DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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RE: Hearing Officer Order and Decision
Hearing Officer Docket Number: H-25-00016
Medicare Advantage/Prescription Drug Plan ("MA/PD"), Appeal Year: 01/01/2026
Medcare Partners Health Plan of Texas, LLC, Contract/Plan/Provider Number: H5099

Dear Ms. Clements 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

MedCare Partners Health Plan of Texas, LLC. Contract No. H5099,	*	**Denial of Initial Application for Medicare Advantage/ Medicare Advantage-Prescription Drug and Chronic or Disabling Condition Plan**
Appellant	*	
v.	*	**Contract Year 2026**
Centers for Medicare & Medicaid Services,	*	**Hearing Officer Docket No. H-25-00016**
Respondent	*	

ORDER GRANTING CMS'S MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

This Decision and Order is being issued in response to the following:

(a) MedCare Partners Health Plan of Texas, LLC's ("MCP's") "Notice of Appeal of CMS Denial of MA, MA-PD Application H5099" ("Appeal Request") filed on May 28, 2025;[1]
(b) MCP's "Plan Hearing Brief" and two exhibits, filed on June 4, 2025 ("Plan Hearing Brief"); and
(c) Centers for Medicare & Medicaid Services' ("CMS's") Brief in Reply to Applicant's Brief in the Matter of the Denial of the Medicare Advantage, Part D and Special Needs Plan Applications Submitted by [MCP] (Contract H5099) ("CMS Brief") and three exhibits, filed on June 11, 2025.

II. JURISDICTION

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

III. ISSUE

Whether CMS's denial of MCP's initial application for a Medicare Advantage ("MA")/Medicare Advantage-Prescription Drug ("MA-PD") and Chronic or Disabling Condition Special Needs Plan ("C-SNP") contract (contract H5099), based on MCP's failure to meet CMS's MA provider and facility 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 7-8. The Hearing Officer finds that there are no material facts in dispute and that the record does not establish that MCP timely provided, in response to the April 14, 2025, Notice of Intent to Deny ("NOID"), CMS with MA provider and facility networks that met CMS network standards. Additionally, the record does not establish that MCP provided CMS with exception requests that addressed providers or facilities that CMS identified as being within the network adequacy criteria, as is required under the exception request regulations. *See* 42 C.F.R. § 422.116(f). Accordingly, the Hearing Officer finds that MCP has not proven, by a preponderance of the evidence, that CMS's denial of its initial application for contract H5099, based on network deficiencies and denied exception requests, was inconsistent with regulatory requirements and, therefore, upholds CMS's denial.

[1] Although the Appeal Request itself was dated May 29, 2025, the request was filed on May 28, 2025.

V. AUTHORITIES, APPLICATION REVIEW PROCESS AND SUBREGULATORY GUIDANCE

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, 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"). *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 at 13 ("Part C Application") (last visited July 21, 2025). 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.

MA plans include coordinated care plans ("CCPs"). 42 C.F.R. § 422.4(a). A CCP is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS. 42 C.F.R. § 422.4(a)(1). A specialized MA plan for special needs individuals ("SNP") includes any type of CCP that meets CMS's SNP requirements and exclusively enrolls special needs individuals as defined by § 422.2. 42 C.F.R. § 422.4(a)(1)(iv). A C-SNP may focus on one severe or disabling chronic condition, as defined in § 422.2, or on a grouping of severe or disabling chronic conditions. 42 C.F.R. § 422.4(a)(1)(iv)(A). The Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA")[2] requires that CCPs offer at least one MA plan that includes a Part D prescription drug benefit ("MA-PD") in each county of its service area. Part C Application at 6. To meet this requirement, the applicant must timely complete and submit a separate Part D application in connection with its Part C application. *Id*. (emphasis omitted). "SNPs are required to follow existing MA and Prescription Drug Benefit program rules[,] [and a]n applicant intending to offer a SNP must be qualified under the MA and Part D application in all counties of the SNP type service area." *Id*. at 61. CMS states that

> [a]t the time of application, [a]pplicants must attest that they understand that the SNP must meet MA requirements. As part of the attestation, applicants are made aware that if a SNP applicant's MA application is denied, the initial SNP application will also be denied.

