

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of

Plan Medico Servicios de Salud Bella Vista, Inc.)
Initial Application) Docket No. 2008-C/D-App-09
Denials, H7739 and H8404) and 10
_____)

Jurisdiction

This appeal is provided pursuant to 42 C.F.R. §422.660. The Centers for Medicare and Medicaid Services (CMS) Hearing Officer designated by the CMS Administrator to conduct this hearing is the undersigned, Benjamin Cohen.

Statutory and Regulatory Background

Section 101 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Pub.L. 108-173), amended Title XVIII of the Social Security Act (the Act) by establishing a voluntary prescription drug benefit and made changes to the Medicare managed care program known as Medicare Advantage (MA or Part C). Specifically, the MMA created coverage for prescription drug benefits and moved managed care toward a competitive bidding system, requiring submission of annual bids and annual contracting. Pursuant to 42 C.F.R. §§422.500 et seq. CMS has respectively established the general provisions for entities seeking to qualify as managed care organizations and/or Prescription Drug Plans (PDP or Part D).

CMS determine whether applicants meet the application requirements to enter into such a contract. The regulation at 42 C.F.R. §422.501(b) states, in relevant part:

(b) Completion of an application.

(1) In order to obtain a determination on whether it meets the requirements to become an MA organization and is qualified to provide a particular type of MA plan, an entity, or an individual authorized to act for the entity (the applicant) must complete a certified application, in the form and manner required by CMS, including the following:

(i) 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; or

(ii) For regional plans, documentation of application for State licensure in any State in the region that the organization is not already licensed.

(2) The authorized individual must thoroughly describe how the entity and MA plan meet, or will meet, the requirements described in this part.

(Emphasis added).

Accordingly, for the 2009 contract year, CMS 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 application and plan applications were evaluated solely on the materials they submitted into the HPMS system within CMS established windows.

After the initial March 2008 filing window closed, CMS reviewed plan submissions and in April 2008, provided the plans with a listing of their deficiencies. The HPMS system was reopened for a second window to submit data into the HPMS to correct the deficiencies.

Upon review of the materials submitted within the second window, some plans still had alleged deficiencies. Prior to issuing a contract determination denial, the regulations at 42 C.F.R. §422.502(c) require CMS to formally send an intent to deny notice which provides the plan ten days to cure their application. The regulation states:

(c) Notice of determination. Within timeframes determined by CMS, it notifies each applicant that applies for an MA contract under this part of its determination and the basis for the determination. The determination is one of the following:

(1) Approval of application. If CMS approves the application, it gives written notice to the applicant, indicating that it qualifies to contract as an MA organization.

(2) Intent to deny.

(i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization and/or has not provided enough information to evaluate the application, CMS gives the contract applicant notice of intent to deny the application for an MA contract and a summary of the basis for this preliminary finding.

(ii) Within 10 days from the date of the intent to deny notice, the contract 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.

(Emphasis added).

During the ten day period plans were given a final opportunity to submit data into the HPMS to correct their deficiencies. On May 19, 2008, the window closed and plans were unable to formally file materials through the HPMS system. CMS reviewed the materials which were filed through timely filed in HPMS and on June 3, 2008 issued denial letters to the plans which had failed to correct their deficiencies.

If CMS denies a Medicare Advantage applicant, they have a right to a hearing before a CMS Hearing Officer under 42 C.F.R. §422.660. The regulation states:

- (a) The following parties are entitled to a hearing:
 - (1) A contract applicant that has been determined to be unqualified to enter into a contract with CMS under part C of Title XVIII of the Act pursuant to 422.501.
 - (2) An MA organization whose contract has been terminated pursuant to § 422.510.
 - (3) An MA organization whose contract has not been renewed pursuant to §422.506.
 - (4) An MA organization who has had an intermediate sanction imposed pursuant to § 422.752(a) through (b).
- (b) The MA organization bears the burden of proof to demonstrate that it was in substantial compliance with the requirements of the MA program on the earliest of the following three dates:¹
 - (1) The date the organization received written notice of the contract determination or intermediate sanction.
 - (2) The date of the most recent on-site audit conducted by CMS.
 - (3) The date of the alleged breach of the current contract or past substantial noncompliance as determined by CMS

¹ The implementing Proposed Rule 70 Fed. Reg. 29367, 29377 states “Based on our experience with appeals of contract determinations, we have found the current regulations do not provide hearing officers with a particular “compliance date” to use as a reference point in issuing a ruling. This creates the potential inconsistency in the decisions issued by hearing officers. We believe our proposal to provide a framework for hearing officer to use in establishing a compliance date as a reference will lessen the potential for such inconsistency.” See also 70 Fed. Reg. 68700, 68713. (Final Rule), December 5, 2007.

(Emphasis added).

