DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244

July 11, 2022

Via Electronic Delivery

Christine Clements
Sheppard Mullin Richter & Hampton LLP
2099 Pennsylvania Avenue, NW
Washington, DC 20006

Marilyn Hunter
MAPD Appeals Team
7500 Security Boulevard
Baltimore, MD 21244

RE: Hearing Officer Decision
Hearing Officer Docket Number: H-22-00014
Medicare Advantage/Prescription Drug Plan Contract Denial
Renal Payer Solutions, Inc., Contract Number: H6207

Dear Ms. Clements and Ms. Hunter:

A copy of the Hearing Officer's decision for the above-referenced appeal is attached.

The Hearing Officer's decision may be appealed to the Administrator of the Centers for Medicare & Medicaid Services. The parties may request review by the Administrator within 15 calendar days of receiving this decision. *See* 42 C.F.R. § 422.692; 42 C.F.R. § 423.666. Requests for review should be sent via email to Jacqueline R. Vaughn, Director, Office of the Attorney Advisor, at Jacqueline.Vaughn@cms.hhs.gov, with a copy to Arlene O. Gassmann, Paralegal Specialist, at Arlene.Gassmann@cms.hhs.gov.

Sincerely,

Office of Hearings

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Renal Payer Solutions, Inc.	*	**Denial of Initial Application to Offer Medicare Advantage/Medicare Advantage-Prescription Drug Plan**
Contract No. H6207,	*	
	*	
Appellant	*	
	*	
v.	*	
	*	**Contract Year 2023**
Centers for Medicare & Medicaid Services,	*	
	*	
	*	**Hearing Officer Docket No. H-22-00014**
Respondent	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

Page No.

I. FILINGS

This Order is being issued in response to the following:

(a) Renal Payer Solutions, Inc.'s ("RPS") Hearing Request submitted by letter dated May 31, 2022, and filed on June 1, 2022;
(b) RPS's Appeal Brief ("RPS Brief") dated and filed on June 9, 2022;
(c) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment Supporting CMS's Denial of RPS's Initial Application for a Medicare Advantage ("MA")/MA-Prescription Drug ("MA-PD") Contract Number H6207 ("CMS MSJ") dated and filed on June 16, 2022; and
(d) RPS's Reply Brief ("RPS Reply") dated and filed on June 22, 2022.

II. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. § 422.660. The CMS Hearing Officer designated to hear this case is the undersigned, Amanda S. Costabile.

III. ISSUE

Whether CMS's denial of RPS's initial application for an MA/MA-PD contract (H6207) (hereinafter "MA-PD")[1] based on RPS's failure to meet CMS's licensure requirements was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officer grants CMS's Motion for Summary Judgment. The parties agree that there are no material facts in dispute. On May 18, 2022, CMS denied RPS's Part C application for Contract Number H6207 due to RPS's failure to submit satisfactory evidence that RPS is licensed as a risk-bearing entity in the State of Nevada (i.e., a "health maintenance organization certificate of authority" or "HMO COA") and failure to submit a fully and appropriately completed State Certification Form ("State Certification") from the Nevada Department of Insurance ("DOI").

RPS has included, as Exhibits J and K attached to its June 22, 2022 Reply Brief, what it indicates are June 16, 2022 issuances of its HMO COA and State Certification documents and requests that the Hearing Officer overturn CMS's contract determination. RPS Reply at 1-2; RPS Brief at 1. CMS, however, has not reviewed the documents and the Hearing Officer does not possess the authority to consider these documents as RPS submitted them after the regulatory deadlines.[2] *See* 42 C.F.R. § 422.502(c)(2)(iii). RPS argues that "CMS has broad contractual and regulatory

[1] RPS states that its application for contract H6207 concerned "a new Medicare Advantage/Medicare Advantage Prescription Drug" plan "under Parts C and D of Title XVIII of the Social Security Act." RPS Brief at 1. RPS asserts, however, that the CMS "Contract Determination" appealed here "did not identify any deficiencies with respect to RPS's Part D application." *Id.* at 1-2. Nonetheless, for clarity sake and consistency with the acronyms in the parties' briefs, the contract application will be described as "MA-PD" throughout this decision.

[2] Within its motion, CMS cites to the 2010 Final Rule that addressed revisions to the regulations governing the MA/MA-PD programs. CMS MSJ at 4 n.24 (citing to 75 Fed. Reg. 19678, 19683 (April 15, 2010).

discretionary authority to allow an applicant to cure its application," RPS Brief at 3, and that its application for a special needs MA-PD plan ("SNP") focused on patients with end-stage renal disease ("ESRD") "is designed to advance health equity consistent with CMS's stated goals." RPS Reply at 3. The Hearing Officer's authority in the instant appeal, however, is limited by regulation and requires the Hearing Officer to decide if CMS's determination was consistent with regulatory requirements. *See* 42 C.F.R. §§ 422.660 and 422.688. It is undisputed that RPS failed to timely meet licensure requirements. RPS has not established by a preponderance of the evidence that CMS's denial of its application was inconsistent with controlling authority.

V. BACKGROUND

Any entity seeking to contract as an 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). Specifically, CMS requires that an application 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)(1)(i).

For state licensure, applicants must attest in their application that they are 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 verify this attestation by uploading an executed copy of the state license certificate with their application if the applicant was not previously qualified by CMS in that state. (*See* Part C – MA and 1876 Cost Plan Expansion Application, located at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html, Downloads; CY 2023 MA (Part C) Application (PDF).)

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, HMO, 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* Part C – MA and 1876 Cost Plan Expansion Application at 50-56.

