DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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July 25, 2024

VIA ELECTRONIC DELIVERY

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Palm Beach Gardens, FL 33408

Amber Casserly
MAPD Appeals Team
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RE: Hearing Officer Decision and Order
Hearing Officer Docket Number: H-24-00018
Medicare Advantage/Prescription Drug Plan Contract Denial
Longevity Health Plan of Florida, Inc., Contract Number: H1644

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 FLORIDA, INC., **Contract No. H1644** **Petitioner** **v.** **Centers for Medicare & Medicaid Services,** **Respondent**	* * * * * * * * * * * * * *	**CMS Hearing Officer Case No.:** **H-24-00018** **Denial of Application to Expand Medicare Advantage /Medicare Advantage – Prescription Drug Plan**

HEARING OFFICER ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

a) May 28, 2024 Hearing Request on Centers for Medicare & Medicaid Services' ("CMS'") Service Area Expansion Application Denial, filed by Longevity Health Plan of Florida, Inc. ("Longevity-FL")
b) June 5, 2024 Longevity-FL's Brief ("Plan Brief") filed by Longevity-FL
c) June 12, 2024 CMS' Memorandum and Motion for Summary Judgment ("Motion for Summary Judgement" or "MSJ") Supporting CMS' Denial of Longevity-FL's Service Area Expansion for a Medicare Advantage Prescription Drug Plan (MA-PD)/Institutional Special Needs Plan (I-SNP) Contract (H1644) for Contract Year 2025 and Exhibits C-1 through C-6 filed by CMS

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-FL's service area expansion application for an MA/MA-PD contract (Contract No. H1644), based on Longevity-FL's failure to meet CMS' provider and facility 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, 9. The Hearing Officer finds that there are no material facts in dispute and the record does not establish that Longevity-FL provided CMS, in response to CMS' April 16, 2024 Notice of Intent to Deny ("NOID"), with Provider and Facility Health Service Delivery tables ("HSD") that met CMS' network adequacy requirements or valid exception requests that specifically addressed the network deficiencies. *See* CMS Exhibit C-1, Calendar Year 2025 Application Determination Notices; CMS Exhibit C-5, Exception Request Dispositions. Specifically, the record does not clearly establish that the HSD tables and exception requests addressed or included providers and facilities that CMS identified as being located within CMS' network adequacy criteria applicable to the counties Longevity-FL seeks to add to contract H1644. *See* CMS Exhibit C-5, Exception Report at column heading Exception Review Deficiency Detail.

Additionally, the Hearing Officer finds that Longevity-FL's policy-related requests for relief, including consideration of regulatory requirements not applicable to the Calendar Year 2025 application cycle, are outside the scope of the Hearing Officer's authority under 42 C.F.R. § 422.688. Thus, the Hearing Officer finds that Longevity-FL has not proven, by a preponderance of the evidence, that CMS' denial of Longevity-FL's application based on Longevity-FL's network deficiencies and denied exception requests was inconsistent with regulatory requirements. Accordingly, the Hearing Officer upholds CMS' denial of Longevity-FL's service area expansion application for contract H1644.

V. AUTHORITIES, APPLICATION REVIEW PROCESS AND SUBREGULATORY GUIDANCE

A. APPLICATION REVIEW

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, 1395w-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").[1] *See* "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf (last visited June 25, 2024). 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.

The regulation at 42 C.F.R. § 422.501 sets forth the application requirements for entities that seek a contract as an MA organization offering an MA plan and additional application requirements for MA organizations seeking to offer a Specialized MA plan for Special Needs Individuals. Among other requirements, applicants must provide documentation of appropriate state licensure, demonstrate that they are licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits, and submit a properly executed CMS State Certification Form. *See also* 42 C.F.R. § 422.400; "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf (last visited June 25, 2024).

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 by using information from a current or prior contract (i.e., 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 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 to Deny ("NOID"). 42 C.F.R. § 422.502(c)(2). Pursuant to 42 C.F.R. § 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

[1] HPMS is the primary information collection vehicle within which MA organizations will communicate with CMS during the application process, bid submission process, ongoing operations of the MA program, reporting and oversight activities. https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf at 6.

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."[2]

B. NETWORK ADEQUACY REQUIREMENTS AND REVIEW

An applicant for a new or 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. 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 HSD tables into HPMS/Network Management Module ("NMM"). CMS Memorandum and MSJ at 3; "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf at 27 (last visited June 25, 2024). 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 new or 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 https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance12-12-2023.pdf at 2 (last updated December 12, 2023) (hereinafter "Network Adequacy Guidance "). An applicant for a new or expanding service area receives a 10-percentage point credit towards the percentage of beneficiaries residing within the

[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.

