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

In the case of:	**Review of CMS Hearing Officer Case No.**
Humana Benefit Plan of South Carolina, Inc.	**H-25-00013**
Contract No. H1396	**Dated: August 15, 2025**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the CMS Hearing Officer's decisions. The Administrative appeals of Medicare Advantage (MA), Medicare Advantage-Part D (MA-PD) application denials are governed by 42 CFR Part 422, Subpart N (Part C), 42 CFR Part 423, Subpart N (Part D). The Humana Benefit Plan of South Carolina, Inc. (Humana-SC) requested review by the Administrator of the CMS Hearing Officer Decision upholding the applications denial. The parties were notified of the Administrator's election to review the Hearing Officer's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND CMS HEARING OFFICER'S DECISION

The issue in the case is whether CMS' denial of Humana-SC's Initial Applications for a MA/MA-PD Highly Integrated Dual-Eligible Special Needs Plan (HIDE-SNP) under Contract H1396 was inconsistent with regulatory requirements.

The CMS Hearing Officer granted CMS' Motion for Summary Judgment in the case. The Hearing Officer found that there were no material facts in the dispute. The Hearing Officer determined that the record did not establish that Humana-SC provided CMS, in conformity with the April 14, 2025 Notices of Intent to Deny (NOIDs) the: 1) Health Service Delivery (HSD) tables meeting CMS' network adequacy requirements; or 2) an exception request for that provider specialty; or 3) a request to withdraw the county at issue from its applications by the May 9, 2025, deadline. Although Humana-SC asserted that it could have submitted a successful application or exception request if not for a clerical error or earlier access to information regarding a provider's availability, this did not obligate the Hearing Officer to instruct CMS to reverse its denial, grant an exception, or permit modifications to the application by allowing Humana-SC to withdraw Sumter County past the deadline for such requests. Accordingly, the CMS Hearing Officer upheld CMS' denial of the Plan's application for contract H1396.[1]

[1] Hearing Officer Decision, (Aug. 15, 2025).

COMMENTS

Humana-SC submitted a request that the Admininstrator elect to review the CMS Hearing Officer decision. Humana-SC asserted that CMS denied Humana-SC's application because the plan barely missed network standards for one specialty in one county (cardiothoracic surgery in Sumter County) out of 46 counties in South Carolina. But Humana-SC countered that it had contracted with all available cardiothoracic surgeons in Sumter County and CMS has granted other plans network adequacy exceptions for cardiothoracic surgery in Sumter County. Human-SC contended that there is no dispute that CMS would have granted Humana-SC such an exception had it been possible for Humana-SC to timely submit such a request. Humana-SC explained that it could not do so because it only later learned, after the deadline, that a provider had exited the market.

Human-SC shared that the South Carolina Department of Health and Human Services (SCDHHS) has expressed concerns about the impact of this denial on beneficiaries and has asked CMS to explore all pathways to permit Humana to continue offering a D-SNP in 2026. [2] Although the Hearing Officer disclaimed authority to consider the common-sense policy implications of CMS' denials or the equities explaining Humana's inability to timely submit a network adequacy exception request or request for county withdrawal, the Administrator should exercise reasonable discretion to avoid the harmful consequences of CMS' denials on beneficiaries

Denying Humana-SC's application would harm beneficiaries without reason. Humana has offered a D-SNP in South Carolina for over a decade, currently enrolling nearly 9,000 beneficiaries. It applied to offer a standalone HIDE-SNP in accordance with South Carolina's transition to integrate dual-eligible enrollees starting next year. CMS' denial would needlessly force these beneficiaries to enroll in a different plan, disrupting their care. Recognizing this serious beneficiary harm, after learning of the reason for CMS' denial, the State has agreed that Humana-SC may offer the plan in all counties except Sumter. It thus supports Humana-SC's offering, regardless, but CMS must still approve Humana-SC's application, either with or without Sumter County. CMS has no good reason not to do so: Humana-SC has contracted with all of the available cardiothoracic surgeons serving Sumter County, and CMS conceded that Humana-SC satisfies the criteria for a network adequacy exception. The only reason, moreover, that Humana-SC did not timely submit an exception request or request to withdraw Sumter County is because it did not learn before those respective deadlines that a provider had exited the market, triggering the network inadequacy. In addition, Humana-SC has now entered into a letter of intent (LOI) with a South Carolina health system to recruit another cardiothoracic surgeon to practice in Sumter County in 2026, which would resolve the need for a network adequacy exception at all.[3]

