DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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August 11, 2025

Via Electronic Delivery

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RE: Hearing Officer Decision
Hearing Officer Docket Number: H-25-00024
Medicare Advantage/Prescription Drug Plan ("MA/PD"), Contract Denial (Service Area Expansion)
American Health Plan of Indiana, Inc, Contract/Plan/Provider Number: H9690

Dear Ms. Ward and Ms. Spaccarelli:

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

AMERICAN HEALTHPLAN OF INDIANA, INC.	*	**CMS Hearing Officer Case No.:**
	*	
Contract No. H9690	*	**H-25-00024**
	*	
Petitioner	*	
	*	**Denial of Application for Service Area Expansion for Existing Medicare Advantage /Medicare Advantage – Prescription Drug Plan**
v.	*	
	*	
CENTERS FOR MEDICARE & MEDICAID SERVICES,	*	
	*	
Respondent	*	
	*	

HEARING OFFICER ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

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I. FILINGS

a) May 29, 2025, Hearing Request titled as American Health Plan of Indiana, Inc. ("AHP IN")[1] Reply Brief ("Hearing Request") regarding the Centers for Medicare & Medicaid Services' ("CMS") Service Area Expansion Application Denial, filed by American Health Plan of Indiana, Inc. and Plan Exhibits P-1 through P-5;

b) June 6, 2025, Applicant's Brief to Appeal [the Centers for Medicare & Medicaid Services' ("CMS's")] Denial of Applicant's Medicare Advantage Service Area Expansion ["SAE"] Application ("Plan Brief") and Plan Exhibits P-6 through P-10; and

c) June 13, 2025, [CMS] Brief in Reply to Applicant's Brief in the Matter of the Denial of the Medicare Advantage and Part D Application Submitted by [AHP IN] (Contract H9690), Docket Number H-25-00024, submitted with a Motion for Summary Judgment ("CMS Brief"), including CMS Exhibits C-1 through C-5.

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, Suzanne D. Rollins.

III. ISSUE

Whether CMS' denial of AHP IN's service area expansion application for an existing Medicare Advantage/Medicare Advantage Prescription Drug ("MA-PD") and Hybrid-Institutional Special Needs ("HI-SNP") contract (Contract No. H9690) based on failure to meet CMS's network adequacy requirements was inconsistent with regulatory requirements.

IV. DECISION SUMMARY

The Hearing Officer grants CMS' Motion for Summary Judgment. CMS Brief at 7-8. The Hearing Officer finds that there are no material facts in dispute and the record does not establish that AHP IN timely provided CMS, in response to the April 14, 2025 Notice of Intent to Deny ("NOID"), with Health Service Delivery tables ("HSD") meeting CMS's network adequacy requirements for Warrick County, Indiana, or a request to withdraw the county from its application. *See* CMS Exhibit C-1 (Deficiency Notice and NOID); Plan Exhibit P-2 (MA-PD Application Denial); Plan Exhibit P-3 (SNP Application Denial); Plan Exhibit P-4 (AHP IN email). AHP IN acknowledges a clerical error and oversight on its part. The Hearing Officer does not have the authority to instruct CMS to reverse its denial or permit amendments to correct or reverse the clerical error. Therefore, the Hearing Officer upholds CMS's denial of the MA-PD and HI-SNP applications for contract H9690.

[1] Within this decision AHP IN is both referred to as "the Plan" and "the Applicant."

V. AUTHORITIES AND SUBREGULATORY GUIDANCE

A. APPLICATION REVIEW PROCESS

Under Title XVIII of the Social Security Act ("the Act") (codified at 42 U.S.C. §§ 1395-1395lll), CMS is authorized to enter into contracts with entities seeking to offer Medicare Part C and Part D benefits to beneficiaries. 42 U.S.C §§ 1395w-27, 1395w-112. Any entity seeking such a contract must fully complete all parts of a certified application in the form and manner required by CMS. 42 C.F.R. § 422.501(c)(1). CMS requires an entity seeking to contract as an MA organization to submit an application through 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 June 26, 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:

> In order to meet the requirements to offer a Special Needs Plan (SNP), SNPs must also meet the MA requirements. At the time of application, applicants 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 associated 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 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 the applicant may cure the deficiencies. *See* CMS Brief at 4. If the applicant fails to cure the

[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 7.

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' 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 an MSJ. 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. Within an application seeking a service area expansion, an MA organization must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served. 42 C.F.R. § 422.112(a)(4). 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 2; "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 June 26, 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

[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).

service area. An organization must list every provider and facility with a fully executed contract in its network in the HSD tables. *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 2024) (hereinafter "Network Adequacy Guidance ").

