DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service
Office of Hearings
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244

August 28, 2025

Via Electronic Delivery

Katherine McDonald
Partner
McDermott Will & Emery LLP
500 N. Capitol Street NW
Washington, DC 20001

Arianne Spaccarelli
Health Insurance Specialist
CMS MAPD Appeals Team
7500 Security Boulevard
Baltimore, MD 21244

RE: Hearing Officer Decision
Hearing Officer Docket Numbers: H-25-00010/00011/00012
Medicare Advantage/Prescription Drug Plan ("MA/PD") Humana Inc.,
Contract Numbers: H7209/H0065/H5216

Dear Ms. McDonald and Ms. Spaccarelli:

A copy of the Hearing Officers' consolidated decision for the above-referenced appeals is attached.

The Hearing Officers' decision may be appealed to the Administrator of the Centers for Medicare & Medicaid Services. The parties may request Administrator review within 15 calendar days of receiving this decision. See 42 C.F.R. § 422.692; 42 C.F.R. § 423.666. Review requests 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

COMPBENEFITS INSURANCE COMPANY, Contract No. H7209	*	**CMS Hearing Officer Case No.: H-25-00010**
HUMANADENTAL INSURANCE COMPANY, Contract No. H0065	*	**CMS Hearing Officer Case No.: H-25-00011**
HUMANA INSURANCE COMPANY, Contract No. H5216	*	**CMS Hearing Officer Case No.: H-25-00012**
Petitioners	*	
v.	*	**Denial of Application for Medicare Advantage /Medicare Advantage – Prescription Drug Plan**
CENTERS FOR MEDICARE & MEDICAID SERVICES,	*	
Respondent	*	

HEARING OFFICERS' ORDER UPHOLDING CMS'S APPLICATION DENIALS

I. DECISION SUMMARY

The Hearing Officers uphold the Centers for Medicare & Medicaid Services' ("CMS's") denials for the three plans listed *supra* (collectively, "the Plans") based on Humana Insurance Company's (hereinafter, "HIC") past performance regarding contract R4845. While the Plans argue that contract R4845's 2025 Health Plan Management System ("HPMS") Star Ratings were only preliminary since they were not publicly released on the Medicare Plan Finder ("MPF") or CMS's webpage, the Hearing Officers find that contract R4845 received its 2025 Star Rating through HPMS in accordance with the past performance regulation at 42 C.F.R. § 422.502(b)(1)(i)(D). The Hearing Officers agree with CMS that "the publication in the MPF of contracts' Star Ratings for a particular time period is a consequence of CMS finalizing the ratings, not the means by which CMS finalizes them." *See* CMS Brief at 7.[1] The past performance regulations are designed to ensure that an organization's actual performance history is considered through the application process, even if it elects not to renew a particular contract. While the Plans also argue that it is unreasonable to deny the applications due to the relative size of contract R4845 in comparison to the larger corporate organizations, the Hearing Officers do not have the authority to assess such policy-related considerations.

[1] Unless otherwise noted, the briefs and exhibits in this decision refer to materials filed under Docket Number H-25-00010.

II. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. §§ 422.660 and 423.650. The Centers for Medicare & Medicaid Services ("CMS") Hearing Officers designated to hear this case are the undersigned, Benjamin R. Cohen and Amanda S. Costabile.

III. ISSUE

Whether CMS properly denied the Plans'[2] 2026 applications for newly requested Medicare Advantage/Medicare Advantage-Prescription Drug ("MA/MA-PD") offerings[3] based on CMS's determination that the Plans' organization/parent organization failed to meet past performance requirements, with CMS finding that HIC's contract R4845 received a combination of Part C and D summary ratings of three stars or less in both of the two most recent Star Rating periods.