Under current regulations and procedures, after receiving an application, CMS reviews the application for any issues. CMS then electronically mails an applicant a Deficiency Notice, when

applicable, to provide notice of any application deficiencies. 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's 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.
>
> (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.
>
> (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, written notice of the determination and the basis for the determination is given to the applicant. 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). The applicant has the burden of proving by a preponderance of the evidence that CMS's 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."

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 17, 2022, RPS filed an initial MA/MA-PD application with CMS to operate in seven counties in Nevada. CMS MSJ at 1. RPS's application concerns a chronic condition SNP developed to address "the significant treatment issues for individuals with [ESRD]." RPS Brief at 1-2.

On March 21, 2022, CMS issued RPS a deficiency notification regarding its Part C application. *Id*. at 2. Among the deficiencies noted, CMS cited RPS's "failure to submit evidence of state licensure as a risk bearing entity, i.e., the HMO COA, and failure to submit the fully and appropriately completed State Certification." *Id*. On April 18, 2022, CMS issued a NOID for RPS's Part C application due to "RPS's failure to submit the HMO COA and the State Certification." *Id*. Within the NOID, CMS stated "that RPS had until 8pm Eastern Standard Time on April 28, 2022, to cure any application deficiencies." CMS MSJ at 4.

RPS asserts that the DOI's "review of RPS's application for an HMO COA was impacted by staff shortages at the DOI." RPS Brief at 2. RPS states that on April 28, 2022, DOI requested that RPS file an extension request with CMS, which RPS filed the same day. *Id.*; RPS Brief Exhibit C at unnumbered page 1. On April 28, 2022, however, CMS denied RPS's request for an extension of time to file its documents. *Id*. Subsequently, on May 18, 2022, CMS issued RPS's contract determination in which CMS denied RPS's application for a new MA/MA-PD plan "under contract number H6207 due to the failure to submit a copy of the HMO COA and the [completed] State Certification[.]" RPS Brief Exhibit D.

RPS filed its Request for a Hearing on June 1, 2022. The Office of Hearings acknowledged the appeal request on the same date, and provided the parties with a hearing date and briefing schedule. RPS Brief Exhibit G. The parties submitted their briefs pursuant to the briefing schedule. In CMS's responsive brief, it moved for summary judgment in its favor. *See* CMS MSJ. Along with its Reply Brief, RPS attached copies of what it indicates are the missing HMO COA and State Certification documents that DOI issued on June 22, 2022. RPS Reply Exhibits J and K.

VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer grants CMS's Motion for Summary Judgment. The parties agree that there are no material facts in dispute. CMS MSJ at 1; RPS Reply at 3.

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 provide CMS with documentation of appropriate state licensure 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-PD contract. 42 C.F.R. § 422.501(c)(1)(i). RPS failed to meet the application requirements when it submitted its initial application and failed to timely cure the deficiencies by April 28, 2022 — the deadline established in the NOID. CMS MSJ at 4.

Within its initial brief, RPS asserts that, upon receipt from the DOI, it "will be able to cure the HMO COA and State Certification deficiencies that resulted in [CMS's] Contract Determination" by immediately "submit[ting] that documentation to CMS[.]" RPS Brief at 3. RPS argues that as "CMS has broad contractual and regulatory discretionary authority to allow an applicant to cure its application[,]" "the Hearing Officer should overturn the Contract Determination and allow RPS time to cure the application." *Id.* RPS claims that the DOI's "review of RPS's application for an HMO COA was impacted by staff shortages at the DOI." *Id.* at 2.

Attached to RPS's Reply Brief are copies of what RPS indicates are the missing HMO COA and State Certification documents that DOI issued to RPS on June 22, 2022.[3] RPS Reply Exhibits J and K. Within its Reply Brief, RPS now argues that as it "has remedied the deficiencies that resulted in CMS's denial of its Part C application[,] . . . it would be a disservice to the ESRD beneficiaries in RPS's service area . . . to deny RPS's application and deprive them of a SNP MA-PD that is focused on their unique treatment and other needs and is designed to advance health equity consistent with CMS's stated goals."[4] RPS Reply at 3.

CMS's position is that there are no disputed material facts, and that RPS cannot demonstrate it has met all of the Part C requirements within the application process. CMS MSJ at 1, 4. As a result, CMS moves for summary judgment. *Id.* at 1. CMS denied RPS's application because RPS, as the Applicant for Contract Number H6207, failed to submit a copy of its State of Nevada licensure and a State Certification Form for the State of Nevada. RPS Brief at 2; RPS Brief Exhibit D.

RPS does not contest CMS's position that the controlling authority requires an applicant to submit the appropriate state licensure to be approved by CMS. Rather, RPS seeks "regulatory discretionary authority" to allow RPS to cure its application in order to, among other things, "advance health equity" specifically for the ESRD beneficiaries it seeks to serve. RPS Brief at 3; RPS Reply at 3.

The CMS Hearing Officer does not possess a broad scope of discretionary authority to provide the relief RPS seeks. The Hearing Officer must decide if CMS's determination was consistent with regulatory requirements. *See* 42 C.F.R. §§ 422.660 and 422.688. The Hearing Officer finds that RPS failed to timely meet CMS's application requirements. Thus, CMS's denial was an appropriate exercise of its delegated authority. Accordingly, the Hearing Officer grants CMS's Motion for Summary Judgment.

[3] As noted *supra*, CMS has not yet reviewed these documents.

[4] Within its Reply Brief, RPS discusses that "[h]ealth equity is the core work of CMS." RPS Reply at 3.

VIII. DECISION AND ORDER

CMS's Motion for Summary Judgment is granted.

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: July 11, 2022