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

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

October 9, 2012

VIA:
EMAIL (rbarasch@universalamerican.com)
AND FACSIMILE (914-934-0700)

Richard Barasch
Chairman and Chief Executive Officer
Universal American Corp.
Six International Drive
Suite 190
Rye Brook, NY 10573
Phone: 914-934-8700

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage - Prescription Drug Plan Contract Numbers: H2775, H2816, H3333, H3706, H3708, H4506, H5378, H5421, H5656, and H6169[1]

Dear Mr. Barasch:

Pursuant to 42 C.F.R. §§ 422.752(c)(1) and 423.752(c)(1), the Centers for Medicare & Medicaid Services (CMS) is providing notice to Universal American Corp. (UAC) that CMS has made a determination to impose a civil money penalty (CMP) in the amount of $325,000 for Medicare Advantage - Prescription Drug (MA-PD) Plan Contract Numbers: H2775, H2816, H3333, H3706, H3708, H4506, H5378, H5421, H5656, and H6169.

CMS has determined that UAC failed to provide its enrollees with services and benefits in accordance with CMS requirements. An MA-PD sponsor's central mission is to provide Medicare enrollees with medical services and prescription drug benefits within a framework of Medicare requirements that provide enrollees with a number of protections.

[1] See Attachment A "Legal Entities by Contract" for a list of each legal entity.

Summary of Noncompliance

CMS conducted an audit at UAC's Houston, Texas offices from May 7, 2012 through May 11, 2012. During the audit, CMS conducted reviews of UAC's operational areas to determine if UAC is following CMS rules, regulations, and guidelines. After conducting an extensive review, CMS auditors concluded that UAC failed to comply with CMS requirements governing the processing of Part C and D grievances, organization/coverage determinations, and Part C and Part D appeals. 42 C.F.R. Part 422, Subparts C, F, K, and M, and 42 C.F.R. 423, Subparts C, K, and M. Violations in these areas can result in enrollees experiencing delays or denials in receiving covered medical services or prescription drugs, and increased out-of-pocket costs. These violations directly adversely affected (or had the substantial likelihood of adversely affecting) UAC's enrollees.

Part C and Part D Grievance, Organization Determination, Coverage Determination and Part C and Part D Appeal Requirements

Medicare enrollees have the right to contact their plan sponsor to express general dissatisfaction with the operations, activities, or behavior of the plan sponsor or to make a specific complaint about the denial of coverage for drugs or services to which the enrollee believes he or she is entitled. Sponsors are required to classify general complaints about services, benefits, or the sponsor's operations or activities as grievances. 42 C.F.R. §§ 422.564 (a-b) and 423.564 (a-b). Sponsors are required to classify complaints about coverage for drugs or services as organization determinations (Part C – medical services) or coverage determinations (Part D – drug benefits). 42 C.F.R. §§ 422.564 (b), 422.566(b), 423.564(b), and 423.566(b). It is critical for a sponsor to properly classify each complaint as a grievance or an organization/coverage determination or both. Improper classification of an organization or coverage determination denies an enrollee their due process and appeal rights and may delay an enrollee's access to medically necessary or life-sustaining services or drugs.

The enrollee, the enrollee's representative, or the enrollee's treating physician or prescriber may make a request for an organization determination or coverage determination. 42 C.F.R. §§ 422.566(c) and 423.566(c). The first level review is the organization determination or coverage determination, which is conducted by the plan sponsor, and the point at which beneficiaries or their physicians submit justification for the service or benefit. 42 C.F.R. §§ 422.566(d) and 423.566(d). If the organization or coverage determination is adverse (not in favor of the beneficiary), the beneficiary has the right to file an appeal. 42 C.F.R. §§ 422.580 and 423.580. The first level of the appeal – called a reconsideration (Part C) or redetermination (Part D) – is handled by the plan sponsor and must be conducted by a physician who was not involved in the organization determination or coverage determination decision. 42 C.F.R. §§ 422.590(g) and 423.590(f). The second level of appeal is made to an independent review entity (IRE) contracted by CMS. 42 C.F.R. §§ 422.592 and 423.600.

There are different decision making timeframes for the review of organization determinations, coverage determinations, and appeals. 42 C.F.R. §§ 422.572, 422.590, 423.572, and 423.590. CMS has a beneficiary protection in place that requires plans to forward coverage determinations

and appeals to the IRE when the plan has missed the applicable adjudication timeframe. 42 C.F.R. §§ 422.590(f) and 423.590(e).

