DEPARTMENT OF HEALTH & HUMAN SERVICES

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

August 2, 2023

Via Electronic Delivery

Tonya Fraser
Sonder Health Plans, Inc.
6190 Powers Ferry Rd NW #320
Atlanta, GA 30339

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

RE: Hearing Officer Decision
Hearing Officer Docket Number: H-23-00022
Medicare Advantage/Prescription Drug Plan Contract Denial
Sonder Health Plans, Inc., Contract Number: H1748

Dear Ms. Fraser 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

Sonder Health Plans, Inc.	*	**Denial of Application to Expand**
Contract No. H1748,	*	**Medicare Advantage/ Medicare**
	*	**Advantage-Prescription Drug**
Appellant	*	**Plan**
	*	
v.	*	
	*	**Contract Year 2024**
Centers for Medicare &	*	
Medicaid Services,	*	
	*	**Hearing Officer Docket No.**
Respondent	*	**H-23-00022**

*

ORDER GRANTING CMS' MOTION FOR SUMMARY JUDGMENT

Table of Contents

I. FILINGS

This Order is being issued in response to the following:

(a) Sonder Health Plans, Inc.'s ("Sonder's") Hearing Request by letter dated and filed on June 1, 2023;
(b) Sonder's Hearing Brief dated and filed on June 16, 2023; and
(c) Centers for Medicare & Medicaid Services' ("CMS'") Memorandum and Motion for Summary Judgment Supporting CMS' Denial of Sonder's Service Area Expansion Application for a Medicare Advantage ("MA")/MA-Prescription Drug ("MA-PD") Contract, Contract Number H1748 ("CMS Memorandum and MSJ") dated and filed on June 23, 2023.

II. JURISDICTION

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

III. ISSUE

Whether CMS' denial of Sonder's service area expansion ("SAE") application for an MA/MA-PD contract (Contract No. H1748) based on Sonder's failure to meet CMS' health services management and delivery requirements was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officer grants CMS' Motion for Summary Judgment. There are no material facts in dispute. CMS Memorandum and MSJ at 1; Sonder Hearing Brief at 1, 3-5. 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, Sonder was required to fully complete all parts of the application in the form and manner required by CMS, including demonstrating compliance with network adequacy standards outlined in 42 C.F.R. § 422.116(a)(1)(ii) by uploading Provider and Facility Health Service Delivery ("HSD") tables within the Health Plan Management System ("HPMS"). *See* 42 C.F.R. § 422.501(c)(1). Additionally, 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.

Sonder concedes that the network HSD table submissions uploaded in response to CMS' April 17, 2023, Notice of Intent to Deny ("NOID") continued to show "gaps" in its "provider network." Sonder's Hearing Brief at 3; *see* CMS Memorandum and MSJ at 6; Sonder Exhibit P-13. Thus, the Hearing Officer finds that there is no dispute that Sonder's application did not, in the form and manner required, demonstrate compliance with CMS' network adequacy standards as displayed on Sonder's as-submitted HSD tables. CMS Exhibits C-14 and C-15.

The Hearing Officer concludes that, in denying Sonder's application, CMS applied and followed the controlling regulations. Accordingly, the Hearing Officer upholds CMS' denial of Sonder's application.

V. BACKGROUND—APPLICATION REQUIREMENTS; EVALUATION AND DETERMINATION PROCEDURES

Under Title XVIII of the Social Security Act ("the 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-3 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 Letter of Intent ("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.* On February 9, 2023, by HPMS e-mail, CMS provided clarification regarding group level LOI submissions, providing that applicants that use a group practice LOI must upload that group practice LOI for each individual provider's National Provider Identifier ("NPI"), within the group practice, that the applicant includes on their HSD table. CMS Exhibit C-4.

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 4. 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-3 at 2.

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 Guidelines at 5. Specifically, an MA Plan may request an exception to network adequacy when (1) certain 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 (2) the 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). In evaluating exception requests, CMS considers whether (1) the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year; (2) there are other factors present that demonstrate[1] that network access is consistent with or better than the original Medicare pattern of care; and (3) approval of the exception is in the best interests of beneficiaries. 42 C.F.R. § 422.116(f)(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. §§ 422.502(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

[1] In accordance with 42 C.F.R. § 422.112(a)(10)(v).

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 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."[2]

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

Sonder timely filed a SAE MA/MA-PD application with CMS to operate in 109 additional counties in Georgia. *See* Sonder Hearing Brief at 2, 5; CMS Memorandum and MSJ at 5. This application sought to extend Sonder's Chronic Condition Special Needs Plans offerings to three other high-risk population segments, namely beneficiaries with Chronic Obstructive Pulmonary Disease, End-Stage Renal Disease, and Dementia. Sonder Hearing Brief at 2.

