DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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August 12, 2025

Via Electronic Delivery

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RE: Hearing Officer Decision
Hearing Officer Docket Number: H-25-00006
Medicare Advantage/Prescription Drug Plan ("MA/PD"), Appeal Year: 2026
Healthy Mississippi, Inc., Contract Number: H8879

Dear Ms. Clements and Ms. Spaccarelli:

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

The Hearing Officers' decision may be appealed to the Administrator of the Centers for Medicare & Medicaid Services. The parties may request review by the Administrator within 15 calendar days of receiving this decision. *See* 42 C.F.R. § 422.692; 42 C.F.R. § 423.666. Requests for review should be sent via email to CMS OAA General Appeals at OAA_Appeal@cms.hhs.gov.

Sincerely,

Office of Hearings

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTHY MISSISSIPPI, INC., Contract No. H8879	*	**CMS Hearing Officer Case No: H-25-00006**
Petitioner	*	
v.	*	
CENTERS FOR MEDICARE & MEDICAID SERVICES,	*	**Denial of Application for Service Area Expansion For Existing Medicare Advantage/Medicare Advantage - Prescription Drug Plan**
Respondent	*	

HEARING OFFICER ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

I. FILINGS

a) May 15, 2025, Hearing Request regarding the Centers for Medicare & Medicaid Services' ("CMS's'") Service Area Expansion Application Denial, filed by Healthy Mississippi, Inc. ("HMI");[1]
b) May 20, 2025, Plan Hearing Brief ("Plan Hearing Brief") and Plan Exhibits P-1 through P-7;
c) May 27, 2025, CMS's Brief in Reply to the Applicant's Brief in the Matter of the Denial of the Service Area Expansion Application Submitted by [HMI] (Contract H8879), Docket Number H-25-00006, submitted with a Motion for Summary Judgment ("CMS Brief"), including Exhibits C-1 through C-5;
d) May 29, 2025, Plan Reply Brief ("Plan Reply Brief").

II. JURISDICTION

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

III. ISSUE

Whether CMS's denial of HMI's service area expansion application for an existing Medicare Advantage/Medicare Advantage Prescription Drug ("MA/MA-PD") plan, under Contract No. H8879, based on CMS's determination that HMI had less than twelve months' experience operating its current MA-PD contract, was inconsistent with the regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officers grant CMS's Motion for Summary Judgment thereby upholding CMS's denial of HMI's application based upon a lack of twelve-month performance history. The Hearing Officers find that there are no material facts in dispute, as the record establishes that HMI admitted, within an attestation on its application, that it does not have the requisite performance history in the MA-PD programs, and CMS's decision was consistent with the regulation at 42 C.F.R. §§ 422.502(b)(2) and 423.503(b)(2). The Hearing Officers reject HMI's assertion that CMS's grant of a minimum enrollment waiver warrants approval of its application here, finding that the minimum enrollment waiver requirements and CMS's past performance criteria are distinctly separate regulatory provisions that serve different purposes in the MA program. Additionally, the Hearing Officers find that HMI's arbitrary and capricious and policy-based arguments are outside the scope of the Hearing Officers' authority under 42 C.F.R. §§ 422.688 and 423.664.

[1] Within this decision HMI is also referred to as "the Plan" and sometimes "the Applicant."

V. AUTHORITIES, APPLICATION REVIEW PROCESS AND SUBREGULATORY GUIDANCE

A. Application Review Process

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").[2] *See* "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy2026-medicare-advantage-part-c-application.pdf (last visited May 29, 2025). 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. 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/cy2026-medicare-advantage-part-c-application.pdf (last visited May 29, 2025) ("Part C Application"). The Part C Application also contains a series of "required attestations that must be completed for each type of application and applicant." Part C Application at 17. Specific to the instant appeal, under the required attestations for "Management, Experience, and History," applicants must answer whether

> The Medicare Advantage plan(s) currently offered by the applicant, applicant[']s parent organization, or subsidiary of the applicant[']s parent organization has been operational since January 1, 2024[,] or earlier . . .

