DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
ORDER

In the case of:	**Review of:**
Longevity Health Plan of North Carolina, Inc.	**Hearing Officer Case No. H-24-00017**
Contract No. H5374	**Dated: July 23, 2024**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the CMS Hearing Officer's decision pursuant to 42 C.F.R. § 422.692. Longevity Health Plan of North Carolina, Inc. (Longevity-NC) requested review by the Administrator. The parties were notified of the Administrator's intention to elect to review the Hearing Officer's decision. Comments were received from Longevity-NC. Accordingly, this case is now before the Administrator for final agency review. The entire record, which was furnished by the CMS Hearing Officer, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

ISSUE AND CMS HEARING OFFICER'S DECISION

The issue in this case, as stated by the Hearing Officer, involved whether CMS' denial of Longevity-NC's service area expansion application for an MA/MA-PD contract (Contract No. H5374), based on Longevity-NC's failure to meet CMS' provider network adequacy requirements was inconsistent with regulatory requirements.

The Hearing Officer granted CMS' Motion for Summary Judgment. The Hearing Officer found that there were no material facts in dispute, and that based on the record, Longevity-NC did not provide CMS with Provider and Facility Health Service Delivery (HSD) Tables that met CMS network adequacy requirements and did not make valid exception requests specifically addressing the network deficiencies. Rather, the Hearing Officer noted, Longevity-NC made policy-related requests for relief, including consideration of regulatory requirements not applicable to the Calendar Year 2025 application cycle, that were outside the scope of the Hearing Officer's authority under 42 C.F.R. § 422.688. Thus, the Hearing Officer upheld CMS' denial of Longevity-NC's service area expansion application for contract H5374.

COMMENTS

Longevity-NC requested review by the Administrator under 42 C.F.R. §422.692(a). The Administrator notified the parties that the Hearing Officer's decision would be reviewed. Longevity-NC submitted additional comments, requesting that the Administrator reverse CMS' denial decision and approve Longevity-NC's service expansion application.

Longevity-NC argued that allowing it to expand its service area to additional counties would support CMS' objective of expanding access to affordable care. Longevity-NC noted that ninety-eight percent of its members are dual-eligible. Many have comorbid conditions, no family in the area, and a disproportionate share are ethnic minorities. Longevity-NC pointed to various studies finding that nursing home residents have poor access to clinical care, resulting in unfavorable health outcomes. Longevity-NC noted that under their "Model of Care", each member is assigned an Advanced Practice Practitioner who, in partnership with the member's PCP, skilled nursing facility staff, and other Longevity staff provides full time onsite, facility-based clinical support to implement an integrated care model. Longevity stated that if it cannot ensure that the providers most commonly needed by its members are available in the SNF or within a very short distance, Longevity does not implement its program in a given SNF. Thus, Longevity-NC argued, nursing home residents enrolled in its I-SNP have greater access to care than residents remaining in fee-for-service Medicare.

Longevity-NC noted that their only line of business is MA I-SNP plans, which generally have low enrollment (beneficiaries residing in nursing facilities with which the I-SNP has a contract). Longevity-NC argued that health plans only offering I-SNP plans often have a harder time contracting with certain providers. Longevity-NC noted that as of June of this year, CMS acknowledged the need for a change to network adequacy requirements for I-SNPs. Longevity-NC acknowledged that while its expansion request must be evaluated under the current rules for network adequacy:

> [I]t is important to note that the real-world effect of the denial is to hinder access to better and more affordable clinical care for an underserved, disproportionately minority population of vulnerable individuals. These people are effectively caught in limbo between CMS' acceptance of a new policy and its implementation.
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> This situation, in our view, cries out for the granting of an exception so that the needs of these unique beneficiaries are timely addressed.
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> The Medicare beneficiaries that Longevity serves in North Carolina, and the skilled nursing facilities where they reside, need help now. By the time the new policy is implemented in 2025, perhaps a third of current institutionalized beneficiaries will no longer be with us due to their high acuity and mortality. Every day that we can collectively work to improve

their lives, and support the SNFs where they reside, is worth the effort to do so.