IV. BACKGROUND AND AUTHORITY

A. Application 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 HPMS. *See* "Part C-Medicare Advantage and 1876

---

[2] The three MA-PD Plans (CompBenefits Insurance Company ("CompBenefits"), (HumanaDental Insurance Company ("HumanaDental") and Humana Insurance Company ("HIC")) involved in this case are related organizations. CMS issued the final denial letters under appeal for each of the three Plans separately. Exhibits P-8 (H-25-00010, H-25-00011, H-25-00012). Consequently, the Plans filed three separate appeal requests, resulting in the Hearing Officers issuing three individual hearing case numbers. Both the Plans and CMS submitted briefs and supporting materials under each of these case numbers (*see* Transcript ("Tr.") at 6-8). However, as the submissions and underlying facts, relating to the central issue in the dispute (i.e., past performance of HIC contract R4845) are parallel, the July 28, 2025, hearing for the three appeals was conducted on a consolidated basis, and the Hearing Officers are issuing a consolidated decision.

[3] CMS summarizes the nature of each of the three applications as follows:

"CompBenefits submitted an application for a local coordinated care plan ("CCP") contract to offer MA-PD plans in several states under contract number H7209. The material submitted with the application identified CompBenefits as being a subsidiary of Humana Inc. ("Humana") and also indicated that CompBenefits was new to the MA program." CMS Brief for H-25-00010 at 5.

"On February 12, 2025, HumanaDental submitted an application for a local [CCP] contract to offer MA and Part D plans in several states under contract number H0065. Material submitted with the application identified HumanaDental as being a subsidiary of Humana, Inc. . . and also indicated that HumanaDental did not currently hold any MA contracts." CMS Brief for H-25-00011 at 5. "HumanaDental did hold an MA-PD contract (H8087) from January 1, 2019 through December 31, 2023. Since that contract was not active during the 12 months prior to February 2025, HumanaDental's performance under that contract is not relevant to the H0065 application." *Id.* at note 5.

"On February 12, 2025, HIC submitted a [Service Area Expansion] application to expand the service area of its MA-PD contract, H5216, into several counties in Idaho, Nevada, Oregon, and Washington. Material submitted with the application identified HIC as being a subsidiary of Humana, Inc[.]" CMS Brief for H-25-00012 at 5.

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 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 Application.

MA organizations seeking to 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, 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.

CMS evaluates an entity's application, whether for an MA plan, Specialized MA, and/or for a Part D 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).

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."

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*. 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. 34975-76 (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 C.F.R. §§ 422.502(b) and 423.503(b) in a final rule published in April 2011 to allow CMS to deny MA and 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).
>
> In a final rule published in April 2018, CMS changed the past performance review period from 14 months to 12 months. 83 Fed. Reg. 16440 (April 16, 2018).
>
> CMS subsequently amended its regulations at 42 CFR §§ 422.502(b) and 423.503(b) in a final rule published in January 2021. 86 Fed. Reg. 5864 (January 19, 2021). Under the amended regulation, an applicant may be considered to have

> failed to comply with a contract for purposes of an application denial under 42 CFR §§ 422.502(b)(1) or 423.503(b)(1) if during the 12-month review period prior to submitting an application it had (1) been subject to the imposition of an intermediate sanction under Part 422 Subpart O or Part 423 Subpart O of the regulation, or (2) failed to maintain a fiscally sound operation as required by 42 CFR §§ 422.504(b)(14) or 423.505(b)(23). 42 CFR §§ 422.502(b)(1)(ii) and 423.503(b)(1)(ii). In the 2021 final rule, CMS also amended its Part C and Part D past performance regulations to codify the long-standing policy attributing the performance of existing [Medicare Advantage Organizations] and Part D sponsors to inexperienced legal entities under the same parent organization. 42 CFR §§ 422.502(b)(1)(ii) and 423.503(b)(1)(ii).

CMS Brief at 3.

CMS again amended its past performance regulations in a Final Rule published in May 2022. 87 Fed. Reg. 27704 (May 9, 2022). In this Final Rule, CMS adopted three additional grounds for denying an application based on an applicant's performance under a current or prior contract. Relevant to this case,

> (i) An applicant may be considered to have failed to comply with a contract for purposes of an application denial under paragraph (b)(1) of this section if during the applicable review period the applicant does any of the following:
>
> . . .
>
> (D) Received any combination of Part C or D summary ratings of 2.5 or less in both of the two most recent Star Rating periods, as identified in § 422.166.

