CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Eden Health Plan	*	**Docket No. 2015 MA/PD App. 3**
Denial of Initial Application Medicare Advantage Organization	*	
Contract Year 2016, Contract No. H0981	*	

ORDER GRANTING CROSS-MOTION FOR SUMMARY JUDGMENT

I. ISSUE

Whether Eden Health Plan ("Eden") proved by a preponderance of the evidence that the Centers for Medicare and Medicaid Services' ("CMS") denial of its Medicare Advantage ("MA") plan application—on the grounds that it failed to document appropriate state licensure, provide adequate evidence of fiscal solvency, and demonstrate network adequacy—was inconsistent with regulatory requirements.

II. DECISION

The Hearing Officer grants CMS' Cross-Motion[1] for Summary Judgment. The parties agree there is no dispute of material facts. The Hearing Officer finds that Eden failed to meet the application requirements of state licensure, fiscal solvency, and CMS' network standards by the established deadlines. Eden has not established by a preponderance of the evidence that CMS' denial was inconsistent with controlling authority.

III. 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.[2] 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:

> (1) document " . . . appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits

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[1] CMS' July 17, 2015 filing was titled "Memorandum and Motion for Summary Judgment in Support of CMS'[] Denial of Eden Health Plan's Contract Year 2016 Initial Application to offer Medicare Advantage/Medicare Advantage-Prescription Drug Contract H0981," but it was filed after Eden's Motion for Summary Judgment.
[2] *See* 42 C.F.R. §§ 422.503(b)(1) and 422.501(c) (2014).

> 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;"[3]
>
> (2) " . . . submit a financial plan acceptable to CMS;"[4] and,
>
> (3) "[m]aintain and monitor a network of appropriate providers . . . sufficient to provide adequate access to covered services to meet the needs of the population served."[5]

CMS is responsible for determining whether an entity qualifies as a MA organization and whether proposed MA plans meet the regulatory requirements.[6]

Under current regulations and procedures, after receiving an application, CMS reviews the application for any issues. CMS 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. After review, CMS notifies each applicant of its determination and the basis for its determination.[7] 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.
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> (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.

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[3] 42 C.F.R. § 422.501(c)(1).
[4] 42 C.F.R. § 422.384(a).
[5] 42 C.F.R. § 422.112(a)(1)(i).
[6] 42 C.F.R. § 422.501(d)(1).
[7] 42 C.F.R. § 422.502(c).

> (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 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).[8] 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.[9]

IV. STATEMENT OF FACTS

On February 18, 2015, Eden submitted to CMS an initial MA application and application to offer a special needs plan.[10] Eden's requested service area was comprised of eight counties in Florida.[11] In its initial review, CMS noted several deficiencies with Eden's application, including failures to upload State licensure and documentation demonstrating fiscal solvency under State law, and failures in Eden's provider services network.[12] CMS informed Eden of its deficiencies in the Deficiency Notice, e-mailed on March 11, 2015.[13] The Deficiency Notice also informed Eden that it had until March 17, 2015 to submit its revisions.[14]

Although Eden timely submitted revisions to CMS, Eden continued to have deficiencies in State licensure, fiscal solvency, and its provider services network. Therefore, on April 20, 2015, CMS issued its NOID. The NOID gave Eden a final ten day cure period to correct any deficiencies in its application.[15]

Eden submitted revised materials by the deadline, April 30, 2015; however, its deficiencies in State licensure, fiscal solvency, and its provider services network remained. Consequently, on May 27, 2015, CMS issued its formal denial of Eden's application. Eden subsequently filed a Hearing Request on June 8, 2015 to establish the instant appeal.[16]

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[8] 42 C.F.R. § 422.660(b)(1).
[9] 42 C.F.R. § 422.684(b).
[10] *See* CMS' Memorandum and Motion for Summary Judgment ("CMS' Brief") at 4, Jul. 17, 2015 and Eden Health Plan's Motion for Summary Judgment ("Eden's Brief") at 1, Jul. 8, 2015.
[11] CMS' Brief at 4.
[12] *Id.*
[13] *Id.*
[14] *Id.* at 4-5.
[15] *Id.* at 5.
[16] *Id.*

On July 8, 2015, Eden filed a Motion for Summary Judgment with the Hearing Officer. CMS filed its Memorandum and Cross-Motion for Summary Judgment on July 17, 2015. Eden elected not to file an optional response.

V. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

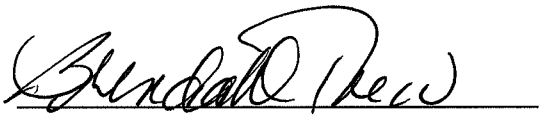
In exercising his or her authority, the Hearing Officer must comply with the provisions of Title XVIII and related provisions of the Social Security Act, regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act.[17]

The regulations are clear that an applicant must have a State license, meet fiscal solvency requirements, and that its contracted network must meet CMS' standards.[18] Eden failed to meet these application requirements when it submitted its initial application, and failed to cure these deficiencies during the application process. The Hearing Officer finds that Eden failed to submit the required materials by CMS' established deadlines.

The parties do not dispute these facts. In its Motion for Summary Judgment, Eden does not offer an argument or explanation regarding its deficiencies. Instead, Eden " . . . submits that the deficiencies . . . will be corrected in the near term." Eden concedes that it did not meet CMS' requirements and essentially requests an extension to cure its deficiencies. The Hearing Officer finds that CMS' denial was an appropriate exercise of its delegated authority. Therefore, Eden did not meet its burden of proof in demonstrating that CMS' determination was inconsistent with controlling authority.

VI. DECISION AND ORDER

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



Brenda D. Thew, Esq.
CMS Hearing Officer

Date: July 31, 2015

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[17] 42 C.F.R. § 422.688.
[18] *See* 42 C.F.R. § 422.501(c)(1); 42 C.F.R. § 422.384(a); 42 C.F.R. § 422.112(a)(1)(i).