CENTERS FOR MEDICARE & MEDICAID SERVICES
Hearing Officer Decision

In the Matters of:		
Unicare Health Plan of West Virginia, Inc.	*	
Amerigroup Insurance Company	*	**Docket Numbers:**
Amerigroup Ohio, Inc.	*	**2018-11 MA/PD**
Denial of Initial Applications	*	**2018-12 MA/PD**
Contract Year 2019	*	**2018-13 MA/PD**
Contract Numbers H0914, H1125 and H6684	*	
AND	*	**AND**
Blue Cross of California	*	
Denial of Service Area Expansion	*	**Docket Number:**
Contract Year 2019	*	**2018-14 MA/PD**
Contract Number H0544		

ORDER GRANTING CMS' MOTION FOR SUMMARY JUDGMENT

I. Filings

This Order is being issued in response to the following:

(a) Anthem Inc.'s Hearing Request for Denial of Contract Year ("CY") 2019 Contract Applications H0914 submitted by Unicare Health Plan of West Virginia, Inc. ("Unicare"), H1125 submitted by Amerigroup Insurance Company ("Amerigroup Insurance"), H6684 submitted by Amerigroup Ohio, Inc. ("Amerigroup Ohio") and Request for Service Area Expansion for Contract H0544 submitted by Blue Cross of California ("BC CA") (collectively, "Anthem") dated June 6, 2018;

(b) Anthem's Motion for Summary Judgment and Prehearing Brief ("Anthem MSJ") dated June 18, 2018;

(c) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment in Support of CMS' Denial of Anthem's Applications for Initial Medicare Advantage ("MA")-Prescription Drug ("MA-PD") Contracts

(H0914, H1125 and H6684) and Application to Expand the Service Area of Anthem's MA-PD Contract H0544 for Contract Year 2019 ("CMS MSJ") dated June 25, 2018; and

(d) Anthem's Reply Brief and Opposition to CMS' Motion for Summary Judgment ("Anthem Reply Brief") dated June 28, 2018.

II. Issue

Whether CMS' denial of Anthem's applications to offer three new MA-PD plans and to expand its service area of an existing contract — due to a failure to comply with the terms of a current or previous year's contract — 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. The Hearing Officer finds that CMS properly applied the low Star Rating from the related, discontinued contract to BC CA. The Hearing Officer also finds that it was appropriate for CMS to apply the 14-month look back period because the 12-month look back period is not yet in effect. Additionally, CMS followed its regulations and policies in aggregating the performance of the various contracts under Anthem. Last, CMS properly imputed the outlier performance of exiting, related contracts to the three entities seeking new contracts. Anthem has not established by a preponderance of the evidence that CMS' denial of its applications was inconsistent with controlling authority.

IV. Background

A. Application Process

Any entity seeking to contract as an 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) (2016)). Specifically, CMS requires that applications be submitted through the Health Plan Management System ("HPMS") and in accordance with instructions and guidelines issued by CMS.

Among other requirements, an applicant must provide "documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to MA plans" as required under 42 C.F.R. § 422.501(c)(i).

Under current regulations and procedures, after receiving an application, CMS reviews the application to determine whether the applicant meets all the necessary requirements. (42 C.F.R. § 422.502(c)(2)(i)). When evaluating applications, CMS bases its decision to approve or deny each application solely on information appropriately submitted by the applicant through HPMS as part of the application itself and relevant past performance history associated with the applicant.

(42 C.F.R. § 422.502(a)(1) and (b)(1)). In general, CMS uses information from an applicant's current or prior contract under 42 C.F.R. § 422.502(b).

Following its review, CMS 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 through an amendment of its application, 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 deficiencies in its application. (*See* 42 C.F.R. § 422.502(c)(2)(ii)). For CY 2019 Applications, CMS provided information about past performance deficiencies in any NOID issued to an applicant. (CMS MSJ at 5 n.31). After a NOID is issued, an applicant has a final ten-day period to cure any deficiencies in order to meet CMS' requirements. If deficiencies are not cured, CMS will deny the application. (42 C.F.R.§ 422.502(c)(2)(ii)–(iii)). If CMS denies the 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)).

When 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)). 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). (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)).