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

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

On March 20, 2023, CMS issued Sonder a Deficiency Notice in which CMS stated that Sonder failed to provide an adequate network for beneficiaries in 83 services areas for which they applied.[3] CMS Memorandum and MSJ at 5; *see* CMS Exhibits C-7, C-8, and C-9. The Deficiency Notice provided Sonder 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. CMS Exhibit C-9 at 2.

Subsequently, Sonder "notified CMS of its intent to withdraw 38 counties from their SAE application . . . [and] CMS processed this request." CMS Memorandum and MSJ at 6; *see* Sonder Hearing Brief at 2. Sonder failed to submit revised Provider and Facility HSD tables and failed to upload all of its LOIs by the March 28, 2023, deadline communicated in the Deficiency Notice. *Id.*

On April 17, 2023, CMS issued Sonder a NOID that indicated that Sonder's contracted network of providers and facilities did not meet CMS network standards, and that "one or more" of Sonder's exception requests were denied. CMS Exhibit C-13. CMS gave Sonder ten days, i.e., no later than April 27, 2023, at 8:00 PM EST, to cure all deficiencies listed, in order to receive approval on its Part C-MA application. *Id.* at 2.

In response to the NOID, Sonder submitted updated HSD tables and exception requests on April 28,[4] 2023. Sonder Hearing Brief at 3; CMS Memorandum and MSJ at 6. On May 3, 2023, Sonder "contacted the CMS portal requesting the opportunity to resubmit provider and facility HSD tables and also submit additional exception requests." CMS Memorandum and MSJ at 6; CMS Exhibit C-17. CMS denied the request. *Id.*

On May 17, 2023, CMS denied Sonder's MA/MA-PD application due to the network adequacy deficiencies, which were described in the denial letter as follows:

> Health Services Management & Delivery
>
> * 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

[3] CMS also found that the CMS State Certification Form did not meet the necessary requirements. *See* CMS Exhibit C-9. However, this deficiency was cured, and is not at issue in this appeal. CMS Memorandum and MSJ at 6; *see* CMS Exhibit C-1.

[4] Sonder's Hearing Brief provides a submission date of April 28, 2023, while CMS' Memorandum and MSJ indicates a submission date of April 27, 2023. Sonder's Hearing Brief at 3; CMS Memorandum and MSJ at 6. Nonetheless, the Hearing Officer observes that CMS has not indicated that Sonder's submission was not timely filed.

> 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 Facility Table - NMM Review - Based upon the automated review of your MA Facility Table, CMS has found that your contracted network of facilities does not meet CMS network standards. Refer to HSD Submission Reports (available in HPMS), including the Automated Criteria Check (ACC) Report for Facilities, for further details on the status of your submission.

Specifically, CMS found that Sonder had network deficiencies in 59 counties and denied 30 exception requests submitted by Sonder. CMS Memorandum and MSJ at 6.

Sonder filed its Request for a Hearing on June 1, 2023. The Office of Hearings acknowledged the appeal request and provided the parties with a hearing date and briefing schedule on June 2, 2023. The parties timely submitted their briefs pursuant to the briefing schedule. In CMS' brief, it moved for summary judgment in its favor. *See* CMS Memorandum and MSJ. On June 27, 2023, the parties filed a joint request for a decision on the written record, which was granted the following day.

VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties agree that there are no material facts in dispute. CMS Memorandum and MSJ at 1, 7; Sonder Hearing Brief at 3. Sonder failed to meet the MA/MA-PD application requirements when it failed to timely cure, via HPMS, the network adequacy deficiencies by the deadline established in the NOID.

Although conceding that its network adequacy deficiencies were not timely cured, Sonder argues that

> CMS's unrealistic timeline for demonstrating network adequacy for CY2024 applications as well as its hyper-technical submission requirements made it extraordinarily difficult for applicants like Sonder to demonstrate an adequate provider network within the abbreviated timeframe afforded by CMS.

Sonder Hearing Brief at 1.

