Magellan Rx MANAGEMENT

FRAUD, WASTE AND ABUSE ATTESTATION IS DUE DECEMBER 31, 2018

The Centers for Medicare & Medicaid Services (CMS) requires plan sponsors administering a Medicare Advantage program or Medicare Part D prescription drug plan implement an effective compliance program that meets the regulatory requirements set forth in 42 C.F.R. §422.503(b)(4)(vi)(C), 42 C.F.R. §423.504(b)(4)(vi)(C) and Chapter 9, §50.3.2 of the Medicare Part D Prescription Drug Benefit Manual. Part D plan sponsors must also ensure that first tier, downstream, and related entities (FDR) have an effective compliance program that includes policies and procedures for preventing fraud, waste, and abuse or conflicts of interest as well as training and education on applicable Medicare Part D laws, rules, regulations and CMS guidance.

As an administrator of pharmacy benefit services on behalf of either a Medicare Advantage or Medicare Part D prescription drug plan, Magellan Rx Management (MRx) has been delegated the responsibility of ensuring that its participating network pharmacies are in compliance with the applicable laws, rules and regulations as well as applicable Medicare Part D regulations and CMS guidance.

Please complete and return the following form attesting that pharmacies affiliated with your chain have completed fraud, waste and abuse training for the 2018 plan year. Forms must be completed and returned by December 31, 2018 via one of the following methods:

Email:
RxNetworksDept@magellanhealth.com

Fax:
(888) 656-4139

If you have any questions regarding the attestation, please call (800) 441-6001 and select option 5.

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My Participating Chain/PSAO, __________________________________, is contracted with Magellan Rx Management, LLC to provide an administrative or health care service function that relates to Medicare Parts D contract(s).

I have the authority to attest on behalf of my organization, and I attest as follows:

1. **Fraud, Waste & Abuse and General Compliance**
   All pharmacy staff (pharmacists, pharmacy technicians and any other staff providing pharmacy services to Medicare Part D patients) at my Participating Pharmacy have fulfilled the regulatory requirement to complete General Compliance and FWA Training within 90 days of hire then annually thereafter by the (choose one):

   ☐ General compliance and FWA training modules located on the CMS Medicare Learning Network (MLN).

   ☐ Downloading, viewing, and printing of the CMS standardized training module from the CMS web site. My Participating Pharmacy has incorporated the content into existing compliance training materials/systems.

   ☐ My Participating Pharmacy is deemed to have met the fraud, waste, and abuse training certification requirements through enrollment into Parts A or B of the Medicare program or accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). If this box is checked, it must be true for each individual pharmacy location. Specify the date and organization that provided accreditation____.

2. **Standard of Conduct and Compliance Policies**
   My Participating Pharmacy has distributed our standards of conduct or the MRx standards of conduct to employees within 90 days of hiring or contracting an annually thereafter. My Participating Pharmacy also agrees to provide evidence to MRx that documentation has been distributed to employees **(choose one):**

   ☐ Our Participating Pharmacy's Standards of Conduct and/or compliance/fraud, waste, and abuse policies and procedures; or

   ☐ The MRx Code of Conduct

3. **Conflicts of Interest**
   My Participating Pharmacy's managers, officers, and directors responsible for the

administration or delivery of Part D benefits are free from any conflict of interest in administering or delivering Medicare Part D benefits. By checking below, I attest that this statement is true.

☐ Participating Pharmacy, and each individual pharmacy location, is free from any conflict of interest.

4. Reporting of FWA and Compliance Issues

My Participating Pharmacy has and will continue to promptly report in writing to the plan sponsor or MRx's Compliance Officer any concerns related to compliance, suspected or actual violations of law or policy related to the services provided to beneficiaries covered by Medicare Part D sponsor or MRx. My Participating Pharmacy will encourage reporting of potential FWA and Compliance issues through **(choose one):**

☐ Medicare Part D sponsor's Hotline or e-mail

☐ MRx Hotline or e-mail

5. Coverage Determination Notices

Acknowledge your compliance with this requirement by checking the box:

☐ My Participating Pharmacy has, and will, continue to provide Medicare Part D beneficiaries with notices instructing the beneficiaries to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist as required by CMS.

6. OIG and GSA Exclusion List

Acknowledge your compliance with this requirement by checking the box:

☐ Monthly during the past twelve (12) months, and going forward on at least a monthly basis, my Participating Pharmacy has and will continue to review the Office of Inspector General List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) exclusion list and no Participating Pharmacy nor an employee, contractor, or agent providing services directly or indirectly ("Covered Individual"), and no Participating Pharmacy, is excluded from participation in government funded health care programs. My Participating Pharmacy is subscribed to the OIG LISTSERV via the OIG website to receive immediate notice of updates to the LEIE. If any such Participating Pharmacy and/or Covered Individual appear on either the LEIE or GSA list, my Participating Pharmacy or PSAO has, and will continue to immediately remove that Covered Individual from the performance of services in support of government funded

healthcare programs, including but not limited to Medicare Part D services. If asked of MRx, my Participating Pharmacy will provide evidence that employees were checked in a timely manner upon request.

7. Offshore Activities

For purposes of this attestation, the term "Offshore" shall be determined in accordance with CMS rules, regulations and guidance and the Health Insurance Portability and Accountability Act of 1996, as amended and all rules and regulations promulgated there under ("HIPAA") and currently refers to any location that is not one of the fifty (50) United States or one of the territories of the United States (American Samoa, Guam, Northern Marianas, Puerto Rico, and the United States Virgin Islands).

Choose the appropriate statement by checking one of the boxes below:

☐ My Participating Pharmacy and its downstream and related entities DO NOT utilize Offshore subcontractors to perform activities **that involve receiving, processing, transferring, handling, and storing or accessing PHI** under or in connection with Medicare Part D at an Offshore location. If this box is checked, my Participating Pharmacy will notifying MRx immediately if this statement becomes inaccurate.

☐ My Participating Pharmacy and its downstream and related entities DO utilize Offshore subcontractors to perform activities **that involve receiving, processing, transferring, handling, and storing or accessing PHI** under or in connection with Medicare Part D at an Offshore location. If this box is checked, my Participating Pharmacy will be asked by the Magellan Rx Medicare Basic Prescription Drug Plan or its processor to provide all necessary information required to comply with CMS rules and regulations.

☐ My Participating Pharmacy and its downstream and related entities DO NOT use Offshore subcontractors to perform activities for Medicare Part D. If this box is checked, my Participating Pharmacy will notify MRx immediately if this statement becomes inaccurate.

Signature:____**Date:**____________________

I certify that I have the signatory authority to attest on behalf of my organization. I also certify that my Participating Pharmacy's FDRs have certified to the Participating Pharmacy compliance with the certification requirements set forth herein.

Magellan Rx MANAGEMENT

Responsible Party (Print):	
Participating Pharmacy or PSAO Name (Print):	
Address (Print):	
FAX:	Email:
Chain Code(s):	
NCPDPD No.:	NPI No.: