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

Updated April 1, 2022

These FAQs were developed for Aetna® FDRs. They summarize common questions and answers about the Medicare compliance, DSNP MOC and attestation requirements (if applicable based on contracted plans).

I. Compliance requirements

1. What is Aetna's Medicare Compliance Program?

Participating providers in our Medicare Advantage (MA), 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 MOC** training. Aetna's Medicare Advantage plans are inclusive of HMO, PPO, DSNP/FIDE.

Note:

- **MA/MMP:** Providers participating **only** in our MA/MMP plans are required to comply with the **FDR Medicare Compliance requirements** but are no longer required to complete an annual FDR Attestation.
- **MA/DSNP/FIDE:** Providers who are in states/regions that offer MA/DSNP/FIDE plans **continue to be required** to complete the Annual **DSNP MOC training** and **attestation**.
  - To find state specific DSNP/FIDE plans information & FAQs click 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 Acrobat Sign and can also attest at **Aetna.com/Medicare.**

Annual Training Notice:
CMS requires that we conduct training to our FDRs. For DSNP/FIDE plans, we are required to provide proof of completion and we use the Attestation process to fulfill this need. Providers ***will receive*** an Adobe Acrobat Sign email, postcard, or request via OfficeLink Newsletter as your annual training notification. You are required to review the **Medicare compliance FDR program guide** to ensure your compliance with the requirements. If participating in DSNP/FIDE plans you are required to review the **Dual Eligible Special Needs Plans (DSNP) Training** and complete the MOC 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.

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 t
   - 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, 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 to assist with 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, 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 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 DSNP MOC Requirements as identified in our FDR program guide/DSNP 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 Prescription Drug Benefit 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 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 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.). Do not worry about retaliation, we enforce a zero-tolerance policy for retaliation against anyone reporting in good faith. You can also make reports anonymously; just refer to **our reporting poster**. If you 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 am not in compliance with the requirements?
We will partner with you to resolve the 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 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 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 Acrobat Sign. Completion of DSNP/FIDE MOC training (if applicable) is still required.

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

13. 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).

14. 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 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 hiring,
- Each calendar year, and
- When changes are made

If you do not 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. 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 & 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 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. Our reporting 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 mechanisms listed in the CVS Health Code of Conduct. Do not worry about retaliation; we enforce a zero-tolerance policy to retaliate against anyone who reports suspected misconduct.

IV. Exclusion lists screening

1. What are the exclusion lists?

There are two exclusion l 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 should I keep as evidence to prove that these checks have been done?**
   Documentation may vary depending on how you complete the screenings. If you perform these 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 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.

VI. DSNP MOC

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 (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.)

2. 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.

3. Why do I need to complete the DSNP 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) MOC. 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. View the **DSNP/FIDE MOC Training.**

4. Does every physician and employee have to complete Aetna's training, or can one person complete for the group?

The only staff in a provider's office who need to take the training and attest are those who provide clinical care. One authorized person for the group can complete the training and include any applicable Tax IDs to receive credit. When completing on behalf of a group, MOC training should be part of overall staff training iso all staff are aware of what an MOC is and their role in it.

5. Please clarify if ALL staff need to be trained or only the appropriate staff must be trained.

Aetna only requires providers, contracted and non-contracted, and their staff in the office who provide direct clinical care to the DSNP member to complete the SNP MOC training. "Staff" meaning if there are other providers/clinicians in the office (i.e., nurses, Physician Assistant, nurse practitioners who provide clinical care to D-SNP members. We do not require or expect, for example, receptionist staff, billing staff, etc. in the office to complete the training.

6. 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 D-SNP payers. Therefore, it must be completed for each D-SNP payer. For example, if a provider contracts with Aetna and UnitedHealthcare, both the Aetna and UnitedHealthcare MOC training process must be followed.

7. For large groups that span more than one state, is it possible to only require completion for those providers located in the D-SNP market?

Yes, only those providers that are participating in D-SNP markets will need to complete the MOC training and attestation for each State where they accept D-SNP.

