DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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May 31, 2024

Via Electronic Delivery

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RE: Hearing Officer Decision
Hearing Officer Docket Numbers: H-24-00005 and H-24-00006
WellCare Health Insurance of North Carolina, Inc., Contract Number: H7175

Dear Ms. Clements and Ms. Williams:

A copy of the Hearing Officer's decision for the above-referenced appeals 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

WELLCARE HEALTH INSURANCE OF NORTH CAROLINA, INC.,	*	**CMS Hearing Officer Case Nos.:**
Contract No. H7175	*	**H-24-00005**
	*	**H-24-00006**
Petitioner	*	
	*	**Review of Termination Notice and Intermediate Sanctions for Medicare Advantage /Medicare Advantage – Prescription Drug Plan Contract**
v.	*	
Centers for Medicare & Medicaid Services,	*	
Respondent	*	

*

HEARING OFFICER ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

a) January 11, 2024 Hearing Request on CMS Termination of Medicare Advantage-Prescription Drug Contract Number H7175, WellCare Health Insurance of North Carolina, Inc. filed by WellCare Health Insurance of North Carolina, Inc. ("WellCare")
b) February 2, 2024 WellCare's Hearing Brief Appealing Contract Termination and Intermediate Sanctions ("WellCare Brief") and Exhibits P-1 through P-3 filed by WellCare
c) March 5, 2024 Centers for Medicare & Medicaid Services' ("CMS") Motion for Summary Judgment ("MSJ") and Brief in Support Thereof ("CMS Brief") and Exhibits 1 through 24 filed by CMS
d) March 14, 2024 Appellant's Reply Brief and Memorandum in Opposition to CMS' Motion for Summary Judgment filed by WellCare ("WellCare Reply")
e) March 25, 2024 CMS' Reply to Appellant's Reply Brief and Memorandum in Opposition to CMS' Motion for Summary Judgment filed by CMS ("CMS Reply")

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' December 27, 2023 Notice of Termination and Intermediate Sanctions for WellCare (Contract No. H7175) was proper.

IV. DECISION SUMMARY

The Hearing Officer grants CMS' motion for summary judgment. It is undisputed that WellCare received Star Ratings of less than three stars for contract years 2022, 2023, and 2024. Accordingly, CMS concluded that WellCare substantially failed to carry out the terms of its contract H7175 "by failing to achieve a Part C summary Star Rating of at least three stars in three consecutive Star Rating periods." WellCare Exhibit P-1 at 1. In addition, pursuant to its authority, CMS exercised its discretion to impose intermediate sanctions against WellCare. CMS' determinations were justified and consistent with the controlling legal authority at 42 C.F.R. § 422.510(a)(4)(xi) and 42 C.F.R. § 422.752(b). WellCare did not establish by a preponderance of the evidence that CMS' decision to terminate and impose intermediate sanctions against contract H7175 was inconsistent with the controlling authority. 42 C.F.R. § 422.660(b)(3) and (4).

V. PROCEDURAL HISTORY AND STATEMENT OF FACTS

WellCare "is a North Carolina domestic corporation duly licensed as a health maintenance organization by the North Carolina Department of Insurance." WellCare Brief at unnumbered page 2. Under CMS contract H7175, effective January 1, 2020, WellCare began operating "one

or more coordinated care plans . . . including at least one [Medicare Advantage-Prescription Drug ("MA-PD")] plan[.]"[1] CMS Exhibit 1.

CMS posted the Contract Year 2022 Star Ratings in October 2021. CMS Brief at 8. WellCare received a Part C summary Star Rating of 2.5 for its contract H7175. *Id*. On February 25, 2022, CMS issued a "CORRECTIVE ACTION PLAN (CAP) REQUEST" to WellCare. WellCare Exhibit P-2.

CMS posted the Contract Year 2023 Star Ratings in October 2022. CMS Brief at 9. WellCare received a Part C summary Star Rating of 2 for its contract H7175. *Id*. On February 22, 2023, CMS issued a "CORRECTIVE ACTION PLAN (CAP) REQUEST" to WellCare. WellCare Exhibit P-3.

CMS posted the Contract Year 2024 Star Ratings in October 2023. CMS Brief at 9. WellCare received a Part C summary Star Rating of 2.5 for its contract H7175. *Id*.

