CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
UnitedHealth Group, Inc.,	*	
UHC of California		**Docket No.**
	*	**2016 MA/PD App. 3**
Denial of Service Area Expansion:		
Medicare Advantage Organization	*	
Medicare Advantage-Prescription Drug		
	*	
Contract Year 2017		
Contract Nos. H0543	*	

I. INTRODUCTION

In February 2016, UnitedHealth Group, Inc., UHC of California ("UHCC") filed an application for the 2017 calendar year ("CY") with the Centers for Medicare & Medicaid Services ("CMS") to expand the service area of its Medicare Advantage – Prescription Drug ("MA-PD") contract in seven counties. By email dated May 26, 2016, CMS notified UHCC that its MA-PD service area expansion ("SAE") application was denied based on deficiencies in certain existing full counties and requested expansion counties, including: (1) UHCC's contracted network of providers in Kern County, California, and (2) UHCC's contracted network of facilities in Contra Costa, Kern, Merced, Riverside, Santa Clara, and San Luis Obispo Counties, California. UHCC timely requested a hearing concerning CMS' determination pursuant to 42 C.F.R. § 422.662 (2015).

II. STATEMENT OF APPLICATION PROCESS AND APPLICABLE AUTHORITY

The Social Security Act authorizes CMS to enter into contracts with entities seeking to offer Part C and Part D benefits to Medicare beneficiaries. CMS has the regulatory authority to set the form and manner for the submission of applications for qualification as a Medicare Advantage Organization ("MAO"). Specifically, CMS requires entities seeking to contract as a MAO to submit applications through the Health Plan Management System ("HPMS"). MAOs must demonstrate that they meet qualifications ranging from appropriate state licensure, sufficient administrative capability to oversee the plan offerings, the capacity to enroll and disenroll beneficiaries, and an ability to offer sufficient medical services to their enrollees. 42 C.F.R. § 422.501.

Applicants must also demonstrate that they "maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served." 42 C.F.R. § 422.112(a)(1)(i). CMS requires applicants to demonstrate compliance with provider network requirements by submitting Health Service

Delivery ("HSD") tables through HPMS. For CY 2017, CMS required that applicants requesting a SAE submit HSD tables for both the new counties into which they are seeking to expand as well as their existing counties. CMS Br. Mem. and Mot. for Summ. J. ("CMS Br.") Ex. A, at 1. An applicant's ability to meet CMS' network adequacy criteria, as demonstrated through its HSD table submissions, is assessed based on the number of providers and facilities that are located within the time and distance criteria of at least one Medicare beneficiary in a given county. CMS Br. Exs. A, B.

On January 12, 2016, CMS released the CY 2017 Part C application, which included HSD guidance describing the process for HSD network submission and automated review, and refinements to the process for the CY 2017 application and beyond. CMS Br. Exs. C, D, and E. The HSD guidance addressed the criteria for determining the maximum travel time and distance to providers or facilities. CMS Br. Exs. A, B. In order to meet the criteria for maximum travel time and distance to providers or facilities, applicants are required to demonstrate "that 90 percent of beneficiaries (or more) have access to at least one provider/facility for each specialty type, within established time and distance requirements for [each] county." CMS Br. Ex. A, at 1. The maximum time and distance requirements were developed using a process of mapping beneficiary locations juxtaposed with provider practice locations. Using mapping software, CMS is able to evaluate contracted networks against beneficiary locations across an entire county, which allows CMS to determine whether an applicant's proposed network meets CMS network adequacy criteria (i.e., minimum number, maximum time, and maximum distance). CMS Br. Ex. A.

To aid applicants in identifying the areas in which their proposed networks fell below the default network adequacy criteria, CMS offered applicants the unlimited ability to check their networks using the Network Management Module ("NMM") in HPMS. CMS advised applicants that the NMM allows organizations to evaluate HSD provider and facility tables against network adequacy criteria and receive the results of that analysis from HPMS. CMS Br. Ex. D. These results help identify geographic areas and specialty types in an applicant's network that require additional successful contracting efforts.

CMS' network review is performed through an automated tool within HPMS that compares an individual applicant's network data submitted (via HSD tables) against standardized CMS network adequacy criteria. HPMS generates two reports– Automated Criteria Check ("ACC") Provider and ACC Facility. The ACC reports are accessible within HPMS. Appeal of Notice of Den. ("UHCC Br.") Ex. A, at 8.

