CENTERS FOR MEDICARE AND MEDICAID SERVICES

Hearing Officer Decision

In the Matter of

American Health Alliance, Inc.	*	
	*	Docket No. 2010 C/D App 1
Denial of Initial Application, H6037	*	
	*	

ORDER GRANTING
MOTION FOR SUMMARY JUDGMENT

Jurisdiction

This appeal is provided pursuant to 42 C.F.R. §423.650. The Centers for Medicare and Medicaid Services (CMS) Hearing Officer designated by the CMS Administrator to hear this case is the undersigned, Paul Lichtenstein.

Issue

Whether CMS' denial of the Applicant's MA-PD initial application for calendar year 2011 was consistent with the requirements of 42 C.F.R. §§423.502 and 423.503.[1]

Statutory and Regulatory Background

The Social Security Act (SSA or the Act) authorizes CMS to enter into contracts with entities seeking to offer Medicare Advantage (MA) benefits (Part C) and Medicare outpatient prescription benefits (Part D) to Medicare beneficiaries. SSA §§1857 and 1860D-12. Pursuant to 42 C.F.R. §§422.500 and 423.500 et seq.,[2] CMS has established

[1] All of the deficiencies cited by CMS relate to the Part D portion of the application. CMS Memorandum and Motion for Summary Judgment, June 18, 2010 at 2.

[2] CMS has recently revised and/or clarified some, but not all of the regulatory text governing the Part C and Part D programs. *See* Proposed Rule, 74 Fed. Reg. 54634 (Oct. 22, 2009) and Final Rule, 75 Fed. Reg. 19678 (April 15, 2010). The Final Rule states in part that "This final rule makes revisions to the regulations governing the Medicare Advantage (MA) program (Part C) and prescription drug benefit program (Part D) based on our continued experience in the administration of the Part C and D programs. The revisions strengthen various program participation and exit requirements; strengthen beneficiary protections; ensure that plan offerings to beneficiaries include meaningful differences; improve plan payment rules and processes; improve data collection for oversight and quality assessment, implement new policies and clarify existing program policy." The Rule is effective June 7, 2010 and applies from contract year 2011(the year at issue) forward.

the general provisions for entities seeking to qualify as Medicare Advantage-Prescription Drug (MA-PD) plans. MA organizations offering coordinated care plans (CCPs) must offer Part D benefits in the same service areas. 42 C.F.R. §422.4(c)(1).

Organizations seeking to qualify as an MA-PD plan have their applications reviewed by CMS to determine whether they meet the application requirements to enter into such a contract. *See* 42 C.F.R. §§422.501 and 423.502.

The current regulation concerning the Part D application requirements at 42 C.F.R. §423.502 states, in relevant part:

> (c) Completion of an application.
>
> > (1) In order to obtain a determination on whether it meets the requirements to become a Part D plan sponsor, an entity, or an individual authorized to act for the entity (the applicant) must fully complete all parts of a certified application, **in the form and manner required by CMS**, . . .
> >
> > (2) The authorized individual must describe thoroughly how the entity is qualified to meet **all requirements** described in this part.

(Emphasis added).

CMS has established an online application process for both Part C and Part D plans called the Health Plan Management System (HPMS). All new applicants and requests to expand service areas had to submit their applications through the HPMS by deadlines established by CMS. CMS provided training and technical assistance to plans in completing their applications and plan applications were evaluated solely on the materials they submitted into the HPMS by the deadline established by CMS.

After an applicant files its initial application, CMS reviews the application, notifies the applicant of deficiencies and the applicant is given an opportunity to correct the deficiencies.

The regulation at 42 C.F.R. §423.503 specifies the evaluation and determination procedures for applications to be determined qualified to act as a Part D sponsor. It states, in relevant part:

> (a) *Basis for evaluation and determination.* (1) With the exception of evaluations conducted under paragraph (b) [Use of information from a current or prior contract], CMS evaluates an entities application solely on the basis of information contained in the application itself and any additional information that CMS obtains through on-site visits. (2) After evaluating all relevant information, CMS determines whether the applicant meets **all the requirements** in this part.

