Banner Health Insurance Division Companies

Compliance Program and Fraud, Waste and Abuse Plan

January 1, 2018 through December 31, 2018

Letter from the CEOs

Dear Banner Health Network (BHN), Banner Plan Administration (BPA), Banner Network Colorado (BNC), and Banner University Health Plan (BUHP) Staff and Business Partners,

BHN, BPA, BNC and BUHP are committed to ethical and legal conduct. This includes meeting the obligations of any governmental health care programs involving the delivery of health care services. BHN, BNC, and BPA participate in multiple government programs including: Medicare Advantage Organizations (MAO); the Center for Medicare and Medicaid Innovation (CMMI) Accountable Care Organizations (ACO); the Centers for Medicare and Medicaid Services (CMS) and under the Employee Retirement Income Security Act (ERISA). BUHP is a Medicare and Medicaid participant and BHN/BPA/BNC are also involved with Medicare, Medicaid and ERISA plans. A key component of our commitment to meeting our obligations under these governmental programs and contractual relationships includes adopting standards that uphold these principles, which is the basis for this Compliance Program. The Compliance Program is described in several documents including the Code of Conduct, policies and procedures, as well as the Fraud, Waste and Abuse Plan. All employees and the Governing Bodies as well as first tier, downstream and related entities, subcontractors and agents (Business Partners) must make a personal commitment to adhere to the Code of Conduct. The companies do not condone unethical, non-compliant or criminal conduct by Staff and Business Partners.

In conjunction with Banner Health (BH), the Centers for Medicare and Medicaid Services (CMS), the Federal Coordinated Health Care Office, Arizona Health Care Cost Containment System (AHCCCS), and all government programs, this Compliance Program is integrated into our services to address the Medicare and Medicaid programs as well as overall company activities. By integrating the Compliance Program across these separate BH entities, we link together the various program rules and align any potential differences between the programs.

Reducing duplication of effort and conflict is important, as the rules governing the healthcare industry are unusually complex. Activities that may be perfectly legal in other industries may be crimes in government programs and staff and Business Partners could face penalties for violations of the law. Thus, the companies have implemented this Compliance Program to help all of our Staff and Business Partners deal with the complexities of government programs.

Your knowledge of, and dedication to, these standards allows us to serve our customers in a professional, caring and compliant manner while maintaining the standards of legal and ethical conduct that we have adopted. On behalf of BHN, BPA, BNC, and BUHP, thank you.

Sincerely,

Chuck Lehn
Banner Health Network
President

Kathy Oestreich
Banner University Health Plans
CEO

Vacant
Banner Network Colorado
Vice President

Compliance Program
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Definitions

Abuse – Includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare or Medicaid programs or other government programs, 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 Abuse of a member includes the intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault.

Accountable Care Organization (ACO) – Are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to populations of patients.

Agents – Agents refers to independent agents/brokers used to sell Medicare Advantage Prescription Drug plans.

AHCCCS (Arizona Health Care Cost Containment System) – Arizona's Medicaid program, designed to deliver quality health care with cutting-edge managed care concepts.

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

Beneficiary/Member – A member of a Medicare, Medicaid, or government program.

Board of Directors – A body of elected or appointed individuals who oversee BUHP, BNC or BHN activities.

Business Partners – The collective grouping of all first tier, downstream and related entities, subcontractors and agents.

CMMI (Centers for Medicare and Medicaid Innovation) – The Innovation Center was created for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid or Children's Health Insurance Program (CHIP) benefits.

CMS/CMMI Program ACO – For purposes of this document, includes both CMS and CMMI programs that BHN or BNC contracts directly with CMS or CMMI. For example, the Medicare Shared Savings Program (MSSP).

CMS (Centers for Medicare and Medicaid Services) – Federal Agency which administers Medicare and Medicaid.

Commercial Health Plan – Health plans that offer any type of health benefit not obtained from Medicare or Medicaid. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan. BHN has entered into shared risk agreements with Commercial Health Plans.

Cost Avoidance – The process of identifying and utilizing all sources of first or third-party benefits before services are rendered or before payment is made by an AHCCCS contractor.

Deemed Provider, Supplier or Business Partner – A provider or supplier that has been accredited by a national accreditation program (approved by CMS) as demonstrating compliance with certain conditions.

Employee Retirement Income Security Act (ERISA) – Federal law that sets standards of protection for individuals in most voluntarily established, private sector retirement plans.

First Tier, Downstream and Related Entities – A First Tier Entity is a party that enters into a written arrangement with BHN, BNC or BUHP to provide administrative or health care services. A Downstream Entity is a party that enters into a written arrangement with BHN, BNC or BUHP below the level between BHN, BNC or BUHP and a first tier entity. These written arrangements continue down to the level of provider of both health and administrative services (e.g., mail order pharmacies, firms providing agent/broker services, agents, brokers, marketing firms, call center firms). A Related Entity is an entity that is related to BHN, BNC or BUHP by common ownership or control and: 1) Performs some BHN, BNC or BUHP management functions under contract or delegation; 2) Furnishes services to members under an oral or written agreement; or 3) Leases real property or sells materials to BHN, BNC or BUHP at a cost of more than $2,500 during a contract period.

Fiscal Agent – Business Partners, First Tier, Downstream and Related Entities, Subcontractors and Agents that process or pay health service claims on behalf of BHN, BNC or BUHP.

Fraud – 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.

Managed Care Organization (MCO) – A Company that agrees to provide most Medicare, Medicaid and/or Marketplace benefits to members in exchange for a monthly payment from the Federal or State government and/or individual private payer.

Medicare Advantage Organizations (MAO) – Health plans that are approved by Medicare and provided by private insurance companies. Medicare sets the rules for MAOs and regulates the private insurance companies who operate the MAO. BHN has entered into delegated, full risk and shared risk agreements with MAOs. BNC has entered into shared risk and shared savings agreements with MAOs. BUHP serves dual-eligible Medicare beneficiaries and has a MAPD/D-SNP Contract.

Misconduct – Any action or behavior that does not conform to the organization's stated or intended standards, guidelines or procedures; or is a violation of any federal/state law or regulation.

Monitoring Activities – Regular reviews performed as part of BHN's, BNC's or BUHP's normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Non-Compliance – Failure or refusal to act in accordance with the organization's Compliance Program; or other standards or procedures; or with federal or state laws or regulations.

Staff – Refers to all of the BHN, BNC or BUHP employees including the Boards of Directors.

Subcontractor – See first tier, downstream and related entities.

Third Party Administrator – In the state of Arizona, a health administrator, also know as a third-party administrator (TPA) collects money or processes claims for residents of Arizona in connection with health insurance coverage. Arizona Revised Statutes (ARS) § 20-485 provides a full definition, including the types of entities that are not considered TPAs.

Waste – Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to federal and state government programs. Waste is generally not considered to be criminally negligent but rather the misuse of resources.

Defining the Banner Health Insurance Division Companies (The Companies)

The following companies (hereinafter throughout this document referred to as "The Companies" except in those instances where a component of this Compliance Program applies to one or some but not all of the companies) are all subsidiaries of Banner Health (BH) and are part of the Banner Health Insurance Division:

- Banner Health Network (BHN)
- Banner Plan Administration (BPA)
- Banner Network Colorado (BNC)
- The Banner University Health Plans (BUHP), which includes The Banner University Health Plans – University Care Advantage, Inc. and the University Family Care and Banner – University Family Care (Banner University Health Plans – Family Care, Inc.).

Banner Health is regarded and recognized as a top health system in the country for the clinical quality consistently provided to patients. BH is deeply committed to its mission: Making health care easier, so life can be better.

Through relationships with the Centers for Medicare and Medicaid Services (CMS); the Arizona Health Care Cost Containment System (AHCCCS); the Center for Medicare and Medicaid Innovation (CMMI); Department of Labor ERISA program; as well as through formal contracts with employer groups and multiple managed care organizations which delegate the performance of some delegated administrative services to BPA, The Companies manage care for government program members as well as BH Staff. Current arrangements are described below.

Banner Health Network (BHN)

BHN is an ACO that joins Arizona's largest health care provider, Banner Health, and an extensive network of primary care and specialty physicians to provide the most comprehensive health care solutions for Maricopa County and beyond. Nationally known as an innovative leader in value-based models, medical providers can now be fully aligned in collaborative efforts to keep members and beneficiaries in optimal health, and reduce costs for employers and individuals.

Banner Network Colorado (BNC)

BNC functions as an ACO. Banner Network Colorado (BNC) was designed to provide a highly coordinated patient care experience for beneficiaries of government and private sector insurance plans in Larimer and Weld counties of Northern Colorado's Front Range. The network is composed of health care providers such as physicians, hospitals and related medical providers who are linked together to improve the quality of care for patients at an affordable price. More than 300 providers are currently participating in BNC. Parent company, Banner Health, is one of the largest nonprofit health systems in the country, with operations in six states.

Banner Plan Administration (BPA)

BPA is a third party administrator (TPA) licensed in the state of Arizona. BPA provides administrative services for the Banner Employee Health Plan and Wellness Benefits. BPA also provides TPA services for Arizona MAOs and Commercial health plans through contractual arrangements with BHN.

Banner University Family Care (B-UFC)

B-UFC is the name BUHP uses for its AHCCCS Arizona Long Term Care Services (ALTCS) plan. Banner University Family Care, Inc. is the legal entity that contracts with AHCCCS to provide health services through a Medicaid HMO Model.

Medicare Shared Savings Program (MSSP)

The Medicare Shared Savings Program was established by section 3022 of the Affordable Care Act. The MSSP is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care. Congress created the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating or participating in an Accountable Care Organization (ACO). MSSP ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare FFS beneficiaries. An ACO is not a Medicare Advantage plan or an HMO.

University Care Advantage (UCA)

UCA is the name BUHP uses to market its Medicare Advantage/Part D (MAPD) plan. The Banner University Health Plans-University Care Advantage, Inc. is the legal entity that contracts with CMS to provide MAPD products to Medicare beneficiaries.

University Family Care (UFC)

University Family Care (UFC) is the name BUHP uses for its AHCCCS Acute plan. The Banner University Health Plans-Family Care, Inc. is the legal entity that contracts with AHCCCS to provide health services through a Medicaid HMO Model.

Staff and Business Partner Guidance on the Implementation and Operation of the Compliance Program

The Compliance Program is updated annually and approved and adopted by The Companies' Boards of Directors (Boards) and The Companies' Compliance Committees. To ensure adoption of the Compliance Program, the Companies require that all of The Companies' employees (including managers and directors) and the Boards (these individuals are collectively referred to as "Staff" throughout this document); subcontractors; vendors; participating providers; suppliers; first-tier, downstream and related entities (FDRs); and agents (these entities and vendors are collectively referred to as "Business Partners" throughout this document) adopt and operate in accordance with this Compliance Program. Therefore, all Staff and Business Partners must read, understand and agree to comply with this Compliance Program. This mandatory Compliance Program provides guidelines to help each Staff and Business Partner understand how The Companies conduct business. It also serves to govern the conduct of all Staff and Business

Partners who support The Companies' operations.

This Compliance Program applies to, has been implemented and put into operation across all lines of business. Staff and Business Partners must apply the principles outlined in these guidelines and as contained in this Compliance Program to all relevant decisions, situations, communications and developments. Any new governmental rule-making or interpretive guidance may require an update to the Compliance Program. As required, significant changes to the Compliance Program are provided to the appropriate governmental entity for review. Once approved by The Companies' Boards and Compliance Committees, The Companies' Compliance Departments will provide Staff and Business Partners with any Compliance Program updates. We know this Compliance Program can be complex so, please do not hesitate to contact the Compliance Departments or Compliance Officers listed below if you have any questions regarding information contained in this Compliance Program:

BUHP:
Theresa (Terri) Dorazio, Medicaid Compliance Officer
520-874-2847 (Tucson Office) / 520-548-7862 (Cell) / 520-874-7072 (Fax) /
Theresa.dorazio@bannerhealth.com
Tucson Office: 2701 E. Elvira, Tucson AZ 85756 (In the Southeast Corner of Building 2731-Room 348)

Linda Steward, Medicare Compliance Officer
520-874-2553 (Tucson Office) / 520-403-3780 (Cell) / 520-874-7072 (Fax) /
Linda.steward@bannerhealth.com
Tucson Office: 2701 E. Elvira, Tucson AZ 85756 (In the Southeast Corner of Building 2731-Room 347)

BHN/BPA/BNC:
Teresa McMeans, Compliance Officer
602-747-3140 (Office) / 619-241-3388 (Cell) / 602-747-3387 (Fax) /
teresa.mcmeans@bannerhealth.com
Office: 2901 N Central Avenue, Phoenix, AZ 85012 (North Tower, 3rd floor)

Key regulations which govern this Compliance Program include:

BHN/BPA/BNC:

- Self-funded Employee Health Plans (ERISA)
- MAO plans
- Commercial/Employer Group plans
- CMS/CMMI Program ACO

BHN and BPA applies principles outlined in various government program guidelines to operate an effective Compliance Program that meets regulatory requirements. This Compliance Program has been implemented to meet regulatory requirements outlined by government programs. For MAO delegation, these requirements can be found in the Code of Federal Regulations (C.F.R.), chapter 42, parts 422 and 423 at: 42 C.F.R. § § 422.503(b)(4)(vi) and 423.504(b)(4)(vi). For the CMS/CMMI Program, ACO, these can be found in 42 C.F.R. 425 Final rule and any guidance issued by CMS. For self-funded employee benefits, this can be found in 29 C.F.R. 2590 ERISA and Department of Labor guidance. CMS publishes compliance program guidelines in publication 100-18, Medicare Prescription Drug Benefit Manual, chapter 9 and in publication 100-16, Medicare Managed Care Manual, chapter 21.

BUHP:

- Arizona Health Care Cost Containment System (AHCCCS)
- Medicare Part C
- Medicare Part D

BUHP applies the principles outlined in AHCCCS, Medicare Part C and D guidelines to operate an effective Compliance Program that meets regulatory requirements. This Compliance Program has been implemented to meet regulatory requirements outlined by AHCCCS and CMS. For CMS, these requirements can be found in the Code of Federal Regulations (C.F.R.), chapter 42, parts 422 and 423 at: 42 C.F.R. § § 422.503(b)(4)(vi) and 423.504(b)(4)(vi). CMS publishes compliance program guidelines in publication 100-18, Medicare Prescription Drug Benefit Manual, chapter 9 and in publication 100-16, Medicare Managed Care Manual, chapter 21. The AHCCCS requirements can be found at 42 C.F.R. 438.608, 455.17, 455.101, 455.104, 455.105 and 455.1(a)(1) as well as in Arizona Revised Statutes (A.R.S.), section 13-2310. AHCCCS includes requirements in paragraph 61 of its contract with UFC and paragraph 64 of its contract with B-UFC as well as in the AHCCCS Contractor Operations Manual (ACOM), Chapter 100, and policy 103.

Governance of the Compliance Program

One of the key elements in the Compliance Program is the creation of The Companies' Compliance Committees (Committees) for the AHCCCS, Medicare and Government Programs lines of business. These Committees are responsible for supporting the Compliance Officers and to review, approve and ensure implementation of the Compliance Program. They evaluate Compliance Program effectiveness through self-auditing; monitoring of metrics and key indicators; and ensure prompt and effective corrective actions are taken where deficiencies are noted. The Compliance Committees are responsible to The Companies' senior-most executive leaders and Boards. The Compliance Officers report to The Companies' top management, have direct access to the BUHP's Chief Executive Officer (CEO), BHN's President, and BNC's Vice President (VP); have direct access to The Companies' senior management; have a dotted line report to the BH Chief Compliance Officer; and have express authority to meet with The Companies' applicable Boards. The Compliance Officers and Committees are responsible for escalating compliance deficiencies and ongoing issues of non-compliance to senior management, the BUHP CEO, BHN President or BNC VP, and the applicable Boards. The Compliance Officers reserve the right to amend and update components of this Compliance Program at any time and to make changes based on regulatory guidance or to enhance the program to improve effectiveness.

Board Compliance Oversight and Senior Management Engagement

The Companies' Boards are ultimately responsible for the Compliance Program, including ensuring adherence to all compliance policies and procedures. The Board's oversight includes the following: 1) Review and approve the Compliance Program, 2) Review and recommend Compliance Program monitoring and auditing activities, and 3) Assist with development strategies to promote compliance with the Compliance Program. BHN's President, BNC's VP, BUHP's CEO and senior management are highly engaged in the Compliance Program. The Executive Teams recognize the importance of the Compliance Program in The Companies' success and all are active members of the Compliance Committee.

Goal of the Compliance Program

The primary goal of this Compliance Program is to provide the guidance and oversight that ensures The Companies' compliance with state and federal law, rules, regulations and

requirements while facilitating improving quality of care and the efficiency of the delivery of care. This includes identifying and correcting inappropriate or illegal conduct and reducing fraud, waste and abuse. This primary goal is accomplished by: 1) The ongoing demonstration of The Companies' commitment to compliant business practices and ethical behaviors; 2) Preventing, identifying, investigating, reporting and correcting fraud, waste and abuse; 3) Ensuring effective internal controls and processes are in place that ensure compliance with state and federal laws and regulations; 4) Establishing a culture of compliance which encourages Staff and Business Partners to operate in a compliant manner and to openly communicate any concerns they may have regarding any non-compliant practices, and; 5) Ensuring a consistent disciplinary approach to any identified non-compliant behavior or practice.

Components of the Compliance Program

The Companies are required to adopt and implement an effective Compliance Program which must include measures to prevent, detect, and correct Medicare, Medicaid and Federal government program noncompliance as well as Fraud, Waste and Abuse (FWA). This Compliance Program includes the following components:

Component 1: Written Policies, Procedures and Standards of Conduct
Component 2: Compliance Officer, Compliance Committee and High-Level Oversight
Component 3: Effective Training and Education
Component 4: Effective Lines of Communication
Component 5: Well-Publicized Disciplinary Standards
Component 6: Effective System for Routine Monitoring and Identification of Compliance Risks
Component 7: Procedures and System for Prompt Response to Compliance Issues
Component 8: Fraud, Waste and Abuse Plan

In order for this Compliance Program to be effective it must be fully implemented, include a written document which outlines all aspects of the Compliance Program, explain how each component above will be carried out and be tailored to The Companies' unique organization, operations and circumstances. The Companies may enter into contracts with FDRs to provide administrative or health care services for members on behalf of The Companies. The Companies do not delegate Compliance Program administrative functions (e.g., Compliance Officer, Compliance Committee, compliance reporting to senior management, etc.) to FDRs; however, The Companies may use FDRs for compliance activities such as monitoring, auditing and training. Because The Companies maintain the ultimate responsibility for fulfilling terms and conditions of The Companies' government program contracts, and for meeting government program requirements, CMS, AHCCCS and other government agencies may hold The Companies accountable for the failure of its FDRs to comply with government program requirements.

