# First-tier, downstream and related entities (FDRs) and model of care — Frequently asked questions

Visit the **Medicare compliance and attestation** training page to access all training documentation.

## I. FDR compliance requirements

### 1. What is our Aetna® Medicare Compliance Program?

Participating providers in our Medicare Advantage (MA), Dual Eligible (D-SNP) or Fully Integrated (FIDE) Special Needs Plans (SNPs) are required to meet the Centers for Medicare & Medicaid Services (CMS) compliance program requirements for first-tier, downstream and related entities (FDR) as identified in the **FDR Medicare Compliance Guide** and/or **Special Needs Plans (SNP) Training**.

The applicable Aetna Medicare Advantage plans include:

- HMO
- PPO
- Dual Eligible Special Need Plan (D-SNP)
- Highly Integrated Dual Eligible Special Needs Plans (HIDE)
- Fully Integrated Dual Eligible Special Needs Plans (FIDE)
- Institutional Special Need Plans (I-SNPs)
- Chronic Condition Special Needs Plans (C-SNPs)

**Annual training notice:**
CMS requires Aetna to conduct annual training for its FDRs. The annual notice and online attestation process is used to meet this requirement. Providers will receive annual training notifications via:

- Adobe Acrobat Sign email (if we have compliance email on file)
- Postcard
- OfficeLink Updates™ newsletter – quarterly reminders via emailed newsletter

All MA FDRs are required to review the **FDR Medicare Compliance Guide** and/or **Special Needs Plans (SNP) Trainings** and complete an attestation.

### 2. What does the FDR acronym mean?

FDR stands for first-tier, downstream and related entities. If you are contracted or perform administrative or health care services on behalf of Aetna Medicare business, then you are an FDR.

**Examples of FDRs include:**

- Physicians, hospitals and other ancillary provider types contracted to provide services to our Medicare Advantage plan members
- Sales partners/agents that are contracted to market and sell our Medicare products
- Vendors providing administrative services for our Medicare members/products
- Delegates contracted to make decisions on our behalf for our Medicare members/products

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**The Centers for Medicare & Medicaid Services (CMS) defines FDRs as:**

• **First-tier entity** — Any party that enters a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage (MA) program or Part D program.
• **Downstream Entity** — Any party that enters into a written agreement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These arrangements continue down to the level of the ultimate provider of both health and administrative services.
• **Related Entity** — This refers to any entity that is related to an MAO or Part D Sponsor by common ownership or control and:

1. Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation.
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

**3. What Aetna® products/plans and providers do these requirements apply to?**

We offer Medicare Advantage (Part C) and prescription drug (Part D) coverage to Medicare members. These requirements apply to all entities that participate in:

- Medicare Advantage (MA) plans, Special Needs Plans (SNP). SNPs include:
  - Dual Eligible SNP (D-SNP)
  - Highly Integrated Dual Eligible SNP (HIDE)
  - Fully Integrated Dual Eligible SNP (FIDE)
  - Institutional SNP (I-SNP)
  - Chronic Condition SNP (C-SNP)
- Medicare Prescription Drug Plans (MAPD)
- Prescription Drug Plans (PDP)

Learn more about **Aetna Medicare Advantage plans.**

**4. I am a provider for Original Medicare (Parts A or B). Do these requirements apply to me?**
If you are a provider that accepts Original Medicare (Part A or Part B) AND contracts with us to provide services to our Medicare members (including our Medicare-Medicaid members), then these requirements apply to you. This includes, but is not limited to, if you are contracted to provide administrative or health care services to our Medicare members. If you are unsure of your contracting status with us, please refer to the "Contact Us" section later in this document to assist with your contracting status.

**5. Am I still required to meet these compliance requirements if I do not accept Medicare Advantage plan members?**
Yes. If your organization provides services that impact our Medicare plans, you are required to meet these requirements. For provider organizations, if your organization participates in one or more of our MA or SNP plans, these requirements apply to your organization even if you do not see members in these plans.

**6. Our organization received an attestation to complete; is this the same attestation as the Council for Affordable Quality Healthcare (CAQH) attestation?**
This request for an attestation is not related to the CAQH attestation. This attestation confirms you are meeting the Medicare Compliance Program and/or SNP Model of Care (MOC) requirements as identified in our **FDR Medicare Compliance Guide** and **MOC Training**.

