Frequently Asked Questions (FAQs) for First Tier, Downstream and Related Entities (FDRs)

These FAQs were developed for Aetna's FDRs. They summarize common questions and answers about the Medicare compliance requirements. The Aetna FDR Guide explains each requirement in more detail. There's also a toolbox of resources for FDRs, to help them meet these requirements.

Table of contents

FAQs for FDRs

I. General questions

1. 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's Medicare business, then you are an FDR.

Examples of FDRs include providers contracted to provide services to our Medicare 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 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.

2. 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 (MA)
- Prescription Drug (MAPD)
- Prescription Drug Plans (PDP)
- Medicare-Medicaid Plans (MMP)
- Dual Eligible Special Need (DSNP)

3. 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, 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, **Attachment A**, for contact information to assist with contracting status.

4. What if I do not service or accept Medicare Advantage plan members. Am I still required to complete the annual attestation?

If you received this notice, you are participating in one or more of our Medicare Advantage, Medicare/Medicaid (MMP) and/or Dual Eligible Special Needs Plans (DSNP). Whether you see or do not see members in these plans these requirements apply to you or your organization.

The attestation is requested from our FDRs to verify that you have received the Medicare Compliance Program requirements and you feel that you are compliant with these requirements. Failure to complete the attestation may result in additional action up to termination of contract. Please refer to the **Contact Us** section, **Attachment A**, for contact information to assist with contracting status.

The attestation is required based upon your contractual relationship with us and not based on whether you see or have seen members for these products. If you do not feel you participate in any of these plans, please contact the Provider Services Center at the number identified in Attachment A.

5. Is this the same attestation that is required by the Council for Affordable Quality Healthcare, Inc. (CAQH)?

This request for an attestation is not related to the CAQH Attestation. This attestation confirms you are meeting the Medicare Compliance Program Requirements as identified in our FDR program guide.

6. 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.

7. 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 aren't familiar with the requirements, just review our FDR Guide.

8. We can't attest because we don't comply with all of 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.

9. 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.

10. Why am I receiving a notice to complete an attestation?

You were identified as a first tier entity because of your contractual relationship with us. We collect attestations to confirm that you understand and are complying with the requirements.

11. I have no employees. Do I have to complete an attestation?

Yes, you should submit an attestation even if you have no employees. This includes solo practitioners, sales partners, agents, etc.

12. 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. For providers, we track attestation completion by Tax ID number (TIN). Please provide the applicable TINs when completing your attestation. For Sales Partners/agents, we track attestation completion by National Producer Number (NPN).

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.

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 our FDR Guide, please refer to the Contact Us section, Attachment A.

II. Standards of Conduct and compliance policies

21. 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.

22. 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
- When changes are made

If you don't have your own Standards of Conduct and compliance policies, you can distribute Aetna's. 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.

23. 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 Aetna's. 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

24. What is Fraud, Waste & Abuse (FWA)?

Fraud: Intentional misuse of information in order 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

25. 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's 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.

26. 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's 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

27. What are the exclusion lists?

There are 2 exclusion lists:

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

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

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

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

FDRs must review both the OIG and GSA SAM exclusion lists. Review both of these 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 person or entity.

30. 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.

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

The documentation may vary depending on how you complete 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
- Date the check was completed

- Names of the individuals and entities that were checked
- Results of the check

If you do screenings manually, you can download our screening log and use it to capture all of the required information.

32. What if an individual or entity is identified as excluded?

You should immediately stop them from doing any work on Aetna's Medicare business. You should also report this to Aetna.

V. Downstream entity oversight

33. 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's 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.

34. 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.

35. 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.

36. 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 monitors and requesting corrective actions when deficiencies are identified.

FAQs for FDRs

ATTACHMENT A: CONTACT US

Medical Providers

PROVIDER SERVICE CENTERS

Aetna or (Aetna & Coventry) Medicare Advantage contracted plans:

***Follow these steps ONLY for Medicare Attestation Questions**

1. Dial 1-800-624-0756
2. Enter your Provider ID number
3. At the prompt for patient ID number, *dial 0* 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

Email: CONTACT US ONLINE

Coventry Only Medicare Advantage contracted providers:

- Call 1-866-784-4916

Medicare/Medicaid Plans (MMP):

- Call 1-800-624-0756
- Email: medicaidmmpfdr@aetna.com

Dental Medicare Advantage contracted providers:

- Call 1-800-451-7715

Sales Partners/Agents

BROKER SERVICES DEPARTMENT

Phone: 1-866-714-9301

Email: brokersupport@aetna.com

Fax number: 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