CENTERS FOR MEDICARE & MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:

Prominence Health First of Florida, Inc.

Denial of Initial Application to Offer
Medicare Advantage/
Medicare Advantage-Prescription Drug Plan **Docket No. MA/PD 2019-05**

Contract Year 2020
Contract No. H5945

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. Filings

This Order is being issued in response to the following:

(a) Prominence Health First of Florida, Inc.'s ("Prominence") Hearing Request submitted by letter and facsimile dated June 5, 2019;

(b) Prominence's Hearing Brief ("Prominence Brief") dated June 17, 2019; and

(c) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment Memorandum Supporting CMS' Denial of Prominence Health First of Florida's Application to Expand the Service Area of MA-PD Contract (H5945) for Contract Year 2020 ("CMS MSJ") dated June 26, 2019.

II. Issue

Whether CMS' denial of Prominence's application to expand the service area of its contract into Palm Beach County, Florida, due to a failure to timely meet State licensure application requirements, was inconsistent with regulatory requirements.

III. Decision

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties have not identified any material facts in dispute. It is undisputed that Prominence failed to timely meet the application requirements. Prominence has not established by a preponderance of the evidence that CMS' denial of its application was inconsistent with controlling authority.

IV. Background

Any entity seeking to contract as a Medicare Advantage ("MA") organization must fully complete all parts of a certified application in the form and manner required by CMS. (*See* 42 C.F.R. §§ 422.501(c) and 422.503(b)(1) (2018)). 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)(i)).

For State licensure, applicants be licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the applicant wishes to offer one or more MA plans. (42 C.F.R. § 422.400(a)). CMS requires applicants to upload an executed copy of the State license certificate with their application if the applicant was not previously qualified by CMS in that State. (*See* CY 2020 Part C – MA and 1876 Cost Plan Expansion Application, § 3.3, *available at* https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/ (last modified May 16, 2019)).

Applicants must also attest that the scope of their license or authority allows the applicant to offer the type of MA plan or plans (*e.g.*, Preferred Provider Organization, Health Maintenance Organization, etc.) that it intends to offer in the State. (42 C.F.R. § 422.400(c)). With the application, applicants must submit a CMS State Certification Form executed by the State that confirms and certifies that the plan type to be offered by the applicant is within the scope of the license. (*See* CY 2020 Part C – MA and 1876 Cost Plan Expansion Application, § 4.4).

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 electronically sending 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"). (42 C.F.R. § 422.502(c)(2)(i)). The NOID affords an applicant a second opportunity to cure its application. (*See* 42 C.F.R. § 422.502(c)(2)(ii)). After a NOID is issued, an applicant has a final ten-day period to cure any deficiencies in order to meet CMS' requirements; otherwise, CMS will deny the application. (42 C.F.R. § 422.502(c)(2)(ii)–(iii)).

The formal NOID process is outlined at 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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> (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, each applicant receives written notice of the determination and the basis for the determination. (42 C.F.R. § 422.502(c)(3)).

If CMS denies an MA application, the applicant is entitled to a hearing before a CMS Hearing Officer. (42 C.F.R. §§ 422.502(c)(3)(iii) and 422.660). Furthermore, 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, either party may ask the Hearing Officer to rule on a Motion for Summary Judgment. (42 C.F.R. § 422.684(b)). The authority of the Hearing Officer is found at 42 C.F.R. § 422.688, which specifies that "[i]n exercising his or her authority, the hearing officer must comply with the provisions of title XVIII [of the Social Security Act ("Act")] and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act."

V. Procedural History and Statement of Facts

On February 13, 2019, Prominence filed an application with CMS to expand the service area of their H5945 contract into six counties in Florida and two counties in Nevada for Contract Year ("CY") 2020. (*See* CMS MSJ at 1). On March 18, 2019, CMS issued a Deficiency Notice to Prominence, noting multiple deficiencies, including the State licensure deficiency relating to the Motion for Summary Judgment herein. Prominence submitted revised application materials, but the revised application did not include a copy of the license to provide health insurance products in Florida, a CMS State Certification form, or any other documentation for the state licensure section. (*See* CMS MSJ at 4-5).

On April 15, 2019, CMS issued an NOID to Prominence, which noted a deficiency in State licensure and past performance of its prior year's contract. (CMS MSJ, Exhibit G). Prominence submitted additional materials in a revised application within the ten-day cure period, but did not include a Florida license to offer health insurance or a CMS State Certification form from Florida. (*See* CMS MSJ at 5 and Exhibits H and I). On May 17, 2019, Prominence notified CMS of its intent to withdraw all counties that it was seeking to expand into, with the exception of Palm Beach County, Florida. (CMS MSJ at 5 and Exhibit K). CMS issued a final determination on May 22, 2019, denying Prominence's application due to past performance of its contract and because it did not cure the licensure requirement. (CMS MSJ, Exhibit A). CMS revoked its determination that Prominence's application should be denied based on past performance in its Motion for Summary Judgment. (CMS MSJ at 1).

Prominence filed the instant appeal in a letter dated June 5, 2019, and as of June 11, 2019, their application to operate an HMO in Florida had been accepted, was under review, and was pending approval.

VI. Discussion, Findings of Fact and Conclusions of Law

In exercising its authority, the Hearing Officer must comply with the provisions of Title XVIII of the Act — Health Insurance for the Aged and Disabled — and related provisions of the Act, regulations issued by the Secretary of Health and Human Services, 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. (*See* 42 C.F.R. § 422.501(c)(1)(i)). Prominence failed to meet the application requirements when it submitted its initial application and failed to timely cure the deficiencies by April 25, 2019 — the deadline established in the NOID.

Ultimately, Prominence is requesting "an extension to the Plan regarding the service area expansion in Palm Beach County, Florida" until Florida has issued the Certificate of Authority. (Prominence Brief at 2). In its brief, Prominence outlines the efforts it has made to correct discrepancies in their application to operate in Florida, noting that its final, updated application to correct those discrepancies was submitted on June 3, 2019. (Prominence Brief at 1-2). CMS

insists that the determination to deny Prominence's application was proper pursuant to 42 C.F.R. § 405.502(c)(3) because Prominence failed to demonstrate that it met the requirements of 42 C.F.R. §§ 422.501 and 422.502 prior to the expiration of the ten-day cure period following the NOID. (CMS MSJ at 6).

The Hearing Officer must decide if CMS' determinations were consistent with regulatory requirements. (42 C.F.R. §§ 422.660 and 422.688). The Hearing Officer finds that Prominence failed to timely meet CMS' application requirements, thus CMS' denials were an appropriate exercise of its delegated authority. Prominence did not meet its burden of proof in demonstrating that CMS' determinations were inconsistent with controlling authority. Accordingly, the Hearing Officer grants CMS' Motion for Summary Judgment.

VII. Decision and Order

CMS' Motion for Summary Judgment is granted.

/Benjamin R. Cohen/
Benjamin R. Cohen, Esq.
CMS Hearing Officer

Date: July 12, 2019