Under specific circumstances and rules, CMS permits applicants that are unable to satisfy the network adequacy criteria to submit exception requests. CMS requires applicants to fully and accurately complete and submit an Exception Request Template through HPMS for each exception requested. Applicants must select from one of the following two criteria on the exception request form:

> (1) An insufficient number of providers are available within CMS' current time and distance criteria to meet the HSD network adequacy standards for a particular county and provider type as specified in the CY 2017 HSD Reference File. However, the plan's contracted provider network is

> consistent with the current pattern of care and provides enrollee access to covered services that is equal to or better than the prevailing original Medicare pattern of care; or,
> (2) The applicant is a Regional Preferred Provider Organization proposing alternative arrangements to a contracted provider network.

UHCC Br. Ex. G.

CMS advised that applicants were only allowed one opportunity to submit exception requests. Exception requests were due on March 1, 2016. CMS Br. Ex. K.

When evaluating applications, "CMS evaluates an application for a MA contract ... solely on the basis of information contained in the application itself and any additional information that CMS obtains through other means such as on site visits." 42 C.F.R. § 422.502(a)(1). CMS reviews the application, submitted through HPMS, to determine whether it meets all the necessary requirements. 42 C.F.R. § 422.502(a)(2). CMS notifies an applicant of deficiencies and allows them a specified period of time to correct the deficiencies through a Deficiency Notice. If an applicant fails to remedy all of the deficiencies in its application, or if CMS determines that it is not able to meet the requirements to become a MAO in the requested service area, then CMS issues a Notice of Intent to Deny (NOID), with a summary of the basis for CMS' preliminary finding. An applicant that receives a NOID is provided ten days from the date of notice to respond, in writing, to CMS' preliminary findings and to revise its application, remedying any defects that CMS has identified.

If an exception request is not approved for any specialty or any one county, and the plan cannot find a way to meet HSD table network adequacy criteria, CMS denies the entire SAE application. Thus, if an applicant fails to submit a revised application within ten days from the date of the NOID issuance, or CMS believes that a revised application fails to meet the necessary requirements to contract as a MAO in the requested service area, CMS denies the application. Applicants that receive an application denial may request a hearing within fifteen calendar days after the receipt of the denial.

III. PROCEDURAL HISTORY AND ISSUE STATEMENT

UHCC currently operates in twenty-seven counties in California, including seven partial counties under its MA-PD contract, H0543. In response to CMS' solicitation for Part C applications, UHCC submitted a timely SAE application to expand its existing partial counties to full counties. For CY 2017, CMS required an applicant to submit provider networks for both existing counties and those counties for which the applicant sought expansion. UHCC's SAE application was denied based on network deficiencies in five of its existing (full) counties and two of its expanding (partial) counties. Upon receipt of the Denial Letter, UHCC filed a timely request for a hearing concerning CMS' determination, pursuant to 42 C.F.R. § 422.660(c), and filed a brief with the Hearing Officers on June 8, 2016. Subsequently, CMS filed its Memorandum and Motion for Summary Judgment and UHCC filed a Reply Brief. A hearing was held on July 19, 2016.

One of the two overarching issues presented relates to the interplay between the HSD Instructions and the Exception Request Instructions for CY 2017. The issue concerns the question of whether non-contracted providers are to be listed on the HSD Tables. The second major overarching issue relates to the data CMS relies upon and the actual sufficiency and availability of providers and facilities in the allegedly deficient service areas.

IV. STATEMENT OF FACTS

A. Facts Related to HSD Table and Exception Request Instructions

On February 17, 2016, UHCC submitted its application for CY 2017, including its HSD tables and, as required, submitted exception requests on March 1, 2016. It is UHCC's belief that CMS' instructions concerning the submission of HSD tables and the instructions regarding the filing of an exception request were at odds with one another. CMS' instructions ("HSD Instructions") regarding how to complete the HSD table for CY 2017 state:

> The tables should reflect the applicants' **executed contracted** network on the date of submission. CMS considers a contract fully executed when both parties have signed. Applicants should only list providers with whom they have a fully executed updated contract. These contracts should be executed on or prior to application submission deadline. In order for the automated network review tool to appropriately process this information, applicants must submit Provider and Facility names and addresses exactly the same way each time they are entered, including spelling, abbreviations, etc. Any errors will result in problems with processing of submitted data and may result in findings of network deficiencies. CMS expects all applicants to fully utilize the opportunities for pre-checks and to fully review the Automated Criteria Check (ACC) reports to ensure that their HSD tables are accurate and complete.

CMS Br. Ex. B, at 7 (emphasis in original).

