

Delegation Attestation

Instructions

This Attestation form must be completed and returned for each Delegated Entity of Baylor Scott & White Health Plan, FirstCare Health Plans and their subsidiaries, together, "Plan."

Check the boxes in each section to attest to compliance or provide explanation for non-compliance.

Section II is only applicable to Agents, Brokers, Agencies and Field Marketing Organizations (FMOs). You may skip this section if it does not apply to your organization.

Complete the form in its entirety. Submit the completed form electronically to HPCompliance@BSWHealth.org.

Please visit our websites which provide education, important links including the Code of Conduct and resources to guide our Delegated Entities through the Compliance Program requirements and our expectations.

BSWHealthPlan.com

RightCare.SWHP.org

FirstCare.com/STAR-CHIP

FirstCare.com/Marketplace

Definitions:

Use of the term "**employee(s)**" throughout this form means the organization's direct employees, temporary employees, volunteers, consultants, contracted workers and others acting as part of the organization's workforce.

The term "**Delegate**" or "**Delegated Entity**" throughout this form means a business entity contracted with the Plan to perform administrative services or healthcare services on behalf of the Plan, including First Tier, Downstream and Related Entities (FDRs) and Material Subcontractors.

Delegation Attestation

Section I: Attestation

Organization Legal Name: _____

DBA Name: _____

I attest our organization maintains compliance with the following:

1. Code of Conduct and Compliance Policies

- a. My organization has adopted its own Code of Conduct and Compliance Policies that are comparable to that of the Plan or has adopted the Plan's Code of Conduct and Compliance Policies. **AND**
- b. My organization provides Code of Conduct and Compliance Policy training to its employees and board members within 90 days of hire, upon revision and annually thereafter. **AND**
- c. My organization maintains documentation of acknowledgement of the Code of Conduct and Compliance Policies within 90 days of hire, upon revision and annually thereafter. **AND**
- d. My organization agrees to provide a copy of our Code of Conduct and Compliance Policies and evidence of Code of Conduct and Compliance Policy training upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

2. General Compliance Training

- a. My organization requires its employees and board members to complete General Compliance training within 90 days of hire and annually thereafter. **AND**
- b. My organization maintains documentation of General Compliance training completion by its employees and board members. **AND**
- c. My organization agrees to provide a copy of our General Compliance training material and evidence of General Compliance training upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

3. Fraud, Waste and Abuse (FWA) Training

- a. My organization, its employees and board members must complete FWA training within 90 days of hire and annually thereafter. **AND**
- b. My organization uses the FWA training provided by a regulatory agency, such as CMS through the Medicare Learning Network (MLN) or uses our own FWA training material tailored to the circumstances surrounding potential FWA and specific functions we perform set forth by delegation agreement. **AND**
- c. My organization maintains documentation of FWA training completion by its employees and board members. **AND**
- d. My organization agrees to provide a copy of our FWA training material and evidence of FWA training upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

To report potential fraud, waste, abuse or any other compliance issues, please contact our Compliance Helpline at 866.245.0815, or through our website: ComplianceHelpLine.BSWHealth.com.

Delegation Attestation

4. HIPAA, Privacy and Security Training

- a. My organization, its employees and board members are required to complete the HIPAA training within 90 days of hire and annually thereafter. **AND**
- b. My organization's HIPAA training includes information on how to report and to whom to report Protected Health Information (PHI) disclosures. **AND**
- c. My organization maintains documentation of HIPAA training completion by its employees and board members. **AND**
- d. My organization agrees to provide a copy of our HIPAA training material and evidence of HIPAA training upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

5. Conflict of Interest (COI)

- a. My organization annually screens its employees and board members for conflicts of interest in performing their job functions. **AND**
- b. There were no conflicts disclosed. **OR**
- c. My organization has already informed the Plan or will inform the Plan of the status of said employees' disclosure upon return of this attestation.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