**7. What is the source of these requirements?**

These regulatory requirements are from CMS. They are described within the **Medicare Managed Care Manual, Chapter 21—Compliance Program Guidelines, and the Prescription Drug Benefit Manual, Chapter 9—Compliance Program Guidelines** updated by the **CY 2015 Final Rule CMS-4159-F, published May 23, 2014.**

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**8. Are the requirements new?**
No, these requirements are not new. You should have received a similar notice about these requirements in previous years. There have been changes to these requirements since they were implemented. If you are not familiar with the requirements, just review the **FDR Medicare Compliance Guide**.

**9. Our organization is not complying with all the Medicare compliance requirements. Who do we report this to? Will we be terminated?**
We will partner with you to resolve any compliance issue. You will be given training and education on the requirement(s), and we will make sure that you develop a comprehensive corrective action plan (CAP). We will ask you to provide a written CAP that addresses the issue and outlines when actions will be completed. If you refuse to comply or fail to implement your CAP, there could be ramifications, up to and including contract termination.

**10. I do not have any employees (solo practitioner) and/or I do not see Medicare patients, do I have to complete an attestation?**
Yes, if you received an attestation completion request, it must be completed even if you have no employees or have not seen Medicare Advantage patients.

**11. What documentation must I keep?**
You must have documentation to show you are compliant with each requirement. Examples include policies and procedures, training logs, and attestations. You're required to keep this documentation for no less than 10 years.

**12. Who do I contact if I have more questions?**
If you have any questions about the Medicare compliance requirements that are not addressed in the FDR Medicare Compliance Guide, please refer to the "Contact Us" section of this document.

**Ready to learn more? View our FDR Medicare Compliance Guide**

## II. Standards of Conduct

**1. What are Standards of Conduct?**
Standards of Conduct are also known in some organizations as the "Code of Conduct." The overarching principles and values by which the company operates and define the framework for the compliance program.

**2. How often must the Standards of Conduct be distributed?**
Your Standards of Conduct and/or compliance policies must be distributed to employees:

1. Within 90 days of hiring,
2. Each calendar year, and
3. When changes are made

If you do not have your own Standards of Conduct and compliance policies, you can distribute our **CVS Health Code of Conduct.**

Aetna® is a CVS Health® company and complies with the Medicare Compliance Policies that describe how our Compliance Program operates.

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**3. Can I use my own Standards of Conduct?** Yes, you can use your own Standards of Conduct and compliance policies. They must contain the elements set forth in Section 50.1 and its subsections of Chapter 9 of the Prescription Drug Benefit Manual. They must also articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations.

If you don't have your own Standards of Conduct and compliance policies, you can use ours. Aetna® is a CVS Health® company and complies with the **CVS Health Code of Conduct**. We also have Medicare compliance policies that describes how our Compliance Program operates.

## III. Reporting mechanisms

### 1. What is fraud, waste and abuse (FWA)?

**Fraud:** Intentional misuse of information to persuade another to part with something of value or to surrender a legal right. It could also be an act of planned deception or misrepresentation.
**Waste:** To use, consume, spend or expend thoughtlessly or carelessly.
**Abuse**: Providing information or documentation for a health care claim in a manner that improperly uses program resources for personal gain or benefit, yet without enough evidence to prove criminal intent.

**Medicare fraud and abuse laws:** Federal laws governing Medicare fraud and abuse include all the following:

- Federal False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)/Social Security Act
- United States Criminal Code

### 2. Do we have to report noncompliance and FWA to Aetna?

- Yes. Your internal processes must include a process to report concerns to Aetna. You must notify Aetna about actual and potential noncompliance and FWA if it impacts our Medicare business.
- As part of CVS Health, Aetna FDRs can make reports using the mechanism found in the **CVS Health Code of Conduct**. We enforce a zero-tolerance policy for retaliation or retribution against anyone who reports suspected misconduct.
- If you don't have internal reporting mechanisms, you can share our reporting poster with your employees and downstream entities so they can report things directly.