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. 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.
>
> (B) All provider and facility time and distance standards.
>
> (C) Ratios established in paragraph (e) of this section in advance of network reviews for the applicable year.
>
> . . .
>
> (ii) A Provider Supply file that lists available providers and facilities and their corresponding office locations and specialty types…

VI. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 12, 2025, AHP IN submitted a Service Area Expansion application under its existing contract number H9690, to expand its MA-PD contract and SNP service area for contract year 2026. Plan Brief at 2. AHP IN's applications sought to offer its product in 29 counties in Indiana, Kentucky, and Ohio. CMS Brief at 4.

Following submission of the application and CMS' subsequent review, CMS issued AHP IN a March 13, 2025, Deficiency Notice in which CMS noted deficiencies regarding state licensure, and network standards for providers and facilities. CMS Exhibit C-1 at pdf pgs. 1-3. The Deficiency Notice instructed AHP IN that application modification was possible, and provided specific instructions regarding how to withdraw counties and reduce the service area for the application. *Id.* at pdf pg. 2.

On March 24, 2025, in response to the Deficiency Notice, AHP IN submitted curing materials including "the annual CMS State Certification Form for CY 2026 for its proposed Indiana expansion counties with CMS." Plan Brief at 2; Plan Exhibit P-1. AHP IN also submitted revised provider and facility HSD networks and a network adequacy exception request. CMS Brief at 5.

Following a review of the curing materials, on April 14, 2025, CMS issued AHP IN a NOID. CMS Exhibit C-1 at pdf pgs. 4-6. The NOID cited the denial of exception request(s), and deficiencies with AHP IN's network of contracted providers and facilities. CMS Exhibit C-1 at pdf pg. 4. The NOID advised AHP IN that the deadline to cure application deficiencies was April 24, 2025, and that curing materials could include revised HSD tables. The NOID provided the same instructions as the Deficiency Notice regarding how to remove a county from the application and established a deadline to do so by May 9, 2025. CMS Exhibit C-1 at pdf pg. 5. *Id*. at pdf pg. 5.

On April 28, 2025, AHP IN requested to withdraw numerous counties from their MA-PD and [Institutional] SNP application. CMS Brief at 5; CMS Exhibit C-3. On April 29, 2025, AHP IN submitted a second withdrawal letter listing all the same counties but correcting the first sentence of the letter to identify that the withdrawal pertained to MA-PD and Hybrid-Institutional applications. CMS Exhibit C-4. Tippencanoe County, IN was included on both withdrawal letters, and Warrick County, IN ***was not included*** on the withdrawal letters. *Id*.; CMS Exhibit C-3.

On May 14, 2025, CMS issued a Denial Letter to AHP IN regarding its MA-PD Service Area Expansion application. The Denial Letter stated that AHP IN's contracted network of providers and facilities did not meet network standards. Plan Exhibit P-2 at 1-2.

Also on May 14, 2025, CMS issued a Denial Letter to AHP IN regarding its SNP application, stating that AHP IN "…failed to meet the requirements of the Part C Medicare Advantage (MA) application. Therefore, the Special Needs Plan (SNP) or SNP Service Area Expansion (SAE) application does not meet the requirements." Plan Exhibit P-3 at pdf pg. 1.

On May 14, 2024, AHP IN e-mailed CMS explaining

> We found that the wrong county was inadvertently added in the withdrawal letter dated May 14, 2025, causing the network deficiency. We had incorrectly added Tippencanoe, IN (15780) when it was our intent to drop Warrick, IN (15860). Is it possible to correct this administrative error?

Plan Exhibit P-4.[4]

On May 21, 2025, CMS replied to AHP IN's email inquiry, stating that it could not modify AHP IN's current service area request as withdrawal requests were due on May 9. Plan Exhibit P-5.

On May 29, 2025, AHP IN timely requested a hearing, and filed a Plan Reply Brief and Plan Exhibits P-1 through P-5. AHP IN filed its Plan Brief and Plan Exhibits P-7 through P-10 on June 6, 2025. CMS filed its CMS Brief, and CMS Exhibits C-1 through C-5, on June 13, 2025. The Hearing Officer postponed the June 20, 2025 hearing to consider CMS' MSJ.

[4] The Hearing Officer notes the two withdrawal letters contained in this record are dated April 28, 2025 (CMS Exhibit C-3) and April 29, 2025 (CMS Exhibit C-4). Regardless of the date cited by AHP IN in its email, the Hearing Officer finds that AHP IN included Tippencanoe County, IN in its withdrawal request letters, and Warrick, IN was not included in the withdrawal request letters.

