Banner
University Health Plans

Banner
Medicare

2022 Compliance Attestation

Your Organization is receiving this "Annual Attestation and Disclosure Statement" because your Organization is contracted with Banner – University Health Plans (B – UHP) – (Banner – University Family Care/ACC; Banner – University Family Care/ALTCS), Banner Medicare (Banner Medicare Advantage Dual D-SNP, Banner Medicare Advantage HMO and Banner Medicare Advantage PPO), and Banner Medicare Rx as a First Tier, Downstream or Related Entity (FDR), and/or an Administrative Service Subcontractor, or Provider for B – UHP/Banner Medicare products.

As a B – UHP/Banner Medicare contractor, the Organization is subject to federal and state laws related to the Medicare and Medicaid programs as well as Centers for Medicare and Medicaid Services (CMS) and state Medicaid program (AHCCCS) rules, regulations, and sub-regulatory guidance. This includes ensuring the Organization's employees and downstream contractors abide by said federal and state laws, regulations, and sub-regulatory guidance.

Instructions:

Review each section

1. **Section 1:** Medicare and Medicaid Participation Compliance Program Requirements

   Section 2: Attestations

   Section 3: Organization Information and Signature

2. **Complete the 2022 Annual Attestation using one of the following methods:**

   1. **Online Portal –** https://eservices.uph.org/Attestation/C2022

      Or

   2. **Email Completed Form to:** BUHPVendorOversight@bannerhealth.com with Subject Line: 2022 Annual Attestation Submission

Definitions

CMS definitions of subcontractors:

First Tier Entity

Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Downstream Entity

Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement, between:

- A Medicare Advantage Organization, or
- Applicant, or
- A Part D plan sponsor, or
- Applicant and a First Tier Entity.

These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity

Any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

- Performs some of the Medicare Advantage Organization or Part D plan Sponsor's management functions under contract or delegation;
- Furnishes services to Medicare enrollees under an oral or written agreement; or
- Leases real property or sells materials to the Medicare Advantage Organization or Part D plan Sponsor at a cost of more than $2,500 during a contract period.

AHCCCS defines subcontractors as:

Administrative Service Subcontracts/Subcontractors

An agreement that B – UHP delegates any of the requirements of the AHCCCS Contracts for either the Banner – University Family Care/ACC or Banner – University Family Care/ALTCS to including, but not limited to the following:

- Claims processing, including pharmacy claims
- Credentialing, including those for only primary source verification (i.e., Credential Verification Organization)
- Management Service Agreements
- Service Level Agreements with any Division or Subsidiary of a corporate parent owner

Provider

Any individual or entity that contracts with AHCCCS or B – UHP for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

Section 1: Medicare and Medicaid Participation Compliance Program Requirements

(For consistency throughout this document, B – UHP/Banner Medicare will refer collectively to its subcontractors as FDRs)

General Compliance and Fraud Waste and Abuse Provisions

Medicare (CMS)

CMS Compliance Program requirements are located in Chapters 9 and 21 of the Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

Medicare program requirements apply to FDRs who have been delegated administrative or health care service functions relating to Banner's Medicare contracts. A link to the guidelines is noted above; FDRs must review the guidelines and ensure appropriate protocols are in place to demonstrate compliance.

FDRs are also required to adhere to the B – UHP/Banner Medicare Provider Manuals located at:
B – UHP: www.BannerUHP.com
Banner Medicare: www.BannerHealth.com/Medicare

Medicaid (AHCCCS)

Compliance requirements for the Arizona State Medicaid Program, AHCCCS, are located in the AHCCCS

Contractor Operations Manual (Policies 103, 104 and 438); the AHCCCS Medical Policy Manual (AMPM).

AHCCCS Contractor Guides & Manuals:
https://azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html

Providers and Administrative Subcontractors are also required to adhere to the B – UHP/Banner Medicare Provider Manuals located at:
B – UHP: www.BannerUHP.com
Banner Medicare: www.BannerHealth.com/Medicare

Policies and Procedures and Code of Conduct

B – UHP/Banner Medicare make available to its FDRs the Banner Health Code of Conduct and Banner Health Insurance Division Companies Compliance Program and Fraud, Waste and Abuse Plan and all applicable Compliance Program policies and procedures via the secure provider portal and/or the B – UHP and Banner Medicare websites.