75 Fed. Reg. 19678, 19683 (Apr. 15, 2010).

published time and distance standards for the contracted network in the pending service area, at the time of application and for the duration of the application review. In addition, applicants may use an LOI signed by both the MA organization and the provider or facility with which the MA organization has started or intends to negotiate, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. 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 in the form and manner directed by CMS. 42 C.F.R. § 422.116(d)(7).

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." Network Adequacy Guidance at 2. CMS explains that it programs network adequacy criteria into the 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. As set forth under 42 C.F.R. § 422.116(a)(4), CMS annually updates and makes available the following reference files:

> (i) A Health Service Delivery Reference file that identifies the following:
>
> > (A) All minimum provider and facility number requirements [and]
> >
> > (B) All provider and facility time and distance standards.
> >
> > . . .
>
> (ii) A Provider Supply file that lists available providers and facilities and their corresponding office locations and specialty types.

CMS further describes its reference "Provider and Facility Supply File" as follows:

> The supply file is a cross-sectional database that includes information on provider and facility name, address, [NPI], and specialty type and is posted by state and specialty[]type. The supply file is segmented by state to facilitate the development of networks by service area. Contracts 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. . . .
>
> Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MA organizations remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file. MA organizations should not rely solely on the supply file[]when establishing networks, as additional providers and facilities may be available.

> **CMS uses the supply file when validating information submitted on exception requests.** Therefore, CMS may update the supply file periodically to reflect updated provider and facility[]information and to capture information associated with exception requests.

Network Adequacy Guidance at 3 (emphasis added).

CMS states that the HPMS automated tool "generates two reports (called the Automated Criteria Check (ACC) Provider and Facility), that shows whether a provider in a given county is passing the network adequacy requirements." *Id.* CMS asserts that "[t]he ACC reports are accessible within HPMS to reflect where the applicant stands with respect to meeting the standardized criteria." *Id.*

C. EXCEPTION REQUEST PROCESS AND REVIEW

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 Guidance at 4-5. Specifically, an applicant may request an exception to network adequacy criteria when both of the following occur:

> (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 applicant 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)(i)-(ii).

When manually reviewing 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 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
>
> (3) approval of the exception is in the best interests of beneficiaries.

42 C.F.R. § 422.116(f)(1)(i)-(iii); CMS Memorandum and MSJ at 4.

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) furnishes 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. *Id.*

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 5 (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 6 (emphasis added).

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 14, 2024,[3] Longevity-FL submitted a service area expansion application for Calendar Year 2025 under its existing contract number H1644, in order to offer an MA Institutional Special Needs Plan ("I-SNP") in "additional Florida counties." Plan Brief at pdf pg. 1. Longevity-FL explains that "[t]he I-SNP eligible population is primarily elderly dual eligible individuals who are long term residents of skilled nursing facilities[.]" *Id*. at 2. Longevity-FL states that it "currently offers I-SNP plans in 24 counties in Florida." *Id*. at 1.

Following submission of the application and CMS' subsequent review, CMS issued Longevity-FL a March 19, 2024 Deficiency Notice in which CMS noted, among other deficiencies not pertinent to the instant appeal, deficiencies related to network adequacy for both the provider and the facility HSD tables. CMS Memorandum and MSJ at 5; CMS Exhibit C-1. In response to the Deficiency

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[3] Within CMS' Memorandum and MSJ, CMS lists the application date as "February 14, 2023." The Hearing Officer notes that the Calendar Year 2025 MA-PD applications were due on February 14, 2024. *See* CMS Exhibit C-3.

Notice, Longevity-FL submitted network adequacy HSD tables. CMS Memorandum and MSJ at 6.

Following a review of the curing materials, on April 16, 2024, CMS issued Longevity-FL a NOID in which CMS once again cited network adequacy deficiencies (in addition to other deficiencies not pertinent to the instant appeal). *Id*. In response, Longevity-FL submitted curing materials. *Id*.

On May 15, 2024, CMS issued a Denial Letter to Longevity-FL, citing the following deficiencies:

- Exception Request Status—NMM Review—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), including the Automated Criteria Check (ACC) Report for Facilities, for further details on the status of your submission.

CMS Exhibit C-1 at pdf pg. 7.

