DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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August 15, 2025

Via Electronic Delivery

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RE: Hearing Officer Decision
Hearing Officer Docket Number: H-25-00013
Medicare Advantage/Prescription Drug Plan ("MA/PD"), Appeal Year: 2026
Humana Inc., Contract/Plan/Provider Number: H1396

Dear Ms. McDonald and Ms. Casserly:

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

HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.,	*	**CMS Hearing Officer Case No.:**
Contract No. H1396	*	**H-25-00013**
Petitioner	*	**Denial of Initial Application for a Medicare Advantage – Prescription Drug Highly Integrated Dual-Eligible Special Needs Plan**
v.	*	
Centers for Medicare & Medicaid Services,	*	
Respondent	*	

HEARING OFFICER ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

a) May 27, 2025, Hearing Request on Centers for Medicare & Medicaid Services' ("CMS's") Initial Application Denial for a Medicare Advantage/Medicare Advantage – Prescription Drug ("MA/MA-PD") Highly Integrated Dual-Eligible Special Needs Plan ("HIDE-SNP") under Contract Number H1396, filed by Humana Benefit Plan of South Carolina, Inc. ("Humana South Carolina")[1];
b) June 13, 2025, "Initial Hearing Brief of Humana Inc." filed by Humana South Carolina ("Plan Initial Brief") and Exhibits P-1 through P-11;
c) June 20, 2025, CMS's "Brief in Reply to Applicant's Brief in the Matter of the Denial of the Part C Application Submitted by Humana [South Carolina] (Contract H1396)" with Motion for Summary Judgment and Exhibits C-1 through C-6, filed by CMS;
d) June 27, 2025, "Reply Brief of Humana Inc." ("Plan Reply Brief").

II. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. § 422.660. The CMS Hearing Officer designated to hear this case is the undersigned, Amanda S. Costabile.

III. ISSUE

Whether CMS's denial of Humana South Carolina's initial application for an MA/MA-PD HIDE-SNP contract (Contract No. H1396), based on Humana South Carolina's failure to meet CMS's provider network adequacy requirements, was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officer grants CMS's Motion for Summary Judgment. *See* CMS Brief at 8-9. The Hearing Officer finds that there are no material facts in dispute and the record does not establish that Humana South Carolina provided CMS, in response to the April 14, 2025 Notice of Intent to Deny ("NOID"), with a Health Service Delivery ("HSD") table meeting CMS's network adequacy requirements for Cardiothoracic Surgery in Sumter, South Carolina; an exception request for that provider specialty; or a request to withdraw the county from its application by the May 9, 2025, deadline. Although Humana South Carolina asserts 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 does not obligate the Hearing Officer to instruct CMS to reverse its denial, grant an exception, or permit modifications to the application by allowing Humana South Carolina to withdraw Sumter County past the deadline for such requests. Accordingly, the Hearing Officer upholds CMS's denial of the Plan's application for contract H1396.

[1] Within the instant decision, Humana South Carolina is also referred to as "the Plan" or "the Applicant."

V. AUTHORITY

A. APPLICATION REVIEW

Under Title XVIII of the Social Security Act ("the Act") (codified at 42 U.S.C. §§ 1395-1395lll), CMS is authorized to enter into contracts with entities seeking to offer Medicare Part C and Part D benefits to beneficiaries. 42 U.S.C §§ 1395w-27, 1395w-112. Any entity seeking such a contract must fully complete all parts of a certified application in the form and manner required by CMS. 42 C.F.R. § 422.501(c)(1). CMS requires an entity seeking to contract as an MA organization to submit an application through the Health Plan Management System ("HPMS").[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 July 10, 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 and additional application requirements for MA organizations seeking to offer a Specialized MA plan for Special Needs Individuals. Among other requirements, applicants must provide documentation of appropriate state licensure, demonstrate that they are licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits, and submit a properly executed CMS State Certification Form. *See also* 42 C.F.R. § 422.400; "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy2026-medicare-advantage-part-c-application.pdf (last visited July 10, 2025).

