Medicare Compliance FDR newsletter

Quarter 4, 2025

Code of conduct

CVS Health® is committed to standards of conduct and/or compliance policies and procedures that reflect our commitment to conduct business based on the highest ethical standards and in strict compliance with applicable federal and state laws and regulations.

We recently updated the **CVS Health Code of Conduct (Code).** The Code is intended to help resolve ethical and compliance issues by providing the information, tools, and resources necessary to make good decisions. It also includes information on how to report issues or concerns. We encourage you to review it.

You can always find our Code of Conduct online.

2026 Medicare plan finder provider directory

On September 18, Centers for Medicare & Medicaid Services (CMS) issued a second Final Rule for Contract Year (CY) 2026 that addresses remaining Medicare Advantage (MA) and Part D policy updates that were not finalized in the April release. This new rule focuses specifically on provider directory requirements for Medicare Plan Finder (MPF).

At CVS Health®, we know strong partnerships are built on trust, accountability, and a shared commitment to compliance. We are providing these details to help us stay aligned and to prepare for us to comply with these requirements.

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Looking for resources?

Quick links

- **Medicare Managed Care Manual**
- **Medicare Prescription Drug Benefit Manual**
- **CVS Health Code of Conduct (updated November 2025)**

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.

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Key provisions included in the 2026.2 Final Rule

- **Medicare Advantage Organizations** (MAOs) must submit their provider directory data directly to CMS for display on Medicare Plan Finder (MPF).
- Submitted data must follow CMS-established formatting requirements.
- Directory data must include provider names, addresses, phone numbers, specialties, and the number and mix of pharmacies in the network.
- Plans must update MPF within 30 calendar days of when they become aware of changes.
- Authorized officials of the MAO must complete an annual attestation electronically via HPMS confirming the provider directory data is accurate.

CMS did not finalize the proposal requiring plans to attest that their directory data aligns with network adequacy standards.

Phase one: In advance of this Final Rule, CMS issued sub-regulatory guidance, where CMS strongly encouraged MAOs to supply their provider data to their contractor, SunFire Matrix, Inc. for display on MPF in time for CY 2026 Annual Enrollment.

Phase two: For CY 2027, MPF will display in-network provider and facility data from publicly accessible provider directory APIs built and maintained by Medicare Advantage (MA) plans.

Phase three: CMS announced plans to develop a National Provider Directory. This directory is intended to connect healthcare providers, payers, data networks, and their related interoperability frameworks. Once fully implemented, the MPF National Provider Directory will use MA Plan provided FHIR-based APIs to display data.

Why is it important?
Improving provider directory data makes it easier for Medicare beneficiaries to use MPF and find doctors and hospitals that are in-network. It also helps keep information consistent across different plans, so people see accurate details. By making provider data more transparent, CMS builds trust and makes things clearer for users. Finally, this change allows provider information to be shared more smoothly across CMS systems, which makes the process faster and simpler.

What's Next?
In November 2025, CMS shared a draft technical implementation guide and asked for feedback on the steps, timelines, and testing plans for Phase two. After reviewing industry comments, CMS will finalize the guidance in January 2026. These requirements are targeted to be in place for CY 2027 Annual Enrollment.

As CMS continues to update provider directory standards, working closely with our **First tier, Downstream or Related entity (FDRs)** partners is key. Staying informed and sending us accurate data on time will help CVS Health stay compliant and ready for the 2026 changes.

Fraud, waste and abuse (FWA)

As our FDR it's important that you understand what is considered fraud, waste, and abuse and the differences among them. One of the primary distinctions is intent and knowledge. **Fraud** requires intent to obtain payment and knowledge that the actions are wrong. **Waste** and **Abuse** may involve obtaining an improper payment or creating unnecessary costs to the Medicare program, but they do not require the same level of intent or knowledge.

Fraud
Fraud means trying to cheat a health care program on purpose. It includes giving false information or making false promises to get money or property from a health care program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a

scheme to defraud a health care benefit program.

Penalties for a standard health care fraud conviction may include:

- Imprisonment for up to 10 years and
- Criminal fines of up to $250,000

In simple terms, fraud means giving false information to the government or a government contractor on purpose to get money or some other benefit.

Examples of fraud

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Waste

Waste means using resources in a way that causes unnecessary costs to the Medicare Program, like overusing services. Waste usually isn't caused by criminal actions but happens when resources are misused.

Examples of waste

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests

Abuse

Abuse means actions that lead to unnecessary costs to the Medicare Program. It happens when Medicare pays for items or services that shouldn't be covered, even though the provider didn't knowingly or intentionally give false information to get paid.