On May 28, 2024, Longevity-FL timely requested a hearing. Longevity-FL filed its Brief on June 5, 2024, and CMS filed its responsive Memorandum and Motion for Summary Judgment on June 12, 2024. On June 20, 2024, the Hearing Officer postponed the June 26, 2024 hearing to consider CMS' Motion for Summary Judgment.

VII. DISCUSSION AND ANALYSIS

The Hearing Officer finds there are no material facts in dispute and grants CMS' Motion for Summary Judgment. CMS Memorandum and MSJ at 1, 9. Longevity-FL does not dispute that its Provider and Facility HSD tables that it submitted in response to the April 16, 2024 NOID contained deficiencies; instead, Longevity-FL believes it is entitled to exceptions based on its submissions (and its public policy arguments). *See* Plan Brief at pdf pgs. 1-2, 4-8. However, the Hearing Officer finds that the record does not establish that Longevity-FL 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-FL seeks to add. *See* CMS Exhibit C-1, Calendar Year 2025 Application Determination Notices; CMS Exhibit C-5, Exception Request Dispositions.; CMS Memorandum and MSJ at 7-9. The Hearing Officer finds that Longevity-FL has not proven by a preponderance of the evidence that CMS' determinations regarding Longevity-FL's network deficiencies and insufficient exception requests was inconsistent with regulatory requirements, and, 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. Accordingly, the Hearing Officer upholds CMS' denial of Longevity-FL's service area expansion request for contract H1644.

Within its Brief, Longevity-FL states that, based on its public policy arguments,[4] "it would be appropriate for CMS to develop I-SNP specific network access standards that use this fact as the foundation for evaluating network access in I-SNPs or to interpret its exceptions request policy in a manner that recognizes that certain providers will not contract with I-SNP only plans due to limited foreseeable utilization of their services." Plan Brief at pdf pg.6. Longevity-FL asserts that "each member is assigned an Advanced Practice Practitioner ("APP") who, in partnership with the member's [Primary Care Physician] and skilled nursing facility staff, provides full time onsite, facility-based clinical support." *Id*. at pdf pg. 7. Longevity-FL explains that "the goal of the I-SNP model of care is to avoid unnecessary hospitalizations and readmissions by treating in the facility in which the member resides when appropriate." *Id*. Longevity-FL also states that "[w]here Longevity[-FL] lacks a contract with a less commonly used specialist, if a need for such a specialist arises, Longevity[-FL] utilizes the CMS regulations[5] permitting the use of non-participating providers to provide care to beneficiaries to ensure member access." *Id.* at pdf pg. 6.

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[4] Longevity-FL includes a number of public policy-related arguments, including:

(1) "A decision favorable to Longevity would support CMS's public policy objective of expanding access to quality affordable care, particularly to traditionally underserved and vulnerable populations." Plan Brief at pdf pg. 4 (emphasis omitted).

(2) According to Longevity-FL, several recent studies and reports support the positive health care outcomes for I-SNP members versus traditional Medicare fee-for-service beneficiaries, including fewer hospitalizations, lower emergency department use and fewer readmissions. *See id.* at pdf pgs. 4-6.

(3) "By nature, I-SNP plans generally have low enrollment since they are targeting a small subset of the Medicare eligible population, specifically those beneficiaries residing in nursing facilities with which the I-SNP has a contract." *Id*. at pdf pg.7.

(4) Longevity-FL explains that "certain types of providers understand that the limited number of members are unlikely to substantially utilize their services[,] [c]onsequently, health plans only offering I-SNP plans offer too limited utilization to be worth the time of some providers for purposes of contract development." *Id*.

(5) Longevity-FL points out that "CMS has already acknowledged that network adequacy requirements will be modified for I[-]SNPs beginning in 2026." *Id*. at pdf pg. 1.

[5] Longevity-FL does include a reference as to the specific regulation it claims applies to the network adequacy evaluation at issue here, but may be referring to 42 C.F.R. § 422.112, "Access to services," under which CMS states that an MA organization must "[a]rrange for and cover any medically necessarily covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs." 42 C.F.R. § 422.112(a)(1)(iii).