B. CMS' Past Performance Analysis

In considering past performance history, CMS uses information from an applicant's current or prior contract. (42 C.F.R. § 422.502(b)). Specifically:

> [I]f an MA organization fails during the 14 months preceding the deadline established by CMS for the submission of contract qualification applications to comply with the requirements of the Part C program under any current or prior contract with CMS under title XVIII of the Act . . ., CMS may deny an application based on the applicant's failure to comply with the requirements of the Part C program under any current or prior contract with CMS even if the applicant currently meets all of the requirements of this part.

(42 C.F.R. § 422.502(b)(1)).

For the CY 2019 applications, CMS reviewed the past performance of organizations in the 14-month period of January 1, 2017 through February 28, 2018. (CMS MSJ Exhibit H at 4). On April 16, 2018, CMS published the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program Final Rule (the "2018 Final Rule") that reduced the past performance review period from 14 months to 12 months. (83 Fed. Reg. 16440, 16638-39 (Apr. 16, 2018)). Under the 2018 Final Rule, the new 12-month review period

will be applied beginning January 1, 2019 (*id.* at 16440), with an application review cycle of March 1 of the year preceding the application submission deadline through February 28 (February 29 in leap years) of the year in which the application is submitted (*id.* at 16639).

Since 2010, CMS has published, on an annual basis, its methodology for analyzing MA organizations' past contract performance through a memorandum issued via HPMS. (CMS MSJ at 8). For the CY 2019 applications, CMS published its Past Performance Methodology ("Methodology") on February 7, 2018. (CMS MSJ Exhibit H). The Methodology "is constructed to identify true or 'extreme' outliers." (*Id.* at 1-2).

Under the Methodology for CY 2019 applications, CMS assesses an MA organization's past performance in 11 distinct performance categories. (CMS MSJ at 8). CMS assigns negative past performance points to a contract for each category in which CMS identifies the contract as having poor performance. (Anthem MSJ at 4). Two of the 11 categories are relevant to this appeal: Compliance Letters and Star Ratings. (CMS MSJ at 8).

1. Compliance Letters Category

For the Compliance Letters category, CMS reviews each Compliance Letter issued during the 14-month review period. CMS issues a Compliance Letter when it learns of a performance problem with a contract. CMS assigns various weights to the different types of Compliance Letters issued, calculates a Compliance Letter score for each contract, "rank[s] the contracts in descending order from highest to lowest score", and then identifies the scores at the 80th and 90th percentiles. (CMS MSJ Exhibit H at 14). For the CY 2019 past performance period, the threshold for the 80th percentile was a Compliance Letter score of 3 and the threshold for the 90th percentile was a Compliance Letter score of 5. CMS then assigned 1 negative past performance point to those contracts that were at or above the 80th percentile, but less than the 90th percentile, and 2 negative past performance points to those contracts that were at or above the 90th percentile. (*See id.* at 7 n.3).

2. Star Ratings Category

For its analysis in the Star Ratings category, the Methodology states that CMS uses the most current MA and Part D Plan Star Ratings as of the end of the 14-month performance review period that were developed by CMS and posted on the Medicare.gov website. (CMS MSJ Exhibit H at 7). CMS determined that a Part C performance outlier for the Star Ratings category was any contract that received a total score of 2.5 stars or below. All contracts defined as an outlier for the Star Ratings category received 2 negative past performance points. (*See id.* at 8).

3. Calculation of Past Performance for CY 2019 Applications

After performance points are assessed at the contract level, CMS summarizes the results at the legal entity level, i.e., the points are assigned to the licensed, risk-bearing legal entity (often the parent organization) that holds the contract with CMS. (*See id.* at 15). When a legal entity holds multiple contracts with CMS, CMS summarizes all of the contract-level performance results at the parent organization level. In doing this, CMS assigns the highest point value assessed for each

performance area among all of the contracts held by that parent organization. (CMS MSJ Exhibit H at 15).

In determining those organizations that are overall performance outliers with significant performance problems, CMS established that an organization with 4 negative performance points is considered an outlier and an overall poor performer to such an extent that CMS can take definitive actions such as denying expansion applications. (*Id.* at 16).

CMS also recognizes in the Methodology that there are instances where new organizations/legal entities submit an application and do not have 14 months of past performance history. (*Id.* at 15). If CMS determines that the new organization has a parent or sibling organization that has operated an MA/MA-PD contract with CMS for a period of at least 14 months, CMS imputes to the new organization the performance of its sibling organizations as part of CMS' Part C and D application assessment.