Organization Requirements

Your Organization is required to:

- Distribute the Banner Health Code of Conduct and applicable Compliance policies and procedures to all employees within 90 days of hire, when there are updates to the policies, and annually thereafter or;
- Your Organization is permitted to utilize your own Code of Conduct and applicable Compliance Program policies and procedures with the condition that they are comparable to those of B – UHP or Banner Medicare; these documents are subject to review upon request.
- You should ensure that employees, as a condition of employment, read and agree to comply with all written compliance policies and procedures and Code of Conduct.
- Employee statements or certifications should be retained and be available to B – UHP/Banner Medicare, AHCCCS, or CMS upon request.
- Records must be maintained for 10 years.
- The Code of Conduct states your Organization's over-arching principles and values by which your Organization operates and defines the underlying framework for the compliance policies and procedures. The Code of Conduct must provide the standards by which your employees will conduct themselves including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations, and policies.
- Your Organization's Code of Conduct should include provisions to ensure employees, managers, officers, and directors responsible for the administration or delivery of the Medicare/Medicaid benefits are free from any conflict of interest in administering or delivering Medicare/Medicaid benefits. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

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

As an Organization that provides health, prescription drug or administrative services to Part C Medicare Advantage (MA) or Part D Prescription Drug Plan (PDP) enrollees on behalf of B – UHP/Banner Medicare, the Organization is required to provide General Compliance and FWA training to its employees (including temporary employees and volunteers) and to the Organization's downstream entities within 90 days of contract with B – UHP/Banner Medicare, within 90 days of new employee hire and annually thereafter.

B – UHP/Banner Medicare have General Compliance and FWA training on our website. FDRs have an option to take our training or a comparable training. FDRs are required to complete this attestation and submit it to B – UHP/Banner Medicare indicating that the employees involved in the administration of Medicare Part C and D benefits have satisfied the training requirement.

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.

B – UHP/Banner Medicare will track completion of training by FDRs through the completion and collection of annual attestations from all FDRs.

False Claims Act

For all FDRs, or Administrative Service Subcontractors, contracted with B – UHP/Banner Medicare for the Medicare and Medicaid lines of business, the Organization must have policies and procedures in place to establish training requirements for all staff and provide training on the following aspects of the False Claims Act:

- The 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.

Reporting Non-Compliance and Suspected Fraud, Waste and Abuse:

Your Organization is required to comply with all applicable laws, whether or not they are specifically addressed. Issues of non-compliance and potential FWA must be reported immediately to B – UHP/Banner Medicare through the appropriate mechanisms and reported issues will be addressed and corrected. Your processes must be documented and include detailed and specific guidance regarding how to report potential compliance issues.

Your Organization may contact B – UHP/Banner Medicare to report Non-Compliance or FWA:

ComplyLine: 1-888-747-7989 Reports can be made anonymously
Email: BHPCompliance@bannerhealth.com
Secure Fax: (520) 874-7072

U.S. Mail: Banner Health Plans
Compliance Department
2701 E. Elvira, Tucson, AZ 85756

Directly call the Medicaid Compliance Officer, Terri (Theresa) Dorazio, at (520) 874-2847
Directly call the Medicare Compliance Officer, Linda Steward, at (520) 874-2553

Instances of suspected FWA for the Medicaid Lines of Business shall be reported to AHCCCS OIG directly also at:

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

Phone: (800) HHS-TIPS (1-300-447-8477)
Fax: (800) 223-8164
TTY: (800) 377-4950

Website: https://oig.hhs.gov/fraud/report-fraud/

Banner University Health Plans

Banner Medicare

Instances of suspected FWA can be reported to Medicare:

Provider Fraud

Providers are required to report all suspected fraud, waste, and abuse to B – UHP/Banner Medicare Compliance or to Medicare directly. 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

Sub-Delegation

Sub-delegation occurs when a B – UHP/Banner Medicare delegated FDR gives another entity the authority to carry out a delegated responsibility that B – UHP/Banner Medicare has delegated to that FDR; this would also be considered a "downstream entity" to both B – UHP/Banner Medicare and your Organization.