As CMS explains:

> All MA special needs plans (SNP) are coordinated care plans and subject to the current application requirements. Dual eligible special needs (D-SNP) plans are a type of SNP and are subject to the requirements under §§ 422.250 through 422.530 (42 CFR 422.107(e)(2)). At the time of application, organizations applying for an SNP are required to attest that they understand that the approval of their SNP application is contingent on the approval of their MA application.

CMS Brief at 2.

CMS evaluates an application based on the information contained in the application itself, any additional information that CMS obtains through other means such as on-site visits, and by using information from a current or prior contract (i.e., any relevant past performance history associated with the applicant). 42 C.F.R. §§ 422.502(a)(1) and (b)(1). After reviewing whether the application meets all requirements, CMS issues, if necessary, a Deficiency Notice in which CMS notifies an applicant of deficiencies within the application and allows a specific time within which

[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 6.

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 NOID. 42 C.F.R. § 422.502(c)(2). Pursuant to 42 C.F.R. § 422.502(c)(2)(ii), the applicant will have ten days from the NOID to respond in writing to correct deficiencies in the application.

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

If CMS denies an MA application, the applicant is entitled to a hearing before a CMS Hearing Officer. 42 C.F.R. § 422.502(c)(3)(iii). The applicant has the burden of proving by a preponderance of the evidence that CMS's determination was inconsistent with the requirements of 42 C.F.R. §§ 422.501 (application requirements) and 422.502 (evaluation and determination procedures). 42 C.F.R. § 422.660(b)(1). In addition, either party may ask the Hearing Officer to rule on a Motion for Summary Judgment. 42 C.F.R. § 422.684(b). The authority of the Hearing Officer is found at 42 C.F.R. § 422.688, which specifies that "[i]n exercising his or her authority, the hearing officer must comply with the provisions of title XVIII [of the Act] and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act."[3]

B. NETWORK ADEQUACY REQUIREMENTS AND REVIEW

An applicant for a new or expanding service area must demonstrate compliance with the network adequacy requirements set forth under 42 C.F.R. § 422.116 as part of its application. 42 C.F.R. § 422.116(a)(2)(ii). As such, the MA organization must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type. 42 C.F.R. § 422.116(a)(3). To demonstrate compliance with these network adequacy standards, applicants must upload, as part of the application, Provider and Facility HSD tables into HPMS/Network Management Module ("NMM"). CMS Brief at 3; "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" at https://www.cms.gov/files/document/cy2026-medicare-advantage-part-c-application.pdf at 27 (last visited July 10, 2025). Furthermore, under 42 C.F.R. § 422.116(a)(2)(ii), CMS may deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area.

[3] 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).

An organization's HSD tables must list every provider and facility with a fully executed contract in its network. *See* Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance, located at https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-12-09-2024.pdf at 2-3 (last updated December 9, 2024) (hereinafter "Network Adequacy Guidance "). An applicant for a new or expanding service area receives a 10-percentage point credit towards the percentage of beneficiaries residing within the published time and distance standards for the contracted network in the pending service area, at the time of application, and for the duration of the application review. 42 C.F.R. § 422.116(d)(7). In addition, applicants may use a Letter of Intent ("LOI") signed by both the MA organization and the provider or facility with which the MA organization has started or intends to negotiate, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. *Id*. As part of the network adequacy review process, applicants must notify CMS of their use of LOIs to meet network standards in lieu of a signed contract and submit copies upon request in the form and manner directed by CMS. *Id*.

The regulatory subsections 42 C.F.R. § 422.116(b)(1)-(2) list the provider-specialty types and facility-specialty types to which the network adequacy evaluation applies. "Access to each specialty type is assessed using quantitative standards based on the local availability of providers and facilities to ensure that organizations contract with a sufficient number of providers and facilities to furnish health care services without placing undue burden on enrollees seeking covered services." Network Adequacy Guidance at 2. CMS explains that it programs network adequacy criteria into the NMM in HPMS. *Id*. The "network review is performed through an automated tool within HPMS that compares the network data submitted by each applicant against standardized CMS network adequacy criteria published in the annual Reference File and then generates a report called the Automated Criteria Check (ACC), that shows whether a provider or facility in a given county is passing the network adequacy requirements." CMS Brief at 3; *see* 42 C.F.R. 422.116(d)(4). CMS states that "the ACC report is accessible to applicants within [HPMS] so at any point in time applicants can see where their application stands with respect to meeting the standardized criteria." CMS Brief at 3. As set forth under 42 C.F.R. § 422.116(a)(5), CMS annually updates and makes available the following reference files:

