CORPORATE COMPLIANCE Attestation Form (Form 3.38)

Integrated Health Home (IHH)/Behavioral Health Home (BHH) Corporate Compliance Plan (Form 3.38.1)

This form is to be completed by all Integrated Health Home (IHH)/Behavioral Health Home (BHH) [or other delegated entities as directed] Compliance Officers on an annual basis and submitted via e-mail to the Health Choice Arizona Corporate Compliance Officer, attesting to the subcontractor's implementation and maintenance of a current Corporate Compliance Plan which contains the following:

Required Elements of Plan (BCBSAZ Health Choice Provider Manual Section 3.38):

- ☐ Purpose/Introduction/Overview
- ☐ Definitions
- ☐ 7 Elements of an Effective Compliance Program:
  - ☐ Implementation of written policies, procedures and standards of conduct;
  - ☐ Designation of a Compliance Officer and Compliance Committee;
  - ☐ Conducting effective training and education;
  - ☐ Developing effective lines of communication;
  - ☐ Enforcing standards through well-publicized disciplinary guidelines;
  - ☐ Conducting internal monitoring and auditing;
  - ☐ Responding promptly to detected offenses and developing corrective actions.
- ☐ Program Goals
- ☐ Plan Addresses/References:
  - ☐ False Claims Act
  - ☐ Correct Coding/Claiming
  - ☐ Overpayments (60-day repayments)
  - ☐ Excluded Providers (monthly checks)
  - ☐ Internal Controls
  - ☐ Provide "Ongoing education to employees"
  - ☐ Fraud & Abuse Aversion
  - ☐ Fraud & Abuse Detection
  - ☐ Fraud & Abuse Investigation
  - ☐ Fraud & Abuse Prevention
  - ☐ Fraud & Abuse Reporting
  - ☐ Reasonable timeframes
  - ☐ Signatures (Corporate Compliance Officer, CEO, Board)

Agency Compliance Representative:

Name: _____Date_____

Title:_____

CORPORATE COMPLIANCE TRAINING
CERTIFICATION FORM (Form 3.38.2)

This form is to be completed by all Integrated Health Home (IHH)/Behavioral Health Home (BHH) Compliance Officers on an annual basis and submitted via e-mail to the Health Choice Arizona Corporate Compliance Officer. This form is due no later than December 30th each Contract Year.

AGENCY NAME and CONTACT Info:		
TOTAL EMPLOYEES:	**TOTAL EMPLOYEES WHO COMPLETED THE TRAINING:**	
Reason(s) for Employees Who Did not Complete Training:	**Plan for Them to Complete Training:**	**Projected Completion Date:**

CERTIFICATION

By signing this form, I certify that the information herein is true and accurate and that I am the duly authorized representative acting as the agency's Compliance Officer. I further certify the following:

☐ That training has been completed:

- ☐ All of the agency's employees received the Health Choice Arizona Corporate Compliance Training; or
- ☐ For any employees who have not yet completed the Health Choice Arizona Corporate Compliance training, the reasons and plan for completion have bene documented above. I will notify Health Choice Arizona upon completion for all agency employees of the training by the specified due date above.

☐ Written documentation is on file (or in e-learning) confirming training completion for each employee

☐ I understand that it is my responsibility to ensure that all new staff members throughout the next year also complete the required training.

SIGNATURE

Name: _____Date_____

Title:_____

Performance of Exclusion Checks (Form 3.38.3)

This form is to be completed by all Integrated Health Home (IHH)/Behavioral Health Home (BHH) [or other delegated entities as directed] Compliance Officers on quarterly basis and submitted via e-mail to the Health Choice Arizona Corporate Compliance Officer, attesting to the performance of exclusion checks on all employees/providers; and promptly reporting an confirmed, positive results to the Health Choice Arizona Corporate Compliance Officer.

AGENCY INFORMATION:	
AGENCY NAME:	
TOTAL EMPLOYEES/PROVIDERS:	**TOTAL EMPLOYEE/PROVIDERS FOR WHOM EXCLUSION CHECKS WERE PERFORMED:**
# of Positive/Confirmed Findings:	**Were positive findings reported to BCBSAZ Health Choice? (Y/N)** **If No. Please provide reasons:**

ATTESTATIONS

By signing this form, I attest that the information herein is true and accurate and that I am the duly authorized representative acting as the agency's Compliance Officer. I further certify the following:

☐ Exclusion checks are conducted on in staff / providers on at least a monthly basis

☐ Positive / Confirmed findings are reported to the BCBSAZ Health Choice Compliance Officer (when applicable); and

☐ I understand that it is my responsibility to ensure exclusion checks are conducted for all new staff members throughout the next year (prior to hire date).

SIGNATURE

Name: _____ Date: _____

Title: _____