For example, B – UHP/Banner Medicare may delegate provider credentialing activities to a Provider Hospital Organization (PHO) and the entity then delegates' a portion of the credentialing process, such as primary source verification, to a Credentialing Verification Organization (CVO) instead of performing the primary source verification itself. In this case, the CVO is the sub-delegate.

In the event the Organization sub-delegates any currently delegated function, the Organization must obtain ninety (90) days advance written approval from B – UHP/Banner Medicare and the contract between B – UHP/Banner Medicare and the Organization will be amended to include the sub-delegation. Any updated agreements shall be filed with the appropriate governmental agency(ies). Any sub-delegation shall be subject to all requirements set forth herein as mandated by CMS.

Note: Your Organization is expected to monitor their downstream entities for compliance with all CMS and Medicaid (AHCCCS) regulations that are applicable to your organization as well.

Offshore Subcontractors

The term "Offshore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Subcontractors that are considered Offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

The Organization must ensure its employees, and downstream and related entities have read and understand

all requirements pertaining to the regulations for services that are performed by workers located in Offshore countries, regardless of whether the workers are employees of American or foreign companies.

Consistent with CMS direction, this applies to entities the Organization may contract or sub-contract with to receive, process, transfer, handle, store, or access beneficiary protected health information (PHI) in oral, written, or electronic form. In the event the Organization sub-delegates any Banner Medicare activities to an offshore subcontractor, the Organization will be required to adhere to the approval process outlined for sub-delegation activities. To ensure that Banner Medicare is compliant with CMS regulations for Offshore subcontracting, Banner Medicare's contract with Organizations based in the United States and its territories and includes contract language that the Organization will inform Banner Medicare ninety (90) days in advance from the date Organization plans to outsource part or all of its responsibilities that includes providing Health Plan member PHI to an Offshore company. Banner Medicare will evaluate the specific circumstances and review the audits conducted by the Organization to ensure proper security is in place. Banner Medicare may be required to terminate its contract with the Organization.

For the State of Arizona's Medicaid Program, AHCCCS, any functions that are described in the specifications or scope of

work that directly serve the State of Arizona, its clients, or AHCCCS members, and involve access to secure or sensitive data or personal client data shall only be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this requirement does not apply to indirect or "overhead" services, redundant backup services or services that are incidental to the performance of the contract. This provision applies to work performed by the Organization and its subcontractors at all tiers.

Exclusion Screening Requirement

As an FDR of B – UHP/Banner Medicare, the Organization is prohibited against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 CFR § 1001.1901). Upon hiring or contracting and monthly thereafter, the Organization is required to verify their employees (including temporary and volunteer), or contractors are not excluded by comparing them against the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM).

Upon discovery of an excluded individual, the Organization must provide immediate disclosure to B – UHP/Banner Medicare. No payment will be made by Medicare, Medicaid or any other Federal or State of Arizona health care programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. According to the B – UHP Contracts with Arizona Medicaid, notification must be provided to B – UHP if any individual or entity is determined excluded from any State Medicaid, not just Arizona.

To assist you with implementation of your OIG/GSA Exclusion process, links to the LEIE and SAM exclusion websites and descriptions of the lists are below.

List of Excluded Individuals and Entities (LEIE) – https://exclusions.oig.hhs.gov/

This list is maintained by the Office of Inspector General (OIG) and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

System for Award Management (SAM) – https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf

All entity records from CCR/FedReg and ORCA and exclusion records from EPLS, active or expired, were

moved to SAM. You can search these records and new ones created in SAM. The SAM is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The SAM keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States.

