MOUNT CARMEL HEALTH PARTNERS, LLC ("MCHP")
2017 ANNUAL COMPLIANCE ATTESTATION

Group Name	Taxpayer Identification Number (TIN)

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 MCHP 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 and are identical in each.

"Personnel" for purposes of this attestation mean 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 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 the FWA and Compliance training requirement via the CMS FWA and Compliance training. All 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, or the equivalent for those that are offshore. 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 MCHP 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 MCHP, which is no less than ten (10) years. My organization will produce evidence of the above to MCHP, a health plan or CMS upon request. 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:	

For additional information or questions, contact Kristi McVay Manager, Credentialing kmcvay@mchs.com or 614-546-4264.

PLEASE RETURN THIS FORM TO:
Email to Renee Sudimack rsudimack@mchs.com or mail in the postage paid envelope provided or to the following address:

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