42 C.F.R. § 422.502(b)(1)(i)(D).

> CMS adopted these three additional bases for past performance denials because it "has an obligation to ensure the organizations with whom it contracts are able to provide health care services to beneficiaries in a high-quality manner." 87 Fed. Reg. 27815. As CMS stated in the January 2021 final rule and reiterated in the May 2022 final rule, "CMS's overall policy with respect to past performance remains the same." 86 Fed. Reg. 5999 and 87 Fed. Reg. 27815. CMS adopted the changes so that it could continue to deny applications where "the level of previous noncompliance is such that granting additional MA or Part D business opportunities to the responsible organization would pose a high risk to the success and stability of the MA or Part D programs and their enrollees." 86 Fed. Reg. 5999 and 87 Fed. Reg. 27815.

CMS Brief at 4.

The Hearing Officers note that, within the preamble to the 2021 Final Rule (86 Fed. Reg. 5864, 6002 (January 19, 2021)), CMS addressed a commenter's suggestion that "the past performance

review should not include contracts that the applicant has already non-renewed or terminated for the upcoming contract year" as follows:

> We believe that the past performance analysis must be based on an applicant's actual performance history, which should not be subject to revision after the fact. An organization that non-renews a particular contract for an upcoming contract year has already established its performance history through its operation of that contract. The non-renewal does not change the fact that there is a record of performance for CMS to review and consider in evaluating whether that entity deserves a new or expanded MA or Part D contract. Moreover, we would be concerned that adopting the commenter's policy would create the wrong set of incentives for contracting organizations. They should be encouraged to improve the performance of their existing contract rather than abandon the contract, and its enrollees, for the opportunity to seek to operate a new set of plans under a new contract.

86 Fed. Reg. at 6002.

In its May 9, 2022, Final Rule, the Secretary directly addressed a similar concern that the Plan raises in this case (Plans' Witness testimony, Tr. at 31; Plans' Attorney, Tr. at 112)[4] that the past performance of one small contract could potentially affect the larger organization. CMS explained:

> CMS acknowledges that one poor performing contract could prohibit an applicant from service area expansions of other contracts or prohibit the applicant from entering into a new contract. As previously stated, if an organization has a poor performing contract, it is in the best interest of the program for that organization to focus on improving the performance of the poor performing contract, no matter how small or how few enrollees are in the contract instead of expanding their footprint. CMS believes all contracts under a legal entity should meet our requirements before that legal entity is permitted to expand into new service areas or add new contracts.

87 Fed. Reg. 27819 (May 9, 2022).

C. Star Ratings Purpose, Development, and Issuance Process

CMS began publishing annual performance ratings for stand-alone Medicare Prescription Drug Plans in 2007. In 2008, CMS "introduced and displayed the Star Ratings for Medicare Advantage Organizations . . . for both Part C only contracts . . . and Part C and D contracts (MA-PDs). Each year since 2008, [CMS has] released the MA Star Ratings [subsequently adding] [a]n overall rating combining health and drug plan measures" in 2011. 83 Fed Reg at 16520.

[4] The Plans represent that contract R4845 had only approximately 5000 members prior to its non-renewal, which represents less than 0.06% of Humana's overall membership and less than 0.02 % of HIC's overall MA membership. Plans' Initial Briefs for Case Numbers H-25-00010 at p. 13, H-25-00011 at p. 13, H-25-00012 at pp. 12 and 13.

As the Secretary explains in the preamble to the April 16, 2018, Final Rule, "[t]he MA and Part D Star Ratings measure the quality of care and experiences of beneficiaries enrolled in MA and Part D contracts, with 5 stars as the highest rating and 1 star as the lowest rating." 83 Fed Reg at 16520. The Secretary states that CMS "publicly report[s] the quality and performance of health and drug plans . . . in the form of summary and overall ratings for the contracts under which each MA plan (including MA–PD plans) and Part D plan is offered[.]" *Id*. at 16519.