The Companies dedicate adequate resources to do the following Compliance Program activities: 1) Promote and enforce the Code of Conduct, 2) Promote and enforce the Compliance Program, 3) Effectively train and educate Staff and Business Partners, 4) Effectively establish lines of communication within The Companies and between The Companies and its Business Partners, 5) Oversee Business Partner compliance with Medicare, Medicaid or government program requirements , 6) Establish and implement an effective system for routine auditing and monitoring, and 7) Identify and promptly respond to risks and findings.

Component 1: Written Policies, Procedures and Standards of Conduct

The Companies have written policies, procedures and standards of conduct that:

- Articulate The Companies' commitment to comply with all applicable Federal and State standards;
- Describe compliance expectations as embodied in the Standards of Conduct;
- Implement the operations of the Compliance Program;
- Provide guidance to Staff and Business Partners on dealing with suspected, detected or reported compliance issues;
- Identify how to communicate compliance issues to appropriate compliance personnel;
- Describe how suspected, detected or reported compliance issues are investigated and resolved by The Companies; and
- Include a policy of non-intimidation and non-retaliation for good faith participating in the Compliance Program, including, but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

Code of Conduct

As a subsidiary of BH, The Companies have adopted BH's Code of Conduct. BH is committed to possessing and demonstrating the reliability, honesty, trustworthiness, and high degree of integrity expected of a leading health care organization and a participant in federally-funded health care programs.

BH's Code of Conduct states The Companies' over-arching principles and standards by which The Companies operate and defines the underlying framework for the compliance policies and procedures. This Code of Conduct provides the standards by which Staff and Business Partners will conduct themselves, in order to protect and promote organization-wide integrity, ensure adherence to The Companies' values and enhance the organization's ability to achieve its mission. The Companies' Staff and Business Partners, from the top to the bottom of the organization have the responsibility to perform their duties in an ethical manner in compliance with laws, regulations and to The Companies' policies. Staff and Business Partners are expected to report issues of noncompliance and potential FWA through the appropriate methods and all reported issues will be promptly addressed and corrected. These standards are intended to provide guidance to Staff and Business Partners. These standards are neither exclusive nor complete. Staff and Business Partners are required to comply with all applicable laws, whether or not specifically addressed. The Companies' Staff complete the Banner Learning Center (BLC) required compliance trainings including the code of conduct training. All Staff and Business Partners must read the Code of Conduct annually and acknowledge/attest that they agree to abide by the Code of Conduct. A copy is provided to all new Staff hires and is available to review on The Companies' intranet and websites by Staff. Each manager, director and officer is responsible for reinforcing the Code of Conduct.

The Companies require that all FDRs supporting the Medicare Advantage and Part D Prescription Drug Program adopt and abide by this Code of Conduct or implement a Code of Conduct that incorporates standards of conduct and requirements consistent with this Code of Conduct. This Code of Conduct is made available to FDR's on the BHN and BNC Compliance Communications websites and the BUHP Compliance website.

The **Banner Health Code of Conduct** contains the following purpose:
Our Code of Conduct helps guide all Banner board members, employees, medical and allied

professional staff members, and volunteers (collectively, “Banner Staff”) and assists us in carrying out our daily activities within appropriate ethical and legal obligations. These obligations apply to our relationships with patients, beneficiaries, third-party payors, subcontractors, independent contractors, vendors, consultants, and one another. They require that we conduct business not only in compliance with laws and regulations but also in an ethical manner. This Code of Conduct is a summary of Banner’s Compliance Program as well as Banner’s policies regarding ethical conduct and workplace behavior. The purpose of our Code of Conduct is to provide general guidance on subjects of wide interest within the organization. It does not eliminate or supersede other policies. Rather, this Code of Conduct should be used in conjunction with these policies. The standards set forth in the Code apply to all Banner Staff and entities.

Identifying a Compliance Issue

It is not uncommon to come across situations where we aren’t quite sure what to do or where we feel that what is happening is not quite right. No compliance program, law or regulation can address all the situations that might occur in the health care environment. Ultimately, it is up to each one of us to apply the general principles learned in compliance training and, when uncertain, ask for help! No one at BH should ever struggle alone with a compliance question or concern.

If you are ever unsure about the legality or appropriateness of an action or proposed action, think of the following:

- Does it comply with the law and BH’s compliance policies and procedures?
- How would it make you feel if you did it?
- How would it look to your family and friends, your coworkers or to our patients and the community?

If you know something is wrong, don’t do it! If you are not sure, ask. And keep asking until you get an answer that makes sense. Get the right answer, not just the easy answer.

Resolving a Compliance Issue

Many resources are available to help Staff members resolve compliance issues:

Compliance Documents

The answers to many questions can be found in the various BH compliance policies and procedures. These policies and documents can be found on the Ethics & Compliance intranet web page and with other BH policies on the intranet under Policies and Procedures. Additional BHN, BNC, and BUHP compliance policies and procedures are also available on the BHN, BNC, and BUHP SharePoint sites.

Banner Health Compliance Program Obligations Policy

The Compliance Program Obligations Policy was adopted by the BH Board of Directors. The Policy establishes a management structure to oversee and monitor BH’s compliance activities. The Policy requires that all facilities, business areas and functional areas of BH and all Staff members and Business Partners within those areas exercise due diligence to prevent, detect and report unlawful conduct or conduct in violation of BH’s compliance policies.

Banner Health Corporate Compliance Plan

The Corporate Compliance Plan (the “Plan”) is a document specifically tailored to BH that specifies the various compliance personnel, documents and activities that make up the Compliance Program. The Plan discusses the designation of compliance personnel and establishes their responsibilities and duties, the development and distribution of compliance policies and procedures, how BH will conduct its compliance education and training activities, the compliance communication lines established for Staff and Business Partners to use in obtaining answers to their compliance questions or concerns, the enforcement standards and disciplinary

guidelines for compliance violations and the various compliance auditing and monitoring activities that BH will use to ensure that its compliance policies and procedures are operating effectively and are being followed by its Staff and Business Partners.

Reporting Potential Compliance Issues:

It is the responsibility of BH Staff to immediately report potential compliance issues upon discovery. Banner Staff should contact their compliance officer or the Ethics & Compliance Department if they have any questions whether an issue is a potential compliance issue. Banner Staff should also report violations of the Health Insurance Portability and Accountability Act (HIPAA) by complying with the respective HIPAA policies.

For compliance questions or concerns that cannot be resolved by reviewing the various BH compliance documents, BH has implemented several avenues for reporting potential compliance issues:

a. BH Staff may report potential compliance issues directly to their supervisor, department manager or director, compliance officer, or Ethics & Compliance Department. If a report is made to a supervisor or a department manager or director, that individual will immediately forward the report to the compliance officer or the Ethics & Compliance Department.
b. BH Staff may also report a potential compliance issue through the ComplyLine. The ComplyLine is available for confidential, anonymous reporting, if Staff have exhausted normal channels or are uncomfortable for any reason reporting directly to their supervisor, department manager or director, compliance officer, or the Ethics & Compliance Department.

BH Staff are free to report potential compliance issues in good faith without fear of retribution or retaliation.

Each Staff member is obligated to report any issue or practice that he or she believes in good faith may constitute a violation of a law or BH's and/or BHN/BNC/BUHP compliance policies. People who are found to have engaged in unlawful conduct or conduct in violation of BH policies, or who have failed to detect, report and/or correct any offense, are subject to corrective action, up to and including termination of employment or contract.

To report a compliance issue, follow the process described above. If a Staff member feels uncomfortable reporting a compliance issue to his or her supervisor or any other BH or organization-specific manager, he or she may call the ComplyLine.

The ComplyLine

BH's ComplyLine (**1-888-747-7989**) and website https://bannerhealthcomplyline.alertline.com is available to all BH callers. Calls to the ComplyLine will not be traced and will be treated confidentially. Staff and Business Partners may remain anonymous if they choose and to the extent allowed by law. No caller will be subject to retaliation for bringing forth a good faith concern. Anyone who attempts to retaliate against an employee who has in good faith made a call to the ComplyLine will be subject to corrective action.

The ComplyLine is toll-free from anywhere in the United States. It is answered 24 hours a day, 7 days a week by an operator who is trained to take your report of suspected illegal or unethical activity. A call to the ComplyLine will satisfy your obligation to report suspected illegal or unethical activity to a compliance officer.

The ComplyLine is intended to supplement existing internal communication channels. It is not intended to replace the local management team or the process outlined above. The ComplyLine

is available when Staff and Business Partners feel they have exhausted normal channels or are uncomfortable about bringing an issue to their supervisor or manager. Inquiries about an investigation can be obtained with the Report Number and PIN by logging into https://bannerhealthcomplyline.alertline.com.

Failing to Act in Accordance with the Compliance Program

The consequences of not acting in accordance with the Compliance Program are significant for Staff and Business Partners as well as BH. BH, its member organizations and the Staff or Business Partners may be subject to criminal and/or civil prosecution resulting in payment of fines and/or imprisonment. In addition, BH, its member organizations and the individual may be excluded or suspended from participation in federal or state government health care programs. Finally, any Staff or business partner who fails to adhere to the Compliance Program will be subject to corrective action, up to and including termination of employment or contract.

Non-Retaliation for Reporting Suspected Non-Compliance

BH strictly prohibits retaliation against any individual, including a patient or health plan member, who in good faith reports a suspected violation of BH policy or suspected illegal or unethical conduct.

Leadership Responsibilities

All BH Staff and Business Partners are obligated to follow our Code of Conduct. We expect our leaders to set the example, to be in every respect a role model. We expect everyone with supervisory responsibility to exercise that responsibility in a manner that is kind, sensitive, thoughtful, and respectful. Each supervisor should create an environment where everyone is encouraged to raise concerns and propose ideas. Supervisors should also ensure that their teams have sufficient information to comply with laws, regulations, the Code of Conduct, policies, as well as the resources to resolve ethical dilemmas. Supervisors must help to create a culture within BH that promotes the highest standards of ethics and compliance.

Responsibilities of Banner Health Employees

Everyone has an obligation to ensure that the Compliance Program is a success. Each Staff and business partner can help to achieve that success by doing the following:

- Comply with BH's Compliance Program, Code of Conduct and BH's policies;
- Take responsibility for their own actions;
- Know and comply with applicable laws and rules, including federal health care program requirements;
- Seek guidance when in doubt about their job responsibilities;
- Refrain from involvement in illegal, unethical, or other improper acts;
- Promptly report any potential or suspected violation of this Code of Conduct, BH's policies, or applicable laws or regulations; and
- When requested, assist BH personnel and authorized outside personnel in investigating all allegations of violations;
- BH provides BH Staff with policies, training, and/or other aids to help fulfill their responsibilities under the Code of Conduct;
- Be alert to situations that could result in illegal or unethical conduct;
- Encourage other Staff and Business Partners to consult with their supervisors, their Entity/Facility/Health Plan Compliance Officer, the Corporate Ethics & Compliance Department or the Legal Department if it appears that they might be in danger of violating the law or the Compliance Program; and
- Report timely all suspected violations of the Compliance Program.

Workplace Conduct and Employment Matters

Equal Employment Protection
Staff member's rights are best protected by open communication and a spirit of cooperation. BH is committed to equal employment opportunity in the workplace. We seek an environment free of prejudice or harassment on the grounds of race, color, religion, sex, sexual orientation, age, disability, national origin or any other legally prohibited factor. We are expected to abide by all federal, state and local laws dealing with employment matters.

Health, Safety and the Environment
Staff members are expected to behave as follows:

- Learn the procedures for handling and disposal of any hazardous materials we use in our jobs.
- Know the safety procedures that apply to our job.
- Share with our supervisor ideas for improving safety and reducing waste.
- Use our best efforts to ensure that our actions are carried out in a safe and healthy manner.
- Recycle or reuse waste whenever possible. Waste that cannot be recycled or reused should be discarded in a safe manner.

Personal Use of Banner Health Resources
It is the responsibility of Staff to preserve our organization's assets including time, materials, supplies, equipment, and information. Organization assets are to be maintained for business-related purposes. As a general rule, the personal use of a BH asset without prior supervisory approval is prohibited. The occasional use of items, such as copying facilities or telephones, where the cost to BH is insignificant, is permissible. Any community or charitable use of organization resources must be approved in advance by one's supervisor. Any use of organization resources for personal financial gain unrelated to the organization's business is prohibited.

Conflict of Interest

A conflict of interest arises whenever a Staff member's interest or that of a Staff or business partner's immediate family conflicts or appears to conflict with the interest of BH. Everyone has a duty to avoid conflicts of interest or the appearance of conflicts of interest. If a Staff member is faced with a personal transaction, decision or situation which he or she thinks may create a conflict of interest, he or she must report it promptly to his/her supervisor, the Entity/Facility/Health Plan Compliance Officer, the Ethics & Compliance Department or the Internal Audit Department. In many situations, if there is no illegal or unethical conduct involved, BH can consent to a Staff member engaging in the proposed activity even though a conflict of interest may exist. BH's Code of Conduct or the Conflict of Interest policy cannot describe all of the situations that may give rise to conflict of interest circumstances, nor can it take the place of a personal commitment to do what is right; each Staff member is accountable his or her own ethical conduct. Frequently encountered conflicts of interest are described below.

Business Partners
Individuals who provide services to BH as Business Partners are required to observe the same standards of conduct as employees of BH.

Business Opportunities
Staff members are prohibited from taking personal financial advantage of a business opportunity that presents as a result of our association with BH without first obtaining written approval from the BH Internal Audit Department. Examples of business opportunities include real estate deals, patents and purchasing options.

Competitors and Suppliers
Staff members may not invest in any company that is a supplier or competitor of BH without first disclosing this in writing to the Internal Audit Department. Ownership of less than 5 percent of a business's publicly traded securities is not a conflict of interest. Key Staff or members of their immediate families may not work for, provide service to or serve as officers or directors of a competitor or supplier of BH without written notification to and approval by the Internal Audit Department. "Key Staff" are department heads and above.

Confidential Information
Sharing information between and among Staff members is encouraged where it supports our mission of improving health. The use of confidential, non-public information is prohibited. In addition, the release of confidential information is prohibited unless authorized. Examples of authorized releases include press releases, advertisements or management announcements as they are released by the BH employees whose duties include such release.

Outside Employment
Employment with non-BH companies must not interfere or conflict with the performance of Staff member's duties at BH.

Loans
Staff and our immediate families may not loan to or borrow from suppliers or customers. Dealings with banks and other financial companies which arise in the normal course of business are allowed.

Property of Banner Health
Staff members may not use or permit others to use BH property or Staff on duty for personal benefit or the gain of others.

Gifts and Entertainment
Staff members may not solicit personal gifts, services or entertainment of any kind from any patient, customer or company doing or seeking to do business with BH. Staff members are discouraged from accepting gifts in general. Cash and cash equivalents may never be accepted. Staff may accept, from outside entities or persons, a non-monetary gift of nominal value which is a token of respect or friendship and is consistent with the following guidelines:

- Nominal value means $50 or less for any single gift, i.e., fruit basket, bottle of wine, etc.
- All gifts accepted from a single person or entity during a rolling three-month period may not exceed $50.
- Staff may accept unsolicited non-monetary gifts if it is clear that the acceptance does not raise an obligation on the part of the recipient.
- Staff may accept unsolicited offers of reasonable and customary entertainment not to exceed $150 in value no more than four times per year from a business associate. Consecutive events occurring on a single day shall be considered a single event for purposes of determining reasonable cost.

For guidance in greater detail, please refer to the following policies located on the Ethics & Compliance web page on BH's intranet site and with the BH policies and procedures:

- Business Courtesies to Potential Referral Sources Policy
- Acceptance of Items from Outside Business Associates
- Travel, Business Expense & Entertainment Policy

Business and Financial Information

Medicare and Medicaid Billing and Claims

Entities such as BH that accept reimbursement for services from or make payments on behalf of Medicare or Medicaid are subject to several laws and regulations designed to prevent fraud. Honesty and accuracy in billing and in the submission or processing of claims for Medicare or Medicaid is vital. It is a federal felony to willfully make a false statement in connection with a claim for payment or an application for certification under Medicare and Medicaid. Failure to obey these laws can result in fines, jail or exclusion from Medicare and Medicaid programs.

Ineligible Persons

Medicare does not permit ineligible persons to work for or on behalf of entities that bill or contract with Medicare. BH does not contract with or employ, or bill for services rendered by, any individual or entity that is excluded or ineligible to participate in Federal healthcare programs. BH also does not contract with or employ, or bill for services rendered by, any individual or entity that has been suspended or debarred from Federal government contracts and has not yet been reinstated. For all Staff and Business Partners, we conduct an initial and then monthly thereafter search of the Department of Health and Human Services (DHHS)' Office of Inspector General (OIG) and General Services Administration (GSA)'s lists of such excluded and ineligible persons as well as multiple state excluded parties' lists.

Anti-trust Matters

Antitrust laws forbid companies from doing business in a way that gives them too much control in the marketplace. The purpose of these laws is to preserve competition. For example, they prohibit agreements to fix prices. Staff members may not share prices or payer rates with competitors such as non-BH hospitals or other health care providers. Staff should also not discuss with competitors the desire to deal with particular payers or patients or groups or BH's granting of membership, privileges or managed care participation status of providers. Anti-trust laws also prohibit agreements between competitors to allocate patients, payer contracts or regions, and they prohibit boycotts of payers, physicians, providers or other parties. If you are concerned that conduct may violate the anti-trust laws, contact the Legal Department or the Ethics & Compliance Department.

Confidential Business Information

Confidential business information is any information about a present or planned business matter that has not been released publicly by BH. Specifically, Staff members are not allowed to release without authorization information about pricing, financial data, marketing programs, or research. In addition, quality assurance/peer review information is confidential pursuant to state law and cannot be released.

Intellectual Property

Intellectual property includes patents, trademarks, service marks, trade secrets, copyrights, proprietary information and inventions or techniques. Intellectual property is protected by federal and state laws. Violations of the intellectual property laws may result in personal civil damages or criminal charges. In addition, BH may be held responsible for the actions of individual Staff members who break intellectual property laws.