While the HSD table instructions indicate that applicants should only list providers under contract, the instruction governing exception requests contained the following language for 2017:

> Applicants requesting Exceptions must complete the **CMS Exceptions Template** for each provider/facility type in each county for which an exception is requested and provide the appropriate information requested in the template. Additionally, all Exceptions must be requested and supported with appropriate documentation within the timeframe established by CMS. **All providers listed in the Exception template must be listed on the HSD table in the county for which the exception is being requested.**

CMS Br. Ex. B, at 12 (emphasis in original).

After receiving a Deficiency Notice on March 9, 2016, UHCC submitted revised HSD tables on March 15, 2016. At the Hearing, UHCC's Compliance Officer testified that, since the Exception Request instructions stated—in bold—that, "all providers listed on the Exception template must be listed in the HSD county for which the exception is being requested," UHCC believed that CMS intended that all providers, contracted and non-contracted, were to be listed. Hr'g. Tr. 59-64, Jul. 19, 2016. UHCC's Compliance Officer further testified that when it " . . . submitted those HSD tables on March 15 we added the providers that were listed on our exception template that had been submitted on March 1 into the HSD tables that we submitted on March 15, according to the instructions." Hr'g. Tr. 63-64. Subsequently, UHCC believed that, as a consequence of including the non-contracted providers on the HSD tables:

> . . . [W]hen CMS did their automated criteria check of the HSD tables that we submitted, it appeared that we were passing the network adequacy time and distance requirements, the criteria in the IISD table, and as a consequence of that, we believe that CMS did not review the exception request that we submitted in March, on March 1.

Hr'g. Tr. 64.

UHCC testified that the basis of this belief is that the ACC tables printed on March 15, 2016, indicated that UHCC had passed the criteria check and "that CMS had determined that they did not need to review the exceptions . . . " that were requested. Hr'g. Tr. 66.

On April 8 and 14, 2016, UHCC sent inquiries to CMS attempting to clarify the inconsistent CY 2017 application instructions. Each time, it was UHCC's belief that CMS' response did not address the questions asked. *See* UHCC Br. Exs. HH, II, JJ. Therefore, UHCC requested a meeting with CMS policy personnel to discuss concerns regarding the HSD table instructions. Next, during an April 21, 2016, phone conference, CMS personnel stated that, per the HSD instruction, the applicant should only include contracted providers in the HSD tables and confirmed that CMS would review the statement in the HSD instructions that UHCC noted. CMS Br. Ex. R, at 3. On April 22, 2016, UHCC resubmitted its HSD tables with only contracted providers, consistent with the CMS' directive.

On April 25, 2016, three days prior to the end of its 10-day cure period, UHCC made a final attempt to escalate its lingering concerns regarding the instructions to the office of Kathryn Coleman, the Director of CMS' Medicare Drug & Health Plan Contract Administration Group. UHCC sent an email requesting a meeting to discuss certain concerns. UHCC noted:

> . . . [W]e continue to work to be transparent and ask questions in an effort to meet CMS expectations. Our discussions have resulted in [UHCC] being given verbal instructions from the CMS team and told to follow processes that are different than the written instructions the rest of the industry is following related to HSD instruction.

UHCC Br. Ex.CC.

Additionally, UHCC explained:

> . . . [B]ecause we previously followed the published HSD instructions, CMS did not review some of the exception requests we previously submitted. . . .
>
> We now have only one opportunity to obtain CMS review and approval of these exception requests, which also may result in different outcomes for UHCC compared to others in the industry that had two opportunities for their exception requests to be reviewed.

Id.

UHCC represents that, to this day, it does not know whether CMS gave similar direction to other plans to clarify that HSD tables should not include non-contracted providers, despite what the written instructions state. UHCC contends this fails to meet CMS' stated goal of wanting "applicants to have a consistent understanding of the expectations on which we base our contract approvals and denials." UHCC Br. at 40.