VII. PLAN'S CONTENTIONS

Within its Plan Brief, AHP IN explains "[i]n submitting its pending county withdrawal list to CMS on April 29, 2025, AHP IN inadvertently, through clerical error, omitted Warrick County, Indiana from the withdrawal list, instead including Tippecanoe County, Indiana on that list. AHP IN acknowledges its clerical error and oversight…" Plan Brief at 2; *See* Plan Exhibit P-4. AHP IN requests that CMS "allow AHP IN to withdraw Warrick County from the SAE application and approve the SAE application for the remaining pending counties of Elkhart County, Indiana and Jefferson County, Kentucky to which AHP IN seeks to expand and for which AHP IN has been found by CMS to meet all applicable application requirements." Plan Brief at 4. AHP IN explains it "is in good standing and has been working in good faith to submit its application in good order and in a timely manner." *Id.*

AHP IN notes that in a different plan during a previous year, CMS permitted corrections to MA applications involving inadvertent clerical errors. Therefore, AHP IN contends that CMS's decision to deny this application is inconsistent with its past actions. *Id.* at 4-6.

AHP IN asserts that administrative law requires CMS to "treat similar facts and circumstances alike, and failing to do so is…'arbitrary and capricious'." *Id.* at 5. AHP IN cites to numerous cases in support of this assertion.[5] AHP IN maintains that CMS's refusal to allow correction of the application error is a "reversal of past CMS practice," that AHP IN "was never informed that it would bear the full cost of any clerical mistake," and "nothing in the underlying statute or regulations prohibits a plan from amending its application to correct clerical errors." *Id.* at 6.

AHP IN asserts there is a "genuine lack of access" to Medicare Advantage institutional special needs plans and that the availability of its contract "would benefit the frail beneficiary populations" in Elkhart County, Indiana, and Jefferson County, Kentucky. *Id.* at 7.

VIII. CMS'S CONTENTIONS

In its response, CMS states it "properly denied [AHP IN]'s application based on its failure to meet network adequacy requirements," and that CMS "provided adequate notice to AHP IN throughout the application process to withdraw pending counties in advance of the application denial." CMS Brief at 5.

CMS responds to AHP IN's claim regarding the rescission of denials for other MA applications involving inadvertent errors, stating that the current refusal is consistent with past practices. CMS distinguishes the error in this appeal from the previous case mentioned by noting that the prior case involved a licensure issue and the mistake was not entirely within the Plan's control. CMS Brief at 6. CMS argues that AHP IN was notified in the Deficiency Notice and the NOID of opportunities to remove a county, and CMS is "acting consistently with past agency practices" in

[5] AHP IN cites to numerous cases including *Commc'ns & Control, Inc. v. FCC,* 374 F.3d 1329 (D.C. Cir. 2004), *Tyler Regional Hospital v. Department of Health and Human Services*, 673 F. Supp. 3d 849 (E.D. Tx. 2023), *FCC v. Fox Television Stations, Inc*., 556 U.S. 502 (2009*), Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs*., 545 U.S. 967 (2005), *Commc'ns & Control, Inc. v. FCC*, 374 F. 3d 1329 (D.C. Cir. 2004), *Tyler Reg. Hosp. v. Dept. of Health and Human Svcs.,* 673 F. Supp 3d 849 (E.D. Tx. 2023).

its "denial to allow AHP IN to remove a pending county and reinstating a previously removed county after the denial of an application." *Id.*

CMS contends the "period for AHP IN to remedy application deficiencies has passed." CMS Brief at 7. CMS claims "[t]o allow applicants additional time to submit information would extend the deadline for that applicant only and would undermine the need for a uniform application process that is applied fairly to all applicants." *Id.* CMS argues

> Due to AHP IN's failure to demonstrate that it met all Part C application requirements, as required under 42 C.F.R. § 422.501 and § 422.502, prior to the expiration of the 10-day cure period following issuance of the NOID, CMS denied AHP IN's application pursuant to 42 C.F.R. § 422.502(c)(3). CMS's determination to deny AHP IN's application H9690 was made in a manner consistent with 42 C.F.R. § 422.501 and § 422.502.

CMS Brief at 7.

CMS asserts it "reviewed AHP IN's application and reached a decision to deny the application in a manner fully in accordance with the applicable statutes, regulations and guidance." CMS Brief at 8. CMS concludes

> AHP IN failed to demonstrate in its application that it fully met all MA requirements to offer a MA/I-SNP contract H9690 for CY 2026. CMS requires that applicants demonstrate compliance with network adequacy requirements in 42 C.F.R. § 422.116 as part of its application for a new MA service area. By AHP IN's own admission, reflected in documents uploaded in each cure period of the application process and its brief submitted to the Hearing Officer, AP IN did not meet CMS's network adequacy requirements throughout the application process.

CMS Brief at 8.

IX. DISCUSSION AND ANALYSIS

The Hearing Officer finds no material facts in dispute and grants CMS's Motion for Summary Judgment. As explained below, AHP IN did not meet CMS's network adequacy requirements.

