VENDORPROOF
by ProviderTrust

Note: *All vendors will be asked to complete the following five (5) questions to ensure that Community Health Systems has documented whether your organization handles any of the following types of information. If these questions do not apply to your organization, simply select "no" and follow the prompts to complete your enrollment.*

General Inherent Risk Questions

1. Do the services provided to or on behalf of Community Health Systems by your organization include creating, receiving, processing, storing/maintaining, or transmitting of Community Health Systems' protected health information ("PHI") as defined in 45 CFR §160.103? **(Yes/No; if Yes then 2-4 and continue to Medicare Advantage Questionnaire, or No then 2-4)**

2. Do the services provided to or on behalf of Community Health Systems by your organization include creating, receiving, processing, storing/maintaining, or transmitting Community Health Systems' personally identifiable information ("PII") as defined in NIST SP 800-122? **(Yes/No; if Yes or No then 3-4)**

3. Do the services provided to or on behalf of Community Health Systems by your organization include creating, receiving, processing, storing/maintaining, or transmitting cardholder data, or data governed by payment card industry data security standards ("PCI DSS")? **(Yes/No; if Yes or No then 4)**

4. Do the services provided to or on behalf of Community Health Systems by your organization include creating, receiving, processing, storing/maintaining, or transmitting Community Health Systems' data outside the jurisdiction of the United States (e.g. "offshoring")? **(Yes/No; if Yes then 5 and proceed to Medicare Advantage Questionnaire if 1 was Yes, if No then proceed to Medicare Advantage Questionnaire if 1 was Yes)**

5. What are the cities and countries outside of the jurisdiction of the United States in which offshoring occurs?

Note: *If your organization answered "yes" to Question 1 on the General Inherent Risk Questions, the following questionnaire applies based on Community Health Systems being a provider under contract with Medicare Advantage Organizations*

Medicare Advantage Organization First Tier, Downstream, Related Entities (FDR) Vendor Survey Questionnaire and Attestation

Why is your organization required to complete this Survey Questionnaire and Attestation?

As Medicare Advantage participants, Community Health Systems affiliated entities are required to have their contractors reviewed to obtain assurance in accordance to Medicare Advantage Organization First Tier, Downstream and Related Entity (FDR) requirements. Community Health Systems hold contracts with Medicare Managed Care Organizations (MCO) nationwide. In order to participate in the various Medicare Advantage Plan Programs, Community Health Systems is required to ensure each FDR contracted to perform services is in compliance with the requirements set forth under the Medicare Advantage Plan Compliance Program Guidance Chapters 9 and 21. Completing this questionnaire and attestation will demonstrate your organizations commitment to compliance and be provided to the Medicare Managed Care Organization or the Centers for Medicare and Medicaid Services upon request.

Medicare Advantage Organization Questionnaire

1. Does your organization have a program based on the Department of Health and Human Services Office of Inspector General's published guidance on an effective Compliance Program? **(Yes/No; if Yes or No then 2)**

2. Has your organization appointed a representative to serve as the Compliance Officer or in a similar capacity to implement, monitor, educate employees and vendors, and enforce the organization's Compliance Program**? (Yes/No; if Yes or No then 3)**

3. Has your organization, or its appointed representative, reviewed Medicare Advantage Plan Compliance Program Guidance Chapters 9 and 21 as applicable? (Yes/No: If Yes or No then 4)

4. Are you aware of your organizations responsibilities as a FDR as set forth by CMS? **(Yes/N; if Yes or No then 5**

5. Has your organization adopted a Code of Conduct and applicable Policies and Procedures which meet CMS requirements relevant to providing services/ items to patients which may include Medicare, Medicare Advantage Plans, or other government beneficiaries? **(Yes/No; if Yes or No then 5(a)).**

a. Does your organization keep a log certifying that employees have read and agree to comply with the Code of Conduct and Policies and Procedures upon hire and annually thereafter? **(Yes/No; if Yes or No then 5(a)(i)).**

    i. Does the log at a minimum include the employees, vendor/contractor, board members, or volunteers name, course completed, and training completion date? **(Yes/No; Yes or No then 5(a)(ii)).**

    ii. Is this log readily available upon request from CMS? **(Yes/No; Yes or No then 5(b)).**

