Frequently Asked Questions (FAQs) —
First-tier, Downstream and Related Entities (FDRs),
FDR and Model of Care (MOC)

I. Compliance requirements

1. What's new for 2021 related to Medicare Compliance?

Participating providers in our Medicare Advantage (MA) plans, Medicare-Medicaid (MMP), Dual Eligible (DSNP) or Fully Integrated (FIDE) Special Needs Plans 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 **Medicare compliance FDR program guide** and/or **DSNP Model of Care (MOC)** training.

Note: Medicare Advantage plans include HMO, PPO, DSNP/FIDE, and MMP

New for 2021:

- **MA/MMP:** Providers who participate **only** in our MA/MMP plans no longer need to complete an annual FDR Attestation.
- **MA/ DSNP/FIDE:** Providers who are located in states/regions that offer MA/DSNP/FIDE plans **continue to be required** to complete the Annual **DSNP Model of Care (MOC) training** and attestation.
  - To verify which states this applies to, please click here: **2021 DSNP Service Area**
  - Find DSNP/FIDE plans information & FAQs at this link: **Medicare and Dual Special Needs Plans expansion information and resources** (found below the Medicare Compliance section)
- **Delegated Entities:** Provider attestation collection for the FDR compliance requirements **continue to be required for Delegated Entities**. Delegated entities will receive their attestation directly through Adobe Sign. Completion of the **DSNP MOC training** and the related attestation is still required.

Providers ***will receive*** an Adobe Sign email or a postcard to review the annual Medicare Compliance training in the **FDR Guide** to ensure your compliance with the requirements. If applicable, you will be asked to complete an MOC attestation if participating in our DSNP/FIDE plans.

These FAQs were developed for Aetna® FDRs. They summarize common questions and answers about the Medicare compliance requirements and MOC requirements. The Aetna FDR Guide (inclusive of the FDR toolbox resources) & DSNP MOC training explains each requirement in more detail.

2. What does FDR mean?

FDR stands for **first-tier**, downstream and related entities. If you 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 provider types (including dental and vision providers) contracted to provide services to our Medicare Advantage plan members, sales partners/agents contracted to market and sell our Medicare products, vendors providing administrative services for our Medicare members/products and delegates contracted to make decisions on our behalf for our Medicare members/products.

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

- **First-tier Entity-** Any party that enters into 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 functionsunder 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 of these plans:

- Medicare Advantage Plans (MA)
- Medicare Prescription Drug Plans (MAPD)
- Prescription Drug Plans (PDP)
- Medicare-Medicaid Plans (MMP)
- Dual Eligible Special Needs Plans (DSNP)
- Fully Integrated Special Needs Plans (FIDE)

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: Individual providers, ancillary providers, dentists, vision, behavioral health, group practices, facilities, hospitals, delegated entities, etc. These requirements apply to you 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 on the final page of this document for contact information to assist with contracting status.

5. Am I still required to meet these compliance requirements if I do not accept Medicare Advantage plan members?

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, MMP, DSNP or FIDE plans, these requirements apply to your organization even if you do not see members in these plans.

6. Our organization received a Medicare Compliance/MOC 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 MOC Requirements as identified inour FDR program guide/DSNP Model of Care 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 Prescription DrugBenefit Manual. Chapter 9 - Compliance Program Guidelines and updated by CY 2015 Final Rule CMS-4159-F published May 23. 2014.

8. Are the requirements new?

No, these requirements are not new. You should have received a similar notice about theserequirements in previous years. There have been changes to these requirements since they were implemented. If you aren't familiar with the requirements, just review our FDR Guide.

9. Our organization is not complying with all the Medicare Compliance requirements. Who do we report this to? Will we be terminated?

If your organization is not meeting the requirements, you can contact your relationship manager (account manager, provider representative, Aetna® liaison, etc.). Don't worry about retaliation, we enforce a zero-tolerance policy for retaliation against anyone reports concerns in good faith. You can also make reports anonymously; just refer to our reporting poster.

If you are willing to comply with the requirements, your contract will not be terminated. Instead, we will collaborate with you to implement a corrective action plan (CAP) to ensure you can comply.

