CENTERS FOR MEDICARE & MEDICAID SERVICES
HEARING OFFICER DECISION

IN THE MATTER OF:

Texas Independence Health Plan, Inc.

Medicare Advantage/Prescription Drug Organization Application Denial **DOCKET NO. 2019 MA/PD APP. 01**

Contract Year 2020
Contract No. H5015

ORDER GRANTING REQUEST TO DISMISS

The Centers for Medicare & Medicaid Services ("CMS") Hearing Officers designated to hear this case are the undersigned, Benjamin R. Cohen and Stephany Young.

I. ISSUE

Whether the Hearing Officers have jurisdiction[1] over Texas Independence Health Plan's ("TIHP") challenge to CMS' March 22, 2019 notification to TIHP that it failed to timely file an initial Medicare Advantage Prescription Drug ("MA/PD") application on the basis that the "submission was non responsive to so many critical elements of the application that it did not represent a good faith effort to provide documentation of the organization's qualifications."[2]

II. DECISION

The Hearing Officers grant CMS' Request to Dismiss. The Hearing Officers do not have jurisdiction over this appeal. In the April 15, 2011 Final Rule, 76 Fed. Reg. 21432, 21527, CMS indicated that it will not review applications for qualification for contracts to operate as Medicare Part C or D sponsoring organizations submitted after the established deadline. CMS expressly stated "[b]ecause we do not review such applications, we do not provide a notice of intent to deny under § 422.502(c)(2) or § 423.503(c)(2), nor is the organization entitled to a hearing under § 422.660 or § 423.650." CMS declared that plans do not have the right to appeal an adverse determination regarding the completeness of an initial application. 76 Fed. Reg. at 21528.

In this case, CMS broadly claims that the initial application was invalid and not timely submitted because it did not appear to constitute a good faith effort. In contrast, TIHP asserts that it made a

[1] CMS asserts that its decision with respect to TIHP is not within the Hearing Officers' jurisdiction and requests that the Hearing Officers dismiss the matter. CMS Reply Brief at 1, 4.
[2] TIHP's March 26, 2019 Request for Hearing, Exhibit 1 at 2.

clerical error and is entitled to cure its application. The Hearing Officers find the preamble language is clear that CMS elected not to provide a right to cure or provide an administrative hearing right over initial reviews involving the completeness of the applications. The Hearing Officers do not have jurisdiction in this case. As such, the Hearing Officers will not conduct a hearing to weigh the factual assertions and to determine whether TIHP's application was valid pursuant to controlling authority.

III. PROGRAM BACKGROUND

The Medicare Advantage ("MA" or "Part C") program offers Medicare beneficiaries the option of receiving health care benefits through a privately-operated coordinated care delivery system.[3] The Social Security Act ("the Act") authorizes the Secretary ("the Secretary") of the United States Department of Health and Human Services to contract with entities seeking to offer MA and Medicare outpatient prescription drug ("Part D") benefits to their plan enrollees.[4] Through regulation, the Secretary has delegated this contracting authority to CMS, which has established the general provisions for entities seeking to qualify as MA/PD plans.[5] An organization may not offer MA or Part D benefits unless it has entered into a contract with CMS.[6] An MA organization offering coordinated care plans (including Health Maintenance Organizations) must offer Part D benefits in the same service area.[7] Entities seeking to offer a new MA product must demonstrate through the submission of an application developed by CMS that they meet the qualifications.[8] To offer a Part D plan, MA organizations must also meet the Part D application requirements in order to demonstrate their qualification as a Part D sponsor.[9] CMS conducts reviews of all submitted Part D applications and issues determinations consistent with 42 C.F.R. § 423.503(c).[10]

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[3] *See* 42 U.S.C. §§ 1395w-21 *et seq.*; *see also* 42 C.F.R. § 422.4(a)(1) "[a] coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS."

[4] 42 U.S.C. § 1395w-27; *see also id.* § 1395w-112.

[5] 42 C.F.R. §§ 422.400 *et seq.*, 422.503(b) *et seq.*

[6] 42 U.S.C. § 1395w-27(a); *see also id.* § 1395w-112(b)(1).

[7] 42 C.F.R. § 422.4(c)(1); *see also* 42 U.S.C. § 1395w-112 (Medicare Part D).

[8] 42 C.F.R. § 422.501; *see also id.* § 423.503(a).

[9] 42 C.F.R. §§ 422.500(a), 423.500, 423.502(c)(1).

[10] 42 C.F.R. § 423.503(c).

