2024 General Compliance and FWA Training For FDRs

Why Do I need Training?

Every year billions of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – including you. This training helps you detect, correct, and prevent FWA. You are part of the solution.

Compliance and combating FWA is everyone's responsibility. As an individual who provides health or administrative services for Medicaid or Medicare enrollees, your every action potentially affects Medicaid or Medicare enrollees, the Medicaid or Medicare Programs, or the Medicare Trust Fund.

Training Requirements

Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in performing or delivering the Medicaid or Medicare Parts C and D benefits. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors"), Medicaid Managed Care Organizations (MCOs) and the entities with which they contract to provide administrative or health care services for enrollees on behalf of the sponsor/contractor (referred to as "FDRs") must receive training about compliance with Centers for Medicare and Medicaid Services (CMS) program rules and Fraud, Waste and Abuse (FWA). This training is required within 90 days of initial hire and annually thereafter.

Course Objectives.

When you complete this course, you should be able to correctly:

- Recognize how a compliance program operates;
- Recognize how compliance program violations and FWA should be reported;
- Recognize FWA in the Medicaid and Medicare Programs;
- Identify major laws and regulations pertaining to Compliance and FWA;
- Recognize potential consequences and penalties associated with violations;
- Identify how to correct FWA; and
- Understand other compliance-related requirements

Compliance Program Requirement

CMS/AHCCCS requires sponsors/Banner Medicaid and Medicare Health Plans to implement and maintain an effective compliance program for its Medicare Parts C & D and MCO plans. An effective compliance program should:

- Articulate and demonstrate an organizations commitment to legal and ethical conduct;
- Provide guidance on how to handle compliance questions and concerns; and
- Provider guidance on how to identify and report compliance violations and FWA.

What is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance and FWA
- Is fully implemented and is tailored to an organization's unique operations and circumstances;
- Has adequate resources;
- Promotes the organization's Standards or Code of Conduct; and
- Establishes clear lines of communication for reporting non-compliance or FWA

It must, at a minimum, include the seven core compliance program requirements.

Seven Core Compliance Program Requirements

1. **Written Policies, Procedures, and Standards (Code) of Conduct**

   These articulate the organization's commitment to comply with all applicable Federal and State Standards and describe compliance expectations according to the Code of Conduct.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight**

   The organization must designate a compliance officer and a compliance committee that will be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated or researched and resolved by the compliance program. The organization's senior management and governing body must be engaged and exercise reasonable oversight of the compliance program.

Seven Core Compliance Program Requirements

3. **Effective Training and Education**

   This covers the elements of the compliance plan as well as prevention, detection and reporting of FWA. This training and education should be tailored to the different responsibilities and job functions of employees.

4. **Effective Lines of Communication**

   Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues and FWA at the Sponsor/MCO and First Tier, Downstream, or Related Entity (FDR) levels.

5. **Well-Publicized Disciplinary Standards**

   The organization must enforce standards through well-publicized disciplinary guidelines.

Seven Core Compliance Program Requirements

6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**

   Conduct routine monitoring and auditing of Sponsor/MCO's and FDR's operations to evaluate compliance with CMS/AHCCCS requirements as well as the overall effectiveness of the compliance program. Sponsors/MCOs are required to ensure that FDRs performing delegated administrative or health care services functions concerning the Medicare or Medicaid program comply with these program requirements.

7. **Procedures and System for Prompt Response to Compliance Issues**

   Organizations must use effective measures to respond promptly to non-compliance or FWA and undertake appropriate corrective actions.

Ethics – Do the Right Thing!

As part of the Medicare and/or Medicaid Program, you must conduct yourself in an ethical or legal manner. It is about doing the right thing!

- Act fairly and honestly;
- Adhere to high ethical standards in all you do;
- Comply with all applicable laws, regulations, contract requirements, CMS and AHCCCS requirements; and
- Report suspected violations without fear of retaliation.