(Emphasis added).[3]

If the applicant fails to correct all of the deficiencies, CMS issues the applicant a Notice of Intent to Deny under the regulation at 42 C.F.R. §423.503(c)(2).[4] The regulations at 42 C.F.R. §423.503 state, in relevant part:

> (c) *Notice of Determination.* * * *
>
> (1) *Approval of Application.* * * *
>
> (2*) Intent to Deny*. (i) If CMS finds that the applicant does not appear qualified to contract as a Part D plan sponsor and/or has not provided enough information to evaluate the application, it gives the applicant notice of intent to deny the application and a summary of the basis for this preliminary finding.
>
> (ii) Within 10 days of the date of the notice, the applicant may respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and may revise its application to remedy any defects CMS identified.
>
> (iii) **If CMS does not receive a revised application within 10 days from the date of the notice, or if after timely submission of a revised application, CMS still finds the applicant does not appear qualified to contract as a Part D plan sponsor or has not provided enough information to allow CMS to evaluate the application, CMS denies the application**.[5]

(Emphasis added.)

If CMS denies an MA-PD applicant, they have a right to a hearing before a CMS Hearing Officer under 42 C.F.R. §§422.660(b) and 423.650(b). Under the current Part D regulation at §423.650(b)(i), it states, at hearing, the applicant has the burden of proving by a preponderance of the evidence that CMS' determination was inconsistent with the requirements of §§423.502 and 423.503.[6]

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[3] The preamble to the recent regulatory revision at 75 Fed. Reg. 19678, 19683 (April 15, 2010), states that "we specifically proposed to make explicit that we will approve only those applications that demonstrate that they meet all (not substantially all) Part C and Part D requirements." CMS also states that expecting applicants to meet "all" standards is practical and explains that "applicants receive enough information to successfully apply and are given two opportunities with instructions to cure deficiencies."

[4] *See* similar provision for Part C at 42 C.F.R. §422.502(c)(2).

[5] The preamble to the final regulation at 75 Fed. Reg. 19678, 19683 (April 15, 2010) states that "[w]e also proposed to clarify our authority to decline to consider application materials submitted after the expiration of the 10-day period following our issuance of a notice of intent to deny an organization's contract qualification application. . . . Further, we noted that consistent with the revisions to § 422.650(b)(2) and § 423.660(b)(2) [sic – § 422.660(b)(2) and 423.650(b)(2)], which are discussed elsewhere in this final rule, the applicant would not be permitted to submit additional revised application material to the Hearing Officer for review should the applicant elect to appeal the denial of its application."

[6] CMS' denial was issued on June 7, 2010, the effective date of CMS revised regulations (*supra*, note 2). Accordingly, pursuant to the unambiguous directive in the Final Rule (and consistent

The regulation at 42 C.F.R. §422.684(b) and 423.662(b) states that either party to the hearing may ask the hearing officer to rule on a motion for summary judgment.[7]

Specific Regulations and Other Rules Related to the Alleged Deficiencies

1) Prescription Origin Code Attestation

Section 1860D-4(e) of the Act requires that prescriptions and certain other information for covered Part D drugs prescribed for Part D eligible individuals that are transmitted electronically be transmitted in accordance with designated uniform standards.[8] In CMS' Prescription Drug Benefit Manual, Section 50.1, it requires that plans utilize the Prescription Origin Code on original prescriptions submitted via the NCPD 5.1 option field 419 DJ and report this code on their PDE submissions. Accordingly, the Part D application requires applicants to complete an attestation that they will meet this requirement in Section 3.2.5, No. 22, and are informed that they must attest "yes" in order to qualify for a Part D contract.[9]

2) Relationships with First Tier, Downstream and Related Entities

The HPMS application instructions at Section 3.1.1, Item B requires that applicants provide a chart showing its structure of ownership, subsidiaries, and business affiliates and a chart that clearly depicts the placement of the Part D operations within their legal entity.[10] In Section 3.1.1, Item C, applicants are required to upload into HPMS, the names of the first tier, downstream and related entities it will use to carry out each of the functions listed in a chart.[11]

Also, the instructions for the Section 3.1.1, Item D require applicants to upload copies of contracts and other agreements (with the organization in Item C), so CMS can ensure they meet various contract requirements.[12] Specifically, Section 3.1.1, Item D, No. 7, states it "[c]learly indicates that the contract is for a term of at least the initial one-year contract period (i.e., January 1 through December 31) for which this application is being submitted. Where the contract is for services or products to be used in preparation for the

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with CMS' April 30, 2010 memorandum to applicants (*see* CMS Exhibit G), the Hearing Officer will apply this new burden of proof. Prior to June 7, 2010 (for hearings involving determination regarding contract year 2010), the burden of proof regulations at 42 C.F.R. §§422.660 and 423.650 required the sponsor "to demonstrate that it was in substantial compliance with the requirements" of the Part C and Part D programs.