### 3. What can I do if I suspect FWA or noncompliance?

You must report the issue to us so we can investigate and respond to it immediately. Our reporting poster describes a few of the ways you can make reports.

## IV. Exclusion lists screening

### 1. What are the exclusion lists and requirements?

There are two exclusion lists:

- **Office of Inspector General (OIG) List of Excluded Individuals/Entities** — The OIG only contains exclusion actions taken by the OIG.

- **General Services Administration (GSA) System for Award Management (SAM)** — The GSA SAM list includes exclusion and debarment actions taken by various federal agencies.

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**IV. Exclusion lists screening (cont)**
Review both lists before hiring or contracting and monthly thereafter. Regular screenings ensure that your employees and downstream entities are not excluded from participating in federal health care programs. Federal money cannot be used to pay for services provided or prescribed by an excluded individual or entity.

Documentation may vary depending on how you complete the screenings. If you perform these checks using an automated system, your documentation may be based on the information available within that system. Regardless of how you do these checks, your documentation should show:

- Which exclusion list(s) were checked
- The date the check was completed
- Names of the individuals and entities that were checked and
- Results of the check

If you do screenings manually, you can download our OIG/SAM Exclusion Screening Log and use it to capture the required information. Be sure to maintain the source documentation to support your screenings, such as input sheets, screenshots and documentation with date stamps.

**2. What if an individual or entity is identified as excluded?**
You should immediately stop them from doing any work on Aetna® Medicare business. You should also report this to Aetna.

**V. Downstream entity oversight**

**1. Which of my subcontractors should be considered downstream entities?**
Not every subcontractor is considered a downstream entity. Only those entities that provide administrative or health care services for Aetna Medicare business are downstream entities. FDRs should have processes in place to identify and classify subcontractors as downstream entities. To help you, we have an Examples of Downstream Entities that lists examples of downstream entities.

**2. Why are you asking about my downstream entities (i.e., subcontractors)?**
We are accountable to CMS for all our FDRs. If you are subcontracting, then we must ensure that you are overseeing your downstream entities.

**3. What requirements apply to downstream entities?**
Downstream entities must comply with all applicable regulatory requirements that apply to the Medicare Parts C & D program. This includes the compliance program requirements explained in our FDR Medicare Compliance Guide.

**4. What oversight is expected for my downstream entities?**
If you use downstream entities, you must have an acceptable oversight of their compliance and performance. This includes testing compliance and performance of your downstream entities through audits or monitoring, and requesting corrective actions when deficiencies are identified.

**5. What are offshore services?**
Any offshore entity that will or may receive, process, transfer, handle, store or access Protected Health Information (PHI) in oral, written or electronic form of Aetna Medicare Advantage members and prescription drug plan members.

**6. What is considered PII and/or PHI?**

**Personally Identifiable Information (PII):**
Information that can be used, alone or with other data, to identify, contact or locate a single person.

**Protected Health Information (PHI):**
Individually identifiable health information created, used or shared by health care providers, health plans or employers, relating to past, present or future health, care or payment for care, as defined by the **Health Insurance Portability and Accountability Act (HIPAA).**

**PII** (like name, Social Security number and address) become PHI when linked to health data.

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**7. What is considered PII and/or PHI? (cont)**
Personal information listed in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Examples of PHI include:
- Beneficiary name
- Birth date (PII)
- Address (PII)
- Social Security number (PII)
- Health insurance claim number
- Patient identifier (PHI)
- Medical diagnosis (PHI)
- Medical history (PHI)
- Treatment records (PHI)
- Type of provider visited
- Use of health care services (PHI)
- Payment information (PHI)
- Evidence of insurance coverage (PHI)
- Any information that could identify a beneficiary

**8. What is considered to be offshore business?**
Offshore business is an individual or entity physically located outside the United States or one of its territories, like American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands. Some examples of offshore countries include Mexico, Canada, India, Germany and Japan. Offshore subcontractors can be American-owned companies or foreign-owned companies with operations outside of the U.S. Offshore subcontractors provide services performed by workers located in offshore countries, regardless of whether they're employed by American or foreign companies.