Part C Application at 19 (Section 3.1.7).[3]

MA organizations seeking to also offer prescription drug plans must, in addition to the requirements under part 422, follow the requirements of part 423 specifically related to the prescription drug benefit. 42 C.F.R. § 422.500. CMS posted the final Solicitation for Applications for Medicare Advantage and Medicare Prescription Drug Plan 2026 Contracts on January 7, 2025,

[2] 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/cy2026-medicare-advantage-part-c-application.pdf at 7.

[3] A similar attestation is found within the Part D Solicitation. *See* https://www.cms.gov/files/document/2026-part-d-application-final.pdf at 23.

at https://www.cms.gov/files/document/2026-part-d-application-final.pdf (last visited July 14, 2025) ("Part D Application"). CMS Brief at 2.

The regulation at 42 C.F.R. § 423.502 sets forth the application requirements to qualify as a Part D sponsor, including that the applicant must fully complete all parts of a certified application in the form and manner required by CMS. 42 C.F.R. § 423.502(c)(1). MA organizations offering qualified prescription drug coverage are known as MA-PD plans. 42 C.F.R. § 423.4.

Like the Part C Application, the Part D Application also contains a series of required attestations that must be completed, with CMS informing applicants that "[b]y providing such attestation, an applicant confirms that its organization complies with the relevant requirements as of the date its application is submitted to CMS[.]" Part D Application at 9. Specific to the instant appeal, under the required attestations for "Management and Operations," applicants must attest to and inform

> If applicant, applicant's parent organization, or any subsidiaries of applicant's parent organization has an existing contract(s) with CMS to provide Part D drug benefits, at least one of those contracts has been in continuous effect since January 1, 2024 or earlier. . . . 42 CFR § 423.503(b)(2).

Part D Application at 23 (Section 3.1.1).

CMS evaluates an entity's application, whether for an MA plan, or for an MA-PD plan, solely based on information contained in the application itself and any additional information that CMS obtains through on-site visits and any essential operations test. 42 C.F.R. §§ 422.502(a)(1) and 423.503(a)(1). However, CMS may deny an MA, Specialized MA, or Part D application if the applicant failed to comply with Part C or Part D program requirements during the twelve months preceding the application deadline. 42 C.F.R. §§ 422.502(b)(1) and 423.503(b)(1).

After reviewing whether an 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 Brief at 2. 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) and 423.503(c)(2). Pursuant to 42 C.F.R. §§ 422.502(c)(2)(ii) and 423.503(c)(2)(ii), the applicant will have ten days from the NOID to respond in writing to correct deficiencies in the application.

If, in response to the NOID, the applicant either fails to submit a revised application within ten days from the date of the NOID, or if after timely submission of a revised application, CMS still finds that the applicant does not appear qualified or has not provided CMS enough information to allow CMS to evaluate the application, CMS will deny the application. 42 C.F.R. §§ 422.502(c)(2)(iii) and 423.503(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) and 423.503(c)(3).

If CMS denies an MA application or Part D application, the applicant is entitled to a hearing before a CMS Hearing Officer. 42 C.F.R. §§ 422.502(c)(3)(iii) and 423.503(c)(3)(iii). The applicant has the burden of proving by a preponderance of the evidence that CMS's determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501, 423.502 (application requirements) and 422.502, 423.503 (evaluation and determination procedures). 42 C.F.R. §§ 422.660(b)(1), 423.650(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), 423.662(b). The authority of the Hearing Officer is found at 42 C.F.R. §§ 422.688 and 423.664, 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."[4]

B. Past Performance Review—Use Of Information From A Current Or Prior Contract

CMS may deny an MA, Specialized MA, or Part D Application if the applicant failed, during the twelve months preceding the application submission deadline, to comply with Part C or Part D program requirements. 42 C.F.R. §§ 422.502(b)(1) and 423.503(b)(1). CMS may deny an application based on the applicant's failure to comply with the requirements of the Part C or Part D program under any current or prior contract with CMS even if the applicant currently meets all of the regulatory requirements. *Id.* Specific to the instant appeal, in the absence of twelve months of performance history, CMS may deny an application based on a lack of information available to determine an applicant's capacity to comply with the requirements of the MA or Part D programs. 42 C.F.R. §§ 422.502(b)(2) and 423.503(b)(2).

