Dual Eligible Special Needs Plan (D-SNP) Model of Care Training & Medicare Compliance Program Guidelines Annual First Tier[1] 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[2], 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, or via Fax 305-489-8110. Please specify which of the following applies to you:

☐ I am an individual Provider who provide services to HealthSun Health Plan members.
☐ I represent an Organization who provides services to Healthsun Health Plan members.

I. HealthSun D-SNP-MOC

This attestation confirms that I / my organization has completed the HealthSun's Dual Eligible Special Needs Plans (D-SNPs) Model of Care (MOC) Training[3] and adhere to the requirements of the HealthSun's D-SNP MOC

[1] *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.*

[2] *"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.*

[3] *The HealthSun D-SNP Model of Care Training is available on the HealthSun's Website and Provider Portal.*

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:

1. **Code of Conduct and/or Compliance Policies**
   I / My organization has reviewed Anthem's Code of Conduct and/or have comparable 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. (*Only applies to organizations*)**
   My organization screens the OIG[4] and the SAM[5] 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**
   I / 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 (*Only applies to organizations*)**
   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)***
   ☐ I am an individual Provider and I do not contract with or use downstream entities for HealthSun business.

   ☐ *My organization **does not contract** downstream entities or uses downstream* entities to support HealthSun business.

[4] *https://exclusions.oig.hhs.gov*

[5] *https://www.sam.gov/SAM/*

☐ 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.

6. **Operational Oversight**
   I / My organization conduct(s) 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**
   I / My organization maintain(s) 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.

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

Please complete this section below:

Name of MSO/Group/Practice: (Only applies to organizations)_____

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

Please submit this attestation form via email to HealthSun's Provider Relations Department at providerservices@healthsun.com or via Fax 305-489-8110.