With respect to its exception requests, Longevity-FL observes that while CMS has stated that it "will generally not accept an organization's assertion that it cannot meet current CMS network adequacy criteria because of an 'inability to contract,' it does not foreclose the possibility[,]" and Longevity-FL "believe[s] it is demonstrable that the many providers in the provider supply file are not available to Longevity[-FL]." *Id*. at pdf pg. 7. Additionally, Longevity-FL asserts that under 42 C.F.R. § 422.116(f)(1)-(2), CMS has the authority to grant exceptions to its network adequacy requirements. *Id*. at pdf pgs. 7-8. Longevity-FL states that such authority, along with "the impending changes to the exceptions process for I-SNP plans as written into the 2025 Final Rule, effective June 2024," further supports its claim that "these exceptions are in the best interest of the beneficiary." *Id*. at pdf pg. 8. Longevity-FL requests that CMS re-review its exception criteria "with the additional understanding that" Longevity-FL's beneficiaries are all institutionalized.[6] *Id*.

In its response, CMS states that "[a]ll 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)." CMS Memorandum and MSJ at 7. CMS asserts that "Longevity[-FL] did not meet the requirements in§ 422.116(f)(1), as they were unable to provide valid rationales for not contracting with available providers within the time and distance criteria." *Id*. at 8.

Without determining whether Longevity-FL's as-submitted application would meet the newly promulgated Calendar Year 2026 exception request requirements, CMS explains the impact of the Final Rule, published within the April 23, 2024 Federal Register, that Longevity-FL cites in its arguments. Specifically, CMS states that it

> issued a final rule that includes a provision specific to facility-based I-SNP network adequacy exception requests. The provisions in the rule are applicable to coverage beginning January 1, 2025, for [Contract Year] 2026 applicants. CMS is unable to apply the regulatory changes in Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F) to Longevity-FL in the current application cycle, to

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[6] Within its Brief, Longevity-FL included a list of counties with particular "Provider Deficiency Types" and "Exception Rationale" as part of its request for re-review. *Id*. at pdf pgs. 8-13. For 16 of the 31 deficiencies listed within Longevity-FL's Brief, the "Exception Rationale" states the following:

> Longevity[-FL] uses Quest Analytics. [Longevity-FL] is a[n] [I-SNP] and our members are long term residents of our partner Skilled Nursing Facilities [("SNF")]. [Longevity-FL] works to treat our members in their home (SNF) as much as possible. Due to our membership and lower utilization of provider[s] outside the SNF setting, we would work with the SNF to find a provider utilizing an SCA or Out of Network process. [Longevity-FL] has contracted with providers or facilities that may be located beyond the limits in the time distance criteria. [Longevity-FL] will contract with SNF partners upon [service area expansion] approval.

Id.; CMS Exhibit C-6, Exception Request Template for Charlotte County, FL. The Hearing Officer notes that neither party defined the initialism "SCA" within their respective briefs. The other 15 deficiencies are addressed in fn. 18, *infra*.

> do so would create a disadvantage to all other facility based I-SNP applicants who were denied and did not appeal CMS' decision.

CMS Memorandum and MSJ at 8.

The Hearing Officer finds that there is no dispute that the Provider and Facility HSD tables that Longevity-FL submitted in response to the April 16, 2024 NOID did not meet CMS' network standards. *See* CMS Exhibit C-1 at pdf pg. 7, May 15, 2024 Denial Letter; Plan Brief at pdf pg. 2. Rather, Longevity-FL asserts that based upon the low utilization rate for certain providers by its I-SNP enrollees, its current Model of Care and its plan to provide its enrollees with non-participating provider care[7] from specialists with which it "lacks a contract," CMS should grant its exception requests. *See* Plan Brief at pdf pgs. 3, 5-7. The Hearing Officer concurs with CMS, however, when CMS states that although an MA plan may request an exception to the network adequacy requirements, their exception must meet the criteria in 42 C.F.R. § 422.116(f)(1).[8] CMS Memorandum and MSJ at 7.

First, applicants must demonstrate that "[c]ertain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file," with CMS requiring 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." 42 C.F.R. § 422.116(f)(1); Network Adequacy Guidance at 5. To specifically demonstrate this, CMS requires applicants to list, within the "Table of Non-Contracted Providers" on CMS' HSD "Delivery Exception Request Template," "any providers/facilities you have identified within or nearby CMS's network adequacy criteria

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[7] Although it did not do so here, CMS has responded to this argument during last year's hearing in Health Spring's appeal under docket number H-23-00007. https://www.cms.gov/medicare/regulations-guidance/hearing-officer/ma-pd-plan-appeals. Specifically, the Hearing Officer's decision described that

