CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Blue Cross and Blue Shield of Michigan	*	**Docket No. 2017-10 MA/PD**
Denial of Service Area Expansion: Initial Application	*	
Contract Year 2018	*	
Contract No. R5668	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. FILINGS

This Order is being issued in response to the following:

(a) Blue Cross Blue Shield of Michigan's ("BCBSM") Request for Hearing submitted by letter, dated June 7, 2017;

(b) BCBSM's Brief on Appeal, dated June 21, 2017 [hereinafter BCBSM's Brief];

(c) "Centers for Medicare & Medicaid Services (CMS) Memorandum and Motion for Summary Judgment in Support of CMS's Denial of Blue Cross Blue Shield of MI Mutual Insurance Company's Application for the Medicare Advantage/Medicare Advantage - Prescription Drug (MA/MA-PD) product under contract number R5668, for contract year (CY) 2018," dated June 28, 2017 [hereinafter CMS' Motion for Summary Judgment]; and

(d) BCBSM's Response to CMS' Motion for Summary Judgment, dated July 5, 2017 [hereinafter BCBSM's Response].

II. ISSUE

Whether CMS' denial of BCBSM's application to offer a new Medicare Advantage ("MA") product—due to a failure to meet the health services management and delivery application requirement—was inconsistent with regulatory requirements.

III. DECISION

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties agree that there is no dispute of material facts. BCBSM admits that it failed to meet the health services management and delivery application requirement by CMS' established deadline. BCBSM has not proved by a preponderance of the evidence that CMS' denial of its application was inconsistent with controlling authority.

IV. BACKGROUND

Any entity seeking to contract as a Medicare Advantage Organization ("MAO") must fully complete all parts of a certified application, in the form and manner required by CMS. *See* 42 C.F.R. §§ 422.501(c) and 422.503(b)(1) (2016). Specifically, CMS requires that an entity submits its application through the Health Plan Management System ("HPMS") and in accordance with instructions and guidelines that CMS may issue.

Among other requirements, for CY 2017, an applicant must submit Health Service Delivery ("HSD") tables through HPMS for both the new counties the applicant is seeking to expand as well as for its existing counties. *See* CMS' Motion for Summary Judgment at 3 (citing CY 2018 Part C – MA and 1876 Cost Plan Expansion Application). Also, applicants must demonstrate that at least ninety percent of beneficiaries "have access to at least one provider/facility, for each specialty type, within established time and distance requirements for each county." *See id.* at 3.

Under current procedures, after receiving an application, CMS reviews the application for any issues. CMS then notifies the applicant of any deficiencies by e-mailing a Deficiency Notice. This is an applicant's first opportunity to amend its application.

If an applicant fails to cure its deficiencies, CMS issues a Notice of Intent to Deny ("NOID"). 42 C.F.R. § 422.502(c)(2)(i). The NOID affords an applicant a second opportunity to cure its application. *See id.* § 422.502(c)(2)(ii). After CMS issues a NOID, an applicant has a final ten-day period to cure any deficiencies in order to meet CMS' requirements; otherwise, CMS will deny the application. *Id.* § 422.502(c)(2)(ii)–(iii).

The formal NOID process is outlined at 42 C.F.R. § 422.502(c)(2)(i)–(iii) which states:

> (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization or Specialized MA Plan for Special Needs Individuals, CMS gives the applicant notice of intent to deny the application for an MA contract or for a Specialized

> MA Plan for Special Needs Individuals a summary of the basis for this preliminary finding.
>
> (ii) Within 10 days from the intent to deny, the applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must revise its application to remedy any defects CMS identified.
>
> (iii) If CMS does not receive a revised application within 10 days from the date of the notice, or if after timely submission of a revised application, CMS still finds that the applicant does not appear qualified or has not provided CMS enough information to allow CMS to evaluate the application, CMS will deny the application.

If CMS denies an MA application, CMS gives the applicant a written notice with the basis for the determination. The applicant is then entitled to request a hearing before a Hearing Officer. *Id.* § 422.502(c)(3)(i)–(iii). Furthermore, the applicant has the burden of proving by a preponderance of the evidence that CMS' determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501 (application requirements) and 422.502 (evaluation and determination procedures). *Id.* § 422.660(b)(1). In addition, either party may ask the Hearing Officer to rule on a motion for summary judgment. *Id.* § 422.684(b).

V. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On November 14, 2016, BCBSM filed multiple Notices of Intent ("NOI") to apply for additional Local Preferred Provider Organization ("LPPO") contracts. BCBSM's Brief at 3. BCBSM sought additional LPPO contracts to address the potential effects of a rapid increase in new MA enrollees[1] from a recent customer who submitted a bid to BCBSM. *Id.* at 2. CMS responded to the NOI by asserting that CMS would treat BCBSM's application as a service area expansion ("SAE") application instead of a request to apply for additional LPPO contracts. *Id.* at 3–4. CMS reasoned that its current policy prohibits an MAO from having more than one LPPO contract in a state at any time. *Id.* at 4. Accordingly, BCBSM instead applied for a Regional Preferred Provider Organization ("RPPO") contract for Employer Group Waiver Plan ("EGWP") enrollees only. *Id.* at 3–4.

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[1] BCBSM claims that this customer could bring up to one hundred thousand new MA enrollees from additional states. BCBSM explains that a potential effect of this increase in new enrollees is the diminished ability of BCBSM to influence provider behavior to implement programs to manage this new population. BCBSM states that because a large portion of enrollees will be outside the state of Michigan, these enrollees will be managed by providers with whom BCBSM does not directly contract. As a result, without direct contractual controls over the providers, BCBSM is unable to shape providers' behaviors to implement relevant programs for the new enrollees. *See* BCBSM's Brief at 2–3.

On February 15, 2017, BCBSM filed its application to offer an RPPO product, which CMS treated as an SAE application to offer an MA/MA-PD product (under contract number R5668 for CY 2018). *See* BCBSM's Brief at 1; *see also* CMS' Motion for Summary Judgment at 1. BCBSM's application to offer this RPPO product was meant to cover Employer Group enrollees in Michigan and nationwide. BCBSM's Brief at 1. On March 3, 2017, CMS issued a deficiency notice which cited, among other items, a deficiency in health services management and delivery. CMS' Motion for Summary Judgment at 4. In other words, BCBSM did not demonstrate that at least ninety percent of beneficiaries would have access to at least one provider or facility, for each specialty type, within established time and distance requirements for each county. *See id.* at 3–4. The deficiency notice stated that BCBSM had until March 9, 2017 to cure all deficiencies. *Id.* at 4.

On April 17, 2017, CMS issued a Notice of Intent to Deny ("NOID") which noted, among other items, a deficiency in health services management and delivery. *Id.* The NOID gave BCBSM a final ten-day cure period—that is, by April 27, 2017—to correct any deficiencies in its application. *Id.* On April 27, 2017, BCBSM submitted to CMS a waiver request[2] asking CMS to waive its policy that, in order to offer an EGWP, an MAO "must also offer an MA plan of the same type for individual (i.e., non-employer) Medicare enrollment." *Id.* at 7. BCBSM requested this waiver because BCBSM already maintained one "local PPO contract under which it offer[ed] both EGWP and individual [MA] plans across a service area that is identical to the Michigan Region, Region 11."[3] BCBSM's Brief at 5. On May 17, 2017, CMS denied the April 27th waiver request due to concerns that approving the request would lead to MAOs "drop[ping] their individual plans and exclusively serv[ing] the employer market . . . ." CMS' Motion for Summary Judgment at 2, 7.

On May 24, 2017, CMS issued a letter denying BCBSM's application on the basis that BCBSM did not meet the health services management and delivery requirement. *Id.* at 4–5. By failing to meet the health services management and delivery requirement, BCBSM did not meet all requisite Part C requirements for its application. *Id.* at 5. The denial letter also advised: "[i]f you plan to request a hearing, you should also plan to submit your Part C and Part D bids by the

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[2] Note that this waiver request was BCBSM's third waiver request with respect to its application to offer an RPPO product for only EGWP enrollees. BCBSM had previously submitted two waiver requests to CMS on February 28, 2017 which were granted on March 29, 2017. The first waiver pertained to a local coordinated care plan in a given service area being able to extend coverage to an employer group sponsor's beneficiaries who live outside of that service area. BCBSM requested that CMS extend this waiver to its RPPO plan application, and CMS extended this waiver accordingly. The second request waived the requirement that an MAO must offer qualified Part D coverage meeting the requirements of 42 C.F.R. § 423.104 in that plan or under another MA plan in the same area. *See* BCBSM's Brief at 4–5.

