Banner University Health Plans

FDR Newsletter

QUARTER 1| MARCH 2023

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QUICK LINKS

- OIG's List of Excluded Individuals and Entities (LEIE)
- System for Award Management (SAM)
- Banner University Health Plan's Compliance Program

The Banner – University Health Plans Compliance Program is committed to compliance and meeting requirements of all applicable laws and regulations of CMS and AHCCCS.

IN THE NEWS

Corporate Compliance Audits

The Annual Corporate Compliance audits have begun! The compliance audit team will be reaching out to all our FDRs for documentation requests. The annual compliance audits are required by CMS standards. If you have any questions regarding the audit, please reach out to BUHPVendorOversight@bannerhealth.com.

Now On LinkedIn

We have launched our Banner Health Plans page on LinkedIn!

The focus of this platform will be to connect with Health Plan Employees, Providers, Vendors, and Community Partners.

We look forward to sharing Staff Spotlights, Organization Updates, Community Events & Involvement, and Health News with you!

Follow our page: www.LinkedIn.com/company/Banner-Health-Plans

NCQA Accreditation

The National Committee for Quality Assurance (NCQA) has awarded Banner - University Family Care (ACC) and Banner - University Care Advantage (ALTCS) a three-year Medicaid Health Maintenance Organization (HMO) Accreditation effective February 22, 2023. This is the highest level of accreditation that can be given to an organization. In addition, the health plans earned the Long-Term Services and Supports Distinction and Medicaid deeming status.

NCQA standards are a roadmap for improvement. The Health Plan standards evaluate plans on: Quality Management and Improvement, Population Health Management, Network Management, Utilization Management, Credentialing and Recredentialing, Members' Rights and Responsibilities, Member Connections and Medicaid Benefits and Services. The Long-Term Services and Supports Distinction standards provide a framework for organizations to deliver effective person-centered care that meets member's needs and aligns with state requirements. The Medicaid Module helps health plans maximize alignment with the Medicaid Managed Care Rule and positions an organization for a streamlined state compliance review.

Achieving this accreditation for the health plans, along with our existing accreditation for our other lines of business, shows we adhere to the highest quality standards for our members, partners, and community.

End of Public Health Emergency

Banner – University Health Plans providers can find up-to-date information regarding the end of the Public Health Emergency, and how it impacts members, under the Resources tab of the Provider page under Public Health Emergency at our website
https://www.banneruhp.com/resources/public-health-emergency

Thousands of AHCCCS Providers to be Terminated for Non-Compliance

In the first month of its planned process to terminate non-compliant providers, AHCCCS has identified 5,288 providers who have not taken the required action to maintain their registered status.

Any provider who has not completed the revalidation process in the AHCCCS Provider Enrollment Portal will receive notification to submit an application. Providers who do not respond will receive written notification of pending disenrollment and appeal rights.

To avoid termination and/or loss of billing privileges, providers must respond and take action, following specific actions outlined in the letter, with the noted time frames. Failure to complete these actions will result in disenrollment and claim denials.

What AHCCCS Providers Need to Know:

• Providers who need to complete the revalidation process or meet additional screening Requirements will be notified in writing through the United States Postal Service mail.

• AHCCCS will review the submitted application and issue a written notice upon completion
• Providers that have an expired license will be notified in writing to submit the current
License or certification.
• Providers who fail to respond to the request could experience delays such as termination

And/or loss of billing privileges.
Providers with questions, those who are no longer participating as a Medicaid provider, and those no longer employed with an organization are asked to contact APEPTrainingQuestions@azahcccs.gov.

