CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Viventium Health Plan, Inc.	*	**Docket No. 2016 MA/PD App. 5**
Denial of Service Area Expansion: Initial Application	*	
	*	
Contract Year 2017 Contract No. H4627	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. FILINGS

This Order is being issued in response to the following:

(a) Viventium Health Plan, Inc.'s (Viventium) Request for Hearing submitted by letter dated June 9, 2016;

(b) Viventium's "Appeal of May 26, 2016, Notice of Denial of a Medicare Advantage Contract Application For Fiscal Year 2017," filed June 21, 2016 (hereinafter "Viventium's Appeal Brief"); and

(c) "Centers for Medicare & Medicaid Services (CMS) Memorandum and Motion for Summary Judgment in Support of CMS's Denial of Viventium Health Plan, Inc.'s (Viventium) application to offer Medicare Advantage Prescription Drug (MA-PD) Contract H4627 for contract year (CY) 2017," dated June 27, 2016 (hereinafter "CMS' Memorandum").

II. ISSUE

Whether Viventium proved by a preponderance of the evidence that CMS' denial of its Medicare Advantage ("MA") plan application, on the grounds that it failed to document appropriate State licensure, a was inconsistent with regulatory requirements.

III. DECISION

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties agree there is no dispute of material facts. The Hearing Officer finds that Viventium failed to meet the

application requirements of State licensure. Viventium has not established by a preponderance of the evidence that CMS' denial was inconsistent with controlling authority.

IV. BACKGROUND

Any entity seeking to contract as a MA organization must fully complete all parts of a certified application, in the form and manner required by CMS. *See* 42 C.F.R. §§ 422.503(b)(1) and 422.501(c) (2015). Specifically, CMS requires that applications be submitted through the Health Plan Management System ("HPMS") and in accordance with instructions and guidelines that CMS may issue. Among other requirements, an applicant must provide:

> Documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to MA plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health care services to be offered under the MA contract. 42 C.F.R. § 422.501(c)(1)(i).

Under current regulations and procedures, after receiving an application, CMS reviews the application for any issues. CMS then notifies the applicant of any deficiencies by e-mailing a Deficiency Notice. This is an applicant's first opportunity to amend its application.

If an applicant fails to cure its deficiencies, CMS will issue a Notice of Intent to Deny ("NOID"). The NOID affords an applicant a second opportunity to cure its application. The regulations provide that, after a NOID is issued, an applicant has a final ten-day period to cure any deficiencies in order to meet CMS' requirements, or else CMS will deny the application.

The formal NOID process is outlined in 42 C.F.R. § 422.502(c)(2)(i)-(iii), which states:

> (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization or Specialized MA Plan for Special Needs Individuals, CMS gives the applicant notice of intent to deny the application for an MA contract or for a Specialized MA Plan for Special Needs Individuals a summary of the basis for this preliminary finding.
>
> (ii) Within 10 days from the intent to deny, the applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must 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 that the applicant does not appear qualified or has not provided CMS enough information to allow CMS to evaluate the application, CMS will deny the application.

If after review, CMS denies the application, written notice of the determination and the basis for the determination is given to each applicant. 42 C.F.R. § 422.502(c).

If CMS denies a MA application, the applicant is entitled to a hearing before a CMS Hearing Officer. The regulations dictate that the applicant has the burden of proving by a preponderance of the evidence that CMS' determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501 (application requirements) and 422.502 (evaluation and determination procedures). 42 C.F.R. § 422.660(b)(1). In addition, the regulations governing the hearing process provide that either party may ask the Hearing Officer to rule on a Motion for Summary Judgment. 42 C.F.R. § 422.684(b).

V. PROCEDURAL HISTORY AND STATEMENT OF FACTS

In February 2016, Viventium filed an initial application with CMS to offer Medicare Advantage ("Part C") and Medicare outpatient prescription drug ("Part D") benefits to Medicare beneficiaries for contract year ("CY") 2017. In its initial review, CMS noted several deficiencies with Viventium's application, including failures to upload its Florida State licensure and a CMS State Certification Form evidencing fiscal soundness under State law. *See* CMS' Memorandum at 1.

CMS informed Viventium of its deficiencies in a Deficiency Notice, e-mailed on March 9, 2016. The Deficiency Notice also informed Viventium that it had until March 15, 2016 to submit its revisions. *Id.* at 6.

Although Viventium timely submitted revisions to CMS, Viventium continued to have deficiencies in State licensure and the required State certification Form. Therefore, on April 18, 2016, CMS issued Viventium a NOID. The NOID gave Viventium a final ten day cure period to correct any deficiencies in its application. *Id.*

Viventium submitted revised materials by the April 28, 2016 deadline, however, it again failed to provide proof of State licensure. Accordingly, on May 26, 2016, CMS issued a formal denial of Viventium's Part C application. *Id.* at 1. Viventium subsequently filed a Hearing Request on June 9, 2016, to establish the instant appeal. The parties then briefed the issue as noted in Section I above.

VI. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

In exercising his/her authority, the Hearing Officer must comply with the provisions of Title XVIII and related provisions of the Social Security Act, regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act. 42 C.F.R. § 422.688.

The regulations are clear that an applicant must document that it has a State license or State certification to meet CMS' standards. 42 C.F.R. § 422.501(c)(1)(i). Viventium failed to meet the application requirements when it initially submitted its application and failed to cure these deficiencies during the application process. The Hearing Officer finds that Viventium failed to submit the required materials by CMS' established deadlines.

The parties do not dispute the material facts in this case. In Viventium's June 21, 2016 Appeal Brief, it acknowledges that it did not timely provide CMS with the documentation necessary to cure its deficiencies. Viventium's Appeal Brief at 12. Viventium describes the efforts it exerted to obtain the required State license and State certification. It explains that it was unable to obtain the documents due to the protracted application review process in the State of Florida but asserts that it continues to pursue State licensure. *Id.*

Viventium cites the Administrator's Decision in Eden Health Plan, Docket No. 2015 MA/PD (CMS August 27, 2015). *Id. at 13.* In that case, Eden alleged that it faced delays, similar to those purportedly experienced by Viventium, in obtaining a State license and State certification from Florida. CMS denied Eden's application for a MA contract when Eden failed to provide the required documentation by the deadline. The Hearing Officer upheld CMS' denial. Upon appeal, the CMS Administrator exercised his broad contractual discretionary authority to modify the denial and Hearing Officer decision and, in addition, allowed Eden the opportunity to cure its application well after the deadline. Although the situation described in Eden and the instant appeal may be comparable, the Hearing Officer does not have the same scope of authority as the CMS Administrator. Instead, the Hearing Officer must decide whether CMS' determination was consistent with regulatory requirements.

VII. DECISION AND ORDER

The Hearing Officer finds that Viventium has not established, by a preponderance of the evidence, that CMS' denial is inconsistent with controlling authority. Viventium admits that it failed to meet CMS' application requirements. Therefore, CMS' Motion for Summary Judgment is hereby granted.

Brenda D. Thew, Esq.
CMS Hearing Officer

Diana K. Hobbs, Esq.
CMS Hearing Officer

Date: July 13, 2016