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SEP - 1 2015

VIA ELECTRONIC AND
FIRST CLASS MAIL

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Re: Provider Partners Health Plan, Docket No. 2015 MA/PD App. 1

Gentlemen:

Enclosed is a copy of the Administrator's decision in the above case modifying the decision of the Hearing Officer. This constitutes the final administrative decision of the Secretary of the Health and Human Services

Sincerely yours,

Jacqueline R. Vaughn
Attorney Advisor

Enclosure

cc: Kathryn A. Coleman, Director, CM/CMS
Cathy Baldwin, MCAG/CM/CMS

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the Matter of:	Claim for:
Provider Partners Health Plan	**Medicare Advantage Prescription Drug Plan** **Period Beginning: 2015** **Review of:** **Docket No. 2015-C/D-App-1** **H8067** **Dated: July 7, 2015**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Hearing Officer's decision. The Provider Partners Health Plan (the Applicant) timely requested Administrator review under 42 C.F.R. §§422.692(a) and 423.666(a). The Administrator elected to review the Hearing Officer's decision. No further comments were received from the Applicant. Accordingly, this case is now before the Administrator for final administrative review pursuant to 42 C.F.R. §§422.692(d) and 423.666(d).

ISSUE

The issue involves whether CMS properly denied Provider Partners Health Plan's application to be a Medicare Advantage Prescription Drug (MA-PD) plan for the program year 2016.

HEARING OFFICER'S DECISION

The Hearing Officer granted CMS' Motion for Summary Judgment and found that CMS' denial of Provider Partners Health Plan's initial application was proper. The Hearing Officer found that, by the deadline for uploading information, the Applicant did not meet all of the program requirements under the regulations. In addition the regulation does not provide for an additional timeframe for curing an application beyond the deadline.

COMMENTS

The Applicant requested review by the Administrator and stated that the cited deficiency was due to a clerical error. The Applicant stated that during the application process, an urologist withdrew from the Plans network. Updating the. Application to reflect this specialist's withdraw, resulted in one county being deficient in the number of urologists, which the Plan failed to recognize in time to cure. The cure could have been easily accomplished by designating an urologist already part of the network for another county and eligible to participate in the county with the deficiency. This inadvertent error resulted in the failure of the Applicant to meet the necessary criteria for approval of the application. The administrative deficiency resulting from clerical error can be easily cured and the application approved. The Applicant argued that, as the deficiency occurred between the time of the Notice of Intent to Deny and the Denial it should be allowed to cure now.

The Applicant pointed out that it was filing for an MA Institutional special needs plan (I-SNP) approval. Public policy supports the allowance of this appeal in order to assist in the expansion of qualified I-SNPs. The Applicants model is structured to achieve CMS' public policy objectives. The Applicant explained how it would further the public policy goals of improved quality of care, cost effectiveness and in turn improve the community health of the 10 counties in its proposed plan through its I-SNP's coordination and quality of care. Allowing for this application to be cured will greatly expand the I-SNP available to the beneficiaries of the 10 counties of Maryland.

DISCUSSION

The entire record furnished by the Hearing Officer has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

Under the regulations at 42 C.F.R. §§422.500 and 423.500 et seq., CMS has respectively established the general provisions for entities seeking to qualify as Medicare Advantaged organizations (MAO) under Part C, and/or Prescription Drug Plans (PDP) under Part D.[1] The MA organizations may be a coordinated care plan, a combination of an MA medical savings account. (MSA) plan and a contribution into an MA MSA established in accordance with § 422.262, or an MA private fee-

[1] The regulations controlling Part C Applications are set forth at Title 42, Chapter IV, Part 422 and the corresponding regulations controlling Part D aspects of the Application are set forth at Part 423.

for-service plan. 42 C.F.R. §422.4. In addition, the regulations provide for "Specialized MA Plans for Special Needs Individuals" which means an MA coordinated care plan that exclusively enrolls special needs individuals as set forth in § 422.4(a)(1)(iv) and that provides Part D benefits under part 423 of this chapter to all enrollees; and which has been designated by CMS as meeting the requirements of an MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population. 42 C.F.R. §422.2 A "special needs individual" means an MA eligible individual who is institutionalized, as defined above, is entitled to medical assistance under a State plan under title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan. 42 C.F.R. §422.2.

Pursuant to 42 C.F.R. §§422.501 and 423.502, 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. However, if an applicant fails to correct all of the deficiencies, CMS will issue the applicant a Notice of Intent to Deny under the regulations at 42 C.F.R. §422.502(c)(2).[2] The regulation at 42 C.F.R. §422.502 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.