Star Ratings also play a role in CMS's "oversight, evaluation, and monitoring of MA and Part D plans to ensure compliance with the respective program requirements and the provision of quality care and health coverage to Medicare beneficiaries." 83 Fed. Reg. at 16520-21. As such, in April 2012, the Secretary "finalized regulations to use consistently low summary Star Ratings—meaning 3 years of summary Star Ratings below 3 stars—as the basis for a contract termination for Part C and Part D plans." *Id*. at 16520; 42 C.F.R. §§ 422.510(a)(4)(xi) and 423.509(a)(4)(x).

Regarding how CMS uses its Star Ratings, 42 C.F.R. § 422.160[5] states:

> (b) Purpose. Ratings calculated and assigned under this subpart will be used by CMS for the following purposes:
>
> (1) To provide comparative information on plan quality and performance to beneficiaries for their use in making knowledgeable enrollment and coverage decisions in the Medicare program;
>
> (2) To provide quality ratings on a 5-star rating system and to be used in determining quality bonus payment (QBP) status and in determining rebate retention allowances; and
>
> (3) To provide a means to evaluate and oversee overall and specific compliance with certain regulatory and contract requirements by MA, where appropriate and possible to use data of the type described in §§ 422.162(c) and 423.182(c).

The MA/Part C and Part D Star Ratings measures reflect structure, process, and outcome indices of quality. 42 C.F.R. §§ 422.162(c)(1) and 423.182(c)(1). The data underlying MA and Part D plan Star Rating measures may include survey data, data separately collected and used in oversight of MA and Part D plans' compliance with contract requirements, data submitted by plans, and CMS administrative data. 42 C.F.R. §§ 422.162(c)(1) and 423.182(c)(1). MA organizations and Part D sponsors are required to collect, analyze, and report data that permit measurements of health outcomes and other indices of quality, and provide such unbiased, accurate, and complete quality data to CMS on a timely basis. 42 C.F.R. §§ 422.162(c)(2) and 423.182(c)(2). CMS calculates an overall Star Rating, a Part C summary rating, and a Part D summary rating for each MA-PD contract using the 5-star rating system. 42 C.F.R. §§ 422.162 and 423.182. CMS calculates MA and Part D summary ratings in accordance with 42 C.F.R. §§ 422.166 and 423.186(c).

[5] 42 C.F.R. § 422.160 addresses the Part C Medicare Advantage Quality Rating System. *See* 42 C.F.R. § 423.180(b) for the parallel regulation addressing the Part D Prescription Drug Plan Quality Rating System.

Under 42 C.F.R. § 422.166(h)(2),[6] CMS conducts "plan preview periods before each Star Ratings release during which MA organizations can preview their Star Ratings data in [HPMS] prior to display on the [MPF]."

In the preamble to the April 16, 2018, Final Rule, the Secretary explains the overall purpose of the two preview periods provided by CMS:

> During the first plan preview, we expect Part C and D sponsors to closely review the methodology and their posted numeric data for each measure. The second plan preview includes any revisions made as a result of the first plan preview. In addition, our preliminary Star Ratings for each measure, domain, summary score, and overall score are displayed. During the second plan preview, we expect Part C and D sponsors to again closely review the methodology and their posted data for each measure, as well as their preliminary Star Rating assignments.
>
> . . .
>
> We urge that Part C and D sponsors regularly review their underlying measure data that are the basis for the Part C and D Star Ratings.
>
> . . .
>
> *Comment*: Several commenters suggested that CMS post national Star Ratings data during the plan preview period.
>
> *Response:* The purpose of the plan previews is for sponsors to review and raise any questions about their own plan's data prior to the public release of data for all plans on Medicare.gov. This allows for any necessary corrections to be made prior to the Star Ratings data being public. Releasing national Star Ratings data (meaning data about other plans' ratings) would not serve this purpose. Furthermore, to the extent that errors are identified and changes need to be made to data, it would mean that updates to the national data render earlier releases inaccurate and less useful.

