DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
7500 Security Boulevard
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August 18, 2023

VIA ELECTRONIC DELIVERY

Beth Socoski
Longevity Health Founders, LLC
11780 U.S. Highway 1 Suite N107
Palm Beach Gardens, FL 33408

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

RE: Hearing Officer Decision and Order
Hearing Officer Docket Number: H-23-00018
Medicare Advantage/Prescription Drug Plan Contract Denial
Longevity Health Plan of Michigan, Inc., Contract Number: H7557

Dear Ms. Socoski and Ms. Casserly:

A copy of the Hearing Officer's Decision and Order for the above-referenced appeal is attached.

The Hearing Officer's Decision and Order 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

Longevity Health Plan of Michigan, Inc. Contract No. H7557,	*	**Denial of Application to Expand Medicare Advantage/ Medicare Advantage-Prescription Drug Plan**
Appellant	*	
v.	*	**Contract Year 2024**
Centers for Medicare & Medicaid Services,	*	**Hearing Officer Docket No. H-23-00018**
Respondent	*	

ORDER GRANTING CMS' MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

This Decision and Order is being issued in response to the following:

(a) Longevity Health Plan of Michigan, Inc.'s ("Longevity-MI's") Request for Hearing by letter dated and filed on June 1, 2023;
(b) Longevity-MI's Initial Brief dated and filed on June 20, 2023;
(c) Centers for Medicare & Medicaid Services' ("CMS'") Memorandum and Motion for Summary Judgment Supporting CMS' Denial of Longevity-MI's Service Area Expansion Application for a Medicare Advantage ("MA")/MA-Prescription Drug ("MA-PD") Contract, Contract Number H7557 ("CMS Memorandum and MSJ") dated and filed on June 27, 2023; and
(d) Longevity-MI's Reply Brief dated June 29, 2023, and filed on June 30, 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 Longevity-MI's service area expansion application for an MA/MA-PD contract (Contract No. H7557), based on Longevity-MI's failure to meet CMS' provider network adequacy requirements was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officer grants CMS' Motion for Summary Judgment. CMS Memorandum and MSJ at 1, 7-8. The Hearing Officer finds that there are no material facts in dispute and that the record does not clearly establish that Longevity-MI provided, in response to CMS' April 17, 2023 Notice of Intent to Deny ("NOID"), CMS with the materials that CMS required to grant Longevity-MI's exception requests. Specifically, the record does not clearly establish that Longevity-MI's as-submitted exception requests provided rationales for not contracting with available providers that CMS found were within its network adequacy criteria or that Longevity-MI's as-submitted exception requests demonstrated evidence or other justifications to support a local pattern of care rationale. The Hearing Officer also finds that Longevity-MI has not proven, by a preponderance of the evidence, that CMS' denial of Longevity-MI's application, based on Longevity-MI's network deficiencies and denied exception requests, was inconsistent with regulatory requirements. Thus, the Hearing Officer upholds CMS' denial of Longevity-MI's service area expansion request for contract H7557.

V. AUTHORITIES, APPLICATION REVIEW PROCESS AND SUBREGULATORY GUIDANCE

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.

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 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. 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 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

A. NETWORK ADEQUACY REQUIREMENTS AND REVIEW

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 Guidance, 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 Guidance"). 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).

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 Guidance 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

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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).

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.

B. EXCEPTION REQUEST PROCESS AND REVIEW

CMS explains that "there are unique instances where a given county's supply of providers/facilities is such that an organization would not be able to meet the network adequacy criteria[,]" and that "[g]enerally, organizations use the exception process to identify when the supply of providers/facilities is such that it is not possible for the organization to obtain contracts that satisfy CMS's network adequacy criteria." Network Adequacy Guidance at 5. As such, CMS permits applicants that are unable to satisfy network adequacy criteria in 42 C.F.R. § 422.116(b)-(e) to submit exception requests. 42 C.F.R. § 422.116(f); *see* Network Adequacy Guidance at 5. Specifically, under 42 C.F.R. § 422.116(f)

> (1) An MA Plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when both of the following occur:
>
> (i) Certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider supply file[2] for the year for a given county and specialty type.
>
> (ii) 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.
>
> (2) In evaluating exception requests, CMS considers whether—
>
> (i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;
>
> (ii) There are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and
>
> (iii) Approval of the exception is in the best interests of the beneficiaries.

