Medicare Compliance Attestation 2019-2020

This attestation must be completed annually by providers and facilities that contract with Moda Health Plan, Inc.'s (Moda Health) Medicare Advantage (Part C) and Prescription Drug (Part D) plans. As a Medicare Advantage sponsor, Moda Health is required to monitor and ensure its contracted providers and facilities (Delegates) operate in compliance with applicable laws and regulations required by the Centers for Medicare and Medicaid Services (CMS).

In this attestation, "employees" refers to those who work temporarily, part-time, full-time, and/or volunteer in providing or administering healthcare services for Medicare Advantage members.

Section 1: Compliance Program, Compliance Policies & Procedures, and Code of Conduct

a. Are Compliance policies and procedures and a Code of Conduct distributed to your employees, contractors and board members within 90 days of hire, when there are updates, and annually thereafter? The Code of Conduct and Compliance policies may be created by the Delegate or provided by Moda.

☐ Yes ☐ No

Comments: Please provide an explanation to a No response:

_____

_____

Section 2: Reporting Mechanisms & Disciplinary Standards

a. Are notices of how employees can report noncompliance or fraud, waste and abuse (FWA) publicized throughout your facility? Notices may include posters or information displayed on an internal website. Notices may include how to report directly to Moda Health:

Medicare Compliance Department
- Email: delegatecompliance@modahealth.com or medicarecompliance@modahealth.com
- Phone: 855-801-2991

Special Investigations Unit (SIU)
- Email: stopfraud@modahealth.com
- Phone: 855-801-2991

Anonymous hotline and website administered by EthicsPoint, a confidential third party
- website: www.ethicspoint.com
- hotline Phone: 866-294-5591

☐ Yes ☐ No

b. Do you have a non-retaliation policy that allows employees and contractors to report instances of FWA or non-compliance, when reporting in good faith?

☐ Yes ☐ No

c. Is the non-retaliation policy communicated to all employees and contractors?

☐ Yes ☐ No

Comments: Please provide an explanation to any No response(s):

_____

_____

Section 3: Sub-Delegation Contracts

a. Do you inform Moda Health prior to entering into a contract that transfers (sub-delegates) an obligation under your contract with Moda Health to a third party (a Sub-Delegate)?

☐ Yes ☐ No

b. Do you monitor subcontractors to ensure they are compliant with the same Medicare regulations and requirements that apply to your contract with Moda Health?

☐ Yes ☐ No

Comments: Please provide an explanation to any No response(s):

_____

_____

Section 4: OIG and GSA Screening

a. Are employees, contractors, board members, and downstream entities screened against the OIG *and* GSA exclusion lists prior to employment or contracting, and monthly thereafter?

☐ Yes ☐ No

b. If an employee, board member or contractor is found on an exclusion list, is that person immediately removed from work related to a federal healthcare program?

☐ Yes ☐ No

Comments: Please provide an explanation to any No response(s):

_____

_____

Section 5: Offshore Activities

a. Does your company utilize any offshore services or sub-delegate to any offshore entity that involves processing, transferring, handling, storing, or accessing protected health information (PHI)?

☐ Yes ☐ No

If yes, an *Offshore Attestation* will apply (page 5-6). Please return the *Offshore Attestation* this attestation.

Section 6: Delegate Information and Attestation Signature

I, the undersigned, certify that the statements above are true and correct to the best of my knowledge. Further, I attest that I am an authorized representative for the Delegate listed below and confirm that the Delegate will maintain supporting documentation for a period of 10 years to be furnished to Moda Health, the Comptroller General, or CMS upon request.

Please complete all boxes:

Delegate Information	
Name[1]	
Address	
Phone	
Tax ID	
NPI	
Authorized Representative Information	
Name	
Title	
Email	
Phone	

[1] If you are completing this attestation on behalf of multiple providers within a provider group with multiple Tax IDs/NPIs, please fill out the Supplemental Provider Information Sheet (page 4).

X _____ _____

Printed name of Authorized Representative **Date**

Please return to us by one of the following:

Email: providerattestation@modahealth.com
Fax: 503-243-3964
Mail: Moda Health/Provider Relations
601 SW Second Avenue, T-8
Portland, Oregon 97204-3156

Supplemental Provider Information

Provider Group Name	

	Provider Name		NPI (10 digits)	Tax ID (9 digits)
	First Name	Last Name		
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Moda Health
Offshore Subcontracting Attestation

Name of Entity Completing Attestation:

Part I. Offshore Subcontractor Information

Offshore Subcontractor Name:	
Offshore Subcontractor Country:	
Offshore Subcontractor Address:	
Describe Offshore Subcontractor Functions:	
Effective Date of Offshore Subcontractor: (MM/DD/YYYY)	

Part II. Precautions for PHI

Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III. Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response
1.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary PHI and other personal information remains secure.	☐Yes ☐No

2.	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the sponsor's contract with the offshore subcontractor.	☐Yes ☐No
3.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No
4.	Offshore subcontracting arrangement includes all required Medicare Part C and D language, such as record retention requirements, compliance with all Medicare Part C and D requirements, etc.	☐Yes ☐No

Part IV. Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response
1.	Organization will conduct an annual audit of the offshore subcontractor.	☐Yes ☐No
2.	Audit results will be used by the organization to evaluate the continuation of its relationship with the offshore subcontractor.	☐Yes ☐No
3.	Organization agrees to share the offshore subcontractor's audit results with Moda Health upon request.	☐Yes ☐No

Signature

By signing my name below, I attest that I have carefully reviewed the information provided on this Attestation Form and attest to its completeness and accuracy, and that I have the authority to fill out this Attestation on behalf of the contractor.

Print Name: _____

Print Title: _____

Signature: _____

Date: _____