8. For large groups that span more than one county or state, how do they attest for just those states?

In the *Attestation* link there is an ability to upload an excel spreadsheet with the providers and TINs that are covered by the training.

9. Do I need to complete the MOC if my main office is not listed as an Aetna DSNP registered County in my state?

Yes, providers that are participating in multiple counties that both are and are not located in D-SNP markets will need to complete the MOC training and attestation only once, because in the *Attestation* link there is an ability to upload an excel spreadsheet with the providers and TINs that are covered by the

training, including different counties and states.

10. **Do we have any tips as to how providers can incorporate payer MOC training in their annual training?**
They could review all their DSNP payers' MOC trainings and then pick one to use as a template to create their own provider and clinical staff annual MOC training. If they do this, we recommend they analyze the payer trainings to incorporate any of the payer specific items. Examples of differences include, but are not limited to, payer-specific: terminology, care team roles, accessing the care plan (hyperlinks, etc.), and contact information.

11. **Are there any types of providers that do not have to complete MOC training?**
Yes. Dentists, Hearing Aid providers, transportation, wellness/fitness, and other "vendor" type providers are typically not an integral part of the members 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 MOC training.

12. **If a provider is in a market that is preparing to launch a D-SNP, when should they complete their initial training?**
The MOC training may change from year to year. If a provider is in a market that is launching a D-SNP on January 1, 2022, they should not complete their initial training until after the 2022 training is available.

13. **Where can the CMS requirements be found that says providers must complete MOC training for each payer?**
MOC training is a CMS requirement for any plans offering DSNP contracts. Therefore, any MA health plan that offers a DSNP contract must have a MOC and adhere to the MOC training requirements for network (and out of network providers) and are subject to be audited by CMS as meeting that standard. 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.***

14. **If a provider doesn't complete the D-SNP MOC attestation this year, what will they receive?**
Providers who continually fail to complete MOC training are reported to the network manager who oversees their contract with the health plan for remediation. All providers who have not attested are sent at least two reminder emails throughout the year notifying them of the requirement.

15. **What are the requirements of the SNP Plan participation?**
SNPs 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 DSNP/FIDEs 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. MOC
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

16. **What are the MOC goals?**
Each Special Needs Plan program must develop a 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

17. What comprises the MOC?

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

VII. Adobe Acrobat Sign Attestation Completion – helpful tips

1. 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 must complete **all** the mandatory drop down/form fields. If you miss any form fields, you will not receive the **"Click to Sign"** link at bottom of the page.
    - Tax ID#(s) must be only numbers (a total of 9 digits) with no hyphens, spaces, or letters: 123456789; if your Tax ID# has zeros in the beginning or end, you must add those to get to the required 9 digits.
        - One valid Tax ID# must be entered even if you are attaching an excel list of Tax ID#s. Only the first Tax ID# form field is mandatory.
        - If you add anything but a string of numbers you will receive an error message by a red block around the form field, and you will not see the link at the bottom of the page to "Click to Sign."

***You can only enter an EXCEL file of Tax IDs as any other document type will not receive credit.**

VIII. 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.

IX. You are not contracted for Aetna Medicare Advantage or DSNP plans

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

- Unsure if you participate in our Medicare and/or DSNP/FIDE plans? **View contact information in Section VII to reach our provider services organization to check your participation status.**
- If you opted out and/or are not permitted to bill Medicare, you do not need to complete an attestation.

X. To update your demographic information, follow the link(s) noted below for the required action:

- 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**.

XI. CONTACT US

Medical providers – contact our Provider Service Center
Follow these steps for Medicare compliance or participation 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 also 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.

Delegates

Email: **NationalDelegationManagement@Aetna.com**

MOC Training and/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 DSNP/FIDE/FIDE markets (except VA and NJ): **MCRDSNP@Aetna.com**
- VA: **Aetnabetterhealth-VAProviderRelations@Aetna.com**
- NJ: **NJ_FIDESNP_Providers@Aetna.com**

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