

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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**Office of the Attorney Advisor**

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PROVIDER REIMBURSEMENT  
REVIEW BOARD

**VIA ELECTRONIC MAIL & OVERNIGHT MAIL**

Ms. Christine Breitzman  
Community Care Alliance of Illinois  
322 S. Green Street, Suite 400  
Chicago, IL 60607

Re: Community Care Alliance of Illinois, Docket No. 2013 MA/PD App. 7

Dear Ms. Breitzman:

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,

A handwritten signature in black ink, appearing to read "Jacqueline R. Vaughn". The signature is fluid and cursive, with a prominent loop at the beginning.

Jacqueline R. Vaughn  
Attorney Advisor

Enclosure

cc: Danielle R. Moon, J.D., M.P.A., Director, CMS  
Cynthia G. Tudor, Ph.D., Director, CMS

# CENTERS FOR MEDICARE AND MEDICAID SERVICES

*Decision of the Administrator*

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JUN 13 2014

PROVIDER REIMBURSEMENT  
REVIEW BOARD

**In the Matter of:**

**Community Care Alliance of Illinois**

**Denial of Service Area Expansion  
Application**

**Claim for:**

**Medicare Advantage  
Prescription Drug Plan  
Period Beginning: 2014**

**Review of:**

**Docket No. 2013-MA/PD-App-07  
H3071**

**Dated: August 04, 2013**

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

**ISSUE**

The issue involves whether CMS properly denied Community Care Alliance of Illinois' (CCAI, or the Plan) application to offer a Medicare Advantage-Prescription Drug (MA-PD) plan for contract year 2014.

**CMS HEARING OFFICER'S DECISION**

The Hearing Officer granted CMS' Motion for Summary Judgment and found that CMS' denial of the Plan's initial application was proper. The Hearing Officer found that the facts of the case were not in dispute and, therefore, summary judgment was appropriate since CCAI's 2014 MA-PD Application No. H3071 did not meet the program requirements by virtue of its failure to include the critical documentation of State licensure. Therefore, CCAI did not meet its burden of proof, set forth at 42 CFR 422.660(b)(1), in demonstrating that CMS' determination was inconsistent with program contracting requirements.

The Hearing Officer found that CCAI's contention that the regulations allow for future compliance with regard to State licensure was misplaced. According to the Hearing Officer, this interpretation takes the regulatory passage cited ("meets, or will meet, all of the requirements") out of context. A number of MA-PD application and program requirements cannot be met prior to the approval of an application. For example, contracting compliance requirements at 42 CFR 422.503(b)(4)(vi)(G)(1) require plans to conduct inquiries into any "evidence of misconduct related to payment or delivery of items or services under the contract." As no payment or delivery of services occurs prior to contract approval, an applicant could not "meet" this requirement prior to the application deadline. The precise phrasing of the "meets, or will meet" regulation encompasses those requirements that can be satisfied at the application deadline, such as State licensure and provider network agreements, as well as those requirements that constitute ongoing obligations subsequent to plan approval, such as compliance and monitoring.

The Hearing Officer also stated that the characterization of State licensure demonstration as an requirement that can, and must, be met prior to the applicant's final submission deadline is made clear in the Medicare Advantage Application instructions (Note 7), which state that:

Applicants must meet and document all applicable licensure and certification requirements no later than the Applicant's final upload opportunity, which is response to CMS' [Notice of Intent to Deny] communication.

The Hearing Officer found that the Plan conceded it does not have the required State licensure at the time of application submission that is a pre-requisite to acquiring CMS approval to offer MA-PD plans. Consequently, the Hearing Office found that the CMS denial of the application was proper

### COMMENTS

The Plan requested review by the Administrator under 42 C.F.R. §422.692. The Plan submitted additional information in the form of an HMO Certificate of Authority issued by the State of Illinois, Department of Insurance which authorizes the Plan to transact business as a Medicare Advantage plan in the State of Illinois. Based on this submission, the Plan stated that it believes that it has met all of the MA-PD application requirements. The Plan stated it operated as a Medicaid plan for special needs and dual eligible patients (Medicaid seniors and adults with disabilities), and requested conditional approval of the MA application in order to ensure continuity of care for its population who age into Medicare, including those who may enroll in a D-SNP.

## 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 Advantage (MA) organizations under Part C, and/or Prescription Drug Plans (PDP) under Part D.<sup>1</sup>

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. The regulation concerning the Part C application requirements at 42 C.F.R. §422.501<sup>2</sup> 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.

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

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<sup>1</sup> CMS has revised and/or clarified some of the regulatory text governing the Part C and Part D programs. See, e.g., Proposed Rule, 74 Fed. Reg. 54634 (Oct. 22, 2009) and final Rule, 75 Fed. Reg. 19678 (April 15, 2010). See, also 77 Fed. Reg. 22072, April 12, 2012 (final rule with comment period.)

<sup>2</sup> See similar language for Part D at 42 C.F.R. §423.504(b)(2).