By letter dated December 27, 2023, CMS issued WellCare a "Notice of Termination[2] and Intermediate Sanctions[3] (Suspension of Enrollment and Marketing) for [MA-PD] Contract Number H7175 [hereinafter "Termination Notice"]." WellCare Brief at unnumbered page 2; WellCare Exhibit P-1. Within the Termination Notice, CMS stated that it had "determined that WellCare has substantially failed to carry out its contract with CMS by failing to achieve a Part C summary Star Rating of at least three stars in three consecutive Star Rating periods for contract H7175," in violation of 42 C.F.R. § 422.504(a)(17) and Art. XI.E of the Medicare Advantage-Prescription Drug contract.[4] WellCare Exhibit P-1 at 1-3. CMS' Termination Notice states that, based on WellCare's Part C summary plan rating of less than 3 stars for 3 consecutive years, it may not only "terminate an MA organization's contract" pursuant to 42 C.F.R. § 422.510(a)(4)(xi), but also, under 42 C.F.R. § 422.752(b), "may impose intermediate sanctions" pursuant to 42 C.F.R. § 422.750(a)(1) and (3). WellCare Exhibit P-1 at 1-3.

Moreover, with regards to a corrective action plan, the Termination Notice informed:

> WellCare has been on notice of the need to improve its Part C summary Star Ratings performance since the issuance of the 2022 Star Ratings on October 6, 2021. Each year CMS provides MA-PDs with two preview periods before Star Ratings become public (see 42 C.F.R. § 422.166(h)(2)). During the preview periods, WellCare had the opportunity to review preliminary calculations and seek corrections, if necessary, to the underlying data and calculations before the Star Ratings became public. In addition, WellCare received a corrective action notice on February 25, 2022, for its 2022 Star Ratings and on February 22, 2023, for its 2023 Star Ratings. The corrective action notices informed WellCare of its Star Rating, requested that

[1] An MA-PD is a Medicare Advantage organization that offers a qualified prescription plan. An MA-PD is subject to the same Part D requirements at 42 C.F.R. Part 423 as a stand-alone Part D plan sponsor. *See* CMS Brief at 2.

[2] Effective December 31, 2024.

[3] Effective January 12, 2024.

[4] *See* CMS Exhibits 1-5 concerning Contract H7175 for 2020 through 2024.

> WellCare develop and implement a corrective action plan to improve its operations for the areas that resulted in a low Star Rating, and put WellCare on notice that its contract would be eligible for termination if it achieves a Part C Summary Star Rating of below three stars for three (3) consecutive years.
>
> Therefore, in accordance with 42 C.F.R. § 422.510(c), WellCare was provided notice of its insufficient Part C summary Star Ratings and was afforded reasonable opportunities to correct this deficiency by improving its Star Rating performance, which it failed to do.
>
> With respect to the intermediate sanctions CMS is imposing, 42 C.F.R. § 422.756(c)(3) provides that the intermediate sanctions will remain in effect until CMS is satisfied that the deficiencies that are the basis for the sanction determination have been corrected and are not likely to recur. However, in light of CMS's decision to terminate contract H7175 and its imposition of intermediate sanctions pursuant to 42 C.F.R. § 422.752(b), the intermediate sanctions at § 422.750(a)(1) and (3) will remain in effect until the contract is terminated.

Id. at 4.

By letter dated January 11, 2024, WellCare timely requested hearings to appeal the Termination and Intermediate Sanctions Notices; subsequently, the Office of Hearings assigned Docket Numbers H-24-00005 and H-24-00006 to the appeals. *See* WellCare Brief at unnumbered page 3. Following a January 19, 2024 Pre-Hearing Conference, the parties agreed to consolidate briefing for the two appeals under Docket Number H-24-00005. *See* January 19, 2024 Summary of Pre-Hearing Conference Discussion. Following WellCare's February 2, 2024 Initial Brief, CMS filed its March 5, 2024 Motion for Summary Judgment and Brief in Support Thereof, then both WellCare and CMS filed Reply Briefs on March 14, 2024, and March 25, 2024, respectively. On March 26, 2024, the parties jointly requested a record hearing, that the Hearing Officer granted on March 29, 2024.

VI. SUBSTANTIVE AUTHORITY — STAR RATINGS AND TERMINATION ACTIONS

CMS' MA Quality Rating System is a 5-star rating scale ("Star Ratings") with each MA Plan's ratings calculated and assigned for numerous purposes. *See* 42 C.F.R. § 422.160. CMS explains that one of the purposes for the Star Ratings is "[t]o provide a means to evaluate and oversee overall and specific compliance with certain regulatory and contract requirements by MA plans, where appropriate and possible to use data of the type described in § 422.162(c)." 42 C.F.R. § 422.160(b)(3).

