CENTERS FOR MEDICARE AND MEDICAID SERVICES
HEARING OFFICER DECISION

IN THE MATTER OF:

Vantage Health Plan of Arkansas, Inc.	*	
	*	DOCKET NO. 2013 MA/PD APP. 2
Denial of Initial Application to Qualify as a	*	
Medicare Prescription Drug Organization	*	
Contract Year 2014, Contract No. H6380	*	
	*	

I. JURISDICTION

This appeal is provided pursuant to 42 C.F.R. § 423.650. The Centers for Medicare and Medicaid Services (CMS) Hearing Officers designated to hear this case are the undersigned, Benjamin R. Cohen and Michael J. McDougall.

II. ISSUE

Whether CMS' denial of Vantage Health Plan of Arkansas, Inc.'s (Vantage-AR, or the Plan) initial application to offer a Medicare Advantage – Prescription Drug (MA-PD) plan for contract year 2014 was a proper application of its contracting authority.

III. PROGRAM BACKGROUND

The Medicare Advantage (MA or Part C) program offers Medicare beneficiaries the option of receiving health care benefits through a privately-operated coordinated care delivery system.[1] Medicare Part D offers an outpatient prescription drug benefit to Medicare beneficiaries.[2] Organizations that are approved to offer MA-PD benefits are required to maintain a provider network that ensures "adequate access to covered services" for its plan enrollees in each operative service area. This network must include a variety of providers, including primary care physicians, specialists, and hospitals.[3] In addition, MA organizations must offer a Part D benefit in the service areas in which they offer a Part C benefit.[4]

The Secretary of the United States Department of Health & Human Services (the Secretary) is authorized to contract with entities seeking to offer MA and MA-PD benefits.[5] Through

[1] *See* 42 U.S.C. § 1395w-21 *et seq.*
[2] *See generally*, 42 U.S.C. § 1395w-112. *See also* 42 C.F.R. Part 423 (Medicare Part D regulations).
[3] 42 C.F.R. § 422.112(a)(1).
[4] 42 C.F.R. § 422.4(c)(1).
[5] 42 U.S.C. § 1395w-27. Part C and Part D contract determinations and appeals are governed by similar, but separate regulations. *See* 42 C.F.R. § 422, Subparts K and N; 42 C.F.R. § 423 Subparts K and N. The present appeal concerns the denial of Vantage-AR's Part D application. CMS articulated that while Part C and Part D contract applications are separately reviewed, the requirement that Part C plans offer a Part

regulation, the Secretary has delegated this contracting authority to CMS, which has established the general provisions for entities seeking to qualify as MA-PD plans.[6]

Potential MA-PD organizations submit applications to CMS, in which the organization must document that it has a provider network in place that meets CMS requirements.[7] Plan sponsors are permitted to utilize subcontractors (referred to as first tier, downstream, and related entities) to fulfill some of their Part D responsibilities. These relationships are defined in identical terms by regulations at 42 C.F.R. §§ 423.4 and 423.501 as follows:

> *Downstream entity* means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Part D benefit, below the level of arrangement between the Part D plan sponsor (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
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> *First tier entity* means any party that enters into a written arrangement, acceptable to CMS, with a Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under Part D.
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> * * * * *
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> *Related entity* means any entity that is related to the Part D sponsor by common ownership or control and
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> (1) Performs some part of the Part D plan sponsor's management functions under contract or delegation;
> (2) Furnishes services to Medicare enrollees under an oral or written agreement;

The Part D regulations at 42 C.F.R. §423.505(i) set out specific provisions that pertain to contracts with such entities:

> (i) *Relationship with first tier, downstream, and related entities.*
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> (1) Notwithstanding any relationship(s) that the Part D plan sponsor may have with first tier, downstream, and related entities, the Part D sponsor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.

D benefit in their service area means that the denial of a Part D application is "tantamount to a rejection" of a Part C application. Transcript of July 9, 2012 Hearing (Tr.) at 111-112.

[6] 42 C.F.R. §§ 422.400 *et seq.*, 422.503(b) *et seq.*

[7] 42 C.F.R. § 422.501(c)(2).