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

The regulation at 42 C.F.R. §422.400(c) further describes the State licensure requirements and states that each MA organization must:

- (a) Be licensed under State law, or otherwise authorized to operate under State law, as a risk bearing entity (as defined in §422.2) eligible to offer health insurance or health benefit coverage in each State in which it offers one or more MA plans;
- (b) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards that the State may required for it to operate as an MA organization; and
- (c) Demonstrate to CMS that
  - (1) The scope of its license or authority allows the organization to offer the type of MA plan or plans that it intends to offer in the State; and
  - (2) If applicable, it has obtained the State certification required under paragraph (b) of this section. (Emphasis added.)<sup>3</sup>

In order to demonstrate that it meets these licensure requirements as authorized under 42 C.F.R. §422.501, applicants are required to upload into the Health Plan Management System (HPMS), an executed copy of a State licensing certificate and the CMS State Certification Form for each State being requested. The application specifically states that “Applicants must meet and document all applicable licensure and certification requirements no later than the Applicants final upload opportunity, which is in response to CMS’ Notice of Intent to Deny communication.”<sup>4</sup>

CMS established an online application process for both Part C and Part D plans pursuant to the Health Plan Management System or HPMS. All new applicants and requests to expand service areas are to be submitted through the HPMS by the strict deadlines established by CMS. CMS provided training and technical assistance to plans in completing their application. Plan applications were evaluated solely on the

<sup>3</sup> See 42 C.F.R. §422.400.

<sup>4</sup> See 2014 Part C Medicare Advantage Application at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html?redirect=/MedicareAdvantageApp>, at 62.

materials that were 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.

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).<sup>5</sup>

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).<sup>6</sup> The regulation at 42 C.F.R. §422.502(c) states, 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 to be able to meet the requirements for an MA organization 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 contract applicant may respond in writing to the issues or other matters that were the basis for CMS' preliminary finding

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<sup>5</sup> The preamble to 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."

<sup>6</sup> See similar language for Part D at 42 C.F.R. §423.503(c)(2).

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 the applicant does not appear qualified to contract as an MA organization or has not provided enough information to allow CMS to evaluate the application, CMS will deny the application.

In this case, in March 2013, CMS provided CCAI with a Deficiency Notice concerning the licensure element of its contract application. The subsequent Notice of Intent to Deny reiterated the Plan's failure to document that it held the appropriate State license to offer MA-PD plans. CMS ultimately determined that the Applicant did not satisfy the State license-related application requirements and denied the MA-PD application.

The Plan is a Not-for-Profit Corporation, organized as a Managed Care Community Network (MCCN) sponsored and governed by Safety-Net providers. The Plan is a subsidiary of Family Health Network, which is the second largest Medicaid Managed Care Plan in the State of Illinois. As an MCCN, the Plan is regulated by the Illinois Department of Healthcare and Family Services (ILHFS) rather than by the Department of Insurance. The Plan is the only Not-for-Profit Safety-Net Provider health plan in the State of Illinois.

The Plan's application to become an MA Organization was denied because the Plan had not demonstrated that it was certified as a risk bearing entity as required by CMS regulations. CCAI acknowledged that it did not have such licensure at the time of its application submission in January 2013, or prior to the May 7, 2013, cure deadline. The Plan anticipated certification as a risk bearing entity from the ILHFS, however, the Plan was notified by ILHFS two days before the Medicare Advantage Application was due that it had determined that ILHFS did not have the authority to certify the Plan as a risk bearing entity for Medicare Advantage plans. The Plan stated it immediately pursued HMO Licensure from the Illinois Department of Insurance (ILDOI) so that the State could certify the Plan as a risk bearing entity for Medicare Advantage. While the Plan was granted HMO licensure, it was not in time to meet the cure notice deadline issued by CMS. Due to the special circumstances, the Plan requested conditional approval of its Medicare Advantage application to ensure continuity of care for Senior and Adults with Disabilities members who transition to Medicare.

The Administrator finds that in order to obtain approval of an application for a MA-PD contract, applicants must demonstrate that they meet the application requirements to enter into such a contract. The record shows the Plan failed to cure the deficiency cited in CMS' Intent to Deny letter by the required deadline. The documentation provided by the Plan was insufficient to qualify for a MA-PD Contract since the Plan had not demonstrated that it was licensed and certified by the State of Illinois as an HMO. Accordingly, the Administrator finds that the CMS denial and the Hearing Officer affirmation was proper and correct.

However, the Administrator recognizes that there are compelling public policy arguments with respect to the beneficiary related value of the Plan's services provided to vulnerable Medicare populations. The Administrator hereby exercises the broad contractual discretionary authority to allow the Plan to cure its application.<sup>7</sup> The CMS denial and Hearing Officer's affirmation were proper and correct, but in light of the special and unique facts and public policy 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 any documentation relating to the State licensure that is required to demonstrate full compliance with the Application provisions. CMS has not at this time reviewed and made a determination on such documentation of State licensure.<sup>8</sup> 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; CMS determination on whether the application meets all the requirements and CMS' determination on whether the Applicant is thereby qualified to contract with respect to the MA-PD application, will herein be incorporated as the final administrative decision in this case under 42 CFR 422.692 and 423.666.

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<sup>7</sup> In addition, the Administrator exercises the broad authority under the regulations at 42 C.F.R. §422.692(d) and §423.666(d), which state that the Administrator may "review the hearing officer's decision and determine, based upon this decision, the hearing record, and any written arguments submitted by the MA organization or CMS, whether the determination should be upheld, reversed or modified."

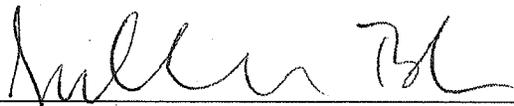
<sup>8</sup> Although the July, 12, 2013 State of Illinois Department of Insurance HMO license submitted by the Plan was submitted in the request for review, the Administrator finds that the Plan must submit the HMO license to CMS for application completion and review.

**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: Aug 30, 2013

  
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Jonathan D. Blum  
Principal Deputy Administrator  
Centers for Medicare & Medicaid Services