DISCUSSION

CMS is authorized to enter into contracts with companies to provide medical coverage under the Medicare Advantage (MA) program to their plan enrollees through Medicare Part C, as well as private prescription drug benefits to their plan enrollees under Medicare Part D. Regulations governing Parts C and D of the Medicare program are set forth at 42 C.F.R §§ 422 and 423, respectively. Under 42 C.F.R. § 422.116, an MA plan must demonstrate that it has 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), and must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type. Beginning with contract year 2024, an applicant for a new or expanding service area must demonstrate compliance with the network adequacy requirement section as part of its application for a new or expanding service area and CMS may deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area. To demonstrate compliance with these network adequacy standards, as part of the application, MA plans must upload Provider and Facility Health Service Delivery (HSD) Tables into the Health Plan Management System (HPMS). An MA plan must list every provider and facility with a fully executed contract in its network in the HSD Tables. A letter of intent (LOI) signed by both the MA organization and the provider or facility with which the MA plan has started or intends to negotiate may be used in lieu of a signed contract to meet network standards.

In certain circumstances, CMS allows plans to request an exception to the network adequacy criteria. Previously, the regulation at 42 C.F.R. § 422.116(f) noted that exceptions were allowed when both of the following occurred: (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. CMS manually reviews exception requests, and considers, among other things, whether the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year; whether there are other factors present that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and whether approval of the exception is in the best interests of beneficiaries. Additional information and instructions regarding exception requests are included in the "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance".[1] The Network Adequacy Guidance provides a non-exhaustive list of what CMS considers to be valid rationales to submit an exception request and why the identified providers cannot contract. Notably, the Network Adequacy

[1] Available online at *https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance12-12-2023.pdf.*

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."

In this case, Longevity-NC submitted a service area expansion application for Calendar Year 2025 under its existing contract number H5374, in order to offer an MA Institutional Special Needs Plan (I-SNP) in two additional North Carolina counties. [2] Per § 1859(f)(2) of the Act, I-SNPs 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) facility, which includes: a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), an inpatient psychiatric hospital, a rehabilitation hospital, an LTC hospital, or a swing-bed hospital.

On March 19, 2024, CMS issued a Deficiency Notice to Longevity-NC which noted deficiencies related to network adequacy for both the provider and the facility HSD tables.[3] Longevity-NC submitted network adequacy HSD tables in response to the Deficiency Notice.[4] After reviewing the revised HSD tables, CMS issued Longevity-NC a Notice of Intent to Deny (NOID) on April 16, 2024, in which CMS once again cited network adequacy deficiencies.[5] In the NOID, CMS noted that Longevity had until 8 PM ET on April 26, 2024, to attempt to cure any application deficiencies, including making any exception requests.[6] On May 10, 2024, CMS issued a memo to applicants who submitted exception requests to the network adequacy criteria, notifying applicants that the results of the exception request were available, and informing applicants that they had until May 13 at 3:00 PM ET to withdraw any pending counties with remaining deficiencies in advance of final notices.[7] In response, Longevity-NC submitted withdraw requests for Franklin and Hertford counties, where the plan failed network adequacy standards, but did not submit exception requests, on May 10, 2024.[8]

On May 15, 2024, CMS issued a Denial Letter to Longevity-NC for their Service Expansion Application, based on the following deficiencies:

> * Exception Request Status—NMM Review—We denied one or more of your Exception Requests, please refer to HSD Submission Reports

