



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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August 29, 2024

VIA ELECTRONIC DELIVERY

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RE: Hearing Officer Decision
Hearing Officer Docket Number: H-24-00019
Medicare Advantage/Prescription Drug Plan Contract Denial
Blue Cross Blue Shield of Michigan, Contract Number: H9529

Dear Mr. Wanerman 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**

**WYOBLUE ADVANTAGE, INC.,
Contract No. H9529**

Petitioner

v.

**CENTERS FOR MEDICARE & MEDICAID
SERVICES,**

Respondent

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**CMS Hearing Officer Case No.:
H-24-00019**

**Denial of Application for
Medicare Advantage /Medicare
Advantage – Prescription Drug
Plan**

HEARING OFFICER DECISION

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I. FILINGS

- a) May 29, 2024 WyoBlue Advantage, Inc. (“WyoBlue”) Hearing Request on Centers for Medicare & Medicaid Services’ (“CMS”) Initial Application Denial;
- b) June 6, 2024 WyoBlue’s Brief in Support of its Appeal of CMS’ Denial of Applicant’s Medicare Advantage Application (“Plan Brief”) and Exhibits P-1 through P-26;
- c) June 13, 2024 CMS’ Memorandum and Motion for Summary Judgment (“Motion for Summary Judgement” or “MSJ”) Supporting CMS’ Denial of WyoBlue’s Application for a Medicare Advantage Prescription Drug Plan (“MA-PD”)
- d) Contract (H9529) for Contract Year 2025 and Exhibits C-1 through C-7;
- e) June 20, 2024 WyoBlue’s Reply Brief;
- f) July 29, 2024 CMS’ Urology Network Exhibits 1 through 14;
- g) July 29, 2024 CMS’ Additional Exhibit C-1; and
- h) August 2, 2024 WyoBlue’s Motion to Strike CMS’ Proposed Exhibit.

II. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. §§ 422.660 and 423.650. The CMS Hearing Officers designated to hear this case are the undersigned, Amanda S. Costabile and Benjamin R. Cohen.

III. ISSUE

Whether CMS’ denial of WyoBlue’s application for an MA/MA-PD contract (Contract No. H9529), based on WyoBlue’s failure to meet CMS’ provider network adequacy requirements and Letter of Intent (“LOI”) deficiencies, was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officers find that by omitting specific providers within the applicable group-level LOI matrix for Banner Health, WyoBlue failed to submit its LOIs associated with its application’s networks in Natrona, Platte, Goshen and Washakie Counties, in the form and manner that CMS requires. 42 C.F.R. § 422.116(d)(7); 42 C.F.R. § 422.501(c)(1); CMS Exhibit C-7. Accordingly, WyoBlue has not proven by a preponderance of evidence that CMS’ denial of its initial application for Contract No. H9529 was inconsistent with the applicable regulatory requirements. 42 C.F.R. § 422.660(b)(1).

While the Hearing Officers uphold CMS’ decision to deny the application as a whole based upon the issue relating to the LOIs, the Hearing Officers would otherwise sustain WyoBlue’s request to withdraw Laramie and Park Counties. The Hearing Officers find that CMS’ exception request disposition report’s comment for WyoBlue’s Laramie County urology exception request, coupled with CMS’ communications relating to both the deadline to withdraw counties and the ability to continue to negotiate contracts, created a lack of clarity regarding the deadline by which an applicant must withdraw a county from its application.

In addition, the Hearing Officers find that WyoBlue’s *Allina*-based challenge and policy-related requests for relief are outside the scope of the Hearing Officers’ authority under 42 C.F.R. § 422.688.

V. LEGAL AUTHORITIES

A. APPLICATION REVIEW

Under Title XVIII of the Social Security Act (“the Act”) (codified at 42 U.S.C. §§ 1395-1395III), 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, 1395w-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) (emphasis added). CMS requires an entity seeking to contract as an MA organization to submit an application through the Health Plan Management System (“HPMS”).¹ See “Part C-Medicare Advantage and 1876 Cost Plan Expansion Application” at <https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf> (last visited June 25, 2024). 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. § 422.501 sets forth the application requirements for entities that seek a contract as an MA organization offering an MA plan and additional application requirements for MA organizations seeking to offer a Specialized MA plan for Special Needs Individuals. Among other requirements, applicants must provide documentation of appropriate state licensure, demonstrate that they are licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits, and submit a properly executed CMS State Certification Form. See also 42 C.F.R. § 422.400; “Part C-Medicare Advantage and 1876 Cost Plan Expansion Application” at <https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf> (last visited June 25, 2024).