[7] *See* 72 Fed. Reg. 68700, 68714, 68725 (December 5, 2007). The preamble to the Final Rule further explains that "In ruling on such a motion, we propose that the hearing officer would be bound by the CMS regulations and general instructions. Where no factual dispute exists, the hearing officer may make a decision on the papers, without the need for a hearing."

[8] *See* 42 C.F.R. §423.160(a).

[9] *See* CMS Exhibit I.

[10] *Id.*

[11] *Id.*

[12] *Id.*

next contract year's Part D operations (e.g., marketing, enrollment), the initial term of such contract must include this period of performance (e.g., contracts for enrollment related services must have a term beginning no later than November 15 extending through the full contract year ending on December 31 of the next year.)."[13]

Factual and Procedural Background

In February 2010, American Health Alliance, Inc. (the Applicant) timely filed an initial application, H6037, to qualify as an MA-PD to offer CCPs in Calvert, Charles, Prince George's and St. Mary's Counties in Maryland. CMS determined that the Applicant did not properly respond to its Part D application and issued a deficiency notice to the Applicant on March 19, 2010.[14] In the notice, CMS informed the Applicant that it had failed to correctly attest to certain required statements, presented inconsistent information in its Part D application and its HPMS file describing its organizational structure and contracting arrangements, and presented contracts that did not contain all provisions required under Part D. Finally, the Applicant failed to execute the proper certification statement required in Section 4.0 of the Part D application.

The Applicant responded to this deficiency notice on April 2, 2010. The Applicant corrected one of the two attestations that were cited in the March 19th deficiency notice. The Applicant failed to correct the list of the entities responsible for performing Part D related functions on its behalf. Specifically, the organizational chart and history information provided in the application indicated that the Applicant would contract with TMG-Health, Inc. (TMG) to perform a series of functions on behalf of the Applicant. Yet, the Applicant made no indication in its HPMS Part D-related functions list of TMG's participation in its Medicare operations, nor did it provide a copy of an executed contract with TMG. There were also discrepancies between the description of delegated functions in the Envision contract and those identified in the HPMS list of delegated key Part D functions. Also, as part of the response to the notice, the Applicant left the Envision contract uncorrected.

CMS issued the Applicant a Notice of Intent to Deny its MA-PD application on May 5, 2010 based on the remaining deficiencies described above.[15] The Applicant responded to the notice on May 15, 2010.[16] However, none of the materials the Applicant uploaded into its HPMS Part D related functions list were responsive to its Part D application deficiencies. Rather, all the submitted materials addressed deficiencies in its Part C application which CMS had identified in a separate notice.[17] As a result, on June 7, 2010, CMS issued an MA-PD application denial notice based on the following application deficiencies.[18]

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[13] *Id.*
[14] *See* CMS Exhibit B.
[15] *See* CMS Exhibit C.
[16] *See* CMS Exhibit D.
[17] *See* CMS Exhibit E.
[18] CMS Exhibit A.

Part D Deficiencies:

Attestations

- Your organization failed to attest correctly. Your organization failed to attest correctly that it will obtain the Prescription Origin Code on original prescriptions submitted via the NCPDP 5.1 option field 419 DJ and report this code on PDE submissions.

Contracting

- The entity your organization identified in HPMS as performing the Part D function for enrollment processing does not correspond with executed contract/administrative services agreement/intercompany agreement contained in your submission.
- The entity your organization identified in HPMS as performing the Part D function for coordination of other drug benefit programs does not correspond with executed contract/administrative services agreement/intercompany agreement contained in your submission.
- The entity your organization identified in HPMS as performing the Part D function for customer service functionality does not correspond with executed contract/administrative services agreement/intercompany agreement contained in your submission.
- The entity your organization identified in HPMS as performing the Part D function for pharmacy technical assistance service functionality does not correspond with executed contract/administrative services agreement/intercompany agreement contained in your submission.
- The executed contract/administrative services agreement/intercompany agreement your organization submitted is not for a term of at least the one-year contract period for which this application was submitted. The executed contract/ administrative services agreement/intercompany agreement reference is with Envision Rx.
- Your organization failed to upload an organizational chart showing the structure, ownership, subsidiaries and business affiliations. The chart provided incorrectly identifies TMG Health as a contracted entity with your organization.
- The organizational chart failed to properly identify where the Part D operations will take place. The chart provided incorrectly identifies TMG Health as a contracted entity with your organization.

