KetteringHEALTH
PHYSICIAN PARTNERS

2024 ANNUAL COMPLIANCE ATTESTATION

Practice Name: _____

Practice Address: _____

Practice Tax ID: _____

As required by the Centers for Medicare & Medicaid Services (CMS), First Tier, Downstream, and Related Entities (FDRs) that provide administrative and/or health care services for Medicare Parts C and D plans must meet specific CMS compliance program expectations. You are receiving this attestation because your organization has elected to participate in one or more contracts through the KHPP network that include a Medicare Advantage and/or Medicaid managed care program/plan. These requirements are further described within CMS's updated guidance on the compliance program requirements and related provisions for Sponsors ("Guidelines"), published in both Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and in Pub. 100-16, Medicare Managed Care Manual, Chapter 21. Often the payers will seek such assurances from KHPP directly instead of seeking assurances from individual network providers. Accordingly, for purposes of ensuring compliance with payer contracts, KHPP has developed a process to validate that each contracted provider has met the requirements ***Please complete the Attestation below to confirm compliance with these payer requirements.***

"Personnel" for purposes of this attestation means your owners, employees, governing body members, volunteers and contractors. The above-named organization attests to the following:

1. Code of Conduct, Compliance Policies, and Compliance Information *(Required)*

My organization has reviewed, understands, and will abide by the payer(s) compliance policies. In addition, my organization **has established and publicized** compliance policies, Code of Conduct, and compliance reference material that meet the requirements set forth by CMS in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A). This information is disseminated to personnel upon hire/appointment/contracting (as applicable) and annually thereafter. A record of receipt of the policies, Code of Conduct, and information by all personnel is maintained and can be provided upon request. The compliance policies and/or Code of Conduct reflect a commitment to preventing, detecting, and correcting non-compliance with CMS requirements.

2. Fraud, Waste and Abuse (FWA) and Compliance Training *(Required)*

My organization has fulfilled FWA and Compliance training and education offered by a payer and/or otherwise conducts its own training and education program that satisfies CMS' requirements. Personnel have completed this FWA and Compliance training within 90 days of hire/appointment/contracting (as applicable) and annually thereafter.

3. Exclusion Screening *(Required)*

My organization **currently performs exclusion screening** prior to hire/appointment/contracting (as applicable) and monthly thereafter to confirm that personnel are not excluded to participate in federally funded healthcare programs according to the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists. If any of these individuals is on an exclusion list, he or she shall be removed from any work related directly or indirectly to federal health care programs and appropriate corrective action will be taken.

4. Fraud, Waste and Abuse and Compliance Issues Reporting Mechanisms *(Required)*

My organization maintains a confidential FWA and Compliance reporting mechanism. It has been distributed and widely publicized for all personnel within the organization to encourage reporting potential FWA and Compliance issues.

5. Offshore Subcontracting *(Required)*

My organization and/or any of our contractors **do not engage in offshore operations** for administrative or healthcare services related to any payer business.

6. Downstream Entity Oversight *(Required*)

Our organization ensures that compliance is maintained by our organization as well as any of our contracted downstream entities. Our organization has strong oversight in place to ensure that any of our subcontracted downstream arrangements that are used to service Medicare business are in compliance with all of the above requirements, as well.

I certify, as an authorized representative of an entity that has a written agreement with KHPP that the statements made above are true and correct to the best of my knowledge. Also, my organization agrees to maintain documentation supporting the statements made above. We'll maintain this documentation in accordance with federal regulations and our contract with KHPP, which is no less than ten (10) years. My organization will produce evidence of the above to KHPP, a health plan or CMS upon request for monitoring or auditing purposes. My organization understands that the inability to produce this evidence may result in a request for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

Signature: _____ ***Date:*** _____

Print Name: _____

Title: _____