Network Requirements

In order to be approved as an MA Organization, an applicant must document that it has a network of health care providers sufficient to ensure that covered benefits are available and accessible to each enrolled individual within the plan's service area as required under both §1852(d)(1)(A) of the Social Security Act and 42 CFR §422.112

The regulation at 42 CFR §422.112(a)(1) requires coordinated care plans to “[m]aintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.”

Factual Background

Plan Medico Servicios de Salud Bella Vista, Inc. (SSBV) submitted two MA applications by the March 10, 2009 deadline. Both applications proposed to provide services in Puerto Rico.

CMS determined that both applications were incomplete and informed SSBV of the specific deficiencies by letters dated March 28, 2008. (CMS Exhibit 6). CMS subsequently performed a more intensive evaluation of both applications and determined that additional documentation and clarification was needed for both applications. CMS informed SSBV of the specific documentation and clarification needed for both applications by letters dated April 15, 2008. (CMS Exhibit 7).

Pursuant to 42 CFR §422.502(c)(2), CMS informed Bella Vista of its Intent to Deny both applications as a result of missing documentation resulting in an inadequate network by two letters dated May 9, 2008. (CMS Exhibit 8). All applicants including SSBV were given until midnight May 19, 2008 to upload corrected materials into the HPMS.

CMS determined that the documentation and clarification necessary to show that either of these applications was complete was not provided. Pursuant to 42 CFR §422.502(c)(3), on June 3, 2008 (upon six identical deficiency) CMS denied both Medicare Advantage applications. (CMS Exhibit 9).

On June 4, 2008, SSBV filed a timely request for a hearing for the denials of both applications. The parties subsequently filed briefs and supporting hearing exhibits as required. In summary, the hearing exhibits which had been filed through HPMS by the May 19, 2008, had been reviewed by CMS before the June 3, 2008 denials; however, CMS considered the submissions inadequate as they were agreements to contract in the future, as opposed to firm contracts. Additionally, SSBV's hearing exhibits which were

not uploaded in HPMS by the May 19th curing deadline (although some were executed before May 19) were never accepted or considered by CMS. Specifically, the SSBV's hearing exhibits submitted to overcome each alleged deficiency are as follows:

Home health services - Before the May 19, 2008 curing deadline, SSBV uploaded into HPMS an agreement with St. Lucas Home Health Care (St. Lucas) to enter into a contract by December 1, 2008. (Plan Exhibit B at Section 1.10). SSBV presented an executed contract dated May 22, 2008 with St. Lucas (Plan Exhibit C) and a May 31, 2008 contract with Servicios de Salud en el Hogar Clinical La Espanola. (Plan Exhibit E).

Skilled nursing services - Before the May 19, 2008 curing deadline, SSBV uploaded into HPMS a May 8, 2008 agreement with Servicios Intergrados De Rehabilitacion Del Oeste, Inc. (SIRO) to enter into a contract by December 1, 2008. (Plan Exhibit F, Section 1.10). SSBV presented a May 13, 2008 final contract with SIRO which was not uploaded into HPMS by the May 19, 2008 deadline. (Plan Exhibit G).

Therapy-outpatient services - SSBV presented hearing exhibits not uploaded into HPMS by the May 19, 2008 deadline (although some were executed before May 19, 2008) (Plan Exhibits G, H, I and J).

Inpatient mental health services - Prior to May 19, 2008, SSBV did upload into HPMS a letter to a provider concerning rates for services but that this was not a firm contract. (Plan Exhibit K). SSBV presented additional agreements with providers but they were agreement to contract at a future date (Plan Exhibits L and M,) which were not uploaded into HPMS by the deadline. Additionally, as of the date of the hearing, SSBV indicated that it was conducting contract negotiations to secure a firm inpatient mental health contract.

Transplant services - Prior to the May 19, 2008 deadline, SSBV uploaded into HPMS information about a proposal to provide transplant services through a re-insurance mechanism. (Plan Exhibit N). Additionally, SSBV presented a May 23, 2008 agreement to contract at a future date. (Exhibit O).

Arrangements to monitor the credentialing of healthcare professionals - Prior to May 19, 2008, SSBV uploaded into HPMS evidence of registration with the National Practitioner Data Bank and a formal transmittal letter to receive the most recent list from the local licensing body. (Plan Exhibits P and Q). SSBV indicates that it also gained access to the American Board of Medical Specialties on May 19, 2008 although it was not submitted to CMS through HPMS by May 19, 2008. (Plan Exhibit R).

Issue

Was the CMS denial of SSBV's initial applications to be MA-PD plans for program year 2009 proper?