The regulation at 42 C.F.R. § 422.162(c) describes the content of the Part C Star Ratings as follows:

> (c) *Data sources*.

(1) CMS bases Part C Star Ratings on the type of data specified in section 1852(e)[5] of the Act and on CMS administrative data. Part C Star Ratings measures reflect structure, process, and outcome indices of quality. This includes information of the following types: Clinical data, beneficiary experiences, changes in physical and mental health, benefit administration information and CMS administrative data. Data underlying Star Ratings measures may include survey data, data separately collected and used in oversight of MA plans' compliance with MA requirements, data submitted by plans, and CMS administrative data.
(2) MA organizations are required to collect, analyze, and report data that permit measurement of health outcomes and other indices of quality. MA organizations must provide unbiased, accurate, and complete quality data described in paragraph (c)(1) of this section to CMS on a timely basis as requested by CMS.

Under 42 U.S.C. § 1395w-27 (section 1857 of the Social Security Act), Congress recognized that MA plans may ultimately be terminated for failure to achieve a minimum quality rating under the 5-star rating system. The statute provides:

> *(a) In general*
> The Secretary shall not permit the election under section 1395w–21 of this title of a Medicare+Choice[6] plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w–23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.
>
> . . .
>
> (c) *Contract period and effectiveness*
> (1) Period
> Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.
> (2) Termination authority
> In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—
> (A) has failed substantially to carry out the contract;

[5] The title of section 1852(e) of the Social Security Act is "Quality Improvement Program."
[6] Effective January 1999, the Balanced Budget Act of 1997 established Part C of the Medicare Program, initially known as "Medicare+Choice." Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare+Choice was renamed "Medicare Advantage." https://www.cms.gov/medicare/enrollment-renewal/health-plans (last visited May 31, 2024).

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or
(C) no longer substantially meets the applicable conditions of this part.

. . .

(h) *Procedures for termination*
(1) In general
The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—
(A) The Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and
(B) The Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

. . .

(3) Delay in contract termination authority for plans failing to achieve minimum quality rating
During the period beginning on December 13, 2016, and through the end of plan year 2018, the Secretary may not terminate a contract under this section with respect to the offering of an MA plan by a Medicare Advantage organization solely because the MA plan has failed to achieve a minimum quality rating under the 5-star rating system under section 1395w–23(o)(4) of this title.[7]

CMS requires that a contract with an MA organization must contain a provision stating that "[t]he MA organization agrees to comply with all the applicable requirements and conditions set forth in this part [i.e., Part 422] and in general instructions." The regulatory subsection goes on to state that "[c]ompliance with the terms of this paragraph (a) is material to the performance of the MA contract." Specifically, the MA organization agrees (among other requirements)—

(17) [t]o maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in subpart D of this part. A Part C summary plan rating is calculated as provided in § 422.166.

42 C.F.R. § 422.504(a).

[7] Section (h)(3) was promulgated through the 21st Century Cures Act, Pub. L. No. 114-255, § 17001, 130 Stat. 1033, 1330 (Dec. 13, 2016). After this moratorium expired, CMS states that it "advised the regulated community that it would resume termination for poor Star Ratings." CMS Brief at 7, n.3.

Moreover, 42 C.F.R. § 422.510(a)(1)-(3) reiterates the elements listed at 42 U.S.C. § 1395w-27(c)(2)(A)-(C) regarding when an MA organization's contract may be terminated. The regulation further specifies that a Part C organization that does not meet Star Ratings requirements may be terminated as follows:

> (a) *Termination by CMS*. CMS may at any time terminate a contract if CMS determines that the MA organization meets any of the following:
> (1) Has failed substantially to carry out the contract.
> (2) Is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of this part.
> (3) No longer substantially meets the applicable conditions of this part.
> (4) CMS may make a determination under paragraph (a)(1), (2), or (3) of this section if the MA organization has **had one or more of the following occur**:
>
> . . .
>
> (xi) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years. Plan ratings issued by CMS before September 1, 2012 are not included in the calculation of the 3-year period.[8]

42 C.F.R. § 422.510(a)(1)-(4)(xi) (emphasis added).

Further, when CMS determines to terminate an MA organization's contract, the regulations require that

> (i) Before providing a notice of intent to terminate the contract, CMS will provide the MA organization with notice specifying the MA organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies.
> (ii) The MA organization is solely responsible for the identification, development, and implementation of its corrective action plan and for demonstrating to CMS that the underlying deficiencies have been corrected within the time period specified in the notice requesting corrective action.