**9. Am I required to also complete an Offshore Attestation?**
If you outsource services to an entity that receives, processes, transfers, handles, stores or accesses Medicare Advantage members' Protected Health Information (PHI), then **Yes**, you're required to complete an Offshore Attestation regarding this work and the related oversight controls. If your activities involve PHI, we will submit an attestation of that fact to CMS.

**10. What do I do if I outsource offshore services to more than one entity?**
You must complete one attestation for each offshore relationship.

**11. I may hire a new offshore services entity; when would an Offshore Attestation be due to Aetna?**
Submission to Aetna® is due within 30 days of the proposed or actual effective date of the offshore activity or service.

**12. Where is the Offshore Services Attestation found?**
You can find our attestation at **Offshore Attestation.** Please click the "**Complete the attestation**" link within the form and follow the instructions.

**13. Do I need to complete a new Offshore Attestation each year?**
No. Each offshore relationship only needs one attestation. You must update us when the offshoring relationship terminates or materially changes, such as adding additional offshored services. Complete the attestation form for changes/terminations to previously submitted Offshore Attestations.

## VI. Special Needs Plans (SNP) model of care (MOC) training and attestation requirements

**1. What is a Special Needs Plan?**
A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

- An institutionalized individual (in a nursing home or home care
- A dual eligible (eligible for Medicare and Medicaid)
- An individual with a severe or disabling chronic condition, as specified by CMS (CHF, HIV/AIDS, dementia, etc.)

Medicare SNP features:
- Enrollment limited to beneficiaries within the target SNP population
- Benefit plans are custom designed to meet the needs of the target population.
- Additional special election periods held throughout the year in which members may change their plan.

**2. Why do I need to complete the Special Needs Plans (SNPs) training?**
CMS requires all contracted medical providers and/or staff to receive and comply with the annual SNPs Training. This training and completion of an attestation are required for new providers and annually thereafter. The SNPs MOC is the plan for delivering coordinated care and care management to special needs members.

**3. Does every physician and employee have to complete Aetna® training, or can one person complete for the group?**
The clinical staff are required to take and comply with the SNPs Training. One authorized person for the group can complete the attestation and include all applicable tax IDs to receive credit. We do not require or expect, for example, receptionist staff, billing staff, etc. in the office to complete the training.

**4. Is there an option for providers to complete one training that covers multiple payers?**
No, there is no option. Currently, the CMS requirement does not allow for providers to complete one training for all their SNP payers. Therefore, it must be completed for each SNP payer. For example, if a provider contracts with Aetna and UnitedHealthcare, both the Aetna and UnitedHealthcare SNPs Training process must be followed.

**5. What are the SNP attestation requirements for large groups/national providers that span more than one county/state?**
Only one (1) attestation is required regardless of where the large group/national provider operates, as long as all clinical staff have completed the annual SNPs Training. Include all applicable tax IDs to receive credit.

**6. Are there any types of providers that do not have to complete SNP training?**
Yes. Dentists, hearing aid providers, transportation, wellness/fitness and other "vendor" type providers are typically not an integral part of the member's MOC care plan, thus Aetna is not required by CMS to send MOC training and attestations to those provider types. Aetna cannot exempt providers who are an integral part of the MOC care plan from receiving and completing the **Aetna®** SNPs Training.

**7. If a provider is in a market that is preparing to launch an SNP, when should they complete their initial training?**
If a provider is in a market that is launching an SNP, they (provider/clinical staff) must complete the annual SNPs Training and attestation.

**8. Where can the CMS requirements be found that says providers must complete Special Needs Plans (SNPs) training for each payer?**
The requirement is in CMS Medicare Managed Care Manual, Chapter 5 — Quality Assessment, Section 20.2.1.3.C. (digital page 14). The attestation process is what Aetna uses to secure proof of completion from providers of our MOC training.

**9. What are the requirements of the SNP participation?**
SNPs must meet all core Medicare Advantage (Part C and Part D) requirements and specific incremental or modified requirements. Some SNP requirements may vary based on the SNP type.