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 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

[2] The MMA "significantly revised the Medicare + Choice managed care program, now called the Medicare Advantage ("MA") program, and added outpatient prescription drugs to Medicare, offered by either stand-alone prescription drug plan sponsors or Medicare Advantage Organizations." Part C Application at 6.

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 Deny ("NOID"). 42 C.F.R. § 422.502(c)(2). Per § 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' 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]

A. 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 and CMS may deny an application on the basis of an evaluation of the applicant's network. 42 C.F.R. § 422.116(a)(2)(ii). A network-based MA plan must demonstrate that it has an adequate contracted provider network that is sufficient to provide access to covered services, including that the MA plan meets maximum time and distance standards and contracts with a specified minimum number of each provider and facility-specialty type. 42 C.F.R. § 422.116(a)(2)(i), (a)(3).

CMS annually updates and makes two files available. 42 C.F.R. § 422.116(a)(5)(i)-(ii). The first file is a Health Service Delivery ("HSD") Reference File that identifies all minimum provider and facility number requirements; all provider and facility time and distance standards; and ratios

[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.

Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 75 Fed. Reg. 19678, 19683 (April 15, 2010).

established in paragraph (e) of 42 C.F.R. § 422.116 in advance of network reviews for the applicable year. The second file is a Provider Supply file that lists available providers and facilities and their corresponding locations and specialty types.[4] *Id*.

To demonstrate compliance with these network adequacy standards, applicants must upload, as part of the application, provider and facility HSD Tables into HPMS. Part C Application at 28; *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. (last updated December 2024) (hereinafter "Network Adequacy Guidance"). An organization must list every provider and facility with a fully executed contract in its network in the HSD Tables. *Id*. at 2-3. 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 start negotiations, in lieu of a signed contract at the time of application and for the duration of the application review, to meet network standards. 42 C.F.R. § 422.116(d)(7). Additionally, new or expanding service area applicants receive a 10-percentage point credit towards the percentage of beneficiaries residing within 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. *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 Network Management Model ("NMM") in HPMS. *Id.* CMS states that 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 annually in the Reference File and then generates a report (called the Automated Criteria Check ("ACC")), that shows whether a provider or facility in a given county passes the network adequacy requirements including the minimum number of contracted providers or facilities located within the time and distance standards required for a given county and specialty[,] and the requirements for beneficiary coverage in a given county and specialty. The ACC reports are accessible to all applicants within the system so at any point in time[,] applicants are able to see where the applicant stands with respect to meeting the standardized criteria.

CMS Brief at 3.

[4] The regulation further explains that the Provider Supply file is updated annually based on information in the Integrated Data Repository, which has comprehensive claims data, and information form public sources. The regulations also state that CMS may update the Provider Supply file based on findings from validation of provider information submitted on Exception Requests to reflect changes in the supply of health care providers and facilities. 42 C.F.R. § 422.116(a)(5)(ii)(A)-(B).

B. EXCEPTION REQUEST PROCESS AND REVIEW

CMS explains that "there are unique instances where a given county's supply of providers/facilities is such that an organization would not be able to meet the network adequacy criteria." Network Adequacy Guidance at 5. CMS states that "[t]he exceptions process allows organizations to provide evidence to CMS when the health care market landscape has changed or does not reflect the current CMS network adequacy criteria." *Id.*; *see* 42 C.F.R. § 422.116(f). CMS also asserts that "[g]enerally, organizations use the exception process to identify when the supply of providers/facilities is such that it is not possible for the organization to obtain contracts that satisfy CMS's network adequacy criteria." Network Adequacy Guidance at 5.

Specifically, under 42 C.F.R. § 422.116(f)

> (1) An MA Plan may request an exception to network adequacy criteria in paragraphs (b) through (e) of this section when either paragraph (f)(1)(i) or (ii) of this section is met:
>
> (i) (A) 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
>
> (B) 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.
>
> (ii) (A) A facility-based Institutional [SNP] ("I-SNP") is unable to contract with certain specialty types required under § 422.116(b) because of the way enrollees in facility-based I-SNPs receive care; or
>
> (B) A facility-based I-SNP provides sufficient and adequate access to basic benefits through additional telehealth benefits . . . when using telehealth providers of the specialties listed in paragraph (d)(5) of this section in place of in-person providers to fulfill network adequacy standards in paragraphs (b) through (e) of this section.
>
> (2) In evaluating exception requests, CMS considers whether—
>
> (i) The current access to providers and facilities is different from the HSD reference and Provider Supply files for the year;

(ii) There are other factors present, in accordance with § 422.112(a)(10)(v),[5] that demonstrate that network access is consistent with or better than the original Medicare pattern of care; and

(iii) Approval of the exception is in the best interests of the beneficiaries.

