2010 compensation schedule amounts for UAC's sales agents;

- November 20, 2009: Notice of Non-Compliance for inaccurate Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents for 2009;

- November 24, 2009: Notice of Non-Compliance for late ANOC and EOC documents for 2009; and

- December 31, 2009: Notice of Non-Compliance for deficiencies discovered during secret shopping of marketing events.

In 2010 UAC received 4 Warning Letters and 6 Notices of Non-Compliance for marketing-related violations:

- February 1, 2010: Notice of Non-Compliance for unreported marketing events;

- February 8, 2010: Warning Letter for secret shopping deficiencies observed during an event on January 12, 2010;

- April 2, 2010: Warning Letter for secret shopping deficiencies observed during three different marketing events;

- April 19, 2010: Notice of Non-Compliance for failure to report on agent compensation, training, and testing in fourth quarter of 2009;

- May 14, 2010: Warning Letter with Request for a Business Plan for use of unqualified sales agents;

- May 17, 2010: Warning Letter with Request for a Business Plan for unreported marketing events;

- June 22, 2010: Notice of Non-Compliance for premium waiver practice by its agents and brokers;

- June 22, 2010: Notice of Non-Compliance for not completing 10,000 verification calls in the first quarter of 2010;

- June 22, 2010: Notice of Non-Compliance for extremely high numbers of marketing misrepresentation complaints in CTM; and

- August 18, 2010: Notice of Non-Compliance for failure to meet Medicare Part D program website requirements.

The deficiency cited in the June 22, 2010 Notice of Non-Compliance is of particular concern. In June 2010, CMS issued UAC a Notice of Non-Compliance for its self-reported failure to make 10,000 verification calls in the first quarter of 2010. A verification call is a plan's most important control to protect beneficiaries from being wrongfully or erroneously enrolled by agents and brokers. Verification calls ensure that a beneficiary fully understands the plan's structure, benefits, premiums, and restrictions before the beneficiary is enrolled. Failure to perform a verification call puts the beneficiary at risk because the information provided by the agent/broker may not be accurate or complete. It is critical for all new enrollees who are enrolled by an agent or broker to receive an outbound education and verification call to ensure receipt of accurate and objective information regarding the plan. UAC's failure to perform 10,000 verification calls indicates a gross lack of internal controls and monitoring.

Analysis of CTM complaints received by CMS in 2009 and 2010 identified UAC as an outlier with respect to beneficiary complaints for marketing misrepresentations. From April 2009 through September 2010, marketing misrepresentation complaints were lodged at a rate of between 3.5 and 7 times the national average, per thousand enrollees. Deficiencies in UAC's performance, identified by CMS through the CTM, encompassed a broad spectrum of violations, including among others:

- marketing misrepresentations;
- unreported marketing events;
- secret shopping surveillance deficiencies; and

- failure to ensure that agents and brokers meet certain requirements in accordance with CMS guidelines.

Between February 1, 2010, and September 30, 2010, Medicare's CTM registered 1,240 formal complaints from beneficiaries for UAC's marketing-related behavior. Complaints were made for all of UAC's MA contracts. UAC submitted validated misrepresentation complaints to CMS from this group of original complaints. CMS validated complaints from this same subset of data. Of the subset of calls that CMS verified by contacting beneficiaries directly, 98% (61 out of 62) were valid and supported the beneficiaries' allegations of marketing misrepresentation and other prohibited marketing tactics, including: aggressive sales practices; unsolicited contact (cold calling and door-to-door selling); enrollment without beneficiaries' knowledge; and misinformation about the plan's provider network, the plan's formulary, and the plan's premiums.

In May 2010, UAC acknowledged in a written statement to CMS that there was "likely a companywide policy" of inaccurately informing prospective enrollees that premium amounts for Medicaid beneficiaries (i.e., dual eligible beneficiaries) would not be collected. However, Medicare regulations in fact require that all MA organizations charge enrollees a monthly MA premium pursuant to 42 C.F.R. §§ 422.262(b) and 423.293(a). UAC's "policy" was addressed in a Notice of Non-Compliance, issued on June 22, 2010, for UAC's prohibited premium waivers by agents and brokers.

On June 15, 2010, in a phone call between CMS senior leadership and UAC senior leadership, including UAC's CEO, CMS notified UAC that it was consistently failing to comply with CMS marketing regulations and demonstrating poor internal controls. CMS indicated that if UAC failed to correct these violations, UAC could be subject to available contract enforcement actions, including intermediate sanctions.