Medicare Opt Out

Certain doctors and other health care providers who don't want to work with the Medicare program may "opt out" of Medicare. Medicare doesn't pay for any covered items or services you get from an opt out doctor or other provider, except in the case of an emergency or urgent need. Opt-out periods last for two years and cannot be terminated early unless the provider is opting out for the very first time and they terminate opt-out no later than 90 days after the effective date of their first opt-out period. Physicians and practitioners may NOT opt-out if they intend to be a Medicare Advantage (Part C) provider or furnish services covered by traditional Medicare fee-for- service (Part B). As an FDR of Banner Medicare, it is your obligation to ensure providers have not opted out to ensure they are able to accept Federal reimbursement. The list is maintained at https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z__

Preclusion List

Effective January 1, 2019, CMS started publishing the monthly preclusion list. The preclusion list consists of certain individuals and entities that are currently revoked from the Medicare program under 42 CFR 424.535 and are under an active reenrollment bar, or have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that led, or would have led, to the revocation is detrimental to the best interests of the Medicare program. The regulations require plan sponsor to reject, or require its pharmacy benefit manager to reject, a pharmacy claim for a Part D drug if the individual who prescribed the drug is included on the ''preclusion list.'' Similarly, a Medicare service or item cannot be covered if the provider that furnished the service or item is on the preclusion list. FDRs must have policies and procedures that prohibits employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are precluded from Medicare. In addition, FDRs are not allowed to reimburse or authorize services provided by individuals listed on the preclusion list. FDRs are required to review the preclusion list monthly.

Effective January 1, 2020, 42 CFR 422.504(g)(1)(iv) was updated to require provider agreements contain a provision stating that after the expiration of the 60-day period specified in § 422.222 the provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan and the provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the beneficiary will have already received notification of the preclusion.

For more information refer to CMS Preclusion List webpage at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List

Standards for Business Continuity Plans

CMS issued a Final Rule (42 CFR §§422.504(o) and §423.505(p)) and this rule outlines the minimum standards for Business Continuity Plans effective 1/1/2016. We are required to validate our FDRs develop, implement and maintain Business Continuity Plans compliant with CMS and AHCCCS (ACOM Policy 104) minimum standards.

✓ **Minimum Requirements**

Business Continuity Plans must contain policies and procedures to protect to ensure the restoration of business operations following disruptions where business operations following disruptions which include

natural or manmade disasters, system failures, emergencies, and other similar circumstances and threat of such occurrences.

Minimum Business Continuity Plan requirements include:

- Completion of a risk assessment
- Documented mitigation strategy
- Annual testing, revision and training
- Record keeping including HIPAA & Privacy
- Identification of essential functions
- Restoration of essential functions
- Chain of command
- Business communication plans

Critical functions

Business Continuity Plans need to address the restoration of identified critical functions within 72 hours of failure, as well as address CMS's minimum requirements.

Critical functions are defined as:

- Benefit authorization (if not waived) for services to be immediately furnished at a hospital, clinic, provider office, or other place of service.
- Benefit authorization (if not waived), adjudication, and processing of prescription drug claims at the point of sale.
- Administration and tracking of enrollees' drug benefits in real time, including automated coordination of benefits with other payers.
- Operation of an enrollee exceptions and appeals process including Coverage Determinations.
- Operation of call center customer service, including translation services and pharmacy technical assistance.
- Production and mailing of essential documents including Banner Medicare's Annual Notice of Change, Evidence of Coverage, Low Income Subsidy Rider, Multi-Language Insert, ID Cards, enrollment/disenrollment letters, formulary guides and enrollee transition supply letters.
- Support of any of the following activities: Medicare appeals, pre-service organization determinations, coverage determinations, utilization management and Medicare websites.

Standards for Cultural Competency Plans

Subcontractors are required to have processes in place to fully comply with their obligations under the civil rights statutes and regulations enforced by CMS and AHCCCS related to cultural competency. Subcontractors with direct member contact shall have an education program in place designed to make their providers aware of the importance of providing services in a culturally competent manner.

CMS aligned with Executive Order 123985 (Advancing Racial Equity and support for Underserved Communities through the Federal Government) to support the need for MA plans addressing health equity. Here is a high-level summary of the Medicare requirements:

Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency (LEP) or reading skills and diverse cultural and ethnic backgrounds. (42 C.F.R. § 422.112(a)(8))

- Have mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request. These mechanisms must include call centers that provide interpreters for non-English speaking and LEP individuals. (42 C.F.R. §§ 422.111(h)(1) and 423.128(d)(1), and the Health Plan

Management System (HPMS) memo 12/30/2020)