The Applicant filed a timely request for a hearing concerning CMS' determination. On June 18, 2010, CMS submitted a Memorandum and Motion for Summary Judgment in support of its denial of the Applicant's initial application based on the deficiencies noted in the denial notice. On June 24, 2010, the Applicant submitted a response requesting relief from the deficiencies in the application denial and a hearing brief.

CMS' Contentions

CMS contends that applicants must demonstrate that they meet all Part D program requirements to qualify as an MA-PD sponsor in their proposed service area. Pursuant to 42 C.F.R. §423.502(c)(1), applicants are required to complete all parts of a certified application in the form and manner required by CMS. Furthermore, the applicant must describe thoroughly how it meets all Part D program requirements. 42 C.F.R. §423.502(c)(2). CMS limits its review to that information contained in the application and determines whether the application meets all Part D requirements. 42 C.F.R. §423.503(a)(1) and (2). If CMS does not receive a revised application or the revised application still does not demonstrate that the applicant is qualified to act as a Part D sponsor, CMS denies the application. 42 C.F.R. §423.503(c)(2)(iii).

CMS also indicated that in accordance with the current version of 42 C.F.R. §423.505 (as well as holdings in previous Hearing Officer decisions) neither CMS nor the Hearing Officer may consider information provided after the expiration of the 10-day period following the Notice of Intent to Deny. Finally, CMS notes that the applicant must prove by a preponderance of the evidence that CMS' determination was inconsistent with the requirements of 42 C.F.R. §§423.502 and 423.503.

Attestation

CMS notes that the MA-PD application contains sets of statements shown in a series of tables concerning Part D program requirements to which organizations must attest. Applicants are advised at the top of each table that they "must attest 'yes' to each of the following qualifications to be approved for a Part D contract."[19] The Applicant attested "no" to the statement at Section 3.2.5, Item A.3 concerning the use of Prescription Origin Codes in the submission of its prescription drug event data to CMS.[20]

Relationships with First Tier, Downstream and Related Entities

CMS notes that the MA-PD application at Section 3.1.1, Item C, requires applicants to upload into HPMS a list that identifies the entities with which it will contract to perform Part D-related functions on its behalf. The instructions for the subsequent Item D then direct the applicant to provide copies of executed contracts with "each first tier, downstream, and related entities [sic] identified in Sections 3.1.1.C."[21] CMS relies on applicants maintaining consistency between the chart in Item C and the materials provided in response to Item D so that the agency can assess whether the contents of each contract accurately reflect the functions each subcontractor has agreed to perform on behalf of the applicant.

CMS identified several inconsistencies between the Applicant's HPMS list of subcontractor functions and the provisions of its contract with Envision. The HPMS list states that the Applicant alone will be performing functions related to "coordination with

[19] *See* Section 3.2.5.A, last page of CMS Exhibit I.
[20] *See* CMS Exhibit J.
[21] *See* CMS Exhibit I.

other drug benefit programs, including for example, Medicaid, state pharmaceutical programs, or other insurance."[22] However, as the Envision contract with the Applicant in Section 2.3 states that Envision will assist the Applicant in performing the benefit coordination function, Envision should have also been listed under that function in the HPMS chart. Also, the HPMS list identifies Envision (and not itself) as performing a "customer service functionality, that includes serving seniors and persons with a disability," while Section 2.14 of the Envision contract explicitly states that Envision's operation of a Help Desk to reply to health plan, pharmacy, and prescriber inquiries does not take the place of the Applicant's own customer service operations.[23]

CMS also notes that the Applicant submitted a chart showing its organizational structure and business relationships and a discussion of its organizational history in response to Section 3.1.1.B. of the MA-PD application.[24] In the history discussion, the Applicant states that TMG will be performing enrollment/disenrollment, claims management, members services, fulfillment, and IT services on behalf of the Applicant.[25] The submitted organizational chart shows the same information in the lower left-hand corner of the document.[26] However, the Applicant's list of subcontractors in HPMS makes no reference to TMG and shows other entities performing the functions ascribed to TMG in the organizational chart and history. Also, the Applicant submitted no executed contract with TMG.