b. Does your Code of Conduct or applicable Policies and Procedures include language about non-retaliation for good faith reporting of suspected violations, noncompliance, or fraud, waste, and abuse? **(Yes/No; if Yes or No then 5(c)).**

c. Has your organization adopted a Conflict of Interest Policy or Procedure requiring the disclosure/ report of all potential and actual conflicts by employees and potential/ current business partners prior to employment/ contract and annually afterwards? **(Yes/No; if Yes or No then 5c(i)).**

    i. Do you monitor to ensure employees and vendors are free of Conflicts of Interest, or that any reported potential conflicts have been vetted, managed, or eliminated, if necessary? **(Yes/No; if Yes or No then 5(d)).**

d. Does your organization have a policy prohibiting employment or contracting with an individual or entity sanctioned or excluded from participating in any federally funded health care program? **(Yes/No; if Yes then 5(d)(i), if No, mark 5(d)(i) and 5(d)(ii) as No and then 5(e)).**

    i. Does the policy require the immediate removal of an employee or subcontractor from work in the event the individual or entity is identified as being excluded, suspended, or debarred from any federally funded benefit program? **(Yes/No; if Yes then 5(d)(ii), if No, mark 5(d)(ii) as No and then 5(e)).**

    ii. Does the organization take corrective action including immediate disclosure to Community Health Systems of any employee/contractor found to be excluded, suspended, or debarred? **(Yes/No; if Yes or No then 5(d)(iii))**

    iii. Do you monitor to ensure employees, board members, volunteers, and contractors/ vendors are not sanctioned or excluded from participating in state or federally funded health care programs prior to hire/ contracting and monthly thereafter? **(Yes/No; if Yes or No then 5(e)).**

e. Does your organization have a well-publicized disciplinary action policy and apply this policy appropriately for compliance related incidents to employees, contractors, and vendors? **(Yes/No; if Yes then 5(e)(i), if No, mark 5(e)(i) as No and then 5(f)).**

    i. Does the policy or procedure specifically state that any violation of these standards will result in appropriate disciplinary action up to and including termination of employment? **(Yes/No; if Yes or No then 5(f)).**

f. Does your organization have a policy requiring employees, contractors/ vendors, board members, and volunteers to report suspected compliance violations to a member of management, the Compliance Officer, or appointed compliance representative, or to a another mechanism implemented to receive reports of noncompliance (e.g. hotline) without the fear of retaliation? **(Yes/No; if Yes then 5(f)(i), if No, mark 5(f)(i) and 4(f)(ii) as No and then 5(f)).**

    i. Does your organization have a policy or procedure requiring documentation of a reported compliance issue and resolution of the reported issue to include corrective actions taken to address any substantiated reports including notification to Community Health Systems, Medicare contractors, and government agencies, as appropriate? **(Yes/No; if Yes then 5(f)(ii), if No, mark 5(f)(ii) as No and then 5(g)).**

    ii. Has the organization taken adequate measures to communicate how to report suspected noncompliance or fraud, waste, and abuse to the organization's Compliance Officer or appropriate representative (e.g. hotline posters, discussion during departmental meetings, etc…)? **(Yes/No; if Yes or No then then 5(g)).**

g. Does your organization have policies and procedures requiring retention of records in accordance with Medicare requirements (e.g. in most cases records must be retained and available to CMS for a period of at least 10 years or longer)? **(Yes/No; if Yes then 5(g)(i), if No mark 5(g)(i) as No then 6).**

h. Are these records readily available upon request by CMS? **(Yes/No; if Yes or No then 6).**

6. Does your organization perform compliance training for employees and governing body members (e.g. board of directors) within 90 days of hire and annually thereafter? **(Yes/No; if Yes then 6(a), if No mark 6(a), 6(b) and 6(c) as No then 7).**

    a. Does your organization's training include completion of CMS' mandatory Compliance and Fraud, Waste, and Abuse Training?

- Relevant CMS Training is located at the two URL's listed below: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

  (Yes/No; if Yes or No then 6(b)).

b. Does your organization's training educate employees, board members, volunteers, and contractor's/vendors on relevant policies and procedures to include but not limited to:

   - The organization's Code of Conduct;

   - Non-retaliation for reporting suspected compliance issues;

   - Disciplinary process; and

   - Reporting mechanisms available to employees for reporting suspected noncompliance or fraud, waste, and abuse?