Applicants are required to identify all first tier, downstream, and related entities that will be carrying out specific functions on their behalf. The 2014 MA-PD Contract Solicitation (the Contract Soliciation), at Section 3.1.1, required plans to identify these entities in a "First tier, Downstream and Related entities Function Chart."[8] This solicitation also called on applicants to document their relationship with other entities that would be involved with plan administration. This requirement was stated as follows:

> D. Except for [Service Area Expansion] applicants, upload copies of executed contracts, fully executed letters of agreement, administrative services agreements, or intercompany agreements (in word-searchable .pdf format) with each first tier, downstream or related entity identified in [the Function Chart] and with any first first tier, downstream or related entity that contracts with any of the identified entities on the applicant's behalf. Unless otherwise indicated, each and every contract must:
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> 1. Clearly identify the parties to the contract (or letter of agreement). If the applicant is not a direct party to the contract (e.g., if one of the contracting entities is entering into the contract on the applicant's behalf), the applicant must be identified as an entity that will benefit from the services described in the contract.
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> 7. Be signed by a representative of each party with legal authority to bind the entity.
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> Each complete contract must meet all of the above requirements when read on its own.[9]

MA-PD applications must be completed "in the form and manner required by CMS."[10] Presently, CMS requires the electronic submission of MA-PD applications via the Health Plan Management System (HPMS) program.[11] Furthermore, the Solicitation requires applicants to provide certain information via HPMS in order to assist CMS in the review process. Section 3.1.1.E of the Solicitation instructs applicants as follows:

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[8] Solicitation for Applications for Medicare Prescription Drug Plan 2014 Contracts (Contract Solicitation) at 27. *Available at* http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/2014-Part-D-Application.pdf (last visited August 20, 2013). *See also* CMS Initial Memorandum, Exhibit 7 (excerpts of Contract Solicitation).
[9] Contract Solicitation at 27-29 (emphasis omitted).
[10] 42 C.F.R. § 423.502(c)(1).
[11] CMS Memorandum at 2.

> Except for [Service Area Expansion] applicants, upload electronic lists of the contract/administrative service agreement/intercompany agreement citations demonstrating that the requirements of Section 3.1.1.D are included in each contract and administrative service agreement. Submit these data by downloading the appropriate spreadsheet found in HPMS that mimics the crosswalk in Appendix X of this solicitation. If the applicant fails to upload crosswalks for executed agreements and contract templates, CMS cannot guarantee that the applicant will receive notice of any deficiencies in the contracting documents as part of this courtesy review.[12]

After receiving a MA-PD application, CMS makes a determination as to whether the applicant organization meets all of the relevant program requirements.[13] This determination is based solely on information contained in the application or obtained by CMS through methods such as onsite visits.[14]

Before final disapproval of an MA-PD application, CMS shall provide a formal "Notice of Intent to Deny," which sets out the basis for the denial and gives the applicant ten days to cure the deficiencies in its application.[15] If CMS denies a MA-PD application, the applicant organization is entitled to a hearing before a CMS hearing officer.[16] The regulation at 42 C.F.R. § 423.650(b)(1) dictates that "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. §§ 423.502 and 423.503]."[17]

IV. FACTUAL AND PROCEDURAL BACKGROUND

Vantage Health Plan, Inc. (Vantage Health) is a Louisiana-based Health Management Organization (HMO) that has offered MA-PD services to beneficiaries in Louisiana since 2007.[18] State law prohibits Louisiana health insurance corporations from owning insurance companies in another state, so when Vantage Health sought to offer services in Arkansas, reorganization was required.[19] A holding company, Vantage Holdings, was created and became the parent organization to Vantage Health. In January 2013, Vantage Holdings created Vantage-AR.[20]

On February 21, 2013, Vantage-AR submitted applications to qualify as a Part C and Part D plan sponsor in Union County, Arkansas for the 2104 contracting year. This application indicated

