



FDR Compliance Guide

2026



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Introduction to the FDR Compliance Guide

Select Health relies on our contracted providers and other contracted individuals and entities to help us meet the needs of our membership according to Medicare Advantage and Part D program requirements. These individuals and organizations are considered First Tier, Downstream, and Related Entities (FDRs). FDRs are individuals or entities to which Select Health has delegated administrative or health care service functions relating to the Select Health Medicare Advantage contract with CMS. They are a vital part of the Select Health Medicare Advantage program and have specific responsibilities under Medicare guidelines.

The purpose of this Compliance Guide is to assist FDRs in understanding and meeting their compliance obligations under the Select Health Compliance Program.



SECTION 2

Select Health Medicare Compliance Program

Select Health is committed, as a Centers for Medicare and Medicaid Services (CMS) contracted Medicare Advantage Organization (MAO), to operating a health plan that meets the requirement of all applicable laws and regulations of the Medicare Advantage and Part D programs.

Intermountain Health is the parent company of Select Health. Our commitment to operate a compliant health plan is embodied in our standards of conduct which are called the Intermountain Health Code of Conduct. The Code of Conduct is something each Select Health caregiver commits to uphold in their job and the standards of which are reinforced often with caregivers and Select Health-contracted providers and vendors.

According to CMS rules, each MAO (or plan sponsor) must implement a compliance program that is effective in preventing, detecting, and correcting Medicare Advantage and Part D program noncompliance as well as program fraud, waste, and abuse. The compliance program is evaluated regularly based on CMS' seven elements of an effective compliance program.

A description of the seven elements of the Select Health Compliance Program as they relate to FDRs is provided below.

1. Written Policies, Procedures, and Standards of Conduct

The Code of Conduct describes the principles and values by which Select Health operates and is the foundation for compliance policies and procedures. Select Health makes its Code of Conduct available to FDRs in Section four of this Compliance Guide and on the [Compliance page and footer of the Select Health Medicare website](#).

2. Designation of Compliance Officer and Committee

The Select Health Compliance Committee oversees the Medicare Compliance Program by supporting and advising the Select Health Medicare Compliance Officer and the Medicare Compliance Team. The Committee meets regularly with the Compliance Officer to discuss the status of the Compliance Program. Select Health senior management, including the Select Health CEO and Board of Trustees, are provided regular reports of compliance activities, risk areas, and strategies.

3. Effective Training and Education

The effectiveness of training and education is apparent when everyone involved with providing health or administrative services to Medicare enrollees understands the rules and regulations that apply to their job and assignments. Effective training also prepares all of us to identify and report Medicare program noncompliance or potential fraud, waste, and abuse (FWA). Due to our strong commitment to the highest standards of ethics and integrity, annual compliance and FWA training is considered a requirement for Select Health caregivers and FDRs.

4. Effective Lines of Communication

Select Health makes available several reporting methods for FDRs including a mechanism for anonymous reporting. Section five of this Compliance Guide outlines the reporting methods and **Appendix A** provides a Reporting Poster that can be distributed to FDR employees. Any concerns, suspected misconduct, potential noncompliance, or possible FWA may be reported to Select Health and Select Health will promptly investigate the report. Select Health policy prohibits retaliation or intimidation against anyone who reports suspected violations in good faith.

5. Disciplinary Standards

Select Health policies enforce standards when an investigation reveals noncompliant or unethical behavior. Disciplinary standards may include re-training, specialized training, or disciplinary action up to and including termination of employment or termination of a contract for behavior that is serious or repeated.

6. Monitoring, Auditing, and Identification of Risk

Select Health performs regular risk assessments, including an assessment of activities delegated to FDRs. Risk assessments are used to guide the work and activities of the Compliance Program and to develop an annual audit plan. Select Health monitoring activities are structured to regularly review normal operations to confirm ongoing compliance using metrics and key performance indicators. As a federally funded health benefit plan sponsor, Select Health also monitors federal lists to identify providers and other individuals and entities that are excluded from participation in federal programs.

7. Response to Compliance Issues and Corrective Action

Compliance issues or suspected FWA may be identified through Compliance Hotline reports, a member complaint, routine monitoring or auditing, or by regulatory authorities. If misconduct is discovered or suspected, a prompt investigation is initiated by Select Health. If the report is substantiated, an appropriate corrective action plan is developed and implemented. At times the corrective action could include disclosing the issue to applicable regulators and/or federal contractors.