Within its brief, CMS provides a comprehensive summary of the historic development of CMS's past performance regulations up to and including the 2022 amendments:

> CMS first adopted the authority to deny Part C contract qualification applications from current Medicare contractors through the interim final rule published in June 1998 as part of the implementation of the Medicare+Choice program, the predecessor to the current MA program. 63 Fed. Reg. 34975-34976 (June 28, 1998). CMS incorporated the same provision into the Part D implementing regulations published in January 2005. 70 Fed. Reg. 4554 (January 28, 2005).
>
> CMS amended its past performance requirements at 42 CFR §§ 422.502(b) and 423.503(b) in a final rule published in April 2011 to allow CMS to deny MA and

[4] 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).

> Part D applications from an existing MA organization and/or Part D sponsor that did not have 14 months' performance history with the MA and/or Part D programs. 76 Fed. Reg. 21432 (April 15, 2011).

CMS Brief at 3.

The Hearing Officers observe that the Secretary further explained, within the preamble to the final rule, the following:

> Each year, as part of the application evaluation process, we conduct a comprehensive review of each Part C and D sponsor's past performance in the operation of its Medicare contract(s). Current regulations provide that organizations with current or prior contracts with CMS are subject to CMS denial of any new applications for additional or expanded Part C or D contracts if they fail during the preceding 14 months to comply with the requirements of the Part C or D programs, even if their applications otherwise demonstrate that they meet all of the Part C or D sponsor qualifications. In the absence of 14 months of performance, however, this leaves a gap whereby CMS must either assume full compliance and exempt the entity from past performance review or deny additional applications from such entities until the applicant has accumulated 14 months' experience, during which it complied fully with the requirements of the Part C and/or Part D programs.
>
> Our interest in protecting Medicare beneficiaries and limiting program participants to the best performing organizations possible strongly suggests that we take the latter approach. Our justification for proposing this change was two-fold. First, we would ensure that new entrants to the Part C or Part D program could fully manage their current contracts and books of business before further expanding. Second, this change would require that entities rightfully focus their attention on launching their new Medicare contracts in a compliant and responsible manner, rather than focusing attention almost immediately on further expansions.

76 Fed. Reg. 21432, 21524 (April 15, 2011).

CMS's brief further explains that

> CMS has modified past performance requirements in several subsequent rulemakings. In a final rule published in April 2018, CMS changed the past performance review period from 14 months to 12 months. 86 Fed. Reg. 16440 (April 16, 2018). CMS made several changes to the past performance requirements in a final rule published in January 2021, including codifying at 42 CFR §§ 422.502(b)(1)(ii) and 423.503(b)(1)(ii) the long-standing policy attributing the performance of existing MA organizations and Part D sponsors to inexperienced legal entities under the same parent organization. 86 Fed. Reg. 5864 (January 19, 2021).

CMS Brief at 3.

C. Additional Authority Cited By HMI Regarding Minimum Enrollment Waiver Regulations

HMI raises an argument that denying its application due to a lack of performance history conflicts with CMS's approval of a minimum enrollment waiver. Although the Hearing Officers reject this argument, the legal authority regarding the minimum enrollment waiver is outlined below:

The minimum enrollment requirements are mandated by statute at 42 U.S.C. § 1395w–27(b), and "are necessary to enable organizations to adequately spread risk across enrolled populations." 65 Fed. Reg. 40170, 40271 (June 29, 2000). To be granted a waiver for minimum enrollment requirements, "a contract applicant must demonstrate to CMS's satisfaction that it is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract[.]" 42 C.F.R. § 422.514(b). These waivers, if granted, are effective for the first three years of a contract. *Id.* When making a minimum enrollment waiver determination, CMS considers whether:

> (1) The contract applicant management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in paragraph (a) of this section; or
>
> (2) The contract applicant has the financial ability to bear financial risk under an MA contract. In determining whether an organization is capable of bearing risk, CMS considers factors such as the organization's management experience as described in paragraph (b)(1) of this section and stop-loss insurance that is adequate and acceptable to CMS; and
>
> (3) The contract applicant is able to establish a marketing and enrollment process that allows it to meet the applicable enrollment requirement specified in paragraph (a) of this section before completion of the third contract year.