**10. Key SNP requirements:**

1. MA-PD Plan, SNP and service area approval
2. Part D prescription coverage
3. Eligibility
4. State Medicaid Agency Contracts (SMACs), which may include additional state-specific requirements
5. MOC
6. Enrollment
7. Benefit flexibility
8. Cost Sharing
9. SNP-Specific plan benefit packages
10. Marketing and sales
11. Member materials
12. Network directory

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**11. What are the MOC goals?**
Each SNP program must develop an MOC and a Quality Improvement Plan to evaluate its effectiveness. The MOC is a plan for delivering care management and care coordination to:

- Improve quality
- Increase access
- Create affordability
- Integrate and coordinate care across specialties
- Provide seamless transitions of care
- Improve use of preventive health services
- Encourage appropriate use and cost effectiveness
- Improve member health

**What comprises the MOC?**

- Interdisciplinary care team (ICT)
- Health risk assessment (HRA)
- Individualized care plan (ICP)
- Care coordination

**VII. I am not contracted for Aetna Medicare Advantage plans. Why did I get a notice?**
If you receive a notice and you are not contracted with Aetna Medicare Advantage plans, you do not need to complete the attestation.

Unsure if you participate in our Medicare Advantage plans? View contact information under "Contact Us" to reach our Provider Services organization. **Or view** your participation status via our **Medicare Advantage Provider Directory.** Locate your practice, click on "Plan and Network Information."

If you opted out and/or are not permitted to bill Medicare, you do not need to complete an attestation. Let us know via "**Contact us.**"

**VIII. How do I update my office information?**

- If your organization is no longer operating or you are retired, use our Provider termination request form.
- If you've changed your tax ID/W-9, use our Update your Tax Identification Number (TIN).
- If you want to update/add your/staff email, phone or fax number or practice address, use this Request Changes to Provider Data.

**IX. Contact us**

**Medical providers –** contact our **Provider Contact Center**
Follow these steps for Medicare compliance or participation questions:

1. Dial **1-800-624-0756 (TTY: 711)**
2. Enter your provider ID number
3. At the prompt for patient ID number, dial O or say "representative"
4. At the prompt for patient ID number, say "general question"
5. Your call will be opted out to a customer service representative You can also contact us via "Send us a message"

**Sales partners/agents — contact our Broker Services department**

- Phone: **1-866-714-9301 (TTY: 711)**
- Email: **BrokerSupport@Aetna.com**
- Fax: **724-741-7285 (TTY: 711)**

You may also contact your account manager/ sales director directly.

**Vendor/suppliers**
Please contact your relationship manager/ contract liaison directly.

**Delegates** — email: **NationalDelegationManagement@Aetna.com**

**SNP training or attestation questions** For general MOC attestation questions, please email us at **DSNPMOC@Aetna.com**

**For care management, email:**

- All DSNP/FIDE markets (except VA and NJ): **MCRDSNP@Aetna.com**
- VA: **ABH_VA_DSNP@Aetna.com**
- NJ: **NJ_FIDE_SNP_CM@Aetna.com**

**To request access to the secure provider portal, email:**

- All D-SNP/FIDE markets (except VA and NJ): **MCRDSNP@Aetna.com**
- VA: **Aetnabetterhealth-VAProviderRelations@Aetna.com**
- NJ: **NJ_FIDESNP_Providers@Aetna.com**

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## X. General changes to provider data

Use this link to update information for doctors, hospitals or facilities found on Aetna® on-line provider directory: **Request Changes to Provider Data**

Use this link to notify us oftax Identification changes or additions: **Update your Tax Identification Number**

To notify us about terminations of medical,mental health, dental and mid-level practitioner providers that leave a practice, click **here.**

## XI. FDR/SNP/Delegated MOC Attestation Assistance

I received a postcard in the mail, where do I attest? See our **Medicare compliance and attestation**.

### How do I know which postcard link to select on the website?

The email will have a link directly to the attestation to complete.

If you received a postcard, it will indicate that you need to complete your MA or MA and SNP attestation, then select the link on the websitethat correlates with the postcard message.

### Adobe system requirements needed to open & complete the form:

Operating systems: Microsoft Windows 10 or newer or MacOS 11 (Big Sur) or newer.

Browsers: The latest versions of Safari, Chrome, Edge (ensure you are running the latest version of Adobe Reader), Firefox.

If you have followed these steps, you meet the system requirements but require additional support, contact **FDRAttestation@Aetna.com**.

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