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FDR Compliance Newsletter

January 2016 – Issue 8

Audit protocols

The Centers for Medicare & Medicaid Services (CMS) performs regular program audits on plan sponsors like Aetna, that offer Medicare Part C and D plans. These audits ensure that we deliver benefits according to the terms of our contract. They also confirm that we evaluate compliance with core program requirements.

Audit protocols

On October 20, CMS released their 2015 and 2016 audit protocols. The protocols don't describe how CMS does the audit step-by-step. They include a description of:

- The audit purpose and process
- Data preparation and submission
- Sample selections
- Elements that CMS reviews

How we measure your performance

The 2016 audit protocols measure performance in the following areas:

- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals and Grievances
- Special Need Plans – Model of Care (SNP-MOC)

In this issue

Quick links

- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **Office of Inspector General (OIG) exclusion list**
- **General Services Administration exclusion list**
- **Aetna's Code of Conduct**
- **CMS' General Compliance Training**
- **CMS' FWA Training**
  - **As of 1/1/2016, FDRs must use CMS training to meet general compliance and FWA training requirements.**

*Aetna maintains a comprehensive Medicare Compliance Program. It includes communication with Aetna Medicare FDRs. Dedicated to Aetna's Medicare Compliance Program is John Wells, Medicare Compliance Officer. He's based in Maryland. You can send questions or concerns for John and/or his Medicare compliance subject matter experts to **MedicareFDR@aetna.com**.*

- Part C and Part D Compliance Program Effectiveness

CMS will launch protocols on provider network adequacy and medication therapy management. These are pilot protocols and haven't been released yet.

Review the protocols

The protocols help us monitor, audit and oversee our Medicare operations. They may also help you do the same.

You can download the 2016 Audit Protocols, including information on any updates or changes to them, on the CMS website.

What is an FDR

First Tiers, Downstream and Related

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or Applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a 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.

Related Entity means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

Performs some of the Medicare Advantage Organization or Part D plan Sponsor's management functions under contract or delegation; or

Furnishes services to Medicare enrollees under an oral or written agreement; or

Leases real property or sells materials to the Medicare Advantage Organization or Part D plan Sponsor at a cost of more than $2,500 during a contract period.

Standards for Business Continuity Plans

The Centers for Medicare & Medicaid Services (CMS) issued a **Final Rule (**42 CFR §§422.504(o) and §423.505(p)) that sets minimum standards for Business Continuity Plans effective 1/1/2016.

We must ensure our FDRs develop, implement and maintain Business Continuity Plans that meet certain minimum standards.

Minimum Requirements

Business Continuity Plans must contain policies and procedures to protect the restoration of business operations following disruptions where business is not able to occur under normal conditions.

Minimum Business Continuity Plan requirements include:

- Completion of a risk assessment
- Documented mitigation strategy
- Annual testing, revision and training
- Record keeping
- Identification of essential functions
- Chain of command
- Business communication plans

Essential functions

Business Continuity Plans need to address the restoration of identified **essential functions** within 72 hours of failure, as well as address CMS's minimum requirements.

Aetna has defined **essential functions** to include, at a minimum:

- Benefit authorization (if not waived) for services to be immediately furnished at a hospital, clinic, provider office, or other place of service.

- Benefit authorization (if not waived), adjudication, and processing of prescription drug claims at the point of sale.
- Administration and tracking of enrollees' drug benefits in real time, including automated coordination of benefits with other payers.
- Operation of an enrollee exceptions and appeals process including Coverage Determinations
- Operation of call center customer service, including translation services and pharmacy technical assistance
- Production and mailing of essential documents including Aetna's Annual Notice of Change , Evidence of Coverage, Low Income Subsidy Rider, Multi-Language Insert, ID Cards, enrollment/disenrollment letters, formulary guides and enrollee transition supply letters.
- Support of any of the following activities: Medicare appeals, pre-service organization determinations, coverage determinations, utilization management and Medicare websites.

If you have questions, just let us know by sending an email to MedicareFDR@aetna.com.

Aetna approved materials

We need your help to ensure Aetna materials are used as they were approved. Some materials are approved by CMS and cannot be modified. In addition, we like to ensure Aetna materials sound and look similar.

If you have questions about whether or not the Aetna materials you use can be changed, contact your relationship manager.

Our brand voice

We like all Aetna materials to sound like they are coming from the same company. We do this by following brand voice and guidelines. By speaking and writing in our brand voice, people see us as a company that cares about them.

Our brand voice is:

- **Clear**: we write and speak in simple, direct language that's easy to understand
- **Genuine**: we're honest – we mean what we say and we say what we mean
- **Optimistic**: we're friendly, helpful and encouraging
- **Purposeful**: we're focused on helping people make the most of their health care benefits, especially during their toughest moments

What can you modify

No matter how small the change, you shouldn't modify an Aetna approved material. This includes font sizes. It may be tempting to change a font size to make the material fit onto a page. But it may be against our guidelines. And sometimes CMS requires we use certain font sizes.

Before you modify a material, contact your relationship manager for approval.

Report to Aetna actual or potential fraud, waste and abuse OR non-compliance:

FDRs can have their own internal processes in place for reporting, however, instances which impact Aetna's Medicare business should be reported back to us by using one of the methods below:

By phone:
1-888-891-8910
(7 days a week, 24 hours a day)

Over the internet:
https://aetna.alertline.com

By mail:
Corporate Compliance
P.O. Box 370205
West Hartford, CT 06137-0205