83 Fed. Reg. at 16588.

Within the preamble to the May 9, 2022, Final Rule, the Secretary further discusses how the Star Ratings serve as a tool for beneficiaries and may serve as the basis for CMS oversight:

> CMS' star ratings are provided to beneficiaries to help them make informed health care choices. Moreover, MA organizations and Prescription Drug sponsors are required by §§ 422.504(b)(17) and 423.505(b)(26) to maintain summary Part C and/or Part D Star Ratings of at least 3 Stars. Contracts that have 2.5 or less Stars are considered to be "low performers." Regulations at §§ 422.510(a)(4) and 423.509(a)(4) permit CMS to terminate a contract for having less than 3 Stars for 3 consecutive years in a row for Part C summary ratings or for having less than 3 Stars for 3 consecutive years in a row for Part D summary ratings. Such a termination carries with it an exclusion from future MA or Prescription Drug application approvals for 38 months under §§ 422.502(b)(3) and 423.503(b)(3), a

[6] *See* parallel language for Part D at 42 C.F.R. § 423.186(h)(2).

more significant consequence than the 1-year application denial we are discussing in this rule.

87 Fed. Reg. 27816 (May 9, 2022).

V. BACKGROUND AND STATEMENT OF FACTS

On May 14, 2025, CMS issued denial notices for the Plans' applications based on 42 C.F.R. §§ 422.502(b)(1)(i)(D), 422.502(b)(1)(ii), 423.503(b)(1)(i)(D), and 423.503(b)(1)(ii).[7,8] These regulations provide that an application may be denied if the organization, a parent, or a subsidiary of the parent has earned a summary rating of 2.5 Stars or less in the two most recent Star Rating Periods, which in this case are 2024 and 2025.[9] In this instance, the organization/contract CMS identifies as earning less than three stars for two consecutive years is HIC's contract R4845.

While it is undisputed that contract R4845 received a finalized 2.5 Stars (Part D) summary rating in 2024, the parties disagree regarding whether this contract received a finalized 2.5 Stars (Part C) summary rating in 2025, which, together with the 2024 Part D summary rating of 2.5, could serve as a legally sufficient basis for the denial notices. The disagreement arose from the circumstances in which Humana did not challenge the 2025 Part C 2.5 Star Rating in HPMS during the preview periods, leading to its finalization in HPMS. Additionally, because Humana elected not to renew contract R4845 for the 2025 contract year, CMS did not publish the 2025 summary rating in the MPF. Consequently, the Plans argue that contract R4845 did not receive a finalized 2025 Part C summary rating through publication on the MPF to justify their respective application denials under the past performance criteria, while CMS maintains that the rating was finalized through HPMS, its system of record. The timeline of events relating to contract R4845 is outlined below:

- October 2023—Contract R4845's Part D Summary Star Rating of 2.5 for CY 2024 was published on the MPF (after the preview periods). Plan Reply Brief at 6.

- December 2023—Issuance of Corrective Action Plan ("CAP") based on 2024 Summary Rating—CMS issued a CAP for contract R4845. The letter stated: "In October 2023, CMS released the CY 2024 Part C and Part D star ratings on the MPF tool on www.medicare.gov. CMS assigned sponsors separate Summary Star

[7] Regarding the reasons why the application for these three organizations were not approved while other entities were, CMS's counsel explained that Humana submitted additional applications this year under different legal entities. "Humana was and is free to expand its business under legal entities that do not have poor performance with CMS. [HIC], unfortunately, did have a record of poor performance for two consecutive star rating years, so was not eligible to expand any of its businesses with CMS . . . And the two additional subsidiaries, CompBenefits and HumanaDental, have no experience of their own, so had to -- CMS had to judge their experience based on the experience of Humana subsidiaries. CMS has expressed their policy determination that allowing new business for organizations that have difficulty under some of their subsidiaries doesn't make sense, even though perhaps a parent organization could have subsidiaries that perform well and some that don't." Tr. at 118.

