DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244

July 12, 2023

**Via Electronic Delivery**

Karina Lopez
VNS Choice
220 East 42nd Street
6th Floor
New York, NY 10017

Amber Casserly
MAPD Appeals Team
7500 Security Boulevard
Woodlawn, MD 21244

RE: Hearing Officer Decision
Hearing Officer Docket Number: H-23-00005
Medicare Advantage/Prescription Drug Plan Contract Denial
VNS Choice Health Plan, Contract Number: H5549

Dear Ms. Lopez 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

| | | |
|---|---|---|
| **VNS Choice Health Plan Contract No. H5549,** | * | **Denial of Application to Expand Medicare Advantage / Medicare Advantage-Prescription Drug Plan** |
| **Appellant** | * | |
| **v.** | * | |
| **Centers for Medicare & Medicaid Services,** | * | **Contract Year 2024** |
| **Respondent** | * | **Hearing Officer Docket No. H-23-00005** |

---

## ORDER GRANTING CMS' MOTION FOR SUMMARY JUDGMENT

**Table of Contents**

**Page No.**


**I. FILINGS ..... 1**

**II. JURISDICTION ..... 1**

**III. ISSUE ..... 1**

**IV. DECISION SUMMARY ..... 1**

**V. BACKGROUND, AUTHORITY, AND CMS APPLICATION REQUIREMENTS AND REVIEW ..... 1**

**VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS ..... 4**

**VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW ..... 5**

**VIII. DECISION AND ORDER ..... 6**

## I. FILINGS

This Order is being issued in response to the following:

(a) VNS Choice Health Plan's ("VNS Choice's" or the "Plan's") Hearing Request and exhibits filed on May 30, 2023;
(b) Centers for Medicare & Medicaid Services' ("CMS'") Memorandum and Motion for Summary Judgment Supporting CMS' Denial of VNS Choice's Application to Expand the Service Area of its Medicare Advantage ("MA")/MA-Prescription Drug ("MA-PD") Contract, Contract Number H5549 ("CMS Memorandum and MSJ") and exhibits filed on June 13, 2023.

## II. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. § 422.660. The CMS Hearing Officer designated to hear this case is the undersigned, Amanda S. Costabile.

## III. ISSUE

Whether CMS' denial of VNS Choice's application to expand the service area of its MA/MA-PD contract (Contract No. H5549) to include Erie County, New York and Monroe County, New York, was inconsistent with regulatory requirements.

## IV. DECISION SUMMARY

The Hearing Officer grants CMS' Motion for Summary Judgment. There are no material facts in dispute. *See* VNS Choice Hearing Request at unnumbered pages 2-3; CMS Memorandum and MSJ at 1. The Hearing Officer's authority is limited to deciding if CMS' determination was consistent with regulatory requirements. *See* 42 C.F.R. §§ 422.660 and 423.650. Within its application, VNS Choice was required to demonstrate that it has an adequate contracted provider network that is sufficient to provide access to covered services as required by regulation. *See* 42 C.F.R. § 422.116(a)(1). VNS Choice concedes that it did not timely submit an MA Provider Table that met the regulatory network adequacy requirements or submit, for certain providers, accurate Letters of Intent ("LOI"). *See* VNS Choice Hearing Request at unnumbered pages 1-3. The Hearing Officer finds that CMS applied and followed the controlling regulations. Accordingly, the Hearing Officer upholds CMS' denial of VNS Choice's application.

## V. BACKGROUND, AUTHORITY, AND CMS APPLICATION REQUIREMENTS AND REVIEW

Under Title XVIII of the Social Security Act (codified at 42 U.S.C. §§ 1395-1395lll) 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, 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). CMS requires an entity seeking to contract as an MA organization to submit an application through the Health Plan Management System ("HPMS"). *See* "Part C-Medicare

Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2024-medicare-advantage-part-c-application.pdf-1 at 6-7 (last visited June 27, 2023). 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.