[2] The Provider Supply File is explained in further detail below.

Moreover, 42 C.F.R. § 422.112(a)(10)(v) provides as follows:

> (10) *Prevailing patterns of community health care delivery.* MA plans that meet Medicare access and availability requirements through direct contracting network providers must do so consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed MA plan health care delivery network include, but are not limited to the following:
>
> . . .
>
> (v) Other factors that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area.

CMS provides additional information and instruction regarding exception requests within its Network Adequacy Guidance. Specifically, CMS informs that

> [t]he organization must include **conclusive evidence in its exception request that the CMS network adequacy criteria cannot be met** because of changes to the availability of providers/facilities, resulting in insufficient supply. The organization must **then** demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnished enrollees with adequate access to covered services and is consistent with or better than the Original Medicare pattern of care for a given county and specialty type.

Network Adequacy Guidance at 5 (emphasis added).

The Network Adequacy Guidance provides a non-exhaustive list of what CMS considers to be valid rationales to submit an exception request. CMS states that such rationale may include, but are not limited to:

- Provider is no longer practicing (e.g., deceased, retired).
- Does not contract with any organizations or contracts exclusively with another organization.
- Provider does not provide services at the office/facility address listed in the supply file.
- Provider does not provide services in the specialty type listed in the supply file.
- Provider has opted out of Medicare.
- Sanctioned provider on List of Excluded Individuals and Entities.

> • Use of Original Medicare telehealth providers or mobile providers.
> • Specific patterns of care in a community.

Id. (emphasis omitted).

Of note, the Network Adequacy Guidance states that CMS "will generally not accept an organization's assertion that it cannot meet current CMS network adequacy criteria because of an 'inability to contract,' meaning they could not successfully negotiate and establish a contract with a provider/facility." *Id*. at 7.

Additionally, CMS provides specific guidance regarding how it requires a rationale to be submitted. For example, with respect to the rationale that a provider does not contract with any organization, CMS instructs that

> [o]n the exception request, from the "Reason for Not Contracting" drop-down list, an organization could select either "Provider does not contract with any organization" or "Other" if the provider/facility contracts exclusively with another organization. **The organization must provide evidence** in the "Additional Notes on Reason for Not Contracting" field.

Id. at 6 (emphasis added).

With respect to the "Pattern of Care" rationale, the Network Adequacy Guidance provides that

> [o]rganizations requesting an exception using the "Pattern of Care" rationale should provide substantial and credible **evidence** that shows there is an insufficient supply of providers/facilities, as well as why they do not contract with available providers/facilities. The organization must show that the pattern of care in the area is unique, and the organization believes their contracted network is consistent with or better than the Original Medicare pattern of care.
>
> On the exception request PDF, an organization must compare the non-contracted providers/facilities closer to enrollees in terms of time and distance to other providers/facilities that may be located farther away. From the "Reason for Not Contracting" drop-down list, an organization could select "Other" and then provide evidence in the "Additional Notes on Reason for Not Contracting" field that demonstrates that the organization did not contract with the available provider/facility because the organization's current network is consistent with or better than the Original Medicare pattern of care. For this pattern of care rationale, CMS will consider the following in the "Additional Notes on Reason for Not Contracting" field:

- Internal claims data with an explanation that demonstrates the current pattern of care for enrollees in the given county for the given specialty type, or
- Detailed explanation that supports the rationale that the contracted network provides access that is consistent with or better than the Original Medicare pattern of care.

Id. at 7 (emphasis added).