B. Facts Related to Data Sources

On February 17, 2016, UHCC submitted its application for CY 2017, and, as required, submitted exception requests on March 1, 2016. CMS determined that UHCC's application failed to adequately demonstrate that it fully met service area requirements. Consequently, CMS issued a Deficiency Notice to UHCC by email on March 9, 2016. In addition to the various deficiencies in UHCC's application, the Deficiency Notice provided instructions for UHCC to resubmit application materials by March 15, 2016, in order to correct the noted deficiencies. In order to cure the MA Provider and Facility Table deficiencies, UHCC was instructed to refer to its HSD Submission Reports (available in HPMS), including the ACC Provider and the ACC Facility Reports. UHCC was further instructed that to resolve any failures in network adequacy criteria, it should submit updated MA Provider and Facility Tables during the next upload period. *See* CMS Br. Ex. L. The Deficiency Notice further informed UHCC that any "Pass" reflected on the HSD Submission Reports is contingent upon the validity of the data submitted on the applicant's HSD tables and in the exceptions uploads, including whether the individual providers are accurately reflected and appropriately contracted with the applicant. UHCC submitted revised application materials, including updated Provider and Facility HSD tables, by the March 15, 2016, deadline.

Despite UHCC's revised application materials, CMS issued a NOID to UHCC by email on April 18, 2016. CMS Br. Ex. P. The NOID detailed the remaining deficiencies in UHCC's application as well as set out UHCC's ten-day opportunity to cure all remaining application deficiencies. In the NOID, UHCC was instructed to refer to the HSD Submission Reports and Exception Status Report available in HPMS for further details regarding its HSD failures. UHCC was also instructed that to resolve any issues, they must upload new HSD tables that meet CMS' network adequacy requirements by the April 28, 2016, deadline. CMS Br. Ex. P.

On April 20, 2016, CMS sent Supplemental ACC Results to UHCC via email regarding its HSD deficiencies related to the partial counties in which UHCC sought to expand for CY 2017. This email clarified CMS' comprehensive review of UHCC's HSD tables and the resulting deficiencies identified in the NOID.

During a conference call on April 21, 2016, UHCC inquired about the deficiencies in its HSD tables. Specifically, since CMS had informed them in the NOID that there were additional providers with whom UHCC could contract, it wanted to know what providers CMS identified. CMS stated that it was aware of other providers with whom UHCC could contract, but stated that CMS could not direct UHCC to the providers as, "[t]he applicant is responsible for finding and contracting with providers to meet CMS time and distance criteria." CMS Br. Ex. R, at 3.

On April 28, 2016, CMS issued an email to all CY 2017 applicants, including UHCC, which identified CMS' public databases that were used to identify potential providers and facilities with whom an applicant could potentially contract within a given geographic area. CMS considered the information found on these databases when reviewing and verifying an applicant's rationale for an exception request. UHCC Br. Ex. S.

Also on April 28, 2016, the final submission deadline, UHCC submitted revised HSD tables in support of its application. Even with the revised HSD tables, CMS found that UHCC continued to have network (HSD) deficiencies in Kern, Merced, Riverside, Santa Clara, and San Luis Obispo Counties, in multiple specialties. Following the April 28, 2016, HSD table submission, CMS identified an additional deficiency in Acute Inpatient Hospitals for UHCC's existing Contra Costa County. On May 12, 2016, UHCC received an email from CMS clarifying the HSD deficiencies related to seven existing partial counties (Los Angeles, Madera, Nevada, Placer, Riverside, San Bernardino, and San Luis Obispo, CA) which UHCC sought to expand in its CY 2017 application.

On May 26, 2016, CMS issued a Denial Letter to UHCC by email for its SAE application under H0543. UHCC was denied for failing to meet CMS network adequacy criteria for the counties and specialties listed on the ACC Provider and ACC Facility Reports. CMS Br. Ex. Y. On May 27, 2016, UHCC submitted an email requesting receipt of its ACC results for H0543. On June 7, 2016, CMS responded that UHCC had already received all ACC results and CMS' final dispositions on any exception requests.

V. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

CMS' denial of UHCC's CY 2017 SAE application must be considered against the backdrop of UHCC's inability to obtain a meaningful iterative review due to confusing instructions and questionable data relied upon by CMS, as well as lingering questions about the accuracy of the deficiencies CMS cited in each individual county. In this light, the Hearing Officers find CMS' denial unsupportable.

A. HSD Table and Exception Request Instructions

The Hearing Officers observe that the HSD instructions for both facility and physician provider HSD tables directed applicants to include only those providers with whom they had executed a contract. CMS Br. Ex. B, at 7. The Hearing Officers note that UHCC was reasonably concerned that the HSD instructions seemingly contradict the exception request instructions, which state "**[a]ll providers listed on the Exception template must be listed in the HSD table in the county for which the exception is being requested.**" CMS Br. Ex. B, at 12 (emphasis in original). This bold-printed directive fairly suggests that, despite its general rule that only *contracted* providers be listed on the HSD tables, CMS wants *all* providers listed on the HSD tables when an exception request is filed.