Beginning with contract year 2024, an MA organization's application for an 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. 42 C.F.R. § 422.116(a)(1)(ii) (2022). Within an application seeking a service area expansion, an MA organization must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet 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. *See* "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2024-medicare-advantage-part-c-application.pdf-1 at 27; *see also* December 22, 2022 Memorandum providing instructions ("December 2022 Instructions"), CMS Exhibit C-5 at 2. 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 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 Guidelines, located at www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance08302022.pdf at 2 (last updated Aug. 30, 2022) (hereinafter "Network Adequacy Guidelines"). Beginning in 2024, applicants may use a LOI, signed by both the MA organization and the provider or facility with which the MA organization has started or intends to start negotiations, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. 42 C.F.R. § 422.116(d)(7) (2022). 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 and in the form and manner directed by CMS. *Id*. Within the December 2022 Instructions, CMS provided applicants with information regarding how to notify CMS of their intent to use one or more LOIs and how the LOIs should be submitted. *Id.*

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. *See* Network Adequacy Guideline at 2. CMS explains that it programs network adequacy criteria into the Network Management Model ("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 3. CMS states that the automated tool "generates two reports," called the Automated Criteria Check ("ACC"), for "Provider" and "Facility," "that show whether a provider in a given county is passing the network adequacy requirements." *Id*. Lastly, CMS asserts that "[t]he ACC reports are accessible within the system to reflect where the applicant stands with respect to meeting the standardized criteria." *Id*; *see also* December 2022 Instructions, CMS Exhibit C-5 at 2.

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 any relevant past performance history associated with the applicant. 42 C.F.R. §§ 422.501(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 Deny ("NOID"). 42 C.F.R. § 422.502(c)(2). Per § 422.502(c)(2)(ii), the applicant will have ten days from the NOID to respond in writing to correct deficiencies in the application.

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 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 Social Security Act ("Act")] and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act."[1]

[1] 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 would, in effect, extend the deadline for submitting an approvable application.

## VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 13, 2023, VNS Choice filed an application with CMS to expand the service area of VNS Choice's contract (H5549) into Erie and Monroe Counties in New York for contract year 2024. CMS Memorandum and MSJ at 1, 5; *see* VNS Choice's Hearing Request at unnumbered page 1 n.2. VNS Choice currently operates in eleven other New York counties. CMS Memorandum and MSJ at 5.

CMS issued VNS Choice a Deficiency Notice on March 20, 2023, stating that some of the state licensure requirements were not met, and that the MA Provider and Facility Tables were not uploaded in HPMS. VNS Choice Exhibit A/P-1 at unnumbered page 2. The Deficiency Notice provided VNS Choice with the opportunity to correct the deficiencies identified in the notice no later than March 28, 2023, and provided instructions on how to do so and where to direct any questions. *Id*. at unnumbered pages 3-4.

VNS Choice submitted revised application materials on March 28, 2023, and CMS found that the State Certification form submitted cured the state licensure deficiency. CMS Memorandum and MSJ at 5. However, CMS found that VNS Choice's application was still deficient for network adequacy (1) in Erie County, New York, for allergy and immunology, chiropractor, dermatology, general surgery, nephrology, oncology – medical, surgical, plastic surgery, podiatry, rheumatology, urology and inpatient psychiatric facility services; and (2) in Monroe County, New York, for the chiropractic specialty. *Id.* at 6.

On April 17, 2023, CMS issued a NOID. VNS Choice Exhibit B/P-2; CMS Exhibit C-11. CMS found that VNS Choice's contracted network of providers and facilities did not meet CMS network standards. *Id.* at 1. Further, CMS found that the MA LOIs uploaded did not support VNS Choice's attestation. *Id.* CMS gave VNS Choice ten days, i.e., no later than April 27, 2023, to cure all deficiencies listed in order to receive approval on its Part C-MA application. *Id.* at 2. VNS Choice submitted its revised application materials "by the April 27, 2023 deadline[.]" CMS Memorandum and MSJ at 6.

After a review of the revised application materials, CMS denied VNS Choice's service area expansion application for its existing MA/MA-PD contract (H5549) on May 17, 2023. *See* VNS Choice Hearing Request at unnumbered page 1; CMS Memorandum and MSJ at 6; CMS Exhibit C-11. CMS found that VNS Choice failed to submit provider HSD tables to show an adequate provider network in Erie County for allergy and immunology, dermatology, and podiatry. CMS Memorandum and MSJ at 6. VNS Choice also attested to the use of 1,513 LOIs on their MA Provider and Facility HSD tables but failed to upload 71 of these LOIs. *Id.* (citing CMS Exhibits C-12 through C-14).

---

Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19678, 19683 (April 15, 2010).

VNS Choice filed its Hearing Request on May 30, 2023. The Office of Hearings acknowledged the appeal request on May 31, 2023, and provided the parties with a hearing date and briefing schedule. VNS Choice did not file an opening brief by the due date of June 7, 2023. However, by correspondence dated June 8, 2023, the Hearing Officer noted that VNS Choice's Hearing Request included an extensive narrative, exhibit list and twelve exhibits. As such, the Hearing Officer accepted VNS Choice's May 30, 2023, Hearing Request and associated filings as its opening brief.