How Do You Know What is Expected of You?

Beyond following the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation? Standards (Code) of Conduct state compliance expectations and the principles and values by which an organization operates. Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations. If you are not aware of your organization's standards of conduct, ask your management where they can be located.

Everyone has a responsibility to report violations of Standards of Conduct and suspected non-compliance or FWA.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

What is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal or State health care program requirements, or an organization's ethical or business policies. The following are high risk areas:

- Agent/broker misrepresentation;
- Appeals and Grievance review (for example, coverage and organization determinations);
- Beneficiary/Member notices;
- Conflicts of interest;
- Claims submissions and processing;
- Credentialing and provider networks;
- Documentation and Timeliness requirements;
- Ethics;
- Exclusion Screening;
- FDR oversight and monitoring;
- Health Insurance Portability and Accountability Act (HIPAA);
- Marketing and enrollment;
- Pharmacy, formulary, and benefit administration;
- Quality of Care.

Know the Consequences of Non-Compliance

Failure to follow Medicare/Medicaid Program requirements and CMS guidance can lead to serious consequences including:

- Contract termination;
- Criminal penalties;
- Exclusion from participation in all Federal health care programs; or
- Civil monetary penalties.

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training;
- Disciplinary action; or
- Termination.

Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance and FWA, we are all at risk and which may result in:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care
- Less money for everyone, due to:
- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

How to Report Potential Non-Compliance or FWA

You can report member and/or provider fraud, waste and/or abuse or any non-compliance to the Banner Medicaid and Medicare Health Plans' Compliance Department using one of the methods below without fear of retaliation:

Customer Care: (800) 582-8686

24-hour hotline – ComplyLine (anonymous and confidential reporting): 1-888-747-7989

Email: BHPCompliance@bannerhealth.com

Secure Fax: (520) 874-7072

Mail: 5255 E Williams Circle, Ste 2050
Attn: BHP Compliance Dept.
Tucson, AZ 85711

Contact the Medicaid Compliance Officer, Terri Dorazio, via cell phone at (520) 548-7862 or email Theresa.Dorazio@bannerhealth.com

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

How to Report Potential Non-Compliance or FWA

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

Provider Fraud

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

In Arizona: 602-417-4045

Toll Free Outside of Arizona Only: 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 Arizona: 602-417-4193

Toll Free Outside of Arizona Only: 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

How to Report Potential Non-Compliance or FWA

Where to Report FWA for Medicare or Other Federal Programs
HHS Office of Inspector General
Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Online: https://oig.hhs.gov/fraud/report-fraud

For Provider Fraud or Abuse in a Medicare Advantage or a Medicare Drug Plan:
Investigations Medicare Drug Integrity Contractor – I-MEDIC at 1-877-7SAFERX (1-877-772-3379

Additional Resources for Reporting for All Federal Health Care Programs:
CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
HHS Hotline at 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
U.S. Department of Justice (DOJ): https://oig.justice.gov/hotline

What Happens After Non-Compliance is Detected

After non-compliance is detected, it must be investigated immediately and promptly corrected. However, internal monitoring should continue to ensure:

- There is no recurrence of the same non-compliance;
- Ongoing compliance with CMS/AHCCCS requirements;
- Efficient and effective internal controls; and
- Enrollees/members are protected.

NOTE: For FWA issues, BHP reports these to AHCCCS OIG and AHCCCS completes the investigation. For Medicare, BHP Special Investigations Unit conducts the investigation.

What are Internal Monitoring and Audits?

Internal monitoring activities are regular reviews that confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures.

Auditing and Monitoring will help to:

- Identify and prevent unethical conduct and non-compliance
- Improve compliance with P&Ps
- Allow for early detection and correction of non-compliance
- Reduce risk and ensure compliance with regulations
- Drive operational excellence
- Ensures the Leadership, Compliance Committee and Board members are informed of the outcomes

Lesson Summary

Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.

To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.

Know the consequences of non-compliance and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

Compliance Is Everyone's Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: If you detect potential non- compliance, report it!

Correct: Correct non-compliance to protect beneficiaries and save money!

Fraud

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.

In other words, fraud is intentionally submitting false information to the Government or Government contractor to get money or a benefit.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a healthcare benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000.

Waste and Abuse

Waste – overutilization or inappropriate utilization of services, misuse of resources, or practices that directly or indirectly result in unnecessary costs to the Medicaid or Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse of the Program – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare/Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Fraud, Waste and Abuse (FWA) Simplified Definitions

Fraud is purposely giving wrong or misleading information in order to receive a benefit or some type of service

Abuse of the Program is provider practices or member practices that result in an unnecessary cost to the AHCCCS or CMS Program

Waste is over-using services or misusing resources or practices

Examples of FWA

Examples of actions that may constitute Medicare/Medicaid fraud include:

- Knowingly billing for services not furnished or supplies not provided including billing Medicare/AHCCCS for appointments that the patient failed to keep;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of actions that may constitute Medicare/Medicaid waste include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Examples of actions that may constitute Medicare/Medicaid program abuse include:

- Billing for unnecessary medical services
- Billing for brand name drugs when generics are dispensed;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

Differences Among Fraud, Waste and Abuse

There are differences among fraud, waste and abuse.

One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong.

Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare/AHCCCS programs but does not require the same intent and knowledge.

Understanding FWA

To detect FWA, you need to know the **law.**

The following screens provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute and Criminal Fraud;
- Anti-Kickback Statute (updated by OIG 11/2020);
- Stark Statute (Physician Self-Referral Law) (Updated by CMS 11/2020);
- Exclusion; and
- Health Information Portability and Accountability Act (HIPAA).

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement supporting a false claim; or
- Presents a false claim for payment or approval.

For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733 on the Internet.

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. The Civil Monetary Penalty (CMP) may range from $13,508 to $27,018 for each false claim (for violations occurring after January 30, 2023) The Department of Justice obtained more than $2.2 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2022.

Civil False Claims Act (FCA)

Whistleblowers: A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent of the money collected.

Health Care Fraud Statute

The Health Care Fraud Statute states that "Whoever knowingly and willfully executes, or attempts to execute, a scheme to … defraud any health care benefit program … shall be fined … or imprisoned not more than 10 years, or both."

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 U.S.C. Section 1346 on the Internet.

Persons who knowingly make a false claim have committed criminal health care fraud and may be subject to:

- Criminal fines up to $250,000; and/or
- Imprisonment for up to 20 years.

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

Health Care Fraud Statute

Examples:

1. A Pennsylvania pharmacist:

   Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;

   Plead guilty to health care fraud; and

   Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan.

2. The owners of two Florida Durable Medical Equipment (DME) companies:

   Submitted false claims of approximately $4 million to Medicaid for products that were not authorized and not provided;

   Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;

   Were sentenced to 54 months in prison; and

   Were ordered to pay more than $1.9 million in restitution.

Anti-Kickback Statute

The Anti-Kickback Statute (AKS) is a Federal criminal law prohibiting persons from knowingly and willfully offering, paying for, seeking, or receiving anything of value to bring about a referral for medical services (in whole or in part) or goods payable under a Federal health care program. The AKS prohibits kickbacks and bribes. It also affects the way health care entities carry out a broad range of ordinary business deals.

Certain business practices may be acceptable under the AKS if they satisfy safe harbors.

Some safe harbors include, but are not limited to:

- Personal services and management contracts
- Office and equipment leases
- Certain managed care arrangements
- Discounts

All the elements of the safe harbor must be satisfied to qualify for protection. If an arrangement falls outside the safe harbor, however, it is not necessarily a violation of the AKS. Failure to comply with the AKS can result in fines, jail time, civil monetary penalties, and/or exclusion from Federal health care programs. For more information, refer to 42 USC Section 1320a-7b(b).