During the course of employment, Staff members may have access to intellectual property, such as computer software, owned by other businesses. This information is private and should not be disclosed to others. Copying computer software violates copyright laws and BH policy. The use of illegal copies of software on company hardware is prohibited. The following activities also may violate the intellectual property laws:

- Installing software programs on more than one computer when it was sold for only one computer. Find out how many computers can use a multiple unit software package before

ordering or installing software.

- Copying (by machine or hand) an entire issue of a journal, magazine or newsletter, unless you obtain permission from the publisher to make such copies. Otherwise, the original should be circulated within a group or several subscriptions purchased.
- Copying (by machine or hand) articles from journals or magazines against the publisher's wishes.

Inventions

"Invention" means, inclusively, technical information, trade secrets, developments, discoveries, know-how, methods, techniques, formulae, data, processes, and other proprietary ideas or matter, including without limitation any such matter or material that is legally protectable by patent or copyright, as a trade secret, or otherwise. Inventions or techniques created by Staff members during the course of their employment are the property of BH, unless there is a written agreement with BH stating differently. Care must be exercised not to disclose trade secrets to others. For additional information, refer to BH's Policy on Patents, Tangible Research, and Other Intellectual Property, number 736.

Accuracy, Retention, and Disposal of Documents and Records

Each Staff member is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements, but also to ensure that records are available to support our business practices and actions. No one may alter or falsify information on any record or document. Records relevant to a government investigation must never be destroyed.

Electronic Media

All communications systems, including but not limited to electronic mail, Intranet, Internet, telephones, and voice mail, are to be used primarily for business purposes in accordance with BH policy. Limited reasonable personal use of BH communications systems is permitted. However, users should presume no expectation of privacy in anything they create, store, send or receive on the computer and telephonic systems. BH reserves the right to monitor and/or access communications usage and content of consistent with BH policies and procedures. For additional information, refer to BH's Information Security Acceptable Use Policy, number 504.

Financial Reporting and Records

BH has established and maintains a high standard of accuracy and completeness in documenting, maintaining, and reporting financial information. This information serves as a basis for managing our business; it is also necessary for compliance with tax and financial reporting requirements. All financial information must reflect actual transactions and conform to generally-accepted accounting principles. All funds or assets must be properly recorded in BH records. BH maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

The financial matters of BH, its employees, physicians and patients are very private. Staff and Business Partners should not reveal these matters to outside parties.

Fraud and Abuse

Entities that accept reimbursement for services provided to Medicare and Medicaid patients/beneficiaries or members are subject to several laws and regulations designed to prevent fraud. Listed below are several applicable laws and regulations including:

- Title XVIII of the Social Security Act
- Medicare Regulations Governing Parts C and D found at 42 CFR § § 422 and 423 respectively

- Patient Protection and Affordable Care Act (Pub. L. No 111-148, 124 Stat. 119)
- Health Insurance Portability and Accountability Act (HIPAA) (public Law 104-191)
- False Claims Acts (31 USC § § 3729-3733)
- Federal Criminal False Claims Statutes (18 USC § § 287.1001)
- Anti-Kickback Statute (42 USC § 1320a-7b(b))
- The Beneficiary Inducement Statute (42 USC § 1320a-7a(a)(5))
- Civil Monetary Penalties of the Social Security Act (42 USC § 1395w-27(g))
- Physician Self-Referral (Stark) Statute (42 USC § 1395nn)
- Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act
- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 USC § 1395w-27(g)(1))(G)
- Fraud Enforcement and Recovery Act of 2009
- All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos and guides
- Federal criminal law

These laws were created to ensure that the federal funds intended to finance Medicare and Medicaid are used only for that purpose. Failure to comply with these laws can result in fines, penalties, imprisonment, and exclusion from participation in federal healthcare programs. Some the most important of these laws are discussed below:

Federal and State False Claim Acts

The Federal False Claim Act ("FCA") imposes civil liability on any person or entity that knowingly submits, or causes to be submitted, a false or fraudulent claim for payment to the U.S. government. It also penalizes anyone who knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay money to the U.S. government. Conspiring with others to commit these acts may also constitute a violation of the FCA. The FCA covers fraud involving any federally funded contract or program such as Medicaid and Medicare. The term "knowingly" includes acting in deliberate ignorance or in reckless disregard of the truth or falsity of the information.

Health care providers who are convicted of violating the FCA can be subject to civil monetary penalties ranging from $10,781 to $21,563 for each false claim submitted. In addition, providers can also be required to pay three times the amount of damages sustained by the U.S. government. If a provider is convicted of a FCA violation, the OIG may seek to exclude the provider from participating in federal health care programs.

The FCA includes a whistleblower provision, or a "qui tam." This provision allows any person to file a lawsuit on behalf of the U.S. government. A company cannot take action against an employee for initiating a *qui tam* claim.

States may also have their own "false claims acts." The Deficit Reduction Act of 2005 ("DRA") encourage states to enact legislation that is comparable to the federal False Claims Act and states may keep an additional 10% of any recoveries obtained if they have a similar state law.

Anti-Kickback Statute

The anti-kickback statute is a federal law prohibiting persons from willfully offering, paying, seeking or receiving anything of value to bring about a referral for medical services or goods payable under Medicare or Medicaid. Failure to obey this law can result in fines, imprisonment or exclusion from the Medicare and Medicaid programs.This law prohibits kickbacks and bribes.

The following activities, among others, are illegal under the anti-kickback statute:

- Routine waivers of co-insurance or deductibles for reasons other than real financial hardship.

Exceptions may exist.
- Offer or acceptance of payment other than at fair market value for healthcare services as a way of getting more business.
- Financial incentives given to physicians that are based on number of referrals or levels of billing.

The following activities must be carefully monitored to assure compliance with the anti-kickback statute:
- Space and equipment leasing.
- Discounts on goods and services.
- Management services agreements
- Personal services contracts.
- Interactions with vendors, including physicians.
- Physician practice purchases.
- Physician recruitment and retention initiatives.
- Employment relationships.
- Managed care initiatives.

In addition to the federal anti-kickback statute, there may be state anti-kickback laws that apply. Exceptions to the prohibitions set forth in the anti-kickback statute do exist, and they can be best handled and applied by the BH Legal Department or the Ethics & Compliance Department. If your job involves these issues, you must consult your supervisor, your Entity/Facility Compliance Officer, the Legal Department or the Ethics & Compliance Department.

Prohibition of Physician Self-Referrals
Generally, a physician (which is broadly defined to include chiropractors, podiatrists, family members and more) who receives payment directly or indirectly from, or has an investment interest in, a healthcare business such as a BH hospital or clinic may not refer patients to that business for services for which Medicare will pay unless the arrangement qualifies for exception from the prohibition of physician self-referrals. Several exceptions exist, and the requirements of an exception must be met before services are furnished and billed. Therefore, any potential relationship must be reviewed and approved in advance by BH's Legal Department, and no claims may be submitted for services performed when the proper steps have not been taken to ensure any referral is proper and meets the requirements of an exception.

Government Relations and Political Activities

Employees are encouraged to take part in community and political affairs and to vote in elections. If you participate in such activities, please remember to make it clear that you are acting as a private citizen and not as a representative of BH.

Campaign Contributions
Generally, not-for-profit businesses like BH may not make political contributions of any sort. This means that BH property, funds or personnel cannot be used to help or support a political candidate. Indirect assistance, such as the supply of goods, services or equipment to candidates, political parties or committees is also banned. There are, however, a few exceptions, and advance approval is required for any such activities.

Additional Code of Conduct Requirements for The Companies

In addition to the BH Code of Conduct standards listed above, The Companies are committed to complying with additional Code of Conduct Standards, including:

Gifts to Public Officials
Federal law makes it a crime to give, offer or promise anything of value to any public official for or because of any official act performed or to be performed by such official. It is also a Federal crime to make any payments to public employees, made on account of or as compensation for public duties.

Payments to Agents and Consultants
Agreements with Business Partners (including agents or FDRs) must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums and be commensurate with the value of the services rendered.

Other Improper Payments (applicable to Medicare Advantage Prescription Drug Plan)
The use of MAPD Plans' funds or assets for any unlawful or unethical purpose is prohibited. Any improper payment made by a Staff member or agent is likewise improper when made by a commissioned agent, or FDR on behalf of the MAPD plans. This is also true for Staff who knows or has reason to know that a payment will be made. The making of any payment to a third party for any purpose other than that disclosed on the payment documentation is also prohibited.

Federal Procurement Integrity Act
The Companies Medicare lines of business are subject to the Federal Procurement Integrity Act when bidding on Federal contracts. This law prohibits certain business conduct for companies seeking to obtain work from the federal government. During the bidding process, Staff may not:

- Offer or discuss employment or business opportunities at The Companies with agency procurement officials.
- Offer or give gratuities or anything of value to any agency procurement official.
- Seek or obtain any confidential information about the selection criteria before the contract is awarded.

In addition, other Federal provisions prohibit Federal officials from accepting anything of value, subject to reasonable exceptions such as modest items of food and refreshments. Because of these restrictions, no Staff shall either offer or make a gift to a federal employee.

Cooperate With All Investigations
The Companies expect truthful and honest responses when participating in internal investigations or external agency reviews, audits or investigations. The Companies are prepared to demonstrate its program upon request by AHCCCS, CMS, DHHS, OIG, the Comptroller General, the state or federal government, other government programs or its designees.

The Companies agree to permit and will fully cooperate with any authorized federal or state officials who conduct an onsite review as well as all legal demands made in any government investigation of any of The Companies. AHCCCS, CMS, OIG, DHHS, the Comptroller General, the state or federal government or other government programs officials may also audit, inspect, investigate, and evaluate any of The Companies' records, books, contracts, documents and other evidence and inspect The Companies' facilities. The Companies will allow reasonable access to Staff and Business Partners, members and records.

BHN's and BNC's CMS/CMMI Program ACO contract with CMS requires that BHN and BNC providers/suppliers participate and fully cooperate in any audits conducted by CMS, DHHS, OIG, or the Comptroller General, to include: 1) BHN and BNC's compliance with its agreement with CMS; 2) The quality of services performed and determination of amount due to or from CMS under the terms of the agreement with CMS; 3) The ability of BHN and BNC to bear the risk of potential losses and to repay any losses to CMS; and, 4) If, as a result of any inspection,

evaluation, investigation, or audit, it is determined that the amount of shared savings due to BHN and BNC or the amount of shared losses owed by BHN and BNC has been calculated in error, agreement that CMS reserves the right to recalculate the amount of shared savings or shared losses. Individuals approached by someone stating that they are a government agent, should confirm the representative's authority by requesting identification and obtaining the person's name, office, address, telephone number and identification number. Individuals must immediately notify their managers who will immediately notify the Compliance Officer who will determine the legitimacy and scope and establish the proper procedures for cooperating with the investigation.

Individuals may agree or refuse to talk with a government investigator and recognize that they have the right to seek legal counsel before responding to any questions. In all cases, it is imperative to tell the truth.

It is against The Companies' policy and a violation of the law to prevent, obstruct, mislead, delay or attempt to prevent, obstruct, mislead or delay the communication of information or records to a government investigator[1].Staff and Business Partners that knowingly and willingly falsify, conceal, or cover up by a trick, scheme or device a material fact or make any false statements or fraudulent representations to a Federal agency may be subject to fines, imprisonment or both[2].

During a government investigation, all policies enabling the destruction of documents shall be suspended until the investigation has been completed and the Compliance Officer has reinstated the policies. If a subpoena or other legal document (such as a Civil Investigative Demand) from any government agency is received, the manager shall contact the Compliance Officer.

Retention of Records

Disposal or destruction of The Companies' records is not discretionary. The retention and disposal or destruction of records will be in accordance with legal and regulatory requirements and The Companies' policies. Records pertaining to litigation or a government investigation or audit will not be destroyed. Records that are subject to audit or current/threatened litigation may not be destroyed unless there is written notification of expiration of the litigation and record destruction is approved by Senior Management and the Compliance Officer.

Records will be maintained in appropriate format (paper, microfilm, microfiche, electronic, and imaged) and available within the timeframes required by Federal and State regulations. The Compliance Officer or designee will oversee destruction of any records, which will comply with written policies and procedures.

For Medicare, The Companies must maintain records as follows:

1. Maintain and give CMS, DHHS and the Comptroller General or their designees access to all books, contracts, records, documents and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the Companies compliance with program requirements, quality of services performed, right to any shared savings payment or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS.
2. Maintain such books, contracts, records, documents and other evidence (excluding any CMS exceptions) for a period of 10 years from the final date of the agreement period or from the date of completion of any audit, evaluation, inspection or investigation, whichever is later unless:
    a. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the applicable entity at least 30 days before the normal disposition date; or

[1] 18 U.S.C. § 1518
[2] 18 U.S.C. § 1518

b. There has been a termination, dispute, or allegation of fraud or similar fault against BHN or BNC, CMS/CMMI Program ACO providers/suppliers, or other individuals or entities performing functions or services related to CMS/CMMI Program ACO activities, in which case BHN or BNC must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute or allegation of fraud or similar fault.

For ERISA, BPA must maintain records as follows:

1. **Section 107** states that all records pertaining to agency filings or to participant or beneficiary disclosures must be retained and kept available for examination for at least **six (6) years** after the **filing date**. The records to be maintained would vary depending upon the type of plan involved, but generally would include worksheets and other supporting data or documentation, committee minutes, Board resolutions, and other information used to prepare the filings or disclosures.
    a. Reporting and disclosure records subject to the six (6) year retention requirement of **ERISA Section 107** include:
        - All forms filed with government agencies with respect to the plan, starting with Form 5500 (including all required schedules and attachments);
        - Determination letter applications and similar filings (on the Form 5300 series);
        - IRS determination letters;
        - Summary plan descriptions and summaries of material modifications; and
        - Participant benefits statements
2. **Section 209 of ERISA** contains a much broader and open ended recordkeeping requirement regarding benefit plans in general. Section 209 states that an employer must "maintain benefit records with respect to each of [its] employees sufficient to determine the benefits due or which may become due to such employees."
    a. Benefits determination records subject to the open-ended retention requirement of **ERISA Section 209** includes:
        - Age and service records that are used to determine waiting periods, eligibility, vesting, breaks in service, and benefits;
        - Payroll records;
        - Marital status records;
        - Beneficiary designations;
        - Participant account records and actuarial accrued benefit analyses;
        - Plan documents and amendments;
        - Benefit claim procedures and procedures for reviewing denied claims;
        - Trust documents, custodial agreements, group annuity contracts and other funding instruments; and
        - Plan notices, election forms, and distribution forms (including COBRA notices, HIPAA certificates of creditable coverage, the written explanation of the joint and survivor annuity option, notice of taxation, distribution election forms, etc.)

For AHCCCS, The Companies must maintain records as follows:

The Companies shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Companies shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Companies agree to make available, at all reasonable times, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or

Federal Government. The Companies are responsible for any costs associated with the reproduction of the requested information.

The Companies shall preserve and make available all records for a period of five years from the date of the final payment under the AHCCCS contract unless a longer period of time is required by law.

The Companies shall comply with the record retention periods specified in HIPAA laws and regulations including, but not limited to 45 CFR 164.530(i)(2).

The Companies shall comply with the record keeping requirements delineated in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the Companies shall ensure compliance with A.R.S. § 12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

This language is contained in provider contracts.

Written Policies and Procedures

The Companies expects Staff and Business Partners to behave in a manner that demonstrates a strong commitment to comply with all Federal and State regulations, standards and sub-regulatory guidance. BH and The Companies' policies and procedures list the steps that Staff and Business Partners are required to follow. Staff and Business Partners are expected to make every reasonable effort to ensure that other Staff and Business Partners comply with these laws and regulations. Should staff or Business Partner suspect a violation of any law, regulation or policy, the Staff and/or Business Partner must report their suspicion to their Compliance Officer or ComplyLine at **1-888-747-7989**. BH and The Companies maintain a repository of policies and procedures so that Staff and Business Partners can know and understand their individual responsibility for compliant and ethical business practices. The Companies policies and procedures are reviewed and revised at least annually or more frequently if there are changes in regulatory requirements or business needs.

BH and The Companies' policies and procedures are the infrastructure which supports the Code of Conduct standards described above and demonstrate to Staff and Business Partners' commitment to operating in an appropriate and compliant manner. In addition, BH and The Companies' policies and procedures provide Staff and Business Partners with needed direction to comply with federal and state laws, regulations, rules and requirements and to reduce potential fraud, waste and abuse in the daily operations of the organization. BH and The Companies' policy and procedures must be followed by Staff or Business Partners to conduct operations in a compliant manner; to respond to potential risks and to help reduce the prospect of fraud, waste or abuse.

The Companies' policies and procedures are created within departments or department units to address contractual elements of The Companies' contracts with AHCCCS, CMS, MAOs, and government programs, and all regulations applicable to those areas. In addition, The Companies

utilize BH corporate policies and procedures to address over-arching protocols, processes or activities, such as in the area of compliance, human resources and information services. The Companies have dedicated Staff who manage the development, writing, approval, storage and retrieval of The Companies' policies and procedures. The Companies have created a set of tools and templates that the policy authors must use to create and revise policies and procedures.

All of The Companies' policies are reviewed annually by the policy and procedure author/owner, department lead (manager, director, or Executive Sponsor) and the Policy and Procedure Committee. The Policy and Procedure Committees review and approve all policies and procedures in order to ensure consistency in formatting and design; to ensure that required elements are included; to reduce potential conflict with other policies and procedures; to ensure appropriate authority and sound business and operational practice.

Staff members are able to access all BHN/BPA/BNC policies and procedures which are housed on BH's SharePoint site titled "BHN and BPA Policies".

Staff members are able to access all BUHP policies and procedures which are housed in BUHP's SharePoint site "Policies & Procedures" on the BUHP intranet by selecting the "Health Plan or Corporate Policies & Procedures" hyperlink on the Health Plan's intranet home page. Notices regarding updated policies are emailed to all Staff from the dedicated Staff who manage the policy and procedures, to alert employees that revisions have been made. Additionally, The Companies' Staff may also access BH corporate policies & procedures which are available via the corporate BH intranet. In addition, The Companies' Business Partners, including FDRs and their employees, are provided with access to key policies and procedures in provider manuals, on The Companies' websites and upon request.