Human-SC stated that the Administrator should either permit the exception request or allow Humana to withdraw Sumter County and direct the approval of Humana-SC's applications under contract H1396. While CMS "may deny an application on the basis of an evaluation of the applicant's network," it is not required to do so under its own regulations. 42 C.F.R. §

[2] *See* Exhibit P-12 (June 27, 2025 Letter from Jordan Desai to Kerry Branick).
[3] Exhibit P-13.

422.116(a)(ii) (emphasis added). Humana-SC concluded it makes no sense to do so here, where the single deficiency is minor and it was practically impossible for Humana-SC to timely file a meritorious exception request and pointed out that CMS acknowledged [4]that "provider availability is dynamic," warranting greater flexibility as long as a plan's offering will satisfy CMS standards and deliver value as of the date that coverage begins. The Administrator should take action – as requested by the State – to prevent the attendant harm to South Carolina beneficiaries.

Finally, Humana-SC requested that, were the Administrator not to take this prompt action allowing Humana to proceed for contract year 2026, he should direct CMS direct CMS to permit Humana-SC to continue offering a D-SNP under H5619 for 2026 to ensure continuity of care for the almost 9,000 beneficiaries enrolled in that plan. To achieve this CMS would need to reverse Humana-SC's crosswalk exception request, which asked CMS to move South Carolina D-SNP beneficiaries from Humana-SC's existing to this new contract H1396. This is the last resort to avoid seriously harming South Carolina dual-eligibles that are currently participating in Humana-SC's offering. The Plan cautioned that absent approval of H1396, these beneficiaries would be left without continuity of care.

The Plan concluded by requesting that the Administrator take prompt action in order to allow CMS' to enter into a contract with the applicant for the coming contract year.

DISCUSSION

The entire record, which was furnished by the CMS Hearing Officer, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

The Centers for Medicare and Medicaid Services is authorized to enter into contracts with companies to provide medical coverage under the Medicare Advantage (MA) program to their plan enrollees through Medicare Part C, as well as private prescription drug benefits to their plan enrollees under Medicare Part D. The regulations governing Parts C and D of the Medicare program are set forth at 42 C.F.R §§ 422 and 423, respectively.

Under 42 C.F.R. § 422.116, an MA plan must demonstrate that it has an adequate contracted provider network that is sufficient to provide access to covered services in accordance with access standards described in section 1852(d)(1) of the Act and in §§ 422.112(a) and 422.114(a)(1), and must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type. Beginning with contract year 2024, an applicant for a new or expanding service area must demonstrate compliance with the network adequacy requirement section as part of its application and CMS may deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area.

To demonstrate compliance with these network adequacy standards, as part of the application, MA plans must upload Provider and Facility Health Service Delivery (HSD) Tables into the Health

[4] *See* CMS Brief, at 6-7.

Plan Management System (HPMS). An MA plan must list every provider and facility with a fully executed contract in its network in the HSD Tables. A letter of intent (LOI) signed by both the MA organization and the provider or facility with which the MA plan has started or intends to negotiate may be used in lieu of a signed contract to meet network standards. CMS reminds Plans, in the "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance", that:

> Given the dynamic nature of the market, the file is a resource and may not be a complete depiction of the provider and facility supply available in real-time. MA organizations remain responsible for conducting validation of a used to populate HSD tables, including data initially drawn from the supply file. MA organizations should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available.[5]

CMS allows plans to request an exception to the network adequacy criteria and will approve such a request if certain criteria are met. The regulation at 42 C.F.R. § 422.116(f) provides that exceptions are allowed when both of the following occurred: (1) certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; and (2) the MA plan has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care. CMS reviews exception requests and pursuant to 42 C.F.R. § 422.116(f)(1)(i)(A)-(B) considers whether (1) the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year; (2) there are other factors present in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and (3) approval of the exception is in the best interests of beneficiaries. 42 C.F.R. § 422.116(f)(2)(i)-(iii).

