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. Changes to this original document will not be accepted. Should you have questions, please reach out to discuss. 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

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.

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.

Section I: Attestation

Organization Legal Name:

DBA Name:

I attest to the best of my knowledge as of the date this document is signed that our organization maintains compliance with the following:

1. Code of Conduct and Compliance Policies

a. My organization has a Code of Conduct and Compliance Policies that state the overarching principles and values by which the company operates **AND**
b. My organization provides copies of our Code of Conduct and Compliance Policies to our employees and board members within 90 days of hire, upon material 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 material revision and annually thereafter. **AND**
d. My organization agrees to provide a copy of our Code of Conduct and Compliance Policies and evidence of distribution of the Code of Conduct and Compliance Policies upon reasonable request by the Plan for auditing and monitoring purposes.

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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_____

2. General Compliance Training

a. My organization requires our 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 our 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 reasonable request by the Plan for auditing and monitoring purposes.

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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3. Fraud, Waste and Abuse (FWA) Training

a. My organization's 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 our employees and board members. **AND**
d. My organization agrees to provide a copy of our FWA training material and evidence of FWA training reasonable request by the Plan for auditing and monitoring purposes.

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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4. HIPAA, Privacy and Security Training

a. My organization's 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 the applicable state and federal timelines. **AND**
c. My organization maintains documentation of HIPAA training completion. **AND**
d. My organization agrees to provide a copy of our HIPAA training material and evidence of HIPAA training upon reasonable request by the Plan for auditing and monitoring purposes.

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

Provide explanation for non-compliance:_____

Please add any additional comments or explanation here:

_____

_____

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 in which a required management plan was not created. **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, as appropriate.

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

Provide explanation for non-compliance: _____

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Please add any additional comments or explanation here:

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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: _____

Please add any additional comments or explanation here:

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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 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: _____

Please add any additional comments or explanation here:

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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.

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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): (where provided by the Plan)

1. CMS Preclusion List

a. My organization screens our 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. My organization screens our 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: _____

Please add any additional comments or explanation here:

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9. Operational Oversight

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

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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10. Offshore Operations

a. My organization does not contract with any offshore Delegated Entity that involves Plan member's PHI/PII. **AND**
b. My organization will notify the Plan at a minimum of 60 days in advance or as required by the contract 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* _____

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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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 applicable 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: _____

Please add any additional comments or explanation here:

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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

Please add any additional comments or explanation here:

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13. Disaster Recovery & Business Continuity

a. My organization has a Disaster Recovery & Business Continuity Plan and attests that it follows 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: _____

Please add any additional comments or explanation here:

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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: _____

Please add any additional comments or explanation here:

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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: _____

Please add any additional comments or explanation here:

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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: _____

Please add any additional comments or explanation here:

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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: _____

Please add any additional comments or explanation here:

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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.

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Delegation Attestation

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

Provide explanation for non-compliance: _____

Please add any additional comments or explanation here:

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Section III: Attestation Authorization and Signature

By signing below, I hereby attest:

- I am authorized to make representations, and attest that to the best of my knowledge, the information noted above is accurate, correct and truthful as of the date this document is signed.
- I understand that updates or new information will be reported to HPCompliance@BSWHealth.org.
- I understand at the Plan's request, documentation validating the accuracy of the information on this form will be provided by my Organization upon reasonable request for auditing and monitoring purposes.
- I understand that federal regulations require records be maintained for 10 years and the Organization agrees 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 Uniform Managed Care Contract
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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