Banner Health Corporate Policies Which Are Part of The Companies' Compliance Program

Policy 1336	HIPAA Use and Disclosure of Protected Health Information (PHI) Requiring Patient Authorization
Policy 263	Prohibition Against Retaliation for Reporting Suspected Non-Compliance
Policy 791	Environmental Compliance and Pollution Prevention Program
Policy 256	Acceptance of Items from Outside Business Associates
Policy 732	Conflict of Interest
Policy 259	Excluded Staff Practitioners and Disallowed Doctors
Policy 207	Compliance Write-offs and Waiver of Co-Payments and Deductibles
Policy 381	HIPAA Contracting with Business Associates
Policy 390	HIPAA Disclosures of Protected Health Information (PHI) to Law Enforcement/Government Officials
Policy 396	HIPAA Patient Request for Records
Policy 1335	Use and Disclosure of Protected Health Information (PHI) Concerning Decedents
Policy 403	HIPAA Transmission of Protected Health Information by Facsimile (FAX)
Policy 408	HIPAA Using, Disclosing and Requesting the Minimum Necessary Amount of Protected Health Information
Policy 2284	HIPAA Sanctions Policy
Policy 1333	HIPAA Disclosures of Protected Health Information (PHI) to Family Members and Persons Involved in an Individual's Care
Policy 404	HIPAA Use and Disclosure of Alcohol and Drug Abuse Records
Policy 405	HIPAA Use and Disclosure of Mental Health Information
Policy 406	HIPAA Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations
Policy 402	HIPAA Responding to Privacy Incidents/Violations
Policy 262	Compliance Program Obligations
Policy 907	Construction Project Financial Controls

Policy 502	HIPAA Encryption of Transmitted Electronic Protected Health Information (e-PHI) and Payment Cardholder Data (CHD)
Policy 828	Supply Contract Exception Request
Policy 410	Workforce Confidentiality
Policy 389	HIPAA Disclosures of Protected Health Information (PHI) Required By Law
Policy 392	HIPAA Marketing/Communication with Patients About Goods and Services, Sale of PHI
Policy 1323	HIPAA Patient Notice of Privacy Practices
Policy 409	HIPAA Patient Request to Amend or Supplement Records
Policy 819	Asset Tagging
Policy 1466	HIPAA Disclosures of Protected Health Information (PHI) in Judicial and Administrative Proceedings – Arizona
Policy 395	HIPAA Patient Request for an Accounting of Disclosures of Protected Health Information
Policy 739	Records Retention and Destruction
Policy 260	Facility Compliance Officers and Compliance Committees
Policy 264	Compliance Reporting and Investigating Potential Compliance Issues
Policy 792	Safety Manual Hazardous Materials Management – Hazard Communication Program
Policy 1319	Social Media
Policy 190	Business Courtesies to Potential Referral Sources
Policy 286	Banner Health Mandatory Compliance Training and Education
Policy 425	Equal Employment Opportunity & Affirmative Action Policy
Policy 418	Corrective Action Policy
Policy 420	Employee Performance Review Policy
Policy 427	Harassment and Sexual Harassment Policy
Policy 194	Federal and State Exclusion Review
Policy 399	HIPAA Protected Health Information Breach Notification
Policy 182	ComplyLine
Policy 811	System Security Incident Reporting and Director Notification
Policy 814	Use of Force
Policy 437	Prohibition Against Retaliation for Protected Activities
Policy 198	Compliance Medicare Provider Opt-Out Policy
Policy 197	Compliance Medicare Advantage Annual Compliance Oversight
Policy 519	Information Technology Sustainable Print Policy
Policy 401	HIPAA Privacy and Security Mandatory Training
Policy 279	Tax Exempt Post-Issuance Compliance
Policy 503	IT Service Continuance Program
Policy 518	Portable Electronic Media Policy
Policy 1339	Identification/Access Cards
Policy 504	Information Security Acceptable Use Policy
Policy 505	Information Security Application Security Policy
Policy 506	Information Security Asset Management Policy
Policy 507	Information Security Contingency Planning Policy
Policy 509	Information Security Enterprise Security Policy
Policy 510	Identity and Access Management
Policy 511	Information Security Incident Management Policy
Policy 512	Information Security Information Protection Policy
Policy 513	Information Security Infrastructure Policy
Policy 514	Information Security Physical Access Policy
Policy 515	Information Security Risk Management Policy
Policy 517	Information Security Third Party Risk Management Policy
Policy 3697	Information Security Glossary

BHN Over-Arching Compliance Program Policies & Procedures

The following over-arching BHN policies and procedures support this Compliance Program and apply to all BHN lines of business:

BHN COMP 07 Banner Health Network Compliance Program Policy
BHN COMP 01 BHN Compliance Audit and Monitoring Policy
BHN COMP 03 Effective Lines of Communication Policy
BHN COMP 04 Monitoring Regulations and Laws Policy
BHN COMP 02 Compliance Attestation Policy
BHN COMP 05 Fraud, Waste and Abuse Policy
BHN COMP 06 BHN Governing Body Onboarding Process Policy
BHN COMP 08 Antitrust Policy
BHN COMP 09 Compliance Officer Responsibilities
BHN COMP 10 Annual Risk Assessment
BHN COMP 11 Compliance Actions
BHN OPS 03 Policy on Policies for BHN and BPA
BHN OPS 05 Delegation Oversight Policy
BHN OPS 06 Delegate Evaluation and Delegation Determination
BHN OPS 07 Delegated Entity Corrective Action Plan Process Policy
BHN OPS 04 Delegation Revocation Process Policy
BHN RSP 01 Claims Audit Process Policy
BHN MM 21 Prior Authorization Policy
BHN MSSP Beneficiary Attribution Policy
BHN MSSP Beneficiary Rights Communication Record Retention
BHN MSSP Marketing Communications Process
BHN MSSP Quality Attestation Policy

BNC Over-Arching Compliance Program Policies & Procedures

The following over-arching BNC policies and procedures support this Compliance Program and apply to all BNC lines of business:

BNC COMP 01 Audit and Monitoring Policy
BNC COMP 03 Effective Lines of Communication Policy
BNC COMP 04 Monitoring Regulations and Laws Policy
BNC COMP 05 Fraud, Waste and Abuse Policy
BNC COMP 06 BNC Governing Body Onboarding Process Policy
BNC COMP 07 Compliance Program Policy
BNC COMP 08 Antitrust Policy
BNC COMP 09 Compliance Officer Responsibilities
BNC COMP 10 Annual Risk Assessment
BNC COMP 11 Compliance Actions
BNC OPS 03 Policy Requirements for BNC
BNC MSSP 01 Quality Attestation Policy
BNC MSSP 02 Program Repayment Policy
BNC MSSP 04 Beneficiary Rights, Communication and Record Retention Policy
BNC MSSP 05 Marketing Material and Communication Policy

BUHP Over-Arching Compliance Program Policies & Procedures

The following over-arching BUHP policies and procedures support this Compliance Program and apply to all BUHP lines of business:

CP 6001 Compliance Program
CP 6004 Reporting Compliance Issues
CP 6006 Health Plan Privacy and Security Safeguards

CP 6007	Protected Health Information
CP 6014	First Tier, Downstream and Related Entity Oversight
CP 6015	Compliance Process for Researching Allegations of Non-Compliance
CP 6016	Five Year Contract Validation Audit
CP 6018	Fraud, Waste and Abuse
CP 6019	FWA FDR Awareness
CP 6020	Employee FWA Awareness
CP 6022	Maintenance and Retention of HP Documents, Member Records and all Related Business Documents
CP 6023	Code of Conduct
CP 6024	Conflict of Interest
CP 6032	Offshore Outsourcing
CP 6033	Sanction Screening
CP 6108	Compliance Actions
CP 6221	Compliance Officer Responsibilities
CP 6227	Monitoring and Auditing
CP 6228	Annual Risk Assessment
CP 6230	Custodian of Records
CP 6801	Employee Commitment to Compliance, Confidentiality and Non-Disclosure
AD 6003	New Employee Orientation and Training
GP 6015	Continuity of Operations and Recovery Plan
GP 6017	Training Material Preparation, Documentation and Tracking
GP 6021	Policy Format and Review
GP 6025	Regulatory Requirement and Guidance Tracking
GP 6034	Compliance Training
GP 6037	Visual Validation
ND 6012	Delegated Administrative Service Agreements
CA 6006	System Security
CA 6008	Claims Fraud, Waste and Abuse Prevention
CA 6104	Claims Auditing
IS 6025	Major System Changes and Upgrades
IS 6026	Technical Security Compliance
MK 6023	Social Media Usage

BUHP AHCCCS Compliance Program Policies & Procedures

The following BUHP policies and procedures support this Compliance Program and apply to all AHCCCS lines of business:

CC 1001A	Cultural Competency
CP 1101A	Disclosure of Ownership Information and Control
CS PA 6023	Prior Authorization
CS MMS 6030	Over and Under Utilization
CS UM 6025	Utilization Management of Emergency Services
CA 1315 A	AHCCCS Monthly Claims Dashboard Report
PH 1206A	Pharmacy Prior Authorization
PH 1222A	Drug Utilization Review

BUHP Medicare Compliance Program Policies & Procedures

The following BUHP policies and procedures support this Compliance Program and apply to all Medicare lines of business:

CC 1001 S	Cultural Competency
MK 1800 S	Marketing and Sales Practices

CP 1806 S	Sales Allegation
GA 1807 S	Complaint Tracking Module (CTM) Monitoring in the Health Plans Management System (HPMS)
CS PA 6023	Prior Authorization
CS MMS 6030	Over and Under Utilization
CS UM 6025	Utilization Management of Emergency Services
GP 1804 S	CMS HPMS Memo Implementation

The Companies require that delegated Business Partners maintain policies and procedures that meet or exceed The Companies' policies and procedures and are compliant with AHCCCS, CMS, and government program rules, regulations or requirements. The Companies will audit delegated Business Partner's policies and procedures to ensure compliance as outlined in Component 7: Auditing and Monitoring.

Component 2: Compliance Officer, Compliance Committee and High Level Oversight

The Compliance Officers serve in an independent role as the primary focal points for The Companies compliance activities. The Compliance Officers have primary responsibility for overseeing and monitoring the Compliance Program implementation as well as ensuring that all policies and procedures are accurate and integrated into The Companies' operations. Coordination and communication of compliance activities are key functions of the Compliance Officer.

The Compliance Officers must reside in the State of Arizona, be full-time employees, are not legal counsel to the CMS/CMMI Program ACO or a CMS/CMMI Program ACO provider/supplier and have the ability to report directly to BHN's President, BNC's VP, or BUHP's CEO and has express authority to provide unfiltered, in-person reports to The Companies' Boards at the Compliance Officer's discretion. The Compliance Officers need not await approval of the Board to implement needed compliance actions and activities. The Companies do not delegate compliance program administrative functions, including the Compliance Officers, Compliance Committees, compliance reporting to senior management, etc. The Companies may use FDRs for compliance activities such as monitoring, auditing and training. The Companies maintain ultimate responsibility for fulfilling the terms and conditions of the contracts with CMS, AHCCCS, government programs and other state and federal entities.

The Compliance Officers and Compliance Committees must periodically report directly to the Boards on the activities and status of the Compliance Program, including issues identified, researched and resolved by the Compliance Program.

The Companies' Boards must be knowledgeable about the content and operation of The Companies' Compliance Program and must exercise reasonable oversight with respect to the implementation and effectiveness of the Compliance Program.

Compliance Officer Responsibilities

The Companies have written criteria for selecting the Compliance Officers. The Compliance Officers have job descriptions that clearly outline the responsibilities and authority of the positions, which includes:

- Is vested with the day-to-day operations of the compliance program and is an employee of Banner.

- Defines the Compliance Program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures and compliance expectations for all Staff and Business Partners.
- Oversees and monitors the implementation of the Compliance Program.
- Ensures Staff and Business Partners have access to and fully understand the Compliance Program.
- Answers Staff and Business Partners questions concerning compliance issues that are not readily answered in this Compliance Program.
- Ensures that the most current government policies and procedures are periodically reviewed and reflected and revised in the Compliance Program and Code of Conduct.
- Verifies that all The Companies policies reflect current and applicable regulations, statute and guidance.
- Ensures the annual Compliance Program is reviewed and approved by the Compliance Committee and Boards. Once approved, ensures distribution to all Staff and is made available to the Business Partners.
- Holds periodic meetings with The Companies management teams to review the Compliance Program and ensures that compliance reports are provided regularly to BHN's President, BNC's VP, BUHP's CEO, Boards and Compliance Committees. Reports should include the status of The Companies' Compliance Program implementation, the identification and resolution of suspected, detected or reported instances of noncompliance, and The Companies' compliance oversight and audit activities.
- Ensures procedures are in place to screen monthly for ineligible providers, Staff and Business Partners. These individuals must not appear in the List of Excluded Individuals (LEIE), the General Service Administration (GSA) list, System for Award Management (SAM) list of debarred individuals/contractors, and any other databases directed by AHCCCS or CMS. Coordinate any resulting personnel issues with The Companies' Human Resources, Security, Legal or other departments as appropriate.
- Develops and participates in educational and training programs that focus on compliance issues. Ensures that Staff and Business Partners, including the applicable Committee members, are informed and comply with applicable federal and state regulations, standards, sub-regulatory guidance and the Code of Conduct.
- Ensures Compliance Program educational and training programs are provided to Staff and Business Partners providing health and administrative services to The Companies.
- Objectively and independently reviews and acts on compliance issues and directs internal investigations and any subsequent corrective measures with all departments, Staff and Business Partners providing health and administrative services on behalf of The Companies.
- Creates policies, reporting procedures, programs and communication materials that are well defined and published which encourage all Staff and Business Partners to report program noncompliance and suspected fraud, waste and abuse and other improprieties. This responsibility includes communication of non-retaliation policies and employee protection measures.
- Creates, periodically reviews and revises fraud, waste and abuse policies and procedures to meet changing regulations and trends.
- Responds to reports of potential and observed instances of fraud, waste or abuse; coordinates internal research and oversees the development and monitoring of the implementation of appropriate corrective or disciplinary actions as necessary.
- Ensures that all government and operational materials and manuals that Staff and Business Partners use are current and are updated on a regular basis.
- Is aware of daily business activity by interacting with the operational units of The Companies.
- Maintains the compliance reporting mechanism and closely coordinates with Internal Audit and Staff.

- Maintains documentation for each report of potential noncompliance or potential FWA received from any source, through any reporting method (e.g., ComplyLine, mail, or in-person).
- Collaborates with other programs, commercial and MAO payers and other organizations where appropriate, when a potential FWA issue is discovered that involves multiple parties.
- The Compliance Officer has the authority to interview employees and other relevant individuals regarding compliance issues.
- Reviews company contracts and other documents pertinent to the Medicare and Medicaid programs or other government programs.
- Reviews or delegates the responsibility to review the submission of data to CMS or AHCCCS or other government programs to ensure that it is accurate and in compliance with CMS, AHCCCS or other government program reporting requirements.
- Independently seeks advice from legal counsel.
- Reports potential FWA to CMS, AHCCCS, its designee other government programs, applicable MAO or law enforcement.
- Conducts and/or directs audits and of any FDRs.
- Conducts and/or directs audits of any area or function involved with Medicare Part C or D plans.
- Recommends policy, procedure and process changes.
- Oversees the creation and monitoring of the implementation of corrective action plans

Compliance Committee Oversight

The Compliance Officers chair the Compliance Committees. The Compliance Committees oversee the Compliance Program and are responsible for reviewing the development, documentation, periodic audit/review of internal controls, and training on risk areas which are annually determined via The Companies' risk assessments. These Compliance Committees are accountable to BHN's senior-most leader and Board, BNC's senior-most leader and Board, and BUHP's senior-most leader and Board, respectively, and will meet at least quarterly to ensure that compliance and compliance-related activity is consistent across the companies. The Compliance Officers will provide quarterly compliance reports to the Boards.

The Compliance Committees will advise the Compliance Officers and assist in implementing the Compliance Program. Compliance Committee members should include individuals with a variety of backgrounds, and reflect the size and scope of The Companies. Members should have decision-making authority in their respective areas of expertise. Each Committee must include the Compliance Officer and BHN's, BNC's, or BUHP's senior-most leadership. In addition, to management and personnel from key functional areas including auditors, pharmacists, registered nurses and others from various departments within the organization who understand the vulnerabilities within their respective areas of expertise.

The Compliance Committees will assist the Compliance Officers in monitoring, reviewing and assessing the effectiveness of the Compliance Program and timeliness of reporting and has the following responsibilities with respect to compliance activities:

- Ensures that The Companies have established effective processes to detect, correct, and prevent non-compliance.
- Ensures that The Companies have a system for Staff and Business Partners to ask compliance questions, raise concerns, and report potential cases of FWA and non-compliance in a timely manner confidentially or anonymously (if desired), without fear of retaliation.
- Ensures that The Companies have appropriate, up-to-date compliance policies and procedures which address Compliance Program components.

- Periodically reviews the training plans and ensures that training and education are effective and appropriately completed.
- Works with the appropriate departments to develop standards of conduct and policies in order to promote adherence to the Compliance Program.
- Recommends, monitors, and reviews the effectiveness, in conjunction with appropriate departments, of the development of internal systems and controls designed to ensure compliance with The Companies' standards, policies and procedures as a part of daily operations.
- Develops strategies to promote compliance with the Compliance Program and detect any potential violations.
- Approves a system to solicit, evaluate and respond to complaints and problems.
- Reviews and addresses reports of monitoring and auditing, including departmental compliance dashboards, in areas that The Companies are at risk for program noncompliance or potential FWA and ensures that corrective action plans are implemented and monitored for effectiveness.
- Assists in the creation, implementation and monitoring of effective corrective and preventive action plans.
- Develops innovative ways to implement appropriate corrective and preventative action.
- Complies with applicable regulations regarding self-reporting of identified compliance issues to appropriate state and federal authorities and when applicable MAOs.
- Assists with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan.
- Supports the Compliance Officer's needs for sufficient Staff and resources to carry out the Compliance Officer's duties.
- Ensures that The Companies have a method for members to report potential FWA.
- Provides regular and ad hoc reports on the status of compliance with recommendations to The Companies' Boards.

High-Level Oversight

The Companies' Boards must be knowledgeable about the content and operation of the Compliance Program and conduct reasonable oversight with respect to the implementation and effectiveness of The Companies' Compliance Program. When compliance issues are presented to the Boards, it makes further inquiry and takes appropriate action to ensure the issues are resolved.