The Hearing Officers find that UHCC reasonably decided to include non-contracted providers, as it first prepared and filed its HSD tables. The Hearing Officers find that UHCC presented sufficient evidence to support the contention that the confusing instruction materially prejudiced UHCC's initial application and its ability to fully obtain a sufficient and meaningful iterative review of its application as contemplated by the regulations and application review process. As UHCC explains:

> . . . [I]t appears that there is no way for CMS to distinguish between contracted and non-contracted providers in the HSD table, meaning that all contracted and non-contracted providers will appear as "contracted" during CMS's automated review. As a result, we believe CMS's automated tool treated the non-contracted providers as part of UHCC's network, and initially found an "adequate" network....[t]his prevented UHCC from receiving legitimate feedback from CMS until it was too late.[1]

UHCC Br. at 37.

Moreover, UHCC presented evidence that it reasonably identified the inconsistencies in CMS' instructions and sought guidance from CMS regarding CMS' policy. Even after obtaining clear direction from CMS on April 21, 2016 regarding how to complete the HSD tables, UHCC continued to express its still-valid concerns regarding the potential impact of the confusing instructions on the overall outcome for UHCC. Accordingly, UHCC proceeded reasonably in light of the uncertainty.

[1] The impact of these contradictory instructions can be seen, for example, in the application for Contra Costa County, where UHCC requested a network adequacy exception for inpatient acute hospitals in particular zip codes. As required, UHCC submitted an exception request that listed non-contracted providers that should be considered in evaluating the exception request. *See* UHCC Br. Ex. EE. Then, as required, UHCC included the non-contracted providers mentioned in the exception request in the relevant HSD table. UHCC Br. Ex. FF. Upon review, CMS' automated tool deemed the Plan's network adequate in Contra Costa County and determined the exception request was not necessary. UHCC Br. Ex. GG. UHCC knew CMS' determination was incorrect about UHCC's network in Contra Costa County, and similarly in other locations, and made concerted efforts to resolve the issue with CMS. *See* Section IV. B. above.

B. CMS' Data Sources

The Hearing Officers recognize that CMS was not mandated, by regulation, to identify the data sources it relied upon in evaluating network adequacy. The Hearing Officers concur that private plans maintain the responsibility to build their networks and file proper and timely documentation to meet CMS' requirements. Moreover, from a practical standpoint, it could be unduly burdensome for CMS to identify specific potential providers and facilities for private MAOs. Similarly, CMS has generally indicated that, while it communicates with plans during the review process, it seeks to avoid providing a single organization with an unfair advantage within the application and review process. Hr'g. Tr. 499. The Hearing Officers find that it is reasonable and administratively prudent for CMS (and MAOs) to use various data sources in conducting network adequacy reviews given that a single, fully reliable and "real time" source of providers and facilities simply does not exist. *See* Hr'g. Tr. 184, 345-346.

Nevertheless, at the hearing, UHCC presented uncontroverted evidence that the data sources, which CMS relied upon when it denied UHCC's SAE application in this case, contained significant levels of error. UHCC explained it had been unable to bring the numerous inaccuracies in CMS' data sources to CMS' attention because CMS did not identify the data it relied upon until April 28, 2016, UHCC's final submission deadline. At the hearing, UHCC's witness testified in detail about UHCC's analysis of the actual available providers and facilities in each individual county in question. For example, UHCC explained that the CMS data sources contained outdated or incorrect information which listed physicians and facilities as providing services that they do not provide. Likewise, the data often contained the wrong addresses for providers which may have made it appear that certain providers were inside relevant HSD time and distance requirements when, in fact, they were not. Moreover, UHCC's witness testified that CMS' data sources identified providers that were retired, no longer with a group practice or had moved out of the area. Hr'g. Tr. 112, 184.

CMS declined to cross examine UHCC's witness. Hr'g. Tr. 249, 253-254, 280-281, 290, 298, 305-306. Further, CMS stated that it elected not to present a witness to specifically address the county-by-county "intricate deficiency details" as it was "unnecessary" and it generally alleged that the UHCC application was "full of discrepancies." Hr'g. Tr. 51, 54. CMS stated that it provided UHCC with all the information needed to cure application deficiencies. Hr'g. Tr. 51-52.