The Methodology also recognizes the unique circumstances presented by contract consolidations and references the CY 2018 Technical Notes ("Notes") posted on the CMS website: *http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html*[1]:

> Consolidations become effective the first day of the calendar year. The Star Ratings are released the previous October so they are available when open enrollment begins. Each of the consumed contracts and the surviving contract will earn its own individual Star Ratings. The Star Ratings for the consumed contracts will be shared with the owning organization in the HPMS previews but will not be released publicly and are not included in determining Quality Bonus Payment (QBP) ratings. The ratings for the consumed contracts will only be used in the Past Performance Analysis performed by CMS. The surviving contract's ratings are posted publicly, used in determining QBP ratings, and included in the Past Performance Analysis.

(CMS MSJ Exhibit R at 18).

CMS' calculation of Anthem's past performance varied for the different legal entities. (CMS MSJ at 9). At the time of the H0544 service area expansion application on February 14, 2018, CMS determined that BC CA had at least 14 months of performance history under two contracts: H0544 and H0564. (*Id.*). CMS analyzed each contract against the 11 performance measures. (*Id.*). Contract H0544 received 2 negative past performance points under the Compliance Letters category, and Contract H0564 received 2 negative points in the Star Ratings category. (*Id.*). Under

[1] As of February 7, 2018. (CMS MSJ Exhibit H at 7). CMS' Exhibit R is the May 10, 2018 version of the Notes. The Methodology, issued February 7, 2018, pre-dates this version. The Hearing Officer observes, however, that the link provided in the Methodology allows the reader to access the September 26, 2016 version of the Notes which would have been current on February 7, 2018. The Hearing Officer confirmed that the language of the Notes quoted by CMS and in this Order is identical in both versions.

the Methodology, CMS then summarized these contract level results for BC CA by assigning the highest point value assessed in each performance category to the organization. (*Id.*, *see* CMS MSJ Exhibit H at 15). As a result, CMS assigned BC CA 4 negative past performance points, which made BC CA an outlier for Part C performance.

Anthem also submitted applications under three new legal entities/organizations: Unicare, Amerigroup Ohio, and Amerigroup Insurance ("New Entities"). These three New Entities do not have a record of past performance with CMS, however, all three attested that they had at least 14 months of performance history through the applicants' parent organization, or subsidiary of the applicants' parent organization. Under the Methodology, CMS imputed the highest negative performance score of the sibling organization, BC CA, of 4 negative past performance points to these New Entities. (CMS MSJ at 9; *see* CMS MSJ Exhibit H at 15).

V. Procedural History and Statement of Facts

On February 13, 2018, BC CA filed an application with CMS to expand the service area in California for its MA-PD plans offered under contract H0544. (Anthem MSJ at 3). On February 14, 2018, Unicare filed an initial application with CMS to offer new MA-PD plans in West Virginia (H0914); Amerigroup Ohio applied to offer new MA-PD plans in Arkansas (H6684); and Amerigroup Insurance applied to offer a new MA-PD plan in Texas (H1125). *Id.* All four of these entities are subsidiaries of Anthem, Inc. (*Id.* at 1). Anthem also has 27 other subsidiaries that hold MA contracts, in addition to BC CA. (*Id.* at 3).

A contract held by a different Anthem subsidiary is relevant to CMS' determination on these four applications. During CY 2017, Anthem, Inc. had two subsidiaries that held MA contracts in California: CareMore, which held contract H0544, and BC CA, which held contract H0564. (*Id.*). On February 1, 2017, Anthem filed for novation of contract H0544 from CareMore to BC CA; CMS approved this request on May 26, 2017. (*Id.*). On April 10, 2017, BC CA requested permission to consolidate H0564 into H0544, effective as of January 1, 2018; CMS approved this consolidation on May 31, 2017. (*Id.*). H0544 remains the surviving contract, now held by BC CA, which sought to expand its service area in CY 2019. (*Id.*).

On March 19, 2018, CMS notified Anthem that it found deficiencies related to licensure requirements for Anthem's applications H0544 and H6684. Those deficiencies were ultimately cured by Anthem and are not relevant to this appeal. (*See* CMS MSJ at 5-7). On the same day, CMS also informed Anthem that it would provide information found that related to any past performance deficiencies in the upcoming NOID. (*Id.* at 5).