[8] Although both CompBenefits and HumanaDental had additional deficiencies cited in their respective denial letters, CMS stated that the Plans had cured these deficiencies and "no longer considers th[ese] deficienc[ies] to be a basis for denial." CMS Brief at 9 for H-25-0010 and H-25-0011.

[9] The 2024 Star Ratings measure performance in 2022 and 2023, and the 2025 Star Ratings measure performance in 2023 and 2024. *See* CMS Witness testimony, Tr. at 74-76.

Ratings for their Part C and Part D operations. Your organization received the following Part D Summary Star Rating: Part D-2.5[].” Plan Exhibit P-14 (emphasis omitted); Plan Reply Brief at 6, 7.

- Spring 2024—Humana indicated that during this time, it made its decision to not renew contract R4845 (or “effectively terminate” contract R4845 on December 31, 2024) for the upcoming plan year (prior to the June bid decision due date). Plans’ Witness testimony, Tr. at 34-35; CMS Brief at 7.

- August 2024/September 2024—Plan Preview Periods of Star Ratings and Display Measures for 2025. Contract R4845’s Star Ratings were displayed during both preview periods. CMS Witness Declaration at 5.[10, 11] For the second plan preview period, CMS notified the Plans, through a September 5, 2024, memorandum, that “prior to the release of data on the MPF, all data in HPMS will be updated with the final 2025 Star Ratings.” Plan Exhibit P-12.

- October 2024—Each plan’s 2025 Star Ratings for MA PD contracts, including contract R4845, were made accessible in HPMS. CMS Witness Declaration at 9; Plan Exhibit 12. The 2025 Star Ratings, excluding contract R4845, were publicly released on the MPF. CMS Witness testimony, Tr. at 22, 84; CMS Brief at 5; Plan Exhibit P-12.

Of note, at the hearing, both parties acknowledged the rationale regarding why contract R4845’s 2025 Star Rating did not appear in the MPF released in October 2024. CMS explained that:

> [The] Plan Finder is a plan comparison tool for beneficiaries to use to select a plan. R4845 non-renewed effective December 31, 2024 and was not available for beneficiaries to select in 2025, so it would not have appeared during the annual

[10] It is not disputed that the 2025 R4845 performance data and the 2.5 Star Ratings were available to Humana throughout the August/September preview period and in October 2024 through the Performance Metrics Section of HPMS (although they considered the Star Rating as not final) (Plans’ Witness testimony, Tr. at 54-55, 65).

Specifically, the Plans’ witness testified as follows:

> [Plans’ Attorney]: Did Humana receive preliminary 2025 star ratings data for R4845?
>
> [Plans’ Witness]: Yes, we did.
>
> [Plans’ Attorney]: How did Humana learn that that information was available?
>
> [Plans’ Witness]: Well, we received the HPMS memo in September here and then, obviously, when we went and downloaded the data for Humana Plan Preview 2 contract, we were able to see it there.

Plans’ Witness testimony, Tr. at 53-54.

The Plan also commented that it “learned” of the 2025 rating in 2024. Plans’ Witness testimony, Tr. at 35. *See also* CMS Brief at 8 and Exhibits C-5, C-6, and C-7. *See* CMS Witness testimony, Tr. at 78-86, for additional background relating to the timing and procedures of the preview period and the publication of the Star Ratings in HPMS (which CMS considers final) each October.

[11] The CMS witness explained that unless a plan raises concerns regarding the score during the preview periods, the score is finalized. CMS Witness testimony, Tr. at 79-80.

> enrollment period, or AEP, that commenced in October of 2024 or on January 1st, 2025, when the new plan year began.

CMS Witness testimony, Tr. at 21-22.

> The whole purpose of MPF is so that a Medicare beneficiary has information to make a decision about what plan they want to enroll in. So it only includes active contracts over that year. So we wouldn't include a terminated contract because a beneficiary cannot choose that contract in the following year.

CMS Witness testimony, Tr. at 84.

The Plans' witness stated that "[t]he contract was non-renewed so it didn't exist anymore for 2025" and concurred with CMS that the MPF was "intended as a beneficiary tool so it would not necessarily make sense" for contract R4585's 2025 rating to be published in the MPF. Plans' Witness testimony, Tr. at 45.

VI. ANALYSIS

The Hearing Officers affirm CMS's denials for the Plans' applications based on HIC's contract R4585 receiving a combination of Part C or D summary ratings in 2024 (Part D - 2.5 Stars) and in 2025 (Part C - 2.5 Stars), as per 42 C.F.R. §§ 422.502(b)(1)(i)(D), 422.502(b)(1)(ii), 423.503(b)(1)(i)(D), and 423.503(b)(1)(ii).

The Plans argue that while CMS may have calculated a final Star Rating, the 2025 Part C ratings for R4585 were not "finalized" or "released" (thus not "received"), as they were not published on the MPF, displayed on the website, or communicated within a CAP notice. Plan Initial Brief at 10, 11; Plan Reply Brief at 1, 3; Plans' Attorney, Tr. at 106-108. In supporting its assertions, the Plans indicate that the Star Ratings data posted by CMS in HPMS during the plan preview periods are preliminary and subject to change. The Plans reference the preamble to the 2018 Final Rule where CMS refers to the HPMS display as "preliminary Star Rating assignments." Plan Initial Brief at 10 (citing 83 Fed. Reg. at 16,588). The Plans explain that

> [t]he subsequent action that the preliminary Star Rating assignments precede is CMS's "public release" of Star Rating assignments by their "display in the MPF" or Medicare Plan Finder. 83 Fed. Reg. at 16,588. Accordingly, the preliminary assignment of Star Ratings—as displayed in HPMS—cannot [be] final ratings from CMS: by definition, the preliminary Star Ratings assignments are merely preparatory to the subsequent, final assignment of Star Ratings as displayed in [MPF].

Id. (emphasis omitted).

The Plans outline several points to support their assertion that the HPMS ratings are preliminary and not finalized until they are publicly released on the MPF.[12] For instance, CMS materials explicitly state that Star Rating assignments cannot be used in marketing materials until CMS publishes them on the MPF. 42 C.F.R. § 422.67(e)(13)(v). Additionally, CAP notices refer to the Star Ratings available on the MPF. Plan Exhibit P-14. Furthermore, documents indicate that the Star Ratings utilized in determining a plan's Quality Bonus Payment are those final versions published on the MPF. Plan Initial Brief at 12-13. Lastly, the Plans argue that "[i]f a contract is not renewed, it shouldn't receive a star rating for the year it is no longer offered when final star ratings are those that appear in [MPF]." Plans' Attorney, Tr. at 107.

The Plans note that CMS informs plans of significant actions, such as the opening of preview periods, Star Rating publications on MPF, and CAP letters, through MPF or HPMS. Plans' Attorney, Tr. at 109-110. However, the Plans contend that Humana never received a clear notification from CMS indicating that contract R4845 had been considered in the finalization of the 2025 Star Ratings through the (internal only) HPMS view. *See* Plans' Attorney, Tr. at 109-111. Similarly, the Plans point out that through contract R4845's CAP notice dated December 28, 2023, Humana received formal notice that contract R4845 received a Part D 2.5 Star Rating for 2024, but it received no such notice for the Part C 2.5 Star Rating for 2025. Plan Reply Brief at 6-7.

The Hearing Officers reject the Plans' interpretations and contentions. It is undisputed that Humana accessed contract R4845's preliminary data and Star Rating on HPMS but did not take the opportunity to challenge the preliminary data or the 2.5 Star Rating. Plans' Witness testimony, Tr. at 53-57, 62-65; *see* 83 Fed. Reg. at 16588. Humana also had access to contract R4845's 2.5 Star Rating after it was finalized in October 2024. Plans' Witness testimony, Tr. at 63. Thus, the Hearing Officers find that Humana "received" contract R4845's Part C 2025 Star Rating for purposes of 42 C.F.R. § 422.502(b)(1)(i)(D), which provides that an applicant may be considered to have failed to comply with a contract if it "received" any combination of Part C or D summary ratings of 2.5 or less in both of the two most recent Star Rating periods. The past performance regulations do not require the Star Ratings to be publicly released to be effective.