Anti-Kickback Statute Changes

The Final Rule implements seven new safe harbors, modifies four existing safe harbors, and codifies one new exception under the Beneficiary Inducements Civil Monetary Penalty (CMP).

- Final Safe Harbor Regulations Protect:
- Value-Based Arrangements including the following:
  - Care Coordination Arrangements to Improve Quality, Health Outcomes and Efficiency
  - Value-Based Arrangements with Substantial Downside Financial Risk; and
  - Value-Based Arrangements with Full Financial Risk.

Anti-Kickback Statute Changes

These new safe harbors vary by the type of remuneration protected, level of financial risk assumed by the parties and safeguards:

Patient Engagement and Support – certain tools and supports furnished to patients

CMS-Sponsored Models – for certain remuneration provided in connection with a CMS-sponsored model

Cybersecurity Technology and Services – for donations of cybersecurity technology and services.

Electronic Health Records Items/Services – adds protections for certain related cybersecurity technology, updates for interoperability, and to remove sunset data.

Anti-Kickback Statute Changes

These new safe harbors vary by the type of remuneration protected, level of financial risk assumed by the parties and safeguards:

Outcomes-Based Payments & Part-Time Arrangements – adds flexibility for certain of these payments and arrangements.

Warranties – revises the definition to provide protection for bundled warranties for one or more items and related services.

Local Transportation – expands and modifies mileage limits for rural areas for patients discharged from an inpatient facility or released from a hospital after observation for 24 hours.

Anti-Kickback Statute Changes

These new safe harbors vary by the type of remuneration protected, level of financial risk assumed by the parties and safeguards:

Accountable Care Organization (ACO) Beneficiary Incentive Programs – for MSSP codified the statutory exception to definition of “renumeration”.

Under Beneficiary Inducements CMP project:

Telehealth for In-Home Dialysis – new statutory exception to the prohibition on beneficiary inducements for “telehealth technologies” furnished to certain patients.

Anti-Kickback Statute

Example:

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

Obtained nearly $2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;

Paid doctors for referring patients;

Pleaded guilty to violating the Anti-Kickback Statute; and

Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Physician Self-Referral – Stark Statute

The Stark Law is a Federal law prohibiting a physician from referring Medicare patients for certain types of services — known as designated health services (DHS) — to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception exists. The Stark Law also prohibits the entity that provided the DHS from submitting claims to Medicare for services that were referred by the physician.

Good or bad intent does not matter under the Stark Law. Physician arrangements must fall within an exception, such as those for leases and personal services contracts, in order to comply with the Stark Law. If there is a financial relationship with a referring physician, the relationship must accurately satisfy an exception – even if the arrangement has nothing to do with Medicare patients.

Examples of violations of the Stark Law are non-employed physicians:

- Providing services without a contract
- Occupying hospital space without a lease

Failure to comply with the Stark Law can result in the obligation to refund money, civil monetary penalties, and/or exclusion from Federal health care programs. For more information, refer to 42 USC Section 1395nn.

Physician Self-Referral – Stark Statute

This law was modified to evolve the regulation to keep pace with the transition of fee-for-service or a volume-based system to a value-based system.

In its previous form, the Stark Law prohibited some arrangements that were designed to enhance care coordination, improve quality and reduce waste.

The final rule creates new, permanent exceptions to Stark Law for value-based arrangements.

Exceptions apply to both arrangements that relate to care for individuals with Medicare or other patients.

Compensation provided to a physician by another healthcare provider generally must be at fair market value and the rule provides guidance on how to determine if compensation meets this requirement.

The final rule also provides clarity and guidance on a wide range of other technical compliance requirements intended to reduce administrative burden.

There is new flexibility for arrangements such as donations of cybersecurity technology.

