Medicare Advantage Offshore Services Attestation

If you are a Quartz contracted provider (also referred to as first tier or downstream entities) using offshore services that involves receiving, processing, transferring, handling, storing, or accessing Quartz Medicare Advantage member PHI, you are required to complete the below information for each entity.

Offshore Services Information

Offshore entity name:

Offshore entity country or countries, if multiple locations:

Offshore entity address or addresses, if multiple locations:
(The offshore entity address should include the full address for each offshore location, including the country, which will receive, process, transfer, handle, store or access PHI).

Describe offshore functions the offshore entity will perform ("offshore services):

State the proposed or actual effective date of the offshore services:
(The proposed or actual effective date is either the effective date of the Medicare contract with Quartz or the effective date of contract with the entity, whichever is later. The proposed or actual effective date for the services must include the month, date and year. Please use this format: MM/DD/YYYY).

Describe the member PHI that will be provided to the offshore entity:
(Please check the boxes to identify the types of PHI the offshore entity may access.)

☐ Name	☐ Age	☐ Date of birth	☐ Address	☐ Phone number
☐ Full SNN	☐ Partial SSN (last four)	☐ Medicare/HICN	☐ Quartz member ID	☐ Prescription history
☐ Claim history	☐ Diagnosis	☐ Medical history	☐ Banking/financial information	☐ Other (provide detailed description)

Explain why providing PHI is necessary to accomplish the offshore services:

Describe any and all alternatives considered to avoid providing PHI. Why was each alternative rejected?
(When describing any alternatives considered to avoid using PHI, be sure to include the reason why the alternative was rejected.)

Name of first tier _____

Offshore entity name _____

With respect to the offshore services provided by the above-named offshore entity, first tier certifies and attests that:

1. The agreement it has with the offshore entity requires the offshore entity to have policies and procedure in place to ensure Quartz's Medicare Advantage Plans' PHI remains secure.
   ◯ Yes ◯ No

2. The agreement it has with the offshore entity prohibits the offshore entity's access to data not associated with the functions the offshore entity staff performs for Quartz.
   ◯ Yes ◯ No

3. The agreement with the offshore entity allows the first tier entity to immediately terminate ~~of~~ the offshore services upon discovery of a significant security breach.
   ◯ Yes ◯ No

4. The agreement with the offshore entity includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with Medicare Part C and D requirements, etc.).
   ◯ Yes ◯ No

5. The first tier conducts an annual audit or review of its relationship with the offshore entity and monitors offshore staff's access to PHI.
   ◯ Yes ◯ No

6. The results from the annual audit or review are used to evaluate the continuation of the relationship with the offshore entity.
   ◯ Yes ◯ No

7. The agreement it has with the entity requires the offshore entity to share such audit results with CMS directly or with Quartz upon request.
   ◯ Yes ◯ No

8. First tier agrees to notify Quartz at least 60 days in advance of the first tier's intent to use a new offshore entity or before employing new offshore staff for a function Quartz has asked the first tier ~~us~~ to perform.
   ◯ Yes ◯ No

Please provide a brief explanation for any "no" responses for the statements above.

Attestation Authorization

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. In addition, my organization agrees to maintain documentation supporting the statement listed above. My organization will produce evidence of the above to Quartz or CMS upon request. My organization understands that the inability to produce this evidence will result in a request from Quartz for a Corrective Action Plan or other contractual remedies, such as contract termination.

_____

First tier organization's authorized representative printed name and title

_____ _____

Signature of first tier organization's authorized representative Date

_____

First tier organization name (printed)

_____ _____

Tax ID# or employer ID# NPI #

_____

First tier organization mailing address

_____

First tier organization's authorized representative phone number and email address

Please return completed form to one of the following:

Email: QuartzFDR@Quartzbenefits.com; or

Fax: (608) 881-8394, Attn: Compliance Department