Dear Valued Partner,

Your organization is receiving this Annual Attestation Form because it is contracted with the Scott and White Health Plan (SWHP) as an Administrative Services Contractor, First Tier Entity, and/or Vendor for SWHP’s Medicare and/or Medicaid Plans. As a SWHP contractor, your Organization is subject to Federal and State laws, regulations, and other requirements relating to the Medicare and Medicaid programs. The Centers for Medicare & Medicaid Services (CMS) require that sponsors of Medicare Part C and Part D plans ensure that First Tier, Downstream, and Related Entities (FDRs) take certain compliance actions including:

* Adoption of policies and procedures to prevent Fraud, Waste and Abuse (FWA) and promote ethical conduct;
* Prevention of Conflicts of Interest;
* Code of Conduct;
* Testing (Agents/Brokers);
* Licensing (Agents/Brokers);
* Provision of Compliance and FWA training;
* Privacy & Security (HIPAA training);
* Exclusion screening; (Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Entities and Individuals (LEIE) and the General Services Administration System for Award Management (SAM) OIG, GSA/Sam);
* Maintaining reporting and communication channels, e.g. Hotline, effective lines of communication, etc.;
* Audit and Monitor any downstream entities to whom vendor delegated functions that were originally delegated to vendor by SWHP.
* Retention of records for 10 years per CMS guidelines;

Additional information is requested on this Attestation Form, to be completed, signed and returned to SWHP on an annual basis after the execution of an Agreement between an Administrative Services Contractor/First Tier Entity/Vendor and the SWHP. Please review each section listed below and make one selection for each section, as well as provide any additional information necessary. It may be submitted electronically to SWHPComplianceDepartment@bswhealth.org or to the Compliance Department, Scott and White Health Plan, 1206 West Campus Drive, Temple, TX 76502. For more information please visit our [Scott and White Health Plan webpage](http://swhp.org/en-us/ind-fam/about-health-insurance/compliance/first-tier-downstream-and-related-entities).

As a duly authorized representative of ENTER VENDOR NAME HERE, I hereby acknowledge and attest that the organization for calendar year ENTER YEAR HERE has complied with the following Federal requirements (except as otherwise noted):

1. **Compliance Requirements**

CMS has issued compliance requirements that are applicable to Medicare Part C and Part D sponsors, as well as FDRs. They are published in the [Medicare Managed Care Manual and Prescription Drug Manuals](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=1&DLEntries=10&DLFilter=mana&DLSort=1&DLSortDir=ascending), CMS Pub. 100-16, chapters 9, 11 and 21. FDRs are obligated to comply with these requirements.

**I attest to the option selected below:**

[ ]  The Organization has reviewed, understands, and is in compliance with the requirements set forth in the Medicare Managed Care and Prescription Drug Benefit Manuals.

[ ]  The Organization has NOT reviewed the compliance requirements set forth in the Medicare Managed Care and Prescription Drug Benefit Manuals.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Compliance Oversight and Response**

The Organization should have policies and procedures for promptly responding to, investigating, and reporting to SWHP all identified compliance deficiencies in accordance with CMS regulations and requirements (as set forth in the Medicare Managed Care Manual, chapter 21, and Prescription Drug Benefit Manual, chapter 9).

**I attest to the option selected below:**

[ ]  The Organization is in compliance with oversight and reporting requirements as established by CMS.

[ ]  The Organization is NOT in compliance with oversight and reporting requirements established by CMS.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Conflict of Interest (COI)**

Employees and downstream entities have been screened for conflicts of interest in performing their job functions as required under the SWHP Conflict of Interest Policy.

**I attest to the option selected below:**

[ ]  The organization screened its employees and there were no conflicts disclosed.

[ ]  The organization has screened its employees and did have a disclosure. The organization will inform SWHP of the status of said employees’ disclosure upon return of this attestation.

[ ]  The organization has NOT screened its employees or downstream entities for COI.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Code of Conduct**

The Organization should have a Code of Conduct that reflects CMS regulations and requirements. Employees, contractors, and downstream entities should have been provided with and adopt the Baylor, Scott and White Health (BSWH) Code of Conduct, which may be accessed via the [Scott and White Health Plan webpage](http://swhp.org/en-us/ind-fam/about-health-insurance/compliance/first-tier-downstream-and-related-entities), or the Organization should have its own Code of Conduct that is consistent with the BSWH Code.

**I attest to the option selected below:**

[ ]  The Organization has adopted the BSWH Code of Conduct.

