**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services
Office of Hearings
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244

August 25, 2023

**VIA ELECTRONIC DELIVERY**

Tyra Wilson
The Cigna Group
530 Mainstream Drive
Nashville, TN 37228

Amber Casserly
MAPD Appeals Team
7500 Security Boulevard
Baltimore, MD 21244

RE: Hearing Officer Decision
Hearing Officer Docket Number: H-23-00007
Medicare Advantage/Prescription Drug Plan Contract Denial
The Cigna Group FFY 23, Contract/Plan/Provider Number: H7787

Dear Ms. Wilson and Ms. Casserly:

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

| | | |
|---|---|---|
| **HealthSpring Life & Health Insurance Company, Inc., Contract No. H7787** | * | **Denial of Application to Expand Medicare Advantage / Medicare Advantage-Prescription Drug Plan** |
| **Appellant** | * | |
| | * | **Contract Year 2024** |
| **v.** | * | |
| | * | |
| **Centers for Medicare & Medicaid Services** | * | **Hearing Officer Docket No. H-23-00007** |
| **Respondent** | * | |

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## ORDER DENYING CMS' MOTION FOR SUMMARY JUDGMENT

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## I. FILINGS

This Order is being issued in response to the following:

(a) HealthSpring Life & Insurance Company, Inc. ("HealthSpring" or "Plan" or "Applicant") Hearing Request filed on May 30, 2023;
(b) HealthSpring's Brief and exhibits filed on June 8, 2023;
(c) Centers for Medicare & Medicaid Services' ("CMS'") Memorandum and Motion for Summary Judgment Supporting CMS' Denial of HealthSpring Life & Health Insurance Company Inc.'s Service Area Expansion Application for a Medicare Advantage ("MA")/MA-Prescription Drug ("MA-PD") Contract (H7787) for Contact Year 2024 ("CMS Memorandum and MSJ") and exhibits filed on June 15, 2023;
(d) HealthSpring's Reply Brief in Further Support of its Appeal filed on June 21, 2023; and
(e) CMS' Reply Brief and exhibit filed on July 11, 2023.

## 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, Benjamin R. Cohen.

## III. ISSUE

Whether CMS' denial of HealthSpring's service area expansion ("SAE") application for an MA/MA-PD contract (Contract No. H7787) based on HealthSpring's failure to meet CMS' health services management and delivery requirements was inconsistent with regulatory requirements.

## IV. DECISION SUMMARY

The Hearing Officer upholds CMS' denial of HealthSprings's application. As HealthSpring was still in negotiations with a provider identified in CMS' Provider Supply File, CMS' decision to not grant HealthSpring's exception request for Obion County, and deny the application in its entirety, is supportable under the controlling authority governing exception requests. Moreover regarding the manner in which CMS evaluated the application (while the novation was ongoing), HealthSpring failed to prove by a preponderance of the evidence that CMS did not follow the controlling authorities.

## V. BACKGROUND, AUTHORITY, AND CMS APPLICATION REQUIREMENTS AND REVIEW

Under Title XVIII of the Social Security Act (codified at 42 U.S.C. §§ 1395-1395lll) CMS is authorized to enter into contracts with entities seeking to offer Medicare Part C and Part D benefits to beneficiaries. 42 U.S.C. § 1395w-27, 112. Any entity seeking such a contract must fully complete all parts of a certified application in the form and manner required by CMS. 42 C.F.R. § 422.501(c)(1). CMS requires an entity seeking to contract as a MA organization to submit an

application through the Health Plan Management System ("HPMS"). *See* "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2024-medicare-advantage-part-c-application.pdf-1 at 6-7 (last visited June 27, 2023). The "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" is specifically "[f]or all new applicants and existing Medicare Advantage organizations seeking to expand a service area[.]" *Id*. at 1.

