



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

Updated March 3, 2026

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), Dual Eligible (DSNP) 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](#). Aetna's Medicare Advantage plans are inclusive of HMO, PPO, DSNP/FIDE/HIDE.

Note:

- **MA/SNP:** Providers who are in states/regions that offer SNP plans **continue to be required** to complete the Annual [Special Needs Plans \(SNP\) Training](#) and **attestation**.
 - To find state specific SNP 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 SNP 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 [FDR Medicare Compliance Guide](#) to ensure your compliance with the requirements. If participating in SNP plans you are required to review the [Special Needs Plans \(SNP\) Training](#) and complete the Model of Care (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:

- Medicare Advantage Plans (MA)
- Medicare Prescription Drug Plans (MAPD)
- Prescription Drug Plans (PDP)
- Dual Eligible Special Needs Plans (DSNP)
- Fully Integrated Special Needs Plans (FIDE)
- Highly Integrated Dual Eligible Special Needs Plan (HIDE)

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 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, MMP, 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 MOC Requirements as identified in our FDR program guide/SNP 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 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?

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. 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.

12. 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.

13. 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:

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 ours. Aetna is a CVS Health® company and complies with the [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 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** includes exclusion and debarment actions taken by various federal agencies.

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 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 [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.

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 (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.)

Medicare SNPs features:

- 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.

2. Why do I need to complete the [Special Needs Plans \(SNP\) Training](#)?

CMS requires all contracted medical providers and/or staff receive and comply with the annual [Special Needs Plans \(SNP\) 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’s training, or can one person complete for the group?

The clinical staff are required to take and comply with the [Special Needs Plans \(SNP\) 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 Special Needs Plans (SNP) 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 [Special Needs Plans \(SNP\) Training](#). Include all applicable Tax IDs to receive credit.

6. Do we have any tips as to how providers can incorporate payer [Special Needs Plans \(SNP\) Training](#) in their annual training? Review all payers’ SNP trainings and then select one to use as a template. Analyze the payer trainings to incorporate payer specific items. Examples include, but are not limited to, payer-specific: terminology, care team roles, accessing the care plan (hyperlinks, etc.), and contact information.

7. 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 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 [Special Needs Plans \(SNP\) Training](#).

8. If a provider is in a market that is preparing to launch a SNP, when should they complete their initial training?

If a provider is in a market that is launching a SNP they (provider/clinical staff) must complete the annual [Special Needs Plans \(SNP\) Training](#) and attestation.

9. Where can the CMS requirements be found that says providers must complete [Special Needs Plans \(SNP\) 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.***

10. 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 requirements may vary based on the SNP type.

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

11. What are the MOC goals?

Each SNP 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

12. 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 received 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 in “**Contact Us**” to reach our provider services organization. You can view your participation status by checking our [Provider Directory](#). Once you 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.

VIII. How do I update my office information?

- Your organization is **no longer operating or you are retired**, use our [Provider termination request form](#).
- You’ve **changed your Tax ID/W-9**, use our [Update your Tax Identification Number \(TIN\)](#).
- 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 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 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

You can also contact us via “[Send us a message](#)”

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

SNP 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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