[12] Contract Solicitation at 29.
[13] 42 C.F.R. § 423.503(a)(2).
[14] 42 C.F.R. § 423.503(a)(1).
[15] 42 C.F.R. § 423.503(c)(2)(ii - iii).
[16] 42 C.F.R. § 423.650.
[17] *See supra* note 5. (The regulations at 42 C.F.R. §§ 423.502 and 423.503 establish the Part D contract application requirements and review procedures).
[18] Vantage-AR Appeal Brief at 2.
[19] *Id. See also* Tr. at 67-69 (Testimony of Vantage Health CEO, President and Chief Medical Officer (CEO) explaining corporate structure of Vantage entities).
[20] Vantage-AR Appeal Brief at 2; Tr. at 71 (Testimony of Vantage CEO stating that, "Vantage Holdings would be the parent of both [Vantage Health and Vantage-AR] companies.").

that Catamaran PD of Maryland (Catamaran), formerly Catalyst Rx Government Services, Inc., would be providing Pharmacy Benefit Management (PBM) services on behalf of the Plan.[21] During its initial application submission, Vantage-AR provided a copy of an agreement with Catamaran (the Catamaran Contract). The introduction to this agreement reads as follows:

> THIS PRESCRIPTION BENEFIT MANAGEMENT SERVICES AGREEMENT (hereinafter referred to as the "Agreement") is entered into this 30th day of July 2009, between Catalyst Rx Government Services, Inc., which is a subsidiary of Catalyst Health Solutions, Inc., with principal offices at [address], hereinafter referred to as "PBM" and Vantage Health Plan, Inc. with principal offices located at [address], hereinafter referred to as "VANTAGE."[22]

However, at the time of submission, Vantage-AR did not provide the required "crosswalk" that identified relevant provisions within that contract for CMS reference.[23] The Plan claims that the crosswalk template file was not available in the HPMS system at the time of its initial submission, a claim that CMS disputes.[24]

In the absence of a contract crosswalk, CMS did not review the substance of the Catamaran Contract and issued a Deficiency Notice on March 28, 2013.[25] On April 3, 2013, Vantage-AR responded to the Deficiency Notice by providing the appropriate crosswalk for the Catamaran Contract. CMS reviewed this material, and noted ten deficiencies within the Catamaran Contract. In particular, CMS noted that the Catamaran Contract, which was executed between Vantage Health and Catamaran, did not include a reference to Vantage-AR.[26] On April 26, 2013, CMS issued a formal Notice of Intent to Deny the MA-PD application. This notice gave Vantage-AR ten days to cure the application prior to a final denial.[27] Upon receipt of this notice, Vantage-AR consulted with an employee in the CMS Dallas Regional Office in hopes of addressing the contract deficiencies.[28] Following this communication, the Plan was left with the

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[21] Vantage-AR Appeal Brief at 4; CMS Memorandum at 3. *See also* Tr. at 32 (discussion of Catalyst name change to Catamaran, with parties agreeing that name change is not an issue in the present appeal).
[22] CMS Memorandum, Exhibit 5 (the Catamaran Contract) at 4 (capitalization in original).
[23] CMS Memorandum at 3.
[24] *See* Tr. at 22. Hearing testimony of Vantage Medicare Compliance Officer explained that no Catamaran crosswalk was submitted prior to March 28th because, "I didn't have the template that needed to be completed. When I downloaded the template documents from HPMS, it was not in there." *But see* Tr. at 75. CMS employee serving as co-lead for application review process testified that in the 2014 contracting cycle, 193 applications were reviewed, 191 contained the appropriate crosswalks, and Vantage-AR was the only plan to claim that a crosswalk template was unavailable in the HPMS system.
[25] CMS Memorandum, Exhibit 2.
[26] CMS Memorandum at 3-4.
[27] Vantage-AR Appeal Brief, Exhibit 6.
[28] Vantage-AR Appeal Brief at 4. *See also* Tr. at 19. (Vantage-AR Medicare Compliance Officer explaining applicant's working relationship with point of contact in CMS Dallas Regional Office, "[A]nytime anything comes up that I'm really unsure about or how to proceed or that I have a question, I usually pick up the phone and call [Regional Office Contact]…"). At hearing, CMS offered that the MA/PD application materials instruct applicants to contact the CMS Central Office, as opposed to the Regional Offices, with any application concerns. *See* Tr. at 56-57. The Hearing Officer notes that the

impression that the "naming convention" of the parties to the Catamaran Contract was not a material element of the agreement.[29]