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[2] Longevity-NC currently offers I-SNP plans in 43 counties in North Carolina. *See* Longevity-NC's comments to the Administrator, dated August 29, 2024. In the end, after withdraws of counties, the requested counties were requested Nash and Scotland.
[3] *See* CMS Brief Exhibit 1. Other deficiencies not relevant to this appeal were also noted.
[4] *See* p. 5-6 of CMS Brief dated June 12, 2024.
[5] *Id.* at 6.
[6] *Id.*
[7] *Id.*
[8] *Id.*

> (available in HPMS), including the Exception Report for further details on the status of your submission.
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> * 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.
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> * MA Letters of Intent—NMM Review—You uploaded information that does not support your attestation. Please refer to HSD Submission Reports (available in HPMS), including the LOI Results Report for further details on the status of your submission.[9]

There are no material facts in dispute in this case. Longevity-NC does not dispute that its Provider and Facility HSD tables that it submitted in response to the April 16, 2024 NOID contained deficiencies. Rather, Longevity-NC made public policy arguments, arguing that allowing Longevity-NC to expand into additional counties would support CMS's public policy objective of expanding access to quality affordable care, particularly to traditionally underserved and vulnerable populations. Longevity-NC also pointed out that CMS should grant special considerations for I-SNP plans which offer too limited utilization to be worth the time of some providers for purposes of contract development, and thus have a harder time meeting network adequacy requirements.

Longevity also argued that CMS should allow for an exception in this case based on the impending changes to the exceptions process for I-SNP plans as written into the 2025 Final Rule, effective June 2024, as well as current regulations, which allows for CMS to make exceptions when network access is consistent with or better than the original Medicare pattern of care, and approval of the exception is in the best interests of beneficiaries.

The record in this case does not establish that Longevity-NC provided CMS with Provider and Facility HSD tables that met CMS' network adequacy requirements; exception requests that provided the information that CMS requires in order to be considered a valid rationale in support of the requests; or HSD tables or exception requests that addressed or included the providers and facilities that CMS identified as being located within CMS' network adequacy criteria applicable to the counties Longevity-NC seeks to add. The failure of the MAO to contract with provider and facilities that met the time and distance criteria etc. due to contracting issues is not a sufficient rational as the basis for the exception request. The lack of availability of specialty types is a threshold criterion that must be met to be further evaluated under the pattern of care or best interest of the beneficiary criteria.[10]

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[9] *See* CMS Exhibit 1. As noted by the Hearing Officer, neither party discusses the LOI deficiencies in their briefs.

[10] *See also* Network Adequacy Guidance. The Network Adequacy Guidance provides a non-exhaustive list of what CMS considers to be valid rationales to submit an exception

As Longevity-NC did not prove by a preponderance of the evidence that CMS' determinations regarding Longevity's network deficiencies and insufficient exception requests were inconsistent with regulatory requirements, and, as 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 new or expanding service area, the Hearing Officer was correct to uphold CMS' denial of Longevity's service area expansion request for contract H1644.

Regarding upcoming changes, for contract year 2026, CMS is establishing new exceptions from the network adequacy evaluations under 42 C.F.R. § 422.116 for its newly establish category of I-SNPs called facility-based I-SNPs (FI-SNPs).[11] This included new factors and evidence CMS will consider in whether to grant the new exceptions. CMS also implemented the new requirement that an MA organization that receives an exception for FI-SNP(s) only offer FI-SNPs under the contract that receives the exception approval. Thus, 42 C.F.R. § 422.116 will now state, effective for January 1, 2025:

> (f) * * *
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> (1) An MA plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when either paragraph (f)(1)(i) or (ii) of this section is met:
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> (i)(A) 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

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request. 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.