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

> (3) *Denial of application.* If CMS denies the application, it gives written notice to the contract applicant indicating—
> (i) That the applicant is not qualified to contract as an MA organization under Part C of title XVIII of the Act;
> (ii) The reasons why the applicant is not qualified; and
> (iii) The applicant's right to request a hearing in accordance with the procedures specified in subpart N of this part

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 the strict deadlines established by CMS. CMS provides training and technical assistance to plans in completing their application. Plan applications are evaluated solely on the materials submitted into the HPMS system within the CMS established windows and deadlines. After the applicant files its initial application, CMS reviews the application and notifies the applicant of any existing deficiencies. The applicant is then given the opportunity to correct the deficiencies within strict timeframes. Failure to correct the deficiencies or the subsequent identification of additional deficiencies will result in the denial of the application.

The regulation concerning the Part C application requirements at 42 C.F.R. §422.501[3] states, in relevant part:

> (c) Completion of an application.
>
> > (1) In order to obtain a determination on whether it meets the requirement 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.

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[3] *See* similar language for Part D at 42 C.F.R. §423.501. *See also* 42 C.F.R. 422.503(b)(2).

(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.

In addition, relevant to this case, 42 C.F.R. § 422.112 states in part that:

(a) *Rules for coordinated care plans.* An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

(1) *Provider network.* (i) Maintain 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.

(ii) *Exception*: MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

CMS requires applicants to demonstrate compliance with 42 C.F.R. §422.112, among other things, by submitting HSD Tables through HPMS.[4] CMS's network review is done largely through an automated tool within HPMS that compares the network data submitted by each applicant against standardized criteria and generates two reports accessible within the system to reflect where the applicant stands with respect to meeting the standardized criteria. The criteria assessed are minimum numbers of providers and facilities within a certain time and distance, which are based on market share assumptions for new applicants. Time and distance requirements are based on providers/facilities type and type of geographic area. Applicants are able to review their network after uploading their Provider and Facility tables, before the deadline for submission of tables.

The regulations at 42 C.F.R. §422.502 specify the evaluation and determination procedures for applications to be determined qualified to act as an MA organization, and states in pertinent 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 for an MA contract 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 application meets *all the requirements* in this part. (Emphasis added).[5]

Thus, if an applicant fails to correct all of the deficiencies or during the time for curing, develops additional deficiencies, CMS will issue the applicant a Notice of Intent to Deny under the regulations at 42 C.F.R. §422.502(c).[6]

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[4] *See also* November 11, 2014 "Release of Contract Year 2016 Medicare Advantage Health Services Delivery Guidance and Reference Tables"; "CY 2016 MA HSD Provider and Facility Specialty and Network Criterion Guidance"; "HSD Instructions for CY 2016 Applications."

[5] 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 applications 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."

[6] *See* similar language for Part D at 42 C.F.R. §423.503(c)(2).

In this case, the Plan's application to become a Medicare Advantage Organization was denied because the Plan had a network deficiency at the time of the deadline. While the Applicant cured the deficiencies noted in the Notice of Intent to Deny, the Plan developed a network deficiency due to the withdrawal of an urologist from participation in the network. The Applicant argues that it should be able to cure after the deadline, as it had no notice of the deficiency because of the timing of the urologist withdraw from the network and the subsequent updating of its network access and clerical error. The Plan points out that the failure in the network access can be easily cured through the addition of an existing urologist to that county network.

The Administrator finds that in order to obtain approval of an application for a MA-PD contract, an applicant must demonstrate that it meets the application requirements to enter into such a contract. The record shows the Plan in fact had the cited deficiency set forth in the CMS' denial notice. As properly explained in the CMS Hearing Officer's decision, an additional cure period is not provided under the regulations under the circumstances set forth in this case where the deficiency occurs during the cure period.

The Administrator hereby exercises the broad contractual discretionary authority to allow the Plan to cure its application. Although the CMS denial and Hearing Officer's affirmation were proper and correct, in light of the facts and considerations presented in this specific case, the Administrator modifies the CMS denial and Hearing Officer decisions to allow the Plan the opportunity to cure the application with submission of documentation, relating to the deficient network and clerical error, which is needed to demonstrate full compliance with the Application provisions. CMS has not at this time reviewed and made a determination on such documentation on whether the Plan has met the network requirements. The Administrator holds that, in allowing the Applicant to cure its application, the Applicant must promptly submit the documentation required by CMS within the timeframes CMS orders. The CMS determination on that documentation and the determination on whether the application meets all the requirements and, thereby, whether the Applicant is qualified to contract with respect to the MA-PD application, will herein be incorporated as the final administrative decision under 42 C.F.R. §422.692 and 423.666.

DECISION

The Administrator modifies the decision of the Hearing Officer in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 8/27/15

Patrick Conway, M.D.
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services