The regulation at 42 C.F.R. § 422.116(a)(1) provides that "when required by CMS, an MA organization must attest that it has an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year." 42 C.F.R. § 422.116(a)(1). Beginning with contract year 2024, an MA organization's application for an expanding service area must demonstrate compliance with the network adequacy requirements set forth under 42 C.F.R. § 422.116 as part of its application. 42 C.F.R. § 422.116(a)(1)(ii) (2022). Within an application seeking a service area expansion, an MA organization must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served. 42 C.F.R. § 422.112(a)(4). As such, the MA organization must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type. 42 C.F.R. § 422.116(a)(2). To demonstrate compliance with these network adequacy standards, applicants must upload, as part of the application, Provider and Facility Health Service Delivery ("HSD") Tables into HPMS. *See* "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2024-medicare-advantage-part-c-application.pdf-1 at 27; *see also* December 22, 2022 Memorandum providing instructions ("December 2022 Instructions"), CMS Exhibit C-5 at 2. Furthermore, under 42 C.F.R. § 422.116(a)(1)(ii), CMS may deny an application on the basis of an evaluation of the applicant's network for the expanding service area.

An organization must list every provider and facility with a fully executed contract in its network in the HSD Tables. *See* Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, located at www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance08302022.pdf at 2 (last updated Aug. 30, 2022) (hereinafter "Network Adequacy Guidance"). Beginning in 2024, applicants may use a Letter of Intent ("LOI"), signed by both the MA organization and the provider or facility with which the MA organization has started or intends to start negotiations, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. 42 C.F.R. § 422.116(d)(7) (2022). As part of the network adequacy review process, applicants must notify CMS of their use of LOIs to meet network standards in lieu of a signed contract and submit copies upon request and in the form and manner directed by CMS. *Id*. Within the December 2022 Instructions, CMS provided applicants with information regarding how to notify CMS of their intent to use one or more LOIs and how the LOIs should be submitted. CMS Exhibit C-5.

The regulatory subsections 42 C.F.R. § 422.116(b)(1)-(2) lists the provider-specialty types and facility-specialty types to which the network adequacy evaluation applies. Access to each specialty type is assessed using quantitative standards based on the local availability of providers and facilities to ensure that organizations contract with a sufficient number of providers and

facilities to furnish health care services without placing undue burden on enrollees seeking covered services. *See* Network Adequacy Guidance at 2. CMS explains that it programs network adequacy criteria into the Network Management Model ("NMM") in HPMS. *Id.* The "network review is performed through an automated tool within HPMS that compares the network data submitted by each applicant against standardized CMS network adequacy criteria published in the annual Reference File[.]" CMS Memorandum and MSJ at 4. CMS states that the automated tool "generates two reports," called the Automated Criteria Check ("ACC"), for "Provider" and "Facility," "that show whether a provider in a given county is passing the network adequacy requirements." *Id*. Lastly, CMS asserts that "[t]he ACC reports are accessible within the system to reflect where the applicant stands with respect to meeting the standardized criteria." *Id*; *see also* December 2022 Instructions, CMS Exhibit C-5 at 2.

Within its Guidance, CMS explains that "there are unique instances where a given county's supply of providers/facilities is such that an organization would not be able to meet the network adequacy criteria[,]" and that "[g]enerally, organizations use the exception process to identify when the supply of providers/facilities is such that it is not possible for the organization to obtain contracts that satisfy CMS's network adequacy criteria." Network Adequacy Guidance at 5. As such, CMS permits applicants that are unable to satisfy network adequacy criteria in 42 C.F.R. § 422.116(b)-(e) to submit exception requests. 42 C.F.R. § 422.116(f); *see* Network Adequacy Guidance at 5. Specifically, under 42 C.F.R. § 422.116(f)

> (1) An MA Plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when both of the following occur:
>
> (i) Certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider supply file[1] for the year for a given county and specialty type.
>
> (ii) The MA plan has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria but are currently available and accessible to most enrollees, consistent with the local pattern of care.
>
> (2) In evaluating exception requests, CMS considers whether—
>
> (i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

[1] The Provider Supply File is explained in further detail below.

> (ii) There are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and
>
> (iii) Approval of the exception is in the best interests of the beneficiaries.

The Network Adequacy Guidance provides a non-exhaustive list of what CMS considers to be valid rationales to submit an exception request.

> • Provider is no longer practicing (e.g., deceased, retired).
> • Does not contract with any organizations or contracts exclusively with another organization.
> • Provider does not provide services at the office/facility address listed in the supply file.
> • Provider does not provide services in the specialty type listed in the supply file.
> • Provider has opted out of Medicare.
> • Sanctioned provider on List of Excluded Individuals and Entities.
> • Use of Original Medicare telehealth providers or mobile providers.
> • Specific patterns of care in a community.