Examples of abuse

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Understanding FWA Laws

To spot FWA, you need to know the law. The links below give information about the key laws you should know:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law)
- Exclusion from all Federal health care programs
- Health Insurance Portability and Accountability Act (HIPAA)

If you have a concern about compliance, fraud, waste or abuse you can report it by calling our Ethics Line at 1-877 CVS-2040 (TTY: 711). The Ethics Line is available 24 hours a day, 7 days a week, all year long. Your call will be kept confidential, and you do not have to give your name. CVS Health does not allow retaliation against anyone who raises a concern in good faith or helps with an investigation.

For more information related to FWA, review the combined Compliance Program Guidelines, Chapters 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual on the Centers for Medicare & Medicaid Services (CMS) website CMS.gov.

Thank you for your ongoing partnership and commitment to compliance. Together, we help ensure the Medicare program operates responsibly and in the best interest of the beneficiaries we serve.

2026 Program audit updates

CMS recently announced updates that will impact 2026 Medicare Part C and Part D Program Audits. These updates include removal

of audit scoring, redefining condition classifications, and introducing a Compliance Program Effectiveness (CPE) pilot.

Audit Protocols
CMS will continue to use the Final Audit Protocols for the Medicare Part C and Part D Program Audits and Industry-Wide Part C Timeliness Monitoring Project (CMS-10717) for the 2026 audit year. The protocols and supporting materials remain available on the CMS Program Audit **website.**

Audit Scoring and Redefining Condition Classifications
CMS will no longer assign point values to audit findings as they determined that audit scoring did not fully reflect overall performance.

They are also redefining condition classifications and removing the Immediate Corrective Action Required (ICAR) and Observation Requiring Corrective Action (ORCA) classifications.

The following condition types will apply when noncompliance is identified:

- **Observation:** A finding that does not require a corrective action plan. Plan sponsors are encouraged to monitor these findings to maintain compliance.
- **Corrective Action Required (CAR):** A finding that requires action to strengthen controls, prevent future issues, or address enrollee impact.
- **Invalid Data Submission (IDS):** A finding used when a plan sponsor does not provide complete or accurate data or documentation.

Evaluating Compliance Program Effectiveness
CMS will be piloting a new approach to evaluating CPE by integrating compliance discussions into the operational audits. During audit fieldwork, CMS will discuss how compliance practices support daily operations, identify root causes of issues, and prevent problems from happening again. Information from the Compliance Oversight Activities universe will continue to support this evaluation. This approach focuses on how the compliance program helps prevent, detect, and correct noncompliance related to audited areas.

Quarterly Compliance Calls
CMS will begin hosting quarterly educational compliance calls with industry compliance officers. These calls will focus on topics related to audit-related issues and will provide an opportunity to discuss best practices and compliance expectations.

Independent Validation Audit Requirements
Simple corrections will not require a validation audit. CMS will confirm these through a webinar or documentation review after the corrective action plan is implemented. Complex findings will still need full validation audits and will be flagged in the audit report. Sponsors with more than five such findings must hire an independent auditor. This change reduces the need for independent auditors and limits audits to findings that require testing.

General Audit Updates

- Engagement letters to be sent February through August 2026.
- Audit fieldwork will continue to take place over a two-week period.
- Part C audits will continue reviewing utilization management requirements to ensure timely access to medically necessary services.
- CMS will continue suspending collection of certain Formulary Administration and Prescription Drug Event data tables.

CMS has additional tools to support audit readiness, including:

- A User Group Resource Document
- An Audit Submission Checklist
- Formulary Administration Validation training materials

If you have any questions, please reach out to us at **MedicareFDR@Aetna.com**

Test your compliance IQ!

R I E F C W F W P T G F Q K L

M K E N F O R C E M E N T W K

Z G M T O Z Z C K Z I G Z T K

E Y H G U P O E Q E S D I Y Y

J F V R F Q Y I K A K G J G Q

A U D I T I N G T O R I N G A

Z G N P L I K B V P S I X Q T

Z C N O J G N F Q Z S E S K Q

N V U R X L Y V O K E X R Z O

T G C T Q T W P Q F S M H F J

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C G C U L T U R E C E A C F H

Z P Z U P Y N B A V N O D V E

H N B B Y T Z I P L T T Z X U

Word Bank:

- ☐ Risk Assessment
- ☐ Monitoring
- ☐ Training
- ☐ Reporting
- ☐ Enforcement
- ☐ Policies
- ☐ Auditing
- ☐ Culture

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

Read our **Aetna® FDR Guide**; it includes a toolbox of resources. If you need the **CVS Health FDR Guide**, contact us.

Past newsletters are available on **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

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