[ ]  The Organization has developed and adopted its own Code of Conduct.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Compliance Training**

The Organization is obligated to have policies and procedures to meet the requirements for Medicare Compliance Training for all employees, contractors, and downstream entities **upon hire or contract, and then annually** thereafter. The Organization is to obtain certificates of completion of the required training, and these certificates must be kept on file and available to SWHP upon request.

**I attest to the option selected below:**

[ ]  The Organization has completed for all employees and contractors the annual requirement of General Compliance Training, including HIPAA Privacy and FWA training via the [CMS General Compliance and FWA training module on the MLN website.](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html)

[ ]  The Organization downloaded and incorporated the content of the CMS standardized training modules from the CMS website into its existing compliance training materials/system. The Organization complies with CMS Compliance, including HIPAA Privacy and FWA training requirements and the training provided includes CMS content.

[ ]  The Organization has NOT met the General Compliance, including HIPAA Privacy and FWA training requirements for all employees, contractors and downstream entities as specified by CMS.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Exclusions Screening**

Consistent with CMS requirements, the Organization is obligated to screen all employees and contractors on **initial hire or contract, and monthly** thereafter, against the Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Entities and Individuals (LEIE) and the General Services Administration System for Award Management (SAM), per the requirements set forth in 42 CFR 422.503(b) (4) (vi) (F). If an individual or entity is determined to be on either list, the Organization must immediately remove the individual or entity from doing any work associated with a Federal Health Care Program, and immediately notify SWHP of the action taken.

**I attest to the option selected below:**

[ ]  The Organization is in compliance with the CMS sanctions screening requirements set forth above.

[ ]  The Organization is NOT in compliance with the CMS sanctions screening requirements set forth above.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Offshore Activities**

**I attest to the option selected below:**

[ ]  I attest that the Organization has complied with the CMS requirements regarding any Offshore Arrangement, including protection of PHI.

[ ]  I attest that the Organization is NOT in compliance with the CMS requirements regarding the reporting of Offshore Activities.

[ ]  Not applicable as the organization does not have offshore activities.

Please provide an explanation for non-compliance: Click here to enter text.

**Section VII. Testing & VIII. Licensing to be filled out by Field Marketing Organizations (FMO).**

**If not an FMO proceed to end of document to complete attestation.**

1. **Testing (Agent/Brokers)**

The Centers for Medicare & Medicaid Services requires that all agents/brokers (employed/captive or independent) selling Medicare products are **trained and tested annually** on Medicare rules, regulations, and on details specific to the plan products that they sell. This means that training and testing **must take place prior** to the broker/agent selling the product. In addition agents/brokers must obtain a passing **score of at least eighty-five percent** on the test per 42 CFR 422.2274 (c) and (d). By selecting one or more of the following options, you hereby attest to which applies to your organization.

**I attest to the option selected below:**

[ ]  All of the organizations agents/brokers selling Medicare products are trained and tested annually on Medicare rules, regulations and on details specific to the plan products they sell. All agents/brokers have obtained a passing score of at least eighty-five percent on the test.

[ ]  I attest that the Organization is NOT in compliance with the CMS requirements mentioned above.

Please provide an explanation for non-compliance: Click here to enter text.

1. **Licensing (Agent/Brokers)**

The Centers for Medicare & Medicaid Services requires that all agents/brokers are licensed in the State in which they do business. The Texas Department of Insurance requires that agents hold a current permanent general life, accident, and health insurance agent license. By selecting the following option, you hereby attest to which applies to your organization.

**I attest to the option selected below:**

[ ]  The organization maintains current licenses for all agents working for Scott and White Health Plan.

[ ]  I attest that the Organization is NOT in compliance with the CMS requirements mentioned above.

Please provide an explanation for non-compliance: Click here to enter text.

**Company Representative Attestation and Signature**

[ ]  I am authorized to make representations and bind the organization and attest that the information noted above is accurate, correct, and truthful.

[ ]  I understand that I have an obligation to notify SWHP of any changes to this information. Any updates or new information will be reported to SWHPComplianceDepartment@bswhealth.org.

[ ]  I understand that SWHP may request proof of training and exclusion screenings or other documentation for oversight, or as required for regulatory or other audits, and agree to provide such information and documentation upon request.

[ ]  I am aware that Federal regulations require that records be retained for 10 years and agree to comply with this requirement.

[ ]  Please include information of your key personnel or a centralized email address for your organization where Scott & White Health Plan (SWHP) can communicate regulatory changes. Once regulatory changes have been communicated, your organization will be responsible for reviewing and implementing the changes, if applicable. Any changes to the information below, must be communicated to SWHP immediately.

**Name, Title, Email address & Contact information:** Click here to enter text.

**Or**

**Organization’s Centralized Email Address:** Click here to enter text.

Print Name and Title Organization

Authorized Representative Signature Date