(iv) As applicable, the facility-based I-SNP submits:

(A) Evidence of the inability to contract with certain specialty types required under this section due to the way enrollees in facility-based I-SNPs receive care; or

(B) Substantial and credible evidence that sufficient and adequate access to basic benefits is provided to enrollees using additional telehealth benefits (in compliance with § 422.135) furnished by providers of the specialties listed in paragraph (d)(5) of this section and the facility-based I-SNP covers out-of-network services furnished by a provider in person when requested by the enrollee as provided in § 422.135(c)(1) and (2), with in-network cost sharing for the enrollee.

(3) Any MA organization that receives the exception provided for facility-based I-SNPs must agree to offer only facility-based I-SNPs under the MA contract that receives the exception.

CMS provides additional information and instruction regarding exception requests within its Network Adequacy Guidance. Specifically, CMS informs that

> [t]he organization must include conclusive evidence in its exception request that the CMS network adequacy criteria cannot be met because of changes to the availability of providers/facilities, resulting in insufficient supply. The organization must then demonstrate that its contracted network (i.e., providers/facilities included on its HSD tables) furnished enrollees with adequate access to covered services and is consistent with or better than the Original Medicare pattern of care for a given county and specialty type.

[5] Moreover, 42 C.F.R. § 422.112(a)(10)(v) provides as follows:

> (10) Prevailing patterns of community health care delivery. MA plans that meet Medicare access and availability requirements through direct contracting network providers must do so consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered. Factors making up community patterns of health care delivery that CMS will use as a benchmark in evaluating a proposed MA plan health care delivery network include, but are not limited to the following:
>
> . . .
>
> (v) Other factors that CMS determines are relevant in setting a standard for an acceptable health care delivery network in a particular service area.

Network Adequacy Guidance at 5.

The Network Adequacy Guidance provides a non-exhaustive list of what CMS considers to be valid rationales to submit an exception request. CMS states that such rationale may include, but are not limited to:

- Provider is no longer practicing (e.g., deceased, retired).
- Does not contract with any organizations or contracts exclusively with another organization.
- Provider does not provide services at the office/facility address listed in the supply file.
- Provider does not provide services in the specialty type listed in the supply file.
- Provider has opted out of Medicare.
- Sanctioned provider on List of Excluded Individuals and Entities.
- Use of Original Medicare telehealth providers or mobile providers.
- Specific patterns of care in a community.

Id. at 6 (emphasis omitted).

Of note, 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." *Id*. at 7. Adding that "[b]ecause of the way enrollees in facility-based I-SNPs receive care, if a facility-based I-SNP is unable to contract with certain specialty types, [CMS] will accept this as a valid rationale." *Id*.

Lastly, within its brief and as set forth in the Network Adequacy Guidance, CMS states that it manually reviews exception requests and that it "uses the supply file when validating information submitted on exception requests." CMS Brief at 3; Network Adequacy Guidance at 3. Within the Network Adequacy Guidance, CMS explains that "[t]he supply file is a cross-sectional database that includes information on provider and facility name, address, national provider identifier, and specialty type and is posted by state and specialty type." Network Adequacy Guidance at 3. CMS states that although "[t]he supply file is segmented by state to facilitate development of networks by service area[,] [c]ontracts 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." *Id*. Additionally, given the dynamic nature of the market, CMS states that the supply "file is a resource and may not be a complete depiction of provider and facility supply available in real-time." *Id.* CMS asserts that "MA organizations remain responsible for conducting validation of data used to populate HSD tables, including data initially drawn from the supply file[,]" and "should not rely solely on the supply file when establishing networks, as additional providers and facilities may be available." *Id.*

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

As background, MCP is a newly licensed HMO that submitted an initial application to offer an MA/MA-PD and SNP in Harris County, Texas, specifically designed to serve "the chronically ill and underserved Hispanic and Vietnamese Medicare beneficiaries" in the county. Plan Hearing Brief at 2. MCP states that the SNP being offered is a C-SNP that will address Diabetes Mellitus, Chronic Heart Failure, and Cardiovascular Disorders. *Id*.