Lastly, within its brief, CMS states that it manually reviews exception requests and that it "uses the supply file when validating information submitted on exception requests." CMS Memorandum and MSJ at 4; *id*. at 3. Within the Network Adequacy Guidance, CMS explains that the supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier, and specialty type and is posted by state and specialty type. Network Adequacy Guidance at 3. CMS states that although "[t]he supply file is segmented by state to facilitate development of networks by service area[,] [c]ontracts with service areas near a state border may need to review the supply file for multiple states, as the network adequacy criteria are not restricted by state or county boundaries." *Id*. Additionally, given the dynamic nature of the market, CMS states that the supply file is a resource and may not be a complete depiction of provider and facility supply available in real-time. *Id.* CMS asserts that MA organizations remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file, and should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available. *Id.*

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

As background, Longevity-MI currently offers an Institutional Special Needs Plan ("I-SNP") in 16 counties in Michigan. Longevity-MI Initial Brief at 2. It's parent organization, Longevity Health Founders, holds eight MA-PD contracts, offering I-SNPs in eight states. *Id.*

On February 15, 2023, Longevity-MI filed a service area expansion MA/MA-PD application with CMS to expand operations to seven[3] additional counties, Bay, Berrien, Clare, Gladwin, Lake, Midland, and Van Buren counties in Michigan for calendar year 2024. CMS Memorandum and MSJ at 1, 5; *see* Longevity-MI Initial Brief at 2.

On March 20, 2023, CMS determined that Longevity-MI's application failed to demonstrate that the organization met network adequacy requirements in 42 C.F.R. § 422.116, and issued a Deficiency Notice. CMS Memorandum and MSJ at 5; CMS Exhibit C-6. The Deficiency Notice provided Longevity-MI 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

[3] Within its Initial Brief, Longevity-MI states that it "applied to CMS for a service area expansion in order to allow it to offer an MA I-SNP in four additional Michigan counties." Longevity-MI Initial Brief at 2. The Hearing Officer notes that on May 9, 2023, Longevity-MI requested—and CMS granted—the removal of three counties from its application which may account for the discrepancy in the number. *See* CMS Exhibit C-14.

questions. CMS Exhibit C-6 at 2. Longevity-MI submitted revised Provider and Facility HSD tables by the March 28 deadline. CMS Memorandum and MSJ at 5-6.

On April 17, 2023, CMS issued a NOID, citing network adequacy deficiencies, and exception request denials. *Id.*; CMS Exhibit C-10. CMS found that Longevity-MI continued to have insufficient provider networks in Bay, Clare, Gladwin and Lake Counties. CMS Memorandum and MSJ at 6; *see* CMS Exhibits C-7 and C-8. CMS found that Longevity-MI failed to submit eighty-nine (89) exception requests that met the criteria for approval because CMS identified available providers located within the time and distance criteria that Longevity-MI failed to include on their exception request submission or HSD submission. CMS Memorandum and MSJ at 6; *see* CMS Exhibit C-9. CMS gave Longevity-MI ten (10) days, i.e., no later than April 27, 2023, to cure all application deficiencies. *Id.* Longevity-MI timely submitted revised application materials, which consisted of revised Provider and Facility HSD Tables, and revised exception request submissions. *Id.*

On May 9, 2023, Longevity notified CMS of its intent to withdraw Berrien, Midland and Van Buren Counties from their service area expansion application in Michigan. *See* CMS Exhibit C-14. CMS processed this request on May 10, 2023.[4] CMS Memorandum and MSJ at 6; CMS Exhibit C-14.

On May 17, 2023, CMS denied Longevity-MI's MA/MA-PD application due to failing to meet network adequacy requirements, and failing to submit valid exception requests, which were described in the application 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 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),

[4] CMS states that the withdrawal of these counties did not, however, cure Longevity-MI's network adequacy deficiencies and did not resolve 24 denied exception requests. CMS Memorandum and MSJ at 6.

> including the Automated Criteria Check (ACC) Report for Facilities, for further details on the status of your submission.

See CMS Memorandum and MSJ at 6; CMS Exhibit C-1.

Specifically, CMS found that Longevity-MI failed to submit valid rationales for not contracting with providers and CMS identified available providers located within the network adequacy time and distance criteria that Longevity-MI failed to include on their exception request submission or HSD submissions. *Id.*; *see* CMS Exhibits C-11, C-12, and C-13.

Longevity-MI 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 the same day. 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. In Longevity-MI's Initial and Reply Briefs, it waived its right to a hearing, and requested a decision on the written record. *See* Longevity-MI Initial Brief at 6; Longevity-MI Reply Brief at 1. The Hearing Officer granted the request for a record hearing on July 3, 2023.

VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer grants CMS' Motion for Summary Judgment and upholds its denial of Longevity-MI's service area expansion application for contract H7557. CMS Memorandum and MSJ at 1, 7-8; Longevity-MI Initial Brief at 3-6. Longevity-MI does not dispute that its application's provider and facility networks contained deficiencies such that it did not meet CMS' network adequacy standards. Longevity-MI Initial Brief at 2. Instead, Longevity-MI argues that "CMS had the authority to accept [its] exception requests and should have accepted those requests." *Id*. The Hearing Officer finds, however, that Longevity-MI has not proven by a preponderance of evidence that it met CMS' exception request requirements when it submitted its revised exception request submissions in response to CMS' April 17, 2023 NOID.

Within its Initial Brief, Longevity-MI explains that, due to the nature of an I-SNP[5] (i.e., low enrollment and limited utilization of certain types of providers), many providers consider that "I-

[5] As background, the Bipartisan Budget Act of 2018 ("the BBA"), Pub. L. No. 115-123, § 50311, 132 Stat. 64, 192 (2018) permanently authorized SNPs, thereby indefinitely "providing continued access to Medicare Advantage special needs plans for vulnerable populations." *See* Act § 1859(f)(1). All SNPs must have in place an evidenced-based model of care with appropriate networks of providers and specialists. *Id.* § 1859(f)(5).

On its website, CMS describes I-SNPs as follows:

> [I-SNPs] are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. . . .
>
> CMS may allow an I-SNP that operates either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents. As

SNP plans offer too limited utilization to be worth the time of some providers for purposes of contract development." *Id.* at 3. Longevity-MI explains that it "utilized the Provider Supply file to identify the providers that would be necessary for it to meet network adequacy standards in the expansion area but was refused for the foregoing reasons." *Id.* Longevity-MI asserts that CMS does not "foreclose the possibility" that it will accept an organization's assertion that "it cannot meet current CMS adequacy criteria because of an 'inability to contract.'" *Id.* at 3-4. Thus, Longevity-MI argues that "[g]iven the previously stated contracting challenges unique to a health plan solely offering an I-SNP line of business, [it] believe[s] [that] it is demonstratable that many of the providers in the provider supply file are not available to Longevity-MI." *Id.* at 4.

Additionally, partially citing the language in 42 C.F.R. § 422.116(f)(1)(ii),[6] Longevity-MI states that it "has contracted with other providers and facilities that are currently available and accessible to most enrollees, consistent with the local pattern of care." *Id.* Specifically, Longevity-MI explains that

> [b]efore [it] offers I-SNPs to residents of a [Skilled Nursing Facility ("SNF")], Longevity first ensures that it has contracts with at least one primary care provider who furnishes services to residents in their SNF home and with the specialty physicians that service the residents of the SNF for the six specialties most commonly used by Longevity members. Thus, unless Longevity can ensure that the providers most commonly needed by their members are available in the SNF or within a short distance, Longevity does not implement its program in a given SNF. This is the case even in counties that meet or exceed CMS network adequacy standards.
>
> Where Longevity lacks a contract with a less commonly used specialist, if a need for such a specialist arises, Longevity enters into a single case agreement with the specialist to ensure member access. To date, Longevity has never received a member grievance concerning access to care.

Id.[7]

> with all MA plans, CMS will monitor the plan's marketing/enrollment practices and long-term care facility contracts to confirm that there is no discriminatory impact.

CMS, Institutional Special Needs Plans (I-SNPs), https://www.cms.gov/medicare/health-plans/specialneedsplans/i-snps (last accessed July 28, 2023).

[6] The complete regulatory subsection states "[t]he 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."

[7] The Hearing Officer notes that, based on Longevity-MI's statement here, Longevity-MI does not clearly establish whether it *has* contracted with the providers that it discusses.

Partially citing the language in 42 C.F.R. § 422.116(f)(2)(ii),[8] Longevity-MI argues that "[t]here are other factors present that demonstrate that network access is consistent with or better than the original Medicare pattern of care." *Id.* Specifically, Longevity-MI explains that under its "Model of Care,"

> each member is assigned an Advanced Practice Practitioner ("APP") who, in partnership with the member's [Primary Care Physician ("PCP")] and skilled nursing facility staff, provides full time onsite, facility-based clinical support to implement an integrated care model. The goal of this model is to improve member access to primary care services, improve timeliness of services, and with the PCP as "coordinator of care" working with specialists, ensure Members receive comprehensive care.
>
> Consequently, beneficiaries enrolled in Longevity have better access to care than similar institutionalized beneficiaries with fee-for-service Medicare.[9]

Id. at 4-5.

