



## **Dual Eligible Special Needs Plan (D-SNP) Model of Care Training & Medicare Compliance Program Guidelines Annual First Tier<sup>1</sup> Attestation**

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff to receive basic training about the Special Needs Plans (SNP) Model of Care. Additionally, per the provisions of the Agency for Health Care Administration (AHCA) Contract<sup>2</sup>, HealthSun is required to provide training to network providers to ensure its enrolled dual eligible members receive the appropriate benefits and services.

This training and completion of an attestation are required for new providers and annually thereafter.

As a HealthSun provider, you are required to complete HealthSun's Dual Eligible Special Needs Plans (D-SNP) Model of Care (MOC) training upon on-boarding, and annually thereafter. In addition, you must be in compliance with the Compliance Program and Fraud, Waste and Abuse Education requirements. These requirements are combined for you in this single attestation. Upon completion of this attestation, please submit the form via email to HealthSun Provider Relations Department at [providerservices@healthsun.com](mailto:providerservices@healthsun.com), or via Fax 305-489-8110.

---

### **I. HealthSun D-SNP-MOC**

This attestation confirms you or your organization completed the HealthSun's Dual Eligible Special Needs Plans (D-SNPs) Model of Care (MOC) Training<sup>3</sup> and adhere to the requirements of the HealthSun's D-SNP MOC

### **II. Compliance and Program and Fraud Waste and Abuse (FWA) Training and Education Requirements**

This attestation confirms your commitment to comply with the following CMS requirements:

---

<sup>1</sup> *First Tier Entity is 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 MA program or Part D program.*

<sup>2</sup> *"AHCA Contract" means the agreement between HealthSun Health Plans, Inc. and AHCA for the purpose of providing and paying for Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Medicaid Covered Services to Members.*

<sup>3</sup> *The HealthSun D-SNP Model of Care Training is available on the HealthSun's Website and Provider Portal.*

**1. Code of Conduct and/or Compliance Policies**

My organization has a Code of Conduct and/or Compliance Program Policies that explain our commitment to comply with federal and state laws, ethical behavior and compliance program operation. The Code of Conduct and or Compliance Policies are distributed to employees within ninety (90) days of hire, upon revision and annually thereafter.

**2. US Department Health & Human Services Office of Inspector General (OIG) and General Services Administration’s System for Award Management (SAM) exclusion screening.**

My organization screens the OIG<sup>4</sup> and the SAM<sup>5</sup> exclusion lists prior to hire or contracting, and monthly thereafter, for all employees and downstream entities. My organization immediately removes any person/entity from working on HealthSun’s Medicare business if found on either of these lists, and we will notify HealthSun right away.

**3. Reporting Mechanisms**

My organization communicates to employees how to report suspected or detected non-compliance or potential Fraud, Waste, or Abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization requests employees to report concerns and maintains confidential and anonymous mechanisms for employees to report internally. In turn, we (our organization) will report these concerns to HealthSun as applicable.

**4. Offshore Operations**

If my organization and/or our downstream entities perform work that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI) offshore, my organization understands and acknowledges that we will not, in connection with any functions, activities or services related to HealthSun’s business, perform any work outside of the United States.

**5. Downstream entity oversight (please mark as appropriate for your organization)**

- My organization **does not contract** downstream entities or uses downstream entities for HealthSun business.
- My organization **contracts with downstream entities** to conduct HealthSun business and conducts oversight to ensure that they abide by all laws, rules and regulations that apply to us as a first tier entity. This includes ensuring that my organization’s:
  - Contractual agreements with downstream entities contain all CMS required provisions.
  - Downstream entities comply with the Medicare Compliance Program requirements described in this attestation.
  - Downstream entities comply with any applicable Medicare operational requirements.

---

<sup>4</sup> <https://exclusions.oig.hhs.gov>

<sup>5</sup> <https://www.sam.gov/SAM/>

**6. Operational Oversight**

My organization conducts internal oversight of the services that we perform for HealthSun and ensure compliance is maintained with applicable laws, rules and regulations including CMS regulatory/sub-regulatory guidance.

**7. Record Retention**

My organization maintains supporting documentation and records for a period of 10 years in accordance to federal and HealthSun contract requirements after training completion for all employees supporting HealthSun’s business, and can furnish the documentation upon request. *(Samples of documentation may include and it is not limited to FWA, General Compliance training, OIG/GSA Exclusion documentation, monitoring/audit records).*

**Attestation**

I hereby certify that I am an authorized representative of the Provider/Physician named below and the statements above made are true and correct to the best of my knowledge.

<b>Name of Provider/FDR/Organization</b>	
<b>Tax ID/ Employer ID</b>	
<b>Name of Authorized Representative</b>	
<b>Authorized Representative Title</b>	
<b>Signature of Authorized Representative</b>	
<b>Date</b>	

Please complete this section below:

**Name of MSO/Group/Practice:**

\_\_\_\_\_

<b>Name of Practitioner/Provider/Staff Member</b>	<b>Rendering NPI Number (as applicable)</b>

Please submit this attestation form via email to HealthSun’s Provider Relations Department at [providerservices@healthsun.com](mailto:providerservices@healthsun.com) or via Fax 305-489-8110.