10. What will happen if I don't comply with the requirements?

If you are willing to comply, we partner with you to resolve the issue. You will be given training and education on the requirements and we will make sure that you develop a comprehensive corrective action plan (CAP). We ask for 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.

11. Why did our organization receive a Medicare Compliance and/or MOC Attestation?

- **MA/MMP:** Providers who participate only in our MA/MMP plans **no longer need** to complete an annual FDR Attestation.
- **DSNP/FIDE:** Providers who also participate in our DSNP/FIDE plans **continue to be required** to complete the Annual Model of Care (MOC) training and attestation requirements.
- **Delegated Entities:** Provider attestation collection for the FDR compliance requirements **continue to be required for Delegated Entities**. Delegated entities will receive their attestation directly through Adobe Sign. Completion of DSNP MOC training (if applicable) is still required.

12. I have no employees (solo practitioner) or I do not see Medicare patients. Do I have to complete an attestation?

If you receive an attestation completion request, it must be completed even if you have no employees or have not seen Medicare Advantage patients.

13. Does each staff member have to complete the attestation?

No. An authorized representative can submit an attestation on behalf of your organization. We describe who might be an authorized representative in the **FDR Guide**. Attestations may be tracked by Tax ID number (TIN) so if these are applicable to your organization, be sure to list all TINs within your attestation.

14. 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 (if applicable).

15. Who do I contact if I have more questions?

If you have any questions about the Medicare Compliance requirements that are not addressed in our **FDR Guide**, please refer to the "Contact Us" section on the last page of this document.

II. Standards of Conduct

1. What are Standards of Conduct?

Standards of Conduct are also known in some organizations as the "Code of Conduct." It states the overarching principles and values by which the company operates and defines 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:

- Within 90 days of hire,
- Each calendar year, and
- When changes are made

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

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 Chapters 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care 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 describe how our Compliance Program operates.

III. Reporting mechanisms

1. What is Fraud, Waste & 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 mannerthat 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 a CVS Health® company, 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. Ourreporting poster describes a few of the ways you can make reports.

As a CVS Health company, Aetna FDRs can make reports using any of the mechanism listed in the CVS Health Code of Conduct. Don't worry about retaliation, we enforce a zero- tolerance policy for retaliation against anyone who reports suspected misconduct.

IV. Exclusion lists screening

1. What are the exclusion lists?

There are two exclusion lists:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities
- General Services Administration (GSA) System for Award Management (SAM)

2. What is the difference between the OIG and GSA SAM?

The GSA SAM includes exclusion and debarment actions taken by various federal agencies. The OIG only contains exclusion actions taken by the OIG. **You must screen both.**

3. What are the requirements related to exclusion list screenings?

FDRs must review both the OIG and GSA SAM exclusion lists. **Review both lists before hiring or contracting and monthly thereafter**. We explain the requirement in more detail within the FDR Guide.

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.

4. How often do the exclusion list screenings have to be completed?

Both the OIG and GSA SAM exclusion lists must be checked before hiring/contracting and monthly thereafter.

5. What evidence must I keep to show that these checks are completed?

The documentation may vary depending on how you complete screenings. If you performthese checks using an automated system or program, 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 screening log and use it to capture the required information. Also, be sure to maintain the source documentation to support your screenings, such as input sheets, screenshots, and documentation with date stamps.

6. 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 who 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 a grid 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 Guide**.

4. What oversight is expected for my downstream entities?

If you use downstream entities, you must have 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 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 (a nursing home or home care),
- A dual eligible (eligible for Medicare and Medicaid), or
- An individual with a severe or disabling chronic condition, as specified by CMS (CHF, HIV/AIDS, dementia, etc.)

6. What are some of the SNP Features?

Medicare SNPs feature:

- Enrollment limited to beneficiaries within the target SNP population (See #1).
- Benefit plans are custom designed to meet the needs of the target population.
- Additional special election periods throughout the year during which members may change their plan.

7. Why do I need to complete the Model of Care (MOC) Training?

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and/or staff receive basic training about the Special Needs Plans (SNPs) Model of Care. This training and completion of an attestation are required for new providers and annually thereafter. The SNPs Model of Care is the plan for delivering coordinated care and care management to special needs members. View the **DSNP MOC Training**.