- For markets with a significant non-English speaking population, provide vital materials in the language of these individuals. Specifically, MAOs and Part D sponsors must translate materials into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area (42 C.F.R. §§ 422.2267(a)(2) and 423.2267(a)(2))
- Plans should refer to the following key resources for guidance on providing culturally and linguistically appropriate services:
    - A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities, and Sexual and Gender Minorities. The toolkit may be accessed at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf
    - Guide to Developing a Language Access Plan. The guide may be accessed at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf
    - Providing Language Services: Lessons from the Field. This resource may be accessed at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field.pdf.
- Comply with the provisions of section 1557 of the Affordable Care Act, title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973, title II of the Americans with Disabilities Act (ADA) of 1990, and the Genetic Information Nondiscrimination Act of 2008; and
- Have procedures in place for each of its MA plans to ensure that enrollees are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Discrimination based on "source of payment" means, for example, that MA providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

B – UHP/Banner Medicare Monitoring and Auditing of FDRs

B – UHP/Banner Medicare monitor their FDRs through annual attestations, metrics, audits, and other oversight monitoring activities. As required by CMS, FDRs are required to respond to identified compliance deficiencies promptly. Accordingly, upon the discovery of a compliance deficiency, either through your internal compliance activities or notification by B – UHP/Banner Medicare, your Organization must promptly address, correct, and report to the deficiency to B – UHP/Banner Medicare in accordance with CMS and AHCCCS rules, regulations, and guidance.

CMS released the 2022 Audit Protocols which will be utilized to measure outcomes in a number of performance areas and to determine a Plan Sponsor's (B – UHP/Banner Medicare) effective oversight of its FDRs. Upon selection by CMS for audit Plan Sponsors and any selected FDRs must be able to show data as requested by CMS (e.g., claims, coverage determinations, notices, etc.) and have a plan representative available to address questions as requested during review.

Note: Per Medicare regulations and AHCCCS requirements, B – UHP/Banner Medicare are required to annually audit all Administrative Service Subcontractors.

Banner University Health Plans

Banner Medicare

Section 2: Attestations

Directions: Please read the information below. Make one selection per section by checking one of the boxes.

1. **The Organization is contracted with B – UHP/Banner Medicare for the following lines of business:**

   ☐ Medicare ☐ Medicaid ☐ Both Medicare and Medicaid

2. **Compliance Program Guidelines Attestation**

   Please select one:

   ☐ **Option 1:** I attest the Organization has reviewed the Compliance Program Guidelines as stipulated in the Medicare Managed Care Manual Chapters 21 and 9 as applicable and is aware of its responsibilities as a First Tier, Downstream or Related Entity (FDR) of B – UHP/Banner Medicare and the Provider Manual Requirements; or

   ☐ **Option 2:** I attest the Organization has **not** reviewed Compliance Program Guidelines as stipulated in the Medicare Managed Care Manual Chapters 21 and 9 as set forth by CMS and the Provider Manual Requirements.

3. **Compliance Oversight Attestation**

   I attest that the Organization has policies and procedures in place to promptly respond to, resolve and report to B – UHP/Banner Medicare all identified compliance deficiencies in accordance with CMS and/or the state Medicaid program AHCCCS rules, regulations, guidance, and contractual requirements.

   Please select one:

   ☐ **Option 1:** The Organization is in compliance with oversight requirements as set forth by CMS and the Arizona State Medicaid Program, AHCCCS (as applicable). ***OR***

   ☐ **Option 2:** The Organization is **not** in compliance with oversight requirements as set forth by CMS and the Arizona State Medicaid Program, AHCCCS (as applicable).

4. **Code of Conduct Attestation**

   Please select one:

   ☐ **Option 1:** I attest that the Organization has a Code of Conduct or Code of Ethics that includes a provision for reporting any potential violations of the code; and has a conflict-of-interest provision to ensure your governing bodies, and senior leadership responsible for the administration or delivery of Medicare and Medicaid benefits are free from any conflict of interest in administering or delivering said benefits.

      ☐ I attest the Organization adopts and complies with B – UHP/Banner Medicare's Code of Conduct; or

      ☐ I attest the Organization has adopted another Code of Conduct that is materially similar to the B – UHP/Banner Medicare Code of Conduct and follows set standards. (Please be prepared to provide copies if requested.)

