2022

First Tier, Downstream and Related Entities (FDR) and Subcontractor Program Guide

Banner University Health Plans

Banner Medicare™

2022

First Tier, Downstream and Related Entities (FDR) and Subcontractor Program Guide

This FDR and subcontractor Program Guide provides an overview and resources to help us meet the needs of our members in accordance with Medicare Advantage (MA)/Part D and Arizona Health Care Cost Containment System (AHCCCS) requirements. In the event that you or your organization is considered a First Tier, Downstream or Related Entity (FDR) or subcontractor – meaning Banner – University Health Plans (B – UHP)/Banner Medicare has delegated administrative or health care service functions related to Banner – University Family Care (ACC and ALTCS), as well as Banner Medicare Advantage Dual D-SNP, Banner Medicare Advantage Prime HMO and Plus PPO, and Banner Medicare Rx PDP contracts with Centers for Medicare and Medicaid Services (CMS) and Arizona Health Care Cost Containment System (AHCCCS).

What is an FDR? We use the definitions from CMS to define First Tier, Downstream, and Related Entities:

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage (MA) program or Part D Program. (See, 42 C.F.R. § 423.501).

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between B – UHP/Banner Medicare 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. (See, 42 C.F.R. §, 423.501).

Related Entity means any entity that is related to B – UHP/Banner Medicare or Part D sponsor by common ownership or control and

- Performs some of the MAO 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 MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).

What is a subcontractor? For AHCCCS Complete Care (ACC) & AHCCCS' Long Term Care Program (ALTCS) We use definitions from AHCCCS Contractor Operations Manual Chapter 438 to define subcontractors:

Administrative Services Subcontracts/Subcontractors - An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification (i.e. Credentialing Verification Organization).
3. Management Service Agreements
4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and
5. DDD acute care subcontractors.

A person (individual or entity) who holds an Administrative Service Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

Additional Definitions:

Abuse – Includes any action (s) that may, directly or indirectly, result in one or more of the following:

- Unnecessary costs to the Medicare or Medicaid programs or other government programs
- Payment for services that fail to meet professionally recognized standards of care
- 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 for AHCCCS, "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.

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

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

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.

Authorized Representative – An individual who has responsibility directly or indirectly for all employees, contracted personnel, providers/practitioners, and all vendors who provide healthcare or administrative services under Medicare and/or Medicaid. Authorized Representatives may include, but are not limited to, a Compliance Officer, Chief Medical Officer, Practice Manager/Administrator, Provider, Executive Officer, or similar related positions.

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

Business Partners – The collective grouping of all B – UHP/Banner Medicare first tier, downstream and related entities, subcontractors and agents.

Centers for Medicare & Medicaid Services (CMS) - Federal Agency which administers Medicare and Medicaid

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.

Cultural Competency - A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, which enables that system, agency, or those professionals to work effectively in cross-culture situations. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. This includes consideration of health status, national origin, sex, gender, gender identity, sexual orientation, and age.

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

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.

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 B – UHP/Banner Medicare'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.

Offshore Subcontracting- provide services that are performed by workers located in Offshore countries, regardless of whether the workers are employees of American or foreign companies.

Staff - Refers to all of B – UHP employees.

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.

B – UHP/Banner Medicare Compliance Programs

B – UHP/Banner Medicare are committed to compliance and meeting requirements of all applicable laws and regulations of CMS and AHCCCS.

Compliance Program Requirements

Your organization and your Downstream Entities must comply with Medicare and Medicaid Compliance Program requirements. This guide provides information about B – UHP/Banner Medicare's compliance program requirements. Please review it and ensure that you have internal processes to support your compliance with these requirements. You will be required to submit an annual attestation confirming your understanding and adherence to the compliance program.

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. 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 B – UHP/Banner 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.

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

FDRs, Providers and Administrative Subcontractors are required to adhere to the B – UHP/Banner Medicare Provider Manuals located at the links below.

B – UHP: www.BannerUHP.com

Banner Medicare: www.BannerHealth.com/Medicare

These compliance program requirements include, but are not limited to:

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 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.