*Id*. (emphasis omitted).

The Medicare Advantage Health Service Delivery Exception Request Template requires MA plans to list "any providers/facilities . . . identified within or nearby CMS's network adequacy criteria with whom you have not contracted" and to provide the reason for not contracting. HealthSpring Reply Brief Exhibit 5 at PDF 4. The Template provides MA plans a drop-down list of reasons for not contracting to choose from. Moreover, CMS indicates that some of the reasons to choose from will not support an exception request. Of note (notwithstanding the LOI process), one of the rationales CMS deems invalid is "Inability to contract with provider." *Id.*

Within its brief, CMS states that it manually reviews exception requests and "identifies available providers for the applicant to contract with . . . using the Provider Supply file." CMS Memorandum and MSJ at 4, 6; *id*. at 3. Within the Network Adequacy Guidance, CMS explains

> The supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier, and specialty type and is posted by state and specialty type. The supply file is segmented by state to facilitate development of networks by service area. Contracts with service areas near a state border may need to review the supply file for multiple states, as the network adequacy criteria are not restricted by state or county boundaries. The current supply file is published in HPMS>Monitoring>Network Management>Documentation>Reference Files.

> Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MA organizations remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file. MA organizations should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available.
>
> CMS uses the supply file when validating information submitted on exception requests. Therefore, CMS may update the supply file periodically to reflect updated provider and facility information and to capture information associated with exception requests.

Network Adequacy Guidance at 3.

Additionally, 42 C.F.R. § 422.550 provides authority regarding how organizations may novate contracts. The regulation states, in relevant part:

> (c) Novation agreement defined. A novation agreement is an agreement among the current owner of the MA organization, the prospective new owner, and CMS—
>
> (1) That is embodied in a document executed and signed by all three parties;
>
> (2) That meets the requirements of § 422.522; and
>
> (3) Under which CMS recognizes the new owner as the successor in interest to the current owner's Medicare contract.
>
> (d) Effect of change of ownership without novation agreement. Except to the extent provided in paragraph (b)(2) of this section, the effect of a change of ownership without a novation agreement is that—
>
> (1) The existing contact becomes invalid; and
>
> (2) If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart K [Application Procedures and Contracts for Medicare Advantage Organizations ] of this part.
>
> (e) Effect of change of ownership with novation agreement. If the MA organization submits a novation agreement that meets the requirements of § 422.552, and CMS signs it, the new owner becomes the successor in interest to the current owner's Medicare contract.

CMS evaluates an application based on the information contained in the application itself, any additional information that CMS obtains through other means such as on-site visits, and any relevant past performance history associated with the applicant. 42 C.F.R. §§ 422.501(a)(1) and (b)(1). After reviewing whether the application meets all requirements, CMS issues, if necessary, a Deficiency Notice in which CMS notifies an applicant of deficiencies within the application and allows a specific time within which the applicant may cure the deficiencies. *See* CMS Memorandum and MSJ at 4. If the applicant fails to cure the deficiencies cited within the Deficiency Notice or if the applicant is otherwise unable to meet the pertinent regulatory requirements, CMS issues the applicant a Notice of Intent Deny ("NOID"). 42 C.F.R. § 422.502(c)(2). Per § 422.502(c)(2)(ii), the applicant will have ten days from the NOID to respond in writing to correct deficiencies in the application.

If, in response to the NOID, the applicant either fails to submit a revised application within ten days from the date of the NOID, or if after timely submission of 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. 42 C.F.R. § 422.502(c)(2)(iii). For an application denial, CMS provides the applicant with written notice of the determination and the basis for the determination. 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' 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."[2]

## VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

HealthSpring is a subsidiary of the Cigna Group ("Cigna"). HealthSpring Brief at 1. Cigna offers MA plans throughout the United States and has more than 585,000 MA members of which over 330,000 are members of MA plans offered by HealthSpring. *Id.* Cigna's subsidiary, Cigna Health and Life Insurance Company ("CHLIC"), offers multiple non-Medicare products and is seeking to

[2] Within the preamble to the 2010 Final Rule, the Secretary provided additional clarification regarding the hearing process:

> [T]he applicant would not be permitted to submit additional revised application material to the Hearing Officer for review should the applicant elect to appeal the denial of its application. Allowing for such a submission and review of such information would, in effect, extend the deadline for submitting an approvable application.

Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19678, 19683 (April 15, 2010).

novate its MA Preferred Provider Organization ("PPO") contract H7849 to HealthSpring, which is solely dedicated to offering MA plans. *Id.* at 3. Cigna indicates that they initially contacted CMS somewhere between late 2022 and January 2023 to ensure that CMS was aware of Cigna's plan to novate its contracts and to confirm the process that it was required to follow. *Id.*; Tr. at 12-15.[3] [4] Although HealthSpring already holds an MA PPO contract (H7787), CHLIC offers PPO plans in counties that HealthSpring does not. HealthSpring Brief at 12. HealthSpring submitted an application to add counties to its service area in H7787 so that its service area aligns with where H7849 offers PPO plans. *Id.* Regarding its understanding of the standard that CMS would consider in reviewing the application, HealthSpring provided its perspective:

> Health Spring submitted the Application to prepare for an internal reorganization and the novation of contract H7849. In fact, the Application does not represent that offering of a new plan, or expansion of a plan under contract H7787. Because HealthSpring is not seeking to expand its service area under H7787, the Application included information about the provider network currently in place and approved by CMS for CHLIC's PPO H7849. To this end, CMS should review the network adequacy data in the same way it reviews this information for an existing plan not seeking to expand its service area. If the network is adequate for H7849's 2023 MA benefit plan, CHLIC would instead be attesting to its network adequacy that will be available by January 1, 2024, not proving six (6) months prior to the plan year that its network is fully contracted. Even if there are distance changes or population changes that CHLIC would otherwise need to address in order to submit its attestation, HealthSpring's Application should be held to the same regular course standard.

HealthSpring Brief at 18.

[3] With regards to timing, Cigna alleges that "CMS's instructions were to (1) complete the service area expansion [("SAE")] process, (2) withdraw the conditionally approved counties that are related to the novation, and (3) file the novation and change of ownership materials." HealthSpring Reply Brief at 12 (emphasis omitted). HealthSpring also states "CMS explained that Cigna needed to first submit the SAE's and once the SAEs were approved, but before the bidding deadline, submit a notice to CMS that such counties were only being added for purposes of qualifying the [MA organization] for potential novation." Tr. at 17. "It was our understanding that . . . once an entity was approved to operate in a service area, it would then be qualified to go through the novation process." Tr. at 18.

[4] On July 12, 2023, this case (H-23-00007) was heard on a consolidated basis with Case No. H-23-00006, another contract determination case involving a separate HealthSpring contract. At the hearing, the parties verified that they had no objections to the previously filed briefing exhibits for both cases. Case No H-23-00006 was withdrawn after the hearing date. The Hearing Officer notes that HealthSpring Brief Exhibit 8 for Case No H 23-00006 contained February-April 2023 e-mail communications between CMS and Cigna which discuss the planned novation. *See* Tr. at 110-11. The parties did not present detailed arguments analyzing these communications, and HealthSpring concedes that "[w]e do not propose or suggest that CMS misled us." Tr. at 19. The Hearing Officer, nevertheless reviewed HealthSpring Brief Exhibit 8 and likewise concludes that the communications are not specific enough to sway the Hearing Officer's analysis in HealthSpring's favor. Nevertheless, for context, HealthSpring Brief Exhibit 8 will be placed into the H-23-00007 hearing record as it is relevant and provides additional context to the factual background.

Ultimately, after HealthSpring had the opportunities to submit materials in response to CMS' deficiencies notices and a NOID, on May 17, 2023, CMS issued the Application Denial. HealthSpring Brief Exhibit 1. The denial notice indicated that (1) CMS denied one or more of HealthSpring's exception requests, (2) based on CMS' automated review of HealthSpring's Provider Table, CMS found that HealthSpring's contracted network of providers does not meet CMS' network criteria, and (3) HealthSpring failed to upload a document for review as required by CMS for use of letters of intent to meet network adequacy standards. *Id.* CMS states that "[o]n May 30, 2023, [it] reissued [the] application denial letter by electronic mail removing HealthSpring's LOI deficiencies. CMS Memorandum and MSJ at 8; *see* CMS Memorandum and MSJ Exhibit 1. On May 30, 2023, HealthSpring filed the subject appeal.