Effect of Non-Compliance on Plan Beneficiaries

UAC's violations cited above pose a serious threat to the health and safety of UAC's enrollees. As a result of UAC's failures (as noted above) to oversee agent/broker marketing activities, UAC, through its agents and brokers, engaged in widespread marketing misrepresentations. In several interviews, beneficiaries indicated they had relied on representations made by the agents about whether specific health care providers were in UAC's network and whether necessary prescription medications were on UAC's formulary. As a consequence, Medicare beneficiaries experienced delays in obtaining health care services and disruptions in prescription drug treatment plans. In numerous cases, beneficiaries experienced hospitalization, destabilization of medical conditions, postponement of surgery, and unnecessary out-of-pocket costs.

For example, a dual eligible beneficiary on original Medicare, who is confined to a wheelchair, enrolled in a plan once the agent confirmed that the beneficiary's doctor of 20 years was in the plan's network of providers. Upon learning that his doctor did not in fact participate in the plan, the beneficiary actually went without medical care for an entire month until he was able to be

reinstated with original Medicare and return to his long-term primary care physician. Similarly, a Low Income Subsidy (LIS) eligible beneficiary lodged a complaint that the UAC agent told her the UAC plan would not interfere with her original Medicare or with her Medicare supplement. In reliance on the agent's "promise" that the beneficiary would no longer have to pay the $96.40 Medicare premium and that the new plan would be at "no cost" to her, the beneficiary enrolled in the UAC plan. When she attempted to have pre-op work performed for a mastectomy, the hospital told her the new plan would not cover all costs of the surgery. As a result, the beneficiary delayed the mastectomy until she was reinstated to original Medicare and could use the hospital of her choice. By way of final example, a beneficiary explained to an agent that she did not want to sign up for any of UAC's plans, but desired to remain on original Medicare. The beneficiary discovered she had been enrolled into the UAC plan without her knowledge when she later went for eye surgery. Her procedure had to be delayed until the beneficiary could be reinstated with Original Medicare to use the surgeon of her choice.

Basis of Intermediate Sanction

CMS has determined that UAC's failure to comply with CMS statutes, regulations, and guidance, as set forth above and incorporated herein by reference, provides sufficient evidence and proves sufficient basis for the imposition of intermediate sanctions. 42 C.F.R. §§ 422.752(b), 423.752(b). Specifically, CMS finds that:

- ***UAC has failed substantially to carry out the terms of its contracts with CMS. 42 C.F.R. § 422.510(a)(1); § 423.509(a)(1)***
- ***UAC 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);§ 423.509(a)(2).***
- ***UAC substantially failed to comply with the marketing requirements in subpart V of Parts 422 and 423. 42 C.F.R. §§ 422.510(a)(12); §423.509(a)(9).***

In addition, UAC's conduct, as described above, is within the scope of marketing violations singled out by Congress for sanctions in the amendments to § 1857(g) of the Social Security Act as set forth in § 6408(b)(2) of the Affordable Care Act.

Opportunity to Respond to Notice

Pursuant to 42 C.F.R. §§ 422.756(a)(2) and 423.756(a)(2), UAC 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 for purposes of responding to this notice or requesting a hearing, CMS considers receipt as the day after the notice is sent by fax, email, or overnight mail, 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 listed below.

Right to Request a Hearing

UAC may also request a hearing before a CMS hearing officer in accordance with the procedures outlined in 42 C.F.R. §§ 422.660 through 696 and 423.650 through 668. Pursuant to 42 C.F.R. §§ 422.756(b) and 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.[1] Please note, however, that a request for a hearing will not delay the date specified by CMS when the sanction becomes 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.

UAC must submit a request for 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 courtesy copy of 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 and 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 UAC may also be subject to

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

other applicable remedies available under law, including the imposition of additional sanctions, penalties, or other contract and/or enforcement actions as described in 42 C.F.R. Part 422, Subparts K and O and Part 423, Subparts K and O.

If you have any questions about this determination, please contact Trish Axt at (410) 786-0095 or by email at 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. Danielle Moon, CMS/CM/MCAG
Ms. Helaine Fingold, CMS/CM/MCAG
Ms. Cynthia Tudor, CMS/CM/MDBG
Ms. Jennifer Shapiro, CMS/CM/MDBG
Ms. Cheri Rice, CMS/CM/MPPG
Mr. Randy Brauer, CMS/CM/MPPG
Mr. Michael Crochunis, CMS/CM/MEAG
Ms. Mary Wallace, CMS/OEABS
Mr. Jon Booth, CMS/OEABS
Mr. Peter Ashkenaz, CMS/OEABS
Mr. Greg Jones, CMS/OL
Mr. John Spiegel, CMS/CPI
Mr. James Kerr, CMS/CMHPO
Mr. Paul Collura, CMS/CMHPO
Ms. Julie Kennedy, CMS/CMHPO/Region VI
Ms. Sue Bradshaw, CMS/CMHPO/Region VI
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. Tawanda Holmes, CMS/CM/PCOG
Ms. Trish Axt, CMS/CM/PCOG