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COMPLIANCE UPDATES

AHCCCS Office of the Inspector General

AHCCCS Office of Inspector General (OIG) is the responsible entity for preventing, detecting, and recovering improper payments as a result of Medicaid fraud, waste, and abuse. There are several state and federal agencies who collaborate and work closely with AHCCCS OIG in addition to the Banner Medicaid Health Plans. These include the Arizona Attorney General's Office Division called the Medicaid Fraud Control Unit, the Federal Bureau of Investigation, the Drug Enforcement Agency, the Federal Health and Human Services Office of Inspector General, local police and law enforcement agencies, the county prosecutors throughout Arizona, and other state agencies. Banner Medicaid Health Plans' Compliance Department refers cases of potential fraud, waste, and abuse to the AHCCCS OIG, and they conduct the investigations. These investigations can be complex and may take significant research and forensic accounting evaluations. It is the obligation of any Administrative Contractor, provider, or vendor to refer any potential fraud, waste, or abuse directly to AHCCCS OIG and to the Banner Medicaid Health Plans' Compliance Department. The ways to report are listed below.

Preclusion List

The preclusion list is sent out monthly and lists providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Requires denial of payment for items or services furnished by an individual on the Preclusion List. Effective as of the April Preclusion List, any prescriber or provider is to be precluded from all B – UHP lines of business (AHCCCS and Medicare).

For Medicare, the definition of fraud is "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."

Types of Fraud can involve members, providers, vendors, subcontractors.

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

- Lying about Arizona or US Residency Status and not informing AHCCCS and CMS when moving out of the eligible area
- Giving inaccurate household composition data
- Not reporting other medical insurance
- Providing false or inaccurate income or failing to report income
- Using someone else's card to receive benefits
- Failing to report employment information
- Falsifying medical conditions

Examples of provider/vendor fraud include, but are not limited to:

- Providing and/or billing for services that are medically unnecessary
- Submitting false claims or statements
- Billing for services twice, unbundling services, and using the incorrect coding
- Arranging for and/or receiving kickbacks, bribes, or funds not owed
- Prescribing medications not needed or medically necessary
- Submitting claims for services/supplies not provided
- Providing services without being qualified to provide

If you identify or suspect FWA or non-compliance issues, immediately notify the Banner Insurance Division Compliance Department:

24- hour hotline (confidential and anonymous reporting): (888) 747-7989

Email: BHPCompliance@BannerHealth.com

Secure Fax: (520) 874-7072

Compliance Department Mail:
Banner Medicaid and Medicare Health Plans Compliance Department
2701 E. Elvira Rd
Tucson, AZ 85756

Contact the Medicaid Compliance Officer Terri Dorazio via phone (520) 874-2847(office) or (520) 548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact the Medicare Compliance Officer Raquel Chapman via phone (602) 747-1194 or email : BMAComplianceOfficer@BannerHealth.com

Banner Medicaid and Medicare Health Plans Customer Care Contact Information

B – UHP Customer Care
Banner – University Family Care/ACC – (800) 582-8686, TTY 711
Banner – University Family Care/ALTCS – (833) 318-4146, TTY 711
Banner – Medicare Advantage Dual HMO D-SNP – (877) 874-3930, TTY 711

Banner Medicare Advantage Customer Care
Banner Medicare Advantage Prime HMO – (844) 549-1857, TTY 711
Banner Medicare Advantage Plus PPO – (844) 549-1859, TTY 711
Banner Medicare Rx PDP – (844) 549-1859, TTY 711

AHCCCS Office of the Inspector General

Providers/Administrative Subcontractors are required to report any suspected FWA to the Banner Medicaid Health Plans Compliance Department and directly to AHCCCS OIG:

Provider Fraud
• In Arizona: (602) 417-4045
• Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
Website -www.azahcccs.gov (select Fraud Prevention)
Mail:
Inspector General
801 E. Jefferson St.
MD 4500
Phoenix, AZ 85034

Member Fraud
• In Arizona: (602) 417-4193
• Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Medicare
Providers/FDRs are required to report all suspected fraud, waste, and abuse to the Banner Medicare Health Plans Compliance Department or to Medicare

Phone: 800-HHS-TIPS (800-447-8477)
Mail:
FAX: (800) 223-8164
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026