[3] Even though BCBSM offers an individual MA plan through its local PPO contract, this individual MA plan does not cover the same service areas that BCBSM's potential RPPO product would cover. BCBSM's RPPO product is aimed at serving Employer Group enrollees from Michigan *and* other states, whereas BCBSM's current individual MA plan serves enrollees only in the state of Michigan. *See* BCBSM's Brief at 1–2, 5. This disparity in the service areas should explain why CMS would still require BCBSM to offer an individual MA plan in order to offer an EGWP.

deadline of Monday, June 5, 2017." *Id.* at 2. BCBSM failed to submit its bids by June 5, 2017. *Id.* BCBSM subsequently filed a Hearing Request on June 7, 2017 to establish the instant appeal. *Id.* The parties then briefed the issue as noted in Section I. above.

VI. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

When exercising his/her authority, the Hearing Officer must comply with the provisions of Title XVIII and related provisions of the Social Security Act ("Act"), regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act. 42 C.F.R. § 422.688.

CMS' application requirements are clear that for CY 2017, an applicant must submit HSD tables through HPMS for both the new counties the applicant is seeking to expand and for its existing counties. *See* CMS' Motion for Summary Judgment at 3 (citing CY 2018 Part C – MA and 1876 Cost Plan Expansion Application). In addition, applicants must demonstrate that at least ninety percent of beneficiaries "have access to at least one provider/facility, for each specialty type, within established time and distance requirements for each county." *See id.*

CMS contends that it is entitled to summary judgment because BCBSM failed to cure the health services management and delivery deficiency, failed to timely submit a bid, and because there is a separate process for reviewing waiver requests. *See* CMS' Motion for Summary Judgment at 1. BCBSM contends that CMS' Motion for Summary Judgment should not be granted because the denial of the April 27, 2017 waiver request was improper, and but for this denial, BCBSM "would not have been required to submit a bid or demonstrate network adequacy for an individual product." *See* BCBSM's Response at 1. BCBSM argues that CMS provides no other forum to BCBSM for appealing the denial of its April 27, 2017 waiver request. *Id.* at 2. Specifically, BCBSM cites 42 C.F.R. § 422.106 to demonstrate that there is no way for a plan to challenge CMS' denial of a waiver request. *See id.* The Hearing Officer, however, does not have the authority under 42 C.F.R. Part 422, Subparts K and N to review CMS' denial of a plan's waiver request(s).[4]

In the instant case, the applicant bears the burden of proof that CMS' determination was inconsistent with controlling requirements at 42 C.F.R. § 422.660. The Hearing Officer finds that CMS' denial of BCBSM's application to offer an RPPO product for EGWP enrollees only—which CMS evaluated as an SAE application—was an appropriate exercise of its delegated authority. BCBSM failed to meet the health services management and delivery application requirement when it submitted its initial application, and BCBSM failed to cure this deficiency by the April 27, 2017 deadline established through the NOID. CMS' Motion for Summary Judgment at 4. The parties

[4] In this proceeding, the Hearing Officer need not reach the question of whether the failure to submit a timely bid would be fatal to a plan's application to offer a new MA product. Nevertheless, BCBSM admitted that it failed to submit a timely bid. *See* BCBSM's Response at 1.

do not dispute these facts. Moreover, BCBSM admits that it did not "provide sufficient information to demonstrate network adequacy for an individual product in the relevant counties." BCBSM's Response at 1. Therefore, BCBSM did not meet its burden of proof to demonstrate that CMS' determination was inconsistent with controlling authority. The Hearing Officer grants CMS' Motion for Summary Judgment.

VII. DECISION AND ORDER

The Hearing Officer finds that CMS' denial of BCBSM's SAE application to offer an RPPO product for EGWP enrollees only was an appropriate exercise of its authority. BCBSM has not established by a preponderance of the evidence that CMS' May 24, 2017 denial of its application was inconsistent with controlling authority. BCBSM failed to timely satisfy the health services management and delivery application requirement. Thus, CMS' Motion for Summary Judgment is hereby granted.

Brenda D. Thew, Esq.
CMS Hearing Officer

Date: August 2, 2017