42 C.F.R. § 422.514(b).

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

HMI received its health maintenance organization license from the State of Mississippi on April 23, 2024. Plan Hearing Brief at 2. HMI operated an approved MA-PD plan under contract H8879 beginning in September 2024 for CY2025. *Id.;* CMS Brief at 4. HMI timely submitted an MA-PD Service Area Expansion application for CY2026 under Contract H8879.

CMS states (and HMI does not dispute) that within HMI's initial application, "HMI accurately attested 'no' to the attestation: 'If the applicant, applicant's parent organization, or any subsidiaries of applicant's parent organization has an existing contract(s) with CMS to provide Part D drug

benefits at least one of those contracts has been in continuous effect since January 1, 2024.'" CMS Brief at 4; *see* Plan Hearing Brief at 4.

Following submission of the applications and CMS's subsequent review, CMS issued HMI March 13, 2025, Deficiency Notices for the MA-PD Part C and Part D Service Area Expansion applications, which cited numerous deficiencies. CMS Exhibits C-1 and C-2.

CMS issued NOIDs to HMI regarding the MA-PD applications on April 14, 2025. CMS Exhibits C-3 and C-4. CMS cited to a lack of twelve-month performance history[5] in addition to other deficiencies regarding the MA-PD Service Area Expansion applications.

On May 14, 2025, CMS issued a Denial Letter to HMI regarding its MA-PD applications, citing the deficiency as follows:

> * Management, Experience and History-Your organization attested that its existing Medicare Advantage plan(s) with CMS have not been operational since January 1, 2024 or earlier. Your organization is therefore not eligible to apply for a new contract or service area expansion for 2026.

CMS Exhibit C-5.

> Attestations . . .
>
> -Your organization attested that its existing contract with CMS was not in continuous effect prior to January 1, 2024. Your organization is therefore not eligible to apply for a new contract or service area expansion for 2026.

Id.

On May 15, 2025, HMI timely requested a hearing regarding the MA-PD Service Area Expansion applications denial. HMI filed its Hearing Brief and seven exhibits on May 20, 2025, and CMS filed its Brief along with five exhibits on May 27, 2025. Within its Brief, CMS maintains it properly denied this Service Area Expansion application based on the fact that HMI had less than twelve months experience operating its current MA-PD contract.

On May 29, 2025, HMI filed its Reply Brief.

On May 28, 2025, the Hearing Officer postponed the June 3, 2025, hearing to consider CMS's Motion for Summary Judgment.

[5]The NOID for HMIs MA application cited the application deficiency as pertaining to HMI attesting "its existing Medicare Advantage plan(s) with CMS have not been operational since January 1, 2024 or earlier." CMS Exhibit C-3 at 1. The NOID for HMIs Part D application cited the application deficiency as pertaining to HMI attesting "its existing contract with CMS was not in continuous effect prior to January 1, 2024." CMS Exhibit C-4 at 2.

VII. FINDINGS

The Hearing Officers grant CMS's Motion for Summary Judgment, thereby upholding CMS's denial of HMI's Service Area Expansion applications. The Hearing Officers find that there are no material facts in dispute, as the record demonstrates that HMI admitted within an attestation on its applications that it does not possess the required twelve-month performance history in the MA-PD programs. Accordingly, CMS's decision was consistent with the regulation at 42 C.F.R. §§ 422.502(b)(2) and 423.503(b)(2).