42 C.F.R. § 422.510(c).

Within the "Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes" Final Rule, CMS explained the development of the 5-star rating system and its use as a basis for termination actions:

[8] *See* 79 Fed. Reg. 29844, 29959 (May 23, 2014); 81 Fed. Reg. 80557 (Nov. 15, 2016); 83 Fed. Reg. 16734 (Apr. 16, 2018); 88 Fed. Reg. 22334 (Apr. 12, 2023).

> We have previously issued guidance (for example, CY 2012 Call Letter, page 119, issued April 4, 2011) to MA organizations and Part D sponsors indicating that we considered organizations with 3 consecutive years of less than 3-star Plan Ratings to be out of compliance with Medicare program requirements. We stated there that organizations with such a Plan Rating history should expect that, prior to initiating a termination action, we would confirm that the data used to calculate the Plan Ratings did reflect an organization's substantial failure to comply with Part C or D requirements. In essence, we noted that poor Plan Rating scores were a strong indication, but not conclusive evidence, of substantial non-compliance. In applying that policy, we include Plan Ratings issued in years prior to the issuance of the guidance to identify organizations whose performance may warrant contract termination.
>
> With the elevation of low Plan Ratings from the status of likely indicator to conclusive evidence of substantial non-compliance, we believe that the use of prospective Plan Ratings is more appropriate in our application of this authority.
>
> . . .
>
> While the plan ratings were originally developed by CMS as a beneficiary comparison tool, and Congress has authorized the awarding of bonus payments based on plan rating performance, those facts do not preclude the use of plan ratings as an indicator of contract compliance. To the extent that the ratings provide reliable evidence of compliance with program requirements, they may be used as a basis for contract termination. Our preamble discussion in the proposed rule and this final rule with comment period describes the connections between each plan measure and a Part C or D requirement, noting that the measures are an effective tool for capturing information on the effectiveness of a sponsor's administrative and management arrangements as opposed to whether the arrangements are merely in place. Thus, a sponsor's failure to meet minimal performance thresholds for 3 straight years can reasonably be said to be evidence of substantial failure to meet contract requirements.
>
> . . .
>
> Our use of low plan ratings as a basis for contract termination does not relieve us of our obligation to prove at least one of the three statutory bases for termination. Rather, the plan ratings are a tool that we will use to establish, consistent with the Part C and D statutes, that a sponsor has substantially failed to meet the requirements of its Part C or D contract. As noted previously and in the proposed rule, the data used to calculate the plan ratings are derived directly from a sponsor's performance of its Medicare program obligations.

77 Fed. Reg. 22072, 22111-13 (Apr. 12, 2012).

The regulation at 42 C.F.R. § 422.752 provides the bases for CMS' imposition of intermediate sanctions. Specifically, the regulation at 42 C.F.R. § 422.752(b) states that "[i]f CMS makes a

determination that could lead to a contract termination under § 422.510(a), CMS may impose intermediate sanctions at § 422.750(a)(1) and (3)." The intermediate sanction listed at 42 C.F.R. § 422.750(a)(1) involves the "[s]uspension of the MA organization's enrollment of Medicare beneficiaries[,]" while the sanction at 42 C.F.R. § 422.750(a)(3) concerns the "[s]uspension of communication activities to Medicare beneficiaries by an MA organization, as defined by CMS."

VII. PROCEDURAL AUTHORITY- RIGHT TO HEARING/MOTION FOR SUMMARY JUDGMENT

MA-PD organizations receiving a notice of intent to terminate and/or a notice of intermediate sanctions have a right to a hearing under 42 C.F.R. Subpart N of Parts 422; 42 C.F.R. § 422.510(d); 42 C.F.R. § 422.756(b). MA-PD plans have "the burden of proving by a preponderance of the evidence that CMS' determination was inconsistent" with the applicable regulatory requirements upon which CMS' determination was based. 42 C.F.R. § 422.660(b). The regulation at 42 C.F.R. § 422.684(b) provides that either party may request that the Hearing Officer rule on a motion for summary judgment.[9] Moreover, 42 C.F.R. § 422.688 specifies that "[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."