Effective Compliance Program

The following seven elements are essential to Select Health achieving and maintaining an Effective Compliance Program.

Let's learn more about each of these elements...



SECTION 3

FDR Compliance Requirements and How to Meet Them

Select Health is committed to operating a health plan that meets the requirements of all applicable laws and regulations of the Medicare Advantage and Part D programs. As part of an effective compliance program, the Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage plans to ensure that any FDRs to which the provision of administrative or healthcare services are delegated are also in compliance with applicable laws and regulations.

The key compliance requirements for FDRs and recommendations for meeting those requirements are outlined below. Select Health provides an FDR Annual Compliance Attestation (see Appendix B) for your organization to validate compliance with these requirements.

1. Standards of Conduct and Compliance Policies

REQUIREMENTS:

In order to communicate the plan sponsor's compliance expectations for FDRs, plan sponsors should ensure that Standards of Conduct and policies and procedures are distributed to FDR employees. Plan sponsors may make their Standards of Conduct and policies and procedures available to their FDRs. Alternatively, the plan sponsor may ensure that the FDR has comparable policies and procedures and Standards of Conduct of their own. Distribution must occur within 90 days of hire, when there are updates to the policies, and annually thereafter. (*Medicare Managed Care Manual Ch. 21 §50.1.3*).

How to Comply:

You can either distribute your organization's own Standards of Conduct and compliance policies and procedures to your employees or you may distribute the Select Health materials. Select Health makes its Code of Conduct available to FDRs in Section Four of this Compliance Guide and also on the **Compliance Program page of the Select Health Medicare website**.

2. General Compliance and Fraud, Waste, and Abuse (FWA) Training

REQUIREMENTS:

General Compliance Education – Plan sponsors must ensure that general compliance information is communicated to their FDRs. The plan sponsor's compliance expectations can be communicated through distribution of the plan sponsor's Standards of Conduct and/or compliance policies and procedures to FDR's employees. (*Medicare Managed Care Manual Ch. 21 §50.3.1*).

FWA Training – The plan sponsor's employees (including temporary workers and volunteers), and governing body members, as well as FDRs' employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Plan sponsors must be able to demonstrate that their employees and FDRs have fulfilled these training requirements as applicable. Examples of proof of training may include copies of sign-in sheets, employee attestations, and electronic certifications from the employees taking and completing the training. (*Medicare Managed Care Manual Ch. 21 §50.3.2*).

How to Comply:

- Have a compliance and fraud, waste, and abuse training in place for employees. You can also use the **CMS Standardized General Compliance Module** and the **FWA Training Module**.
- Ensure that any of your employees that support Select Health Medicare programs take the training within 90 days of hire and annually thereafter.
- If you are "deemed" (see definitions in Section Seven) for FWA training, you do not need to take the Select Health FWA training or the CMS Standardized FWA training, but are still required to complete general compliance training. Select Health must still communicate general compliance information to its FDRs. Select Health provides General Compliance information to you and your employees through the following methods:
 - This FDR Compliance Guide
 - The Select Health Code of Conduct
 - The Select Health Reporting Flyer
 - Providing access to the CMS standardized General Compliance and FWA Training Module.

These resources are available on the **Compliance Program page of the Select Health Medicare website**.

3. Reporting Mechanism for FWA and Compliance Issues

REQUIREMENTS:

Plan sponsors must have a system in place to receive, record, respond to and track compliance questions or reports of suspected or detected noncompliance or potential FWA from employees, members of the governing body, enrollees and FDRs and their employees. Reporting systems must maintain confidentiality (to the greatest extent possible), allow anonymity if desired (e.g., through telephone hotlines or mail drops), and emphasize the plan sponsor's/FDR's policy of non-intimidation and non-retaliation for good faith

reporting of compliance concerns and participation in the compliance program. FDRs that partner with multiple plan sponsors may train their employees on the FDR's reporting processes including emphasis that reports must be made to the appropriate plan sponsor.

The methods available for reporting compliance or FWA concerns and the non-retaliation policy must be publicized throughout the sponsor's or FDR's facilities. Plan sponsors must make the reporting mechanisms user friendly, easy to access and navigate, and available 24 hours a day for employees, members of the governing body, and FDRs. It is a best practice for plan sponsors to establish more than one type of reporting mechanism to account for the different ways in which people prefer to communicate or feel comfortable communicating. (*Medicare Managed Care Manual Ch. 21 §50.4.2*).