As an FDR, 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/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 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 Banner Medicare, within 90 days of new employee hire and annually thereafter.

B – UHP/Banner Medicare has 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 and 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 Medicaid or Medicare 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: (888) 747-7989 (reports can be made anonymously)
- Email: BHPCompliance@bannerhealth.com
- Secure Fax: (520) 874-7072
- U.S. Mail: **Banner – University Health Plans/Banner Medicare**
  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:

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 P.O. 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://oig.hhs.gov/fraud/report-fraud/

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.

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.

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.

You must request permission to perform offshore services or to use an individual or offshore entity to perform services for Banner Medicare plans. The only acceptable approval is from an authorized Banner Medicare representative obtained in advance and in writing. You should inform Banner Medicare ninety (90) days in advance from the date Organization plans to outsource part or all its responsibilities that includes providing Health Plan member PHI to an Offshore company. If you already use an offshore entity, let us know right away. To request permission to perform offshore services, submit an offshore attestation to us.

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.

A 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 to 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/MedicareProviderSupEnroll/PreclusionList.html

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 and ensure the restoration of 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's 2020 Audit Protocols will be utilized to measure outcomes in several 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.

B – UHP/Banner Medicare take noncompliance seriously. Depending upon the severity of each noncompliance issue, B – UHP/Banner Medicare may require training, corrective action plan development, or termination of the FDR's/Subcontractors contract**.**

Note: Per Medicare regulations and AHCCCS requirements, B – UHP/Banner Medicare are required to conduct annual audits of all Administrative Service Subcontractors.

Annual Attestation

B – UHP/Banner Medicare's commitment to compliance includes ensuring that our FDRs/Subcontractors are in compliance with applicable state and federal regulations and contractual requirements. B – UHP/Banner Medicare contracts with these entities to provide administrative and healthcare services to our enrollees; we are responsible for fulling the terms and conditions of our contracts with the Center for Medicare and Medicaid Services (CMS) including meeting the Medicare and Medicaid program requirements. FDRs/Subcontractors are responsible for ensuring that they and their downstream and related entities, if applicable, are in compliance with these compliance program requirements, policies, and applicable Federal and State statutes, rules, and regulations. An Authorized Representative from each FDR is required to complete the Annual Attestation upon contract and on an annual basis thereafter. Completion of this form will confirm or deny that your internal processes are compliant with B – UHP/Banner Medicare, Medicare, and Medicaid Compliance Program

requirements. These requirements include, but are not limited to: compliance oversight, conflict of interest, record retention, HIPAA & Privacy, Medicaid specifics, compliance program guidelines, code of conduct, audit protocols, sub-delegation activities, offshore activities, exclusion screenings, standards for business continuity, and the preclusion list screenings.

Requirements & Resources

Resource Requirements	Duration
Exclusion Lists: Office of the Inspector General (OIG) System for Award Management (SAM)	**Before hiring or contract** **Monthly ongoing thereafter**
Opt Out List: Opt Out Affidavits - Centers for Medicare & Medicaid Services Data (cms.gov)	
AHCCCS Resources: AHCCCS Guides and Manuals AHCCCS Contractor Operations Manual (ACOM) AHCCCS Medical Policy Manual (AMPM)	**Ongoing**
CMS Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance CMS.Gov	**Ongoing**
CMS Preclusion List	**Monthly Ongoing - Disseminated by plan –** requires denial of payment for a healthcare item or service furnished by an individual or entity on the Preclusion List. For those FDRs delegated for credentialing, the preclusion list should be included within your Credentialing processes. Providers on the precluded list should not be added to the provider network for Medicare lines of business.
General Compliance & FWA Training	**Within 90 days of hire or contract** **Annually thereafter**
Offshore Subcontracting Attestation	**Immediate** if contracting with an offshore entity *AHCCCS contracts – AHCCCS does not allow individuals, organizations, or entities to subcontract offshore.
Record Retention	**Minimum of 10 years**