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

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

> The supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier [("NPI")], and specialty type and is posted by state and specialty[]type. The supply file is segmented by state to facilitate the development of networks by service area. Contracts with service areas

near a state border may need to review the supply file for multiple states, as the network adequacy criteria are not restricted by state or county boundaries. . . .

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

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

Network Adequacy Guidance at 3 (emphasis added).

C. EXCEPTION REQUEST PROCESS AND REVIEW

Under specific circumstances and rules, CMS permits applicants that are unable to satisfy network adequacy criteria to submit timely filed exception requests. 42 C.F.R. § 422.116(f); *see* Network Adequacy Guidance at 5. Specifically, an applicant may request an exception to network adequacy criteria when both of the following occur:

(1) certain providers or facilities are not available for the MA plan to meet the network adequacy criteria as shown in the Provider Supply file for the year for a given county and specialty type; and

(2) the applicant has contracted with other providers and facilities that may be located beyond the limits in the time and distance criteria, but are currently available and accessible to most enrollees, consistent with the local pattern of care.

42 C.F.R. § 422.116(f)(1)(i)(A)-(B).

When reviewing exception requests, CMS considers whether

(1) the current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

(2) there are other factors present in accordance with § 422.112(a)(10)(v), that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and

(3) approval of the exception is in the best interests of beneficiaries.

42 C.F.R. § 422.116(f)(2)(i)-(iii).

VI. PROCEDURAL HISTORY AND INITIAL STATEMENT OF FACTS

On February 12, 2025, Humana South Carolina filed an initial application seeking a contract as a new HIDE-SNP under contract number H1396.[4] Plan Initial Brief at 1, 6; CMS Brief at 4.

Based on contract H1396's ACC Report dated February 13, 2025, CMS determined that Humana South Carolina's initial provider HSD submission failed for cardiothoracic surgery providers in Sumter County. CMS Exhibit C-3, row 2095; CMS Brief at 7.

On March 13, 2025, CMS issued Humana South Carolina a Deficiency Notice. CMS Exhibit C-1. The March 13, 2025, Deficiency Notice stated the following deficiency (among others not pertinent here):

> - MA Provider Table - NMM Review – Based upon the automated review of your MA Provider Table, CMS has found that your contracted network of providers does not meet CMS network standards. Refer to HSD Submission Reports (available in HPMS), including the Automated Criteria Check (ACC) Report for Providers, for further details on the status of your submission. **To resolve any areas where these reports show that you fail the network criteria, you must submit an updated MA Provider Table in the next upload period. Additionally, during the upload period following CMS' initial deficiency notice, or NOID, you may submit Exception Requests for any provider(s) that fail the network criteria as long as you can appropriately justify your request for the exception by following the Exception Template.** In addition, any "Pass" reflected on the HSD Submission Reports is contingent upon the validity of the data submitted on the applicant's HSD tables and in the exceptions uploads, including whether the individual providers are accurately reflected and appropriately contracted with the applicant.

CMS Exhibit C-1 (emphasis added).

The Deficiency Notice stated that Humana South Carolina would have

> an opportunity to correct the deficiencies identified in this notice. CMS opened the Health Plan Management System (HPMS) gates so you can make changes to your application under H1396. You must submit all changes in HPMS and hit Final Submit no later than 03/24/2025 8:00:00 PM Eastern.