> *Notice of determination*. Except for fallback entities, which are governed under subpart Q of this part, CMS notifies each applicant that applies to be determined qualified to contract as a Part D plan sponsor, under this part, of its determination on the application and the basis for the determination. The determination may be 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 a Part D plan sponsor.
> (2) *Intent to deny*.
> (i) If CMS finds that the applicant does not appear qualified to contract as a Part D sponsor, 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 from the date of the notice, the applicant may respond in writing to the issues or other matters that were the basis for CMS's 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

In the preamble section of the Final Rule, 76 Fed. Reg. at 21527, CMS cited a pattern among organizations participating in the application process whereby organizations would "provide substantially incomplete applications" as "'placeholders' designed to save eligibility." CMS contends that this defeated the purpose of application deadlines and advised that it does not review applications for qualification for contracts to operate as Medicare Part C or D sponsoring organizations submitted after the established deadline. CMS stated "[b]ecause we do not review such applications, we do not provide a notice of intent to deny under § 422.502(c)(2) or § 423.503(c)(2), nor is the organization entitled to a hearing under § 422.660 or § 423.650." CMS indicated:

> [t]o avoid the consequences of missing the initial submission deadline, some organizations have submitted applications that we considered so lacking in required information or correct detail as to fail to constitute a valid, timely submission. We suspect that in many instances, these organizations expected to take advantage of our policy of affording applicants two later opportunities during the review process (including the 10-day cure period following the issuance of a notice of intent to deny an application issued under § 422.502(c)(2) and § 423.503(c)(2)) to make their applications complete by providing information that had been omitted from the initial submission. Organizations that provide substantially incomplete applications are effectively submitting "placeholders" designed to save their eligibility to participate in the application review process until they can produce all the required materials. We find this practice to be an abuse of the application review process that defeats the purpose of the established deadline.
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> We believe that confusion about our authority to enforce the application deadline may be created by the provisions of § 422.502(c)(2)(i) and § 423.503(c)(2)(i), which state that we will provide an applicant a notice of intent to deny when the organization "has not provided enough information to evaluate the application." We intended this language to afford an organization that had made a good faith effort to complete a contract qualification application the opportunity to provide the materials necessary to cure a discrete application deficiency. As noted in our November 2010 proposed

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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.

(3) *Denial of application*. If CMS denies the application, it gives written notice to the applicant indicating -

(i) That the applicant is not qualified to contract as a Part D sponsor under Part D of title XVIII of the Act;

(ii) The reasons why the applicant does [sic] is not so qualified; and

(iii) The applicant's right to request a hearing in accordance with the procedures specified in subpart N of this part.

> rule, it appears that this language could provide an unintended protection to an organization that circumvented our established application deadline by submitting a "placeholder" application.

With regards to whether an applicant possesses the right to appeal a finding that an initial application is invalid, CMS continued:

> therefore, to remove all ambiguity that may exist concerning our authority to decline to accept or review substantially incomplete applications, we proposed to revise the provisions of § 422.502(c)(2)(i) and § 423.503(c)(2)(i) to delete the phrase, "and/or has not provided enough information to evaluate the application."

In the Final Rule, 76 Fed. Reg. at 21528:

> Comment: A commenter urged that CMS provide appeal rights to those organizations whose applications CMS excludes from consideration pursuant to this proposed regulatory provision.
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> Response: The point of the proposed provision is to document our authority to determine when an organization has even qualified for further consideration of its application, including the rights that attach to that process, such as the opportunity to cure deficiencies and appeal a denial, by meeting the submission deadline. To afford appeal rights in instances where we have determined that an organization submitted an invalid application would re-create the very program vulnerability this provision is intended to eliminate.

CMS finalized the proposed revision without modification at 42 C.F.R. § 422.502(c)(2)(i) and § 423.503(c)(2)(i), effective June 6, 2011.

IV. FACTUAL AND PROCEDURAL BACKGROUND

On January 9, 2019, CMS posted the final solicitation for applications for Medicare Advantage and Medicare Prescription Drug Plan 2020 Contracts (solicitation) on its website. The solicitation required Part D contract applicants to provide responses to a series of attestations related Part D requirements as well as documentation demonstrating their ability to meet program requirements. Organizations were to submit their applications through the Health Plan Management System ("HPMS"), CMS' electronic system of record for the administration of the MA and Part D program. Organizations submitted the applications under contract identification numbers that HPMS assigned each entity that provided a notice of intent to apply after October 2018. The applications were due to CMS by February 13, 2019.[11]

[11] CMS' April 12, 2019 Response to TIHP's Appeal Request at 2; *see also* CMS' Response to TIHP's Second and Third Briefs, Exhibit 8.