On February 12, 2025, MCP filed its initial application for the MA/MA-PD and C-SNP product in Harris County, Texas under contract number H5099. CMS Brief at 4. Subsequently, CMS issued MCP a Part C Deficiency Notice on March 13, 2025, that informed MCP that, among other deficiencies not pertinent to the instant appeal, its MA provider and facility networks failed to meet the CMS network standards. *Id.*

After submitting additional materials on March 24, 2025, CMS issued MCP a NOID on April 14, 2025. Plan Hearing Brief at 3; CMS Brief at 5; Plan Exhibit P-2. The NOID stated that following CMS's review, MCP's Part C Application was deficient as follows (in pertinent part):

- CMS denied one or more of MCP's exception requests;
- CMS found that MCP's contracted network of providers did not meet CMS network standards; and
- CMS found that MCP's contracted network of facilities did not meet CMS network standards.

Plan Exhibit P-2 at 1.

The NOID informed that MCP

> 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 [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 8:00:00 PM Eastern.

Id. at 2.

The NOID also stated that "[a]pplicants may submit revised [HSD] tables, [LOIs] and Exception Requests to cure network adequacy deficiencies." *Id*.

On April 24, 2025, in response to the NOID, MCP submitted revised provider and facility HSD networks. CMS Brief at 5. According to CMS (and unchallenged by MCP), "MCP only submitted four exception requests in response to the NOID to try to cure four of the twenty-six remaining deficiencies[,]" addressing the provider network deficiencies in Neurology, Neurosurgery, Plastic Surgery, and Cardiothoracic Surgery. *Id*. CMS states (and MCP does not dispute) that the exception requests contained the following narrative:

> We are submitting a Provider Exception Table because despite extensive research using multiple reputable sources, we were unable to locate or verify the provider information for the specified ZIP codes. The following resources were thoroughly reviewed and utilized during this process: Physician Compare[.] Checked for all applicable providers within the specified zip codes but was unable to find a comprehensive list or accurate provider data for all specialties. Downloaded and examined the NPI registry, but not all providers were listed or matched the required criteria for these zip codes. Provider of Services (POS) file, Texas Commission file but was unable to locate providers.

Id.; CMS Exhibit C-2 at 3 (MCP Exception Request Template for Neurology).

On May 14, 2025, CMS denied MCP's MA/MA-PD and C-SNP application due to MCP's failure to meet provider and facility network adequacy requirements or submit valid exception requests. Plan Hearing Brief at 3; MCP Denial Letter at 1-2 (submitted as an attachment to MCP's Notice of Appeal). Within MCP's Exception Report dated April 24, 2025, CMS states that, for the four provider network exception requests submitted, "CMS identified provider(s) . . . located within CMS network adequacy criteria that [MCP] failed to include on [the] Exception Request and/or HSD table(s)." CMS Exhibit C-3. Additionally, the Exception Report lists five providers that CMS states were identified "within the criteria" for each of the four provider specialties. *Id*.

MCP filed its Notice of Appeal on May 28, 2025, and filed its initial brief on June 4, 2025. CMS filed its initial brief and a Motion for Summary Judgment on June 11, 2025. *See* CMS Brief at 7-8. MCP did not file a Reply Brief. On June 12, 2025, the Hearing Officer postponed the hearing to consider CMS's Motion for Summary Judgment.

VII. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Hearing Officer finds that there are no material facts in dispute and grants CMS's Motion for Summary Judgment upholding its denial of MCP's initial application for contract H5099, as explained below. *See* CMS Brief at 7-8 (CMS Motion for Summary Judgment).

MCP does not dispute that its post-NOID application revisions contained provider and facility networks deficiencies; rather, MCP requests that it now be permitted to demonstrate that, as of June 3, 2025, it has cured all network deficiencies. Plan Hearing Brief at 3, 5. MCP asserts that as a "new market entrant" for contract year 2026, it faced challenges securing the required network contracts. *Id*. at 3. MCP states that the challenges were "magnified" by the characteristics of the county and by CMS's "unrealistic" timeline to establish network adequacy for a new applicant. *Id*. at 4. MCP argues that CMS's "deadline was effectively illusory for new entrants like MCP, because providers often will not engage with MA/MA-PDs or SNPs until much closer to the plan start date." *Id*.

