DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice
7500 Security Boulevard, Mail Stop C4-23-07
Baltimore, Maryland 21244-1850

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

February 19, 2009

VIA:
FEDERAL EXPRESS DELIVERY
EMAIL (heath.schiesser@wellcare.com)
AND FACSIMILE (813-290-6306)

Mr. Heath Schiesser
CEO & President
WellCare Health Plans, Inc.
8735 Henderson Road
Tampa, FL 33634
Phone Number: (813) 290-6205

Re: Notice of Intent to Impose Intermediate Sanctions (Suspension of Enrollment and Marketing) For: Contract Numbers H0117, H0712, H0913, H0967, H1032, H1112, H1216, H1264, H1340, H1416, H1657, H1903, H2491, H3361, H4577, H6499 and S5967.

Dear Mr. Schiesser:

Pursuant to 42 C.F.R. §422.756 and 42 C.F.R. §423.756, the Centers for Medicare & Medicaid Service (CMS) hereby provides notice to WellCare Health Plans, Inc. (WellCare) of CMS' imposition of intermediate sanctions for contract numbers H0117, H0712, H0913, H0967, H1032, H1112, H1216, H1264, H1340, H1416, H1657, H1903, H2491, H3361, H4577, H6499, and S5967. These intermediate sanctions will consist of the suspension of enrollment of Medicare beneficiaries (42 C.F.R. §422.750(a)(1), 42 C.F.R. §423.750(a)(1)) and the suspension of all marketing activities to Medicare beneficiaries (42 C.F.R. §422.750(a)(3), 42 C.F.R. §423.750(a)(3)). This determination to impose intermediate sanctions will be effective 15 calendar days after the date of this notice, or on March 7, 2009, and will remain in effect until CMS is satisfied that the deficiencies upon which the determination was based have been corrected and are not likely to recur.

Summary of WellCare Noncompliance

WellCare has demonstrated a longstanding and persistent failure to comply with CMS' requirements for the proper administration of its Medicare Advantage Prescription Drug Plan (MA-PD) and Prescription Drug Plan (PDP) contracts. As a result, WellCare has demonstrated numerous deficiencies in serving its enrollees in the following areas, including, but not limited to: enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance, and marketing and agent/broker oversight activities. In imposing this sanction, CMS is relying upon the following types of information, including but not limited to: CMS' 2007 and 2008 audits of WellCare, beneficiary complaints via the CMS Complaints Tracking Module, CMS performance data, and WellCare's own acknowledgement of compliance failures through its written and verbal contacts with CMS.

CMS has afforded WellCare numerous opportunities to bring its MA-PD and PDP contracts into compliance with CMS requirements. CMS has brought these compliance issues to the attention of WellCare's management on a number of occasions, including in person meetings with senior management on November 20, 2008 and February 4, 2009, a conference call with senior management on January 26, 2009, regular bi-weekly conference calls with the Atlanta Regional Office and several corrective action plans (CAPS) resulting from audits in March 13, 2007, June 26, 2007, and July 29, 2008, none of which have resulted in sufficient improvement in WellCare's operations or correction of the underlying deficiencies.

Pursuant to CMS requirements, MA-PD and PDP plans are required to maintain accurate and up-to-date information regarding enrollment and disenrollments and to be responsive to beneficiary complaints and requests for assistance. From January 1, 2009 through February 1, 2009, CMS has received over 2,500 complaints from Medicare beneficiaries enrolled under WellCare's contracts. CMS believes that the large number of prescription drug access complaints is attributable to WellCare's failure to conduct proper and timely enrollment operations that meet CMS requirements. Almost 800 of these complaints were designated as "immediate need" complaints, which are required to be resolved within 2 calendar days of receipt in the CMS Complaints Tracking Module. WellCare failed to resolve approximately 300 of these complaints within CMS required timeframes.

CMS audits conducted in 2007 demonstrated deficiencies with WellCare's marketing procedures. CMS concluded that WellCare engaged in activities which misled and confused beneficiaries and engaged in door-to-door solicitation. Although WellCare assured CMS these problems had been corrected, a July 2008 audit found the same marketing deficiencies.