[11] A specific subtype of I-SNP is the newly established facility-based I-SNP (FI-SNPs), the definition of which was set forth in the April 23, 2024 final rule (89 Fed. Reg. 30,448, 30,673). As noted, a FI-SNP restricts enrollment to MA-eligible individuals who meet the definition of institutionalized; owns or contracts with at least one institution, specified in the definition of institutionalized in § 422.2, for each county within the plan's county-based service area; and owns or has a contractual arrangement with each institutional facility serving enrollees in the plan. As CMS stated in the April 23, 2024 Final Rule, I-SNPs enrollees reside either temporarily or permanently in an institution, and receive most of their healthcare through or at the facility. In order to comply with the network evaluation requirements in § 422.116, an I-SNP must contract with sufficient providers of the various specialties within the time and distance requirements specified in that regulation, yet many I-SNPs have noted difficulty contracting with providers outside their facilities, due to their model of care—providers know that enrollees of the I-SNP will not routinely seek care with these providers since they generally do not travel away from the facility for care.

> (B) 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; or
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> (ii)(A) A facility-based Institutional-Special Needs Plan (I-SNP) is unable to contract with certain specialty types required under paragraph (b) of this section because of the way enrollees in facility-based I-SNPs receive care; or
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> (B) A facility-based I-SNP provides sufficient and adequate access to basic benefits through additional telehealth benefits (in compliance with § 422.135) when using telehealth providers of the specialties listed in paragraph (d)(5) of this section in place of in-person providers to fulfill network adequacy standards in paragraphs (b) through (e) of this section.
>
> (2) * * *
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> (iv) As applicable, the facility-based I-SNP submits:
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> (A) Evidence of the inability to contract with certain specialty types required under this section due to the way enrollees in facility-based I-SNPs receive care; or
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> (B) Substantial and credible evidence that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits (in compliance with § 422.135) furnished by providers of the specialties listed in paragraph (d)(5) of this section and the facility-based I-SNP covers out-of-network services furnished by a provider in person when requested by the enrollee as provided in § 422.135(c)(1) and (2), with in-network cost sharing for the enrollee.
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> (3) Any MA organization that receives the exception provided for facility-based I-SNPs must agree to offer only facility-based I-SNPs under the MA contract that receives the exception. [12]

The MAO states that it complies with the criteria applicable for contracts filed for the application filing period beginning January 1, 2025. The future provisions have very specific criteria that include that this exception process only applies to FI-SNPs; that the MA organization receiving the exception must agree to offer only FI-SNPs under the MA contract. The MA organization in order to meet the FI-SNP criteria must restrict enrollment to MA eligible individuals who meet the definition of institutionalized; requires that the organization must own or contract with at least one institution, specified in the definition of institutionalized for each county in the plan's service area; and must own or have a

[12] *See* 89 Fed. Reg. 30,448, 30,672 (Apr. 23, 2024).

contractual arrangement with each institutionalized facility serving enrollees in the plan. In addition, the MA organization must demonstrate with evidence presented showing an inability to contract as well credible evidence showing that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits. Further, the evidence must demonstrate that the FI-SNP is unable to contract with certain specialty types "because of the way enrollees in facility-based I-SNPs receive care." The criteria were carefully developed to assist, industry-wide, all FI-SNPs in meeting network requirements while ensuring the most vulnerable are protected and ensured adequate network access to healthcare.

However, after considering the MAO's contributions to the best interest of institutionalized beneficiaries, the Administrator exercises contractual discretion to vacate the CMS Hearing Officer decision and remand the matter to CMS for further decision. The Administrator therefore orders:

That the CMS Hearing Officer Decision is vacated; and

That the MAO's application is hereby remanded to CMS; and

That CMS is to determine if the exception criteria for the 2026 contract year set forth at 42 C.F.R. § 422.116(f) is met by the MAO's application; and

That CMS shall have the discretion as to whether to allow any additional documentation, which, if additional documentation is allowed, shall be submitted in the times and form required by CMS; and

That, if the MAO should meet the exception criteria for the 2026 contract year, and all other application criteria are met; the MAO expansion application may only be approved for the 2025 contract year if the contract restrictions of 42 CFR §422.116(f)((3) are met; and,

That the CMS determination shall be incorporated as the final decision of the Secretary on the matter.

Date: September 24, 2024

Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services