> CMS indicated that ensuring that "as needed" arrangements for beneficiaries to "get out of network care at in network costs" is already a requirement. Tr. at 117. . CMS further explained
>
> > [I]t's important for an organization to have an adequate network that's . . . communicated well to beneficiaries through their provider directory. Now, if a beneficiary calls up and is having a problem seeking care because . . . their doctor dropped out of the network, then the organization is expected to arrange for that care. But it's not necessarily noted or required to be noted in the provider directory.
>
> Tr. at 119.
>
> The Hearing Officer observes that 42 C.F.R. § 422.116(a)(1)(i) specifies that an MA plan "must demonstrate that it has an adequate contracted provide network that is sufficient to provide access to covered services." 42 C.F.R. § 422.116(a)(1)(i) . . . . *See also* 42 C.F.R. § 422.112(a)(1), 42 C.F.R. § 422.114. In turn, CMS established an application process that requires that MA plans demonstrate network adequacy by submitting a list of contracted providers.

Health Spring at 10.

[8] As noted *supra*, those documentary requirements include (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 for the year for a given county and specialty type, and (ii) that 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)(i)-(ii).

with whom you have not contracted." CMS Exhibit C-6 at pdf pg. 3. Then, applicants must select a "Reason for Not Contracting"[9] from the available drop-down list.[10] *Id*.

Second, "the organization must then demonstrate that[]its contracted network (i.e., providers/facilities included on its HSD tables) furnishes 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; *see* 42 C.F.R. § 422.116(f)(1)(ii).

As stated within CMS' "Exception Request Disposition" Report for Longevity-FL, CMS' review found—and listed out on the report—**numerous** providers/facilities[11] within the network adequacy criteria that Longevity-FL did not "include on [its] Exception Request and/or HSD table(s)." CMS Exhibit C-5 at column heading Exception Review Deficiency Detail. In addition, CMS asserts that, for the denied exception requests, Longevity FL "did not provide valid rationales for not contracting with available providers to meet network adequacy[.]" Instead, CMS states that Longevity provided the following narrative:[12] "the plan is 'an [I-SNP] and our members are long term residents of our partner Skilled Nursing Facilities [("SNF")]. [Longevity-FL] works to treat our members in their home (SNF) as much as possible.'"[13] CMS Memorandum and MSJ at 8.

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[9] CMS only provided the specific HSD "Delivery Exception Request Template" for "Orthopedic Surgery" in Charlotte County, FL. *See* CMS Exhibit C-6.

[10] For the "Table of Non-Contracted Providers," CMS requires applicants to complete all columns within the table, including providing a "Reason for Not Contracting" by selecting from a drop-down list. CMS Exhibit C-6 at pdf pg. 3. This list includes "valid" rationales—i.e., specific reasons—in support of exception requests, as well as two "non-valid rationales." The options for selection from the drop-down list are as follows:

- Provider is no longer practicing (e.g., deceased, retired);
- Provider does not provide services at the office/facility address listed in the database;
- Provider does not provide services in the specialty type listed in the database and for which the exception is being requested;
- Provider has opted out of Medicare;
- Provider does not contract with any Medicare Advantage Organization;
- Sanctioned provider on List of Excluded Individuals and Entities;
- Inability to contract with provider (Note to MAOs: This is not a valid rationale for submitting an exception);
- In the process of negotiating a contract with provider (Note to MAOs: This is not a valid rationale for submitting an exception);
- Provider is at capacity and is not accepting new patients;
- Other (Note to MAOs: Please provide an explanation in the "Additional Notes on Reason for Not Contracting" field).

CMS Exhibit C-6 at pdf pg. 3.

[11] For each of the denied exception requests, CMS lists, by name and address, between 4-5 providers/facilities that it states are "located within CMS network adequacy criteria[.]" CMS Exhibit C-5.

[12] Longevity-FL states that for clinical social work and clinical psychology, "the service is provided inside the facility by on-site staff due to the nature of institutionalized setting." Plan Brief at pdf pgs. 3-4.

[13] Longevity-FL's narrative included the following additional language that CMS omitted:

> Due to our membership and lower utilization of provider[s] outside the SNF setting, we would work with the SNF to find a provider utilizing an SCA or Out of Network process. [Longevity-FL] has contracted with providers or facilities that may be located beyond the limits in the time distance criteria. [Longevity-FL] will contract with SNF partners upon [service area expansion] approval.

