# CENTERS FOR MEDICARE & MEDICAID SERVICES
## Hearing Officer Decision

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| **In the Matter of:** | * | |
| **Bright Health Insurance Company of New York, Inc.** | * | |
| **Denial of Initial Applications to Offer Medicare Advantage/Medicare Advantage-Prescription Drug Plans** | * | **Docket Nos. 2018-03 and 2018-05** |
| **Contract Year 2019**<br>**Contract Nos. H2288 and H9516** | * | |

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## ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

### I. Filings

This Order is being issued in response to the following:

(a) Bright Health Insurance Company of New York, Inc.'s ("BHC") Requests for Hearing submitted by letters dated May 31, 2018;

(b) BHC's Hearing Brief ("BHC Brief") dated June 11, 2018;

(c) Centers for Medicare & Medicaid Services' ("CMS") Motion for Summary Judgment and Memorandum in Support of CMS' Denial of BHC's Initial Application to offer Medicare Advantage ("MA")/Medicare Advantage - Prescription Drug ("MA-PD") under contract numbers H2288 and H9516 for contract year ("CY") 2019 ("CMS MSJ") dated June 15, 2018; and

(d) BHC's Reply Brief and Memorandum in Opposition to CMS' Motion for Summary Judgment ("BHC Reply Brief") dated June 25, 2018.

### II. Issue

Whether CMS' denial of BHC's applications to offer new MA products, due to a failure to timely meet State licensure application requirements, 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. While BHC now submits additional licensure materials for CMS review, it is undisputed that BHC failed to timely meet the application requirements. BHC has not established by a preponderance of the evidence that CMS' denial of its applications 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)).

For State licensure, applicants must attest in their application that they are licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the applicant wishes to offer one or more MA plans. (42 C.F.R. § 422.400(a)). CMS requires applicants to verify this attestation by uploading an executed copy of the State license certificate with their application if the applicant was not previously qualified by CMS in that State. (*See* CY 2019 Part C – MA and 1876 Cost Plan Expansion Application, located at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html (last modified Apr. 2, 2018)).

Applicants must also attest that the scope of their license or authority allows the applicant to offer the type of MA plan or plans (*e.g.*, PPO, HMO, etc.) that it intends to offer in the State. (42 C.F.R. § 422.400(c)). With the application, applicants must submit a CMS State Certification Form executed by the State that confirms and certifies that the plan type to be offered by the applicant is within the scope of the license. (*See* CY 2019 Part C – MA and 1876 Cost Plan Expansion Application).

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* 42 C.F.R. § 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.
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> (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. (42 C.F.R. § 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). (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 Social Security Act ("Act")] and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act."

## V. Procedural History and Statement of Facts

On February 14, 2018, BHC filed two initial applications with CMS to offer new MA/MA-PD products under contract numbers H2288 and H9516 for CY 2019. (*See* CMS MSJ at 1). During the first review of BHC's applications, CMS found multiple deficiencies, including the State

licensure deficiency relating to the Motion for Summary Judgment herein. On March 19, 2018, CMS sent deficiency letters to BHC. (CMS MSJ at Exhibits G and H).

On March 27, 2018, BHC submitted final applications resolving the deficiencies that were unrelated to State licensure. (*See* CMS MSJ at 4). BHC responded with the same February 14, 2018 memos previously submitted with the initial applications, stating that it was still in discussions with the State of New York and expected a favorable result that would lead to the issuance of licenses. (*See* CMS MSJ at Exhibits P and Q).

On April 17, 2018, CMS issued NOID letters, which noted a deficiency in State licensure. (CMS MSJ at Exhibits I and J). The NOIDs gave BHC a final ten-day cure period to correct any deficiencies in its applications — that is, until April 27, 2018. BHC again submitted the February 14, 2018 memos regarding discussions with New York State and the expectation of the licenses being issued. (*See* CMS MSJ at Exhibits P and Q). CMS issued final determinations on May 23, 2018, denying BHC's applications on the basis that BHC did not cure the licensure requirement. (CMS MSJ at Exhibits K and L).

BHC filed the subject appeals on May 31, 2018 from CMS' May 23, 2018 final denial letters. (BHC Brief at Exhibit C). Along with BCH's June 25, 2018 Reply Brief, BHC attached a copy of a June 19, 2018 New York State license from the New York Department of Financial Services ("NY DFS") and a CMS State Certification Form completed by BHC and the NY DFS. BHC explained it was "ready to submit such CMS State Certification Form to CMS." (BHC Reply Brief at 3).

## VI. Discussion, Findings of Fact and Conclusions of Law

In exercising their authority, the Hearing Officer must comply with the provisions of Title XVIII of the Act — Health Insurance for the Aged and Disabled — and related provisions of the Act, regulations issued by the Secretary of Health and Human Services, 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* 42 C.F.R. § 422.501(c)(1)(i)). BHC failed to meet the application requirements when it submitted its initial applications and failed to timely cure the deficiencies by April 27, 2018 — the deadline established in the NOID.

Ultimately, BHC argues that the CMS Administrator should "exercise [] the broad contractual discretionary authority to allow [BHC] to cure its application[s]." (BHC Reply Brief at 4 (citing *In re Eden Health Plan*, Docket No. 2015 MA/PD App. 3, CMS Adm'r Dec. (Aug. 27, 2015); *In re Cmty. Care Alliance of Ill.*, Docket No. 2013 MA/PD App. 7, CMS Adm'r Dec. (Aug. 30, 2013); and *In re Senior Whole Health, LLC*, Docket No. 2011 C/D App. 12, CMS Adm'r Dec. (Aug. 25, 2011))). BHC also claims that allowing it to cure its application would benefit vulnerable Medicare populations and increase competition.

CMS asserts that BHC did not comply with CMS' application requirements and that CMS appropriately denied BHC's applications based upon the information BHC submitted during the application processing period. (CMS MSJ at 7). CMS asserts that neither CMS nor the Hearing Officer may consider additional documentation or new information beyond the final filing submission deadline. (CMS MSJ at 3-4, 6-7). CMS claims that "[t]o allow applicants additional time to submit additional 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.* at 7).

The CMS Hearing Officer does not possess a broad scope of discretionary authority; rather, the Hearing Officer must decide if CMS' determinations were consistent with regulatory requirements. (42 C.F.R. §§ 422.660 and 422.688). The Hearing Officer finds that BHC failed to timely meet CMS' application requirements, thus CMS' denials were an appropriate exercise of its delegated authority. BHC did not meet its burden of proof in demonstrating that CMS' determinations were inconsistent with controlling authority. Accordingly, the Hearing Officer grants CMS' Motion for Summary Judgment.

## VII. Decision and Order

CMS' Motion for Summary Judgment is granted.

/Benjamin R. Cohen/
Benjamin R. Cohen, Esq.
CMS Hearing Officer

Date: July 19, 2018