Lastly, Longevity-MI argues that taking into account that "I-SNPs focus on a historically underserved population and leverage a Model of Care that decreases the fragmentation in service delivery for their members who are frail, vulnerable and have complex needs[,] [a]pproval of the exception is in the best interest of beneficiaries." *Id*. at 5.

In answering Longevity-MI's arguments, CMS responds as follows:

> All network-based MA plans, including I-SNPs, applying for a new or expanding service area, must demonstrate that [they have] an adequate contracted provider network that is sufficient to provide access to covered services in accordance with access standards described in section 1852(d)(1) of the Act and in §§ 422.112(a) and 422.114(a)(1).
>
> A MA plan may request an exception to the network adequacy criteria if their exception meets the criteria in 42 C.F.R. § 422.116(f). Longevity did not provide valid rationales, required for all network-based MA plans, including I-SNPs, for their twenty-four (24) denied exception requests, instead Longevity stated that

[8] The complete regulatory subsection states "[t]here are other factors present, in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care."

[9] In support of its assertion that its "pattern of providing care to I-SNP members in their home facility is common[,]", Longevity-MI included, as its sole exhibit, a March 7, 2022, comment letter regarding the then proposed rule CMS-4192-P from the American Health Care Association and the National Center for Assisted Living ("AHCA/NCAL"). Longevity-MI Initial Brief at 5; Longevity-MI Exhibit 1.

> they were unable to contract with the providers CMS identified in the Provider Supply file. CMS does not consider "inability to contract" as a valid rationale for an Exception to the network adequacy criteria. The non-interference provision at section 1854(a)(6) of the Act prohibits CMS from requiring any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services or require a particular price structure for payment under such a contract. As such, we cannot assume the role of arbitrating or judging the bona fides of contract negotiations between an MA organization and available providers or facilities.
>
> CMS will consider a local pattern of care rationale for an exception to the network adequacy criteria when there are other factors present, outlined in 42 C.F.R. § 422.112(a)(10) that demonstrate that network access is consistent with or better than the original Medicare pattern of care, as the exception request requirements under 42 C.F.R. [§] 422.116(f) apply to all MA applicants.
>
> Longevity did not demonstrate in their exception requests, with evidence or other justifications to support a local pattern of care rationale for not meet[ing] network adequacy requirements.

CMS Memorandum and MSJ at 8.

The Hearing Officer observes that in evaluating Longevity-MI's exception requests under the standard at 42 C.F.R. § 422.116(f)(2)(i), i.e., whether the current access to providers and facilities is different from the HSD reference and Provider Supply Files for the year, CMS found Longevity's exception requests failed as "Longevity did not provide valid rationales for not contracting with available providers inside the time and distance requirements and where applicable, did not provide evidence of contracting outside of the time and distance requirements to ensure adequate provider access." *Id.* at 7. Additionally, CMS states that Longevity-MI's exception request rationale "inability to contract" is not "a valid rationale for an Exception to the network adequacy criteria." *Id*. at 8; *see* Network Adequacy Guidance at 7. Longevity-MI argues that it "utilized the Provider Supply file to identify the providers that would be necessary for it to meet network adequacy standards in the expansion area" but, due to the nature of I-SNP enrollees' limited utilization of certain providers, Longevity-MI was "refused."[10] Longevity-MI Initial Brief at 3.