How to Comply:

- Distribute the Select Health FDR Reporting Poster to your employees or post it in your facility. The Select Health FDR Reporting Poster will provide the required notifications regarding the availability of an anonymous reporting method and the Select Health policy prohibiting retaliation or retribution against anyone who reports suspected violations in good faith. The Select Health FDR Reporting Poster is in Appendix A of this Compliance Guide and is also available on the **Compliance Program page of the Select Health Medicare website**.
- If you partner with multiple Medicare Advantage plan sponsors, train your employees on your organization's reporting processes including an emphasis that reports must be made to the appropriate Medicare Advantage plan sponsor. Select Health provides guidelines for when issues should be referred/reported to Select Health in Section Five of this Compliance Guide.
- Notify your employees that they are **protected from retaliation** for False Claims Act complaints, as well as any other applicable anti-retaliation protections your organization has.

4. OIG and GSA Exclusion Screening

REQUIREMENTS:

Plan sponsors must review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. Monthly screening is essential to prevent inappropriate payment to providers, pharmacies, and other entities that have been added to exclusions lists since the last time the list was checked. (Note: The General Service Administration (GSA) has incorporated the EPLS within the System for Award Management (SAM)). (Medicare Managed Care Manual Ch. 21 §50.6.8).

How to Comply:

- Review the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) **List of Excluded Individuals and Entities (LEIE)** at the time of hiring or contracting and monthly thereafter.
- Review the General Service Administration (GSA) **System for Award Management (SAM)** at the time of hiring or contracting and monthly thereafter.
- Be prepared to produce evidence that your employees and any entities with whom you contract have been timely checked against the exclusion lists.

5. Downstream Entities

REQUIREMENTS:

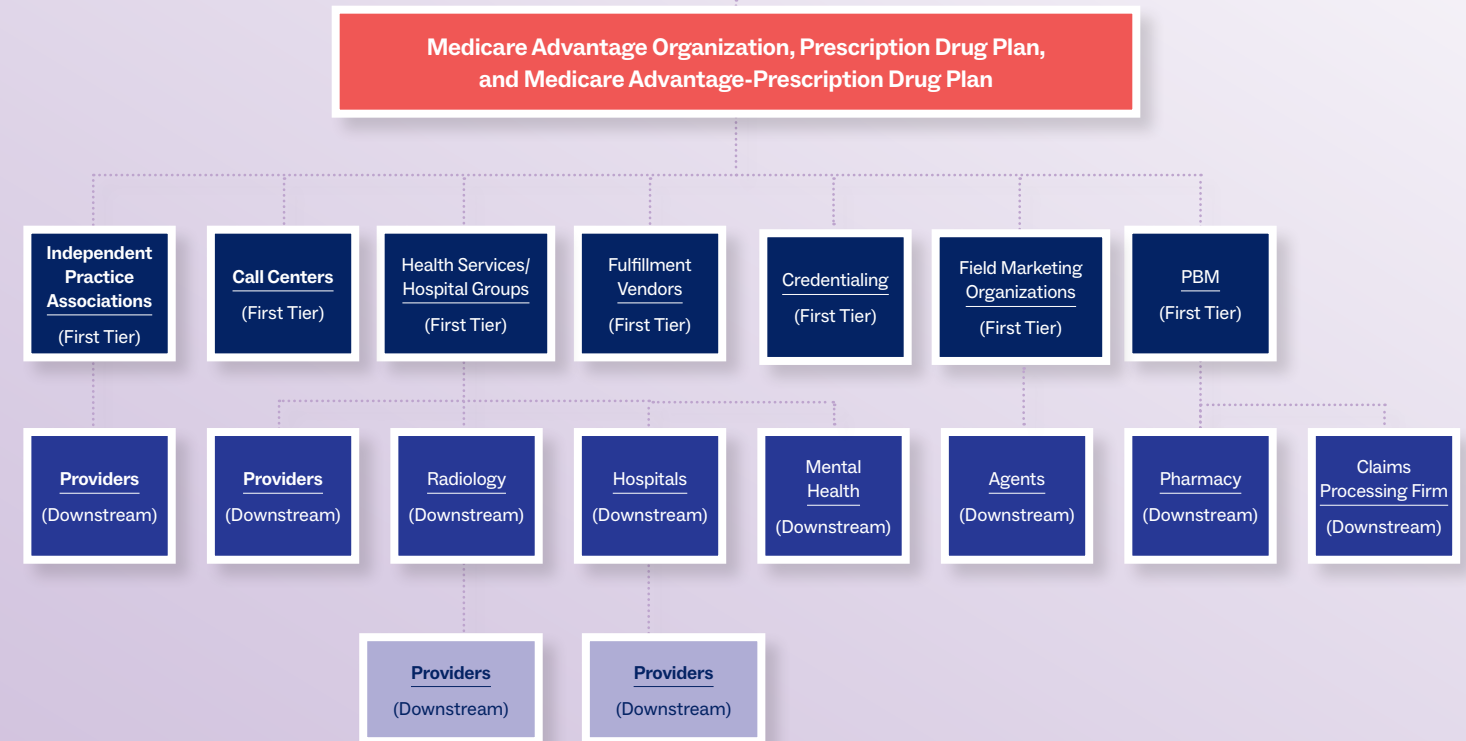
Plan sponsors are responsible for the lawful and compliant administration of the Medicare Parts C and D benefits under their contracts with CMS, regardless of whether the plan sponsor has delegated some of that responsibility to FDRs. The plan sponsor must develop a strategy to monitor and audit its first tier entities to ensure that they are in compliance with all applicable laws and regulations, and to ensure that the first tier entities are monitoring the compliance of the entities with which they contract (the plan sponsors' "downstream" entities).

