PARAMOUNT
Affiliate of ProMedica

2021 Annual Attestation

Contracted Entity/Individual (Broker or Provider): _____

Section I: Instructions for Completing the Attestation
Please complete this form in its entirety and return the completed form to one of the following: Paramount, Attention: Delegation Oversight Email: PhcDelegateOversight@ProMedica.org; or Fax: (567) 585-9457; or Mail: 1901 Indian Wood Circle, Maumee, Ohio 43537 **For FDR resources and helpful information, please visit our website at:** http://www.paramounthealthcare.com/medicare-fdr-compliance

Section II: Annual Attestation	**Response**
1. I attest that my organization has provided, and will continue to provide, **compliance training** for all employees (including temporary employees, volunteers and others acting as part of our workforce) and contractors involved in providing services for Paramount's Medicare Advantage Plan (PMAP). The training is provided to employees and contractors at the time of hire/contract execution and annually thereafter.	Yes ☐ No* ☐
2. I attest that my organization has read and understand Paramount's policies, procedures, including FWA/Compliance, and Standards of Conduct or my organization has equivalent documentation. My organization has implemented and distributed them to all appropriate employees, board members, partners, and contractors of my organization within 90 days of hire/contract execution and annually thereafter.	Yes ☐ No* ☐
3. I attest that my organization has reviewed, and will continue to review, the Office of the Inspector General (OIG)/List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) for our employees (including temporary employees, volunteers and others acting as part of our workforce), governing board members or any shareholders, and contractors responsible for providing services for PMAP. Exclusion screenings from these sources are checked prior to initial hire/contract execution and monthly thereafter. Any individual found on such lists, will immediately be removed from any work directly or indirectly related to PMAP. If applicable, I attest that my organization meets all CMS Preclusion List screening, notification, and termination requirements because I contract with PMAP.	Yes ☐ No* ☐
4. My organization agrees to maintain records of training, disciplinary standards, and exclusion checking of all governing body members, all employees, including temporary staff and volunteers as well as downstream entities, for a minimum of 10 years. Records maintained must include, but not limited to: Training materials and training logs, documentation of exclusion checks, and compliance program policies and procedures.	Yes ☐ No* ☐
5. I attest that my organization is and will remain in compliance with all applicable CMS, State, and Federal guidance, during the term of the Agreement with Paramount, and will immediately notify Paramount of all suspected or known instances of noncompliance, FWA, and/or privacy breaches impacting Paramount or Paramount's members. Providers of healthcare services are excluded from notifying Paramount of privacy breaches.	Yes ☐ No* ☐
6. I attest that my organization has and will continue to monitor our contractors (downstream and related entities) with which we have contracted to provide services for PMAP, and will, upon Paramount's request, obtain the same documentation requirements listed above from those entities.	Yes ☐ No* ☐

Explanation required for any "No*" response to the questions above (attach additional pages as necessary):

_____

Please refer to Paramount's FDR Compliance Guide on the Paramount website for offshore subcontractor regulations and other helpful information.	
Section III: Offshore Subcontracting Attestation	**Response**
1. My organization uses an offshore subcontractor to perform functions that support our contract with	Yes ☐

(Continued on next page)

Medicare FDRs

Paramount. **If no, skip to #9.**	No ☐
Offshore subcontractor name (if applicable – attach additional pages as necessary):	
Country of offshore function:	Offshore address:
Offshore function(s):	
Description of PHI to be provided to offshore subcontractor/staff:	
Description of the reason providing PHI offshore is necessary:	
Description of alternatives considered to avoid providing PHI offshore and why each was rejected:	
Proposed or actual effective date for offshore subcontractor or staffing:	
2. Offshore subcontractor/staff has policies and procedures in place to ensure that Protected Health Information (PHI) and other personal information remains secure.	Yes ☐ No* ☐
3. Offshore subcontractor/staff does not have access to (or is prohibited from accessing) member data not associated with the functions subcontractor/staff performs for our organization.	Yes ☐ No* ☐
4. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	Yes ☐ No* ☐
5. Offshore subcontracting agreement with our organization includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.).	Yes ☐ No* ☐
6. My organization conducts (or will conduct) an annual audit of offshore subcontractor and monitors offshore staff's access to PHI.	Yes ☐ No* ☐
7. Offshore subcontractor audit results will be used by our organization to evaluate the continuation of its relationship with the offshore subcontractor.	Yes ☐ No* ☐
8. My organization agrees to share offshore subcontractor's audit results with Paramount and/or CMS upon request.	Yes ☐ No* ☐
9. My organization agrees to notify Paramount at least 60 days in advance of our intent to use new offshore subcontractor(s) or before employing new offshore staff for a function Paramount has asked us to perform.	Yes ☐ No* ☐

Explanation required for any "No*" response to the questions above (attach additional pages as necessary):

_____

Section IV: Attestation Authorization
By signing below, I hereby attest that the information contained herein is true, correct and complete and agree to complete this attestation on an annual basis.

Printed Name of Authorized FDR Representative:	Date:
Title of Authorized FDR Representative:	Email address:
Signature of Authorized FDR Representative:	Phone #: