CENTERS FOR MEDICARE AND MEDICAID SERVICES
HEARING OFFICER DECISION

In the Matter of:	*	
HealthSpring Life & Health Insurance Company	*	
Denial of Medicare Advantage Service Area Expansion Application	*	**Docket No. MA/PD 2018-06**
Contract Year 2019 Contract No. H4513	*	
	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. Filings

This Order is being issued in response to the following:

(a) HealthSpring Life and Health Insurance Company's ("HealthSpring") Request for Hearing dated June 4, 2018;

(b) Applicant's Brief to Appeal CMS's Denial of Applicant's Request to Expand its Service Area dated June 13, 2018 ("HealthSpring Brief");

(c) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment in Support of CMS' Denial of HealthSpring Life & Insurance Company, Inc.'s Application to Expand the Service Area of its Medicare Advantage-Prescription Drug Contract H4513 for Contract Year 2019 dated June 20, 2018 ("CMS MSJ");

(d) Applicant's Reply Brief dated June 26, 2018 ("HealthSpring Reply Brief").

II. Issue

Whether CMS' denial of HealthSpring's application for a Service Area Expansion ("SAE"), which was denied on the basis that HealthSpring non-renewed a contract within the past two years, was inconsistent with regulatory requirements.

III. Decision

The Hearing Officer grants CMS' Motion for Summary Judgment. HealthSpring elected to non-renew a contract with CMS that is subject to the two-year contracting prohibition at 42 C.F.R. § 422.506(a)(4). CMS generally maintains ultimate discretion to determine whether an exception to the two-year contracting prohibition based upon special circumstances be granted. Furthermore, CMS' denial of the exception request was consistent with CMS' current regulations and policies, which communicate that CMS is authorized to apply the prohibition in situations where an applicant's prior and proposed service areas differ. Accordingly, HealthSpring has not established by a preponderance of the evidence that CMS' denial of its application was inconsistent with the controlling authority.

IV. Legal Background

A. Application and Appeals Process - General

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

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

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

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

> (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization or Specialized MA Plan for Special Needs Individuals, CMS gives the applicant notice of intent to deny the application for an MA contract or for a Specialized MA Plan for Special Needs Individuals a summary of the basis for this preliminary finding.
>
> (ii) Within 10 days from the intent to deny, the applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must revise its application to remedy any defects CMS identified.

> (iii) If CMS does not receive a revised application within 10 days from the date of the notice, or if after timely submission of a revised application, CMS still finds that the applicant does not appear qualified or has not provided CMS enough information to allow CMS to evaluate the application, CMS will deny the application.

If after review, CMS denies the MA application, written notice of the determination and the basis for the determination is given to each applicant. (42 C.F.R. § 422.502(c)(3)). The applicant is then entitled to a hearing before a CMS Hearing Officer. (*Id.* § 422.502(c)(3)(iii)). However, 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)).

The Hearing Officer must comply with the provisions of the Social Security Act (the "Act"), Title XVIII (Health Insurance for the Aged and Disabled), and related requirements, regulations issued by the Secretary of Health and Human Services, and general instructions issued by CMS in implementing the Act. (42 C.F.R. § 422.688).

B. Non-renewal of Contract - Authority

MA organization contract applicants must attest that they "[m]aintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served." (42 C.F.R. § 422.112(a)(1)(i)). Section 1857(c)(4)(A) of the Act (42 U.S.C. § 1395w-27(c)(4)(A)) prohibits organizations from re-entering the MA program in the event that a previous contract with the organization was terminated at the request of the organization within the preceding two-year period. The statute specifies that the two-year period would not apply "in such other circumstances which warrant special consideration, as determined by the Secretary." (*Id.*). Likewise, the regulation at 42 C.F.R. § 422.503(b)(vi)(G)(6)(ii) indicates that CMS may "determine[] that circumstances warrant special consideration." CMS also clarified that it will consider circumstances warranting special consideration on a "case by case" basis. 80 Fed. Reg. 7912, 7945-46 (Feb. 12, 2015).

Regarding the central issue in this case with respect to how CMS evaluates variances between the prior non-renewed contacts and proposed SAEs and applies the two-year contracting prohibition, the regulation at 42 C.F.R. § 422.506(a)(4) (2015) specifies:

> If an MA organization does not renew a contract under paragraph (a) of this section, CMS may deny an application for a new contract or a service area expansion from the MA organization for 2 years unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the

> product type, contract type or service area of the previous contract. (Emphasis added).