Subsequently, CMS discovered past performance deficiencies pertinent to the Motion for Summary Judgment on all four applications and, on May 23, 2018, CMS issued Denial Letters for each of the applications. (CMS MSJ Exhibits M, N, O and P). Specifically, these Denial Letters stated, "CMS has determined, pursuant to 42 CFR §422.502(b) and 42 CFR §423.503(b), that your organization failed to comply with the terms and conditions of a current or previous year's contract with CMS."

Anthem filed this consolidated appeal on June 6, 2018, challenging CMS' findings on the past performance deficiencies in all four applications.

VI. Discussion, Findings of Fact and Conclusions of Law

In exercising the regulatory authority under 42 C.F.R. § 422.688, the Hearing Officer must comply with the provisions of Title XVIII of the Social Security Act ("Act") and related provisions of the Act, regulations issued by the Secretary of Health and Human Services, and general instructions issued by CMS in implementing the Act.

The parties agree that the controversy may be solved by a Summary Judgment as there is no material dispute regarding the facts that Anthem failed to meet CMS' past performance requirements. (Anthem MSJ at 2; CMS MSJ at 2).

A. Appeal of Denial of BC CA Service Area Expansion Request

1. Appropriateness of Negative Performance Points in Star Ratings Category

Anthem argues that CMS erred in applying the 2.5 Star Rating associated with the discontinued Contract H0564 to BC CA's application for a service area expansion under Contract H0544. Anthem contends that, "[t]his computation is inconsistent with CMS' published Past Performance Methodology which states that '[t]he most current MA and Part D Plan Star Ratings data as of the end of the 14-month performance period developed by CMS **and posted on the Medicare.gov website'** will be used for the purposes of identifying outliers with respect to Star Ratings." (Anthem MSJ at 9 (emphasis in Anthem MSJ)). Anthem asserts that: 1) Contract H0564 no longer exists, 2) its CY 2018 Star Rating was never posted on Medicare.gov, and 3) in contrast, the 4.5 Star Rating for Contract H0544 **was** posted to the website. (Anthem MSJ at 9).

The Methodology explains that the "most current" Star Ratings will be applied to the CY 2019 applications and provides a reference for how the most recent performance metrics (which are used to compute a Star Rating) were calculated. BC CA had an active contract and received a Star Rating most recently in CY 2018, therefore the CY 2018 Technical Notes were relevant to the Methodology and properly applied in the review of CY 2019 applications.

The Notes define "consolidation" as follows:

> Consolidation: when an organization/sponsor that has at least two contracts with CMS for offering health and/or drug services to beneficiaries combines multiple contracts into a single contract with CMS. Consolidations occur only at the change of the contract year. The one or more contracts that will no longer exist at contract year's end; these are known as the consumed contracts. The contract that will still exist is known as the surviving contract and all of the beneficiaries still enrolled in the consumed contract(s) are moved to the surviving contract.

(CMS MSJ Exhibit R at 18).

Although Anthem refers to Contract H0564 as a "discontinued" contract, it meets CMS' definition of a "consumed contract" because H0564 ceased to exist at the end of the contract year, leaving only Contract H0544 in this transaction. Further, the Notes state that when one contract is consolidated or "consumed" into another, the Star Rating for the consolidated contract will not be released publically, but will be used by CMS for Past Performance Analysis. Therefore, CMS properly followed its process when it did not post a Star Rating for H0564, the "consumed" or "discontinued" contract.

The Hearing Officer finds that under the Methodology and associated Notes, the Star Rating for Contract H0564 was properly used in CMS' Past Performance Analysis of H0544 - the contract that "consumed" the contract with the 2.5 Star Rating. This led CMS to impute 2 negative performance points to BC CA's Contract H0544. The Hearing Officer finds that CMS was correct in its calculation of negative performance points for Contract H0544 in the Star Rating category and in imputing the Star Rating of the consumed contract (H0564) to the surviving contract H0544.

2. Appropriateness of Two Negative Performance Points in Compliance Letters Category

Anthem contends that the Past Performance Methodology's use of a 14-month look back period from January 1, 2017 until February 28, 2018 results in CMS double counting Compliance Letters it issued in January and February 2017. Anthem points to the preamble of the 2018 Final Rule in which CMS acknowledges that the 14-month time period is too long and results in some noncompliance being double counted. The Rule also provides for a new 12-month look back period, from March 1 through February 28, beginning with next year's past performance cycle. (Anthem MSJ at 9-10). Anthem asserts that if CMS had applied its new look back period for the CY 2019 past performance review cycle, BC CA would have received 4 points in the Compliance Letters category, rather than 5. (*Id.* at 10). The Hearing Officer finds that CMS correctly followed its Methodology in applying the 14-month review period to assess past performance in the CY 2019 application cycle because the 12-month look back period is not effective until January 1, 2019.