   ☐ **Option 2:** I attest the Organization is **not** in compliance as set forth by CMS.

5. **Conflict of Interest Attestation**

Please select one:

☐ **Option 1:** Contractor has a process in place to effectively screen its governing bodies and senior leadership for conflicts of interest.

☐ **Option 2:** The Organization is not in compliance with Conflict-of-Interest requirements as set forth by CMS Chapter 21, 50.6.4, 42 CFR §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F), 42 CFR 1001.1901.

6. **Compliance & FWA Training Attestation**

For FDRs contracted with Banner Medicare for the Medicare Line of Business: I attest that the Organization has policies and procedures in place to establish the requirements for Medicare Compliance and FW A training upon hire and annually thereafter to all persons (employees, temporary employees, or downstream entities) involved in the administration or delivery of Medicare benefits.

Please choose all that apply:

☐ I attest that the Organization is in compliance with, upon hire, and annually. the requirements of General Compliance and FWA Training as set forth by CMS.

☐ I attest that the Organization is not in compliance with the General Compliance and FWA training requirement as set forth by CMS.

☐ N/A – Not contracted for the Medicare Line of Business.

7. **False Claims Act**

I attest that the Organization has policies and procedures in place to establish training requirements for all staff and has provided training for all staff on the following aspects of the **False Claims Act:**

- The 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.

Please select one:

☐ **Option 1:** I attest that the Organization has policies and procedures in place to establish training requirements for all of the Organization's staff on the False Claims Act and has trained all staff per our Organization's policy on such.

☐ **Option 2:** I attest that the Organization is not in compliance with the requirement to train on the False Claims Act as set forth by CMS and the Arizona State Medicaid Program, AHCCCS.

8. **For FDRs contracted with B – UHP for the Medicaid Line of Business**

Please select one:

☐ **Option 1:** I attest the Organization has reviewed the AHCCCS Contractor's Manual Policies 103, 104 and 438 and the B – UHP Provider Manual and is aware of its responsibilities as an Administrative Services Subcontractor.

☐ **Option 2:** I attest that the Organization has not reviewed the AHCCCS policies noted above and the B – UHP Provider Manual.

☐ **Option 3:** N/A – Not contracted for the Medicaid Line of Business

9. For FDRs contracted with Banner Medicare for the Medicare Line of Business

Please select one:

☐ **Option 1:** I attest the Organization has reviewed the applicable CMS Medicare Managed Care Manual, CMS policies and rules, the Banner Medicare Provider Manual and is aware of its responsibilities as an FDR.

☐ **Option 2:** I attest that the Organization has not reviewed the applicable CMS policies and Medicare Managed Care Manual noted above and the Banner Medicare Provider Manual.

☐ **Option 3:** N/A – Not contracted for the Medicare Line of Business

10. Reporting Non-Compliance and Fraud, Waste and Abuse

Please select one:

☐ **Option 1:** The Organization agrees to and has processes in place to report non-compliance and FWA immediately to B – UHP/Banner Medicare.

☐ **Option 2:** The Organization does not agree to and will not report non-compliance and FWA immediately to B – UHP/Banner Medicare.

11. Sub-Delegation Activities Attestation

Please select one:

☐ **Option 1:** I attest the Organization currently does not subcontract or sub-delegate any B – UHP/Banner Medicare contracted functions. AND I attest if the organization engages in a subcontract or sub-delegate contract and/or agreement we will notify B – UHP/Banner Medicare at least ninety (90) days in advance, obtain B – UHP/Banner Medicare approval and provide to B – UHP/Banner Medicare a copy of any sub-delegation contract to ensure that all Medicare and delegation language is included (e.g., record retention requirements, compliance with all Medicare Part C & D, as required) and complete required attestation; **Please provide list of any sub-delegated activities.**

☐ **Option 2:** I attest that the Organization is not in compliance with sub-delegation requirements as set forth by B – UHP/Banner Medicare, CMS, and AHCCCS. **Please provide list of any sub-delegated activities.**

12. Offshore Activities Attestation

Please select one:

☐ **Option 1:** I attest that the Organization will abide by the Offshore requirements outlined above.

