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

In the case of: **Emphesys Insurance Company** **Contract No. H7617**	**Review of:** **Hearing Officer Case No. H-25-00015** **Dated: August 14, 2025**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the CMS Hearing Officer's decision. 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). Emphesys Insurance Company/Humana Inc. (Emphesys or the Plan) requested review by the Administrator. 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

Whether C~~MS's denial of Emphesys' service area expansion application for its MA/M~~A-PD, chronic condition special need plan (C-SNP), and dual eligible special need plan (D-SNP) Contract H7617, based on Emphesys' failure to meet CMS' provider network adequacy requirements, was inconsistent with regulatory requirements.

The Hearing Officer granted CMS's Motion for Summary Judgment in the case. The Hearing Officer found that there were no material facts in dispute and the record did not establish that Emphesys provided CMS, in response to the April 14, 2025 NOID, with Provider and Facility Health Service Delivery (HSD) Tables meeting CMS's network adequacy requirements; an exception request for that provider specialty; or a request to withdraw the counties at issue from its applications by the May 9, 2025, deadline. Although Emphesys 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 Emphesys to withdraw the at issue counties past the deadline for such requests. Accordingly, the Hearing Officer upheld CMS' denial of the Plan's application for contract H7617.[1]

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

COMMENTS

Humana Inc. and Emphesys Insurance Co. requested Administrator review of CMS's denial of Emphesys's application to expand the service area offered under contract number H7617 for the 2026 contract year. Emphesys contracts with employer and union groups in 44 states to offer Employer Only coverage under H7617. For the 2026 contract year, Emphesys applied to expand the service area of H7617 to offer Individual market coverage in 37 states under H7617. The current application encompasses 104 Plan Benefit Packages (PBPs) across 37 states and over 2,000 counties. Within these plans, Emphesys intends to provide D-SNPs and C-SNPs.

The Plan explained that CMS denied the entire application because of a network adequacy deficiency in a single specialty (cardiology) in a micro-county in Texas (Aransas). The Plan stated that CMS does not dispute Emphesys has a substantively meritorious bases for an exception request. The only reason that CMS maintains the denial is because Emphesys could not submit its exception request when it submitted all others because of a technical timing limitation with CMS' system—requiring the change to deficit was recognized by the system-and Emphesys then missed uploading the request during the resultant narrow three business-day window when CMS's system could have accepted it.

The Plan argued that the consequences of CMS' denial are enormous: Emphesys has historically offered only Employer Group Waiver Plan (EGWP) options in 44 states under this contract but, with these applications, intended to expand its offerings to provide Individual coverage—including a Dual-Eligible Special Needs Plan (D-SNP) and Chronic Condition Special Needs Plan (C-SNP)—across 37 states with the potential to benefit many thousands of beneficiaries nationwide. However, CMS would deny the entire application because of a harmless clerical error that affected only a single specialty in a single micro-county in a single state.

The Plan argued it is uncontroverted that CMS would have granted such a request as CMS has granted identical requests for other Humana contracts that did not face the technical limitation that prevented Emphesys from submitting its own request in the ordinary course. This is just a case of a clerical error that primarily resulted from CMS's delay in releasing network adequacy results to open up Emphesys's ability to submit an exception request.

The Plan pointed out that the Administrator has the authority to approve Humana's application based on the best interests of beneficiaries. 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. § 422.116(a)(ii) (emphasis added). The Administrator should not jettison this important plan offering for Medicare beneficiaries across 37 states because of a single network deficiency for which the agency admits is substantively deserving of an exception. That is especially so here given that Emphesys would have timely submitted the exception request were it not for the technical limitations of the HPMS Portal. This application will bring expanded services to an estimated 8,000 beneficiaries—including extremely vulnerable populations that may access

coverage through D-SNPs and C-SNPs—across 37 states. A deficiency based on one small county in Texas—for which a network exception is undisputedly appropriate—cannot justify denying this application. The Plan therefore requested that the Administrator accept review, reverse the Hearing Officer's decision, and approve Emphesys's application to expand the service area under contract H7617.2

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 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.[2]

[2] "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*.

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"[3] 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.

Emphesys initially filed service area expansion applications on February 12, 2025, followed by CMS issuing a Deficiency Notice on March 13, 2025. CMS issued a Notice of Intent to Deny (NOID) on April 14, 2025, citing deficiencies in both provider network adequacy and State licensure requirements. On the same date, CMS opened a Network Exception Window for Contract H7617, allowing exception requests until April 30, 2025. CMS also sent a reminder email on April 16, 2025, reiterating that the deadline to withdraw counties from applications was May 9, 2025.

In response to the NOID, Emphesys resubmitted its provider and facility Health Service Delivery (HSD) tables, including a new cardiology provider for their network. However, this submission created a new deficiency in Aransas County, Texas for cardiology services, yet the Plan contends was not immediately recognized by the system preventing the submission of the exception request at that time. On April 26, 2025, CMS notified Emphesys that the automated processing for their submitted network was complete, revealing the cardiology deficiency. Despite having prepared a draft exception request, Emphesys failed to submit it before the April 30, 2025 deadline, with company personnel admitting they "did not notice in the short window before April 30th that Aransas County cardiology had failed. CMS ultimately denied Emphesys' application on May 14, 2025.

[3] *Id.*

While Emphesys successfully addressed the State licensure issue by submitting a Florida State Certification Form on June 18, 2025, which CMS accepted, the provider network adequacy problem remained unresolved. Emphesys filed a Request for Hearing on May 27, 2025, arguing they were not given a meaningful opportunity to cure the deficiency due to the limited timeframe and system constraints.

The record in this case does not establish that Emphesys provided CMS with Provider and Facility HSD tables that met CMS' network adequacy requirements; or exception request that provided the information that CMS requires in order to be considered a valid rationale in support of the request; or HSD tables or exception requests that addressed or included the providers and facilities that CMS identified as being located within CMS' network adequacy criteria applicable to the county.

As Emphesys did not prove by a preponderance of the evidence that CMS' determination denying the applications were inconsistent with regulatory requirements, and, as 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, the Hearing Officer was correct to uphold CMS' denial of Emphesys' service area expansion request for contract H7617.

However, the Administrator, using his discretionary contractual authority has determined that for the best interests of the beneficiaries, the Administrator modifies the Hearing Officer's decision in this case. The Plan requested that the Administrator grant the network exception, which the plan argues would have been permitted if not for a clerical error that occurred within the contract. Alternatively, it is asked that the Administrator permit the Plan to withdraw the county at issue and approve the application.

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 applications at this time, whether through curing the network deficiency, filing an approvable exception, or withdraw of the county or reduction of the service area, the Applicant must promptly submit the documentation required by CMS within the timeframes CMS orders consistent with this decision.

DECISION

The Admininstrator modifies the decision of the CMS Hearing Officer consistent with this opinion. The CMS determination on whether Contract H7617 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