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 by using information from a current or prior contract (i.e., any relevant past performance history associated with the applicant). 42 C.F.R. §§ 422.502(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 to Deny (“NOID”). 42 C.F.R. § 422.502(c)(2). Pursuant to 42 C.F.R. § 422.502(c)(2)(ii), the applicant will have ten days from the NOID to respond in writing to correct deficiencies in the application.

¹ HPMS is the primary information collection vehicle within which MA organizations will communicate with CMS during the application process, bid submission process, ongoing operations of the MA program, reporting and oversight activities. <https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf> at 6.

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 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. 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 Act] and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act.”²

B. NETWORK ADEQUACY REQUIREMENTS AND REVIEW

An applicant for a new or 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. Within its application, an MA organization must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet the 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/Network Management Module (“NMM”). CMS Memorandum and MSJ at 3; “Part C-Medicare Advantage and 1876 Cost Plan Expansion Application” at <https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf> at 27 (last visited June 25, 2024). 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 new or 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 <https://www.cms.gov/files/document/medicare-advantage-and-section-1876->

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 as part of the hearing would, in effect, extend the deadline for submitting an approvable application.

75 Fed. Reg. 19678, 19683 (Apr. 15, 2010).

[cost-plan-network-adequacy-guidance12-12-2023.pdf](#) at 2 (last updated December 12, 2023) (hereinafter “Network Adequacy Guidance ”). An applicant for a new or expanding service area receives a 10-percentage point credit towards the percentage of beneficiaries residing within the published time and distance standards for the contracted network in the pending service area, at the time of application and for the duration of the application review. In addition, applicants may use an LOI signed by both the MA organization and the provider or facility with which the MA organization has started or intends to negotiate, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. **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 in the form and manner directed by CMS.** 42 C.F.R. § 422.116(d)(7) (emphasis added).

Beginning with Calendar Year 2025 applications, if an applicant utilizes “group practice LOIs to meet network standards, **applicants must upload one LOI for the group practice and identify the individual providers that are included under the group practice.**” CMS Exhibit C-7 at 2 (emphasis added). The memorandum states that “[a]pplicants must use the ‘MA LOI Group-to-NPI Matrix Template’ to identify the individual providers under the group practice LOI.” *Id.* (emphasis added).

The regulatory subsections 42 C.F.R. § 422.116(b)(1)-(2) list 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.” Network Adequacy Guidance at 2. CMS explains that it programs network adequacy criteria into the 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. As set forth under 42 C.F.R. § 422.116(a)(4), CMS annually updates and makes available the following reference files:

- (i) A Health Service Delivery (HSD) Reference file that identifies the following:
 - (A) All minimum provider and facility number requirements [and]
 - (B) All provider and facility time and distance standards.
 - ...
- (ii) A Provider Supply file that lists available providers and facilities and their corresponding office locations and specialty types.

CMS further describes its reference “Provider and Facility Supply File” as follows:

The supply file is a cross-sectional database that includes information on provider and facility name, address, [NPI], 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. . . .

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.

CMS states that the HPMS automated tool “generates two reports (called the Automated Criteria Check (ACC) Provider and Facility), that shows whether a provider in a given county is passing the network adequacy requirements.” CMS Memorandum and MSJ at 4. CMS asserts that “[t]he ACC reports are accessible within HPMS to reflect where the applicant stands with respect to meeting the standardized criteria.” *Id.*

C. EXCEPTION REQUEST PROCESS AND REVIEW

Under specific circumstances and rules, CMS permits applicants that are unable to satisfy network adequacy criteria to submit exception requests. 42 C.F.R. § 422.116(f); *see* Network Adequacy Guidance at 4-5. Specifically, an applicant may request an exception to network adequacy criteria when both of the following occur:

- (A) [c]ertain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; and
- (B) [t]he 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.

42 C.F.R. § 422.116(f)(1)(A)-(B).

When manually reviewing exception requests, CMS considers whether

- (i) [t]he current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

- (ii) [t]here 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) [a]pproval of the exception is in the best interests of beneficiaries.