In addition, beneficiary complaint data for an extended period of time shows that WellCare has the highest rate of marketing complaints among MA plans with 100,000

enrollees or more, with a significant number of the complaints involving alleged marketing misrepresentations. The most recent marketing casework report, adjusted for enrollment, shows that WellCare's complaints are three times the national average. Of the marketing misrepresentation cases reviewed across all WellCare contracts from October 2008 through mid-January 2009, WellCare's two Private Fee-For-Service (PFFS) plans (H1340 and H4577) contributed to 52% of the reviewed sample. In addition, CMS' concerns about marketing misrepresentation have been reinforced by recent developments, including but not limited to reports from several State Departments of Insurance about enrollment application forgeries, Congressional inquiries, reports of agent and marketing misrepresentations from State Health Insurance Assistance Programs, and additional CTM complaints. These finding demonstrate WellCare's continued failure to exercise proper oversight of its agent and broker activities. CMS' review of marketing events monitored under CMS' Secret Shopper program further demonstrate that WellCare agents provided inaccurate or misleading information to potential enrollees on a number of occasions.

CMS' 2008 audit also found WellCare substantially failed to comply with CMS requirements by failing to properly process grievances, organization determinations, and appeals. These deficiencies include, but are not limited to, WellCare failing to properly forward adverse claims reconsiderations to the IRE for independent review and WellCare failing to timely effectuate a third-party reversal of an expedited reconsideration.

CMS routinely monitors data relating to the performance of Medicare Advantage Plans and Part D Prescription Drug Plans. The data includes customer service indicators, the reliability of data provided to beneficiaries and health providers, beneficiary complaints concerning access to covered items and services, the proper handling of appeals and the accuracy of pricing and Medicare beneficiary out of pocket costs. The data is used by CMS to compare the performance of Medicare Advantage Plans and Prescription Drug Plans. The data is also used to provide comparative information to Medicare beneficiaries through the CMS website that can be used by Medicare beneficiaries to make informed choices about the plan that they select. For the past two years, CMS performance data showed that WellCare's performance was substandard in numerous areas and WellCare was one of the overall worst performers among all plans.

Basis of Proposed Intermediate Sanctions

CMS has determined that WellCare's compliance deficiencies, as described above and further detailed below, provide sufficient basis for intermediate sanctions (42 C.F.R. §422.752(b) and 42 C.F.R. §423.752(b)). CMS' determination to impose intermediate sanctions is based on the following regulatory violations, each of which provides an independent basis for the imposition of an intermediate sanction, and which are supported by examples of WellCare's noncompliance, as described below:

1. **WellCare substantially failed to comply with marketing requirements in 42 C.F.R. Part 422 Subpart V (formerly 42 C.F.R. §422.80) and 42 C.F.R. Part 423 Subpart V (formerly 42 C.F.R. §423.50).**

    - WellCare engaged in activities that misled and confused Medicare beneficiaries and misrepresented its organization. 42 C.F.R. §422.2268 and 42 C.F.R. §423.2268;
    - WellCare engaged in unauthorized door-to-door solicitation. 42 C.F.R. §422.2268 and 42 C.F.R. §423.2268;
    - WellCare failed to establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in its plan, and understand the rules applicable to the plan. 42 C.F.R. §422.2272 and 42 C.F.R. §423.2272.

    These determinations are supported by:

    - WellCare's failure to comply with CMS marketing requirements as demonstrated in both the 2007 and 2008 audits;
    - WellCare's consistently high number of marketing misrepresentation complaints (adjusted for enrollment) by beneficiaries (WellCare is approximately three times the national average);
    - WellCare's agents misleading beneficiaries and misrepresenting WellCare plans at sales events in December 2008 during CMS' secret shopping activities;
    - WellCare's failure to report marketing events to CMS; and
    - WellCare's failure to adequately identify, monitor, and correct the practices of agents who misrepresented WellCare's plans, including, WellCare's failure to discover forged applications through its own monitoring systems.

2. **WellCare violated CMS enrollment and disenrollment requirements at 42 C.F.R. §422 Subpart B and 42 C.F.R. §423 Subpart B and, therefore, substantially failed to carry out the terms of its Medicare Advantage contracts and its Prescription Drug Plan contracts with CMS (42 C.F.R. §422.510(a)(1) and 42 C.F.R. §423.509(a)(1)) and 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), 42 C.F.R. §423.509(a)(2)).**

    - WellCare substantially failed to carry out the terms of its contract, as demonstrated in the 2008 audit, which requires proper processing of enrollment and disenrollment requests.
        - As discovered in both the 2007 and 2008 audits, WellCare failed to send enrollment confirmations and denial notices to beneficiaries within the timeframe specified by CMS under 42 C.F.R. §422.60 and 42 C.F.R. §423.32.