The Hearing Officers find that UHCC methodically refuted CMS' allegation that UHCC's network was, in fact, full of discrepancies. *See* UHCC Br. Ex. JJJJ (Summary chart). UHCC's witness presented testimony that factually countered the specific network deficiencies CMS identified in UHCC's application. Furthermore, the Hearing Officers find that UHCC established that the inaccuracies in CMS' data sources added to UHCC's uncertainty regarding the validity of the deficiencies CMS cited throughout the review process, and whether the alleged deficiencies were, in reality, correctible.[2] Accordingly, the Hearing Officers reject CMS' assertion that it was unnecessary to

[2] The Hearing Officers discount UHCC's suggestion that CMS' standard codes/descriptions which describe alleged deficiency codes are generally insufficient as they do not provide enough substantive information for plans to act upon. UHCC Br. at 29. The Hearing Officers recognize that utilizing standardizing codes and descriptions may be administratively efficient and

examine, at the hearing, the county-specific "intricate" details underlying CMS' denial. Rather, the Hearing Officers note that such information constitutes the core basis of the adverse determination challenged in this appeal. The Hearing Officers find that UHCC fairly met the controlling application and network adequacy standards in light of CMS' communications.

Finally, CMS argued that other applicants met network adequacy criteria where UHCC failed. CMS Br. at 11. UHCC responded:

> As with CMS's own data sources, there could be inaccuracies in other Plans' submissions. UHCC has no way of identifying those inaccuracies or bringing them to the Agency's attention because UHCC does not have other Plans' submissions and CMS has not identified any specifics in its discussions with UHCC or in its Brief. UHCC also has no way of knowing if all of the providers listed by other Plans are included in the public sources that CMS provides. As such, UHCC has no way of identifying the other providers with whom Plans purportedly contracted and CMS has failed to adequately respond to UHCC's explanations of why particular providers that it guesses are the reason for CMS's denial of an exception request actually are not available for contracting, e.g., because the physician has retired or the facility has closed.
>
> Further, this year, other Plans may also have followed the flawed HSD instruction that indicated Plans should include non-contracted providers listed in exception requests. Their provider networks might consequently appear to meet HSD adequacy criteria, as UHCC's did initially, when in fact they do not. There is simply no way for UHCC to know why some Plans may have fulfilled HSD network criteria in areas where UHCC believes it cannot be done, and CMS's brief sheds no light on that issue.[3]

UHCC's Reply Br. at 6-7 (citation omitted).

The Hearing Officers understand that CMS did not believe it was appropriate to share other MA applicants' proposed HSD tables during the application process. At the hearing, however, CMS introduced an argument relating to the success level of other plans within the application process. Now

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promote consistency. Nevertheless, given the circumstances surrounding this case, CMS' generic description added to UHCC's inability to effectively understand or verify that the alleged deficiencies were reliable or correctable. In addition, UHCC explained that the Exception Request Template states that the "[i]nability to contract is not a valid reason for submission of an Exception Request." The Hearing Officers note that although CMS indicated, at the hearing, that it has applied its policy in various scenarios for years, the policy was not transparent to UHCC. Hr'g. Tr. 460-464. This presented an additional layer of uncertainty as UHCC attempted to guess the meaning and accuracy of CMS' position. Hr'g. Tr. 368-370, 429-443, 461-463. For example, CMS indicated that, without written public guidance, it considers a competitor's refusal to contract as an invalid reason for an exception request, while a non-competitor provider's or facility's refusal to contract based on full capacity or refusal to contract with any MAO is a valid reason for an exception request.

[3] At the hearing, CMS conceded that it had no way of knowing if other plans included a non-contracted provider on the HSD table which could have impacted its algorithm. Hr'g. Tr. 423-425.

that CMS has "opened the door," it seems fundamentally fair and reasonable for CMS to at least share the names of the providers or facilities that it believes are available within the denied service areas for UHCC to independently verify. Hr'g. Tr. 123-125, 423-426.

V. DECISION

The Hearing Officers find that UHCC presented sufficient evidence to support its argument that the confusing HSD instructions materially prejudiced UHCC's initial application and denied it the meaningful iterative review contemplated by the regulations and application review process. Additionally, the Hearing Officers note that the uncontested issue relating to the inaccuracy of the data sources that CMS relied upon further contributed to UHCC's uncertainty regarding the reliability of CMS' feedback and determinations throughout the application and iterative review process.

In light of a fair reading of the controlling authorities and CMS' communications with UHCC, the Hearing Officers determine that UHCC has shown by a preponderance of the evidence that CMS' determination regarding its SAE application was incorrect. Accordingly, UHCC has met its burden of proof that CMS' determination was inconsistent with controlling authorities.

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Date: August 31, 2016