[4] Humana South Carolina states that prior to filing the application being appealed here, it offered a Health Maintenance Organization ("HMO") Dual Eligible Special Needs Plan ("D-SNP") in South Carolina under contract number H5619 that covered "roughly 8,600 dual-eligible individuals," but it did not "file its current HMO D-SNP plan benefit package under the H5619 contract number for the 2026 contract year." Plan Initial Brief at 6. Rather, it explains that it "wishes to continue providing coverage to these beneficiaries and, starting with the 2026 contract year, was planning to do so through a new HIDE-SNP under the[] H1396 contract number" in order to meet South Carolina's new requirement that "Medicaid managed care organizations . . . launch new, statewide, standalone HIDE-SNPs starting January 1, 2026." *Id*.

Id.

The Deficiency Notice also informed Humana South Carolina that it had "the option to withdraw or reduce the service area of your pending application[,]" which included requesting to "remove pending counties from the proposed service area[.]" *Id*.

In response to the Deficiency Notice, CMS states (and Humana South Carolina does not dispute) that "Humana South Carolina did not submit an exception request for Cardiothoracic Surgery in Sumter, South Carolina. where the organization also had a network adequacy deficiency."[5] CMS Brief at 5; *see* CMS Exhibit C-3, row 2095. Based on contract H1396's March 2025 ACC Report, CMS determined that within Humana South Carolina's provider HSD submission, cardiothoracic surgery providers in Sumter County received an ACC Status of "Fail."[6] CMS Exhibit C-4, row 2095; *see* CMS Brief at 5, 7.

On April 14, 2025, CMS issued Humana South Carolina a NOID, within which CMS cites that Humana South Carolina's MA Provider Table does not meet CMS network standards as follows:

- Exception Request Status – We denied one or more of your Exception Requests, please refer to HSD Submission Reports (available in HPMS), including the Exception Report for further details on the status of your submission.

- MA Provider Table - NMM Review – Based upon the automated review of your MA Provider Table, CMS has found that your contracted network of providers does not meet CMS network standards. Refer to HSD Submission Reports (available in HPMS), including the Automated Criteria Check (ACC) Report for Providers, for further details on the status of your submission. **To resolve any areas where these reports show that you fail the network criteria, you must submit an updated MA Provider Table in the next upload period. Additionally, during the upload period following CMS' initial deficiency notice, or NOID, you may submit Exception Requests for any provider(s) that fail the network criteria as long as you can appropriately justify your request for the exception by following the Exception Template.** In addition, any "Pass" reflected on the HSD Submission Reports is contingent upon the validity of the data submitted on the applicant's HSD tables and in the exceptions uploads, including whether the individual providers are accurately reflected and appropriately contracted with the applicant.

Plan Exhibit P-1 (emphasis added).

Additionally, the NOID warns applicants that

[5] CMS notes (and Humana South Carolina does not dispute) that, by the March 24, 2025, deadline set forth in the Deficiency Notice, Humana South Carolina uploaded materials into HPMS that included, among other things not relevant to the instant appeal, a revised provider network and at least one exception request. CMS Brief at 5.

[6] On its Exhibit List and in its Brief, CMS states that this report is a March 14, 2025 ACC Report, but the Hearing Officer notes that the document itself reflects a date of March 25, 2025.

> [y]ou must cure all deficiencies listed above in order to receive approval on your Part C – MA application. You have ten (10) days after the date of this notice to submit materials that cure the identified deficiencies in accordance with 42 CFR 422.502(c)(2). CMS opened the Health Plan Management System (HPMS) gates so you can make changes to your application. You must submit all changes in HPMS and hit Final Submit no later than 04/24/2025.

Id.

The NOID warns that "[i]f the material you submit during the ten (10) day period cures the identified deficiencies, CMS will issue a conditional approval letter. If the material does not cure the deficiencies, CMS will deny your application." *Id*.

The NOID also informed Humana South Carolina that it had "the option to withdraw or reduce the service area of your pending application." *Id*. Specifically, CMS stated that requests to withdraw counties from an application must "[b]e received no later than May 9, 2025, 8:00 PM ET." *Id*.

Also on April 14, 2024, CMS notified contract H1396 (Humana South Carolina) that the "Network Exception Window [was] Open for H1396." Specifically, the message stated that "[t]he Exception Gate submission window to request Exceptions [and upload supporting documentation] for H1396 will be open **from 4/14/2025 3 PM ET through 4/30/2025 8 PM ET**." CMS Exhibit C-2 (emphasis added).