On February 13, 2019, TIHP submitted both MA and Part D applications for a coordinated care plan contract to CMS.[12] On March 22, 2019, CMS issued TIHP a Notice of Non-Receipt of 2020 MA/PD application indicating that CMS did not consider a valid contract year 2020 MA/PD Plan Sponsor application to have been submitted under its pending contract number, H5015, because TIHP submitted a substantially incomplete set of responses to the Part D application instructions by the February 13, 2019 deadline. CMS stated that TIHP's submission was non responsive to so many critical elements of the application that it did not represent a good faith effort to provide documentation of the organization's qualifications for a CY 2020 MA/PD contract. CMS determined that TIHP did not submit a timely Part D application and advised TIHP that it would not review the submitted materials nor any additional materials under the contract number during the CY 2020 application cycle. CMS indicated that it afforded no administrative appeal rights for its determination.[13]

On March 26, 2019, TIHP filed a Request for a Hearing with the CMS Office of Hearings. On March 27, 2019, the CMS Hearing Officer acknowledged receipt of TIHP's Hearing Request and provided CMS with the option of filing a written response to TIHP's Request for Hearing. On April 12, 2019, CMS filed a response to TIHP's Request for Hearing requesting that the case be dismissed. On April 15, 2019, TIHP filed a response to CMS' April 12, 2019 letter. On April 23, 2019, TIHP filed a supplement to its April 15, 2019 response. On that same date, CMS filed an objection to TIHP's April 15th and April 23rd responses and requested that the CMS Hearing Officer exclude the April 15th and 23rd submissions from the record. TIHP objected to CMS' request. On April 25, 2019, the CMS Hearing Officer admitted TIHP's April 15th and 23rd responses into the administrative record and provided CMS with the option of filing a written response. On April 30, 2019, CMS filed a response to TIHP's April 15th and April 23rd briefs.

V. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officers do not have jurisdiction over this appeal which challenges CMS' March 22, 2019 notification of Non-Receipt of 2020 MA/PD application for contract number H5015. In the April 15, 2011 Final Rule, 76 Fed. Reg. at 21527, CMS indicated that it does not review applications for qualification for contracts to operate as Medicare Part C or D sponsoring organizations submitted after the established deadline. CMS stated "[b]ecause we do not review such applications, we do not provide a notice of intent to deny under § 422.502(c)(2) or § 423.503(c)(2), nor is the organization entitled to a hearing under § 422.660 or § 423.650." Moreover, CMS expressly indicated "to afford appeal rights in instances where we have determined that an organization submitted an invalid application would re-create the very program vulnerability this provision is intended to eliminate." 76 Fed. Reg. at 21528.

In this case, CMS has determined that TIHP's submission did not constitute a valid, timely submission because CMS claims that TIHP's submission was non responsive to so many critical elements of the application that it did not represent a good faith effort to provide documentation of the qualification.[14] TIHP however, largely contends that the issue was caused by a clerical

[12] CMS' April 12, 2019 Response to TIHP's Appeal Request at 3.
[13] CMS' March 22, 2019 Notice of Non-Receipt of 2020 MA/PD Application at 1-2.
[14] TIHP's March 26, 2019 Request for Hearing, Exhibit 1 at 2.

mistake.[15] TIHP maintains there is no statutory or regulatory provision giving CMS the right to reject an application submitted by a legitimate applicant; CMS' regulations give applicants the right to receive notices of deficiencies and the right to correct those deficiencies. TIHP argues CMS' policy providing for issuance of Notices of Non-Receipt denies applicants this important due process right.[16] TIHP contends CMS lacks the authority absent CMS undergoing rulemaking in compliance with the Administrative Procedure Act to establish a process to reject placeholder applications. TIHP maintains CMS cannot deny through sub-regulatory guidance rights and responsibilities that are conferred by CMS regulations on applicants.[17]

The Hearing Officers do not have the authority to disregard the preamble language in the April 15, 2011 Final Rule, 76 Fed. Reg. at 21527-28. The regulation at 42 C.F.R. § 423.664 entitled Authority of Hearing Officer provides: "[i]n exercising his or her authority, the hearing officer must comply with the provisions of title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act." The Hearing Officers find the preamble language is clear that CMS elected not to provide a right to cure or an administrative hearing right over CMS' initial reviews involving the completeness of the applications. Accordingly, the Hearing Officers will not reach weighing the competing factual assertions to determine whether CMS otherwise erred in concluding that the Plan was not entitled to cure its application pursuant to the controlling authority. TIHP does not have a right to a hearing in accordance with 42 C.F.R. §§ 422.660 and 423.650. The Hearing Officers lack jurisdiction over the appeal. CMS' Request to Dismiss is granted.

VI. ORDER

CMS' Request to Dismiss is granted.

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

May 15, 2019

/Stephany Young/
Stephany Young, Esq.
Hearing Officer

May 15, 2019

[15] *Id*. at 1, 3.
[16] *Id*. at 7.
[17] TIHP's April 15, 2019 Response to CMS' Opposition to Request for Hearing at 3.