The Companies' Boards receive training and education as to the structure and operation of the Compliance Program. The Boards are knowledgeable about compliance risks and strategies, understand the measurements of outcome, and are able to gauge effectiveness of the Compliance Program.

Board oversight includes:

- Approving the Standards of Conduct.
- Understanding The Companies' Compliance Program Structure.
- Remaining informed about the Compliance Program outcomes, including results of internal and external audits.
- Remaining informed about governmental, contractor or MAO compliance enforcement activity such as Notices of Non-Compliance, Warning Letters and/or more formal sanctions.
- Receiving regularly scheduled, periodic updates from the Compliance Officer and Compliance Committee.
- Reviewing the results of performance and effectiveness assessments of the Compliance Program.

The Boards collect and review measurable evidence that the Compliance Program is detecting and correcting Medicare, Medicaid, or government program noncompliance on a timely basis. The Companies' take steps to ensure that CMS or government programs are able to validate, through review of Board meeting minutes or other documentation, the active engagement of the Boards in the oversight of the Compliance Program.

BHN's President, BNC's VP, and BUHP's CEO and senior management are highly engaged in the Compliance Program. The Executive Teams recognize the importance of the Compliance Program in The Companies' success. The CEOs and Executive Teams ensure that the Compliance Officers are integrated into the organization and are given the credibility, authority and resources necessary to operate a robust and effective Compliance Program. BHN's President, BNC's VP, and BUHP's CEO receive periodic reports from their Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies. The CEO, President, and VP and Executive Teams are also advised of all governmental and contractor compliance enforcement activity, from Notices of Non-compliance to formal enforcement actions.

Component 3: Effective Training and Education

Training and education of Staff (which includes all employees, managers and directors) and Business Partners (which includes all FDRs and providers/suppliers) is an important component of The Companies' Compliance Program, especially training related to compliance. Compliance training and education is required of all new Staff hires and temporary employees within 60 days of initial hiring and annually thereafter. Staff and Business Partners are required to participate in training sessions and will be required to attest that they have received, read, understood and will apply the written materials describing various laws, regulations and policies.

The Companies' managers are responsible for ensuring that Staff and Business Partners have completed all required compliance training. Required training courses are delivered via classroom sessions or electronically via Banner Learning Center (BLC) (a web-based training program) for Staff; and via online training modules, BHN, BNC, or BUHP websites or paper documents for all other Staff and Business Partners. BLC tracks training completion rates and alerts managers to any overdue training requirements.

All employees and FDRs receive training and recurring education on the Federal False Claims Act; administrative remedies for false claims and statements; any state laws relating to civil or criminal penalties for false claims and statements; and the whistleblower protections under such laws.

FDR Compliance and FWA Training

All FDRs must, at a minimum, receive General Compliance and Fraud, Waste and Abuse Training within 90 days of hire/contract, and annually thereafter.

All of The Companies' FDRs are required to attest that all employees engaged in the administration of Medicare Part C and D benefits have satisfied the training requirement. The Companies' will accept the certification of completion from the Medicare Learning Network (MLN) website as proof of training completion or internal certification or documentation from the organizations web-based training modules.

FDRs who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics,

Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste and abuse. However, these deemed FDRs will still be required to complete the General Compliance training through the CMS MLN website and obtain a certificate of completion for all employees required to receive the training. The FDRs may also download the training or incorporate it into their internal training as long as it contains all of the elements of the CMS training. Documentation of internal training can be through an individual certificate or a list showing the information for all of those who completed it through the internal web-based training.

The Compliance Departments or applicable Network Department Staff track completion of training by FDRs through the completion and collection of annual attestations from all FDRs.

Staff and Business Partners receive regular reminders of training requirements. Completion of mandatory training is tied to each employee's annual performance goals. Failure to complete required training will result in performance actions, possibly including termination of employment.

Formal Standardized Training Programs

Staff and Business Partners will receive standard training regarding the organization and its adherence to Federal and State statutes and requirements. CMS/CMMI Program ACO providers/suppliers will either receive standard compliance training or will attest that they have provided training that is consistent with BHN training. Additionally, Staff will receive compliance training from BH to ensure organizational compliance with all BH policies and applicable laws and regulations.

The following trainings are developed by BH, BHN, BPA and BNC Compliance and assigned to all BHN, BPA and BNC Staff. Curriculum is reviewed and updated annually.

- Code of Conduct
    1. Compliance Program
    2. EMTALA
    3. Anti-Kickback
    4. Anti-Trust
    5. Prohibited Billing Practices
    6. HIPAA
    7. Conflicts of Interest
    8. Employee Rights
    9. Federal and State False Claims Act
    10. Program Fraud Civil Remedies Act
    11. Banner Intellectual Property
    12. Non-Retaliation
    13. ComplyLine
- MLN General Compliance Training
- MLN Fraud, Waste and Abuse Training
- HIPAA and Privacy Compliance (Staff only)

The following trainings are developed by BH or BUHP Compliance, Customer Service, Operations, or Quality Department and assigned to all BUHP Staff. Curriculum is reviewed and updated annually.

- Code of Conduct
    1. Compliance Program
    2. EMTALA
    3. Anti-Kickback
    4. Anti-Trust
    5. Prohibited Billing Practices

6. HIPAA
7. Conflicts of Interest
8. Employee Rights
9. Federal and State False Claims Act
10. Program Fraud Civil Remedies Act
11. Banner Intellectual Property
12. Non-Retaliation
13. ComplyLine

- MLN General Compliance Training
- MLN Fraud, Waste and Abuse Training
- Quality Management Training (Staff only)
- HIPAA and Privacy Compliance (Staff only)
- Cultural Competency (Staff only)
- Organizational Determinations and Coverage Determinations
- Business Continuity
- ALTCS Trainings (Staff Only)

Formal Specialized Training Programs

Staff and Business Partners will receive specialized training based on their roles, responsibilities and job functions within The Companies. Specialized training will be relevant to the Staff or Business Partner's role in the organization. The specialized training will include adherence to Federal and State statutes and requirements. The Companies' Departments are responsible for developing the curriculum and organizing the trainings. All training materials and curricula will be designed to address the various skills, knowledge and experience of Staff and Business Partners. Specialized trainings for The Companies will include the following:

- Staff and Business Partners are provided with written copies of relevant laws, regulations and guidelines regarding activities conducted by that Staff or Business Partner or that Staff or Business Partner's department. Training materials will include the relevant policies & procedures; relevant government requirements, rules, regulations and/or guidance specific to that Staff or Business Partner or that Staff or Business Partner's department as well as access to AHCCCS or CMS resources.
- Specialized trainings that are applicable to daily work performance and responsibilities may be based on a new or changing regulation or business requirement, or to enhance an area that has been identified as a potential risk for non-compliance or operational inefficiency, or for which a corrective action plan has been issued.

The Companies' Staff are required to complete all assigned training modules and/or read the assigned materials and must sign (attest) that they have received, read and understand the training. Many training modules include a test that Staff members are required to pass. Banner Learning Center retains the signed/electronic attestations and Compliance Staff will monitor to ensure that 100% of Staff complete all required training.

The Companies maintain ongoing communication and distribute information to Staff and Business Partners regarding compliance issues in order to reflect the most recent and accurate information available regarding applicable federal and state laws and regulations. Training sessions, including attendance sheets and test scores, will be maintained for a period of 10 years.

Component 4: Effective Lines of Communication

Creating a culture of compliance throughout the organization is an important strategic goal for The Companies. This is accomplished by establishing and implementing effective lines of

communication, ensuring confidentiality between the Compliance Officers, members of the Compliance Committees, Staff and Business Partners (especially First Tier, Downstream and Related Entities). The Companies regularly communicate the importance of complying with regulatory requirements and reinforcing The Companies' expectations of ethical and lawful behavior. Information communicated includes the Compliance Officer's names, office locations and contact information (see page 8 for contact information); laws, regulations and guidance for The Companies and Business Partners (such as statutory, regulatory and sub-regulatory changes (e.g., HPMS memos or CMS/CMMI Program ACO Briefings) and changes to policies and procedures and the Code of Conduct.

Staff and Business Partners are free to communicate their concerns to the Compliance Officers via phone call, email, in-person report, mail or fax (see page 8 for contact information) or to any member of the Compliance Committees. The methods available for reporting compliance or FWA concerns and the non-retaliation policy are publicized via posters, the Compliance Program, Compliance Week, training programs, BH's/BHN's/BNC's/BUHP's intranet and websites for all lines of business. To support this regular communication, The Companies have established systems to receive, record and respond to compliance questions or reports of potential or actual non-compliance from Staff or Business Partners or members/beneficiaries. These established systems act as a mechanism for identifying and addressing any compliance problems related to the CMS/CMMI Program ACO's operations and performance. The Companies educate Staff, Business Partners and members/beneficiaries about identifying and reporting potential FWA. Education is published on BH and The Companies' websites, and in The Companies' provider manuals and the BUHP member handbook. To further ensure effective lines of communication between The Companies and FDRs, employees of the Compliance Department are members of recurring Joint Operations Committee (JOC) meetings between The Companies and delegated FDR's. JOC meetings are designed to ensure ongoing oversight of a delegated FDR's performance and to also encourage the regular exchange of information related to routine operations. JOC meetings are documented with formal minutes. Any issue of noncompliance identified at a JOC must be reported to the Compliance Officers or to members of the Compliance Committee for research and action. In addition, he Companies provide the FDRs with access to their websites and a compliance attestation is sent annually. Both of these are resources for the FDRs that communicate The Companies' expectations including reporting noncompliance issues.

Any reports from Staff, Business Partners and enrollees received through any channel of communication of a potential or observed violation of compliance policies, federal and state requirements, regulations or statutes will be documented and investigated promptly by the Compliance Departments and Compliance Officers to determine authenticity and significance. This includes any reports of suspected fraud, waste and abuse. A Matter log is maintained to record all reports, including the nature of any allegation, the results of any review, and the identification of patterns and opportunities for additional training or corrective action. This information is reviewed by the Compliance Officers and reported to the Compliance Committees and The Companies' Boards. These reports are documented in Compliance Committee and Board minutes.

BH and The Companies have written policies of non-retaliation toward any person who reports a potential or observed violation. Staff and Business Partners are made aware of these policies and encouraged to report incidents of potential or observed fraud, waste or abuse or other concerns. All involved are made aware that the identity of any anonymous reporter may have to be revealed.

Effective communication can occur via multiple avenues including accessing the Compliance Officers via phone call, email, in-person report, mail or fax (see page 8 for contact information); accessing any member of the Compliance Committee; contacting the Compliance Departments or the Banner Corporate Ethics & Compliance Department; communicating with a BHN, BPA, BNC

or BUHP supervisor, manager, director or chief; or calling the ComplyLine at **1-888-747-7989.** Any Staff or Business Partner aware of any violation of the Code of Conduct has a duty to report the violation.

Communication Options

An open line of communication between the Compliance Officers and Staff or Business Partners is critical to the success of the Compliance Program and these lines of communication are accessible to all. Staff or Business Partners are expected and encouraged to report any actual or suspected violation of the laws or regulations relating to Medicare, AHCCCS, government program or any other State or Federal law. Staff or Business Partners are required to report any compliance concerns to a supervisor, the Compliance Officers via phone call, email, in-person report, mail or fax (see page 8 for contact information), the ComplyLine at **1-888-747-7989** or to BHN's President, BNC's VP, or BUHP's CEO. Any Staff or Business Partner who is aware of a violation of the law or regulation and does not report it, or who is not aware of a violation of a law or regulation that should have been detected, is subject to disciplinary action, up to and including termination of employment or relationship with BHN, BNC, or BUHP. Staff are encouraged to follow the communication process described in the Code of Conduct.

ComplyLine for Reporting Potential Misconduct

All calls to the ComplyLine are confidential and reviewed by BH Corporate Compliance or the BHN/BNC/BUHP Compliance Officers or designee. BH tracks calls to the ComplyLine to ensure proper research and resolution and to identify patterns and opportunities for additional training or corrective action.

- Staff or Business Partners who want to report potential misconduct can use the contracted toll-free ComplyLine number at **1-888-747-7989** to confidentially and anonymously report potential or observed violations of BH or The Companies' compliance policies, suspected CMS/CMMI Program ACO problems, or federal or state requirements. The Companies will make every reasonable effort to maintain the anonymity of any Staff or Business Partner who reports suspected or observed misconduct, but they will be informed that there may be some circumstances under which it is necessary to disclose the reporter's identity during the process. Reports and questions can also be directed to The Companies' management teams, the Compliance Officers or BHN's President, BNC's VP, or BUHP's CEO. If a staff member or Business Partner makes an anonymous report, they will be provided with a reference number for future contact. Should the reporter request to receive confidential updates regarding their reported concern, the reporter may confidentially re-contact the ComplyLine (**1-888-747-7989**) and use the reference number to obtain updates from ComplyLine representatives.
- BUHP enrollees, providers, staff or other individuals who want to report potential or observed misconduct or potential FWA should contact the BUHP Customer Care Center at **1-800-582-8686**, the toll-free ComplyLine number at **1-888-747-7989**, the Compliance Officer or BUHP's CEO. They can remain anonymous if they wish, but they will be informed that their identity may need to be revealed during the process of review.
- BHN/BNC providers and staff who want to report potential observed misconduct or potential FWA should contact the BPA Service Center at 1-800-827-2464, the toll-free ComplyLine number at 1-888-747-7989 the Compliance Officer, BHN's President or BNC's VP. They can remain anonymous if they wish, but they will be informed that their identity may need to be revealed during the investigation.

Compliance Resources

For BUHP, the Medicaid Compliance Officer, Terri Dorazio, can be reached at: **(520) 874-2847**; via email at **Theresa.Dorazio@bannerhealth.com**; via fax at the fax number below; or via U.S.

mail at the address below. The Medicare Compliance Officer, Linda Steward, can be reached at **(520) 874-2553** via email at **Linda.Steward@bannerhealth.com**. The Compliance Officers have an open door policy and have offices for in-person reports at the Elvira address below. BUHP's CEO can be reached at: **(520) 874-5531.**

If you are unsure about who to contact with a compliance-related question or issue, or if you receive a response you do not consider adequate, you may contact the Compliance & Audit Department in confidence using one of the following methods:

	Confidential and Anonymous ComplyLine: 1-888-747-7989 24 hours/day & 7 days/week. Service provided by outside agency; no caller ID is used	**BUHP Compliance & Audit Department Compliance Medicaid Officer: (520) 874-2847** **BUHP Compliance & Audit Department Compliance Medicare Officer: (520) 874-2553**
	U.S. Mail: Banner University Health Plans Compliance & Audit Dept. 2701 E. Elvira Road Tucson, AZ 85756	**Interoffice Mail:** Compliance & Audit Dept. Elvira Road, Tucson
	Email: BUHP UAHPComplianceandAuditMailbox@bannerhealth.com	**Secure Fax:** (520) 874-7072

For BHN, BNC, and BPA, the Compliance Officer, Teresa McMeans, can be reached at: **(602) 747-3140**; via email at **Teresa.McMeans@bannerhealth.com**; via fax at the fax number below; or via U.S. mail at the address below. The Compliance Officer has an open door policy and has offices for in-person reports at the Phoenix address below. BHN's President can be reached at: **(602) 747-3236**. BNC's VP can be reached at: **(970) 346-3719.**

If you are unsure about who to contact with a compliance-related question or issue, or if you receive a response you do not consider adequate, you may contact the Ethics & Compliance Department in confidence using one of the following methods:

	Confidential and Anonymous ComplyLine: 1-888-747-7989 24 hours/day & 7 days/week. Service provided by outside agency; no caller ID is used	**BHN/BNC/BPA Compliance Officer: (602) 747-3140**
	U.S. Mail: Banner Health Ethics & Compliance Dept. 2901 N Central Avenue Phoenix, AZ 85012	**Interoffice Mail:** Ethics & Compliance Dept. Phoenix Plaza North Tower, Phoenix
	Email: Teresa.McMeans@bannerhealth.com	**Secure Fax:** (602) 747-3387

Component 5: Well-Publicized Disciplinary Standards

As part of The Companies' Compliance Program, The Companies have published the Code of Conduct, which articulates: 1) Expectations for reporting compliance issues and how Staff and Business Partners will be assisted in issue resolution; 2) The requirement that Staff and Business Partners identify non-compliance and unethical behavior, and; 3) Stipulates BH and The Companies' policy on non-retaliation for reporting suspected non-compliance. Staff and Business Partners are required to comply with the Code of Conduct and to report any situation where Staff member or Business Partner believes illegal, unethical or noncompliant conduct may have occurred. FDRs must comply with the Code of Conduct or demonstrate that the FDR has implemented a similar Code of Conduct. The Companies take the Code of Conduct seriously and will immediately investigate and take disciplinary action if anyone violates the Code of Conduct, BH or The Companies' policy or the law.

Enforcing the Code of Conduct

BH and The Companies' policies provide specific instructions for handling reports of potential violations of BH/BHN/BNC/BUHP policies, rules, regulations or law. Any Staff or Business Partner who identifies a potential violation of policy or law, noncompliance or unethical behavior is required to report the matter to their supervisor, manager, director, Compliance Officer, the ComplyLine at **1-888-747-7989,** or the senior-most executive leader. See BH policy 264 Compliance Reporting and Investigating Potential Compliance Issues or BUHP policy CP 6004 Reporting Compliance Issues or BHN/BPA/BNC policy COMP 03, Effective Lines of Communication.

The Companies do not tolerate retaliation. No Staff or Business Partner may discriminate or retaliate against another Staff, Business Partner or member/beneficiary who has, in good faith, complied with the requirements of the Compliance Program by reporting his or her concerns to a supervisor, manager director, the Compliance Officer, the ComplyLine at **1-888-747-7989** or the senior-most executive leader.

Publicizing Disciplinary Guidelines

The Companies provide guidance about disciplinary action against any Staff and Business Partners who fail to comply with The Companies' Code of Conduct, policies and procedures, federal and state health care program requirements and laws, as well as those who have engaged in wrongdoing. This guidance is provided in this Compliance Program; in BH policies: Compliance Program Obligations (262) and Corrective Action (418); in BHN/BPA/BNC policy COMP 03 Effective Lines of Communication and COMP 07 Compliance Program and in BUHP policy CP 6004 Reporting Compliance Issues, CP6108 Corrective Action and CP 6001 Compliance Program. The Companies will enforce disciplinary policies consistently.