3. Appropriateness of Aggregating Points from Different Contracts

Anthem asserts that the denial notice was incorrect in stating that "Blue Cross of California 'failed to comply with the terms and conditions of *a current or previous year's contract* with CMS." (*Id.* at 10-11 (emphasis in Anthem MSJ)). Anthem points out that CMS' Methodology aggregates points from different contracts. (*Id.* at 10). It characterizes this process as a "mix-and-match approach" which Anthem asserts is not authorized by regulation. (*Id.* at 11). Anthem believes that this approach incorrectly skewed BC CA's performance score especially since, overall, CMS found Anthem entities performed well in comparison to other MA organizations. (*Id.*).

Section 422.502(b) governs CMS' use of past performance information in evaluating contract applications. While the provision itself speaks in the singular, i.e., "if an MA organization fails .

. . to comply with the requirements of the Part C program under any current or prior contract with CMS," it logically extends to a review of multiple contracts related to an MA organization. The preamble to the Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program Final Rule clarifies the scope of CMS' authority, which is:

> [N]ot . . . equivalent to an additional compliance or enforcement action taken against any of the organization's existing Medicare **contracts.** Our denial of an application based on an applicant's past contract performance is a reflection of our belief that an organization demonstrating significant operational difficulties should focus on improving its **existing operations** before expanding into new types of plan offerings or additional service areas.

(75 Fed. Reg. 19678, 19685-86 (Apr. 15, 2010) (emphasis added)).

The preamble explains CMS' policy of considering multiple existing contracts, not just one, under a single contracting organization. CMS further explains that, regardless of the number of contracts held, CMS intends for an organization to focus on its entire book of business (i.e., "its existing operations") which could be a single or many contracts. This approach prevents an organization with serious performance problems from evading CMS' past performance review authority by creating new subsidiaries that then apply for new contracts. (*See* CMS MSJ Exhibit H at 15). Accordingly, the Hearing Officer finds that CMS' Methodology, which compares multiple legal entities and contracts, is not inconsistent with regulatory requirements.

There is no dispute that BC CA held two contracts during the relevant past performance review period and, as discussed above, one contract consumed the other. The Methodology addresses contracting organizations, and their parent organizations, that hold multiple contracts:

> Frequently a contracting organization (i.e., a licensed, risk-bearing legal entity) holds multiple contracts with CMS. In turn, some parent organizations own numerous legal entities, each of which hold one or more CMS contracts. We summarize the contract-level performance results at the contracting organization level by assigning to a contracting organization the highest point value assessed for each performance area among all of the contracts held by that organization. The assigned scores for each performance area are then added to produce a total score for that contracting organization.

(CMS MSJ Exhibit H at 15).

Here, Anthem, a parent organization, owns multiple legal entities including BC CA, which itself held two contracts during 2017. Across the 11 performance categories used to evaluate CY 2019 applications, BC CA's Contract H0544 received 2 negative past performance points under the Compliance Letters category and BS CA's Contract H0564 received 2 negative points in the Star Ratings category. (CMS MSJ at 9). Following its Methodology, CMS added those point values

and assigned BC CA 4 negative past performance points. (*Id.*). Under the Methodology, a Part C contracting organization is determined to be an outlier if it has 4 negative performance points. (CMS MSJ Exhibit H at 16).

Accordingly, the Hearing Officer finds that CMS followed its Methodology and correctly aggregated the performance points from the two contracts held by BC CA in the previous year. In that the total negative performance points exceeded CMS' threshold for outlier status, CMS properly categorized BC CA as an outlier and denied BC CA's CY 2019 application for service area expansion.