CMS states (and Humana South Carolina does not dispute) that "Humana South Carolina submitted revised provider networks on April 15, 2025[,]" and resubmitted exception requests on April 24, 2025, "but these requests were unrelated to the failure in Sumter." CMS Brief at 5.

CMS states (and Humana South Carolina does not dispute) that it "notified Humana South Carolina that they were still failing network adequacy in Sumter County with their last provider HSD resubmission." CMS Brief at 7; *see* CMS Exhibit C-5, row 2095; Plan Exhibit P-6 at pdf page 13; Plan Initial Brief at 7.

CMS indicates (and Humana South Carolina does not dispute) that Humana South Carolina did not file additional exception requests, before the applicable April 30, 2025, deadline, that addressed "the failure in Sumter." CMS Brief at 5; *see id*. at 7; Plan Reply Brief at 1. Additionally, Humana South Carolina did not request to withdraw Sumter County before the applicable May 9, 2025, deadline. *See* Plan Initial Brief at 8, 12; Plan Reply Brief at 2, 6.

On May 14, 2025, CMS issued a Denial Letter to Humana South Carolina (based upon the cardiothoracic surgeon deficiency in Sumter County). The denial letter referenced the HSD Submission reports and ACC report and stated (in pertinent part):

- MA Provider Table—NMM Review—Based upon the automated review of your MA Provider Table, CMS has found that your contracted network of providers does not meet CMS network standards. Refer to HSD Submission Reports (available in HPMS), including the Automated Criteria Check

(ACC) Report for Providers, for further details on the status of your submission.

Plan Exhibit P-4 ("Denial Letter").

On May 27, 2025, Humana South Carolina timely requested a hearing. Humana South Carolina filed its initial brief on June 13, 2025; CMS filed its responsive brief on June 20, 2025; and Humana South Carolina filed its Reply Brief on June 27, 2025. On June 23, 2025, the Hearing Officer postponed the July 2, 2025, hearing to consider CMS's Motion for Summary Judgment.

VII. PLAN'S CONTENTIONS

Humana South Carolina does not challenge CMS's denial as improper based upon CMS's review of the information that Humana South Carolina submitted within the application period. Rather, Humana South Carolina indicates that, in hindsight, it now realizes that it may 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. Humana South Carolina explains

> [a]t the time Humana South Carolina submitted its application, it was in the process of negotiating a contract extension with MUSC Health, which would have included the cardiothoracic surgeon [Dr. Y],[7] a contracted physician who then accepted patient appointments at [ADDRESS A].[8] Ex. P-8, Email correspondence…… (June 10, 2025) **Regrettably, Humana South Carolina inadvertently omitted this provider when compiling its HSD tables. Because of this clerical error, it appeared to CMS that H1396 did not satisfy network adequacy for cardiothoracic surgery in Sumter County**: the cardiothoracic surgeons contracting with Humana South Carolina in Sumter County seemingly covered in aggregated only 70.7 percent of the county, failing short of the 80 percent coverage required by CMS network adequacy standards. In actual fact, [Dr. Y] was serving Sumter County and hence the H1396 met network adequacy requirements for cardiothoracic surgery in Sumter County "at the time of application." 42 C.F.R. 422.116(d)(7).
>
> **On June 10, 2025, MUSC Health alerted Humana South Carolina for the first time, and only following prompting, that, as of April 23, 2025, [Dr. Y] had stopped accepting patient appointments at [ADDRESS A] and had relocated to [ADDRESS B]**.[9] Ex. P-8
>
> Because– as of April 23, 2025—[Dr Y] was no longer located such that he serves Sumter County and without [Dr. Y], the available cardiothoracic surgery providers can only achieve 70.7 percent coverage, not the 80 percent coverage required for

[7] The physician's name has been masked.

[8] This address has been masked.

[9] This address has been masked.