42 C.F.R. § 422.116(f)(2)(i)-(iii); CMS Memorandum and MSJ at 4.

Moreover, 42 C.F.R. § 422.112(a)(10)(v) provides as follows:

- (10) *Prevailing patterns of community health care delivery.* MA plans that meet Medicare access and availability requirements through direct contracting network providers must do so consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed MA plan health care delivery network include, but are not limited to the following:

...

- (v) Other factors that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area.

CMS provides additional information and instruction regarding exception requests within its Network Adequacy Guidance. Specifically, CMS informs that

[t]he organization must include conclusive evidence in its exception request that the CMS network adequacy criteria cannot be met because of changes to the availability of providers/facilities, resulting in insufficient supply. The organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnishes enrollees with adequate access to covered services and is consistent with or better than the Original Medicare pattern of care for a given county and specialty type.

Network Adequacy Guidance at 5.

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

Of note, the Network Adequacy Guidance states that CMS “will generally not accept an organization’s assertion that it cannot meet current CMS network adequacy criteria because of an ‘inability to contract,’ meaning they could not successfully negotiate and establish a contract with a provider/facility.” *Id.* at 7.

Additionally, CMS provides specific guidance regarding how it requires a rationale to be submitted. For example, with respect to the rationale that a provider does not contract with any organization, CMS instructs that

[o]n the exception request, from the “Reason for Not Contracting” drop-down list, an organization could select either “Provider does not contract with any organization” or “Other” if the provider/facility contracts exclusively with another organization. The organization must provide evidence in the “Additional Notes on Reason for Not Contracting” field.

Id. at 5.

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 14, 2024,³ WyoBlue submitted a Calendar Year 2025 initial application under Contract Number H9529, in order to offer MA “services in multiple counties in the rural state of Wyoming.” CMS Memorandum and MSJ at 5; Plan Brief and MSJ at 1.

Following submission of the application and CMS’ subsequent review, CMS issued WyoBlue a March 19, 2024 Deficiency Notice in which CMS noted, among other deficiencies not pertinent to the instant appeal, deficiencies related to network adequacy for both the provider and the facility HSD tables. CMS Exhibit C-1 at pdf pgs. 1-2. On April 2, 2024, in response to the Deficiency Notice, WyoBlue submitted a revised network adequacy HSD table and “provider network exception requests for Laramie County covering Gastroenterology, Ophthalmology, and Urology, and with respect to its network for Park County, an exception request for plastic surgery.” Plan Brief and MSJ at 3.

Following a review of the curing materials, on April 16, 2024, CMS issued WyoBlue a NOID in which CMS “denied one or more of [WyoBlue’s] Exception Requests[,]” cited network adequacy deficiencies for both WyoBlue’s provider and facility tables, and stated that WyoBlue “failed to upload a document for review” with respect to its LOIs. Exhibit C-1 at pdf pg. 4. The NOID contained the following instruction:

You must cure all deficiencies listed above in order to receive approval on your Part C - MA application. You have ten (10) days after the date of this notice to submit materials that cure the identified deficiencies in accordance with 42 CFR 422.502(c)(2). CMS opened the Health Plan Management System (HPMS) gates so you can make changes to your application. You must submit all changes in HPMS and hit Final Submit no later than 04/26/2024 8:00:00 PM Eastern.

...

³ Within CMS’ Memorandum and MSJ, CMS lists the application date as “February 14, 2023.” The Hearing Officer notes that the Calendar Year 2025 MA-PD applications were due on February 14, 2024. *See* CMS Exhibit C-3.

You have the option to withdraw or reduce the service area of your pending application. . . . You must . . . follow the instructions below to request that CMS remove pending counties from the service area you proposed in your application:

1. You must submit your request as a PDF attachment in an email to <https://dmao.lmi.org/dmaomailbox>. . . . The PDF document must:

. . .

- Be received **no later than May 10, 2024, 8:00 PM ET**.

Id. at pdf pg. 5 (emphasis added).

In response, “WyoBlue submitted⁴ revised exception requests for the three Laramie County exceptions and the one Park County exception [and] the LOI Excel spreadsheet matrix for the Banner Provider Group and the associated LOIs.” Plan Brief and MSJ at 4. WyoBlue explained that it “inadvertently omitted the names of two providers from the Banner Provider Group LOI matrix[;] [t]hus, there were two providers⁵ listed on [WyoBlue’s] HSD table as being under an LOI that were not cross-walked to the Banner Provider Group LOI matrix[.]” *Id.*

WyoBlue emailed the Division of Medicare Advantage Operations (“DMAO”) mailbox on May 2, 2024, using the subject “Network Adequacy Inquiry and Plan request for discussion.” Plan Exhibit P-12 at 1. Within the email, WyoBlue provided a detailed explanation regarding its attempts to achieve network adequacy in Laramie County with respect to gastroenterology, ophthalmology and urology. *Id.* at 1-2. WyoBlue concluded its email with an “Additional Plan Inquiry: If plans have counties within their service area that are in a pending CMS response status for exception requests, will the plan’s entire application be denied for not removing the counties by the 5/10 deadline?” *Id.* at 2.

Later, on May 2, 2024, CMS responded with the following message:

[A]pplicants have until 8 PM ET tonight to submit Exception Requests when they meet the requirements under 422.116[(f)](1).

CMS will not consider Exception Requests submitted through the DMAO portal.

Per the regulation at 42 CFR 422.116(a)(1)(ii), an applicant for a new or expanding service area must demonstrate compliance with the network adequacy standards under 422.116 as part of its application for a new or expanding service area and CMS may deny an application on the basis of an evaluation of the applicant’s network for the new or expanding service area.

⁴ WyoBlue states that it submitted these materials “[p]rior to the April 26th deadline[.]” Plan Brief and MSJ at 4. CMS does not contest this statement.

⁵ One of the providers is “a pulmonologist serving Natrona County and the other a primary care provider serving Platte, Goshen, and Washakie Counties.” *Id.* at 4-5.

As a reminder, **applicants have until May 10th** to remove any pending counties from their application. However, applicants with pending Exception Request dispositions related to their network adequacy deficiencies may withdraw their pending service areas in advance of final dispositions.

Plan Exhibit P-13 at 1 (emphasis added).

On May 10, 2024, CMS emailed the following information:

The final exception review submission results for Contract Year (CY) 2025 applications are available to view in the Network Management Module [("NMM")] via the Automated Criteria Check (ACC) Reports link (under Reports).

...

[Please note that the results of [LOIs] submitted in response to the [NOID] will be available to view on May 11, 2024.

Additionally, we want to remind you that you have the option to remove any failing counties from your pending service area by **3:00 pm EDT on May 13, 2024**.

Plan Exhibit P-16 at 1; *see* CMS Memorandum and MSJ at 6.

The NMM revealed that CMS denied “four of WyoBlue’s exception requests—three for Laramie County and the one for Park County.” *See* Plan Exhibit P-26 at 4. Specifically with respect to WyoBlue’s Laramie County urology exception request, CMS stated, within the column titled “Exception Review Deficiency Detail”:

EXC-U2: CMS identified numerous available provider(s)/facility(ies) within the criteria, for example:

[list of five provider names and addresses]

EXC-U8: Your interim contracting rationale for the following provider(s)/facility(ies) is invalid. **However, you may continue to negotiate your contract(s) and add the provider(s)/facility(ies) to your HSD table once the contract(s) are fully executed.**

[list of identical provider names and addresses as immediately indicated *supra*]

CMS Network Exhibit 3 (emphasis added).

On May 13, 2024, WyoBlue requested to withdraw Lincoln, Sublette, and Teton counties from its application. Transcript (“Tr.”) at 40; CMS Memorandum and MSJ at 6.⁶

⁶ Within its Brief, CMS incorrectly states that WyoBlue requested to drop 23 counties from its application.

On May 15, 2024, CMS issued an application Denial Letter to WyoBlue, citing the following deficiencies:

- Exception Request Status—We denied one or more of your Exception Requests, please refer to HSD Submission Reports (available in HPMS), including the Exception Report for further details on the status of your submission.
- MA Provider Table—NMM Review—Based upon the automated review of your MA Provider Table, CMS has found that your contracted network of providers does not meet CMS network standards. Refer to HSD Submission Reports (available in HPMS), including the Automated Criteria Check (ACC) Report for Providers, for further details on the status of your submission.
- MA Letters of Intent—NMM Review—You uploaded information that does not support your attestation. Please refer to HSD Submission Reports (available in HPMS), including the LOI Results Report for further details on the status of your submission.

CMS Exhibit C-1 at pdf pg. 7.

On May 29, 2024, WyoBlue timely requested a hearing. WyoBlue filed its Brief and Motion for Summary Judgment on June 6, 2024, and CMS filed its responsive Memorandum and Motion for Summary Judgment on June 13, 2024. The Petitioner filed its Reply Brief on June 20, 2024. On June 21, 2024, the Hearing Officer postponed the June 27, 2024 hearing as both parties stated that there are no material facts in dispute. CMS Memorandum and MSJ at 1; Plan Reply Brief at 2.

Following review of the record and the parties' submissions, the Hearing Officers denied the parties' respective Motions for Summary Judgment and rescheduled the hearing for August 5, 2024. A hearing was held on August 5, 2024. WyoBlue was represented by Robert Wanerman, Esq., and Helaine Fingold, Esq., of Epstein, Baker and Green; and CMS was represented by Amber Casserly and Erica Sontag.

VII. DISCUSSION AND ANALYSIS

A. OVERVIEW

The Hearing Officers find that by omitting specific providers within the applicable group-level LOI matrix for Banner Health, WyoBlue failed to submit its LOIs associated with its application's networks in Natrona, Platte, Goshen and Washakie Counties, in the form and manner that CMS requires. 42 C.F.R. § 422.116(d)(7); 42 C.F.R. § 422.501(c)(1); CMS Exhibit C-7.⁷ Accordingly,

⁷ Although WyoBlue claims that CMS allowed a post-denial letter curing opportunity to applicants with LOI deficiencies during the 2024 application cycle, the Hearing Officers find that whether CMS allowed a curing opportunity in a prior year application cycle is not part of the Hearing Officer's reviewing authority for WyoBlue's 2025 application cycle appeal. See 42 C.F.R. § 422.688.

WyoBlue has not proven by a preponderance of the evidence that CMS' denial of its initial application for Contract No. H9529 was inconsistent with the applicable regulatory requirements. 42 C.F.R. § 422.660(b)(1).

While the Hearing Officers uphold CMS' decision to deny the application as a whole based upon the issue relating to the LOIs, the Hearing Officers would otherwise sustain WyoBlue's request to withdraw Laramie and Park Counties.⁸ The Hearing Officers find that CMS' exception request disposition report comment for WyoBlue's Laramie County urology exception request coupled with CMS' communications relating to both the deadline to withdraw counties and the ability to continue to negotiate contracts, created a lack of clarity regarding the deadline by which an applicant must withdraw a county from its application.

In addition, the Hearing Officers find that WyoBlue's *Allina*-based challenge and policy-related requests for relief are outside the scope of the Hearing Officers' authority under 42 C.F.R. § 422.688.

B. WYOBLUE'S EXCEPTION REQUESTS

WyoBlue argues that "[b]ased on the lack of clarity in CMS' guidance on whether an application could move forward with unresolved exception requests . . . CMS should allow [WyoBlue] to drop the two counties in question and approve H9529 with the remaining eighteen counties." Plan Brief and MSJ at 1. With respect to CMS' deadline to drop counties from an application, WyoBlue explains that

[i]n the [NOID], CMS informs WyoBlue that it must submit changes to cure the deficiencies in the application by **April 26, 2024** and that WyoBlue had the "option" to withdraw or reduce its requested service area no later than **May 10, 2024**. However, in its May 2, 2024 email response to the Applicant's question on the need to drop counties with unresolved exception requests,⁹ CMS says that applicants had until 8pm that night, **May 2, 2024**, to submit exception requests, clearly beyond the April 26, 2024 date CMS had previously stated as the deadline for curing application deficiencies. . . .

⁸ As the Hearing Officers find that the county withdrawal deadline date was unclear, the Hearing Officers do not need to reach a decision regarding WyoBlue's argument, with respect to CMS denying WyoBlue's request to "drop Laramie and Park Counties" from its application after CMS issued Denial Letters, as to whether "CMS, by guidance or emails alone, can establish a deadline by which applicants must demonstrate compliance with network adequacy requirements." Tr. at 9; see Plan Brief and MSJ at 7. Nevertheless, the Hearing Officers find that CMS' authority, under 42 C.F.R. § 422.116(a)(1)(ii), to deny an application based on the evaluation of an applicant's network for a new or expanding service area; CMS' authority, under 42 C.F.R. § 422.501(c)(1), to require an applicant to complete an application in "the form and manner required by CMS"; and CMS' authority under 42 C.F.R. § 422.502(c) to determine the timelines within which CMS notifies applicants of CMS' determination and the basis for the determination; provides CMS with the necessary discretion to set deadlines during the application process.

⁹ Within the May 2, 2024 email, WyoBlue asked "[i]f plans have counties within their service area that are in a pending CMS response status for exception requests, will the plan's entire application be denied for not removing the counties by the 5/10 deadline?" Plan Exhibit P-12 at 2.

On **May 10, 2024**, [WyoBlue] received an email notice from CMS stating that CMS had made determinations on [WyoBlue's] exception requests and LOIs and that these determinations were available to view in the HPMS [NMM]. A few lines down in the email, CMS states that the results of the LOIs would not be available to view until **May 11, 2024**. Finally, in contrast to its previous instructions in the [NOID], CMS now advises WyoBlue that it has until **May 13, 2024**, "to remove any failing counties from your pending service area[.]" In the response to [WyoBlue's] urology exception request for Laramie County, CMS states that [WyoBlue] "**may continue to negotiate your contract(s) and add the provider(s)/facility(ies) to your HSD table once the contract(s) are fully executed**" with no deadline indicated.

Plan Brief and MSJ at 17-18.

Within the hearing, WyoBlue's witness testified that

based on the information contained within the exception request, as well as my prior experience, I understood that CMS was allowing WyoBlue more time to correct our deficiencies and to continue negotiating contracts. We also understood that CMS would allow us to drop counties if our contracting did not result in a cure for those network gaps, rather than deny our application in full.

Tr. at 34.

WyoBlue argues that "[t]he result of the CMS providing changing and contradictory information as to deadlines for curing deficiencies and dropping counties left [WyoBlue] confused on how to proceed and with the belief that CMS had indicated that the application could move forward to approval despite the unapproved exceptions." Plan Brief and MSJ at 18.

In response, CMS argues that

[t]he period for WyoBlue to withdraw [Calendar Year] 2025 pending counties has passed. CMS notified WyoBlue throughout the application process of the option to withdraw any failing pending counties in advance of CMS issuing final determinations. Because WyoBlue did not withdraw Laramie and Park counties where they failed to demonstrate network adequacy, CMS must deny WyoBlue's entire application.

To allow applicants additional time to withdraw pending counties with application deficiencies would extend the deadline for that applicant only and would undermine the need for a uniform application process that is applied fairly to all applicants.

CMS Memorandum and MSJ at 9.

Within the hearing, with respect to the Laramie County urology exception request disposition, CMS explained that in its response for that request, CMS' use of "EXC-U8"¹⁰ represents "a deficiency code" used in HPMS that provides a "rationale and a denial." Tr. at 113-14. CMS states that the deficiency code EXC-U8 "is applicable for triennials where they also have a curing opportunity [and] for the exception request that's submitted in response to [a] deficiency where they also have a curing opportunity." *Id.* at 116. In further explaining why the curing opportunity associated with EXC-U8 did not apply to WyoBlue's urology exception request submitted after the NOID, the following exchange took place:

Hearing Officer: So, there was no curing opportunity here?

CMS Witness: No, this would be the last chance to submit their exception. The response to the NOID would be their cure.

Id.

Hearing Officer: [M]y question is why you put . . . you may continue to negotiate if there's no curing opportunity[?]

CMS Witness: [T]he submissions for network in the [NMM] are not only used for applicants who are submitting at different hearing periods, but it's also used for provider terminations and a triennial review.¹¹ And they're also released at multiple times during each cycle. So, if you were to receive this during the March disposition, it would say, you know what, if you have these contractor providers, if you've executed this contract, you can add them to this table, because we review networks at a point in time. So, if you . . . had secured a contract in between the deficiency notice and the NOID, you can add that contractor provider to your table.

CMS: So are these deficiency codes preprogrammed into the system?

CMS Witness: They are.

Tr. at 121-22.

In explaining why the EXC-U8 deficiency code did not appear on WyoBlue's Laramie County gastroenterology exception request disposition despite the language for the two exception requests being almost identical, the following exchange took place:

¹⁰ For reference, EXC-U8 states "[y]our interim contracting rationale for the following provider(s)/facility(ies) is invalid. However, you may continue to negotiate your contract(s) and add the provider(s)/facility(ies) to your HSD table once the contract(s) are fully executed." CMS Network Exhibit 3.