The Plan then provided additional materials for CMS review on May 1, 2013.[30] These materials included an amendment to the Catamaran Contract (the Catamaran Amendment), that Vantage-AR believes specifically addresses all of the cited deficiencies.[31] The full title of the Catamaran Amendment, as submitted, reads, "AMENDMENT No. 3 TO THE PRESCRIPTION BENEFIT MANAGEMENT SERVICES AGREEMENT BETWEEN CATAMARAN PD OF MARYLAND, INC. F/K/A CATALYST RX GOVERNMENT SERVICES, INC. AND VANTAGE HEALTH PLAN, INC."[32] Throughout the Catamaran Amendment Vantage Health is identified as "Client."[33]

CMS' review of the Catamaran Amendment determined that the submission did not address all of the previously-cited deficiencies, and issued a formal Denial Notice of the Plan's application on May 31, 2013.[34] The Denial Notice cited five deficiencies, all listed under the subheading "Contracting." These items read as follows:

- The contract your organization submitted for key Part D functions does not contain language that you have the authority to revoke the contract in the event that you or CMS determine that the first tier, downstream or related entity is not performing satisfactorily. The contract referenced is with Catamaran

- The contract your organization submitted for key Part D functions does not contain language stating that your organization will monitor the first tier, downstream or related entity's performance on an ongoing basis. The contract referenced is with Catamaran

- The contract your organization submitted for key Part D functions does not contain language stating that your organization retains the authority to

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record contains no substantial evidence to demonstrate the advice, if any, that the Regional Office provided the Plan with regard to the Notice of Intent to Deny.

[29] Tr. at 28-29. At hearing Vantage-AR's Medicare Compliance Officer addressed her thought process following the Plan's communication with the Regional Office: ". . . I took away from those discussions that the name of the entity contracting, again was Catamaran, was not a problem as both were affiliated with one another, and in fact, you know, basically the same people were doing the job for both companies. . ."

[30] Vantage-AR Appeal Brief at 4.

[31] *Id.* The Plan points to clauses within the Catamaran Amendment that were designed to address each of the deficiencies raised by CMS. Tr. at 43-48 (Vantage-AR representative noting purpose of Medicare Compliance Officer testimony and exhibits: "We're matching [the Catamaran Amendment] up against the five deficiencies noted in the denial letter from CMS."). *See, e.g.* Vantage-AR Appeal Brief, Exhibit 8 (Catamaran Amendment language, stating, "Catamaran acknowledges that the Client shall oversee and monitor Catamaran's performance on an ongoing basis.").

[32] Vantage-AR Appeal Brief, Exhibit 8 (capitalization in original).

[33] *Id.*

[34] Vantage-AR Appeal Brief, Exhibit 10.

approve, suspend, or terminate any pharmacy arrangement made by the first tier, downstream or related entity on behalf of your organization. The contract referenced is with Catamaran

- The contract your organization submitted for key Part D functions does not include a reference to your organization. The contract referenced is with Catamaran

- Your organization did not upload an executed contract with one of the first tier, downstream or related entities that is performing a Part D function on your behalf. The first tier, downstream or related entity referenced is Vantage Health Plan, Inc.[35]

CMS has since indicated that these deficiencies stem from the fact that Vantage-AR was not named as a party to the Catamaran Contract as amended.[36] CMS interpreted the apparent deficiency in the Catamaran Contract as indicating that the Plan intended to engage Vantage Health as a first tier contractor to engage Catamaran on its behalf.[37]

On June 4, 2013, Vantage-AR requested the present appeal. The Plan filed its initial Appeal Brief on June 11, 2013. CMS submitted its appeal Memorandum on June 19, 2013, and the Plan filed an additional, optional Reply Brief on June 24, 2013.