Within its Hearing Request, VNS Choice claims that it is "presently in compliance with application standards" and that "its failure to meet CMS' deadline by a matter of eleven days . . . should not limit access in an already restricted market for MA/MA-PD plans to the detriment of Erie and Monroe dual-eligible patients." VNS Hearing Request at unnumbered page 1. VNS Choice argues that the CMS "hearing officer may exercise discretion in considering evidence that a plan has become fully compliant prior to rendering a decision[,]" and requests that "CMS apply such discretion" or, in the alternative, that the Hearing Officer "overturn the service area expansion denial." *Id*. at unnumbered pages 1-2. In support of its request, VNS Choice states that its May 10, 2023 "test submission of the MA Provider and Facility tables" reflect "that it has closed network adequacy gaps[,]" and that its LOI deficiencies resulted from "scrivener's errors mislabeling NPIs [i.e., National Provider Identifiers]." *Id*. at unnumbered page 3.

VNS Choice asserts that the regulatory subsections at 42 C.F.R. §§ 502(a)(1) and (c)(2) support CMS' "discretionary authority in these determinations." *Id*. at unnumbered pages 3-4. VNS Choice argues that the former subsection provides that CMS will base its application decisions on the application "'and any additional information that CMS obtains through other means,' such as the hearing process[]"; while the latter "requires the Plan to describe how it meets 'or will meet' all the requirements in the application in advance of an applicable performance year." *Id*.

CMS filed its responsive brief on June 13, 2023, in which it moved for summary judgment in its favor. *See* CMS Memorandum and MSJ at 1, 6-7.

## VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer grants CMS' Motion for Summary Judgment. There are no material facts in dispute as VNS Choice acknowledged that it was not able to correct all deficiencies listed in the NOID by the required deadline. VNS Choice Hearing Request at unnumbered pages 2-3; CMS Memorandum and MSJ at 1.

As noted above, and contrary to VNS Choice's assertions, the authority of the Hearing Officer is limited under 42 C.F.R. § 422.688, which mandates that "the hearing officer must comply with the provisions of Title XVIII of the Act — Health Insurance for the Aged and Disabled — 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."

Additionally, VNS Choice misconstrues the regulations that it relies upon. The regulations provide that CMS evaluates an MA organization's service area expansion application solely on the basis

of information contained in the application itself, any additional information that CMS obtains through other means such as on-site visits, and any relevant past performance history. *See* 42 C.F.R. §§ 422.502(a)(1) and (b)(1). Prior to CMS' final application decision, CMS provides applicants two opportunities to correct deficiencies identified within an application or, alternatively, applicants "have the option to withdraw or reduce the service area" of an application. *See* CMS Exhibit C-8 (March 20, 2023 Deficiency Notice); CMS Exhibit C-10 (April 17, 2023 NOID); CMS Memorandum and MSJ at 4-5. The regulations indicate that, following these opportunities to correct an application, if CMS does not receive a revised application, or if after timely submission of a revised application the applicant does not appear qualified/has not provided enough information, CMS will deny the application. *See* 42 C.F.R. § 422.502(c)(2)(iii).

The regulations provide that an applicant for an expanding service area must demonstrate compliance with the network adequacy requirements. *See* 42 C.F.R. § 422.116. VNS Choice admits that its MA Provider HSD table uploaded into HPMS as part of its application contained deficiencies and it does not contest CMS' position that it did not demonstrate compliance with CMS' network adequacy requirements by the required deadline.[2]

## VIII. DECISION AND ORDER

The Hearing Officer finds that VNS Choice has not proven, by a preponderance of evidence, that CMS' denial of its service area expansion application was inconsistent with regulatory requirements. *See* 42 C.F.R. §§ 422.660 and 422.688. The Hearing Officer finds that CMS applied and followed the controlling regulations. Accordingly, the Hearing Officer grants CMS' MSJ and upholds CMS' denial of VNS Choice's service area expansion application.

Amanda S. Costabile -S

Digitally signed by Amanda S. Costabile -S
Date: 2023.07.12 11:57:21 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: July 12, 2023

[2] Although VNS Choice claims that it is "presently" in compliance with application standards, VNS Choice has not proven, by a preponderance of evidence, that CMS must, at this stage, consider or accept VNS Choice's purported corrections from its final application submission upon which CMS issued its May 17, 2023 denial determination.