2019

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 and FDR or subcontractor – meaning Banner University Health Plans has delegated administrative or health care service functions relating to Banner University Health Plan's Special Needs Plan and ACC/ALTCS 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 BUHP 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 BUHP 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) & 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 BUHP 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.

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 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.

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 Banner University Health Plan 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.

Banner University Health Plans Compliance Program

Our compliance program is committed to practicing business in an ethical manner and in part of that it helps to reduce or eliminate fraud, waste, and abuse (FWA). Ensures we comply with applicable laws, rules, and regulations. As well as, part of reinforcing our commitment to compliance, we extend this duty to our FDRs/subcontractors.

Banner University Health Plans is an AHCCCS & CMS Contractor, which requires us to fulfill specific Medicare Compliance Program Requirements and AHCCCS requirements.

Compliance Program Requirements

Your organization and all of your Downstream Entities must comply with Medicare compliance program requirements. This guide summarizes the Medicare compliance program requirements. Please review it and ensure that you have internal processes to support your compliance with these requirements each calendar year. These compliance program requirements include, but are not limited to:

- Completion of the Fraud, Waste, and Abuse Training and General Compliance Training. FDRs and subcontractors can provide their own training program or can use BUHP's training. (Must be completed within 90 days of hire and annually thereafter)
- Code of conduct and compliance program policy distribution (Within 90 days of hire and annually thereafter)
- Exclusions list screenings (HHS-OIG List of Excluded Entities (LEIE) and the U.S. General Services Administration System for Award Management (SAM))

- Preclusion list screenings
- Reporting FWA and compliance concerns to Banner University Health Plans
- Offshore operations and CMS reporting (note: AHCCCS does not allow offshore activities)
- Specific federal and state compliance obligations
- Ongoing monitoring and auditing of First Tier, Downstream, and Related Entities
- Document retention must maintain records for 10 years to demonstrate compliance with regulatory requirements.

Failure to be in Compliance

Banner University Health Plans takes all noncompliance seriously. Depending upon the severity of each noncompliance issue, Banner University Health Plans may require training, corrective action plan development, or termination of the FDR's/Subcontractors contract.

Monitoring and Auditing of First Tier, Downstream, and Related Entities & Subcontractors

BUHP contracts with FDR and Subcontractors to administer and/or deliver benefits on BUHP's behalf. These vendors are referred to as delegated FDRs/Subcontractors 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 FDRs/Subcontractors with which BUHP contracts and utilizes multiple methods to monitor and audit FDRs/Subcontractors to ensure that they are compliant with all applicable laws and regulations, and to ensure that the FDRs/Subcontractors are completing the required oversight (auditing and monitoring) of the entities with which they contract.

Auditing:

An audit is a formal review of compliance with a particular set of standards used as base measures.

Monitoring:

Monitoring activities are reviews performed as part of normal operations to confirm ongoing compliance and to help ensure corrective actions happen and are effective.

CMS and AHCCCS regulators require our organization to monitor and/or audit to confirm FDRs/Subcontractors compliance with the following:

- Medicare and Medicaid regulations;
- Sub-regulatory guidance;
- Contractual agreements;
- All applicable federal and state laws; and
- BUHP policies and procedures to protect against noncompliance and potential fraud, waste and abuse.

These monitoring and auditing requirements are noted in:

- 42 CFR § 422.503(b)(4)(vi)(F) for MA
- 42 CFR § 423.504(b)(4)(vi)(F) for Part D

- Medicare Managed Care Manual, Chapter 21 § 50.6.6
- AHCCCS Guides and Manuals

Downstream Oversight Requirements

FDRs/Subcontractors who subcontract the administrative or health benefit services for BUHP to a subcontractor, or downstream entity, have an obligation to notify BUHP at least 90 days in advance of contracting and to ensure the downstream entity complies with all same applicable federal and state laws, regulations and requirements through contract language, compliance oversight, monitoring and auditing activities.

Offshore Operations and Reporting

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 BUHPs Medicare plan. The only acceptable approval is from an authorized BUHP representative obtained in advance and in writing. You should inform BUHP 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. 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 back- up 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.

Annual Attestation

BUHP's commitment to compliance includes ensuring that our FDRs/Subcontractors are in compliance with applicable state and federal regulations and contractual requirements. BUHP 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 BUHP, 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.

How to Report Compliance and FWA Concerns

BUHP is committed to Compliance and preventing Fraud, Waste, and Abuse (FWA).

If you suspect a noncompliance or provider or member of fraud and abuse, please contact us at any of the following methods:

By Phone	Customer Care Center: (877) 874-3930; TTY users should dial 711. ComplyLine (anonymous): (888) 747-7989; 24 hours a day / 7 days a week.
By Email	BUHPCompliance@bannerhealth.com
By Mail	Banner University Health Plans Compliance and Audit Department 2701 E. Elvira Road Tucson, AZ 85756
By Fax	(520) 874-7072
By Form	Report Fraud, Waste, and Abuse Form

Reporting to AHCCCS

Instances of suspected FWA can also 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 by email at AHCCCSFraud@azahcccs.gov.

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
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	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