2020 Attestation of Compliance Form

You or your organization (_____) is contracted with Select Health Network (Select) and participates in plans through Select, which may include Medicare, Medicaid, Exchange or other governmental programs approved by Select's Board of Directors. As a contracted provider or organization, you are subject to all applicable federal and state laws, regulations and sub-regulatory guidance, which includes ensuring the compliance of your organization, contractors, and downstream contractor employees. This document attests to your organization's yearly required compliance, reporting and training. The person who signs this Attestation of Compliance Form must have the authority to attest for the organization.

1. My organization has created, uses and requires board members, partners, executive management, volunteers, subcontractors, agents, employees and temporary employees to abide by the following:
    a. A Compliance Plan
    b. A Code of Conduct, which includes Conflict of Interest
    c. Policies and Procedures, which includes:
        i. Fraud, Waste and Abuse (FWA) requirements outlined in the Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network (MLN) Module
        ii. Privacy and Security Policies as required by the Health Care Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH)

2. My organization requires board members, partners, executive management, volunteers, subcontractors, agents, employees and temporary employees to:
    a. Complete a Conflict of Interest form upon hire and my organization resolves any identified issues.
    b. Complete a Conflict of Interest form annually and my organization resolves any identified issues.
    c. Attest annually to following my organization's:
        i. Corporate Compliance Plan
        ii. Code of Conduct

iii. Conflict of Interest
iv. Fraud, Waste and Abuse Policies and Procedures
v. HIPAA and HITECH Privacy and Security Policies

d. Conducts compliance training within ninety (90) days of hire and thereafter annually, which:
   i. Utilizes the CMS FWA and Compliance Training Module on CMS's MLN; or
   ii. Utilizes my organization's own training program that includes unaltered content from the CMS MLN and separate HIPAA and HITECH Privacy and Security training programs
e. Be screened against the Office of Inspector General (OIG) List of Excluded Individual/Entities (LEIE) and the General Services Administration's System for Award Management (SAM) upon their appointment, hire or date of contracting and at least monthly thereafter.

3. My organization:
   a. Follows all FWA requirements outlined in the CMS Medicare Learning Network Module and provides a way to confidentially (i.e. anonymously) report all instances of FWA. Emphasizes non-retaliation and non-intimidation for good faith reporting of all allegations of noncompliance and/or FWA.
   b. Understands the definitions of fraud, waste and abuse and will report any concerns or suspected violations of the False Claims Act, Stark Law and the Anti-Kickback Statute to Select if it involves any Select plan, contract, business and/or member.
   c. Will immediately report all compliance, legal, and ethical concerns to Select if related to any Select plan, contract, business and/or member.
   d. Is and will remain compliant with all applicable provisions of HIPAA and HITECH.
   e. Will and has reported all non-permitted disclosures and/or breaches of protected health information (PHI) to Select if related to any Select plan, contract, business and/or member.
   f. Is not excluded from participation in any Federal healthcare programs.
   g. Understands that it must keep a printed copy of all verifications in number 2 above.
   h. Understands that it must immediately notify Select if the ownership or controlling interest of our practice or corporate entity changes. This includes ownership and controlling interest by a spouse, parent, child or sibling.

i. Does not contract with any offshore subcontractors to provide services in support of Select plan, contract, business and/or members.
j. Has notified Select of any offshore subcontractor and received written approval from Select to use such resources for a specific scope of work related to any Select plan, contract, business and/or member.
k. Understands that should it have any offshore contractors in the future, the organization must notify Select to receive prior, written approval of work related to any Select plan, contract, business and/or member.
l. Will retain at least 10 years documentation evidencing the compliance requirements have been met and will make those documents available for inspection and review by Select upon request or in support of an audit.

ATTESTATION

The organization identified below (and its affiliates, contractors, and downstream entities), involved in the administration or delivery of services for any Select Health Network contracted plans, contracts, business and/or members, attest to the requirements identified above in this Attestation of Compliance.

_____
Signature

_____
Date

_____
Name (Printed)

_____
Title

SELECT HEALTH NETWORK

_____

Organization Name