The inconsistencies in the statements of the Applicant's subcontracting relationships among its HPMS file, its submitted subcontracts, and its organizational chart and history preclude CMS from making an assessment of whether the Applicant has sufficient arrangements in place to operate a Part D benefit plan. It also causes CMS to question whether the Applicant has in fact made final, binding arrangements within its own organization and with subcontractors for the operation of its Part D plans. Most importantly, the inconsistency means that the Applicant cannot correctly certify that information provided in its application is "true, correct, and complete" as required by the certification statement in Section 4.0 of the application.[27]

<u>The Contract Between the Applicant and Envision Is Not for the Correct Term.</u>

Finally, CMS notes that the MA-PD application at Section 3.1.1, Item D, No. 7, requires that contracts between an applicant and any of its subcontractors for services used in preparation for the delivery of Part D benefits during the upcoming contract year have a

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[22] *See* CMS Exhibit K.
[23] *See* CMS Exhibits K and L. CMS noted that the Applicant made unauthorized changes to its subcontractor list in HPMS on June 15, 2010. *See* June 15, 2010 e-mail at CMS Exhibit M. These changes were made after the 10-day period following the Notice of Intent to Deny and they were not considered as part of the application. Because of the unauthorized changes, the earlier HPMS screenshot that would demonstrate the inconsistency no longer exists.
[24] *See* CMS Exhibit I.
[25] *See* CMS Exhibit O.
[26] *See* CMS Exhibit P.
[27] *See* CMS Exhibit Q.

term starting no later than November 15, 2010.[28] The Applicant provided a contract it executed with Envision, an organization identified as performing negotiation with prescription drug manufacturers, development and maintenance of a pharmacy network, and maintenance of a pharmacy and therapeutic committee, all tasks to be performed as part of any new Part D sponsor's start-up activities in anticipation of operating a Part D plan in the coming contract year.[29] The Envision contract, however, provided states that it is "entered into the 17th day of February 2010 for an effective date of January 1st, 2011 . . . "[30]

Applicant's Contentions

The Applicant indicates that all of the deficiencies in its application were related to the Part D and that no deficiencies were identified in the Part C portion of their application. The Applicant provided the following explanation concerning each of the identified administrative deficiencies in the application.

Attestation

The Applicant acknowledged making an error in responding "no" instead of "yes" to the attestation concerning the Prescription Origin Code. The Application asserts that it is willing to attest "yes" if given the opportunity to change its application.[31]

Relationships with First Tier, Downstream and Related Entities

The Applicant notes that when it filed its initial application in February 2010, it was in negotiations with TMG to perform select administrative functions; accordingly, it identified TMG in all supporting documents in the application for which a reference to a third party administrative management entity was required.[32] The Applicant states that negotiations with TMG were unsuccessful and it alternately contracted with MedStar and Envision and upload contracts for them into the HPMS by the May 15, 2010 deadline, however, it acknowledged that associated changes were not made in the Part D Data Section of the HPMS.[33]

The Applicant further explained which entity would actually perform the enrollment processing, coordination with other drug benefit programs, customer services functionality and pharmacy technical assistance functionality and provided an updated Part D Data Section.[34]

[28] *See* CMS Exhibit I.
[29] *See* CMS Exhibit K**.**
[30] *See* CMS Exhibit L.
[31] Applicant Letter, June 24, 2010 at 1.
[32] Applicant Hearing Brief at 1.
[33] *Id.* at 2.
[34] In support of the change, the Applicant submitted an Exhibit, entitled, "Screenshot of Part D Business Function Tables," dated June 15, 2010.

With regard to the deficiency that the term of its administrative contract was for a period of less than one year, the Applicant indicated that its Envision contract is for a period of 3 years, as noted in Section 5.1 of the contract.

With regard to the organizational chart, the Applicant conceded that it failed to negotiate a contract with TMG and instead signed a contract with MedStar. Again, the Applicant notes that it uploaded the contract with MedStar but failed to change the TMG indicator on the organizational chart to MedStar.[35]

The Applicant indicates that its deficiencies represent administrative errors that can be efficiently resolved.

Decision

The Hearing Officer notes that pursuant to 42 C.F.R. §423.502(b), CMS may set deadlines and dictate the form and manner of the application process (e.g., CMS has the right to require the use of the HPMS and to specify documentation requirements). The Hearing Officer also notes that the regulation at 42 C.F.R. §423.503(b)(2) specifies that in evaluating an applicant, "CMS determines whether the applicant meets all of the requirements described in this part." (emphasis added). In addition, 42 C.F.R. §423.503(c)(2)(ii) requires that applicants revise their applications within 10 days from the date of the Notice of Intent to Deny letter. Accordingly, CMS is within its authority to only consider documentation which is filed through its HPMS system by May 15, 2010, the last day of the 42 C.F.R. § 423.503(c)(2)(ii) cure window. Therefore, when deciding if the application met the all of the program requirements, the Hearing Officer will evaluate only materials timely and properly filed with the agency by the May 15, 2010 deadline.[36]

The Hearing Officer notes that the facts in this case are not at issue and therefore, a summary judgment based on the parties' written briefs is appropriate. 42 C.F.R. §423.662(b).