Monitoring of first tier entities for compliance program requirements must include an evaluation to confirm that the first tier entities are applying appropriate compliance program requirements to downstream entities with which the first tier contracts. (Medicare Managed Care Manual Ch. 21 §50.6.6).

How to Comply:

If your organization subcontracts with other entities (external vendors to your organization and downstream entities to Select Health) to perform any of the services contractually delegated to your organization to perform on behalf of Select Health that relate to the Select Health Medicare and/or Part D program(s), your organization must distribute materials and information to those downstream entities and monitor and audit the downstream entities' performance to ensure they also comply with all applicable CMS requirements and the requirements discussed in this Compliance Guide.

Where does your organization fit in?



6. Offshore Subcontractors

REQUIREMENTS:

Medicare Advantage Organizations that work with offshore subcontractors (first tier, downstream and related entities) to perform Medicare-related work that uses beneficiary protected health information (PHI) are required to provide CMS with specific offshore subcontractor information and complete an attestation regarding protection of beneficiary PHI. (CMS Memo dated August 28, 2008: Offshore Subcontractor Data Module in HPMS).

How to Comply:

- Notify Select Health if your organization or if any of your organization's subcontractors or delegates perform contractually delegated services offshore that require the sharing of member protected health information (PHI) as defined in §160.103 of the HIPAA Privacy Rule. Select Health will request the information necessary to complete the Offshore Subcontractor Data Module in HPMS. **Please see Appendix C.**
- Verify that any contractual agreements with those entities include all required Medicare Part C and D language.
- Conduct annual audits of offshore subcontractors and make audit results available upon request.

7. Record Retention and Record Availability

REQUIREMENTS:

First tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. (*Medicare Managed Care Manual Ch. 11 §100.4*)

Plan sponsors are accountable for maintaining records for a period of 10 years of the time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered to their employees, and must require FDRs to maintain records of the training of the FDRs' employees. (*Medicare Managed Care Manual Ch. 21 §50.3.2*)

CMS has the discretionary authority to perform audits under 42 C.F.R. 44 422.504(e)(2) and 423.505(e)(2), which specify the right to audit, evaluate, collect or inspect any books, contracts, medical records, patient care documentation, and other records of plan sponsors or FDRs that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract or as the Secretary of Health and Human Services may deem necessary to enforce the contract. Plan sponsors and FDRs must provide records to CMS or its designee. Plan sponsors should cooperate in allowing access as requested. Failure to do so may result in a referral of the plan sponsor and/or FDR to law enforcement and/or implementation of other corrective actions, including intermediate sanctioning in line with 42 C.F.R. Subpart O. (*Medicare Managed Care Manual Ch. 21 §50.6.11*)

How to Comply:

- Maintain all records, reports, and supporting documentation that relate to the functions your organization is performing or providing under the Select Health Medicare Advantage program for 10 years.
- Maintain records of any Medicare general compliance and fraud, waste, and abuse training and education taken by your employees for 10 years. The records must demonstrate the date of the training, the topic, attendance, and certificates of completion and/or test scores, if applicable. Examples of proof of training may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training.
- Be prepared to make your records available to Select Health as part of a Select Health audit or monitoring activity and to CMS or a CMS designee in the event of a program audit.

