CVSHealth

Medicare Compliance FDR newsletter

Quarter 3, 2024

Medicare Parts C and D regulatory communications

The Centers for Medicare & Medicaid Services (CMS) routinely sends out communications, sometimes referred to as HPMS memos, on the Medicare Advantage (MA) and Part D Programs. If you're interested, you may request to subscribe to their HPMS Listserv supplemental mailing list.

A few HPMS memos from over the summer that we'd like to highlight include:

- On July 22, 2024, CMS published the 2023 Part C and Part D Program Audit and Enforcement Report. The report summarizes results and tips from the 2023 Part C and Part D program audits conducted, as well as the issues that resulted in enforcement actions. The agency shares this information to encourage improvement in industry performance.
- On July 19, 2024, CMS published updated Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Chapter Guidance (effective July 19, 2024).

As a CVS Health® First Tier, Downstream, and Related Entities (FDR), your organization performs an important role in compliantly executing functions on our behalf. We have highlighted areas of focus along with some we've we have found helpful as an organization to enhance compliance program effectiveness.

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Quick links

- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **CVS Health Code of Conduct (updated March 2024)**

Exclusion list links:

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

Link 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**

Compliance program effectiveness
A strong compliance program is the foundation. CMS emphasizes that all FDRs must have a compliance program that meets CMS requirements and actively identifies and mitigates risks.

- Leadership and accountability: Ensure that your compliance officer and committee are engaged and take accountability for CMS regulatory requirements. They should drive regular compliance reviews and lead staff training efforts.
- Risk assessments: Conduct regular risk assessments to find potential gaps in compliance. Complete routine monitoring and audits of your internal processes to ensure you meet standards.
- Employee training: Employees involved in Medicare-related operations must be regularly trained on current CMS requirements.

Part D coverage determinations, appeals and grievances
CMS closely scrutinizes timely and accurate handling of these processes ensure that beneficiaries receive the coverage they need while meeting CMS's strict deadlines.

- Response timeliness: Ensure all coverage determinations and appeals are processed within CMS's required timeframes. Delays or failures to process these in a timely manner could result in non-compliance penalties.
- Proper documentation: Maintain thorough documentation for each case, detailing the reasoning behind determinations and appeal decisions. This will be essential during any audits or reviews by CMS.
- Grievance tracking: Review grievances regularly to identify patterns that could indicate systemic issues. Proactively addressing these can reduce compliance risks and improve beneficiary satisfaction.

Part C organization determinations, appeals and grievances
Organization determinations and the subsequent appeal and grievance processes are critical to beneficiary satisfaction and regulatory compliance. CMS expects plans to resolve coverage disputes efficiently and fairly.

- Accurate decision-Making: Ensure that organization determinations are made with a clear understanding of CMS requirements and communicated clearly to beneficiaries.
- Appeals procedures: Implement and regularly review your appeals procedures to ensure beneficiaries have adequate access to appeal coverage decisions. Appeals must be resolved within CMS-specified timeframes.
- Grievance management: Monitor and document all grievances to track trends and take corrective actions where necessary. This helps prevent recurring issues and shows a proactive approach to compliance.

Medicare Advantage and Part D 2025 final rule

The Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2025 Medicare Advantage (MA) and Part D programs on April 5, 2024. Areas of focus include Dual Special Needs Plans (D-SNPs), new standards for supplemental benefits for the chronically ill (SSBCI) and a new mid-year enrollee notification of available supplemental benefits.

Enhanced care coordination requirements
CMS has introduced stricter care coordination requirements for D-SNPs, focusing on improving the integration of Medicare and Medicaid benefits for dual-eligible beneficiaries. Under the new rule, D-SNPs must show that they offer enhanced, coordinated care that aligns with Medicare and Medicaid policies.

Unified grievance and appeals process
D-SNPs must implement a streamlined grievance and appeal process that aligns with Medicare and Medicaid standards. This will reduce beneficiaries' confusion and improve the overall experience.

New standards for SSBCI supplemental benefits
Changes are intended to provide more comprehensive and responsive care for Medicare beneficiaries, especially those facing the challenges of chronic illness. The expansion and flexibility of SSBCI supplemental benefits is designed to address the non-medical needs of individuals managing chronic conditions.