Civil Monetary Penalties Law

Under the Civil Monetary Penalties (CMP) Law, the Office of Inspector General (OIG) may impose civil penalties for several reasons.
These reasons include:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant the OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

Damages and penalties:

Can be around $15,000 to $70,000 depending on the specific violation

Violators are also subject to three times the amount:

- Claimed for each service or item
- Of remuneration offered, paid, solicited, or received

For more information, refer to 42 USC 1320a-7a and the Social Security Act, Section 1128A(a).

Exclusion Screenings

As a registered provider with the AHCCCS Administration, (Arizona's Medicaid Program), and as a Medicare provider, you are obligated to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs.

You must complete screening prior to hire or contract and monthly thereafter. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at https://www.oig.hhs.gov/exclusions/index.asp.

You are also obligated to search the System for Award Management at https://www.sam.gov/SAM/pages/public/index.jsf

As of 10/1/2018, AHCCCS requires the Health Plan to notify the Office of Inspector General if there is a positive confirmed match in any State Medicaid screening. They will direct the HP if any actions such as terminating the contract are required.

If an individual or entity is confirmed on either of the federal exclusion lists or any State Medicaid exclusion list, you must report it immediately to the BHP Compliance Department.

Medicare Preclusion List

What is the Medicare Preclusion List?

CMS made the first Preclusion List available to plans **JANUARY 1, 2019** and is issued monthly thereafter. A list of 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.

Plans and FDRs are required to:

- To reject a pharmacy claim (or deny an enrollee's request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.
- To deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.
- Ensure provider/practitioner agreements contain a provision stating that after the expiration of the 60-day period specified in § 422.222:

  (A) 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 per § 422.504(g)(1)(iv); and

  (B) 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.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA. For more information, visit http://www.hhs.gov/ocr/privacy on the Internet.

Damages and Penalties

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

What Are Your Responsibilities

You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare/Medicaid non-compliance.

FIRST, you must comply with all applicable statutory, regulatory, and other Medicaid or Medicare Part C or Part D requirements, including adopting and using an effective compliance program.

SECOND, you have a duty to the Medicare/Medicaid Programs to report any compliance concerns, and suspected or actual violations that you may be aware of.

THIRD, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

Look for suspicious activity;

Conduct yourself in an ethical manner;

Ensure accurate and timely data/billing;

Ensure you coordinate with other payers;

Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance, AHCCCS Guidance; and

Verify all information provided to you.

Stay Informed About Policies and Procedures

The Banner Plans and Networks Compliance Program and FWA Plan which includes the Code of Conduct, and Compliance Policies are available on the Banner University Health Plans Website and BMA Website in the Compliance Section.

B – UHP Website includes: Banner University Family Care – ACC and ALTCS

BMA Website includes: Banner Medicare Advantage Prime and Plus and

Banner Medicare Advantage Dual (formerly B-UCA)

Make sure to become familiar with the elements contained in these documents.

B – UHP Website: https://www.banneruhp.com

BMA Website: https://www.bannerhealth.com/medicare/for-healthcare-providers

Reporting Potential Non-Compliance or FWA

Everyone must report suspected instances of FWA or non-compliance. Banner Medicaid and Medicare Health Plans' Code of Conduct clearly states this obligation. Banner Medicaid and Medicare Health Plans will not retaliate against you for making a good faith effort in reporting.

No formal form needed – just get it to us any way you can. We want to know.

Recommend addressing it with your immediate supervisor, especially if it is specific to your work. Your supervisor may have the answer you need.

Utilize the chain of command escalation process when it makes sense.

Report directly to your Compliance Officer or to the BHP Compliance Department.