HMI did not dispute that it had less than twelve months of performance history as its current contract with CMS (H8879) was not effective until September 2024. Plan Hearing Brief at 3. Nevertheless, HMI contends that CMS's denial based on the lack of twelve months of performance history is both arbitrary and capricious because it overlooks the potential benefits to Medicare beneficiaries and fails to assess the actual performance capabilities of HMI. HMI argues:

> [i]n implementing 42 C.F.R. § 422.502(b)(2) to deny MA organizations that are in their first year of operations from expanding regardless of their performance history, CMS has acted in an arbitrary and capricious manner in violation of the Administrative Procedure Act. Rather than advancing CMS's stated objective of protecting Medicare beneficiaries and limiting program participants "to the best performing organizations possible", the regulation deprives Medicare beneficiaries, particularly those in rural underserved areas, of much needed health plan options. Moreover, it cannot be said that 422.502(b)(2) limits beneficiaries' access to the best performing organizations since CMS makes no assessment of an MA organization's performance before denying the application in reliance on the regulation.

Id. at 4.

HMI also alleges that the arbitrary and capricious nature of CMS's determination is "further demonstrated by the fact that had HMI's parent organization submitted the applications under a newly formed legal entity with no operational history with CMS, 422.502(b)(2) would not have prevented the new affiliate from expanding based on HMI's lack of 12 months of performance history." *Id*. at 5 (emphasis omitted).

HMI also contends that the application warrants approval because, by approving "a minimum enrollment waiver for HMI in connection with HMI's initial application under H8879 for 2025[,]", CMS has already recognized HMI's capability to operate as a Medicare Advantage Plan and "the subject application denial is in direct conflict with CMS's prior grant of" that waiver. *Id.* at 4. Specifically, HMI asserts that in granting HMI a minimum enrollment waiver for H8879, pursuant to 42 C.F.R. § 422.514(b), CMS had already determined that HMI "is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract during the first 3 years of the contract." Plan Reply Brief at 1 (emphasis omitted). HMI elaborates:

> Pursuant to 42 C.F.R. 422.514(a), unless the requirement is waived by CMS, CMS "does not enter into a contract" unless the organization meets the specified

> minimum enrollment requirement. However, pursuant to 422.514(b), CMS may waive the minimum enrollment requirement for the first 3 years of the contract if the "contract applicant [demonstrates] to CMS's satisfaction that it is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract during the first 3 years of the contract . . . . Therefore, as a prerequisite to approving HMI's minimum enrollment waiver and its participation in the MA program for 2025, CMS determined that HMI was capable of performing its MA Program obligations—not just for 12 months but for three years.

Id. at 4-5 (emphasis and footnote omitted); Plan Reply Brief at 1-2 (emphasis omitted).

CMS indicates that the denial should be upheld as it is undisputed that HMI did not have the requisite twelve months of experience as required by the controlling regulations. CMS also provides an explanation regarding the rationale for the twelve-month experience requirement. CMS explains:

> [f]or 14 years, CMS has prohibited entities from receiving new or expanded MA and Part D contracts until they have demonstrated the ability to operate their existing contracts for at least a single contract year. As CMS explained when it adopted the regulations at 42 CFR §§ 422.502(b)(2) and 423.503(b)(2), this restriction on immediately expanding their MA and Part D offerings was intended to encourage organizations to focus on the challenge of operating MA and Part D plans for the first time rather than immediately turning their attention to expanding their business. 76 Fed. Reg. 21524. HMI concedes that it has no prior experience operating MA or Part D plans and that H8879 has only been effective since September 2024 and only started serving beneficiaries on January 1, 2025. The fact that it does not have 12 months of experience operating MA and Part D plans is undisputed. CMS therefore acted consistently with its longstanding regulations when it denied HMI's 2026 [Service Area Expansion] application under H8879.

CMS Brief at 4-5.