Nonetheless, MCP states that it "has worked tirelessly to contract with a sufficient number of providers and facilities to meet CMS network standards[,]" and that it "made significant gains in closing network adequacy gaps in just the last few weeks." *Id*. at 5. Thus, MCP states this "shows

how critical every week is to closing gaps and how unrealistic CMS's network adequacy timeframe is[] particular for new entrants." *Id*.

Additionally, MCP argues that if CMS's denial is upheld, it will not be in the best interests of Harris County Medicare beneficiaries with certain unique healthcare needs as such beneficiaries will be deprived of access to plans specifically designed to meet those needs. *Id*. at 6.

CMS states that MCP failed to timely meet network standards by the final application despite the "flexibilities" it affords "to new applicants to allow plans to demonstrate network adequacy[.]" CMS Brief at 6. CMS asserts that such flexibilities include a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards and the use of LOIs in lieu of an executed contract at the time of application. *Id*.

With respect to MCP's request to now demonstrate that its network deficiencies were cured as of June 3, 2025, CMS asserts that it "limits its review to that information contained in the application and determines whether the application meets all MA network adequacy requirements through [the] applicant's last HSD submission through the [NMM]." *Id*. CMS states that it "determines an applicant's compliance with network adequacy by what is submitted by the ten-day deadline for applicants to respond to the NOID." *Id*. (citing 42 C.F.R. § 422.502(c)(2)). CMS argues that to allow MCP to submit additional information past the deadline, such as MCP's new evidence of an adequate network, would extend the application deadline for that MCP only, thus undermining the need for a uniform application process that is applied fairly and consistently to all applicants. *Id*. at 7

The Hearing Officer observes that for contract year 2026, CMS informed applicants that completed applications were due by February 12, 2025, followed by two opportunities to correct application deficiencies, ending with the post-NOID Final Submit date to "remedy any defects CMS identifies" being April 24, 2025. Part C Application at 11; CMS Brief at 2; Plan Exhibit P-2 at 2; 42 C.F.R. § 422.502(c)(2)(ii). Here, the Hearing Officer finds that MCP does not dispute that it failed to cure the NOID deficiencies regarding its provider and facility networks by the NOID-communicated Final Submit due date of April 24, 2025, to make such changes. Plan Hearing Brief at 3. Additionally, MCP does not dispute CMS's claim that MCP did not submit exception requests to address all its network deficiencies, nor does MCP challenge CMS's denial of the four that it did submit, as CMS denied them based on identification of "numerous available providers within the [network adequacy] criteria." CMS Brief at 5; CMS Exhibit C-3. Thus, the Hearing Officer finds that CMS's denial of MCP's application for contract H5099, based on a determination that MCP's provider and facility contracted networks submitted by the NOID's application deadline did not meet CMS network standards and that MCP's exception requests failed to address available providers, is supported by the undisputed facts. *See* 42 C.F.R. § 422.116(a)(2)(ii) and (f)(1)(i)(A).

MCP also alleges that CMS's deadlines are "untenable," thus MCP should be permitted to demonstrate that, as of June 3, 2025, it has cured all network deficiencies, and that CMS's denial of MCP's application is not in the best interests of Medicare beneficiaries. The Hearing Officer finds, however, that the Hearing Officer's authority under 42 C.F.R. § 422.688 is limited and requires the Hearing Officer to comply with the regulations issued by the Secretary. Here, the pertinent regulatory scheme provides the bases for denial of an application and sets certain

application deadlines that the Hearing Officer must follow but does not extend to granting policy-based relief. *See* 42 C.F.R. §§ 422.502(c)(2)(ii) and 422.116(a)(2)(ii).

VIII. DECISION AND ORDER

CMS's Motion for Summary Judgment is granted. The Hearing Officer finds that there are no material facts in dispute. The Hearing Officer also finds that MCP has not proven 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. *See* 42 C.F.R. § 422.660(b)(1).

Amanda S. Costabile -S

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Date: 2025.08.12 12:15:00 -04'00'

Amanda S. Costabile, Esq.
CMS Hearing Officer

Date: August 12, 2025