CMS also cites its Contract Year 2016 Annual Final Call Letter,[1] which was published on April 6, 2015, which states:

> In the Contract Year (CY) 2016 Medicare Program; Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Program Final Rule, 80 FR 7945, CMS adopted a final rule to amend the regulations, expanding application of the two-year prohibition (found at 42 CFR §§ 422.502, 422.503, 422.506, 422.508, and 422.512) to avoid (1) (unnecessarily narrowing the scope of the two-year prohibition, or (2) precluding CMS from preventing poor performing MA organizations from reentering the MA program.
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> Once the new regulation is effective in CY 2015 and moving forward, CMS interprets §§ 422.503(b)(6) and 422.503(b)(7) as authorizing denials of new contracts and service area expansions, consistent with the proposed text for §§ 422.503, 422.506 and 422.512, regardless of the contract type, product type, or service area of the previous nonrenewal. CMS will apply this new interpretation to all organizations that mutually terminate or non-renew a contract starting April 2015, and moving forward.

In its brief, HealthSpring cites Chapter 11, Section 50 of the Medicare Managed Care Manual, published in February 2006, [2] which had taken a different approach regarding how CMS evaluates variances between prior non-renewed service areas and proposed new service areas:

> [T]here are certain special circumstances under which CMS generally will grant an exemption to the 2-year contracting prohibition . . . . These circumstances are:
>
> . . . .
>
> 2. The organization is proposing to introduce MA plans in counties other than the counties they had previously withdrawn from when they ended their earlier contract with the Medicare program;

[1] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf at 137.

[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c11.pdf.

V. Statement of Facts

A. Pre-Application Background

HealthSpring currently operates in 41 counties in two states (Georgia and Texas) under H4513. CMS denied HealthSpring's H4513 SAE request on the basis that within the past two years, HealthSpring did not renew a prior contract (H6972). Specifically, under H4513, HealthSpring seeks to expand the service area to seven counties in Arkansas (Faulkner, Garland, Grant, Lonoke, Perry, Pulaski, and Saline) and one county in Virginia (Arlington) for CY 2019. HealthSpring operated the prior contract, H6972, which covered the Fort Smith, Arkansas service area outside of H4513, from January 1, 2013 through the end of the 2017 contract year. (HealthSpring Brief at 4).

B. SAE Application and Review Process

In response to CMS' solicitation for Part C applications, HealthSpring submitted an application under contract H4513 by the February 14, 2018 deadline. As part of the MA SAE application, HealthSpring uploaded a request for a waiver of the two-year contracting prohibition indicating that it "non-renewed contract H6972 effective 1/1/2018" and that "[t]he non-renewal request was due to low membership and lack of engaged physicians in the service area." (HealthSpring Brief, Exhibit 2).

On March 19, 2018, CMS issued a deficiency notice that indicated HealthSpring's application was deficient on the basis that HealthSpring was not in compliance with the CMS requirement that prohibits an organization from expanding its service area for a period of two years following a contract non-renewal. The notice provided instructions for HealthSpring to resubmit application materials in order to "correct the deficiencies" and provide "clarification or further explanation" regarding the waiver request by March 27, 2018. (HealthSpring Brief, Exhibit 3).

HealthSpring submitted revised application materials by the March 27, 2018 deadline, which included the following explanation:

> This H contract was acquired by HealthSpring Life & Health Insurance Company, Inc. ("HSLH") as a result of a CMS/DOJ mandated divestiture that was required of Humana in order to acquire the Arcadia business. HLSH agreed to accept this contract in addition to other assets being acquired. Despite ongoing efforts to create a successful market presence through this H contract, HSLN was [sic] been unable to generate physician engagement with the provider network and growth in this locality. This has included but was not limited to a refusal by the primary provider organization to participate in initiatives focused on reducing gaps in care, adherence to referral guidelines and plan policies and procedures. As a result of this unengaged provider network, the company was unable to achieve desired levels of physician engagement, growth

> and quality sufficient to maintain the contract with services and benefits to beneficiaries at the level customarily undertaken by Cigna-HealthSpring. Based upon these factors, the company made the decision to non-renew the contract. The non-renewal in this particular area will enable a stronger focus on areas where Cigna-HealthSpring can provide the greatest value to beneficiaries seeking enrollment in a value-based Medicare-Advantage plan with the focus upon beneficiaries and compliance. (HealthSpring Brief, Exhibit 4).