The Hearing Officers note that the "past performance" regulation subsections at 42 C.F.R. §§ 422.502(b) and 423.503(b), specifically encompass the "[u]se of information from a current or **prior** contract" (emphasis added). Accordingly, the Hearing Officers find that the past performance regulations are designed to ensure that an organization's actual performance history is considered through the application process, even if the organization elects not to renew a particular contract. The decision by CMS not to publish the final rating of the defunct organization in the MPF or on the webpage intended for beneficiaries to review and compare active plans is prudent to prevent any potential confusion. *Supra* p. 10-11. The examples cited by the Plans referring to the Star Rating on the MPF as final or released are out of context, as they mainly pertain to how the score is used in more public-facing or subsequent interactions. In summary, the Hearing Officers agree with CMS that "the publication in the MPF of contracts' Star Ratings for a particular time period is a consequence of CMS finalizing the ratings, not the means by which

[12] Similarly, the Plans indicate that besides the Star Ratings not being published (and finalized) on the MPF as required, contract R4845's Star Ratings were also not publicly released on spreadsheets available on CMS's webpage. Plans' Witness testimony, Tr. at 45-46; Plans' Attorney, Tr. at 107-108.

CMS finalizes them." CMS Brief at 7. Essentially, the 2025 Star Ratings were finalized and accessible in October 2024, and CMS subsequently released these same scores to the public via the MPF for plans that were still operating and available for beneficiaries to enroll in for Part C and/or Part D coverage in the following year.

Regarding the Plans' allegation that they did not receive a clear notification from CMS indicating that CMS considered contract R4845's 2025 Star Ratings, which were viewable to the Plans through HPMS, as final, a memorandum notifying plans of the second preview period specifically informed that "prior to the release of data on the MPF, all data in HPMS will be updated with the final 2025 Star Ratings." Plan Exhibit P-12.

Similarly, regarding the Plans' suggestion that R4845 did not receive a 2025 Part C Star Rating due to the absence of an associated 2025 Star Rating CAP notice (unlike the 2024 Part D rating), the Hearing Officers find CMS's response to be reasoned. CMS explains that it does not issue CAPs to plans that have already terminated, explaining that "[t]he purpose of [CMS] issuing the star ratings CAPs is to provide the corrective action period required under" 42 C.F.R. §§ 422.510 and 423.509 (regulations addressing termination of a contract by CMS) and provide notice that the period has started. CMS Witness testimony, Tr. at 102. Accordingly, the Hearing Officers find that once CMS was on notice that Humana was not planning on renewing R4845, the necessity to issue a CAP in late 2024 was no longer necessary.

Moreover, the Hearing Officers find that the preamble to the 2021 Final Rule is on point. *Supra* p. 5-6. The Final Rule states:

> We believe that the past performance analysis must be based on an applicant's actual performance history, which should not be subject to revision after the fact. An organization that non-renews a particular contract for an upcoming contract year has already established its performance history through its operation of that contract. The non-renewal does not change the fact that there is a record of performance for CMS to review and consider in evaluating whether that entity deserves a new or expanded MA or Part D contract.

86 Fed. Reg. at 6002.

Finally, while the Plans argue that it is unreasonable to deny the applications due to the relative size of contract R4845 in comparison to the larger corporate organizations, the Hearing Officers do not have the authority to assess policy-related considerations and override the application denials which were made in accordance with the controlling authorities. *See* 42 C.F.R. §§ 422.660(b)(1), 423.650(b)(1), 422.688 and 423.664.

VII. ORDER

The Hearing Officers uphold the CMS's application denials for contract numbers H7209, H0065, and H5216.

BENJAMIN COHEN -S Digitally signed by BENJAMIN COHEN -S Date: 2025.08.28 15:07:46 -04'00'

Benjamin R. Cohen, Esq.
CMS Hearing Officer

Amanda S. Costabile -S Digitally signed by Amanda S. Costabile -S Date: 2025.08.28 15:11:29 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: August 28, 2025