CMS also provides that it "will not accept an organization's assertion that it cannot meet current CMS network adequacy criteria because of an inability to contract meaning that they could not successfully negotiate and establish a contract with a provider/facility." *Id*. at 9.

The Hearing Officer observes that when demonstrating that 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,[14] the rationales for not contracting with available providers that CMS considers "valid" provide specific reasons why an applicant is unable to contract with an individual provider or facility located within the network criteria (i.e., provider is deceased, provider has opted out of Medicare, etc.).[15] The Hearing Officer finds, however, that Longevity-FL's generic exception request rationale, on its face, does not provide such individualized reasons, but, instead, appears to provide an I-SNP policy justification for why it has not provided a contracted network[16] that meets CMS specifications, and the justification does not appear to address specific providers and facilities that CMS claims are within its network criteria.[17] *See* CMS Exhibit C-5.

As such, based on the record here, the Hearing Officer finds that Longevity-FL has not demonstrated that CMS' determination to deny its network adequacy exception requests based on a finding that Longevity-FL did not submit valid rationales for not contracting with available providers is supportable.

In addition, the Hearing Officer notes that the policy-related relief summarized by Longevity-FL when requesting that the Hearing Officer "apply existing flexibilities to ensure that vulnerable

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See Plan Brief at pdf pgs. 10-24; CMS Exhibit C-6, Exception Request Template for Charlotte County, FL.

[14] Pursuant to 42 C.F.R. § 422.116(f)(1)(i).

[15] *See supra* note 13.

[16] Within its Brief, Longevity-FL has provided a number of exception request rationales that indicate that a health system or provider is"newly contracted" "[a]fter the 4/26 submission." *See* Plan Brief at pdf pgs. 10-13. However, 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.

75 Fed. Reg. 19678, 19683 (Apr. 15, 2010).

Accordingly, here, the Hearing Officer will not consider additional curing materials not included within the application and the Hearing Officer will not consider whether Longevity-FL has successfully "closed the gap" with certain providers/facilities after the application deadline.

[17] Additionally, Longevity-FL argues that CMS should approve its exception requests as they are in the best interest of their beneficiaries considering that all Longevity-FL's beneficiaries are institutionalized. Plan Brief at pdf pg.8. However, under the exception request evaluation procedures under 42 C.F.R. § 422.116(f)(2)(i)-(iii), in order to get to the consideration of whether the approval of the exception is in the best interest of the beneficiaries, an applicant must first demonstrate that the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year. As discussed *supra*, Longevity-FL has not demonstrated this to be the case as CMS found numerous providers/facilities within the network adequacy criteria that Longevity-FL did not "include on [its] Exception Request and/or HSD table(s)." CMS Exhibit C-5 at column heading Exception Review Deficiency Detail.

high-need beneficiaries don't lose out on a targeted care model as we navigate timing challenges associated with the transition" to the I-SNP network adequacy modifications being implemented for the Calendar Year 2026 application cycle, is outside the scope of the Hearing Officer's authority in this appeal. Plan Brief at 1; 42 C.F.R. § 422.688.[18] Additionally, as noted by CMS, the provisions regarding establishing a specific facility-based I-SNP exception to the current CMS network adequacy requirements outlined in 42 C.F.R. § 422.116 are expressly not applicable until January 1, 2025. CMS Memorandum and MSJ at 8; *see* 89 Fed. Reg 30448, 30674-75 (Apr. 23, 2024).

Thus, the Hearing Officer concludes that CMS' determinations regarding Longevity-FL's exception requests are supportable under the current regulatory framework. Additionally, the Hearing Officer finds that Longevity-FL's "plan" expressed within its exception rationale that it will "work to find providers" and that on-site staff will provide certain services does not meet the regulatory requirement under 42 C.F.R. § 422.116(a)(1)(i) that applicants "must demonstrate that [they have] an adequate contracted provider network that is sufficient to provide access to covered services[.]"[19] The Hearing Officer finds that Longevity-FL has not proven by a preponderance of the evidence that CMS' denial of its application based on its network deficiencies and insufficient exception requests was inconsistent with regulatory requirements and, 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 Thus, the Hearing Officer upholds CMS' denial of Longevity-FL's service area expansion request for contract H1644.

VIII. <u>ORDER</u>

The Hearing Officer grants CMS' MSJ. The Hearing Officer upholds CMS' May 15, 2024 Denial of Longevity-FL's service area expansion application for contract H1644.

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Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: July 25, 2024

[18] The regulation 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."

[19] For a detailed explanation, *see supra* note 11.