The Companies educate Staff and Business Partners about these standards through its Compliance Program, recurring training, policies and procedures, Business Partner contracts and reference manuals. Staff and Business Partners are made aware that failure to report violations due to negligence or reckless conduct may result in disciplinary action. Sanctions for Staff range from oral warnings to immediate termination of employment, or other sanctions as appropriate. Disciplinary actions for Business Partners range from contract sanctions to immediate contract termination, as appropriate. Disciplinary policies are made available to Staff via BH and The Companies' intranet and externally to Business Partners via BH and the Companies websites.

Employment of and Contracting with Ineligible Persons

The Companies will not delegate substantial authority to make decisions to entities that it knows, or should have known, have a propensity to engage in inappropriate or improper conduct. The Companies' organizational policies prohibit hiring or entering into contracts with individuals or entities who have been recently convicted of a criminal offense related to health care; or who are listed as debarred, suspended, and excluded; or are ineligible for participation in federal health care programs; or lawfully prohibited from participating in any public procurement activity; or from participating in non-procurement activities. BH and The Companies conduct monthly screenings of all Staff and Business Partners to verify if they appear in the following lists or databases: The DHHS OIG List of Excluded Individuals / Entities (https://exclusions.oig.hhs.gov/); The System for Award Management (SAM); state exclusion lists and any other databases directed by AHCCCS, CMS, or government programs. The Companies require that any FDR who is delegated to perform administrative functions on behalf of The Companies also conduct this sanction screening and prohibits hiring or entering into contracts as outlined above.

Enforcing Disciplinary Standards

The Companies enforce disciplinary standards in a timely, consistent and effective manner when noncompliance or unethical behavior is determined. BH policy 264 Compliance Reporting and Investigating Potential Compliance Issues, BHN/BPA/BNC policy COMP 03 Effective Lines of Communication and BUHP policy CP 6004 Reporting Compliance Issues and CP 6015 Compliance Process For Researching Allegations of Non-Compliance provide a detailed outline of the reporting, timely review and enforcement of discipline standards. Records are maintained for a period of 10 years for all compliance violation disciplinary actions. BH Human Resources Department periodically reviews records of discipline to ensure that disciplinary actions are appropriate to the seriousness of the violation, fairly and consistently administered, and imposed within a reasonable timeframe. The Compliance Program requires that the promotion of and adherence to all elements of its compliance program will be factors in evaluating the performance of all appropriate employees. Employees will be periodically trained in new and revised compliance policies and procedures as appropriate. The Compliance Program includes several key policies that impact Human Resources operations and activities.

Component 6: Effective System for Routine Monitoring and Identification of Compliance Risks

An ongoing evaluation process is critical to having a successful Compliance Program. The Compliance Program incorporates ongoing BHN, BPA, BNC, and BUHP internal monitoring and auditing activities; regular reporting of audit outcomes to the Compliance Officer, The Companies' executives, the Compliance Committees and Boards; and implementing correction, as necessary to improve contract compliance and operational excellence. This process of The Companies self-identification and corrective action along with monitoring the effectiveness of the corrective action is a key component of the Compliance Program.

Before monitoring and auditing begins, an annual risk assessment must be conducted to identify areas of risk within The Companies. From this risk assessment, the audit program is developed. General auditing and monitoring of The Companies operations is done utilizing The Companies' established metrics. The metrics for evaluating The Companies' compliance with regulatory standards are drawn from BHN's contracts with CMS, government programs or delegating health plans, BNC's contracts with CMS, government programs or delegating health plans and BUHP's contracts with CMS and AHCCCS. These metrics become the basis for the monitoring and auditing program and allows The Companies to identify areas that require corrective action.

Auditing and monitoring activity also includes oversight of administrative activities that The Companies have delegated to an FDR to ensure FDR's compliance with all federal and state laws and regulations.

General Auditing and Monitoring Process

The Companies have developed procedures for internal auditing and monitoring that will assess compliance with federal and state regulations, sub-regulatory guidance, applicable laws, contractual agreements, and internal policies and procedures. This process provides a mechanism for identifying and addressing compliance problems related to government programs, including the CMS/CMMI Program ACO's operations and performance. The Companies' general auditing and monitoring procedures include, but are not limited to, the following components:

Risk Assessment

While a risk assessment is required for the Medicare line of business, The Companies conduct a risk assessment for all lines of business. The Companies conduct a formal risk assessment once a year; however, the Compliance Departments continuously review the risk assessment to ensure that The Companies can respond to new issues that arise. The risk assessment is ranked to determine areas within the organization at greatest risk for fraud, waste and abuse and noncompliance with regulatory and contractual requirements. The Compliance Officers and/or members of the Compliance Committees participate in the risk-assessment process. The Companies' auditing and monitoring activities will focus on the areas identified as high risk. The Companies will document its annual risk assessment activities, findings and any corrective or preventive actions adopted. The annual risk assessment will utilize data and information from a variety of sources, including, but not limited to:

- Regulatory risks based on CMS, AHCCCS, Arizona Department of Insurance (ADOI), Department of Labor, ERISA, or other government program guidance
- Risks as identified in the OIG Work Plan or AHCCCS Program Integrity Guidance
- Audit findings from CMS, AHCCCS, delegating health plans, external auditors, internal audit, the compliance department and/or DOL/ADOI
- Notices of Non-Compliance from CMS, AHCCCS, other government programs, from delegating health plans, and/or DOL/ADOI
- Complaints filed with CMS on its Complaint Tracking Module (CTM) or AHCCCS
- Pharmacy & Therapeutics Committee (BUHP)
- Management survey, focused groups, interviews as to greatest areas of risk
- CMS, AHCCCS and/or DOL/ADOI payment operations and bid preparation
- Complaints related to Medicare sales and marketing issues (BUHP)
- Secret shopper issues and findings identified by CMS
- Audit findings from business unit self-audits/internal monitoring
- Identified high risk areas including but not limited to marketing and enrollment violations, agent/broker misrepresentation, selective marketing, enrollment/disenrollment noncompliance, credentialing, quality assessment, appeals and grievance procedures, benefit/formulary administration, transition policy, protected classes policy, utilization management, accuracy of claims processing, detection of potentially fraudulent claims, and FDR oversight and monitoring.
- Corrective Action Plan monitoring
- New or revised regulatory requirements
- New operational systems or practices

The results of the risk assessments drives the development of the annual audit work plans for oversight audits. The annual audit work plans may be modified based on issues that arise within The Companies during the execution of the annual audit work plans. Compliance audits are based on regulatory guidance and, depending on the department being audited, may rely on

CMS, AHCCCS and/or DOL/ADOI guidance. For Medicare, the basis for specific audits may be outlined in the CMS Audit Protocols, Medicare Managed Care Manual, the Medicare Prescription Drug Benefit Manual, the CMS Monitoring Guide and/or other applicable CMS guidance, or other applicable government program guidance. For AHCCCS, the basis for specific audits may be outlined in the AHCCCS Contractor Operations Manual (ACOM), the AHCCCS Medical Practice Manual (AMPM), and/or other applicable AHCCCS guidance. The audit work plans include:

- Audits to be performed
- Audit schedules, including start and end dates
- Audit methodology
- Type of audit: desk or onsite
- Person(s) responsible
- Follow-up activities from findings to determine if implemented corrective actions have fully addressed the underlying problems
- External Audits contractually required by federal and state agencies
- Tracking and Analysis of internal Operational Monitoring Activities

Internal Audit

The Compliance Departments and BH Internal Audit Department have an implemented audit function which includes adequate and dedicated audit staff that are responsible to perform quality audits as part of its overall program to identify and reduce risk and ensure compliance with Medicare, Medicaid, and government program regulations. Staff dedicated to the audit function are knowledgeable about operational requirements for the areas under review and are independent and do not engage in self-policing. The Companies' audit process of all functional areas may include scheduled, unannounced or spot check audits.

The Companies analyze data to identify patterns of unusual and potentially abusive health care utilization and non-compliance. Analysis also extends to reviewing department compliance with AHCCCS, CMS, government programs, and/or DOL/ADOI requirements. The auditor provides a summary report of audit results to The Companies' departments. The report will include any findings of non-compliance. If non-compliance is identified, a corrective action is issued to the BHN, BPA, BNC, or BUHP Department and the Department will be required to submit a Corrective Action Plan (CAP) that outlines the root cause and how it will modify its operations in order to return to compliant performance. The Department's CAP must identify the root cause, explain how correction will be implemented, how the solution will be verified as effective and how the Department will monitor its performance to ensure the deficiency is unlikely to recur. The Compliance Departments also validate all completed CAPs to ensure the intended result was achieved. Overall reporting of audit activities and results are provided to The Companies' Compliance Committees, and the Boards.

Department Self-Audits and Monitoring

Departments are required to conduct self-audits to measure performance against CMS, AHCCCS, government program, and/or DOL/ADOI requirements. Some self-audits are conducted monthly. Additionally, the Compliance Departments may conduct focused monitoring of department performance. Non-compliance is to be self-reported to the Compliance Officers and the Department's management and a Corrective Action Plan as described above will be developed by the Department to correct any identified deficiencies. The results of self-audits and monitoring are reported along with other compliance metrics to the Compliance Officers and Compliance Committees.

External Auditors

The Companies also contract with external auditors to audit its processes and operations. This includes the required annual audit of BUHP's Compliance Program. The results of these external

audits are reported to senior management, the Compliance Officers, the Compliance Committees and the Boards.

BHN/BPA/BNC Monitoring and Auditing of First Tier, Downstream and Related Entities (FDRs)

BHN, BPA and BNC contract with vendors to administer and/or deliver benefits on their behalf. These vendors are referred to as delegated FDRs and they must abide by BHN/BPA/BNC contractual and regulatory requirements. BHN/BPA/BNC is responsible for the lawful and compliant administration of government program benefits.

BHN/BPA and BNC have a Delegation Oversight Committees (DOCs) which ensures regular and ongoing oversight of BHN's relationships with delegated FDRs. The Committee monitors delegated FDR activities and performance to ensure they fulfill contractual requirements and meet established standards. DOC members are from appropriate departments and department units throughout BHN/BPA/BNC. Specific BHN and/or BNC Departments are assigned as owners to oversee specific delegated FDRs, including, but not limited to:

- Credentialing
- Provider Relations
- Network Management
- Operations
- Service Center
- Care Management
- Claims Processing
- Compliance
- Accreditation
- Medical Management
- Quality Management

For delegated FDRs with responsibility in multiple functional areas, the owners are responsible for arranging recurring Joint Operations Committees (JOC). JOCs are composed of a cross-functional group of individuals from both BHN/BPA/BNC and the delegated FDR. The JOCs work collaboratively to enhance operational efficiencies and address any areas of risk.

The DOC ensures that the audit tools are up-to-date. The DOC's work plan includes the number of First Tier Entities that will be audited each year and how the entities will be identified for auditing. BHN//BPA/BNC ensures that First Tier Entities fulfill the Compliance Program requirements, including the First Tier Entity's application of Compliance Program requirements to its Downstream Entities. In addition, the DOC ensures that the functional area conducts routine audits to validate delegated FDR compliance. If BHN//BPA/BNC identifies FDR non-compliance, corrective action plans are required to respond to detected offenses. BHN/BNC ensures that corrective actions are taken. Reports on overall oversight activities are given to the respective DOC and to the respective Compliance Committee.

BUHP Monitoring and Auditing of First Tier, Downstream and Related Entities (FDRs)

BUHP contracts with vendors to administer and/or deliver benefits on BUHP's behalf. These vendors are referred to as delegated FDRs and they must abide by BUHP contractual and regulatory requirements. BUHP is responsible for the lawful and compliant administration of Medicare and Medicaid benefits under our contracts with AHCCCS, CMS and ADOI, regardless of delegation. BUHP has clearly defined processes and criteria to evaluate and categorize all vendors with which BUHP contracts and utilizes multiple methods to monitor and audit First Tier Entities to ensure that they are compliant 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. Methods include on-site audits, desk reviews, external audits, and monitoring of self-audit reports. BUHP's audit work plan of First Tier Entity oversight includes multiple components as follows:

- Regular reporting of FDR activities
- Auditing FDR operations at least annually
- Requiring contractual terms for all FDRs that:
  1. Mandate compliance with applicable federal and state laws
  2. Outline BUHP accountability and FDR delegation responsibilities
  3. Allow for inspections, provide beneficiary protection and require record retention
  4. Allow for cost-containment recovery for infractions or errors made by FDRs
  5. Provide for revocation of the delegation activities or other remedies when CMS, AHCCCS or BUHP determine that the delegated FDR has not performed satisfactorily.
  6. Report the FDR to appropriate government agencies and/or law enforcement for any applicable civil and criminal laws for fraud perpetrated in the delivery of the Part C and D benefits.
- Stipulating that all FDRs certify the accuracy, completeness and truthfulness of any claims data submitted on behalf of BUHP and acknowledging that claims submitted on behalf of BUHP will be used for the purpose of obtaining federal reimbursement
- Maintaining cost-containment recovery provisions for infractions

BUHP's Vendor Oversight Team (VOT) ensures regular and ongoing oversight of BUHP's relationships with delegated FDRs. The Committee monitors delegated FDR activities and performance to ensure they fulfill contractual requirements and meet established standards. VOT members are from appropriate departments and department units throughout BUHP. Specific Departments are assigned as owners to oversee specific delegated FDRs, including, but not limited to:

- Credentialing
- Provider Relations/Network Development
- Pharmacy Benefit Manager
- Call Center
- Prior Authorization
- Claims Processing
- Compliance

For delegated FDRs with responsibility in multiple functional areas, the owners are responsible for arranging recurring Joint Operations Committees (JOC). JOCs are composed of a cross-functional group of individuals from both BUHP and the delegated FDR. The JOCs work collaboratively to enhance operational efficiencies and address any areas of risk.

The VOT ensures that the audit tools are up-to-date. The VOT's work plan includes the number of First Tier Entities that will be audited each year and how the entities will be identified for auditing. BUHP ensures that First Tier Entities fulfill the Compliance Program requirements, including the First Tier Entity's application of Compliance Program requirements to its downstream entities. In addition, the VOT ensures that the Compliance Department conducts routine audits to validate delegated FDR compliance. If BUHP identifies FDR non-compliance, corrective action plans are required to respond to detected offenses. BUHP ensures that corrective actions are taken. Reports on overall oversight activities are given to the VOT to the Quality Management / Performance Improvement Committee and to the Compliance Committee.

Fraud, Waste and Abuse Research

The Compliance Departments are responsible for coordinating research of potential fraud, waste and/or abuse. In addition, training and awareness programs are developed and implemented to

promote The Companies' commitment to ethical conduct for all Staff and Business Partners. The BUHP FWA Specialist works with the Medicare Drug Integrity Contractor (MEDIC) and law enforcement or other agencies, as required. Analytics employed include data mining to identify referral patterns, possible payment errors, utilization trends and other indicators of potential fraud, waste and abuse. Furthermore, for BUHP data analysis of medical and prescription drug claims is conducted to detect outliers that may indicate potential member or provider fraud, waste and abuse. Results of BUHP FWA research may result in the FWA Specialist or the Compliance Officer conducting provider education, making referrals to the Arizona Inspector General or MEDIC, or taking other actions. For BUHP AHCCCS members, this may include limiting choice. For both BUHP AHCCCS and Medicare members, this will result in case management referrals. For BHN's MAO members, BHN compliance may report to the MA Plan Special Investigations Unit (SIU)/Compliance Contact or the MEDIC. For FDRs for The Companies, this may result in formal contract actions, up to and including FDR termination. Results of FWA research efforts are reported to the Compliance Officers and The Companies' Compliance Committees and the Boards.

Auditing of The Companies by State or Federal Agencies or External Parties

The Companies consider regulatory audits and reviews as an opportunity to confirm effectiveness of The Companies compliance efforts. Should the outcome of an audit indicate that BHN, BPA, BNC or BUHP has not met a regulatory requirement, The Companies will use the audit findings to perform root cause analyses and develop corrective action plans to address identified areas of non-compliance. The Companies may also contract with external vendors to perform audits and assist with operational/program changes to enhance The Companies' compliance.

The Companies cooperate with state and federal agencies or external vendors when audits are conducted and provide auditors access to information and records related to The Companies and delegated FDR operations.

Tracking and Documenting Compliance and Compliance Program Effectiveness

The Companies track and document compliance efforts, including tracking through formal audits and monitoring, as well as through dashboards, scorecards, self-assessment tools and other mechanisms that show the extent to which operational areas and FDRs are meeting compliance goals. Issues of noncompliance identified in dashboards, scorecards, self-assessments, etc. are shared with The Companies' senior management.

Component 7: Procedures and System for Prompt Response to Compliance Issues

The Companies have established and implemented procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence and ensuring ongoing compliance with CMS, AHCCCS, and government programs regulations. The Companies conduct appropriate corrective actions (e.g., repayment of overpayments and disciplinary actions against responsible individuals) in response to any potential violation. The Companies may detect the non-compliance through multiple avenues including self-reporting, AHCCCS or Medicare audits, government program audits, internal audits, the ComplyLine calls, external audits or member/beneficiary complaints. When The Companies identify an incident, they take prompt action to research the matter, determine the root cause and implement an effective corrective action. BH and The Companies maintain policies and procedures to outline how to promptly respond to any detected offenses and develop CAPs related to The Companies' contracts. See BH policy 7647 Corrective Action Policy,

BHN/BPA/BNC policy COMP 01 Audit and Monitoring Policy and BUHP policy CP 6108 Corrective Action. The Companies have procedures to voluntarily self-report potential fraud or misconduct related to the Medicaid program to AHCCCS or its designee, the Medicare program and/or the CMS/CMMI Program ACO to the applicable delegating health plan, CMS or its designee.

Timely and Reasonable Inquiry

The Companies will make a timely, well-documented and reasonable inquiry into any situation where evidence suggests there has been misconduct related to The Companies' contractual requirements, including but not limited to payment, delivery of services, and/or prescription drug items. This includes any misconduct by Staff or Business Partners. Regardless of where the misconduct is identified, The Companies will initiate a timely and reasonable inquiry.

Potential instances of fraud, waste and abuse may come to the attention of the Compliance Officers or members of senior management through Staff, Business Partner or beneficiary / member reports, audits or other sources. The Companies will conduct a reasonable inquiry as soon as possible, but no later than two weeks from the date the potential misconduct was identified or reported. The Companies' inquiry includes a preliminary review of the matter by the Compliance Officer or designee.