On April 17, 2018, CMS issued a NOID, finding that the application was still deficient. (HealthSpring Brief, Exhibit 5). HealthSpring submitted revised application materials by the final April 27, 2018 submission deadline, articulating that:

> [A]fter five years of effort, the company made the business decision that the financial and other resource investments in this contract were not resulting in operational improvements or growth in enrollment and, therefore, made the corporate decision to non-renew. (HealthSpring Brief, Exhibit 6 at 2).

HealthSpring provided additional information relating to service area geography and beneficiary access patterns:

> **Service Areas do not overlap**
>
> Cigna-HealthSpring further notes that under the currently pending service area expansion application, HSLH is looking to enter a market that is clearly differentiated from the counties served under the non-renewed contract both, in terms of geography and beneficiary access patterns. The geographies do not overlap.
>
> As set forth on the map below, the non-renewed contract was focused on counties surrounding the Ft. Smith geography, located on the western border of Arkansas and Oklahoma. Beneficiaries in that area traditionally sought care within the Ft. Smith area or at times would cross into Oklahoma for care not available within Ft. Smith. The proposed expansion under H4513 is focused on counties surrounding the metropolitan area of Little Rock, located in the central part of Arkansas, which has clearly differentiated access patterns of care that are focused in Little Rock, due to the breadth of providers available (both facility and physician based). In addition, Cigna-HealthSpring is seeking to expand into Arlington, Virginia under H4513 as set forth in the applicable expansion filings.

> **Increased beneficiary choice**
>
> The company believes that participation in both of these markets (Little Rock, Arkansas and Arlington, Virginia) will create increased beneficiary choice and access to MAO's operating at a 4 STAR or greater level in accordance with the goals of the Medicare Advantage program.
>
> Based upon the above clarification, we request that CMS allow the expansion by HealthSpring Life & Health Insurance Company, Inc. under H contract 4513 into Little Rock, Arkansas and Arlington, Virginia due to the special circumstances created by the Company's voluntary acceptance of the request to take on the Western Arkansas counties due to the Arcadian/Humana transaction and operational and business considerations that led to the non-renewal as described above.
>
> (HealthSpring Brief, Exhibit 6 at 3-4).

On May 23, 2018, CMS issued a final denial letter, which indicated that HealthSpring still failed to present sufficient information to qualify for a waiver of CMS' two-year contracting prohibition. HealthSpring filed a timely request for a hearing pursuant to 42 C.F.R. § 422.660(a).

V. Discussion, Findings of Fact and Conclusions of Law

The Hearing Officer grants CMS' Motion for Summary Judgment. It is undisputed that HealthSpring non-renewed a contract with CMS that is subject to the two-year contracting prohibition. CMS maintains the legal authority to deny an MA SAE application when the applicant has non-renewed a contract within the past two years in accordance with 42 C.F.R. §§ 422.503(b)(4)(vi)(G)(6) and 422.506(a)(4) (2015). The Hearing Officer agrees with CMS that it may "'look[] at each waiver on a case-by-case basis for any other factors that may warrant special circumstance" and that CMS maintains the discretion to determine whether special circumstances exist.

HealthSpring asserts that CMS failed to properly consider the special circumstances in accordance with its published policies. HealthSpring primarily relies upon Chapter 11, Section 50, of the Medicare Managed Care Manual (issued February 2006), which indicated that an organization which introduced plans in counties other than the counties it had previously withdrawn from may obtain an exemption to the two-year contracting prohibition. The Hearing Officer agrees with CMS that the 2006 manual policy is no longer controlling as 42 C.F.R. § 422.506 (2015) expressly indicates that the two-year prohibition may apply regardless of the service area of the previous contract. Furthermore, the April 6, 2015 Call Letter also communicated the change that it was authorizing denials of new contracts and SAEs, consistent with the new regulation text.

Finally, while HealthSpring asserts that its decision to acquire contracts as a result of the Federal Government's order constitutes special circumstances, CMS retains the discretion not to consider such factor.[3] Accordingly, HealthSpring has not established by a preponderance of the evidence that CMS' denial of its application was inconsistent with the controlling authority.

VI. Decision and Order

CMS' Motion for Summary Judgment is hereby granted.

/Benjamin R. Cohen/
Benjamin R. Cohen, Esq.
CMS Hearing Officer

Date: August 15, 2018

[3] CMS responded that "All MA organizations must assess their ability to maintain their health plan in a given market each year as part of normal business operations." (CMS Brief at 8-9). CMS adds that, "[w]hile the change to HealthSpring's book of business may have been significant at the time of the acquisition, in 2013, that change has no bearing following five (5) years of operations." (*Id.*).