<table>
<tr><td colspan="3">HEALTH PLAN POLICY</td></tr>
<tr><td colspan="2">Policy Title: Annual Attestations from FDRs</td><td>Number: AC31
Revision: D</td></tr>
<tr><td>Department: Administration</td><td colspan="2">Sub-Department: Compliance</td></tr>
<tr><td colspan="3">Applicable Lines of Business: ☐ Children’s Health Insurance Plan ☒ Medicare
☐ Commercial Insured ☐ Non Insured Business
☐ Health Insurance Exchange ☐ USFHP
☐ Medicaid</td></tr>
<tr><td colspan="3">Effective Date: 03/27/2019</td></tr>
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PURPOSE:

The purpose of this policy is to provide written guidelines for the process of ensuring all delegates are in compliance with all applicable laws, rules, and regulations.

DEFINITIONS AND ACRONYMS:

- **Centers for Medicare and Medicaid Services (CMS)** – The federal agency responsible for setting guidelines, regulations, and standards for healthcare providers as well as administering the Medicare and Medicaid programs.
- **Department of Health and Human Services (HHS)**
- **First-Tier, Downstream, or Related Entity**
  - **First Tier Entity** – Any party that enters into a written arrangement, acceptable to CMS, with an 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 Program or Part D program.
  - **Downstream Entity** – Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization (MAO) or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health plan and administrative services.
  - **Related Entity –** Any entity that is related to an MAO or Part D sponsor by common ownership or control.
- **Fraud, Waste, and Abuse (FWA)**
  - **Fraud** – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.
  - **Waste** - Includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
  - **Abuse –** Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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POLICY:

CHRISTUS Health Plan (CHRISTUS), by written contract, may delegate certain functions under its contracts with State and Federal Regulatory Agencies. Functions which may be delegated in whole or in part through the delegation process include, but not limited to, are: network development, credentialing, utilization management, member services, and claims processing/payment. CHRISTUS shall oversee and remains accountable for any functions and responsibilities that it delegates. Besides the delegated processes, CHRISTUS' contract requires all delegates to stay in compliance with CHRISTUS' Compliance Program requirements.

All delegates are required to have an effective Compliance Program and submit an annual attestation to CHRISTUS' Compliance Department attesting that they have complied with, at a minimum, the following Compliance Program requirements:

- All employees/vendors/consultants/governing body member are trained and have access to Compliance, HIPAA and FWA P&Ps within 90 days of hire/contract and annually thereafter.
- All employees/vendors/consultants/governing body member are trained and have received the Code of Conduct within 90 days of hire/contract and annually thereafter.
- All employees/vendors/consultants/governing body member have signed conflict of interest disclosures/attestations.
- All employees/vendors/consultants/governing body member are screened against the OIG/GSA Exclusion List before hire/contract date and monthly thereafter.

The attestation is provided by CHRISTUS at the time of contract, emailed to all delegates annually as well as it is made available on the provider portal. A copy of the attestation is attached with this Policy.

REFERENCES:

- Medicare Managed Care Manual Chapter 21and Prescription Drug Benefit Manual Chapter 9, Section 50.
- The Act §1862(e)(l)(B), 42 CFR §§ 422.503(b)(4)(vi)(A); 423.504(b)(4)(vi)(A).

RELATED DOCUMENTS:

None

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	03/27/2019	Initial release.	Executive Leadership
A	03/11/2020	Annual review. Updated timeframe to receive P&Ps and code of conduct.	Executive Leadership
B	02/27/2021	Annual review. No change to policy content.	Executive Leadership
C	01/31/2022	Annual review. No change to policy content.	Executive Leadership
D	02/21/2023	Annual review. No change to policy content.	Executive Leadership