CENTERS FOR MEDICARE AND MEDICAID SERVICES
Hearing Officer Decision

In the Matter of:	*	
Bright Health Company of New York, Inc.	*	**Docket No. 2017-3 MA/PD**
Denial of Service Area Expansion: Initial Application	*	
	*	
Contract Year 2018 Contract No. H1209	*	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

I. FILINGS

This Order is being issued in response to the following:

(a) Bright Health Company of New York, Inc.'s ("Bright Health Company") Request for Hearing submitted by letter, dated June 2, 2017;

(b) Centers for Medicare & Medicaid Services' ("CMS") Memorandum and Motion for Summary Judgment in Support of CMS' Denial of Bright Health Company's Initial Application to offer Medicare Advantage/Medicare Advantage-Prescription Drug Contract H1209 for contract year ("CY") 2018, dated June 8, 2017 [hereinafter CMS' Motion for Summary Judgment]; and

(c) Bright Health Company's Hearing Brief and Memorandum in Opposition to CMS' Motion for Summary Judgment, dated June 13, 2017 [hereinafter Bright Health Company's Brief].

II. ISSUE

Whether CMS' denial of Bright Health Company's application to offer a new Medicare Advantage ("MA") product—due to a failure to meet the State licensure application requirement—was inconsistent with regulatory requirements.

III. DECISION

The Hearing Officer grants CMS' Motion for Summary Judgment. The parties agree that there is no dispute of material facts. The Hearing Officer finds that Bright Health Company failed to meet the State licensure application requirement. Bright Health Company has not established

by a preponderance of the evidence that CMS' denial of its application was inconsistent with controlling authority.

IV. BACKGROUND

Any entity seeking to contract as an MA organization must fully complete all parts of a certified application, in the form and manner required by CMS. *See* 42 C.F.R. §§ 422.501(c) and 422.503(b)(1) (2016). Specifically, CMS requires that applications be submitted through the Health Plan Management System ("HPMS") and in accordance with instructions and guidelines that CMS may issue. Among other requirements, an applicant must provide:

> Documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to MA plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health care services to be offered under the MA contract. 42 C.F.R. § 422.501(c)(i).

Under current regulations and procedures, after receiving an application, CMS reviews the application for any issues. CMS then notifies the applicant of any deficiencies by e-mailing a Deficiency Notice. This is an applicant's first opportunity to amend its application.

If an applicant fails to cure its deficiencies, CMS will issue a Notice of Intent to Deny ("NOID"). 42 C.F.R. § 422.502(c)(2)(i). The NOID affords an applicant a second opportunity to cure its application. *See id.* § 422.502(c)(2)(ii). After a NOID is issued, an applicant has a final ten-day period to cure any deficiencies in order to meet CMS' requirements; otherwise, CMS will deny the application. *Id.* § 422.502(c)(2)(ii)–(iii).

The formal NOID process is outlined at 42 C.F.R. § 422.502(c)(2)(i)–(iii), which states:

> (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization or Specialized MA Plan for Special Needs Individuals, CMS gives the applicant notice of intent to deny the application for an MA contract or for a Specialized MA Plan for Special Needs Individuals a summary of the basis for this preliminary finding.
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> (ii) Within 10 days from the intent to deny, the applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must revise its application to remedy any defects CMS identified.

> (iii) If CMS does not receive a revised application within 10 days from the date of the notice, 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.

If after review, CMS denies the application, written notice of the determination and the basis for the determination is given to each applicant. 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. *Id.* § 422.502(c)(3)(iii). Furthermore, 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). *Id.* § 422.660(b)(1). In addition, either party may ask the Hearing Officer to rule on a Motion for Summary Judgment. *Id.* § 422.684(b).

V. PROCEDURAL HISTORY AND STATEMENT OF FACTS

On February 15, 2017, Bright Health Company filed an initial application with CMS to offer a new Medicare Advantage ("MA")/ Medicare Advantage - Prescription Drug ("MA-Only/MA-PD") product under contract number H1209 for contract year ("CY") 2018. *See* Bright Health Company's Brief at 2. CMS then issued a deficiency notice on March 3, 2017, citing deficiencies in State licensure, fiscal soundness, and health services management and delivery. *Id.* This deficiency notice provided that Bright Health Company had until March 9, 2017 to cure all deficiencies. *See* CMS' Motion for Summary Judgment at 4.

In response, Bright Health Company cured the fiscal soundness deficiency. *Id.* However, on April 17, 2017, CMS issued a Notice of Intent to Deny ("NOID") which stated deficiencies in State licensure and health services management and delivery. *Id.* The NOID gave Bright Health Company a final ten-day cure period to correct any deficiencies in its application—that is, by April 27, 2017. *See id.* at Exhibit F.

Thereafter, Bright Health Company cured the health services management and delivery deficiency, but CMS issued the Contract Determination on May 24, 2017 via e-mail, denying Bright Health Company's new MA-Only/MA-PD product application. *Id.* at 1. Specifically, the Contract Determination stated that CMS denied Bright Health Company's application because it did not have a license under State law as a risk-bearing entity eligible to offer health insurance or health insurance benefits coverage across the service area. *See* Bright Health Company's Brief at 2. Bright Health Company subsequently filed a Hearing Request on June 2, 2017, to establish the instant appeal. *Id.* The parties then briefed the issue as noted in Section I. above.

VI. DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

In exercising his/her authority, the Hearing Officer must comply with the provisions of Title XVIII and related provisions of the Social Security Act ("Act"), regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act. 42 C.F.R. § 422.688.

The regulations are clear that an applicant must document that it has a State license or State certification to meet CMS' standards. *See id.* § 422.501(c)(1)(i). Bright Health Company failed to meet the application requirements when it submitted its initial application, and it failed to cure these deficiencies by April 27, 2017—the deadline established in the NOID.

The parties do not dispute these facts. Bright Health Company acknowledges in its June 13, 2017, hearing brief that it does not possess a State license but anticipates curing the licensure deficiency in the future. *See* Bright Health Company's Brief at 5. Bright Health Company explains that the New York Department of Financial Services ("DFS") advised Bright Health Company to file an expansion application for New York insurance business using a wholly-owned Colorado C Corporation. *Id.* at 3. However, filing this expansion application ultimately created increased capital requirements and caused delay in the licensure process. *Id.* at 7.

Then, Bright Health Company decided to change course and file for a New York domestic insurance company, but this would take another two months to complete. *Id.* Thus, Bright Health Company argues that if it had initially filed for licensure via a domestic company, it "may have already obtained state licensure." *Id.* Furthermore, Bright Health Company explains that it has made efforts recently to secure licensure, such as addressing the pre-filing requirements of forming a domestic insurance company, and submitting the licensure application to DFS on June 9, 2017. *Id.* at 5. Ultimately, Bright Health Company argues that the CMS Administrator should "exercise her broad contractual and regulatory discretionary authority to allow the applicant to cure its application." *Id.* at 8 (citing *In re Eden Health Plan*, Docket No. 2015-MA/PD-App. 3 (July 31, 2015 Decision of the Administrator); *In re Community Care Alliance of Illinois*, Docket No. 2011-MA/PD-App. 7 (Aug. 4, 2013 Decision of the Administrator); and *In re Senior Whole Health, LLC*, Docket No. 2011-C/D-App. 12 (July 31, 2011 Decision of the Administrator)).[1]

The Hearing Officer finds that CMS' denial was an appropriate exercise of its delegated authority. Bright Health Company did not meet CMS' application requirements by the April 27, 2017 deadline. Therefore, Bright Health Company did not meet its burden of proof in demonstrating that CMS' determination was inconsistent with controlling authority.

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[1] The CMS Hearing Officer does not possess the same scope of authority as the CMS Administrator.

VII. DECISION AND ORDER

The Hearing Officer finds that Bright Health Company has not established by a preponderance of the evidence that CMS' denial was inconsistent with controlling authority. It is undisputed that Bright Health Company failed to timely meet the State licensure application requirement. Thus, CMS' Motion for Summary Judgment is hereby granted.

Benjamin R. Cohen, Esq.
CMS Hearing Officer

Diana K. Hobbs, Esq.
CMS Hearing Officer

Date: July 3, 2017