Key changes include:
- Broader eligibility for SSBCI: Expands the eligibility criteria, enabling more beneficiaries to qualify for supplemental benefits. This change recognizes chronic conditions' diverse and complex nature, allowing plans to offer a more comprehensive support services, such as transportation, in-home support and meal delivery.
- Tailored benefit design: Greater flexibility to personalize supplemental benefits based on individual enrollee needs. By offering services that address specific health-related challenges, plans can better support beneficiaries in managing their conditions while improving overall health outcomes.
- Support for caregivers: Allows plans to include caregiver support benefits. This addition acknowledges the essential role that family members and other caregivers play in managing chronic conditions, providing respite care and other resources to help ease the burden.

Mid-year enrollee notification of available supplemental benefits
Medicare Advantage (MA) organizations will be required to notify enrollees of newly available supplemental benefits mid-year. This requirement emphasizes the importance of ensuring enrollees are informed about how they can fully take advantage of their plan's offerings throughout the year, even after the plan year has begun.

Key changes included:
- Timely and clear communication: Plans will notify enrollees mid-year about any supplemental benefits that become available or are expanded. This ensures that beneficiaries, particularly those with chronic conditions, don't miss out on valuable services that could improve their care or quality of life.
- Focus on chronic condition management: For chronically ill enrollees, timely notification of SSBCI benefits is especially crucial. The mid-year updates will inform beneficiaries about newly available services, such as meal delivery, home-based care, transportation or other non-medical benefits directly impacting their ability to manage their chronic conditions.
- Improved access to benefits: Mid-year notifications seek to empower enrollees to take full advantage of the benefits provided by their MA plan. By keeping beneficiaries informed, it ensures that the services designed to support their health and well-being are utilized, resulting in better care management and improved health outcomes.

CVS Health® is actively reviewing all the changes in this final rule. You'll hear from us if we need your organization to implement any changes for the services you perform for our organization.

Medicare contract addendums

Two common questions we sometimes receive from our FDRs are:

Does my organization have a contractual obligation to meet Medicare requirements?

Can CVS Health® and/or Aetna® audit my organization for the services we're contracted for?

The answer is "yes."

When an FDR contracts with CVS Health and/or Aetna to perform administrative or health care services related to Medicare, a regulatory addendum/amendment is part of your contract. It details the compliance obligations.

It also addresses key topics, such as:
- Exclusion screening duties
- Compliance program requirements
- Record retention obligations
- Audit participation requirements
- Delegated entity oversight
- corrective action plan
- code of conduct standards

Not familiar with your organization's Medicare Addendum? Now is a good time to reacquaint yourself with it.

Looking for resources and want test your compliance knowledge?

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 CMS. And you can rely on us for the teamwork and support you need.

Read our **FDR Guide**; it includes a toolbox of resources. You can also find archived newsletters **Provider Newsletter Archive (aetna.com)**

Need to report noncompliance or potential fraud, waste and abuse (FWA)?
Here are the different ways to report:
- **Call** the CVS Health Ethics Line at **1-877-287-2040 (TTY: 711)**
- **Visit CVShealth.com/ethicsline**
- **Write to** Chief Compliance Officer, CVS Health, One CVS Drive, Woonsocket, RI 02895

Compliance crossword

P	D	E	T	E	C	T	I	O	N	U	L	H
Q	O	U	E	T	O	M	O	N	I	T	O	R
G	A	S	T	A	M	B	I	O	E	H	B	E
N	F	S	A	D	P	Q	N	I	T	G	J	G
I	R	I	G	I	L	W	T	T	A	I	V	U
T	H	U	E	L	I	Z	E	N	C	S	K	L
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C	E	I	L	T	R	O	N	U	M	Q	O	H
T	K	V	U	E	E	T	T	I	M	M	O	C

Correction	Committee	Interview
Prevention	Oversight	Visualize
Code of Conduct	Issue	Policies
Auditing	Delegate	Regulations
Monitor	Communicate	Detection
Compliance Officer	Screen	Contract
Test	Validate	