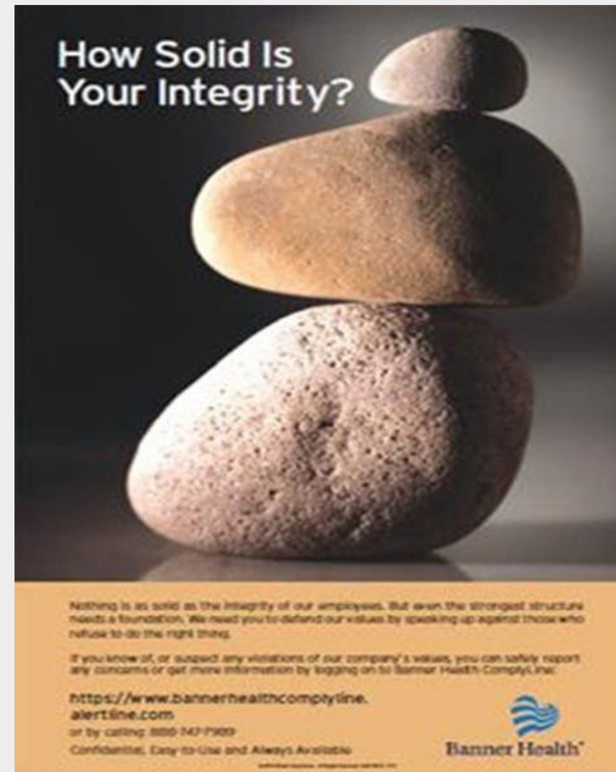
BHP has a 24-hour hotline – ComplyLine – (anonymous and confidential reporting): 1-888-747-7989 or

You can email the Compliance Department directly at Email: BHPCompliance@bannerhealth.com

BHP's Compliance Department will investigate or review and make the proper determination.

ComplyLine: 1-888-747-7989

- Banner Health uses the ComplyLine.
- This is always available for employees, contractors and vendors. It is available 24/7.
- The phones are answered by a contracted service, not Banner employees. You may report anonymously and in confidence. You may report online.



Reporting FWA Outside Your Organization Will Be Facilitated By Compliance

If warranted, Sponsors, Health Plans and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice, CMS or AHCCCS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to the Federal OIG may due so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-Directed investigation and/or civil administration litigation.

In addition, AHCCCS OIG, also has a self-disclosure protocol and the guidelines can be located on the AHCCCS website at:

https://www.azahcccs.gov/Fraud/Downloads/SelfDisclosure.pdf

Reporting FWA Outside Your Organization Will Be Facilitated By Compliance

Details to Include When Reporting FWA:

When reporting suspected FWA, you should include:

Contact information for the source of the information, suspects, witnesses;

Details of the alleged FWA;

Identification of the specific Medicare/Medicaid rules allegedly violated; and

The suspect's history of compliance, education, training, and communication with your organization or other entities.

Correction

Once FWA has been detected, it must be promptly corrected. Correcting the problem saves the Government money and ensures you are in compliance with CMS and AHCCCS requirements.

Develop a plan to correct the issue. Consult your organization's compliance officer to find out the process for the corrective action plan development. The actual plan is going to vary, depending on the specific circumstances. In general:

Design the corrective action to correct the underlying problem that results in FWA Program violations and to prevent future non-compliance;

Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;

Document corrective actions addressing non-compliance or FWA committed by an FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and

Once started, continuously monitor corrective actions to ensure they are effective.

Correction

Corrective actions examples may include:

- Adopting new document review requirements;
- Conducting mandatory training;
- Providing educational materials;
- Revising policies or procedures;
- Sending warning letters;
- Taking disciplinary action;
- Terminating an employee or provider.

Questions

Contact the BHP Compliance Department at:

Email: BHPCompliance@bannerhealth.com

Secure Fax: (520) 874-7072

Mail: 5255 E Williams Circle,
Ste 2050
Attn: BHP Compliance Dept.
Tucson, AZ 85711

Medicare Compliance Officer: Raquel Chapman at BMAComplianceOfficer@bannerhealth.com or (602) 747-1194

Medicaid Compliance Officer: Terri Dorazio at theresa.dorazio@bannerhealth.com or (520) 548-7862

Thank you!