Deficiencies Related to Grievances, Organization Determinations, Coverage Determinations and Appeals

CMS identified multiple, serious violations of Part C and Part D requirements in UAC's grievances, organization determinations, coverage determinations and appeals operations. UAC's violations discovered during the audit and through subsequent monitoring include:

Part C

- Substantial failure to ensure that organization determinations and plan reconsiderations were processed and enrollees notified within the required timeframes, in violation of 42 C.F.R. §§ 422.568(b-f), 422.572(a), and 422.590 (a-d);

- Failure to forward reconsideration requests to the IRE within the required timeframes, in violation of 42 C.F.R. § 422.590;

- Failure to conduct appropriate outreach to the requesting provider or treating physician for missing clinical information in violation of 42 C.F.R. §§ 422.566 and 422.578;

- Failure to process cases as expedited despite a physician's request to do so, in violation of 42 C.F.R. §§ 422.570(c)(2)(ii) and 422.584(c)(2)(ii);

- Failure to accept and process organization determination and appeal requests from treating physicians by inappropriately requesting Appointment of Representative (AOR) documentation, in violation of 42 C.F.R. §§ 422.566(c), 422.570(a), 422.582(a), and 422.584(a);

- Routinely used the 14-day extension for processing organization determinations and reconsiderations without justification for the delay, in violation of 42 C.F.R. §§ 422.568(b), 422.572(b), and 422.590(a)(1) and (d)(2);

- Routinely processed enrollees' requests for organization determinations or appeals as grievances, in violation of 42 C.F.R. §§ 422.566(c) and 422.578.;

- Failure to timely or correctly effectuate the IRE's expedited pre-service decisions or payment decisions, in violation of 42 C.F.R. §§ 422.619(b) and 422.618(b);

- Denied enrollees coverage of Medicare-covered services, in violation of 42 C.F.R. § 422.101(a);

- Failure to consider applicable Medicare coverage criteria when making medical necessity decisions for organization determinations and appeals, in violation of 42 C.F.R. § 422.101(b); and

- Failure to pay for Medicare-covered emergency medical services received at a non-contracted facility, in violation of 42 C.F.R. § 422.113(b).

Part D

- Made adverse coverage determinations without conducting sufficient outreach to prescribers or enrollees to obtain additional information necessary for a clinical decision, in violation of 42 C.F.R. §§ 423.562(a) and 423.566(a); IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 18, Section 30.2.2;

- Failure to properly distinguish coverage determinations from grievances, in violation of 42 C.F.R. § 423.564(b); IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 18, Section 20.2; and

- Failure to provide appropriate and timely notification to the enrollee regarding adverse coverage determinations, in violation of 42 C.F.R. § 423.568(g); IOM Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 18, Section 40.3.4.

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. §§ 422.752(c) and 423.752(c), CMS has determined that UAC's violations of Medicare Parts C and D requirements are significant enough to warrant the imposition of a civil money penalty. UAC failed substantially to carry out the terms of its contracts with CMS, and failed to carry out its contracts with CMS in a manner that is consistent with the effective and efficient implementation of the program. 42 C.F.R. §§ 422.510(a)(1) and (2), and 423.509(a)(1) and (2).

Right to Request a Hearing

UAC may request a hearing to appeal a CMS determination in accordance with the procedures outlined in 42 C.F.R. Parts 422 and 423, Subpart T. UAC must send a written request for a hearing to the Departmental Appeals Board office listed below within 60 calendar days from receipt of this notice, or by December 10, 2012. 42 C.F.R. §§ 422.1006, 423.1006, 422.1020, and 423.1020. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which UAC disagrees. UAC must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

Civil Remedies Division
Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6132
330 Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

A copy of the hearing request should also be sent to CMS at the following address:

Patricia Axt, Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
MAIL STOP: C1-22-06
Baltimore, MD 21244
Email: Trish.Axt@cms.hhs.gov
FAX: 410-786-6301

If UAC does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on December 11, 2012. To pay this penalty, UAC may select one of the following three options: (1) CMS deduction from UAC's monthly payment; (2) Electronic Transfer of Funds; or (3) Mail a check to CMS.

CMS has determined that a CMP is the appropriate enforcement option for UAC's conduct at this time given that UAC has demonstrated an understanding of the nature of the violations and provided CMS with a plan for correcting the violations. Validation activities are scheduled for October 2012 and CMS will be closely monitoring to determine if UAC has continuing problems in the same areas, or continues to demonstrate new violations in these or other areas. Further failures by UAC will result in additional applicable remedies available under law, up to and including contract termination, the imposition of intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O. CMS notes particularly that the Medicare contracts of several UAC subsidiaries have received summary plan ratings below three stars for each of the past six years. As we have communicated to UAC previously, CMS considers these ratings to indicate a persistent pattern of contract performance failure, and continued ratings below three stars during the next rating period may provide the basis, on their own or in combination with continued failures in the areas described above, for the termination of certain UAC subsidiaries' contracts.

If UAC has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

Gerard J. Mulcahy
Acting Director
Program Compliance and Oversight Group

cc: Mr. Jonathan Blum, CMS/CM
Mr. Timothy Love, CMS/CM
Ms. Julie Kennedy, CMS/CMHPO/Region VI
Mr. Art Pagan, CMS/CMHPO/Region VI
Ms. Pamela Conroy, CMS/CMHPO/Region VI

Attachment A
Universal American Corp.
Legal Entities by Contract

Contract Number	Legal Entity
H2775	American Progressive Life & Health Insurance Company of NY
H2816	American Progressive Life & Health Insurance Company of NY
H3333	American Progressive Life & Health Insurance Company of NY
H3706	Today's Options of Oklahoma, Inc.
H3708	Selectcare of Oklahoma, Inc.
H4506	Selectcare of Texas, Inc.
H5378	The Pyramid Life Insurance Company
H5421	The Pyramid Life Insurance Company
H5656	The Pyramid Life Insurance Company
H6169	Selectcare Health Plans, Inc.