The Hearing Officer notes, however, that as a threshold matter, CMS requires applicants to "include conclusive evidence in its exception request that the CMS network adequacy criteria **cannot be met** because of changes to the availability of providers/facilities, resulting in

[10] Longevity-MI's complete quote reads as follows: "Longevity-MI utilized the Provider Supply file to identify the providers that would be necessary for it to meet network adequacy standards in the expansion area but was refused for the foregoing reasons." Longevity-MI Initial Brief at 3.

insufficient supply." Network Adequacy Guidance at 5 (emphasis added). Within its review of Longevity-MI's exception requests and as displayed within the spreadsheet documenting that review, CMS found—and listed—specific providers within the network adequacy criteria that Longevity-MI did not "include on [its] Exception Request and/or HSD table(s)." CMS Exhibit C-13. As the record does not clearly establish that Longevity-MI's as-submitted exception requests addressed these providers that CMS states are within its network adequacy criteria, the Hearing Officer finds that CMS' determination based on 42 C.F.R. § 422.116(f)(2)(i)'s standards is supportable. *See* CMS Memorandum and MSJ at 6.

Consistent with the evaluation standard under 42 C.F.R. § 422.116(f)(2)(ii), Longevity-MI also argues that "[t]here are other factors present that demonstrate that network access is consistent with or better than the original Medicare pattern of care." Longevity-MI Initial Brief at 4-5. In support of this assertion, Longevity-MI's brief sets forth a summary of its Model of Care and its reasons why it believes its model provides beneficiaries in an I-SNP "better access to care than similar institutionalized beneficiaries with fee-for-service Medicare." *Id*.

In response, CMS states that it "will consider a local pattern of care rationale for an exception to the network adequacy criteria when there are other factors present, outlined in 42 C.F.R. § 422.112(a)(10)[v] that demonstrate that network access is consistent with or better than the original Medicare pattern of care." CMS Memorandum and MSJ at 8-9. However, CMS concluded that "Longevity did not demonstrate in their exception requests, with evidence or other justifications to support a local pattern of care rationale for not meet[ing] network adequacy requirements." *Id*.

Here, the Hearing Officer finds that the record does not clearly establish that Longevity-MI's as-submitted exception requests provided CMS with the specific information required,[11] as set forth

[11] With respect to the "Pattern of Care" rationale, the Network Adequacy Guidance provides that

> [o]rganizations requesting an exception using the "Pattern of Care" rationale should provide substantial and credible evidence that shows there is an insufficient supply of providers/facilities, as well as why they do not contract with available providers/facilities. The organization must show that the pattern of care in the area is unique, and the organization believes their contracted network is consistent with or better than the original Medicare pattern of care.
>
> On the exception request PDF, an organization must compare the non-contracted providers/facilities closer to enrollees in terms of time and distance to other providers/facilities that may be located farther away. From the "Reason for Not Contracting" drop-down list, an organization could select "Other" and then provide evidence in the "Additional Notes on Reason for Not Contracting" field that demonstrates that the organization did not contract with the available provider/facility because the organization's current network is consistent with or better than the Original Medicare pattern of care. For this pattern of care rationale, CMS will consider the following in the "Additional Notes on Reason for Not Contracting" field:
>
> - Internal claims data with an explanation that demonstrates the current pattern of care for enrollees in the given county for the given specialty type, or

in the Network Adequacy Guidance, for CMS to consider Longevity-MI's "Pattern of Care" exception request.

Additionally, when considering the exception request standard under 42 C.F.R. § 422.116(f)(2)(ii), the Hearing Officer notes that when determining if there are other factors present, as outlined in 42 C.F.R. § 422.112(a)(10)(v), the regulatory subsection specifically provides that CMS considers "[o]ther factors that **CMS determines** are relevant in setting a standard for an acceptable health care delivery network in a particular service area." (Emphasis added). In other words, the regulation grants CMS the discretionary authority to determine which factors, if any, are relevant for its consideration. The Hearing Officer finds that review of such discretionary determinations is outside the scope of the Hearing Officer's authority under 42 C.F.R. § 422.688. Specifically, 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, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act.

VIII. DECISION AND ORDER

CMS' Motion for Summary Judgment is granted. The Hearing Officer finds that there are no material facts in dispute. The Hearing Officer also finds that Longevity-MI has not proven by a preponderance of evidence that CMS' denial of its service area expansion application for contract H7557, based on network adequacy deficiencies and CMS' denials of Longevity-MI's exception requests, was inconsistent with regulatory requirements.

Amanda S. Costabile -S

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Date: 2023.08.18 15:13:43 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: August 18, 2023

- Detailed explanation that supports the rationale that the contracted network provides access that is consistent with or better than the Original Medicare pattern of care.

Id. at 7.