2024 First Tier, Downstream and Related Entity (FDR) Annual Attestation of Compliance

The Centers for Medicare and Medicaid Services (CMS) requires any organization or individual that contracts with ATRIO Health Plans who provides administrative or healthcare service functions on behalf of ATRIO to comply with various CMS program requirements. By completing the following attestation, you certify that your organization is compliant with all applicable ATRIO and CMS requirements. If you are not compliant with any of the requirements, please contact us at Compliance@atriohp.com so that we can discuss your specific situation and ways to ensure compliance.

Completion of Required Training
1 ☐ My organization complies with required HIPAA training as outlined in 45 CFR 164.530 2 ☐ My organization conducts General Compliance training and Fraud, Waste, and Abuse (FWA) training to identify, correct, and prevent potential FWA for its employees and contractors involved in the administration or delivery of ATRIO benefits or services within 90 days of hire or contracting, and annually thereafter as required in 42 CFR 422.503(b)(4)(vi)(C). **My organization maintains records of satisfaction of educational requirements:** 3 ☐ My organization maintains records such as attestations, training logs, or certificates of completion to confirm completion of education requirements and will make such records available for inspection by ATRIO, the Department of Health and Human Services, the Comptroller General, or the designee of any of the aforementioned entities for a period of 10 years from the end of my organization's contract with ATRIO or longer, if required by CMS.
Code of Conduct
ATRIO's Code of Conduct (COC) has been made available to our organization for the contract year and (please select applicable box): 4 ☐ We provided ATRIO's COC to all our employees and contractors within 90 days of hire or contracting, when there are updates to the COC, and annually thereafter. We require employees and contractors involved in ATRIO Services to perform their job functions in accordance with ATRIO's COC. 4a ☐ My organization utilized our own comparable version of the COC which satisfies all requirements for COC according to 42 CFR 422.503(b)(b)(vi)(A) and Managed Care Manual Chapter 21 Section 50.1.1 for the contract year. We provided our own COC to all our employees and contractors within 90 days of hire or contracting, when there were updates, and annually thereafter. We require employees and contractors involved in ATRIO Services to perform their job functions in accordance with my organization's COC.
Compliance Policies
5 ☐ My organization has implemented and maintained compliance policies and procedures specific to my organization that demonstrate my organization's commitment to operating in compliance with applicable Medicare regulations and to detection, prevention, and correction of issues of noncompliance according to 42 CFR 422.503(b)(4)(vi)(A) and Medicare Managed Care Manual Chapter 21 Section 50.1.3

6 ☐ My organization has distributed compliance policies to our employees who support ATRIO's Medicare business within 90 days of hire, when there are updates, and annually thereafter.

LEIE/EPLS Exclusion Screening

7 ☐ As required in The Act 1862(e)(1)(B), 42 CFR 422.752(a)(8), 42 CFR 1001.1901 and the Medicare Managed Care Manual Chapter 21 Section 50.6.8; During the contract year, my organization reviewed the DHHS Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the SAM database maintained by General Service Administration (GSA) Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, subcontractor and/or downstream entity, **and monthly thereafter**, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

Reporting Non-Compliance, FWA and HIPAA Incidents

8 ☐ During the contract year, my organization's employees and contractors were informed of their obligation to report any suspected FWA, non-compliance or HIPAA incidents for internal investigation.

9 ☐ My organization maintains a reporting mechanism that allows employees and contractors to report HIPAA incidents and suspected FWA or non-compliance anonymously.

10 ☐ My organization prohibits retaliation or intimidation against anyone who reports suspected FWA or non-compliance in good faith.

If the above stated verbiage in 1 – 10 does not align with the actions of your organization, please provide an explanation below:

Offshore Subcontractor Reporting

During the contract year, my organization *and/or any of its downstream or related entities* (CHECK ONE):

11 ☐ DID

11a ☐ DID NOT

engage in offshore operations for any **administrative or healthcare services** related to ATRIO business.

If your organization and/or any of our downstream/related entities DID engage in offshore operations, please complete the "Offshore Subcontractor Attestation" for each entity.

Downstream Entity Oversight

12 ☐ My organization does not delegate performance of ATRIO Services to any other entity.

13 ☐ My organization delegates performance of one or more of the ATRIO Services to another entity, and:

13a ☐ During the contract year, my organization obtained or will obtain the same attestation(s) provided herein from each such entity.

13b ☐ During the contract year, my organization performed ongoing oversight of all such entities.

Please list any/all delegated entities and the services they perform:

As authorized representative for the below named organization, I certify that I have reviewed and understand all the requirements within ATRIO's FDR policy, that the above statements are true to the best of my knowledge, and that my organization maintains records that support our compliance.

Organization Name: _____

Organization Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative (print name): _____

Authorized Representation (signature): _____

Date: _____

Organization's Authorized Representative's Title:

_____

Organization's Authorized Representative's Phone Number: _____

Organization's Authorized Representative's Email Address: _____

Please send the completed and signed attestation to Compliance@atriohp.com

You may also direct questions or concerns regarding this attestation to Compliance@atriohp.com