¹¹ Within the Network Adequacy Guidance, CMS explains that it "monitors network compliance by reviewing contract-level networks on a triennial basis. This requires each contract to upload its full network into the NMM in HPMS." <https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance12-12-2023.pdf> at 3.

Hearing Officer: I'm wondering if the disposition is the same.

CMS Witness: So the disposition is different. However, it was a choice by the reviewer to justify, to say, we're not accepting the interim, but did the EX[C-U]2¹² is the same where they still identify providers that are located within time and distance.

Hearing Officer: It's just the EX[C-U]8 that's not there?

CMS Witness: Yes.

Hearing Officer: Okay.

Hearing Officer: Different reviewers? So you use different reviewers?

CMS Witness: Yes. We use a team of reviewers.

Hearing Officer: So different people on the team can review one application?

CMS Witness: Yes. Multiple exception types.

Tr. at 127.

The Hearing Officers find that the Laramie County urology exception request disposition rationale EXC-U8 may have been reasonably read by WyoBlue as allowing additional curing time for its Laramie County urology provider deficiency. Indeed, CMS testified that the deficiency code EXC-U8 is used in exactly that manner during a triennial review. Tr. at 113-16. Thus, the Hearing Officers find that the use of the EXC-U8 rationale comment for WyoBlue's Laramie County urology exception request coupled with CMS' multiple changes in the deadline to withdraw counties from a Calendar Year 2025 application created a lack of clarity regarding the deadline by which an applicant must withdraw a county from its application.

C. WYOBLUE'S LOI DEFICIENCIES

WyoBlue explains that, in response to its LOI deficiency cited in the April 16, 2024 NOID, it "inadvertently omitted the names of two providers from the Banner Provider Group LOI matrix." Plan Brief and MSJ at 4. Specifically, a pulmonologist for Natrona County and a primary care provider for Platte, Goshen, and Washakie Counties. *Id.* at 5. WyoBlue asserts, however, that its network of providers for those counties is "sufficient to meet network adequacy standards without the" omitted providers. *Id.* at 5. WyoBlue also points out that "during the contract year 2024 application cycle, CMS allowed denied applicants to cure [issues with . . . LOI submissions]¹³ after CMS had sent out the denial notices." *See Provider Partners of North Carolina, Contract*

¹² For reference, EXC-U2 states: "CMS identified numerous available provider(s)/facility(ies) within the criteria, for example: [list of providers]." CMS Network Exhibit 3.

¹³ *See* Plan Brief and MSJ at 12 n.3.

No. H4439 v. CMS, Hearing Officer Docket No. H-23-00008, Hearing Officer Remand Order (Aug. 14, 2023) (“Provider Partners”).”¹⁴ *Id.* at 12.

Within the hearing, WyoBlue’s witness explained that, with respect to the two providers at issue

They do have an LOI and they’re LOI contracted. So they’re not fully execute[d] contract[s]. But they do have an LOI in place. We just did not denote their name. The LOI was uploaded with other providers, but those two NPIs¹⁵ were inadvertently left off of our matrix because as you noted in the initial submission,¹⁶ we were not permitted to include LOI providers.

Tr. at 75.

During the hearing, CMS clarified the LOI deficiency noted in the Denial Letter, stating that “in response to the NOID[,] WyoBlue . . . listed two provider NPIs where they did not submit valid LOI[s] for that documentation that we would need for approval.” Tr. at 94-95. Specifically, CMS states that WyoBlue “indicated yes on their HSD submission, but they did not upload a letter of intent PDF with a signature and/or they did not include those providers[’] crosswalks as practicing under a group practice.” Tr. at 95; *see* CMS Exhibit C-7. Thus, “there was no submission to tell [CMS] that [the provider] was part of a group practice [and] no way for [CMS] to tell that [WyoBlue] met the requirements.” Tr. at 103.

Additionally, during the hearing, the parties further clarified the LOI deficiency as follows:

WyoBlue: I would like to just add that to the extent that CMS is going to say regardless of, even if they drop . . . Park and Laramie, that those are two . . . LOIs where we neglected to include the two providers on the crosswalk so that the LOI had been submitted. It’s just CMS couldn’t put those pieces together because the providers were inadvertently left off the crosswalk. We would argue that CMS has, in past years allowed applicants to cure LOI issues after denial, as we referenced in our brief. And we would ask that they could similarly allow us to cure those, that error and to update the crosswalk along the way. Again, with the concern being the access for rural beneficiaries in Wyoming where everything is in place, and particularly where it’s a small issue, such as leaving people off of a crosswalk when the information has been submitted. So, we would ask that as well. Thank you.

¹⁴ *See* note 7, *supra*.

¹⁵ “NPI” stands for National Provider Identifier.

¹⁶ Within CMS’ December 14, 2023 “Contract Year 2025 Medicare Advantage Applicant Training and Updated Letter of Intent Submission Instructions,” CMS states that “[f]or the first submission, applicants must submit HSD tables that contain only contracted providers.” CMS Exhibit C-7 at 1.

Hearing Officer: I'm unsure and unclear. You're saying that . . . CMS has possession of the actual letters, just that they just haven't been submitted in the place where CMS allegedly should be submitted?

WyoBlue: CMS has the LOI. They just were not able to connect these two providers to the LOI that had been submitted.

Hearing Officer: CMS?

CMS: Right. Yes, because there's no way for us to marry them together without knowing the NPI. And that would have been included on the matrix. So, there was, you know, we weren't remiss. We just didn't have the information.

Tr. at 141-44.

The Hearing Officers note that, under 42 C.F.R. § 422.116(d)(7), CMS allows applicants to use an LOI signed by both the MA organization and the provider with which the MA organization has started or intends to negotiate, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. However, the regulatory subsection also states that 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 in the form and manner directed by CMS. Here, WyoBlue indicated the use of LOIs for two providers but failed to submit the documentation for those providers in the form and manner directed by CMS. *See* Plan Brief and MSJ at 4; CMS Exhibit C-7. 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 and as noted, the LOI submissions are part of that network adequacy review. Thus, the Hearing Officers find that WyoBlue has not proven by a preponderance of the evidence that CMS' denial of WyoBlue's application is inconsistent with the regulatory requirements. 42 C.F.R. § 422.660(b)(1).

D. WYOBLUE'S ALLINA-BASED CHALLENGE AND PUBLIC POLICY ARGUMENTS

In support of its request for the Hearing Officers to overturn its application denial,¹⁷ WyoBlue asserts that "CMS may not prohibit WyoBlue from dropping Laramie and Park Counties where a substantive standard, such as an arbitrary deadline for proving network adequacy, has not been promulgated through notice and comment rulemaking."¹⁸ Plan Brief and MSJ at 13. WyoBlue cites to a number of federal court decisions to support its assertion, most notably the Supreme Court's decision in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

¹⁷ WyoBlue's request for relief involves CMS either allowing WyoBlue to drop Laramie and Park Counties from its application or, in the alternative, "afford[ing] WyoBlue until January 1, 2025 to cure the alleged deficiencies in the two counties[.]" Plan Brief and MSJ at 1, 8.

¹⁸ The Hearing Officers note that, based on the finding that the deadline to drop counties was unclear here, as explained *supra*, this argument is moot.

WyoBlue also argues that approving its application supports “policy interests in providing choice of MA plans to the beneficiaries in Wyoming.” Plan Brief and MSJ at 1.

The applicable appeals regulations direct the Hearing Officers to determine whether an applicant has proven by a preponderance of the evidence that CMS’ determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501 and 422.502 (application requirements and evaluation procedures). 42 C.F.R. § 422.660(b)(1). In exercising this 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 in implementing the Act. 42 C.F.R. § 422.688. The Hearing Officers find that the regulations do not extend authority to reach a determination that invalidates the regulatory scheme governing the CMS’ MA-PD application process¹⁹ nor to consider WyoBlue’s policy-related arguments. 42 C.F.R. § 422.688; *see* Plan Brief and MSJ at 1.

VIII. ORDER

The Hearing Officers uphold CMS’ May 15, 2024 Denial of WyoBlue’s initial application for contract H9529.

Amanda S. Costabile, Esq.
CMS Hearing Officer

Benjamin R. Cohen, Esq.
CMS Hearing Officer

Date: August 29, 2024

¹⁹ As the Hearing Officers find that invalidating CMS’ authority to deny applications with network deficiencies based on a purported notice-and-comment deficiency are fully outside the Hearing Officers’ authority under 42 C.F.R. § 422.688, the Hearing Officers will not reach whether *Allina* is controlling over MA-PD contract determinations/appeals as a whole. Moreover, the Hearing Officers will not reach whether CMS’ imposition of application related deadline dates qualifies as a “substantive legal standard” under *Allina*.