CENTERS FOR MEDICARE & MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Constellation Health, LLC	*	**Docket Nos.: 2018-08**
Denial of Service Area Expansion:	*	**2018-09**
Initial Applications		**2018-10**
	*	
Contract Year 2019		
Contract Nos. H3054, H4876 and H8266	*	
	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. Filings

This Order is being issued in response to the following:

(a) Constellation Health, LLC's ("CH") Request for Hearing, which included all three contracts, dated June 6, 2018;

(b) CH's Motion for Summary Judgment ("CH MSJ") and Memorandum in Support of Motion for Summary Judgment ("CH Memo") dated June 14, 2018;

(c) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment in Support of CMS' Denial of CH's three Medicare Advantage ("MA")/Medicare Advantage Prescription Drug ("MA-PD") Plan Service Area Expansion applications under contract numbers H3054, H4876 and H8266 for contract year ("CY") 2019 ("CMS MSJ") dated June 22, 2018; and

(d) CH's Reply Brief ("CH Reply Brief") dated June 27, 2018.

II. Issue

Whether CMS' denial of CH's applications for Service Area Expansions, due to a failure to timely meet the State licensure application requirements, was inconsistent with regulatory requirements.

III. Decision

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties agree that there is no dispute of material facts. While CH now presents additional licensure materials for CMS review, it is undisputed that CH failed to timely meet the application requirements. CH has not established by a preponderance of the evidence that CMS' denial of its application was inconsistent with the 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.*, PPO, 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* 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.
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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, 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. Procedural History and Statement of Facts

On February 8, 2018, CH filed three initial applications with CMS to offer new MA-PD service area expansion plans under contract numbers H3054, H4876 and H8266 for CY 2019. (*See* CMS MSJ at 1). During the first review of CH's applications, CMS found multiple deficiencies,

including the State licensure deficiency relating to the Motion for Summary Judgment herein. On March 19, 2018, CMS sent deficiency letters to CH. (CMS MSJ at Exhibits I, J and K).

On March 27, 2018, CH submitted final applications, but the deficiency pertaining to State licensure remained. (*See* CMS MSJ at 4). CH provided a memo to CMS stating CH was in the last stage of the process for receiving the State Certification Form and would provide such fully executed form as soon as it was received from the Office of the Commissioner of Insurance of Puerto Rico ("OIC"). (*See* CMS MSJ at Exhibits L, M and N).

On April 17, 2018, CMS issued NOID letters, which noted a deficiency in State licensure. (CMS MSJ at Exhibits O, P and Q). The NOIDs gave CH a final ten-day cure period to correct any deficiencies in its applications — that is, until April 27, 2018. CH provided an Attestation dated April 27, 2018, stating that OIC could not provide CH with the State Certification Form. (*See* CMS MSJ at Exhibits R, S and T). CMS issued final determinations on May 23, 2018, denying CH's applications on the basis that CH failed to cure the licensure related requirements. (CMS MSJ at Exhibits U, V and W). CH filed the subject appeal for all three contracts on June 6, 2018, from CMS' May 23, 2018 final denial letters. (CMS MSJ at Exhibit A).

On June 7, 2018, the Chief Deputy Commissioner of Insurance of OIC signed a State Certification Request Form, which indicated that CH was licensed in Puerto Rico as a risk bearing entity. (CH MSJ at Attachment 1). On the same date, the Chief Deputy Commissioner sent a letter to the undersigned Hearing Officer stating that while CH has been under rehabilitation since April 2016 due to a capital impairment, co-owners have made representations to the Commissioner's Office that they are willing to invest $10,000,000 each "with the sole condition that the expansion of the service area by CMS has been granted."[1] (CH MSJ at Attachment 2). The letter continued:

> [A]ccording to their representations, for CH to get that injection of capital, such expansion must have been approved by CMS.
>
> Taking into consideration these new set[s] of representations, this Office has re-evaluated its position regarding its opinion on CMS grating [sic] CH the Service Area Expansion contract number H3054 for Year (CY) 2019, to a favorable one. Thus, such expansion could provide CH the sufficient resources to maintain an adequate [risk-based capital] thereafter. Together with this letter, is the CMS State Certification Form for your consideration. Please note that this form was not submitted on timeframe due to a very complicate[d] agenda of this Office due to the consequences of Hurricanes Irma and Maria in Puerto Rico.[2]

[1] The Chief Deputy Commissioner's June 8, 2018 letter to the Hearing Officer only references contract number H3054.
[2] CH's President and CEO stated, via affidavit, "[i]n many occasions the OIC would postpone meetings scheduled to attend to other more pressing matters the OIC was handling in face of the crisis created by Hurricanes Irma and Maria." (CH Memo at Attachment C No. 9).

VI. Discussion, Findings of Fact and Conclusions of Law

The parties agree that the controversy may be solved by a Summary Judgment as there is no dispute regarding the fact that CH submitted its licensure documentation material after the filing deadline had passed and the denial letter was issued. (CMS MSJ at 5; CH Reply Brief at 6).

In exercising their 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)). CH failed to meet the application requirements when it submitted its initial applications, and failed to timely cure the deficiencies by April 27, 2018 — the deadline established in the NOIDs.

Ultimately, CH requests that "the Hearing Officer [] recommend to the CMS Administrator to exercise the broad contractual discretionary authority" to consider the untimely filing as "cured and allow CH to offer its insurance services to the remaining municipalities in Puerto Rico based on the extenuating circumstances as a result of the effects of Hurricanes Irma and Maria." (CH Reply Brief at 5-6). CH cites the precedent established in *In re Senior Whole Health, LLC,* Docket No. 2011 C/D App. 12, CMS Adm'r Dec. (Aug. 25, 2011), which also involved a licensure deficiency.

CH explains that "Puerto Rico has been undergoing an extremely challenging process . . . which was not addressed nor refuted" by CMS in it filings "because of its exclusive reliance on the mechanistic process outlined by the existing regulations." (CH Reply Brief at 7). To further explain the reasons for the untimely filing, CH's Memorandum contains detailed sections describing the extreme impact of the hurricanes on health insurance services and OIC operations. (CH MSJ at 8-10). CH points out that CMS recognized the disastrous effects of the hurricanes and declared the existence of a Public Health Emergency. (CH MSJ at 10-11).

Regarding CMS' claim that allowing additional time to extend the deadline "undermine[s] the need for a uniform application process that is applied fairly to all applicants," CH responds "there are no other applicants for a service area expansion in Puerto Rico." (CH Reply Brief at 6 (emphasis omitted)).

CMS asserts that CH did not comply with CMS' application requirements and that CMS appropriately denied CH's applications based upon the information CH submitted during the application processing period. (CMS MSJ at 6). CMS asserts that neither CMS nor the Hearing Officer may consider additional documentation or new information beyond the final filing submission deadline. (CMS MSJ at 3-4, 6-7).

The CMS Hearing Officer does not possess a broad scope of discretionary authority; rather, 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 CH failed to timely meet CMS' application requirements, thus CMS' denials were an appropriate exercise of its delegated authority. CH 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 23, 2018