

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



CENTER FOR MEDICARE

May 15, 2026

WARNING LETTER

Contract ID: H1290, H2041, H2526, H2686, H2697, H2923, H3041, H3080, H4808, H5299, H5453, H5718, H6018, H6545, H6586, H6813, H6852, H7028, H7147, H7151, H7199, H7355, H7397, H7471, H7605, H7993, H8173, H8320, H8917, H9231, H9700, H9884, H9888

Parent Organization: Devoted Health, Inc.

Legal Entity: DEVOTED HEALTH INSURANCE COMPANY, DEVOTED HEALTH INSURANCE COMPANY OF ALABAMA, INC., DEVOTED HEALTH INSURANCE COMPANY OF ARIZONA, INC., DEVOTED HEALTH INSURANCE COMPANY OF ARKANSAS INC, DEVOTED HEALTH INSURANCE COMPANY OF COLORADO, INC., DEVOTED HEALTH INSURANCE COMPANY OF GEORGIA INC, DEVOTED HEALTH INSURANCE COMPANY OF HAWAII, INC., Devoted Health Insurance Company of Illinois, Inc., DEVOTED HEALTH INSURANCE COMPANY OF INDIANA, DEVOTED HEALTH INSURANCE COMPANY OF KENTUCKY INC, DEVOTED HEALTH INSURANCE COMPANY OF MISSISSIPPI, DEVOTED HEALTH INSURANCE COMPANY OF OREGON, INC., DEVOTED HEALTH INSURANCE COMPANY OF PENNSYLVANIA, INC., DEVOTED HEALTH INSURANCE COMPANY OF SOUTH CAROLINA, INC., DEVOTED HEALTH INSURANCE COMPANY OF TENNESSEE, INC., DEVOTED HEALTH INSURANCE COMPANY OF TEXAS, DEVOTED HEALTH INSURANCE COMPANY OF WASHINGTON, DEVOTED HEALTH PLAN OF ALABAMA, INC., DEVOTED HEALTH PLAN OF ARIZONA, INC., DEVOTED HEALTH PLAN OF COLORADO, INC., DEVOTED HEALTH PLAN OF FLORIDA, INC., DEVOTED HEALTH PLAN OF ILLINOIS, INC., DEVOTED HEALTH PLAN OF MISSOURI INC, DEVOTED HEALTH PLAN OF NORTH CAROLINA, INC., DEVOTED HEALTH PLAN OF OHIO, INC., DEVOTED HEALTH PLAN OF OREGON, INC., DEVOTED HEALTH PLAN OF PENNSYLVANIA, INC., DEVOTED HEALTH PLAN OF SOUTH CAROLINA, INC., DEVOTED HEALTH PLAN OF TENNESSEE, INC., DEVOTED HEALTH PLAN OF TEXAS, INC., Devoted of Illinois, Inc.

Shannon O'Kane
Medicare Compliance Officer
221 Crescent Street
Suite 202
Waltham, MA 02453

VIA EMAIL: sokane@devoted.com

Subject: Failure to Investigate Marketing Misrepresentation Complaints and to Ensure Third-Party Marketing Organizations' Marketing and Communications Activities Meet CMS Requirements

Dear Shannon O'Kane:

The Centers for Medicare & Medicaid Services (CMS) is issuing this warning letter to the legal entities listed above, which operate the Medicare Advantage Prescription Drug Plan (MA-PD) Contract IDs listed above, regarding your organization's failure to conduct full investigations of a large number of marketing misrepresentation (MMR) complaints and failure to oversee the marketing and communications activities of contracted third-party marketing organizations (TPMOs).

Your organization is non-compliant with the following:

- 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi), which require plans to adopt and implement an effective compliance program.
- 42 C.F.R. §§ 422.504(i)(1) and 423.505(i)(1), which state that, notwithstanding any relationship(s) that the plan may have with first tier, downstream, and related entities, the plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.
- 42 C.F.R. §§ 422.2262(a)(1) and 423.2262(a)(1), which prohibit plans from providing information that is inaccurate or misleading, or engaging in activities that could mislead or confuse Medicare beneficiaries or misrepresent the plan.
- 42 C.F.R. §§ 422.2263(b) and 423.2263(b), which prohibit plans from providing cash or other monetary rebates as an inducement for enrollment or otherwise, offering gifts to beneficiaries (unless the gifts are of nominal value, are offered to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates), and marketing non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation (this is considered cross-selling and is prohibited).
- 42 C.F.R. §§ 422.2264(a)(2)(iv) and 423.2264(a)(2)(iv) which prohibit plans from using telephone solicitation (that is, cold calling) if unsolicited.
- 42 C.F.R. §§ 422.2272(c) and 423.2272(c), which require plans to employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities in that State.
- 42 C.F.R. §§ 422.2272(e) and 423.2272(e), which require plans to establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.
- 42 C.F.R. §§ 422.2274(c) and 423.2274(c), which require plans to oversee first tier, downstream, and related entities that represent them to ensure agents and brokers abide by all applicable State and Federal laws, regulations, and requirements.
- 42 C.F.R. §§ 422.2274(c)(7) and 423.2274(c)(7), which require plans to submit agent or broker marketing materials to CMS through the Health Plan Management System (HPMS) prior to use, following the requirements for marketing materials.
- 42 C.F.R. §§ 422.2274(c)(9)(ii) and 423.2274(c)(9)(ii), which require plans to establish and maintain a system for confirming that agents and brokers appropriately complete Scope of Appointment records for all marketing appointments (including telephonic and walk-in).
- 42 C.F.R. §§ 422.2274(c)(12) and 423.2274(c)(12), which require plans to ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed, including, but not limited to, primary care providers' and specialists' network

status, pharmacies' network status, prescription drug coverage and costs, costs of health care services, premiums, and benefits.