- For Medicare, the Organization is required to complete the Offshore Attestation (refer to addendum A) providing additional details of any Offshore arrangement, including protection of PHI.
- For Medicaid (AHCCCS), the Organization will not perform any services Offshore that directly serve the State of Arizona or its clients and involve access to secure or sensitive or personal client data. However, services that are indirect or overhead, redundant back-up services, or incidental may be performed Offshore, subject to strict privacy and security requirements.

☐ **Option 2:** I attest the Organization is not in compliance with reporting of Offshore Activities as set forth by CMS or AHCCCS.

13. Exclusion Review Attestation

I attest the Organization has policies and procedures in place to review the Office of the Inspector General (OIG) and General Services Administration (GSA) exclusion lists upon initial hire and monthly thereafter to ensure that no employee, temporary employee, volunteer, consultant, governing body member responsible for administering or delivering Medicare benefits is excluded from federal health care programs and (ii) if the undersigned entity identifies an employee as being confirmed on such list(s), the undersigned entity will immediately remove the employee from any work related directly or indirectly to any Federal health care program and take appropriate corrective action, including notifying Banner Medicare. Your organization will retain documentation to show that your organization conducted the required review of the lists. This information must be available upon request by Banner Medicare or CMS and records should be maintained for 10 years.

Please select one:

☐ **Option 1:** I attest the Organization is in compliance with Exclusion Review requirements as set forth by CMS and the state Medicaid program, AHCCCS.

☐ **Option 2:** I attest the Organization is not in compliance with Exclusion Review as set forth by CMS and the state Medicaid program, AHCCCS.

14. Medicare Opt Out

I attest the Organization understands its obligation to ensure providers have not opted out of the Medicare Program so and are able to accept Federal reimbursement.

Please select one:

☐ **Option 1:** I attest the Organization is in compliance with Medicare Opt Out requirements as set forth by CMS.

☐ **Option 2:** I attest the Organization is not in compliance with Medicare Opt Out requirements as set forth by CMS.

15. Preclusion List

I attest the Organization has policies and procedures in place to review the monthly preclusion list, to not authorize or reimburse individuals listed on the preclusion list effective April 1, 2019.

Please select one:

☐ **Option 1:** I attest the Organization is in compliance with the Preclusion List Review requirements as set forth by CMS.

☐ **Option 2:** I attest the Organization is not in compliance with the Preclusion List Review as set forth by CMS.

☐ **Option 3:** N/A – Other – Please provide explanation

16. Standards for Business Continuity Plans

I attest that the Organization has a Business Continuity Plan which includes at minimum policies and procedures to protect the restoration of business operations following disruptions where business is not able to occur under normal conditions.

Please select one:

☐ **Option 1:** I attest the Organization is in compliance with minimum standards for Business Continuity Plans as set forth by CMS and the state Medicaid program, AHCCCS.

☐ **Option 2:** I attest the Organization is not in compliance with minimum standards for Business Continuity Plans as set forth by CMS and the state Medicaid program, AHCCCS.

17. Standards for Cultural Competency Plans

I attest that the Organization has a Cultural Competency Plan which includes having an education plan designed to make providers aware of the importance of providing services in a culturally competent manner and that the Organization has processes in place to fully comply with the civil rights and statutes enforced by CMS and AHCCCS related to cultural competency.

Please select one:

☐ **Option 1:** I attest the Organization is in compliance with the Cultural Competency Plan requirements as set forth by CMS and the state Medicaid program, AHCCCS.

☐ **Option 2:** I attest the Organization is not in compliance with the Cultural Competency Plan requirements as set forth by CMS and the state Medicaid program, AHCCCS.

18. Record Retention Attestation

Please select one:

Option 1: Contractor retains records to support this attestation including but not limited to time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered to Employees for at least ten (10) years, or longer if required by applicable law.

Option 2: The Organization is not in compliance with Record Retention requirements as set forth by CMS Chapter 21, Section 50.3.2, 42 C.F.R. §§ 422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C), 42 CFR 422.504 (e) (4).