6. Compliance Structure

- a. My organization has a Compliance Officer who has reporting capability free of conflicts of interest to senior leadership, the compliance governing body and the board of directors. **AND**
- b. My organization has a Compliance Committee that oversees the Compliance Program. **AND**
- c. My organization has a governing body (e.g. board of directors or board of trustees) that exercises reasonable oversight of the implementation and effectiveness of the Compliance Program.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

7. Communication and Reporting Mechanisms

- a. My organization has a system to receive, record, respond and track compliance questions or reports of suspected or detected non-compliance or potential FWA from employees, board members and Delegated Entities. This reporting system is available 24 hours a day. **AND**
- b. My organization's reporting system allows for anonymous reporting. **AND**
- c. My organization has a non-retaliation policy for employees, board members and Delegated Entities who report potential compliance and FWA issues in good faith. **AND**
- d. My organization well-publicizes the methods for reporting potential compliance and FWA issues within the organization.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

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Delegation Attestation

8. Exclusion and Identity Screening

The Plan's Delegates are paid in whole or in part from Federal and/or State funds. The list below reflects the exclusion and identity screening requirements.

All Lines of Business:

1. Office of Inspector General's List of Excluded Individuals and Entities (LEIE)
2. System for Awards Management (SAM) [the successor to the Excluded Parties List System (EPLS) (includes OPM)]
3. State Level Excluded Parties Lists (Texas)
4. OFAC SDN and BIS (Patriot Act)

Medicaid ONLY (in addition to 1 – 4 above):

1. SSA-DMF
2. NPPES (only applicable to clinical staff with an NPI)

Medicare ONLY (in addition to 1 – 4 above):

1. CMS Preclusion List

- a. My organization screens its employees, board members and its Delegated Entities working on the Plan business prior to hire or contracting and monthly thereafter, at a minimum, against the sources listed above. **AND**
- b. Additionally, my organization screens its employees working on the Plan Medicaid business against the SSA-DMF prior to initial hire and monthly thereafter and screens all clinical staff who have an NPI against NPPES prior to initial hire and monthly thereafter. **OR**
- c. My organization is not contracted with the Plan to provide services under the Plan's Texas Medicaid Managed Care Contract.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

9. Operational Oversight

- a. My organization performs routine internal operational oversight (consisting of monitoring and auditing activities) to ensure compliance is maintained with all applicable law, rules, regulations and contractual requirements. **AND**
- b. My organization regularly provides operational oversight reporting to the Plan per an agreed schedule or as requested by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

Delegation Attestation

10. Offshore Operations

- a. My organization does not contract with any offshore Delegated Entity. **AND**
- b. My organization will notify the Plan at a minimum of 60 days in advance and obtain approval prior to contracting with an offshore Delegated Entity to perform work on the Plan business. **OR**
- c. My organization contracts with an offshore Delegated Entity to perform work on the Plan business. **AND**
- d. My organization provides the following information:
 - Legal name of the offshore Delegated Entity _____
 - DBA name _____
 - Delegated Entity Address _____
 - Is PHI or PII shared with the Delegated Entity: Yes No
 - Detailed description of the specific function or service performed by the offshore Delegated Entity. _____
 - If more than one offshore Delegated Entity, please provide the requested information for each on a separate attachment.

Plan use only:

- *Plan aware and previously approved offshore arrangement* **OR**
- *Date of offshore arrangement approved* _____ **OR**
- *Offshore arrangement not approved.* **AND**
- *Date of denial communicated to Delegate* _____

11. Delegation Oversight

- a. My organization conducts oversight of its Delegated Entities to validate compliance with all applicable laws, rules, regulations and contractual requirements. **AND**
- b. My organization applies the same requirements set forth in this attestation to its Delegated Entities working on the Plan business. **OR**
- c. My organization does not use any Delegated Entities for the Plan business.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

12. Delegated Entity List

- a. Complete the below grid to list your Entities working on the Plan business/accounts.
- b. If additional space is needed, please provide the requested information on a separate attachment.

