CVS Health.

Medicare Compliance FDR newsletter

Quarter 3, 2023

Table of contents

Reporting issues of non-compliance and FWA to CVS Health®

Document retention requirements

CMS 2024 Medicare Advantage (MA) and Part D "Final Rule" translation requirements

Exclusion and preclusion lists

Looking for resouces?

Reporting issues of noncompliance and FWA to CVS Health®

As a Medicare First Tier, Downstream and/or Related Entity (FDR), you have an obligation to report issues of noncompliance and Fraud, Waste and Abuse (FWA) to CVS Health.

The requirement for reporting can be found in the Medicare Managed Care Manual Chapter 21 and the Prescription Drug Benefit Manual Chapter 9, Compliance Program Guidelines section 50.4.2 Communication and Reporting Mechanisms.

CVS Health must require our FDRs to report compliance concerns, as well as suspected or actual violations related to the Medicare program, to us. CVS Health has included this requirement in our FDR Medicare contracts and addendums, and our FDR training packet and compliance attestations. We also evaluate compliance with this requirement as part of Compliance Program Effectiveness (CPE) oversight reviews.

Refer to the **First Tier, Downstream and Related Entities (FDR) guide** for more details.

There are a number of ways to report suspected or detected noncompliance or potential FWA.

- CVS Health Ethics Line:
  1-877-287-2040 (1-877-287-2040) (TTY: 711)
- CVS Health Online Ethics Line:
  CVSHealth.com/EthicsLine
- Write us: Chief Compliance Officer, CVS Health
  One CVS Drive, Woonsocket, RI 02895

Quick links

- Medicare managed care manual
- Medicare prescription drug benefit manual
- CVS Health Code of Conduct (updated March 2023)

Exclusion list links:

- OIG list of excluded individuals and entities (LEIE)
- GSA System for Award Management (SAM)

Links not working? Go to **SAM.gov/SAM/** to access the site directly.

We have a robust Medicare Compliance program, including communication with our Medicare FDRs. Our Medicare Compliance Officer is Patrick Jeswald. Questions or concerns? Email **MedicareFDR@Aetna.com**.

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Document retention requirements

CVS Health® requires our FDRs to keep documentation related to the Medicare services your organization performs on our behalf for at least ten (10) years. This includes documentation related, but not limited, to:

- Training records
- Office of Inspector General/General Services Administration (OIG/GSA) screenings
- Policies and Standards of Conduct, including records of updates and distribution
- Conflict of interests
- Reports of and responses to suspected non-compliance and/or fraud, waste, or abuse
- Human Resources records, including disciplinary actions
- Auditing and monitoring
- Downstream Oversight activities
- Corrective actions taken

Your organization needs to have a policy in place that outlines your organization's document retention policy and process, and that your organization regularly self-reviews to ensure that employees understand your policy.

CMS 2024 Medicare Advantage (MA) and Part D "Final Rule" translation requirements

On April 5, 2023, CMS issued the annual Medicare Advantage (MA) and Part D final rule outlining new regulatory policies for plan year 2024. Provisions of this rule were effective June 5, 2023, for the 2024 plan year unless otherwise noted within the rule.

The Final Rule revised regulations for translated materials and accessible formats. CVS Health will need to comply for 2024 plan year materials, beginning September 30, 2023.

Standing translation requirements: CVS Health must provide materials on **a standing basis** in any non-English language that is the primary language of 5% of the individuals in a service area, and in any accessible formats upon request or learning of the enrollee's preferred language or need for accessible format.

Applicable materials: The requirement applies to **all 2024 plan year required materials** described at § 422.2267(e) and Individualized Care Plans (ICPs). It doesn't extend to other supplemental documents such as health education materials. CMS expects the tracking and use of standing requests to begin with requests received from enrollees in connection with materials for coverage in 2024. CVS Health must provide materials in the enrollee's preferred format as long as the enrollee remains in the plan or until they request materials in a different manner. ID cards have been excluded from new translation requirements.

Special Needs Plans (SNP) applicability: CMS is applying the **same translation standards** for SNPs, though an individual State may impose higher or more stringent requirements.

Meaningful access to individuals with Late Enrollment Penalty (LEP) and disabilities: These new translation requirements are **in addition** to requirements to provide meaningful access to individuals with LEP and effective communication for individuals with disabilities. Where one set of regulations has a higher or different standard, CVS Health must comply with both.

CVS Health® is actively reviewing all the changes in this final rule. You'll **hear from us** if we need

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your organization to implement changes for the services performed for our organization.

Exclusion and preclusion lists

CVS Health® is subject to both exclusion and preclusion list screening requirements for Medicare plans. CMS requires that we screen against the below lists at least monthly.

Office of Inspector General List of Excluded Individuals/Entities (OIG LEIE) include the individuals and entities currently excluded from participation in the Medicare, Medicaid or other federally funded health care program.

General Services Administration System for Award Management (GSA SAM) List includes parties who have been excluded from receiving federal contracts, certain subcontracts, and federal financial and non-financial assistance and benefits**.**

CMS Preclusion List includes providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

The preclusion list and exclusion files do have some overlap. Excluded providers will be on the preclusion list. But precluded providers who are not excluded will not be on the exclusion file. Therefore, if CVS Health identifies a provider on the OIG LEIE, we must also check the Preclusion List.

We must deny payment for a health care item or service provided by an individual or entity on one of the Exclusion and/or Preclusion Lists. In addition, we must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on one of these lists.

If CVS Health determines that payments were made to excluded or precluded providers for Medicare services, we must **attempt to recoup** any recoverable payments.

As our FDR, you have an obligation to **review these lists**, as they relate to the Medicare services your organization performs on our behalf and take the needed actions to ensure that **only eligible providers receive payments** for Medicare services following Medicare payment rules. If you a find positive match during monthly exclusion screening, you must **disclose your finding** to CVS Health and/or Aetna.

Looking for resources?

Our relationship with you — a first tier, downstream or related entity (FDR) — is important to us. We need you to help fulfill our contracts with the CMS. And you can rely on us for the teamwork and support you need.

You can read **our Aetna FDR Guide**; it includes a toolbox of resources. In addition, archived newsletters are available online. If you would like the CVS Health FDR Guidebook, a past newsletter, or have additional questions, you can email us at **MedicareFDR@Aetna.com**.

Need to report noncompliance or potential fraud, waste, and abuse (FWA)?
We have a number of ways for you to report suspected or detected noncompliance or potential FWA.

- CVS Health Ethics Line: **1-877-287-2040 (1-877-287-2040) (TTY: 711)**
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