Note

The recommendations provided in this Section for "How to Comply" are suggestions and should not replace analysis by your organization regarding your compliance obligations. Additionally, the above recommendations are not intended to encompass all of your compliance obligations as they relate to the function(s) your organization may be performing under the Medicare Advantage program.

SECTION 4:

Select Health Code of Conduct

For more than 30 years, Select Health has been committed to helping members stay healthy, offering Superior Service, and providing access to the highest quality of care. As part of Intermountain Health, Select Health shares a nonprofit mission of healthcare excellence.

OUR MISSION

Helping people live the healthiest lives possible.®

OUR VISION

Be a model health system by providing extraordinary care and superior service at an affordable cost.

OUR VALUES



OUR CODE OF CONDUCT



View Online

The **Code of Conduct** can be accessed and reviewed at any time.

SECTION 5:

Reporting Compliance Issues and Fraud, Waste, & Abuse (FWA)

Reporting is key in the prevention, detection, and correction of program noncompliance and FWA. Select Health policy protects any individual or organization who reports a legitimate concern in good faith from retaliation and intimidation.

Failure to report a possible violation or suspected FWA that you know about may result in an investigation of you and/or your organization and potentially disciplinary action. To the extent possible, reports are kept confidential. Anonymous reporting and interpretation services are available through the Compliance Hotline.

Reports can be made to Select Health by doing any of the following:

- Call the 24-hour Compliance Hotline at **800-442-4845**
- Email us at **SHCompliance@selecthealth.org**
- Email the Select Health Compliance Officer at **Clifton.Schmidt@selecthealth.org**

A Select Health FDR Reporting Poster is available for your use. See Appendix A of this Compliance Guide. The Select Health FDR Reporting Poster can also be accessed electronically on the **Compliance Program page of the Select Health Medicare website**.

Your organization may have its own reporting process. It's important that concerns relating to Select Health Medicare are reported to Select Health either directly or through your organization's procedures for referring issues to Medicare Advantage plan sponsors.

Here are suggested criteria for referring reported issues to Select Health. The list is not intended to be all inclusive. Any concerns about program noncompliance or suspected FWA should always be reported.

- Generally, any complaints or allegations that reference Select Health.
- Complaints from a Select Health member about quality of care received from a Select Health contracted provider or any entity involved with the Select Health Medicare program.
- Complaints from Select Health members regarding access to care or services.
- Complainants wishing to appeal a Select Health coverage decision (medical or pharmacy) or file a grievance about Select Health.
- HIPAA violations that impact Select Health members.
- Allegations that the complainant has been contacted by "someone" from Select Health requesting personal or medical information.
- Instances where Medicare Advantage requirements (e.g., timeframes, appropriate enrollee notifications, marketing guidelines, etc.) are not being met.
- Instances of alleged FWA.
- Instances where you or your organization become aware that an individual or entity involved with the Select Health Medicare program has become excluded from participation in federal programs.

SECTION 6:

CMS Medicare Advantage Program Audits

The CMS Medicare Parts C and D Oversight and Enforcement Group (MOEG) conducts Part C and Part D program audits to ensure Medicare Advantage plan sponsors are appropriately delivering benefits to Medicare beneficiaries and are safeguarding beneficiaries' access to medically necessary services and prescription drugs. Program audits evaluate compliance with a number of requirements including a Medicare Advantage plan's oversight of activities delegated to FDRs.

During a CMS Program Audit, Medicare Advantage plans may be requested to produce the following documentation related to FDRs:

- Evidence of FDR compliance and FWA training
- Evidence of OIG/Exclusion list checks
- Documents related to monitoring and auditing of FDRs
- Copies of detailed corrective actions taken with FDRs in response to identified issues
- Timelines demonstrating implementation of corrective actions

- Other documentation CMS may request to demonstrate effective oversight of FDR activities

Part of our continuous process improvement efforts is to be "audit ready" at any time. Included in audit readiness is working with our FDRs to ensure we coordinate efforts so that all parties are evaluating their performance for compliance on an ongoing basis and are prepared to produce the necessary audit documentation within the CMS required timeframes and formats.