Under 42 C.F.R. § 422.660(b)(1), for the appeal of its contract determination, AHP IN 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 AHP IN to fully complete all parts of an application in the form and manner required by CMS. The regulatory framework also contains required notices, with CMS affording AHP IN two opportunities to cure an application and providing numerous means to achieve provider and network adequacy, including multiple opportunities to withdraw counties from the application. Additionally, under 42 C.F.R. § 422.502(a)(1), CMS evaluated AHP IN's applications "solely on the basis of information contained in the application itself and any additional information that CMS obtains through other means such as on-site visits." CMS

determined the applications failed to meet network adequacy requirements contained in 42 C.F.R. § 422.116.

The Hearing Officer finds the record contains the following facts: CMS notified AHP IN of provider and facility network deficiencies on March 13, 2025, and April 14, 2025; AHP IN was afforded two opportunities to cure its application and/or modify its application by withdrawing counties from its service area; and AHP IN did not withdraw Warrick County, IN from its applications.

AHP IN acknowledges that a clerical error resulted in its failure to withdraw Warrick County, IN, as intended, and instead, AHP IN mistakenly withdrew Tippecanoe County, IN. Plan Brief at 1. AHP IN acknowledges that this error ultimately resulted in a network deficiency. Plan Exhibit P-4. Nevertheless, AHP IN argues it was never informed that it would bear the full cost of a clerical mistake on its application, and nothing in the statutes or regulations prohibits it from now amending the application to correct errors. Plan Brief at 6. Additionally, AHP IN asserts it must be permitted to correct its applications based on CMS's past actions of allowing correction to an application after denial and during appeal. *Id.* at 5.

The Hearing Officer finds AHP IN did not properly or timely modify its application as instructed by CMS, and AHP IN failed to submit its application in the form and manner required by CMS pursuant to 42 C.F.R. § 422.501(c)(1). The Hearing Officer does not have the authority to instruct CMS to reverse its denial or permit amendments to the application (i.e., withdrawal of Warrick County, Indiana, consideration of additional state licensure information,[6] approval of additional counties, or consideration of any other additional application information) in this situation, where the Plan withdrew a different county than it intended. The Hearing Officer's authority does not extend to permitting AHP IN to submit additional revised application material beyond CMS's application deadlines.[7] Additionally, in reviewing this current matter, the Hearing Officer has no general authority to consider a claim that CMS is inconsistent as it exercised its discretion to rescind a denial in allegedly similar circumstances.[8] The Hearing Officer must comply with Title

[6] AHP IN addresses State licensure in its brief, stating "should CMS determine that such information is required in order to approve the application at issue, the Hearing Officer should require CMS to allow AHP IN to submit such information…". *Id.* AHP IN explains "it holds a valid State license that authorizes it to operate in any geographic area within Indiana and Kentucky . . . so long as AHP IN meets each state's financial solvency requirements (*see* Exhibits P-6 – AHP IN Kentucky Certificate of Authority, and P-7 - 4.4 AHP IN Kentucky CMS State Certification Form, and P-8 - Bradley Dec.). Plan Brief at 3. AHP IN notes that "[t]he absence of such documentation was never cited by CMS as an application deficiency or basis for ultimate denial of the application.. . . . ." *Id*. at 4.

[7] 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 (April 15, 2010).

[8] Moreover, while the prior case is irrelevant in this proceeding, CMS has provided a credible argument that the circumstances are distinguishable.

XVIII of the Social Security Act as well as the regulations and CMS's general instructions implementing the Act. 42 C.F.R. §§ 422.660 and 422.668.

Lastly, while AHP IN contends there is a lack of access to Medicare Advantage SNPs and approval of these applications will benefit frail beneficiary populations, the Hearing Officer does not have the authority to consider policy-related requests for relief under 42 C.F.R. §§ 422.660 and 422.668.

Upon reviewing the materials submitted prior to the application deadline, the Hearing Officer concludes that AHP IN has not demonstrated by a preponderance of the evidence that CMS' denial of AHP IN's applications, based on failure to meet CMS's provider and facility network standards, was inconsistent with the requirements of 42 C.F.R. §§ 422.501 and 422.502. Specifically, AHP IN failed to properly cure its application in response to the April 14, 2025 NOID, by providing CMS with HSD tables meeting CMS's provider and facility network adequacy requirements. CMS may deny an application on the basis of an evaluation of the applicant's network for a new or expanding service area pursuant to 42 C.F.R. § 422.116(a)(2)(ii).

X. ORDER

The Hearing Officer grants CMS' Motion for Summary Judgment. The Hearing Officer upholds CMS' May 14, 2025 Denial of AHP IN's service area expansion application for an existing MA-PD and HI-SNP contract (Contract No. H9690) based on failure to meet CMS's network adequacy requirements

Suzanne D. Rollins -S

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Date: 2025.08.11 08:46:35 -04'00'

Suzanne D. Rollins, Esq.
CMS Hearing Officer

Date: August 11, 2025