Hospital Attestation of Compliance with QHP Participation Standards

In Accordance with 45 CFR § 156.1110

I. Hospital Information

Hospital Name:		
Address:		
City:	State:	Zip Code:

Date of Attestation:

II. Attestation of Compliance

Pursuant to 45 CFR § 156.1110, I, the undersigned authorized representative of the above-named hospital, do hereby attest that the hospital meets the applicable patient safety and quality improvement requirements as specified by the U.S. Department of Health and Human Services (HHS) and required of hospitals with more than 50 beds participating in a Qualified Health Plan (QHP) network.

The hospital affirms the following:

A. Patient Safety Evaluation System (PSES)

☐ The hospital has implemented and maintains a Patient Safety Evaluation System in accordance with 42 CFR Part 3 (Patient Safety and Quality Improvement Act of 2005).

B. Hospital Participation Option

Select at least one of the following (as required under 45 CFR § 156.1110(a)(2)):

☐ Option 1: The hospital has implemented a mechanism for comprehensive, person-centered hospital discharge that improves care coordination and health care quality for each patient;

OR

☐ Option 2: The hospital has implemented an evidence-base initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.

C. Documentation and Data Sharing

☐ Hospital agrees within 30 days of request from Ambetter Health of Delaware to provide sufficient documentation or data demonstrating compliance with the above standards.

III. Authorized Signature

I certify that the above information is true, accurate, and complete to the best of my knowledge and that I am duly authorized to make this attestation on behalf of the hospital listed in **Section I – Hospital Information**.

Name of Authorized Representative:

Professional Title/Position:

Email Address: Phone Number:

Signature: Date:

Please return this completed form to our Delaware Provider Communications Mailbox: DEProviderCommunications@delawarefirsthealth.com