The "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance"[6] also provides additional information and instructions regarding exception requests including a non-exhaustive list of what CMS considers to be valid rationales to submit an exception request and why the identified providers cannot contract. The Network Adequacy Guidance states that CMS "will generally not accept an organization's assertion that it cannot meet current CMS network adequacy criteria because of an 'inability to contract,' meaning they could not successfully negotiate and establish a contract with a provider/facility." Finally, an MA plan may also have the option to timely withdraw or reduce the service area of a pending application to demonstrate compliance with the application requirements.

Humana-SC has offered a dual eligible special needs plan (D-SNP) in South Carolina since 2012. South Carolina has recently planned for the integration of Medicare and Medicaid benefits for dual-eligible enrollees. The State explained that over the next four years, the State intends to

[5] "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance" at 3. Available online at *https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance12-12-2023.pdf*.
[6] *Id.*

transition all services into the managed care service delivery model. To ensure members receive quality integrated care through this transition and the sunset of the South Carolina Healthy Connections PRIME Financial Alignment Demonstration, the State Medicaid program is offering both HIDE-SNP and Coordination Only State Medicaid Agency Contract opportunities to existing South Carolina partners. This State approach has required Medicaid managed care organizations to establish new, statewide, standalone Highly Integrated Dual-Eligible Special Needs Plan (HIDE-SNPs) starting January 1, 2026.[7]

Humana-SC explained that to meet South Carolina's new requirements, Humana-SC did not file its previous D-SNP plan benefit package under the H 5619 contract number for the 2026 contract year—a D-SNP that according to Human-SC currently has approximately 8,600 dual-eligible enrollees. Humana-SC instead intended to continue providing coverage to these beneficiaries through a new HIDE-SNP under the H1396 contract number. Humana-SC thus applied to CMS on February 12, 2025, to offer this new HIDE-SNP.[8]

CMS issued a notice of intent to deny or NOID of the applications on April 14, 2025.[9] CMS explained that it intended to deny the applications because the plan's contracted network of providers did not meet network adequacy standards. CMS informed Humana-SC that it had to cure the deficiencies no later than April 24. CMS indicates, and Humana-SC did not dispute that Humana-SC did not file an exception request, before the applicable April 30, 2025, deadline, that addressed the failure in Sumter. Additionally, Humana-SC did not request to withdraw Sumter County before the applicable May 9, 2025, deadline. On May 14, CMS denied Humana-SC's application to offer a new MA/MA-PD contract because of the single network deficiency in cardiothoracic surgery in Sumter County. In turn, CMS also denied Humana-SC's Part D application because Humana-SC had failed to meet the requirements of the MA application.[10]

After the CMS' denial, Humana-SC stated that the South Carolina Department of Health and Human Services (SCDHHS)—the State's Medicaid agency—agreed to include a provision in Humana-SC's State Medicaid Agency Contract that would grant Humana-SC an exception for the 2026 contract year from the State's requirement to maintain adequate statewide Medicare and Medicaid provider networks.[11]

On May 27, 2025, Humana timely appealed CMS' denial of the application to the Office of Hearings. Humana-SC subsequently learned on June 10 that the health entity at issue had relocated as of April 2025 and had exited the Sumter County market.[12] Humana-SC asserted that CMS should grant it a network exception request for cardiothoracic surgery in Sumter County post-denial because Humana-SC could not have timely submitted an exception request without

[7] Humana- SC, Exhibit P-12.
[8] Humana's Request for Administrator Review, at 2 (Aug. 21, 2025).
[9] *Id*.
[10] *Id*.
[11] *Id*., at 3.
[12] *Id*.

knowledge that the health entity had exited the market. Alternatively, Humana-SC argued that CMS should permit it to withdraw Sumter County from the H1396 contract post denial and approve the application because this withdrawal would cure the deficiency that resulted in CMS' denial, while minimally impacting existing beneficiaries.

Specifically, Humana-SC indicated that it would have been eligible to have its application approved or an exception request granted if not for its clerical error and/or if it had realized that a doctor had ceased serving Sumter County prior to the application deadline.[13] Humana-SC further argues that it was practically impossible for Humana to have timely submitted such an exception request. Humana-SC did not learn until more than a month after the deadline to submit network exception requests that the physician had stopped serving patients in the relevant location more than a month earlier, right before the deadline for Humana-SC to respond to CMS' NOID. The deadline for Humana-SC to submit an exception request to resolve a network deficiency identified in the NOID was April 24, 2025—one day after the physician in question stopped serving the county. Humana-SC could not have submitted an exception request in time to meet the April 24 deadline when the physician did not alert Humana-SC to his status change. The Plan argued that if its applications are denied, nearly 9,000 dual-eligible Medicare and Medicaid beneficiaries currently enrolled in Humana-SC's D-SNP would be forced to change plans, disrupting their care.[14]

Alternatively, Humana-SC argued that if the Administrator does not grant an exception request for Sumter County, he should still permit Humana-SC to remove Sumter County from the H1396 applications and approve them. This withdrawal would cure the deficiency that resulted in CMS' denials while minimally impacting beneficiaries considering the South Carolina Department of Health and Human Services' agreement, confirmed via email on June 12, 2025, to allow Sumter County's withdrawal from the application while still permitting Humana-SC's contract H1396 to operate for 2026.[15]

Finally, Humana-SC argued that if all else fails, the Administrator should direct CMS to permit Humana to continue offering a D-SNP under H5619 for 2026 in order to ensure continuity of care for the almost 9,000 beneficiaries enrolled in that plan. In order to achieve this, CMS would need to treat Humana-SC's D-SNP plan benefit package bid submission for H1396 as if it were submitted as a D-SNP plan benefit package under the H5619 bid submission. CMS would also need to disregard Humana-SC's crosswalk exception request, pursuant to which Humana asked to have South Carolina D-SNP beneficiaries participating under Humana-SC's current contract (H5619) moved to this new contract (H1396). While Humana-SC submits that H1396 should be approved, if it is not, CMS should permit the beneficiaries currently enrolled in the D-SNP under H5619 to remain in their current plan. This is the last resort option to avoid upsetting service for the more than 9,000 South Carolina dual-eligibles that currently receive their Medicare and Medicaid benefits through a Humana-SC plan.[16]

[13] *Id.* at 4.
[14] *Id*.
[15] *Id*. at 4-5.
[16] *Id*. at 5.

After a review of the record, the Admininstrator finds that the CMS Hearing Officer properly found that the record did not establish that Humana-SC provided CMS with the: 1) Health Service Delivery (HSD) tables meeting CMS' network adequacy requirements; or 2) an exception request for the insufficient provider specialty; or 3) a request to withdraw the county at issue from its applications by the May 9, 2025, deadline. Humana-SC did not prove by a preponderance of the evidence that CMS' determination regarding their network deficiencies and the lack of an exception request filing were inconsistent with regulatory requirements. Under 42 C.F.R. § 422.116(a)(1)(ii), CMS may deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area, and, thus, the Hearing Officer was correct to uphold CMS' denial of Humana-SC's application for contract H1396.

However, Humana-SC has submitted a letter from the South Carolina Department of Health & Human Services in support of approval of Contract H1396.[17] The State expressed serious concerns that if the application is not approved, there will be serious disruption for Humana-SC's existing members.[18] Although the Hearing Officer's decision was proper, the Administrator, using his discretionary contractual authority, determines that it is in best interest of the beneficiaries to modify the Hearing Officer's decision. Accordingly, the Administrator finds that the CMS denial and the Hearing Officer affirmation were proper and correct. However, in light of the special and unique considerations presented in this specific case, the Administrator modifies the CMS denial and Hearing Officer decision to allow the Applicant another opportunity to demonstrate that it meets the specific contractual requirements and is in compliance with the standards that it failed to meet during the application review process. The Administrator further holds that, in allowing the Applicant to correct the deficiencies in the application at this time, whether through curing the network deficiency, filing an approvable exception, or removal of Sumter County, the Applicant must promptly submit the documentation required by CMS within the timeframes CMS orders consistent with this decision.

[17] *See* Exhibit P-12.
[18] *Id*.

DECISION

The Admininstrator modifies the decision of the CMS Hearing Officer consistent with this opinion. The CMS determination on whether Contract 1396 meets the criteria for approval after submission of the required documentation shall be herein incorporated as the final decision of the agency.

Date: September 18, 2025

John Brooks
Chief Policy and Regulatory Officer & Deputy Administrator
Centers for Medicare & Medicaid Services