8. What are the requirements of SNP Plan participation?

Special Needs Plans (SNP) must meet all core Medicare Advantage (Part C and Part D) requirements and specific incremental or modified requirements.

Some SNP specific requirements apply to all SNPs and some to DSNPs only.

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. Model of Care

6. Enrollment
7. Benefit Flexibility
8. Cost Sharing
9. SNP-Specific Plan Benefit Packages 1
10. Marketing and Sales
11. Member materials
12. Network Directory

9. What are the MOC goals?

Each Special Needs Plan program must develop a Model of Care (MOC) and a Quality Improvement Plan to evaluate its effectiveness. The MOC is a plan for delivering care management and care coordination to:

1. Improve quality
2. Increase access
3. Create affordability
4. Integrate and coordinate care across specialties
5. Provide seamless transitions of care
6. Improve use of preventive health services
7. Encourage appropriate use and cost effectiveness
8. Improve member health

10. What comprises the MOC?

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

11. How to contact us regarding MOC Training and/or Attestation?

For general MOC attestation questions please email us at **DSNPMOC@Aetna.com**

For Care Management, email:

- All DSNP 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 DSNP markets (except VA and NJ): **MCRDSNP@Aetna.com**
- VA: **Aetnabetterhealth-VAProviderRelations@Aetna.com**
- NJ: **NJ_FIDESNP_Providers@Aetna.com**

VI. Attestation helpful information (quick tips)

- Only one attestation is required to be completed based on your contracted status in our plans
- Only one attestation is required if you have multiple Tax ID's within your organization, simply list them in the form or attach an excel file of Tax ID's
- We are **not** accepting manually completed, faxed or emailed attestations, you must complete the **online attestation** via Adobe Sign.

- Our FDR Attestation is **not** in Availity – We use Adobe Sign.

If you can't access the form check your browser setting as Adobe Sign accepts:

- Microsoft Windows 10 using Microsoft Edge, Internet Explorer 11, or a current version of Firefox, or Chrome
- Microsoft Windows 8 using Internet Explorer 11 or later, or a current version of Firefox, or
- Chrome
- Mac OS X v11 or later using Safari 7 or later, or a current version of Firefox, or Chrome

Adobe Sign Attestation Completion - helpful tips

If you do **not** see the **"Click to Sign"** option at the bottom of the attestation, it is due to one of the following issues:

You didn't receive a signed and filed copy of your FDR Attestation

This happened due to one of the following reasons:

- You entered an incorrect email address when signing
- It can take up to 24 hours to receive a signed copy
- The email is in your spam folder

If you do not receive a signed and filed copy of your attestation within 24 hours, complete the attestation again and be very careful to type the correct email address.

You are a non-contracted Aetna® Medicare Advantage provider

If you received an email or postcard notice and you are **not contracted** with Aetna Medicare Advantage, Medicaid/Medicare (MMP) or DSNP plans, **you do not need to complete the FDR Attestation**.

- Unsure if you participate in our Medicare and/or DSNP plans? **View contact information in Section VII.**
- If you opted out and/or are not permitted to bill Medicare, you do not need to complete an attestation.

To update your demographic information

Follow the link(s) noted below for the action required

- If you/your organization is **no longer practicing or retired**, moved out-of-state or changed provider groups, use this **link** to update information.
- To **change your email, phone or fax number or practice address**, use this **link**.

VII. Contact us information

Medical providers – contact our Provider Service Center

Follow these steps for Medicare compliance questions:

1. Dial **1-800-624-0756**
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 email us via "**Contact Us Online"**

Medicare/Medicaid Plans (MMP}:

- Call **1-800-624-0756**
- Email: **MedicaidMMPFDR@Aetna.com**

Sales Partners/Agents:

- Broker Services Department
- Phone: **1-866-714-9301**
- Email**: BrokerSupport@Aetna.com**
- Fax: **1-724-741-7285**

You may also contact your Account Manager/Sales Director directly

Vendor/Suppliers

Please contact your Relationship Manager/Contract Liaison directly.

Delegate

Email: NationalDelegationManagement@Aetna.com

58.00.800.1 (6/21)