Delegate Legal Name	Delegate DBA Name	Tax ID# or Employer ID#	Delegated Function

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Delegation Attestation

13. Disaster Recovery & Business Continuity

- a. My organization has a Disaster Recovery & Business Continuity Plan and attests that both plans follow all applicable laws, rules, regulations and contractual requirements. **AND**
- b. My organization applies the same requirements set forth in this attestation to its Delegated Entities working on the Plan business. **OR**
- c. My organization does not use any Delegated Entities for the Plan business.

- Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

Delegation Attestation

Section II: Sales Attestation

*This section is **ONLY** applicable to Agents, Brokers, Agencies and Field Marketing Organizations (FMOs). If not Agent, Broker, Agency/FMO, proceed to Section III Attestation Authorization and Signature.*

Medicare:

14. Agent/Broker Training and Testing

- a. My organization validates agents/brokers selling Medicare Products are trained and tested annually on Medicare rules, regulations and on details specific to the plan products they sell. **AND**
- b. My organization validates agents/brokers obtained a passing test score of at least 85% prior to selling. **AND**
- c. My organization agrees to provide copies of training materials and testing documentation upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

15. Agent/Broker Licensing

- a. My organization validates agents/brokers are licensed in the State in which they do business. Specifically, my organization validates agents/brokers doing business in Texas, hold a current permanent general life, accident and health insurance agent license. **AND**
- b. My organization agrees to provide copies of licensure upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

Qualified Health Plans (QHPs):

16. Agent/Broker Registration and Training

- a. My organization validates agents/brokers (including web-brokers) are registered with the Exchange prior to enrolling qualified individuals in a QHP or assisting individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. **AND**
- b. My organization validates agents/brokers (including web-brokers) receive annual training in the range of QHP options and insurance affordability programs through the Marketplace Learning Management System or a CMS-approved vendor prior to enrolling qualified individuals in a QHP or assisting individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. **AND**
- c. My organization agrees to provide copies of registration and training verification evidence upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

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Delegation Attestation

17. Agent/Broker Licensing

- a. My organization validates agents/brokers (including web-brokers) are licensed in the state in which they do business. Specifically, my organization validates agents/brokers doing business in Texas, hold a current permanent general life, accident and health insurance agent license. **AND**
- b. My organization agrees to provide copies of licensure upon request by the Plan.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

18. Website Requirements

- a. My organization validates agents/brokers (including web-brokers) use a federal facilitated Exchange website for enrolling qualified individuals in a Qualified Health Plan (QHP) or assisting individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. **OR**
- b. My organization validates agents/brokers (including web-brokers) use a website which prominently displays the required disclaimers and information required by 45 CFR 155.205(b) for enrolling qualified individuals in a QHP or assisting individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

Yes, my organization attests to compliance. **OR**

Provide explanation for non-compliance: _____

Delegation Attestation

Section III: Attestation Authorization and Signature

By signing below, I hereby attest:

- 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 the Plan of any changes to this information. Any updates or new information will be reported to HPCompliance@BSWHealth.org.
- I understand at the Plan's request, I must provide documentation validating the accuracy the information on this form to which I have attested.
- I understand that federal regulations require records be maintained for 10 years and agree to comply with this requirement.

Printed Names of Authorized Representative

Date

Title of Authorized Representative

Email address

Signature of Authorized Representative

Phone number

Organization Legal Name

Tax ID# or Employer ID#

Organization DBA Name

Organization Mailing Address

Sources:

42 C.F.R.

45 C.F.R.

CMS Medicare Managed Care Manual and Prescription Drug Benefit Manual

Texas Medicaid Managed Care Contact

QHP Issuer Agreement

Texas Administrative Code Title 28, Part 1, Chapter 11

Texas Insurance Code Title 8, Subtitle C, Chapter 1272

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