Because of the complex nature of some of the Medicare cases, particularly fraud reviews, the Compliance Officers may also refer the matter to the Medicare Drug Integrity Contractor (MEDIC) within two weeks of the date the potential misconduct is identified or reported so that investigations into suspected or observed fraudulent or abusive activity may be expedited. For BHN, BPA and BNC, this may also include reporting to the Ethics & Compliance Department of the delegating MAO Plan.

For BUHP, per state Medicaid requirements (AHCCCS), the Compliance Officer or designee shall immediately report, within one business day, any incidents of alleged fraud, waste, or abuse to the AHCCCS-OIG through the online reporting form. All documentation that may assist the AHCCCS-OIG in its investigation will be included with the referral. Once the case is referred, BUHP will not take any actions to recoup or otherwise offset any suspected overpayments. In the event, that BUHP has received or recovered an overpayment, BUHP will notify AHCCCS-OIG immediately. If BUHP identifies an incident that requires self-disclosure, the AHCCCS-OIG will be immediately notified within one business day by completing the Provider Self-Disclosure form on the AHCCCS-OIG webpage. Any information which may assist the AHCCCS-OIG in its investigation will be included.

Corrective Action

Any time an incident of non-compliance is discovered or a department's processes or systems results in non-compliance with AHCCCS, CMS, government programs, and/or DOL/ADOI/CDOI requirements, the department is required to submit a corrective action plan (CAP) to the applicable Compliance Department. The Department's CAP must: 1) identify the root cause; 2) explain how correction will be implemented; 3) discuss how the solution will be verified as effective; and, 4) advise how the Department will monitor its performance to ensure the deficiency is unlikely to recur. CAPs represent a commitment from the department to correct the underlying problem of an identified issue in a timely manner and to prevent future noncompliance. CAPs may include revising processes, updating policies & procedures, retraining Staff, reviewing systems edits and addressing other identified root causes. The CAP must achieve sustained compliance with the overall AHCCCS, CMS, government programs, and/or DOL/ADOI/CDOI requirements.

The status of open CAPs is reported to the applicable Compliance Officer and the Compliance Committee. The Compliance Departments monitor CAP implementation and requires that the department regularly report the completion of all action steps. Once the CAP is complete, the Compliance Departments validate the CAP by monitoring individual action items over a period of time to demonstrate sustained compliance was achieved and the CAP was effective.

The Compliance Committees are responsible for overseeing ongoing activity to ensure the CAPs are being implemented in a timely and effective manner and to report ongoing non-compliance risks to senior management.

The Companies' oversight of delegated FDRs includes a requirement that FDRs submit CAPs to address FDR non-compliance. Non-compliance may be identified through BHN, BPA, BNC or BUHP oversight, compliance audits, ongoing monitoring or self-reporting. The Companies take appropriate action against any delegated vendor that does not comply with a CAP or does not meet its regulatory obligations. The Companies' relationship with delegated FDRs includes a written agreement that includes penalties up to and including termination of the delegated FDR's contract.

The BUHP Compliance Department is responsible for reviewing all BUHP sales allegations or complaints of marketing misrepresentation against a sales agent. Each allegation is investigated. Complaints may be received through multiple avenues including member/beneficiary complaints filed with CMS, the CMS regional office, Customer Care, the Compliance Department, the ComplyLine or the Grievance & Appeals Department. Should the research substantiate the sales allegation, BUHP will implement prompt disciplinary action to include additional training, ride-alongs, verbal or written warnings, suspension of sales production or termination of employment or termination of the external agent's agreement.

BHN, BPA, BNC and BUHP Self-Reporting

Should The Companies discover an incident of significant Medicare or Medicaid program or CMMI noncompliance, potential fraud or misconduct, The Companies will report the incident to the applicable delegating health plan, CMS, AHCCCS, or government agency designees (e.g., MEDIC) as soon as possible after its discovery. In addition, CMMI program is required to report any probable violations of law to an appropriate law enforcement agency.

Component 8: Fraud, Waste and Abuse Plan

Health care fraud is a crime that has a significant effect on the private and public health care payment system. Program abuse results in unnecessary costs to AHCCCS, CMS, and government programs. Taxpayers pay higher taxes because of FWA in public programs such as Medicare and AHCCCS. Employers and individuals pay higher private health insurance premiums because of FWA in the private sector health care system. Because of the profound impact FWA has on health care financing, CMS, AHCCCS, and other government programs require BHN, BNC, or BUHP and other Medicare, and AHCCCS plans to actively pursue the prevention, detection, research, reporting and correction of FWA.

Examples of fraud include, but are not limited to:
- Billing for services that were not rendered;
- Misrepresenting as medically necessary non-covered or screening services by reporting them as covered procedure or revenue codes;
- Signing blank records or certification forms, or falsifying information on records or certification forms for the sole purpose of obtaining payment;

- Up-coding or consistently using procedure/revenue codes that describe more extensive services than those actually performed;
- Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement;
- Selling or sharing Medicare/AHCCCS health insurance identification numbers so that false claims can be filed;
- Falsifying information on applications, medical records, billing statements, cost reports or on any documents filed with the government.

Examples of waste and abuse include, but are not limited to:

- Billing for services or items in excess of those needed by the patient;
- Unbundling services that are to be bundled or double billing in order to receive increased payment
- Adding inappropriate or incorrect information to cost reports;
- Collecting in excess of the deductible or co-insurance amounts;
- Requiring a deposit or other payment from patients as a condition for admission, continued care or other provision of service.

Examples of member fraud include, but are not limited to:

- Misrepresenting or concealing facts that would cause BUHP to provide coverage to persons who are otherwise not eligible.

The three types of conduct that are generally prohibited by health care fraud laws are false claims, kickbacks and self-referrals. The consequences for violating these laws can include, in addition to imprisonment and fines, civil monetary penalties, loss of licensure, loss of Staff privileges and exclusion from participation in federal health care programs.

The Companies do not tolerate FWA of AHCCCS, Medicare, or government program resources and has implemented this FWA Plan to help prevent, detect, investigate, report and correct areas where FWA activity may occur. All Staff and Business Partners are prohibited from committing or participating in fraudulent, wasteful or abusive activity. The Companies' FWA Plan is a component of the Compliance Program and the focus on reducing FWA is woven throughout this document. The Companies are taking a layered approach which includes considering multiple aspects of FWA: prevention, detection, research reporting and correction.

FWA Prevention

FWA prevention is an important first step in the FWA plan and occurs via multiple avenues including policies and procedures, awareness/training, screening and risk assessment.

Policies & Procedures

The Companies' Compliance Officers and Compliance Departments reference state and federal policy and have developed FWA policies and procedures that are clear, concise, well-defined and updated regularly. Further, The Companies reference corporate policies and procedures that reinforce The Companies' activities. Staff and Business Partners may reference these policies and procedures to better understand the overall fraud, waste and abuse process. These policies and procedures include:

BH Policy:	264 Compliance Reporting and Investigating Potential Compliance Issues
BH Policy:	410 Workforce Confidentiality
BH Policy:	194 Federal and State Exclusion Review
BH Policy:	732 Conflict of Interest
BUHP Policy	CP 6001 Compliance Program
BUHP Policy	CP 6006 Health Plan Privacy and Security Safeguards
BUHP Policy:	CP 6018 Fraud, Waste and Abuse
BUHP Policy:	CP 6019 FWA FDR Awareness
BUHP Policy:	CP 6020 FWA Employee Awareness
BUHP Policy	CP 6023 Code of Conduct
BUHP Policy	CP 6024 Conflict of Interest
BUHP Policy:	CP 6033 Sanction Screening
BHN Policy:	COMP 07 Compliance Program Policy
BHN Policy:	COMP 05 Fraud, Waste and Abuse
BNC Policy:	COMP 07 Compliance Program Policy
BNC Policy:	COMP 05 Fraud, Waste and Abuse

Awareness

The Companies ensure all Staff and Business Partners are made aware of the importance of preventing, detecting, investigating, reporting and correcting FWA. FDRs receive FWA training, including training provided as a new Staff member within 90 days of initial hiring (or contracting of Business Partners) as well as annually thereafter. In addition, specialized FWA training for FDR Staff based on their individual job functions may be developed. Completion of FWA training is documented for all Staff and Business Partners. The Companies' managers are responsible for ensuring Staff training has been completed during staff member's annual reviews and The Companies' training must be completed within 90 days of initial hiring as well as annually thereafter.

All contracted providers are supplied with FWA materials via the provider manual, provider portal and from their Provider Relations Representatives.

BHN, BPA, and BNC FDRs have access to FWA information and reporting forms on BHN/BPA and BNC websites for all lines of business. Information to report FWA is found on the BH intranet for employees and on BHN/BPA and BNC websites for Business Partners.

BUHP FDRs have access to FWA information and reporting forms on BUHP websites for all lines of business. Members receive FWA materials in the Member Handbook. Information to report FWA is found on the BUHP intranet for employees and on BUHP websites for members and providers.

Screening

A key element of the FWA Plan is ensuring Staff and Business Partners are fit for employment/contracting in the health care industry. For Staff, this includes conducting pre-employment background checks to review for felony convictions. For Staff and Business Partners this also includes reviewing the OIG or GSA or SAM sanctions or exclusions list. The Companies' organizational policies prohibit hiring or entering into contracts with individuals or entities who have been recently convicted of a criminal offense related to health care, including those related to FWA, or who are listed as debarred, suspended, excluded, otherwise ineligible for participation in federal health care programs, or lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities. BH and The Companies screen all Staff and Business Partners, including new employees, temporary employees, volunteers, consultants, governing body members monthly to verify that they do not appear in the following

lists or databases: The DHHS OIG List of Excluded Individuals / Entities (LEIE) (https://exclusions.oig.hhs.gov/); The System of Award Management (SAM), formerly known as The Excluded Parties List (EPLS); state exclusion databases and any other databases directed by AHCCCS, CMS, or government programs. The Companies require that any FDR who is delegated to perform administrative functions on behalf of The Companies also conduct the sanction screening and prohibit hiring or entering into contracts as outlined above. Fiscal Agents as defined in 42 CFR 455.101 that have control interest and their managing employees are screened on a monthly basis. Fiscal Agents are required to provide timely notification to The Companies of any changes in ownership or managing employees.

The Companies require its FDRs to screen all employees and Downstream Entities monthly with the above lists and databases and/or any additional lists required by AHCCCS, CMS, and government programs. FDRs are required to attest to monthly screenings on an annual basis and documentation of regular screening must be provided to The Companies upon request.

Risk Assessment

To effectively deploy resources, risk must be assessed. The Companies' Compliance Departments conduct an annual risk assessment of The Companies' operations for all programs. This integrated approach identifies risk across The Companies. The assessments identify measure, and prioritize risks that may materially impact The Companies, including fraud and abuse risk. The risk assessments are used to build the annual audit and monitoring programs. The risk assessment are used to determine areas within the organizations at greatest risk for fraud, waste and abuse. The Companies' FWA elements considered may include: 1) Any internally reported findings on payment aberrancies; 2) Any self-identified payment system limitations; 3) Results from FWA Committees implemented interventions; 4) Outcomes of data analytic studies conducted by Staff as well as FWA vendors; and 5) Comparing annual FWA savings to national FWA benchmarks to ensure savings are in alignment.

FWA Detection

The Companies have developed a multiple and layered operational process in an effort to detect potential fraud, waste and abuse. The Companies' detection methods include the following elements: monitoring and auditing, publicizing communication channels to Staff, Business Partners, Providers, and members/beneficiaries; and regularly communicating to Staff and Business Partners.

Monitoring and Auditing

The Companies are required to perform effective monitoring in order to prevent and detect FWA. Staff and Business Partners are encouraged to monitor their work and interactions for any suspected FWA. The Companies' Compliance Departments receive FWA referrals from sources such as:

- Claims Department Referrals
- Customer Care/Service Center calls
- Medical Management Department Referrals
- Case Manager Referrals
- Quality Department Referrals
- Finance Department Referrals
- Network Development Department Referrals
- Claims Educator Referrals
- Coding Educator Referrals
- Grievance and Appeal Trending

- Auditor Findings
- Contracted Providers
- Third-Party Referrals including former employees of The Companies or Business Partners
- Literature, such as news reports or industry newsletters like the Health Care Compliance Association's weekly report
- Referrals from delegating health plans
- CMS Fraud Alerts. When received reviews past paid claims to identify whether payments have been made to any entities identified in a fraud alert and remove them from their sets of prescription drug event data submissions.
- Notices from the OIG and AHCCCS OIG

Specific system applications and departments conduct routine monitoring on an ongoing basis to proactively identify potential FWA.

The Compliance Department

The Compliance Departments employ FWA Specialists to conduct audits and reviews. The FWA Specialists along with the Compliance Officers and other applicable Compliance Staff conduct surveillance, interviews and other methods of review relating to potential FWA. The FWA Specialists coordinate all FWA monitoring and facilitate additional FWA steps including: reducing or eliminating Medicare, Medicaid, or government program benefit costs due to FWA; reducing or eliminating fraudulent or abusive claims paid with federal or state dollars; preventing illegal activities; identifying members with overutilization issues; identifying and recommending providers for exclusion, including those who have defrauded or abused the system to the MEDIC, AHCCCS OIG and/or law enforcement; referring suspected, detected or reported cases of illegal drug activity, including drug diversion, to MEDIC, AHCCCS OIG and/or law enforcement and conducting case development and support activities for MEDIC, AHCCCS OIG and law enforcement investigations; and assisting law enforcement by providing information needed to develop successful prosecutions. The Compliance Departments also deploy Regulatory Compliance Staff and the Director of BUHP Compliance is a Certified Professional Coder (CPC). All focus on areas of risk—including fraud and abuse identification and annual audits of The Companies' subcontractors—to ensure that fraud and abuse prevention programs are in place. The Compliance Audit teams consists of auditors who also monitoring Corrective Action Plans. At BPA and BUHP, Claims Auditors conduct monthly quality audits to review processed claims for financial and processing accuracy. They look for unusual claims payment patterns. Compliance Staff in conjunction with BH Corporate Compliance Staff also monitor sanction screening and exclusion databases to ensure employees and vendors are eligible to participate in federal and state programs.

For BHN/BPA:

BPA Claims Committee
BPA has a Claims Committee which is composed of BPA management and other Staff from cross-functional areas throughout BHN and BPA, including the Compliance Department. The Compliance Department regularly reports on FWA activities. Results are also reported to the BHN/BPA Compliance Committee and the BHN and BPA Boards.

BPA Claims Department
To ensure provider payments are appropriate, the Claims Department monitors for FWA via pre-payment system edits, live payment edits and coordination of benefits. The Claims Department also monitors for trends and provider patterns and reports any suspicious activities to the Compliance Department. The Claims Department also conducts quality audits of its individual Claims Processors; should the audit identify consistent or recurring errors, the Claims Department

will provide additional training and/or discipline the processor, as appropriate. When suspicious billing is identified, Claims can place a provider on manual review status and require review of all claims prior to payment.

Banner Health (BH) Information Technology
BH addresses the issue of fraud and abuse through several software solutions. BH's claims adjudication system is called IMPACT, a solution provided by the Phoenix-based software vendor Managed Care Systems, Inc. (MCSI). IMPACT allows the configuration of business rules to identify claims that require management review or that suggest questionable billing patterns. The IMPACT System prices all MA Plan claims per Medicare guidelines as approved and interpreted by the BPA Operations leads. BH uses Edifecs' HIPAA Express product as a claims editing / scrubber application. BH has a tightly controlled Change Management Model that ensures cross-departmental communication and monitoring of edits and updates to the claims environment. Banner IT has built a reporting environment which affords the BPA Analytics team the opportunity to identify trends, look for billing anomalies, and perform analyses to reveal irregularities. Additionally, the datamining software, LexisNexis, is employed as a fraud detection and risk identification solution. FWA specialized analyze medical claims data from the system.

BPA Service Center
The Service Center monitors incoming member calls for any FWA activities. This includes members who may be "doctor or prescription shopping" in an effort to obtain large quantities of pain/other illegal drugs or member and providers who are making Service Center Representatives aware of other suspected FWA activity. Service Center Representatives report suspected FWA activity voluntarily disclosed by member, providers or other callers to the Ethics & Compliance Department. All Service Center Representatives are encouraged to report suspicious activity to the Ethics & Compliance Department.

BH/BHN/BPA Finance Department
The BH/BPA Finance Department ensures compliance and contract adherence through consistent, thorough financial analysis and review. During standard monthly reporting and analysis, review is done to ensure anomalies and aberrant results are examined and investigated. Upon review, items requiring further analysis and review are then turned over to the appropriate operational team to address the issue, including mitigation, where necessary.

BHN Network Management/Provider Relations
In addition, in the course of servicing providers, BHN Provider Relations Representatives (PRRs) make unannounced provider office visits. Sometimes the PRR is joined by other BHN representatives, including the CMO, Medical Director, Quality Management Director or Director of Medical Management. If a provider is confirmed by the OIG, the Attorney General's Office or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider.

BHN/BPA Medical Management
The Medical Management Department includes staff whom are responsible for completing retrospective review of specific claims including durable medical equipment, professional fees and facility claims. For retrospective review, medical records are examined to determine medical necessity and appropriate medical care. This type of review covers any services or treatment. The reviews conducted are based on Medicare Coverage Determinations, Milliman Care Guidelines, Hayes Evidence-Based Guidelines or MAO's established guidelines that pertain to correct coding, covered service and associated reimbursements. Should fraud or abuse be suspected, a referral is made to the Ethics & Compliance Department.

BHN/BPA FDRs

All BHN/BPA FDRs have access to the BHN/BPA Compliance Communications website for all lines of business. The website includes instructions on how to report potential issues or excluded individuals or entities.

For BNC:

<u>BNC Finance/Data Analysis Department</u>
The BNC Finance/Data Analysis Department ensures compliance and contract adherence through consistent, thorough financial analysis and review. During standard monthly reporting and analysis, review is done to ensure anomalies and aberrant results are examined and investigated. Upon review, items requiring further analysis and review are then turned over to the appropriate operational team to address the issue, including mitigation, where necessary.

<u>BNC Network Management/Provider Relations</u>
In addition, in the course of servicing providers, BNC Provider Relations Representatives (PRRs) make provider office visits. Sometimes the PRR is joined by other BNC representatives, including the Medical Director and/or Clinical Operations Coordinator. If a provider is confirmed by the OIG, the Attorney General's Office or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider.