On, June 2, 2023, HealthSpring and CHLIC submitted a change in ownership notice and novation agreement to CMS for review. HealthSpring Brief Exhibit 6.[5]

The parties filed briefing materials and exhibits in accordance with the Office of Hearings instructions. CMS also filed a motion for summary judgment which was denied on the basis that "both parties have presented a number of facts and it remains unclear as to which facts are undisputed (e.g., communications); thus, additional development at a hearing is appropriate."

On July 11, 2023, CMS filed a notice with the Hearing Officer which indicated that exception requests for seven additional counties were approved and that the only exception requests remaining in dispute were:

> Obion, TN, Ophthalmology
> Aransas, TX, General Surgery

A hearing was held on July 12, 2023.

## VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer upholds CMS' denial of HealthSpring's H7787 application. As a threshold matter, the parties addressed whether Cigna's stated intention to novate the CHLIC H7849 to HealthSpring (H7787) should impact the application review process here. In review, in support of

[5] Regarding the timing of the novation filing, HealthSpring explained that

> [w]hen it became clear that the CMS team wanted to see the novation and change of ownership materials to consider the service area expansion applications and related appeals, Cigna submitted all nine packages by the end of the week and before the June 5, 2023 bid deadline. Cigna asked CMS for additional guidance numerous times throughout the spring and at no point did CMS instruct that submitting the novation and change of ownership materials before the service area expansion process was completed would be helpful to CMS's review. If that were the case, Cigna would have submitted the materials immediately upon request.

HealthSpring Reply Brief at 13.

its application for H7787, HealthSpring largely points to the provider network currently in place and approved by CMS for CHLIC's PPO H7849.

HealthSpring acknowledges that the application process and novation processes are separate. Tr. at 123. Nevertheless, regarding how the authority governing the application and novation processes intersect, HealthSpring states that the authority "does not provide any sort of operational guidance in terms of what is expected[,]" and "there is certainly . . . a lot of room for imagination as to what is expected of an [MA organization] that is seeking to go through this process." Tr. at 124. HealthSpring indicated that "CMS has not developed a separate process or timeline for related party notations" and that "this is an incredibly administratively complex process with shockingly limited published guidance." Tr. at 13-14. HealthSpring also reflected that:

> This is a cumbersome and technical process with many moving parts. We do not propose or suggest that CMS misled us. We simply believe that this was the timing that we were instructed to follow and that's what we were working with. Cigna at no time sought to delay submissions or to submit anything in a manner that it believed did not meet CMS' published requirements or guidance that Cigna received either through emails or the portal communications or on the calls. So, with all of that as background and as I have explained, the service areas expansion applications were submitted to prepare for the novations, not for HealthSpring to expand its operations under the two contracts at issue. We are ultimately seeking to allow the plans that are operating today under other Cigna affiliates to continue to be able to operate by HealthSpring in 2024, if we can then move through the novation process. This means that members would continue to be able to use their current plans and continue to be able to receive services from their current providers

Tr. at 19-20.

On closing argument CMS summarized

> All applicants for contract year 2024, were held to the same network adequacy standards during the application process outlined in [42] CFR 422.166(a)(1)(ii), that was finalized in 2022. We understand that these applications were submitted by this organization to support a novation and appreciate the applicant's acknowledgement that these are two separate processes. And as such, we don't consider the fact that there is a novation involved when we're reviewing the application. Once the application review begins, we're very careful about communicating with organizations about the application outside of the application process. We do our best to advise organizations of how to navigate our processes to meet their business goals. But note that while we can accept novation requests well ahead of time, we don't require the submission until at least until 60 days ahead of the effective date. We followed up several times during the application process to ask when the organization would submit the official novation request. And as the organization noted, they submitted the novation after the application letters were issued

Tr. at 115-16.

The Hearing Officer finds that based on the communications, HealthSpring clearly made a good faith effort to simultaneously timely navigate through the two-track application and novation requirements to effectively "transfer the ownership" of a contract to support an "internal reorganization." HealthSpring Brief at 2-3. The regulations and controlling authority do not provide specific information or detailed step-by-step guidance regarding how the application and novation processes intersect in terms of timing. Nevertheless, the regulation at 42 C.F.R.§ 422.550(d)(2), Effect of change of ownership without novation agreement, broadly states "If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart K [Application Procedures and Contracts for Medicare Advantage Organizations ] of this part." At end, the Hearing Officer finds that HealthSpring did not prove by a preponderance of the evidence that CMS' denial was inconsistent with the controlling authorities in the manner that CMS evaluated the application (i.e., as a service area expansion application without considering the novation).

Next, regarding the network adequacy issues relating to Arnasas County, TX and Obion County, TN, HealthSpring notes that it agreed to pay out-of-network claims at the Medicare rate and limit the enrollee cost sharing to in-network amounts for beneficiaries in the affected county until they were able to meet network adequacy requirements. HealthSpring Brief at 5-6. HealthSpring indicates this "commitment ensures that beneficiaries have network access that is consistent or better than original Medicare as required by MA regulations." HealthSpring Brief at 18 and HealthSpring Brief Exhibit 7 (Cigna Support for Exception Requests).

At the hearing, CMS indicated that ensuring that "as needed" arrangements for beneficiaries to "get out of network care at in network costs" is already a requirement. Tr. at 117. CMS further explained

> [I]t's important for an organization to have an adequate network that's . . . communicated well to beneficiaries through their provider directory. Now, if a beneficiary calls up and is having a problem seeking care because . . . their doctor dropped out of the network, then the organization is expected to arrange for that care. But it's not necessarily noted or required to be noted in the provider directory.

Tr. at 119.

The Hearing Officer observes that 42 C.F.R. § 422.116(a)(1)(i) specifies that an MA plan "must demonstrate that it has an adequate *contracted* provide network that is sufficient to provide access to covered services." 42 C.F.R. § 422.116(a)(1)(i) (emphasis added). *See also* 42 C.F.R. § 422.112(a)(1), 42 C.F.R. § 422.114. In turn, CMS established an application process that requires that MA plans demonstrate network adequacy by submitting a list of contracted providers. Accordingly, the Hearing Officer upholds CMS' decision that HealthSpring's commitment to ensuring access to out-of-network care "as needed" does not necessitate that the contract denial be overturned.

Additionally, regarding CMS denials of the exception requests for Obion County, TN, HealthSpring explains

> the CMS Supply Files identified seven providers. Of the 7 providers recommended, 3 are already represented in contracted network data, 2 providers declined to join the network, 1 provider is 104 miles away, and 1 provider relocated to a different state: [Providers A, B, and C[6]] practice at addresses already contracted in the network and do not add to or improve network adequacy; [Provider D], who is located in Kentucky, is unwilling to participate in an out-of state MA plan (the plan operates in Tennessee); [Provider E] is in the process of being added to the network; [Provider F] is located 104 miles away, and [Provider G] relocated and currently practices in Paducah, KY. None of the recommended providers would cure the current network deficiency, thus approving an Exception Request is appropriate.
>
> The current network ensures members only need to travel and additional 2.9 - 3.9 miles to receive in-network care. The attached report and visualization from Quest[7] demonstrates that members, on average, only need to travel 33.2 miles to receive in-network care, further supporting why adding a provider that is 104 miles away would not add to or improve network adequacy.[8]

HealthSpring Reply Brief at 6-7.

Regarding Aransas, TX, HealthSpring indicates

> the CMS Supply File identified seven providers. Of the 7 providers recommended, 3 are the incorrect specialty (1 pediatric transplant surgeon, 1 pediatric general surgeon, and 1 vascular surgeon), 2 providers are not at the address cited, 1 provider would not provide any network adequacy gain, and 1 provider was previously contracted and failed the Cigna re-credentialing process. [Provider A] is a pediatric transplant surgeon, [Provider B] is a pediatric general surgeon, [Provider C] is a vascular surgeon, [Provider D and E] were not at the addresses cited, [Provider G] would not add to or improve network adequacy, and [Provider H] was previously contracted but failed Cigna's recredentialing process. None of the recommended providers would cure the current network deficiency, thus approving an Exception Request is appropriate.
>
> The current network ensures members only need to travel an additional 3.2 miles to receive in-network care. The attached report and visualization from Quest

[6] The actual provider names which appear in the record materials are omitted from this decision.