19. HIPAA & Privacy Attestation

Health Insurance Portability and Accountability Act of 1996 and 45 Code of Federal Regulations. HITECH Act provisions within the American Recovery and Reinvestment Act of 2009. If the Contractor has access to B – UHP/Banner Medicare's protected health information, there must be a Business Associate Agreement (BAA). This also requires that the Contractor have a process to notify B – UHP/Banner Medicare if a breach of unsecured protected health information occurs. Must provide notice to B – UHP/Banner Medicare without reasonable delay and not later than 30 days from discovery of the breach.

Please select one:

☐ **Option 1:** Contractor has appropriate safeguards and controls in place to protect and secure B – UHP/Banner Medicare's protected health information from any intentional or unintentional use or disclosure.

☐ **Option 2:** The Organization is not in compliance with HIPAA & Privacy requirements as set forth by set forth by CMS and the Arizona State Medicaid Program, AHCCCS.

Banner University Health Plans

Banner Medicare

20. Audit Protocols Attestation

Please select one:

☐ **Option 1:** I attest that the Organization has the capabilities to conduct WebEx of their systems upon request and if the plan and entity are selected for an audit by CMS, the entity, upon request and as applicable, will permit personnel of the plan on-site access during any interviews, or system walkthroughs of applicable systems and the entity will provide a dedicated resource responsible for working with B – UHP/Banner Medicare throughout the audit process; or

☐ **Option 2:** I attest the Organization does not have the capability listed above to satisfy audit protocols as set forth by CMS.

☐ **Option 3:** N/A – Other – Please provide explanation

Section 3: Organization Information and Signature

I, the undersigned, attest that I am an authorized representative with signature authority for the organization or company listed below, which is hereinafter referenced as the "Organization". The Organization is contracted with B – UHP/Banner Medicare as a First Tier, Downstream or Related Entity (FDR) for B – UHP/Banner Medicare's Medicare and/or Medicaid products.

As a B – UHP/Banner Medicare contractor, I understand the Organization is subject to Federal and state laws related to the Medicare and Medicaid programs as well as CMS and AHCCCS rules, regulations and sub-regulatory guidance. This includes ensuring the Organization and the Organization's employees and downstream contractors are also required to abide by all Federal and Arizona State laws related to the Medicare and Medicaid programs as well as CMS and AHCCCS rules, regulations and sub-regulatory guidance. I attest on behalf of the Organization that all Organization employees and downstream entities (including the Organization's contractors and subcontractors) who provide health or administrative services for

B – UHP/Banner Medicare members through or on behalf of the Organization have access to compliance information provided by B – UHP/Banner Medicare, through the B – UHP/Banner Medicare website, secure provider portal, training materials, or other communications provided by B – UHP/Banner Medicare.

Please note that the certification is intended to be completed at the contract level. If your Organization has multiple tax identification numbers (TINs) under one contract, please complete one form and list each TIN.

Organization Information

_____ _____

Date (xx/xx/xxxx) **Organization Name**

_____ _____

Compliance Contact Name & Title **Email Address**

_____ _____

Phone Number (xxx) xxx-xxxx **Fax Number (xxx) xxx-xxxx**

Tax Identification Number(s) – 9 Digits – (*Required)

1. _____ **2.** _____ **3.** _____

Banner
University Health Plans

Banner
Medicare

National Provider Identifier (NPI) – 10 Digits

1. _____	**6.** _____	**11.** _____	**16.** _____
2. _____	**7.** _____	**12.** _____	**17.** _____
3. _____	**8.** _____	**13.** _____	**18.** _____
4. _____	**9.** _____	**14.** _____	**19.** _____
5. _____	**10.** _____	**15.** _____	**20.** _____

Authorized Representative Information

_____ _____

Authorized Representative Name | Title

_____ _____

Email Address | Phone Number

By signature, I certify that the information provided here is true and correct and I understand that CMS, AHCCCS, The Arizona Department of Insurance and/or B – UHP/Banner Medicare may request additional information to substantiate the statements made in this attestation:

_____ _____

Signature | Date

Upon completion, please send via one of the following methods:

Banner – University Health Plans/Banner Medicare – Vendor Oversight

Department Fax: (520) 874-7072

Mail: Banner Health Plans
Attention: Vendor Oversight Department
2701 E. Elvira, Tucson, AZ 85756