Attestation

The Hearing Officer notes that CMS' application in Section 3.2.5, No. 22, requires applicants to attest "yes" that they will utilize the Prescription Origin Code on original

[35] Applicant Hearing Brief at 3.

[36] The Hearing Officer notes that the Applicant indicates that it will change its attestation to "yes" to the Prescription Origin Code; that it made changes to the correct the Part D function table (the record indicates that these changes were made after the May 15, 2010 deadline, *see* CMS Motion for Summary Judgment, Note on 6 and CMS Exhibits M and N) and has prepared a revised business organization chart to properly reflect the replacement of TMG with MedStar. *See* Applicant Exhibit, Edited Organizational Chart. The Hearing Officer notes, however, that only materials timely and properly filed with the agency by the May 15, 2010 deadline may be considered.

prescriptions submitted via the NCPD 5.1 option field 419 DJ and report this code on their PDE submissions.[37] The heading of this section of the application specifically states that an "[a]pplicant must attest 'yes' to each of the following qualifications to be approved for a Part D contract." *Id.* With respect to this requirement, the Applicant acknowledged that it made an error in recording a 'no' in this section of the application.

Relationships with First Tier, Downstream and Related Entities

The HPMS application instructions at Section 3.1.1, Item B requires that each applicant provide a chart showing its structure of ownership, subsidiaries, and business affiliates and a chart that clearly depicts the placement of the Part D operations within your legal entity.[38] In Section 3.1.1, Item C, the applicants is required to upload into HPMS a list the names of the first tier, downstream and related entities it will use to carry out each of the functions listed in a function chart.[39] And finally, the instructions for the Section 3.1.1, Item D require applicants to upload copies of executed contracts and other agreements with the organization in Item C so CMS can ensure they meet various contract requirements.[40]

The record in this case indicates that the Applicant initially planned to utilize TMG as a third party administrative management entity for various functions in its Part D plan and that it identified TMG both in the organizational history and organizational chart it submitted in response to Item B.[41] The Applicant stated that it was unable to reach an agreement with TMG and instead signed a contract with MedStar to perform the administrative functions initially identified and associated with TMG.[42] The Applicant indicated that it uploaded the MedStar and Envision contracts into the HPMS by the May 15, 2010 deadline, however, it acknowledged that it did not made associate changes in the Part D Function Chart or in its organization chart.[43] As a result, the application in the HPMS as of the May 15, 2010 deadline contained the errors that CMS identified in its June 7, 2010 denial letter with respect to contract functions and its organizational chart.[44]

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[37] *See* CMS Exhibit I.
[38] *Id*.
[39] *Id.*
[40] *Id*.
[41] *See* CMS Exhibits O and P and Applicant's June 24, 2010 letter and Hearing Brief at 1.
[42] Applicant Hearing Brief at 1.
[43] *Id*. at 2 and 3.
[44] CMS' Notice of Denial, *see* CMS Exhibit A, states that the executed contract with Envision was not for a term of at least the one-year contract period. The Applicant's June 24, 2010 response and hearing brief provided a copy of the contract, s*ee* Applicant Exhibit – Envision Rx Contract, that indicates in Section 5.1 that the term of the contract was for a period of three years. In CMS' subsequent Memorandum and Motion for Summary Judgment, it provided a seemingly additional argument, that the Envision contract includes services or products to be used in preparation for the next contract year and that Section 3.1.1, D.7, requires that such contracts have a beginning date no later than November 15, 2010. The Applicant's brief did not address CMS' new position. The Hearing Officer finds that additional information would be needed to address this issue, however, there is no need to reach this issue, as the other errors in the application already preclude the application from being approved.

Based on the above record, the Hearing Officer finds that, by the deadline for uploading information into the HPMS, it is undisputed that the Applicant failed to make a proper attestation and made numerous errors in submitting information concerning its organizational structure and subcontractors performing various Part D functions such that CMS could not assess the sufficiency of its arrangements to operate a Part D plan. The Hearing Officer finds that these failures supported CMS determination that the Applicant did not meet all of the program requirements under the regulations.

Conclusion

The Hearing Officer grants CMS' Motion for Summary Judgment and finds that CMS' denial of the Applicants initial application was proper.

Paul Lichtenstein
Hearing Officer

Date: July 9, 2010