In addressing HMI's arguments that the subject application denial, based upon lack of performance history, conflicts with CMS's approval of HMI's minimum enrollment waiver, CMS asserts that

> [i]n adopting its current policy, CMS has sought to strike a balance between facilitating competition and innovation by contracting with organizations new to MA and Part D, and reducing the risk to beneficiaries posed by inexperienced plans. If CMS were to forbid all applications from newly formed legal entities or from entities with no current health insurance enrollment (as would be the case if CMS did not waive its minimum enrollment requirements in the manner described in HMI's brief), CMS would essentially eliminate new entrants into the MA and Part D markets. This would be unfair both to organizations wishing to operate in these markets and to beneficiaries who might benefit from lower costs or innovative practices by new insurance companies. Rather, CMS has opted to continue to allow

> inexperienced organizations to obtain MA and Part D contracts after demonstrating that they have met all other application requirements and to operate their business for a full year before expanding those contracts.

Id. at 5.

The Hearing Officers reject HMI's argument that the service area application warrants approval on the basis that CMS granted a minimum enrollment waiver, as the minimum enrollment waiver requirements (42 C.F.R. § 422.514(b)) and CMS's past performance criteria (42 C.F.R. §§ 422.502(b)(2) and 423.503(b)(2)) are distinctly separate regulatory provisions and clearly serve different purposes in the MA program. CMS's minimum enrollment waiver determination concerns whether a new applicant has provided assurance, on a prospective basis, that it would be able to meet the initial requirements for a new contract. On the other hand, CMS's required past performance review is conducted as a part of the annual MA application evaluation cycle and is a retrospective-based assessment regarding whether an existing Plan has an established actual history to warrant an expansion.[6]

Additionally, with respect to HMI's assertions that CMS acted in an arbitrary and capricious manner when denying HMI's application and that "CMS's denial harms [rather than protects] beneficiaries in Mississippi by depriving them" "of a provider-sponsored Medicare Advantage plan that is designed to meet the unique needs of beneficiaries in HMI's service area[,]" the Hearing Officers note that the applicable appeals regulations direct the Hearing Officers to determine whether an applicant has proven by a preponderance of the evidence that CMS's determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501, 423.502 and 422.502, 423.503. In exercising this authority, the Hearing Officers must comply with the provisions of title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions implementing the Act. 42 C.F.R. § 422.688 and 423.664. Accordingly, the Hearing Officers find that HMI's policy-related arguments, its claim that CMS's implementation of 42 C.F.R. § 422.502(b)(2) is arbitrary and capricious, and whether CMS chooses to exercise its discretion in a past performance review under 42 C.F.R. § 422.502(b), are outside the scope of the Hearing Officers' authority under 42 C.F.R. §§ 422.688 and 423.664.

VIII. ORDER

The Hearing Officers find no material facts in dispute and find that HMI has not proven by a preponderance of the evidence that CMS's determination was inconsistent with 42 C.F.R.

[6] As further support, in the preamble to the 2011 Final Rule CMS states that the past performance requirement helps to ensure that new plans can "fully manage their current contracts . . . before further expanding[,]" and that new plans will focus on "launching their new Medicare contracts in a compliant and responsible manner, rather than focusing" on expanding. 76 Fed. Reg. at 21524. The Hearing Officers observe that within the preamble to the final rule for the minimum enrollment waiver regulation, in response to a commenter questioning the proposed expansion of the minimum enrollment waiver time period from one year to three years under 42 C.F.R. § 422.514(b), CMS drew a distinction between the minimum waiver request reviews and other forms of CMS oversight that are meant to protect beneficiaries and addressed the additional MA compliance requirements that continue to apply to organizations that are granted minimum enrollment waivers. 83 Fed. Reg. at 16621.

§§ 422.501, 423.502 and 422.502, 423.503. Therefore, the Hearing Officers grant CMS's Motion for Summary Judgment and uphold CMS's denial for HMI's contract H8879.

Amanda S. Costabile -S
Digitally signed by Amanda S. Costabile -S
Date: 2025.08.12 19:07:49 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Suzanne D. Rollins -S
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Date: 2025.08.12 15:04:29 -04'00'

Suzanne D. Rollins, Esq.
CMS Hearing Officer

Date: August 12, 2025