Your organization is out of compliance with these Parts C and D requirements because you failed to ensure that your TPMOs complied with CMS requirements, resulting in a large number of beneficiary complaints related to these non-compliant activities.

As part of the ongoing monitoring of health plans, CMS conducted daily reviews of MMR complaints submitted for your organization, held monthly meetings with your organization to address Complaints Tracking Module (CTM) trends, and discussed CMS's concern about insufficient CTM investigations and/or resolutions provided to beneficiaries. Nevertheless, over the past two years, your organization has consistently generated a high volume of MMR complaints within the CTM. CMS has repeatedly discussed the high volume of MMR complaints with your organization, and you have assured CMS that you were working to lower the volume of MMR complaints in the CTM. Your organization failed to lower the volume of MMR complaints to an acceptable level, therefore, CMS responded by conducting a desk review in March 2025. CMS selected a sample of 31 CTMs received between March 2024 and February 2025. For this CTM sample, CMS requested enrollment call recordings, including those from lead vendors and TPMOs, evidence of permission to contact, and all marketing and communications materials.

Your organization reviewed all 31 CTMs prior to CMS's sample request. Of the 31 total CTMs, you deemed 17 as unfounded. However, CMS identified violations or concerns in 27 of the 31 CTMs. For these 27 CTMs, CMS identified one or more of the following:

- Misleading, confusing, or inaccurate information provided during sales presentations
- Telephonic enrollments conducted without a Scope of Appointment
- Unsolicited/cold calls made to beneficiaries by lead vendors and/or TPMOs
- Marketing materials advertising non-health care related products
- Marketing language embedded in materials labeled as "communication pieces" that were not submitted to HPMS for CMS review
- Incomplete enrollment discussions, where agents/brokers failed to address all CMS-required topics, such as provider/pharmacy network status and potential out-of-pocket costs for out-of-network services
- Unauthorized enrollments or lack of beneficiary consent
- Unlicensed agents/brokers conducting marketing activities
- Misleading language in TPMO marketing and communications materials used as purported permission to contact beneficiaries
- Multi-plan marketing materials used by TPMOs without your organization's opt-in authorization

Additionally, your organization failed to provide CMS with evidence that TPMOs were authorized to contact beneficiaries and failed to fully investigate beneficiary reports of unsolicited calls from unknown agents/brokers. Notably, your organization deemed the unsolicited call allegations unfounded. In contrast, CMS found that in some of the call recordings, agents/brokers were making unsolicited outbound calls and were giving potential enrollees inaccurate information, including having them call back in to complete enrollments, potentially in part to cover up the fact that the interactions were the product of unsolicited outbound calls. Based on these findings, CMS disagrees with your organization's conclusion that the unsolicited call allegations were unfounded. Your organization also permitted TPMOs to use misleading materials that improperly offered incentives such as gifts, \$5,000 cash awards, or stimulus checks to

encourage beneficiaries to contact the TPMO.

Your organization provided the following explanations during CMS's review:

- During the review period, no internal policy existed requiring investigation into beneficiary allegations of receiving inbound calls from unknown sales agents/brokers.
- Investigations did not include review of lead vendor calls, unless a beneficiary explicitly stated, "I received an unsolicited call."
- Your marketing team does not review multi-plan advertisements that your TMPOs label as communication pieces, citing that CMS does not require plans to submit communication pieces to HPMS for approval, and therefore, your organization does not require TPMOs to submit them for internal review either.

To remediate the non-compliance, your organization took the following steps:

- Reassessed the 31 CTMs and the supporting documentation provided to CMS and identified a trend of poor-performing TPMOs;
- Acknowledged the communication pieces contained misleading, confusing language, and at times marketing-related language that should have been approved by CMS;
- Instructed the lead vendors and/or TPMOs to immediately stop using the non-compliant pieces to market/sell your organization's products;
- Suspended or suppressed the sales activity of poor-performing TPMOs and placed them on a corrective action plan;
- Requested high-selling TPMOs provide documentation of oversight, monitoring, and audit plans for their contracted lead vendors; and
- Began requiring lead vendor communication and marketing pieces be obtained for investigating CTMs in which a beneficiary alleges an inbound call from an unknown agent/broker (starting May 1, 2025), and CTMs in which a beneficiary alleges enrollment without consent (starting July 1, 2025).

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 our review of any application for new or expanded Medicare contracts your organization may submit. CMS determines this instance of non-compliance a Parts C and D issue. CMS notes that this compliance notice is being issued based exclusively on information that we obtained from sources other than your organization's self-disclosure.

If you fail to come into compliance, then CMS may consider taking additional compliance actions, including a formal request for a corrective action plan, or taking enforcement actions, including intermediate sanctions (e.g., the suspension of marketing and enrollment activities) or civil money penalties.

If you have any questions about this notice, please contact your CMS Account Manager Treesie Farmer at: (816) 426-6505, or Treesie.Farmer@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:

Treesie Farmer, CMS
Christine Reinhard, CMS Baltimore