VIII. DISCUSSION AND ANALYSIS

The Hearing Officer grants CMS' Motion for Summary Judgment. There are no material facts in dispute, rather, WellCare presents legal arguments regarding its interpretation of the controlling legal authority with respect to CMS' notice requirements as well as additional policy-related contentions that are beyond the scope of the Hearing Officer's authority. It is undisputed that WellCare received Star Ratings of less than three stars for contract years 2022, 2023, and 2024. CMS accordingly concluded that WellCare failed to substantially carry out the terms of its contract "by failing to achieve a Part C summary Star Rating of at least three stars in three consecutive Star Rating periods." WellCare Exhibit P-1 at 1. As support, CMS cited the regulations at 42 C.F.R. §§ 422.504(a)(17), 422.510(a)(4)(xi), and Article XI.E of the MA-PD contract. In addition, pursuant to its authority under 42 C.F.R. § 422.752(b), CMS exercised its discretion to impose intermediate sanctions against WellCare. The Hearing Officer finds that CMS' determinations and actions were justified and consistent with the plain language of the controlling legal authority. Accordingly, WellCare did not establish by a preponderance of the evidence that CMS' decisions to terminate contract H7175 and impose intermediate sanctions were inconsistent with the controlling authority. 42 C.F.R. § 422.660(b).

WellCare argues that contrary to Medicare regulations and the statutory requirements, CMS failed to provide WellCare with the required opportunity to develop and implement a Corrective Action Plan ("CAP"). WellCare Brief at unnumbered pages 4-5. WellCare asserts that the "regulation at 42 C.F.R. § 422.510(c)(1)(i) is clear as to the process CMS must follow and the right that was to

[9] *See* 72 Fed. Reg. 68700, 68714 (Dec. 5, 2007) ("Where no factual dispute exists, the hearing officer may make a decision on the papers, without the need for a hearing.")

be afforded WellCare before CMS could issue the [Termination] Determination." WellCare Reply Brief at 1. Specifically, WellCare states that

> [t]he language of §422.510(c)(1)(i) is clear: when CMS intends to terminate a contract, it must first provide the Medicare Advantage organization ("MAO") with a notice that specifies the MAO's deficiencies that are the basis for CMS's intent to terminate and a reasonable opportunity of at least 30 calendar days to develop and implement a [CAP] to correct those deficiencies.

Id. at 2.

WellCare asserts that, with respect to the Star Rating years involved with this appeal CMS' February 25, 2022, and February 22, 2023 CAP requests were routine deficiency notices[10] "that cannot and do not replace the statutorily mandated opportunity to develop and implement a [CAP]" prior to termination." WellCare Brief at unnumbered page 6. WellCare argues that these deficiency notices "explicitly told WellCare that no [CAP] was required[,]" specifically stating that "CMS is not requiring a CAP submission from your organization." *Id*. Thus, WellCare states that it was "never put on notice that a CAP was required to avoid termination or that CMS's prior deficiency notices would satisfy CMS's obligation to afford WellCare an opportunity to develop a CAP prior to issuing notice of termination." *Id*. WellCare states that had CMS issued a notice of deficiencies and given it 30 days to develop and implement a CAP before issuing the termination notice, "WellCare would have shown that it is correcting the deficiencies as evidenced by the fact that the Contract is projected to have a 3-star rating for both Part C and part D for contract year 2025." *Id*. at unnumbered page 7.

CMS asserts that its February 25, 2022, and February 22, 2023 CAP requests comport "with the statutory and regulatory provisions that WellCare be provided with a reasonable opportunity of at least 30 days to develop and implement a [CAP] to correct deficiencies prior to termination." CMS Brief at 17. CMS argues that "[t]here is no regulatory requirement that the CAP requests provide a notice of intent to terminate the contract[,]" just that "before providing a notice of intent to terminate the contract[,] CMS will provide the MAO organization: (1) notice specifying the MA organization's deficiencies and (2) a reasonable opportunity of at least 30 calendar days to develop and implement a [CAP] to correct the deficiencies." CMS Reply at 1-2 (emphasis and internal quotation marks omitted); *see* 42 C.F.R. § 422.510(c)(1)(i). CMS asserts that "[b]efore [it] issued the notice of intent to terminate contract H7175 on December 27, 2023, CMS issued two CAP requests to WellCare." *Id*. at 2 (emphasis omitted). Moreover, CMS asserts that

> [t]o the extent MAOs do not improve their performance by achieving at least a 3-star rating by the third year, the MAOs "have demonstrated that they have substantially failed to meet the requirements of the Part C and D programs and failed to take timely and effective correction action.