For BUHP:

<u>FWA Committee</u>
BUHP has created a FWA Committee which is composed of BUHP Executive Management and the Compliance Department Staff responsible for detecting and correcting FWA. The FWA Committee is responsible for overseeing the coordination of FWA activities; developing FWA interventions; monitoring FWA activities including tracking & trending reports; and reporting results to the Compliance Committee and Board.

<u>BUHP Data Analysis</u>
BUHP conducts data analysis, which compares claim information against other data to identify unusual patterns, suggesting potential errors and/or potential fraud and abuse. Data analysis is factored into prescribing and dispensing practices of providers who serve a particular population. Use of data analysis includes monitoring pharmacy, dental and medical billing to detect unusual patterns.

<u>BUHP Information Technology</u>
BUHP employs multiple software solutions that allow it to efficiently prevent fraud and abuse. To support correct payment activities, BUHP's core claims processing system, GE Centricity Business MCA (GE MCA) contains very flexible rule banks for identifying claims that should be pended for process or manager review. BUHP uses Burgess Pricing Solution, which prices all CMS claims per Medicare guidelines and AHCCCS acute facility claim types. BUHP has also implemented OptumInsight's claims editing application, iCES. iCES supplies all required claims editing and BUHP has customized iCES incorporating various AHCCCS reference tables within the Medicaid profile. BUHP has also implemented the Oracle Siebel Customer Relationship Management (Siebel) application, a state-of-the-art customer relationship management solution. Siebel employs a workflow engine that allows technology-based cross-departmental communication and task/activity assignment. When members and providers contact BUHP, their calls are uniformly logged. Employees operate within a workflow queue, completing their tasks in the appropriate sequence. Siebel then routes the tasks to the next accountable employee. Activities, timing and results are stored and tracked for review and analysis of trends. The FWA Specialist receives referrals from BUHP's call center through Siebel. The Medical Management Department also uses Siebel for retrospective claims review. This process identifies claims that result in outliers, which are routed for review by certified coders for errors, fraud or abuse. The

task is initiated from the Claims Department and routed to Medical Management. Upon completion, the results are routed back to Claims. Another technology solution is a prior authorization (PA) management system. This has a web-based component enabling providers to send and receive PA requests and responses as well as communicate with BUHP. These communications are stored within the PA management system. BUHP also has a custom-developed provider portal, eServices. eServices supplies providers with online eligibility verifications, claims status inquiry and the ability to submit an electronic PA form. Providers who use eServices can easily validate their member's eligibility.

BUHP Claims Department
To ensure provider payments are appropriate, the Claims Department monitors for FWA via iCES, which applies pre-payment system edits, live payment edits and coordination of benefits. BUHP's Pharmacy Benefit Manager (PBM) employs point-of-sale edit software and coordination of benefits. The edits ensure that governmental funds are not being improperly distributed and that payments are being prepared correctly for claims submitted from authorized providers for eligible members. The Claims Department also monitors for trends and provider patterns and reports any suspicious activities to the Compliance Department. The Claims Department also conducts quality audits of its individual Claims Processors; should the audit identify consistent or recurring errors, the Claims Department will provide additional training and/or discipline the processor, as appropriate. When suspicious billing is identified, Claims can place a provider on manual review status and require review of all claims prior to payment.

BUHP Customer Care Center / Call Center
The Customer Care Center monitors incoming member calls for any FWA activities. This includes identifying members who may have moved out of the area and no longer qualify for benefits, members who may be "doctor or prescription shopping" in an effort to obtain large quantities of pain/other illegal drugs or members and providers who are making Customer Care Representatives aware of other suspected FWA activity. Customer Care Center Representatives report suspected FWA activity voluntarily disclosed by members, providers or other callers to the Compliance Department. All Customer Care Center Representatives are encouraged to report suspicious activity to the Compliance Department. Furthermore, the BUHP Customer Care Department conducts outbound service verification calls on an ongoing basis and annually with a random sample. Based on paid claims, Customer Care calls members to verify the receipt of a paid service. The outcome of the call is documented and regularly reported to AHCCCS. Should a member indicate that the service was not provided; a referral is made to the FWA Specialist for further review. When BUHP receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member, a referral is made to the FWA Specialist and a report is immediately made to AHCCCS OIG or MEDIC.

BUHP Finance Department
The Finance Department contracts with Health Management Systems (HMS), which conducts retrospective third-party liability monitoring. On a monthly basis, BUHP reports claims to HMS that contain the "trigger" diagnostic codes that identify injuries that may have been prompted by a third party. This includes identifying other payers, such as private insurers, which have primary payment responsibility for the health care services rendered. This monitoring occurs after a medical claim has been processed and is often referred to as "pay and chase". Should another payer be identified, monies already paid out are recovered. The savings is reported to AHCCCS and to the Utilization Management/Finance Committee. BUHP's Finance Department performs quarterly oversight audits to ensure HMS remains compliant in all areas required by AHCCCS and CMS.

BUHP Network Development/Provider Relations

In the course of servicing providers, BUHP Provider Relations Representatives (PRRs) make unannounced provider office visits. Sometimes the PRR is joined by other BUHP representatives, including the Chief Medical Officer, Medical Director, Quality Management Director or Director of Medical Management. If a provider is confirmed by the OIG, the Attorney General's Office or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider.

BUHP Medical Management

The Medical Management Department includes a Medical Management Systems Unit which is staffed in part to retrospectively review specific claims including durable medical equipment, professional fees and facility claims. For retrospective review, medical records are examined to determine medical necessity and appropriate medical care. This type of review covers any services or treatment including medications that have already been administered or provided. The reviews conducted are based on AHCCCS criteria, CMS guidelines and business decisions that pertain to correct coding and associated reimbursements. Should fraud or abuse be suspected, a referral is made to the FWA Specialist.

BUHP Pharmacy Department

The Pharmacy Department works to provide safe and appropriate medications, but it sometimes identifies members who misuse medications, the most common of which are prescribed opioids. BUHP's Pharmacy team developed processes to address the misuse of opioids. These include: 1) Pharmacy and Therapeutics Committee oversight, including PA edits for most long-acting opioids and carisoprodol, a medication commonly associated with inappropriate opioid use. This medication was removed from the formulary because there are safer alternatives to replace it; 2) Conducting a complete medication history review as part of the PA process for long-acting opioid prescription requests and any "refills too soon" or lost prescriptions are thoroughly researched; 3) Reviewing retrospective drug utilization reports from the PBM to identify members exhibiting drug-seeking behaviors, including multiple prescribers, multiple pharmacies and frequent prescriptions for small quantities of controlled substances; 4) Encouraging communication between PCPs, pain specialists and BUHP to better manage member care; 5) Researching and responding to drug-seeking member referrals from the FWA Specialist, Case Managers, pharmacy providers and medical providers. When substantiated, the FWA Specialist reports the member to AHCCCS OIG and/or MEDIC. The member is then referred to the Case Management Department wherein members can be restricted to a specific pharmacy and/or prescriber to better monitor care.

BUHP Quality Management

The Quality Management Department (Quality) includes added steps to identify fraud and abuse. The Quality Department supplies abuse of member reports and investigates member abuse allegations. When cases of suspected child or elder abuse are encountered by Staff, these are referred to Quality to ensure appropriate reporting occurs. If potential member fraud or abuse is identified, the Quality Management Department makes a referral to the FWA Specialist.

BUHP Claims Recovery Unit

The Claims Recovery Unit (CRU) performs systemic post payment review of claims payments to ensure that payments for health care services are accurate based on CMS guidelines, AHCCCS guidelines, provider contracts and nationally accepted, widely acknowledged coding standards. The CRU will audit overutilization of billed services or other practices that result in unnecessary reimbursements, waste or costs to CMS and/or AHCCCS lines of business. This CRU program is aligned to the Health Plan Compliance Program and the FWA Plan.

BUHP Subcontractors

BUHP collaborates with providers and subcontractors to identify fraud and abuse. BUHP's PBM, MedImpact, provides fraud and abuse data-mining decision-support tools and services. The PBM evaluates claims data utilizing a prospective and retrospective process to detect patterns of

deviant or abnormal dispensing behavior, MEDIC reported targets, areas of high incidence of fraud and other potential areas of abuse. The PBM reports suspicious activities to BUHP's FWA Specialist and uses the analysis to increase proactive interventions such as pharmacist education. The PBM supplies BUHP with quarterly and annual reports that identify any prevented overpayments. PBM representatives are required to make unannounced pharmacy visits to confirm the location is a legitimate business. BUHP's dental network subcontractor, DentaQuest (DQ), monitors its contracted providers via qualitative and quantitative utilization data management that compares dentists to identify aberrant practice or billing patterns. They analyze 100% of paid claim history and conduct medical record reviews on an average of 5%-10% of the network. Should aberrant patterns be identified, DQ may implement a provider education program to modify provider behavior and may report the provider to BUHP's FWA Specialist or directly to AHCCCS OIG. DQ representatives are required to make unannounced dental office visits to confirm the location is a legitimate business.

BUHP FDRs

All BUHP FDRs have access to an online FWA reporting form (on the BUHP website for all lines of business) that is directly routed to the BUHP Compliance Department and then to the FWA Specialist for review.

FWA Research

The Companies will review in a timely and reasonable manner any potential misconduct including but not limited to activities associated with treatment, payment, operations, delivery of services, or prescription drug items. This includes any misconduct by Staff or Business Partners. Should FWA be suspected, the Compliance Department is responsible for coordinating the review. The dedicated FWA Specialists will lead an internal review; utilize a contracted vendor; or collaborate with the MEDIC, AHCCCS OIG, law enforcement or other agencies, as required.

The Companies utilize FWA software to analyze BUHP/BHN/BPA/BNC claims data and report any potential FWA to the FWA Specialists. For BUHP this includes pharmacy, dental and medical claims. For BHN, this includes medical claims processed by BPA. The vendor provides decision-support tools and services to identify and prevent fraud and abuse. Searches are conducted by analyzing The Companies' referrals and data mining of BUHP and BHN/BPA's claims data. Data mining establishes baseline data to enable The Companies to recognize unusual trends, changes in utilization over time, potential overpayments, fraud or abuse by identifying patterns that are aberrant when compared to other like claims. These patterns are identified through techniques including visualization designed to reveal hidden relationships such as unbundling, upcoding, duplicate billing, services not rendered, and misrepresentation of services. The FWA Specialist then validates the vendor's findings.

Generally there are three types of resolutions for these reviews: 1) request for reimbursement; 2) recoupment from future payments when appropriate; 3) educate providers on how they can improve billing practices.

If it is determined a provider or group has suspicious claims activity, The Companies have directed the contracted vendor to also perform focused audits and reviews. The comprehensive referral and review process includes conducting trend analysis, medical record audits, Department of Insurance (DOI) reporting, and/or other regulatory reporting, if appropriate.

Because of the complex nature of some of Medicare cases that may be involved, particularly fraud audits and reviews, the Compliance Officers may also refer the matter to the MEDIC within two weeks of the date the potential misconduct is identified or reported so that investigations into suspected or observed fraudulent or abusive activity may be expedited.

For cases of suspected FWA involving the state Medicaid program (AHCCCS), BUHP shall immediately report the incident to the AHCCCS-OIG within one business day through the online reporting form on the AHCCCS-OIG webpage along with any documentation or information that may assist AHCCCS-OIG in its investigation. Once BUHP has made the referral, it will make no attempt to recoup or otherwise offset any suspected overpayments. In the event, that BUHP has received or recovered an overpayment, BUHP will notify AHCCCS-OIG immediately.

If BUHP identifies an incident that warrants self-disclosure, it will be reported immediately within on business day to the AHCCCS-OIG using the Provider Self-Disclosure form.

For BHN cases involving the delegating health plans, the FWA Specialists will report/refer any potential fraud to the delegated health plan's Compliance or SIU areas.

FWA Correction

Upon completing an audit or review, The Companies will seek to correct the identified FWA, including, but not limited to the following actions for FDRs:

- Provider Education: If it is determined the claims contained unintentional billing errors and FWA is not suspected; the FWA Specialists collaborate with the Network Development/Provider Relations Department to educate the provider regarding errors and appropriate billing techniques.
- Prospective Review: When directed, the Claims Department may place a provider on a prospective/pending flag status that requires review of all claims prior to payment.
- Recovery: When The Companies determine there have been overpayments, either recoups or reimbursement requests will be made unless a referral has been made to AHCCCS OIG for FWA.
- Administrative Remedy: If consistently inappropriate billing trends are noted, The Companies' Compliance Departments will collaborate with the Network Management/Provider Relations Department to educate the provider. If provider education does not produce a positive result, a provider may be disciplined up to and including removal from the network and subjected to any applicable civil and criminal laws for fraud. This extends to FDRs.
- Government Agency Referral: Certain circumstances may require The Companies to report findings to the appropriate government agencies, including the OIG, MEDIC or the Department of Justice (DOJ). Depending on the nature of the issue, a referral can be made to local law enforcement agencies.
- Change in Policy: The Companies may determine the need to modify a policy to ensure compliance with government regulation.
- Close Case: When the evidence does not support findings of inappropriate benefits, payments, or the legal/medical merits of the cases do not indicate need for further pursuit.

For BHN/BPA/BNC members, audits and reviews may result in:

- Member Education: Members may receive a call from the Service Center, their assigned Case Manager or their health plan to educate the member regarding FWA.
- Case Management Referrals: Members may be assigned to a Case Manager to ensure the member is receiving appropriate care.
- Increased Monitoring: The Service Center or their applicable health plan can place a flag in its system of suspected FWA behavior. Should the member call in, the Service Center or their health plan will note the flag and route the call appropriately. The call can be routed to case management, compliance or law enforcement.
- Network Restriction: Members may be subject to limited provider or pharmacy choice.
- Government Agency Referral: Certain circumstances may require BHN/BPA to report findings to the appropriate health plan, government agencies including the OIG, MEDIC or the DOJ.

Depending on the nature of the issue, a referral can be made to local law enforcement agencies, as deemed appropriate.

- Referral to MA Plans: When applicable, the FWA Specialist may refer the potential FWA case to the applicable MA Plan for review or reporting.
- Close Case: Closing the case may be the best option when the evidence does not support the finding.

For BUHP members, audits and reviews may result in:

- Member Education: Members may receive a call from the Customer Care Center or their assigned Case Manager to educate the member regarding FWA.
- Case Management Referrals: Members may be assigned to a Case Manager to ensure the member is receiving appropriate care.
- Increased Monitoring: The Customer Care Center can place a flag in its Customer Resource Module (CRM) system of suspected FWA behavior. Should the member call in, the Customer Care Center will note the flag and route the call appropriately. The call can be routed to case management, compliance or law enforcement.
- Network Restriction: AHCCCS members may be subject to limited provider or pharmacy choice.
- Government Agency Referral: Certain circumstances may require BUHP to report findings to the appropriate government agencies including the OIG, MEDIC or the DOJ. Depending on the nature of the issue, a referral can be made to local law enforcement agencies, as deemed appropriate.
- Close Case: Closing the case may be the best option when the evidence does not support the finding.

FWA Reporting and Tracking

The Companies require any Staff or Business Partner who suspects inappropriate FWA behavior to report the suspicion to the Compliance Departments or the FWA Specialist. FWA reporting can be done by telephone, email, internet message submission and mail. Staff and Business Partners may also use the ComplyLine at **1-888-747-7989** for anonymous reporting of any suspected FWA. The Compliance Departments also formally report any suspected FWA to the designated state and federal agencies, including the AHCCCS-OIG, the MEDIC, delegating health plans, and law enforcement.

Instances of suspected FWA shall be reported to AHCCCS OIG directly at:

Provider Fraud
To report suspected fraud by medical provider, please call the number below:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686
- Or by accessing the AHCCCS website directly at: https://www.azahcccs.gov/Fraud/ReportFraud/

Member Fraud
To report suspected fraud by an AHCCCS member, please call the number below:

- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686
- Or by accessing the AHCCCS website directly at: https://www.azahcccs.gov/Fraud/ReportFraud/

Questions
If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS OIG.

- Email: AHCCCSFraud@azahcccs.gov

Instances of suspected FWA can be reported to Medicare:

Providers are required to report all suspected fraud, waste, and abuse to the Health Plan or to Medicare directly.

Mail: US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

Phone: 1-800-HHS-TIPS (1-300-447-8477)
Fax: 1-800-223-8164
TTY: 1-800-377-4950
Website:
https://forms.oig.hhs.gov/hotlineoperations

Any reports received—through any channel of communication—of a potential or observed violation of compliance policies, federal and state requirements, regulations or statutes will be documented. A log will be maintained to record all such reports, including the nature of any review and its results and to identify patterns and opportunities for additional training or corrective action. This information will be included in reports to the Compliance Committees.

BH and The Companies have written policies of non-retaliation toward any person who reports a potential or observed violation. Staff and Business Partners will be made aware of these policies and encouraged to report incidents of potential or observed FWA or other compliance concerns. All involved will be made aware of the fact that the identity of any anonymous reporter may have to be revealed.

Reporting BUHP FWA to AHCCCS
If BUHP determines that potential fraud or misconduct related to the AHCCCS program has occurred, BUHP's Compliance Department will report to the AHCCCS-OIG using the online reporting form, within one business day and in accordance with AHCCCS ACOM policy 103, Fraud, Waste and Abuse and BUHP policy and procedure CP 6018 Fraud, Waste and Abuse.

Reporting FWA to Medicare
If The Companies determine that potential fraud or misconduct related to the Medicare Advantage Prescription Drug Plan Part D program or CMMI Program has occurred, the Compliance Department will report the potential fraud or misconduct to either (a) directly to the MEDIC, or (b) to the applicable third party payer as per policy or specific contractual obligation.

The Companies may also consider reporting potentially fraudulent conduct to government authorities such as the OIG or the DOJ.

FWA Tracking
The Companies will maintain files for a period of 10 years on both in-network and out-of-network providers who have been the subject of complaints, reviews, violations and prosecutions. This includes enrollee/member complaints, MEDIC investigations, OIG and/or DOJ investigation, US Attorney prosecution, and any other civil, criminal or administrative action for violations of Federal health care program requirements. The Companies also maintain files that contain documented warnings (e.g., fraud alerts) and educational contacts, the results of previous reviews, and copies of complaints resulting from audits and reviews. The Companies will comply with requests by law enforcement, CMS, AHCCCS or CMS designee regarding monitoring of providers within BHN's/BNC's/BUHP's network that CMS or AHCCCS has identified as potentially abusive or fraudulent.