     (Yes/No; if Yes or No then 6(c)).

c. Does your organization monitor completion of employees, board members, contractors/ vendors, and volunteers regarding training requirements and logs certifying that employees have read and agree to abide by the organizations Code of Conduct and Policies and Procedures?

   (Yes/No; if Yes or No then 7)

7. Does your organization have a system in place to monitor the effectiveness of your Compliance Program and affiliated entities' compliance with Medicare, Medicare Advantage Plans, or other government requirements? **(Yes/No; if Yes then 7(a), if No then mark 7(a) and 7(b) as No then 8).**

   a. Does your organization develop an audit and monitoring plan to include review of business practices to ensure compliance with applicable federal and state regulations? **(Yes/No; if Yes or No then 7(b)).)**

   b. Does your organization's compliance program assess regulatory and compliance risks at least annually? **(Yes/No; if Yes or No then 8)**

8. Does your organization or any of your subcontractors/ vendors perform functions which are physically located outside of the United States or one of its territories? **(Yes/No; if Yes then 8(a), if No move to Attestation Statement).**

    a. Provide the following information for any person or entity contracted to provide services/ items for Medicare, Medicare Advantage Plans, or other governmental beneficiary which are physically located outside of the United States or one of its territories: **(Then 8(a)(i)).**

        i. Vendor Name; **(Text Data; then 8(a)(ii)).**

        ii. Offshore Subcontractor Country; **(Text Data; then 8(a)(iii)).**

        iii. Offshore Subcontractor Address; **(Text Data; then 8(a)(iv)).**

        iv. Proposed or Actual effective date for offshore subcontract; **(Text Data; then 8(a)(v)).**

        v. Will PHI be provided to the Offshore contractor? **(Yes/No; if Yes then 8(a)(v)(1), if No then move to Attestation Statement)**

            1. Explain why PHI is necessary to provide to offshore contractor; **(Text Data; then 8(a)(v)(2)).**

            2. Describe alternatives considered to avoid providing PHI and why each alternative was rejected; **(Text Data; then 8(a)(v)(3)).**

            3. Does offshore contracting arrangement have policies and procedures in place to ensure PHI and other personal information remains secure; **(Yes/No/Unknown; if Yes, No or Unknown then 8(a)(v)(4)).**

            4. Does offshore subcontract arrangement prohibit subcontractor's access to data not associated with the sponsors contracts; **(Yes/No; if Yes or No then 8(a)(v)(5)).**

            5. Does offshore subcontracting arrangement have policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach; **(Yes/No/Unknown; if Yes, No or Unknown then 8(a)(v)(6)).**

            6. Does offshore subcontracting arrangement include 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; if Yes or No then 8(a)(v)(7)).**

7. Does the organization conduct an annual audit of the offshore subcontractor; **(Yes/No; if Yes or No then 8(a)(v)(8)).**

8. Will the audit results by the organization be utilized to evaluate the continuation of its relationship with the offshore contractor; **(Yes/No; if Yes or No then 8(a)(v)(9)).**

9. Does the organization agree to share offshore subcontractor's audit results with CMS, upon request? **(Yes/No; if Yes or No then 7(a)(v)(10)).**

10. For your arrangements with offshore subcontractors requiring PHI to be provided to the offshore entity does your organization audit against the criteria listed above at 8(a)(v)(2-10)? **(Yes/No; if Yes or No then 8(a)(v)(11)).**

11. Does your organization or any of your subcontractors/ vendors perform functions which are physically located outside of the United States or one of its territories other than those already disclosed? **(Yes/No; if Yes then 8(a), if No move to Attestation Statement)**

As an authorized representative of (Insert name of vendor), I attest that the information provided above is accurate and complete. Our organization shall maintain evidence and records and shall provide said documentation upon request. I also attest the organization is compliant with applicable laws, rules and regulations governing Medicare Advantage Organization requirements. **(Once Rep indicates acceptance of Attestation Statement, mark Complete)**

_____

Representative Print/ Typed Name

_____

Representative Signature