CMS Brief at 17 (quoting 77 Fed. Reg. at 22074) (emphasis omitted).

[10] *See* WellCare Exhibits P-2 and P-3.

CMS further explains that "by the third year of poor ratings, the regulatory scheme contemplates that the opportunity for corrective action had already been provided but the MAO's performance did not improve enough to bring its contract into compliance with Part C program requirements." CMS Brief at 17. CMS argues that "[a]n MAO's third consecutive year of poor performance does not suddenly present 'a deficiency' that is amenable to corrective action[,]" and that "WellCare's argument amounts to an attempt to require CMS to provide WellCare a fourth year to improve its Star Ratings." CMS Reply at 4.

In support of its assertion that WellCare had sufficient notice and opportunity to develop and implement a CAP prior to termination, CMS points to the specific language in the CAP requests that CMS issued to WellCare on February 25, 2022 (concerning WellCare's 2022 Part C Summary Ratings), and February 22, 2023 (concerning WellCare's 2023 Part C Summary Ratings). *See* CMS Brief at 14-15; WellCare Exhibits P-2, P-3.

Within the February 25, 2022 CAP Request, CMS informs

> CMS advises your organization to take steps to improve its operations in the areas identified above and bring its Summary Star Rating(s) to a level that indicates at least average contract performance, compliant with Medicare requirements. CMS is not requiring a CAP submission from your organization. CMS will simply look at your organization's star rating performance in the coming year to determine whether you took the necessary corrective action to achieve at least a three-star summary rating.
>
> Section 17001(b) of the 21st Century Cures Act, enacted in December 2016, prohibited CMS from terminating MA organization contracts based on low Star Ratings through December 31, 2018. With the expiration of this prohibition, CMS announced in a February 6, 2019, Health Plan Management System (HPMS) memorandum that the next contracts eligible for termination would be those with low CY 2020, 2021, and 2022 Star Ratings.

WellCare Exhibit P-2 at 2 (emphasis omitted).

Within the February 22, 2023 CAP Request, CMS includes the same language in the first paragraph quoted immediately *supra*, while also providing the following warning:

> Please be advised that pursuant to 42 C.F.R. § 422.510(a)(4)(xi), your organization will be eligible for termination if it achieves a Part C Summary Star Rating of below three stars for three (3) consecutive years.

WellCare Exhibit P-3 at 2.

The Hearing Officer notes that WellCare does not argue that its 2022, 2023, and 2024, Part C Summary Star Ratings were incorrect. Instead, WellCare asserts that CMS failed to provide it "the formal notice and opportunity to develop and implement a [CAP] before issuing the termination notice, in violation of 42 C.F.R. § 422.510(c)(1)(i)." WellCare Brief at unnumbered page 6. WellCare argues that if it had been given 30 days to implement a CAP, it would have shown that

it was correcting the cited deficiencies and is projected to have a 3-star rating for contract year 2025. *Id*. at unnumbered page 7. The Hearing Officer notes, however, that in addition to the specific warnings within the February 25, 2022, and February 22, 2023 CAP requests issued to WellCare (summarized above), CMS states that, for some time, MA organizations have been on notice of CMS' intent to terminate Part C contracts "that fail to achieve at least a 3-star plan rating for 3 consecutive years." CMS Brief at 7. Specifically, CMS points to notice and comment rulemaking in 2012 and 2020, and to its "Note to: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties," dated April 4, 2014, and its notification titled "End of Moratorium on Authority to Terminate Medicare Advantage Organization Contracts Based on Low Star Ratings" dated February 6, 2019. *See* 77 Fed. Reg at 22074, 22111; 85 Fed. Reg. 19230, 19270 (April 6, 2020); CMS Exhibit 9 at 57; CMS Exhibit 10 at 1.

In addition, the Hearing Officer observes that the activity and data that CMS used to calculate WellCare's Star Ratings for contract years 2022, 2023 and 2024 cannot, at this point in time,[11] be "undone" as the Star Ratings are based on historical information from past years.[12] Although WellCare may take steps to try to raise its Star Rating and avoid receiving CAP requests in the future, the Hearing Officer finds that it is impossible to take remedial steps to "undo" the past and more specifically, "undo" the prior three consecutive years of summary Star Ratings below a "3." Accordingly, the Hearing Officer finds that WellCare was provided adequate notice that its failure to improve its Star Ratings would lead to termination and upholds CMS' determination.