A live hearing was held at the CMS Office of Hearings in Baltimore, Maryland on July 9, 2013. Mr. Robert Bozeman, Vantage Health General Counsel, represented the Plan. Mr. Scott Nelson, from the CMS Medicare Drug Benefit Group, responded on behalf of CMS. The undersigned Hearing Officers conducted the proceeding.

V. CONTENTIONS

The core issue in this appeal is whether Vantage-AR, through its relationship with Vantage Health, should be considered a party to, or beneficiary of, the Catamaran Contract. The parties offer contrasting views on this matter.

[35] *Id.* Vantage-AR's Medicare Compliance Officer testified as to her understanding of the May 31st Denial Notice, the final item of which contemplates an agreement between Vantage-AR and Vantage Health, "Again, I really did not understand what they were asking for. Everything to me, it's one group of people doing the same job and it's just a technicality that there's two different names on the organization. So to me, it's still one company. I really did not understand what they were asking for." Tr. at 49-50.

[36] CMS argues that the term "Client," as used throughout the Catamaran Amendment is not specific enough for the agency to determine that the applicant, Vantage-AR, has the necessary control over the downstream entities to which performance of Part D functions would be delegated. *See* CMS Memorandum at 7-8; Tr. at 61-64.

[37] CMS Memorandum at 6.

A. Vantage-AR's Contentions

The Plan acknowledges that Vantage-AR was not expressly named as a party in the Catamaran Contract as amended.[38] However, Vantage-AR argues that its relationship with Vantage Health obviates the need for a direct agreement between the Plan and Catamaran. The Plan's representative summarized its contentions at hearing by stating:

> That Catamaran Contract will follow Vantage Health Plan, which if there's a binding relationship between the parties, then it will in effect inure to the benefit of Vantage Health Plan of Arkansas, Inc., which is what we have. The binding legal relationship is a matter of law, is a matter of fact, because you have the same individuals. The same people are providing the same service on Vantage Health Plan's side and on the side of Vantage Health Plan of Arkansas.[39]

The Plan expands on the concept of its relationship with Vantage Health, noting that Vantage-AR and Vantage Health "share a common parent organization, common board members, officers and management."[40] Vantage-AR provided documentation and witness testimony that it feels demonstrate this relationship.[41] Under this structure, in the context of the Arkansas Part D plan, "All of Vantage-AR's activities will be controlled by Vantage Health."[42] Therefore, the Plan believes, "the question of substance [in this appeal] is whether Vantage Health is qualified to offer MA/MA-PD plans." To this end, the Plan notes that CMS has determined that Vantage Health has been qualified to offer MA/PD plans since 2007.[43]

In addition, the Plan notes a perceived inconsistency in CMS' review process, as Vantage-AR's Part C application for 2014, which was built on an identical corporate structure, received program approval. In conclusion, the Plan argues that its fitness to offer Part D services in Union County Arkansas is not in dispute.[44]

B. CMS' Contentions

CMS argues that its review of the Plan's contract application must be confined to whether Vantage-AR, on its own, meets Part D program qualifications. Despite the Plan's contentions

[38] Tr. at 84 (Plan counsel: "Nowhere are you going to find in the Catamaran Amendment reference to Vantage Health Plan of Arkansas. It's not there.").
[39] Tr. at 92.
[40] Vantage-AR Reply Brief at 3. *See also* Vantage Appeal Brief at 3 ("In other words, the personnel who are currently providing services for Vantage Health will be the same individuals who will provide services for Vantage-AR. It should be noted that Vantage Health and Vantage-AR both share the same board of directors, officers and management."); testimony of Vantage-AR Medicare Compliance Officer concerning role of Vantage Health personnel in functions of Vantage-AR, *supra* notes 29 and 35.
[41] Vantage-AR Appeal Brief, Exhibits 1-5; Tr. at 34 (Medicare Compliance Officer testimony on Vantage-AR relationship with Vantage Health, "it's going to be the same people doing the same thing").
[42] Vantage-AR Appeal Brief at 7.
[43] *Id.* at 8.
[44] *Id.*

that Vantage Health will control Vantage-AR's operations, CMS notes that "Vantage Health, after all is not the applicant for H6380. . . ."[45]

CMS contends that, as the Part D applicant, Vantage-AR is required to fully document its relationships with any entities that will be performing plan functions on its behalf, including Catamaran.[46] CMS notes that this requirement could have been met in several ways. First, the Plan could have provided a directly-executed agreement between itself and Catamaran. In the alternative, the Plan could have provided an express agreement with Vantage Health, under which Vantage Health would act as a first tier entity to contract with Catamaran for PBM services on behalf of Vantage-AR.[47]

While the Plan argues that an agreement between it and Vantage Health is unnecessary, CMS notes that, as sister organizations, Vantage-AR and Vantage Health are separate legal entities.[48] Accordingly, CMS claims that it is unclear whether either organization has the legal authority to bind its sibling in contract.[49] Therefore, CMS argues that program regulations require documentation of the relationship.[50]

Finally, CMS argues that, in failing to provide a crosswalk for the Catamaran Contract, the Plan did not take full advantage of the guidance and cure opportunities that are built into the contract review process.[51]

VII. DETERMINATION

CMS' denial of Vantage-AR's application was squarely within its review authority. During its evaluation of the Plan's application, CMS determined that Vantage-AR is not a party to the Catamaran Contract. This fact is undisputed. Accordingly, in order for the Plan to demonstrate Catamaran's obligation to provide PBM services to Vantage-AR, CMS determined that the submission of an additional agreement between Vantage-AR and Vantage Health was required. No such agreement was provided for review, but the Plan contends that the commonality between the organizations means that the Catamaran Contract will cover PBM services for Vantage-AR. [52]

However, the Plan's view of the application and plan administration process is at odds with program regulations and requirements. First, the regulations governing Part D contracting are clear with regard to the role of the plan sponsor in the context of related entities:

[45] CMS Memorandum at 5.
[46] *Id.* at 5-6.
[47] *Id.* at 6. *See also* Tr. at 103 (CMS official on whether the timely submittal of an agreement between Vantage-AR and Vantage Health would have cured the application: "That [agreement] would have cured the issue. That was exactly the document we were looking for.").
[48] CMS Memorandum at 7.
[49] Tr. at 112-113.
[50] CMS Memorandum at 6.
[51] *Id.* at 8.
[52] *See supra* note 29.

> Notwithstanding any relationship(s) that the Part D plan sponsor may have with first tier, downstream, and related entities, the Part D sponsor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.[53]

Furthermore, the Solicitation requires that "each complete contract" a Plan sponsor executes with a first tier, downstream or related entity must satisfy certain requirements. These requirements include the clear identification of the contract parties, with the applicant being identified as an entity that will benefit from the contract.[54] Here, the Catamaran Contract for PBM services, as amended prior to the final submission deadline, did not meet these requirements. Moreover, CMS requires that all subcontracts must "be signed by a representative of each party with legal authority to bind the entity."[55] The Hearing Officer finds that CMS was reasonable in determining that the Plan had not demonstrated that Vantage Health had the authority to bind its sister organization, Vantage-AR.

It is undisputed that Vantage-AR and Vantage Health are both subsidiaries of Vantage Holdings. The record indicates that Vantage-AR was created to act as Vantage Health's counterpart in Union County, Arkansas, and the sister organizations share many elements, such as Vantage Holdings parentage, and common management and personnel. These facts demonstrate a general relationship within a larger corporate holdings structure, but do not clearly establish that either sibling entity has the legal capacity to bind the other in contract. Therefore, in the context of the Medicare Part D application process, CMS was reasonable in requiring a mutually-expressed manifestation of authority between Vantage-AR and Vantage Health with regard to the Catamaran Contract.

[53] 42 C.F.R. § 423.505(i) (emphasis added).
[54] *See supra* note 9.
[55] *Id.*

VIII. CONCLUSION

Vantage-AR has not demonstrated that CMS' determination was inconsistent with the Medicare Part D program regulations at 42 C.F.R. 423.502 and 423.503. CMS' denial of Contract No. H6380 is upheld.

Benjamin R. Cohen
August 20, 2013

Michael J. McDougall
August 20, 2013