  - WellCare failed to follow CMS regulations with processing disenrollments for members moving out of service areas under 42 C.F.R. §422.74 and 42.C.F.R. §423.44.
  - WellCare failed to correctly submit requests for retroactive disenrollments under 42 C.F.R. §422.66.
- WellCare failed to properly ensure enrollments had been processed timely as required by CMS, demonstrated by:
  - WellCare's failure to download online enrollments, resulting in delays in beneficiary enrollments and receipt of services pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32;
  - WellCare's failure to properly ensure their own telephonic enrollment processes were carried out, resulting in delays in beneficiary enrollments and receipt of services pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32;
  - The excessive number of complaints due to beneficiaries not being properly enrolled and unable to receive access to their prescription drugs pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32.
- WellCare failed to ensure beneficiaries had a valid Special Election Period prior to enrolling pursuant to 42 C.F.R. §422.62 and 42 C.F.R. §423.38.

3. WellCare substantially failed to comply with the requirements related to grievances, organization determinations and appeals in 42 C.F.R. Part 422 Subpart M.

- WellCare failed to properly forward adverse claims reconsiderations to the IRE for independent review and failed to notify members that adverse claims reconsiderations were forwarded to the IRE as required by 42 C.F.R. §422.590.
- WellCare failed to timely notify members about decisions of expedited reconsiderations under 42 C.F.R. §422.590.
- Wellcare failed to timely effectuate a third party reversal of an expedited reconsideration as required by 42 C.F.R. §422.619.
- WellCare failed to properly notify enrollees of adverse expedited organization determinations as required by 42 C.F.R. §422.572.
- WellCare failed to correctly distinguish between organization determinations, reconsiderations and grievances as required by 42 C.F.R. §422.561, §422.564, §422.566 and §422.580.
- WellCare, based on misclassified cases, failed to demonstrate to CMS that it processes grievances timely and accurately as required by 42 C.F.R. §422.564.
- WellCare, based on misclassified cases, failed to demonstrate to CMS that it properly identified, processed and timely responded to members regarding pre-service reconsiderations as required by 42 C.F.R. §422.590 and §422.618.

4. **By failing to adhere to numerous CMS requirements, WellCare substantially failed to carry out the terms of its Medicare Advantage contracts (Article II) and its Prescription Drug Plan contracts (Article I) with CMS (42 C.F.R. §422.510(a)(1) and 42 C.F.R. §423.509(a)(1)) and 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) and 42 C.F.R. §423.509(a)(2)).**

    - WellCare failed to adhere to CMS notification requirements concerning security breaches.
    - WellCare failed to adhere to CMS requirements concerning beneficiary complaint resolution timelines.
    - WellCare has failed to respond in a timely manner to requests from CMS and State Departments of Insurance

Opportunity to Respond to Notice

Pursuant to 42 C.F.R. §422.756(a)(2) and 42 C.F.R. §423.756(a)(2), WellCare has ten (10) calendar days from the date of receipt of this notice to provide a written rebuttal, or on March 2, 2009. If the 10th day falls on a weekend or federal holiday, you have until the next regular business day to provide a written rebuttal. Please note that CMS considers receipt as the day after the notice is sent by fax, e-mail, or overnight mail, or in this case, February 20, 2009. If you choose to submit a rebuttal, please send it to the attention of Brenda J. Tranchida at the address noted below.

Right to Request a Hearing

WellCare may also request a hearing before a CMS hearing officer in accordance with the procedures outlined in 42 C.F.R. §§422.660 through 684 and 42 C.F.R. §§423.650 through 662. Pursuant to 42 C.F.R. §422.756(b) and 42 C.F.R. §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 March 7, 2009. Please note, however, a request for a hearing will not delay the date specified by CMS when the sanction becomes effective. If the 15th day falls on a weekend or federal holiday, you have until the next regular business day to submit your request. Your hearing request will be considered officially filed on the date that it is mailed; accordingly, we recommend using an overnight traceable mail carrier.

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

If you have any questions about this determination, please do not hesitate to contact Brenda Tranchida at (410) 786-2001.

Sincerely,

Abby L. Block
Director
Center for Drug and Health Plan Choice

cc: Ms. Carol Bennett, DHHS/OS/OGC
Mr. James Kerr, CMS/OA/CMHPO
Ms. Nancy Brown DHHS/OIG/OCIG
Ms. Carol Messick, CMS/OA
Mr. Robert Tagalicod, CMS/OA
Mr. Peter Ashkenaz, CMS/OEA
Ms. Kimberly Brandt, CMS/OFM/Program Integrity
Ms. Mary Agnes Laureno, CMS/OBIS
Mr. Louis Polise, CMS/CPC/MCAG
Ms. Cynthia Tudor, CMS/CPC/MDBG
Mr. Anthony Culotta, CMS/CPC/MEAG
Ms. Gloria Parker, CMS/CMHPO/Region IV
Ms. Colleen Carpenter, CMS/CMHPO/Region IV
Ms. Laurie McWright, CMS/OL
Mr. Randy Brauer, CMS/CPC/MPPG