Specifically, Sonder states that, following receipt of the March 20, 2023, Deficiency Notice, it "eliminated from its application certain counties where it could not satisfy CMS network adequacy standards." *Id.* at 2. Sonder states that it subsequently "submitted updated [HSD] tables showing its improved provider network[,]" but the CMS system's "unload validation" message that Sonder received following Sonder's submission of the updated HSD tables was "confusing" and caused Sonder "to mistakenly believe that the HSD tables as well as exception requests that Sonder

submitted in response to the Deficiency Notice had been accepted by CMS." *Id* at 2, 4. Sonder states that, as a result, its "plan personnel . . . did not click on 'final submit' to send the files to the [ACC] process to confirm whether Sonder's submitted network met CMS network adequacy standards." *Id*. at 2. Additionally, Sonder opines that "CMS's naming, uploading requirements, and size limits exponentially increased the amount of time needed to upload LOIs, and prevented Sonder from uploading all of its LOIs before the HPMS gate closed."[5] *Id.* at 4-5.

After receiving CMS' April 17, 2023, NOID, Sonder states that it "again submitted updated HSD tables and the exception requests [,] [but] [a]fter this submission, however, Sonder learned that its vendor, Quest Analytics, had logic errors in the coding of the HSD tables[.] *Id.* at 3. Thus, Sonder explains that "gaps still remained in Sonder's provider network." *Id.* Although Sonder subsequently requested an extension and then "sought to eliminate additional counties from its application to avoid a denial of its application," its requests were denied by CMS. *Id.*

Finally, Sonder asserts that "[h]ad the upload and other errors not occurred during the application process, Sonder could have demonstrated that it met CMS network adequacy requirements in 60 counties." *Id*. at 5. Sonder asks that it "be permitted to cure its application by demonstrating that it has met network adequacy in these 60 counties and be allowed to remove the remaining counties from its application." *Id*.

In its responsive brief, CMS explains that it "provided training for applicants on January 4, 2023. The training included instructions for exception request submissions, and examples of rationales that would be considered valid by CMS in order to meet the requirements in 42 C.F.R. § 422.116(f)." CMS Memorandum and MSJ at 7. CMS states that it "provided additional instructions in a separate exception request notification on March 31, 2023. *Id*. With respect to LOIs, CMS asserts that it "provided instructions to applicants submitting LOIs on December 22, 2022, [and] additional guidance regarding group level LOI submissions on February 9, 2023." *Id*.

CMS argues that "applicants were made aware of the requirement to demonstrate compliance with current network adequacy requirements well in advance of the 2024 application cycle[,]" and that it "provided sufficient information throughout the application process to allow Sonder . . . to cure any identified deficiencies with their application." *Id*. (emphasis omitted). CMS states that in addition to the "multiple trainings," it also "released guidance memos[;][6] responded via the CMS

[5] Sonder states that CMS' LOI requirements "resulted in Sonder having to upload the same LOI over 900 times[,] [and that] [t]hese requirements together with the limited periods during which CMS's gates were open for applicants to submit LOIs, set up applicants like Sonder for failure." Sonder Hearing Brief at 4.

[6] Within the December 2022 Instructions, CMS provides the following instruction for applicants:

> **IMPORTANT:** As part of submitting the Part C application through HPMS, applicants will be directed to submit their provider networks in the Network Management Module (NMM) in HPMS. CMS encourages applicants to prepare and submit HSD tables before the application deadline to help them determine ahead of the application submission deadline whether there are any errors in their tables to correct before clicking final submit. This will help applicants determine

[Division of Medicare Advantage Operations or "DMAO"] portal to remedy any confusion around submissions[;] [and] provided banner alerts on HPMS reminding applicants in advance of every deadline that they must hit final submit on their application in order to process their network submissions." *Id*.

Within the instant appeal, the Hearing Officer's authority is limited and the Hearing Officer must comply with the provisions of Title XVIII of the Act, 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. 42 C.F.R. § 422.688. Here, the Hearing Officer must decide if CMS' determination was consistent with regulatory requirements. *See* 42 C.F.R. §§ 422.660 and 422.688. The regulations state that an applicant must provide CMS, in the form and manner required by CMS, documentation demonstrating compliance with the network adequacy requirements outlined in 42 C.F.R. § 422.116(a)(1). Additionally, 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. Sonder concedes that, following its April 2023, submission of its updated HSD tables, "gaps still remained in Sonder's provider network." Sonder Hearing Brief at 3. The Hearing Officer finds that Sonder has not proven, by a preponderance of the evidence, that CMS' denial of Sonder's application, based on Sonder's network deficiencies, was inconsistent with regulatory requirements. Thus, the Hearing Officer concludes that CMS' denial was an appropriate exercise of its delegated authority.

VIII. DECISION AND ORDER

CMS' Motion for Summary Judgment is granted.

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Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: August 2, 2023

more quickly whether to prepare Exception Requests in response to network deficiencies.

CMS Exhibit C-3 at 2.