B. Appeal of Denial of Initials Applications submitted by the New Entities

1. Appropriateness of Denial Based on Failure to Comply with Current or Prior Contract

Anthem argues that the New Entities could not have failed to comply with a current or prior year's contract because each is a new entity and thus has not previously contracted with CMS. Anthem points to the language in 42 C.F.R. § 422.502(b)(1), which states that "*if an MA organization* fails . . . to comply with the requirements of the Part C program *under any current or prior contract* with CMS . . ., CMS *may deny* an application based on the *applicant's* failure to comply with the requirements of the Part C program *under any current or prior contract* with CMS . . . ." (Anthem Reply Brief at 8 (emphasis in Brief)). Anthem does not contest that the language of the Methodology "provides for CMS to impute negative points" as it did here. (*Id.* at 9). Anthem argues, however, that the Methodology "is inconsistent with, and cannot be based in the regulatory provision at issue here, 42 CFR § 422.502(b)(1), which specifies *the MA organization* and *the applicant's* failure to comply with a prior contract as the grounds for denying the contract." (*Id.* (emphasis in Brief)). It contends that CMS incorrectly conflated the MA organizations (the New Entities) with Anthem (the parent organization) in denying the new applications by the New Entities, thus CMS' denial is inconsistent with regulatory requirements. (*Id.* at 8).

The Methodology expressly addresses new entities that do not have a history with CMS. Specifically, the Methodology states:

> [W]e identify applying contracting organizations with no recent prior contracting history with CMS (i.e., a legal entity brand new to the Medicare program, or one with prior Medicare contract experience that precedes the 14-month review period). We determine whether that entity is held by a parent of other Part C or D contracting organizations . . . . In these instances, it is reasonable in the absence of any recent actual contract performance by the applicant due to a lack of recent Part C or Part D participation, to impute to the applicant the performance of its sibling organizations as part of CMS' application evaluation.

(CMS MSJ Exhibit H at 15).

The Hearing Officer finds that CMS' Methodology is consistent with the regulation, and was properly applied by CMS in this instance. CMS' policy implements its intent to prevent organizations with operational difficulties from expanding into new plan offerings. Anthem has not shown by a preponderance of the evidence that CMS' denial of the New Entities' initial applications was inconsistent with regulatory requirements.

2. Whether BC CA's Past Performance Score Supports Denial of the New Entities' Initial Applications

A. Reasons for Denial

Anthem argues that CMS' denial of the New Entities' applications cannot stand because CMS provided two different reasons for the denial. The Denial Notice stated that the organization (each of the New Entities) failed to comply with the terms of a previous contract. In contrast, when asked to clarify its reasons via e-mail, CMS attributed the denial to BC CA's status as an outlier. In addition, Anthem argues that even if BC CA's past performance is attributable to the New Entities, BC CA "is not an outlier, as CMS should not have imposed four negative performance points on it." (Anthem MSJ at 12).

The Hearing Officer's decisions above are dispositive on this issue. As explained above, under the Methodology, CMS properly assigned negative past performance points—based on the past performance of BC CA's Contract H0544—to Anthem, as a parent organization, and to BC CA's Contract H0564 and, in turn, accurately classified BC CA as an outlier. Further, CMS' Denial Notice and subsequent e-mail, read in context with each other and in light of this decision, are not inconsistent.

B. Lack of Comparison to High Performing Anthem Entities

Anthem maintains that CMS disregards the performance of the other 27 Anthem subsidiaries that are sibling entities of the New Entities. Anthem provides detailed information on the "exceptionally good performance" ratings received by those sibling entities. (*Id.* at 13-14).

At its core, Anthem's challenge is to the process developed by CMS to evaluate the CY 2019 Applications and set forth in its Methodology. Under 42 C.F.R. § 422.688, the Hearing Officer has no authority to modify CMS' methodology.

C. Whether Approval of the Application Would Further the Interest of the MA Program

Anthem points out the benefit that would come from offering varying types of MA plans to beneficiaries. (Anthem Reply Brief at 9). While Anthem paints the picture of a long and successful history in the MA program, the CMS Hearing Officer does not possess a broad scope of discretionary authority; rather, the Hearing Officer must decide if CMS' determinations were consistent with regulatory requirements. (42 C.F.R. §§ 422.660 and 422.688).

VII. Decision and Order

The Hearing Officer finds that CMS properly exercised its delegated authority when it denied the initial applications and service area expansion of the Anthem subsidiaries in this appeal based on past performance scores of BC CA's Contract H0544. Anthem has not shown by a preponderance of the evidence that CMS' determinations were inconsistent with controlling authority. Accordingly, the Hearing Officer grants CMS' Motion for Summary Judgment.

/Brenda D. Thew/
Brenda D. Thew, Esq.
CMS Hearing Officer

Date: August 15, 2018