CENTERS FOR MEDICARE & MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Legacy Health Plan, Inc.	*	
Denial of Initial Application to Offer Medicare Advantage/Medicare Advantage-Prescription Drug Plan	* *	**Docket No. 2018-04 MA/PD**
Contract Year 2019 **Contract No. H3016**	* *	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. Filings

This Order is being issued in response to the following:

(a) Legacy Health Plan, Inc.'s ("LHP") Request for Hearing submitted by letter dated June 1, 2018;

(b) LHP's Brief ("LHP Brief") dated June 13, 2018;

(c) Centers for Medicare & Medicaid Services' ("CMS") Motion for Summary Judgment and Memorandum in Support of CMS' Denial of LHP's Initial Application to offer Medicare Advantage ("MA")/Medicare Advantage - Prescription Drug ("MA-PD") under contract number H3016 for contract year ("CY") 2019 ("CMS MSJ") dated June 22, 2018; and

(d) LHP's Reply Brief in Opposition to CMS' Motion for Summary Judgment ("LHP Reply Brief") dated June 27, 2018.

II. Issue

Whether CMS' denial of LHP's application to offer a new MA-PD plan, due to a failure to meet the State licensure application requirements, was inconsistent with regulatory requirements.

III. Decision

The Hearing Officer grants CMS' Motion for Summary Judgment as there is no dispute of material facts that LHP did not provide the required licensure materials to CMS. Accordingly, LHP failed to meet the application requirements. LHP 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 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) (2016)). 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 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* CY 2019 Part C – MA and 1876 Cost Plan Expansion Application, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html (last modified Apr. 2, 2018)).

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 2019 Part C – MA and 1876 Cost Plan Expansion Application).

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 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"). (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. (*Id.* § 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 each 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)). 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 [of Health and Human Services], and general instructions issued by CMS in implementing the Act."

V. <u>Procedural History and Statement of Facts</u>

Within its brief, LHP presents e-mail chains with CMS that occurred during the application process. Prior to filing its initial application, LHP corresponded with CMS as follows (LHP Brief, Exhibit A1 - e-mails spanning January 30 and January 31, 2018):

January 30, 2018

LHP: Legacy Health Plan is currently in [the] process of obtaining a state license through [the Department of Managed Health Care ("DMHC")] and are anticipating that we should have our license before February 14th. In the event we do not obtain our license prior to the submission deadline date of February 14th, what documentation, if any, would Legacy Health Plan need to submit for the application?

CMS: You should submit evidence that you submitted your licensure application for approval and that it is pending with the state.

January 31, 2018

LHP: Is there a specific document CMS would like for us to submit or would a letter from DMHC suffice? Also for the "MA State Certification Form", how would we answer the following question?

"2. Type of State license or Certificate of Authority currently held by referenced applicant . . . ."

CMS: A letter from DMHC or something similar would suffice. The state certification form depends on the state and is filled out by the state. The State should indicate what kind of license you possess.

On February 5, 2018, DMHC sent an e-mail to LHP confirming that LHP applied for licensure on August 4, 2017, and that such license was under review. (LHP Brief at Exhibit A-2). On the same date, LHP forwarded the e-mail to CMS and questioned whether "this email [would] suffice as proof that we have submitted our application or would we need a formal letter?" CMS responded "Yes" on February 6, 2018.

On February 14, 2018, LHP filed an initial application with CMS to offer a new MA-PD plan under contract number H3016 for CY 2019. (*See* CMS MSJ at 1). During the first review of LHP's application, CMS found multiple deficiencies, including the State licensure deficiency addressed in CMS' MSJ. On March 19, 2018, CMS sent a deficiency letter to LHP citing deficiencies for State Licensure, Fiscal Soundness, and Experience and Organization History. (CMS MSJ at Exhibit G). The licensure deficiencies cited are as follows:

State Licensure

* State Licensure - You attested that your organization is not licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage, including the authority

> to offer the managed care product for which you are applying, across your entire service area.
>
> * Copy of State Licensure - You failed to submit satisfactory evidence that your organization is licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage, including the authority to offer the MA product for which you are applying, across your entire service area.
>
> * CMS State Certification Form - You failed to submit a fully and appropriately completed CMS State Certification Form demonstrating that you meet the necessary requirements.

On March 27, 2018, LHP submitted a revised application resolving only the Fiscal Soundness deficiency. (*See* CMS MSJ at 5). CMS issued a NOID letter on April 17, 2018, which noted deficiencies in State licensure and Experience and Organization History. (CMS MSJ at Exhibit H). The NOID gave LHP a final ten-day cure period to correct any deficiencies in its application — that is, until April 27, 2018.

LHP made the changes necessary to resolve the Experience and Organization History deficiency. As for the licensure deficiency, LHP sent an e-mail to CMS on April 20, 2018, informing CMS of the earlier e-mail communications. LHP also asserted that they "anticipate obtaining [their] license hopefully in the next 30 days or so" and asked for guidance. (LHP Brief at Exhibit B). CMS responded on April 23, 2018, maintaining that

> CMS cannot intervene or advise on matters between an applicant and the state agencies. Please submit the appropriate documents as soon as they are provided to your organization. Please note that your organization must meet CMS requirements at the time of the final upload. (*Id.*)

LHP also indicated that on an April 25, 2018 telephone call, CMS explained that it would not accept documentation in lieu of the state licensure to show that LHP is in good standing with the DHMC. (LHP Brief at 2).

CMS issued a final letter on May 23, 2018, denying LHP's application on the basis that LHP did not cure the licensure requirement. (CMS MSJ at Exhibit J). LHP filed the subject appeal on June 1, 2018 from CMS' May 23, 2018 denial letter.

VI. <u>Discussion, Findings of Fact and Conclusions of Law</u>

In exercising his authority, the Hearing Officer must comply with the provisions of Title XVIII of the Social Security Act ("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)). It is undisputed that LHP failed to meet the application requirements when it submitted its initial application, failed to meet the licensure requirements when responding to CMS' deficiency letter and failed to timely cure the deficiency by April 27, 2018 — the deadline established in the NOID.

The Hearing Officer must decide if CMS' determination was consistent with regulatory requirements. (42 C.F.R. §§ 422.660 and 422.688). The Hearing Officer finds that LHP failed to meet CMS' application requirements, thus CMS' denial was an appropriate exercise of its delegated authority. LHP did not meet its burden of proof in demonstrating that CMS' determination was inconsistent with controlling authority.

LHP contends that CMS "never redirected [LHP] to the appropriate person that could provide . . . the proper guidance" and was under the impression that the February 5, 2018 e-mail from DMHC would "suffice to show they are in good standing and moving towards obtaining a license." (LHP Reply Brief at 1). Reviewing the January 30, 2018 to February 5, 2018 e-mail exchange between CMS and LHP, the Hearing Officer finds that CMS appears to be indicating that DMHC's February 5, 2018 note, which verified that LHP applied for a license, could be appropriately submitted with the initial application filing (in the event that the license was not obtained by February 14, 2018, as LHP expected). CMS did not indicate that the submission of such note would negate the requirement that licensure materials be submitted to CMS by the final April 27, 2018 deadline. Moreover, even if LHP was unclear regarding the requirement to obtain a license by the final application deadline, the subsequent deficiency notice, the NOID, and the April 2018 e-mails from CMS unambiguously indicated that a license was required to be filed by the April 27, 2018 final deadline.

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: August 2, 2018