[7] Quest Analytics offers provider network management, including network adequacy and provider data accuracy. https://questanalytics.com/how-we-help/.

[8] *See also* HealthSpring Reply Brief Exhibit 5 (Medicare Advantage Health Service Delivery Exception Request Template, Obion TN).

> demonstrates that members only need to travel 38.2 miles to receive in-network care.[9]

*Id.* at 8-9.

Notably, with regards to Obion County, HealthSpring notes that Provider E is in the process of being added to the network. HealthSpring Reply Brief at 7; Tr. at 45-47. HealthSpring also concedes that "working to contract with one or more . . . providers" is not a valid rationale according to CMS' guidance." Tr. at 66. CMS stated that is will not accept the rationale that a plan is in "the process of contracting, otherwise known as a placeholder rationale." Tr. at 24-25. CMS continues that:

> Cigna, the organization said that you are working to contract with additional providers, and we appreciate that. However, all applicants including this organization, attested to having an adequate network at the time of the application. And it's important to note that CMS reviews what is submitted as part of the exception request process. When an exception request is submitted with an invalid rationale as these two remaining exceptions were, CMS denies the exception request.

Tr. at 116-17.

In justifying its application's exception request for the Obion County, Tennessee, specialty of "ophthalmology," HealthSpring provided a rationale that CMS specifically warned was not valid (i.e., "in the process of negotiating a contract with provider") within its exception request for Provider E.[10] *See* HealthSpring Reply Brief Exhibit 5 and *supra* p. 4. Accordingly, the Hearing Officer finds that CMS' decision to not accept the Obion County exception request, and to deny the application as a whole, was supportable.

Finally, HealthSpring also requests that CMS use its discretion, which is beyond the Hearing Officer's scope of review under 42 C.F.R. § 422.660(b)(1). HealthSpring alleges that CMS is seeking "to apply a standard essentially at a perfect standard" as it is a "national plan that has two minor deficiencies from a filing perspective." Tr. at 125; *see also* Tr. at 67. HealthSpring also argues that CMS should use its discretion to approve the application because it would effectively allow the new contract to use a current provider network in an existing contract in its current service areas. HealthSpring Brief at 19-20; HealthSpring Reply Brief at 16. Similarly,

[9] *See also* HealthSpring Reply Brief Exhibit 7 (Medicare Advantage Health Service Delivery Exception Request Template, Aransas, TX).

[10] At the hearing, CMS did not provide extensive responses countering many of HealthSpring's reasons for not contracting with specified providers for the two counties. Many of the HealthSpring's explanations are valid rationales (e.g., incorrect provider address or specialty). The Hearing Officer will not reach whether the following reasons are valid: 1) unwillingness to participate in an out-of-state MA plan (Tr. at 44), 2) the assertion that adding certain providers neither adds to nor improves the overall network adequacy, and 3) HealthSpring's explanation that a provider did not meet their recredentialing standards.

HealthSpring requests that CMS use its discretionary authority to facilitate the novation so that that ”beneficiaries would be afforded continued access to their current provider network.” HealthSpring Brief at 19. HealthSpring alternatively requests that CMS should “use its discretion to sever the portions of the Application that CMS denied from CMS’s approval of HealthSpring’s Application to expand” into three counties which are unrelated to Cigna’s novation requests. HealthSpring Reply Brief at 15. While CMS did not address all of HealthSpring’s arguments for relief, which are based on CMS utilizing discretion, CMS broadly stated that allowing HealthSpring additional time beyond the deadline to submit information “would undermine the need for a uniform application process that is applied fairly to all applicants” CMS Memorandum and MSJ at 12.

## VIII. DECISION AND ORDER

The Hearing Officer finds that HealthSpring has not proven, by a preponderance of the evidence, that CMS’ denial of its service area expansion application was inconsistent with regulatory requirements. The Hearing Officer upholds CMS’ application denial.

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Benjamin R. Cohen, Esq.
CMS Hearing Officer

Date: August 25, 2023