CMS' Contentions

CMS maintains that SSBV should not be afforded an opportunity based on 42 C.F.R. §422.650(b)(1) to submit to the Hearing Officer documentation concerning its qualifications that have not previously been reviewed by CMS by May 19, 2008 during the 2009 application process and to permit the submission of such information would, in effect, extend the deadline for submitting an approvable application. CMS noted that pursuant to 42 C.F.R. §422.501(b), it has the right to set the application filing requirements and to expect such requirements to be fully met.

CMS continues that upon the issuance of a notice of intent to deny, applicants are afforded no more than 10 days to respond to the issues identified in the notice, per 42 C.F.R. §422.502(c)(2)(ii). Accordingly, CMS closed the HPMS system on May 19, 2008. CMS neither has any obligation to consider any materials beyond the May 19th deadline nor materials which were not submitted through HPMS.

Regarding the hearing exhibits which were filed through HPMS by May 19, 2008 deadline, as a whole, CMS determined that such materials were letters of agreements to enter into contracts by a future date, as opposed to fully executed firm contracts which ensure adequate access to covered services in accordance with the regulations and CMS requirements. Additionally, CMS contends that as of the date of the hearing, it was undisputed that SSBV still did not have an Inpatient Mental Health Network in place.

Accordingly, SSBV did not provide sufficient documentation to demonstrate that its networks are adequate in accordance with Social Security Act §1852(d)(1)(A) and 42 C.F.R. §422.112 (a)(1)(i), the denial of its application must be upheld.

SSBV's Contentions

As background, SSBV alleges that “the Puerto Rico Medicare Advantage Market has been adversely affected by many plans that have not complied with its contractual agreements with participating providers at the same time not complying with CMS payment regulations.”² As a result SSBV had difficulties reaching agreements with provider and obtaining reasonable rates.

Nevertheless, SSBV indicates that it has presented evidence of contracted providers for all of the deficiencies. SSBV states that agreement to enter into a contract prior to the effective date of the contract year and should be accepted as satisfying program requirements.

SSBV indicates that as of May 19, 2008, it submitted most of the information to cure its application, and that the only two deficiencies remaining deficiencies (inpatient mental health services and arrangements to effectively credential healthcare providers), have since been cured. Accordingly, the Hearing Officer should overturn the June 3, 2008

² See Plan brief at 1.

denials as SSBV has demonstrated substantial compliance with the requirements of the MA program.

Decision

CMS' June 3, 2008 denials are upheld as SSBV has not demonstrated that it was in substantial compliance with the requirements of the MA-PD program.

The Hearing Officer finds that the appeal regulations at 42 C.F.R. §422.660 establish the same burden of proof and standard of substantial compliance to both initial applicants and existing contractors. Regarding the evidence that the Hearing Officer may consider when evaluating "substantial compliance" on the date of the June 3, 2008 contract determination, the Hearing Officer notes that pursuant to 42 C.F.R. §§422.501(b), CMS may set time frames and dictate the form and manner of the application process (e.g., CMS has the right to require the use of the HPMS). In addition, 42 C.F.R. §422.502(c)(2)(ii) require that plans revise their applications within 10 days from the date of the intent deny letter.

Accordingly, CMS was within its authority to only accept and review documentation which was filed through its HPMS system by May 19, 2008, the last day of the 42 C.F.R. §422.502(c)(2)(ii) cure window. CMS was not obligated to consider Plan Exhibits C, E, G, H, J, L, M, O and R. Therefore, when deciding if a plan was in substantial compliance on June 3, 2008, the Hearing Officer will evaluate those materials which were timely and properly filed with the agency by May 19, 2008.³

Regarding the hearing exhibits which were filed through HPMS by May 19, 2008, the Hearing Officer agrees with CMS that the letters of agreements to enter into contracts by a future date, do not ensure adequate access to covered services in accordance with Social Security Act §1852(d)(1)(A) and 42 C.F.R. §422.112(a)(1)(i). Finally, as of the date of the hearing, it was undisputed that SSBV still did not have an Inpatient Mental Health Network in place.

Conclusion

CMS' June 3, 2008 denials are affirmed. SSBV did not sustain the burden that it was in substantial compliance with the requirements of the MA program.

³ Reading 42 C.F.R. §422.660(b) in isolation could be misleading as it suggests that the Hearing Officer may consider any documentation which was submitted to CMS (or which potentially existed) up to the date of denial, i.e. June 3, 2008. However, such reading would require reading this section within a vacuum and would effectively invalidate the necessity to comply with all other regulatory (and instructional) filing requirements and deadlines. The Hearing Officer, accordingly finds, to interpret 42 C.F.R. §422.660, one must read the application, determination and appeals regulations together. Moreover, the Hearing Officer notes that 42 C.F.R. §§422.660(a)(1) explicitly references 42 C.F.R. §422.501 which addresses the application process.

Benjamin Cohen
CMS Hearing Officer

July 21, 2008