SECTION 7:

Definitions

The terms used in this FDR Compliance Guide are consistent with the definitions of those terms in the CMS Medicare Managed Care Manual Chapter 21, Section 20:

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Audit is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

Deemed FDRs who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or FDR or employee of an FDR is deemed. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant, a Part D plan

sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501)

Employee(s) refers to those persons employed by the plan sponsor or a First Tier, Downstream or Related Entity (FDR) who provide health or administrative services for an enrollee.

Enrollee means a Medicare beneficiary who is enrolled in a plan sponsor’s Medicare Part C or Part D plan.

FDR means First Tier, Downstream or Related Entity.

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. (See, 42 C.F.R. § 423.501).

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.

FWA means fraud, waste and abuse.

I-MEDIC means Investigation Medicare Drug Integrity Contractor, an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The I-MEDIC’s primary role is to identify potential FWA in Medicare Parts C and D.

Medicare is the health insurance program for the following:

- People 65 or older,
- People under 65 with certain disabilities, or
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Monitoring Activities are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Related Entity means any entity that is related to an MAO or Part D plan sponsor by common ownership or control and

1. Performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than \$2,500 during a contract period. (See, 42 C.F.R. §423.501).

Special Investigations Unit (SIU) is an internal investigation unit responsible for conducting investigations of potential FWA.

Plan sponsor refers to the entities described in the Introduction to these guidelines.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. It’s generally not considered to be caused by criminally negligent actions but rather the misuse of resources.



APPENDIX A:

FDR Reporting Poster

Compliance is Important

Your help makes a difference!

There are many people available to respond to your concerns. If you witness non-compliant or unethical behavior, or if you suspect fraud, waste, or abuse, let someone know.

You can “Speak Up” using the following resources:

- Your manager, team lead, or supervisor
- Human Resources at AskHR@imail.org
- 24-hour Compliance Hotline
(Anonymity and interpretation services are available)
- Email

All reports are treated confidentially. Select Health policy prohibits intimidation or retaliation against anyone who reports suspected violations in good faith.



Speak
UP!

IN PERSON

Your manager, team lead, or supervisor

ONLINE

Human Resources at AskHR@imail.org

COMPLIANCE HOTLINE

1-800-442-4845
1-800-442-5844

EMAIL

SHCompliance@SelectHealth.org
SHPrivacy@SelectHealth.org

APPENDIX B:

FDR Annual Compliance Attestation

The Select Health commitment to compliance includes ensuring that our contracted business partners who are first-tier, downstream, and related entities (FDRs) under the Medicare Advantage program also observe all applicable laws, regulations, and sub-regulatory guidance.

Oversight of FDRs is a CMS requirement for all Medicare Advantage plan sponsors. Select Health has developed a compliance attestation as part of our efforts to validate that each contracted FDR has met CMS requirements. The attestation is requested within 90 days of contracting and annually thereafter. The attestation must be completed by an individual in your organization who has signatory authority to make the representations in the attestation.

The attestation addresses the compliance requirements covered in this guide, including:

1. Distribution of Standards of Conduct and maintaining record of that distribution
2. Completion of FWA and General Compliance training and maintaining record of the completion of that training
3. The availability of a system to receive reports (reporting mechanism) of suspected noncompliance and/or FWA that is confidential, allows anonymity, and includes a policy of non-intimidation and non-retaliation.
4. Federal exclusion list screening and maintaining record of timely checks against those lists
5. Monitoring and auditing downstream entities
6. Identification of use of offshore subcontractors
7. Record retention for 10 years





APPENDIX C:

Offshore Subcontractor Information

Add Offshore Subcontractor Data

A. OFFSHORE SUBCONTRACTOR CONTACT INFORMATION

Offshore Subcontractor Name:

Offshore Subcontractor Country:

Offshore Subcontractor Address:

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor:

B. OFFSHORE SUBCONTRACTOR INFORMATION

Describe the PHI that will be provided to the Offshore Subcontractor:

Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives:

Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:

Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response
I.1	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	Yes No
I.2	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the plan sponsor's contract with the offshore subcontractor	Yes No
I.3	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
I.4	Offshore subcontracting arrangement 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

Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response
II.1	Organization will conduct an annual audit of the offshore subcontractor.	Yes No
II.2	Audit results will be used by the Organization to evaluate the continuation of its relationship with the offshore subcontractor.	Yes No
II.3	Organization agrees to share offshore subcontractor's audit results with CMS, upon request.	Yes No

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

Select Health Medicare **1-855-442-9900 (TTY: 711)** /
Select Health: **1-800-538-8038**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。

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