

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions



FDR Compliance Newsletter

January 2018 – Issue 16

What is “Deemed”?

For FDR requirements, it means that FDRs (and/or their applicable employees) don't need to complete the CMS *Combating Medicare Parts C & D Fraud Waste and Abuse (FWA)* training. This doesn't exempt the FDR from completing the *CMS Medicare Parts C and D General Compliance* training.

An FDR may be deemed. But their downstream entities might not be deemed. It's still necessary to monitor and oversee compliance for downstream entities.

How do I know if I'm deemed?

FDRs (and/or their applicable employees) are deemed if they are enrolled in Medicare Parts A or B of the Medicare program or through accreditation as a supplier of Durable Medical, Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

What documentation do I need to keep if our organization or if our employees are deemed?

You don't need any more documents. To establish that an employee or FDR is deemed, you just need the documentation necessary for proper credentialing.

In this issue

- What is “Deemed”?
- Scope of Appointment Regulations
- Balance Billing of Qualified Medicare Beneficiary individuals is prohibited
- Member ID Card Update

Quick links

- [Archived newsletters](#)
- [Aetna's FDR Guide](#) (updated 3/2017)
- [Medicare Managed Care Manual](#)
- [Medicare Prescription Drug Benefit Manual](#)
- [Aetna's Code of Conduct](#) (updated 12/2016)
- [CMS's General Compliance Training](#)
- [CMS's FWA Training](#)
- **Exclusion lists:**
 - [OIG's List of Excluded Individuals and Entities \(LEIE\)](#)
 - [GSA's System for Award Management \(SAM\)](#)

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 to John and/or his Medicare compliance subject matter experts to MedicareFDR@aetna.com.

Scope of Appointment (SOA) regulations

The Centers for Medicare & Medicaid Services (CMS) released their updated Medicare Marketing Guidelines (MMG) on July 20, 2017.

One notable change affects the SOA guidelines. The SOA is a document that confirms the beneficiary's consent to a sales appointment with an agent. It also lists the specific products that they'll discuss.

Did you know that as of October 1, 2017, you don't need to get the SOA 48 hours in advance? This is because CMS updated their guidelines on the SOA. We've updated our policies to align with the changes in the MMG, including those focusing on SOA requirements. The timing has been updated. But MA and Part D plans, and their First Tier agents, must still get an SOA before discussing plan options and benefits.

Agents must also continue to track their SOAs. They can do this through a written signed agreement with the beneficiary, or a recorded oral agreement. According to section 70.4.3 of the MMG, "...must document the scope of appointment *prior* to the appointment."

This means as an agent, your documentation must show that you completed the SOA documentation before you set up the appointment with the beneficiary. What if the SOA and the appointment happen on the same day? Then agents should record the actual times the SOA and appointment took place.

Balance billing of qualified Medicare beneficiary individuals is prohibited

The Qualified Medicare Beneficiary (QMB) program is a Medicaid program for Medicare beneficiaries. It exempts them from being charged for Medicare cost sharing.

State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But, federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers **must** accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions.

Clarifications about balance billing

Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements:

- All Original Medicare and Medicare Advantage providers — not just those that accept Medicaid — must abide by the balance billing prohibitions.

QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can't charge QMB individuals even if the patient's QMB benefit is provided by a state that's different from the one where care is rendered.

More information

Visit CMS' [Medicare-Medicaid General Information](#) website. You'll learn more about dual eligible categories and benefits. You'll also get information on the QMB program and on other individuals dually eligible for Medicare and Medicaid benefits.



What is an FDR

First tier, downstream and related entities

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. They agree to provide administrative 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. And this party is 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

Visit the Medicare Learning Network® publication SE1128 "[Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary \(QMB\) Program.](#)" You'll learn about the prohibition on billing dually eligible individuals enrolled in the QMB program.

Member ID card update

Between April 2018 and April 2019, CMS will remove Social Security numbers from Medicare cards. They'll mail each person a new red, white, and blue Medicare card. The new card will include a new, unique Medicare number but it won't change a Medicare member's coverage or benefits. When Medicare members get their new card, they should destroy their old card. They can start using the new card right away.

This change is only to the CMS-issued red, white, and blue Medicare card. The current Aetna ID card will remain the same. Medicare members should use their current Aetna ID when they go to the doctor.

They don't need to do anything to get a new card. But their mailing address needs to be up to date with CMS. To correct their mailing address, they can visit www.ssa.gov/myaccount or call **1-800-772-1213 (TTY: 1-800-325-0778)**.

Medicare members should be careful and not give their info to anyone who contacts them about their new Medicare card. Medicare will never ask you to give us personal or private information to get a new Medicare number and card.

You can find more information on the [CMS website](#).

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