WellCare proffers additional arguments in support of its position. Specifically, with respect to the imposition of intermediate sanctions, WellCare argues that "[d]espite identical bases for termination, CMS imposed marketing and enrollment sanctions on WellCare" but did not do the same to a similarly situated MA-PD plan that was terminated last year. WellCare Brief at unnumbered page 8. WellCare states that "CMS has engaged in disparate treatment of WellCare" and the other MA-PD plan, without "provid[ing] a reasoned explanation or justification for doing so, [thus] imposing intermediate sanctions on WellCare is arbitrary and capricious." *Id*.

In response, CMS argues that it has discretion to enforce or not enforce a remedy and that it may "take into account the facts and circumstances of each contract determination and decide[s] which sanctions to impose." CMS Brief at 13. CMS states that "[i]t is undisputed that CMS had a basis [in the present case] to impose intermediate sanctions under the applicable regulations." *Id*. at 14. The Hearing Officer agrees and finds that whether CMS properly exercised its discretion when deciding whether to impose intermediate sanctions against a similarly situated Plan and/or whether CMS accordingly engaged in disparate treatment is neither the subject of the instant appeals nor within the jurisdiction of the Hearing Officer. *See* 42 C.F.R. §§ 422.660 and 668.

Next, WellCare argues that due to the public health emergency in 2020 (the first year that the WellCare contract H7175 operated), CMS should have afforded WellCare the same 2022 Star Ratings protective "steps" that CMS afforded to other plans that had been in operation prior to

[11] CMS explains that "[e]ach year, CMS . . . offers [MA organizations] two preview periods to review their data and the methodology relevant to calculating their Part C summary Star Ratings, as well as each underlying metric used for the Star Ratings, before the ratings become public." CMS Brief at 5.

[12] *See* note 2, *supra*.

2020.[13] WellCare Brief at unnumbered pages 9-11. To do so, WellCare asserts that "CMS should drop WellCare's 2022 Star Rating altogether and provide an additional year for WellCare to establish . . . performance in the post-pandemic world." *Id*. at unnumbered page 11.

CMS responds that "WellCare is essentially requesting that the CMS Hearing Officer waive WellCare's 2022 Star Ratings due to the COVID-19 pandemic," and that the Hearing Officer "cannot waive the applicable regulatory requirements[.]" CMS Brief at 19. The Hearing Officer agrees and finds that the relief that WellCare requests is outside the scope of the Hearing Officer's jurisdiction. *See* 42 C.F.R. §§ 422.660 and 668.

Finally, WellCare also argues that "[t]erminating H7175 would reduce the number of [Preferred Provider Organization] offerings in a state service area that is dominated by [Health Maintenance Organization] plans and impair health equity for the minority and chronically ill beneficiaries currently enrolled under the Contract." WellCare Brief at unnumbered page 1. In response, CMS argues that "the termination of contract H7175 will not result in harm to [Medicare] beneficiaries or undermine CMS' health equity goals." CMS Brief at 22-23. Regardless, the Hearing Officer does not have the authority to consider this policy-related request for relief. *See* 42 C.F.R. §§ 422.660 and 668.

IX. ORDER

The Hearing Officer grants CMS' MSJ. The Hearing Officer upholds CMS' December 27, 2023 decision to terminate and impose intermediate sanctions on WellCare's contract number H7175.

Amanda S. Costabile -S

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Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: May 31, 2024

[13] WellCare explains that in response to the federal government's 2020 COVID-19 public health emergency ("PHE") declarations and specific to the 2022 Star Ratings, "CMS took several steps to protect [MA organizations] that had been in operation prior to 2020 from decreases in their 2022 Star Ratings in light of the anticipated decline in 'performance during the 2020 measurement period . . . for plans across the nation.' The steps CMS took were to: (i) delay implementation of the guardrails so that cut points could change by more than five percentage points if national performance declines as a result of the COVID-19 PHE; and (ii) expand the existing hold-harmless protections for application of Part C and D Improvement measures to include all preexisting contracts for 2022 Star Ratings." WellCare Brief at unnumbered pages 9-10 ("guardrails" and "cut points" are defined within WellCare footnotes 25 and 26 on unnumbered page 10 of its Brief).