> metro counties like Sumter, Humana South Carolina qualifies for an exception to CMS's network adequacy requirements. See 42 C.F.R. 422.116(f)(1)(i)…Ex. P-9, Declaration of [J.G.] (June 13, 2025).
>
> Because of the protracted negotiations with MUSC Health, Humana South Carolina—through no fault of its own—was only notified by MUSC Health of [Dr. Y]'s April 23, 2025, relocation on June 10, 2025. It was therefore unable to submit an exception request in time to meet the April 24, 2025, deadline to cure deficiencies highlighted by CMS in the Notice of Intent to Deny.

Plan Initial Brief at 9-10 (emphasis added).

Humana South Carolina argues that it "would have timely applied for and received a network adequacy exception for cardiothoracic surgery in Sumter County had it known what is does now[,] [thus] [i]t was practically impossible . . . to timely submit a network exception request excluding a provider that Humana did not know had exited." Plan Reply Brief at 1, 3. Humana South Carolina asserts that "CMS admits that it approved this exact exception for other contracts because 'provider supply was insufficient[],'" yet "disregards the relevance of" Humana South Carolina's timeline here and, therefore, Humana South Carolina has not "had a meaningful opportunity to submit an exception request." Plan Reply Brief at 4, 5. Humana South Carolina contends that, accordingly, "CMS should grant the same exception for Humana South Carolina as it did for other contracts" and reverse the application denial. *Id*. at 6.

Alternatively, Humana South Carolina states that CMS should allow it to withdraw Sumter County from its application, especially 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 South Carolina's contract H1396 to operate for 2026. Plan Exhibit P-7; Plan Reply Brief at 6-7; Plan Initial Brief at 8, 11.

VIII. CMS'S CONTENTIONS

CMS states that "Humana South Carolina was notified of their network adequacy deficiencies in the [D]eficiency [N]otice and the NOID[,]" and asserts that "all required application materials [must] be provided by the final submission deadline, including requests to cure application deficiencies by withdrawing pending counties." CMS Brief at 6-7.

CMS contends that if Humana South Carolina was "in the process of contract negotiations with" Dr. Y (or any provider), it "had the opportunity to include non-contracted providers on their HSD tables if they had a valid Letter of Intent (42 CFR 422.116(d)(7))." *Id*. at 6. Likewise, "[i]f Dr. Y had in fact stopped accepting patients on April 23, 2025, as Humana South Carolina argues, at the location identified by CMS in the Provider Supply File, Humana South Carolina had the opportunity to submit an exception request by April 30, 2025." *Id*. at 7.

Regarding Humana South Carolina's suggestion that this application should be approved because CMS approved exception requests for contracts under the same Parent Organization for cardiothoracic surgery in Sumter, South Carolina, CMS notes that

> CMS approved these exceptions under those contracts because the contracts demonstrated in their application that provider supply was insufficient (either through evidence that the provider location was incorrect or that the provider was no longer accepting patients at that location), and the contracts demonstrated in their applications that they could provide adequate beneficiary coverage outside of time and distance requirements for Sumter, South Carolina.

Id. at 8.

IX. DISCUSSION AND ANALYSIS

The Hearing Officer finds no material facts in dispute and grants CMS's Motion for Summary Judgment, as Humana South Carolina did not meet CMS's network adequacy requirement for Sumter County cardiothoracic surgery, as explained below.

Under 42 C.F.R. § 422.660(b)(1), for the appeal of its contract determination, Humana South Carolina 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 and 422.502. As part of that regulatory scheme, 42 C.F.R. § 422.501(c)(1) requires Humana South Carolina to fully complete all parts of the application **in the form and manner required by CMS**. The regulatory framework also contains required notices, with CMS affording applicants two opportunities to cure an application and providing numerous means for applicants to achieve provider and network adequacy, including multiple opportunities to submit exceptions to the network. Additionally, under 42 C.F.R. § 422.502(a)(1), CMS evaluates an application for an MA contract **solely on the basis of information contained in the application itself**.[10]

Here, the record before the Hearing Officer reflects the following undisputed facts: CMS notified Humana South Carolina on multiple occasions during the application process that Sumter County cardiothoracic surgery was a network deficiency; during the two opportunities to cure its application, Humana South Carolina did not provide CMS an HSD provider table that met network adequacy for cardiothoracic surgery in Sumter County; Humana South Carolina did not submit an exception request to address the Sumter County cardiothoracic network deficiency; and, Humana South Carolina did not timely request to withdraw Sumter County from its service area.

Humana South Carolina asserts that a clerical error (on its part), along with information it subsequently acquired about Dr. Y, well after the relevant deadlines had passed, resulted in the realization that at the time of the application, it could have qualified for approval (or been eligible for an approved exception request). Consequently, Humana South Carolina requests that the Hearing Officer now accept an exception request or permit Humana South Carolina to withdraw Sumter County from its application, subsequently approving the revised H1396 application. Plan Reply Brief at 7.

Specifically, with respect to the Sumter County cardiothoracic surgery exception request, Humana South Carolina argues that, based on information it received on June 10, 2025, **after** filing the

[10] The regulation goes on to state "and any additional information that CMS obtains through other means such as on-site visits."

instant appeal, cardiothoracic surgeon Dr. Y purportedly no longer practices in Sumter County and, therefore, had it known that it would have filed an exception request. But, based on the record here, Dr. Y was **never included** in Humana South Carolina's as-filed application materials ("[r]egrettably, Humana South Carolina inadvertently omitted this provider" Plan Initial Brief at 9), and was not part of the provider network evaluated by CMS. Thus, Dr. Y did not factor into CMS's evaluation of Humana South Carolina's application's sufficiency for the Sumter County cardiothoracic surgery network.

Humana South Carolina explains that only after it "prompted" MUSC Health, an entity with which it contracts, did it discover that Dr. Y no longer accepted patients in Sumter County after April 24, 2025. Plan Initial Brief at 9-10. Humana South Carolina later states that because the "cardiothoracic surgeon had not communicated his relocation to Humana," it was "practically impossible" to submit a "compliant" exception request. Plan Reply Brief at 1. But, once again, Humana South Carolina **did not include** Dr. Y on its HSD table, so regardless of when that communication took place, Dr. Y was not part of the HSD table that was evaluated by CMS during the application process. This is despite the Hearing Officer's finding that CMS repeatedly informed Humana South Carolina that its application's Sumter County cardiothoracic surgery network was deficient.

Additionally, regarding Humana South Carolina's claim that its knowledge about Dr. Y's change in practice locations impacted its ability to timely file a compliant exception request, the Hearing Officer notes that, as stated in the Network Adequacy Guidance, CMS places the responsibility of conducting validation of data used to populate HSD tables (including practice/office locations) squarely on the MA organizations/applicants themselves. *See* Network Adequacy Guidance at 3.

Upon reviewing the materials submitted prior to the application deadline, the Hearing Officer concludes that Humana South Carolina has not demonstrated, by a preponderance of the evidence, that CMS's denial of application H1396 was inconsistent with regulatory requirements. Specifically, Humana failed to timely address its cardiothoracic network deficiency in Sumter County and did not file a related exception request within the required timeframe. Additionally, the Hearing Officer finds that the circumstances that Humana South Carolina presents regarding the omission of Dr. Y and the subsequent information that it received in June, do not compel CMS to now accept an exception request or allow Humana South Carolina to withdraw a county beyond the respective April 30, 2025, and May 9, 2025, deadlines.

Finally, Humana South Carolina requests that CMS consider the "best interests of beneficiaries" as nearly 9,000 dual-eligible Medicare and Medicaid beneficiaries currently enrolled in its D-SNP would otherwise be forced to change plans, disrupting their care. Plan Reply Brief at 6-7. The Hearing Officer finds that Humana South Carolina's policy-related request for relief is outside the scope of the Hearing Officer's authority under 42 C.F.R. § 422.688. *See also* 42 C.F.R. § 422.660.

X. ORDER

The Hearing Officer grants CMS's Motion for Summary Judgment and upholds CMS's May 14, 2025, Denial of Humana South Carolina's initial application for contract H1396.

Amanda S. Costabile -S
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Date: 2025.08.15 14:54:06 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: August 15, 2025