Health Choice
Compliance Program
Subcontractor Reporting Guide

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Purpose of this Guide

Health Choice, which is a subsidiary of IASIS Healthcare, is committed to complying with applicable laws, rules, regulations and CMS guidance.

To help promote compliance and offer mechanisms for reporting issues and concerns, we offer this guide ("Guide") as a resource for our subcontractors, including first tier, downstream, and related entities as well as delegated entities (collectively referred to hereafter as "Partners").

The Guide provides our Partners with information about the (i) types of compliance, privacy/security and fraud, waste and/or abuse ("FWA") events that must be reported and (ii) the options available for reporting them to Health Choice.

The list of reportable events is intended for informational purposes and does not represent an exhaustive list of all items for which reporting is required.

We encourage our Partners to report events, including but not limited to non-compliance and suspected FWA, through any available channels within their respective organizations, the mechanisms listed on the last page of this Guide and/or other options offered by federal or state regulatory entities.

Health Choice will immediately review and respond to reported events. We will hold the information reported as confidential to the extent possible for us to conduct an investigation. We will not retaliate against anyone who reports an event and offer anonymous reporting options, if desired.

In addition, the Health Choice Code of Conduct, Conflict of Interest and Whistleblower policies are available upon request for reference and/or training purposes.

We value your partnership and appreciate your commitment to serving our Members and the communities in which they reside.

Reportable Compliance Events

The following are examples of reportable compliance events:

1. Failure to adequately arrange for or provide access to medically necessary, covered services for one or more members more than once in a month;

2. A pattern of failing to notify or provide information to members as required by legal or contractual standards (e.g. ID cards, notices of denials/appeal rights, etc. if performed by a Health Choice Partner);

3. Failure to comply with the standards applicable to a discrete function or activity (e.g. denials of treatment requests the handling of appeals, timely claims processing, etc. if performed by a Health Choice Partner);

4. Any failure to obtain regulatory approval in advance of an action (including but not limited to communications to providers, members or prospective members) whenever required by legal or contractual standards;

5. Any failure to provide a regulatory agency a report in an acceptable format or a piece of information (e.g., notice of material network change) on a timely basis as required by legal or contractual standards (unless the deadline is extended by the agency and the extension is confirmed in writing);

6. Any failure on a monthly, quarterly or annual basis to meet financial or performance benchmarks as required by legal or contractual standards, such as for the call center, service management, etc. if performed by a Health Choice Partner);

7. Any written or oral communication received from a federal, state or other regulator or licensing agency that raises any issue regarding non-compliance with any contractual provision or regulatory or other legal requirement, requests corrective action, or imposes or threatens to impose sanctions due to non-compliance by a Health Choice Partner or a Partner's subcontractor;

8. The existence of any other non-compliance with legal or contractual standards that if not corrected could reasonably be expected to result in a finding of less than substantial compliance during an agency licensing or audit or the threatened or actual imposition of sanctions, whether identified internally or by a regulatory agency;

9. Any receipt of, access to or use and/or disclosure of protected health information (PHI) that is not permitted under State and/or Federal law (privacy breach).

10. Any failure to utilize an administrative safeguard, such as the use encryption or an established file transfer protocol site for data submission, etc., to protect PHI.

Other Examples of Reportable Events:

Member Fraud

Eligibility Determination Issues that include the following items:

- Resource Misrepresentation (Transfer / Hiding)
- Residency
- Household Composition
- Citizenship Status
- Unreported Income
- Misrepresentation of Medical Condition
- Failure to Report Third Party Liability (TPL)

Provider Fraud

Falsifying Claims/Encounters that include the following items:

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Administrative/Financial actions that include the following items:

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent Third Party Liability (TPL) Reporting
- Fraudulent Recoupment Practices

Falsifying Services that include the following items:

- Billing for Services / Supplies Not Provided
- Misrepresentation of Services / Supplies
- Substitution of Services

Abuse

Any abuse, neglect and/or exploitation

Other

Any healthcare acquired conditions, injuries, and unexpected death.

Other Reportable Events:
Fraud, Waste and Abuse Examples (Continued)

Medicare Fraud

Member - Examples

1. Misrepresentation of medical condition
2. True-Out-Of-Pocket (TrOOP) manipulation
3. Prescription forging or altering
4. Prescription diversion and inappropriate use
5. Prescription stockpiling
6. Falsifying eligibility applications
7. Using another person's health plan identification card to obtain medical care
8. Doctor shopping to obtain multiple prescriptions for controlled substances/ prescriptions drugs
9. Failing to report third party liability
10. Improper coordination of benefits

Prescriber - Examples

1. Script mills
2. Prescription drug switching
3. Illegal remuneration schemes
4. Provision of false information
5. Theft of prescriber's Drug Enforcement Agency's (DEA) number or prescription pad

Provider/Facility - Examples

1. Falsifying credentials
2. Double-billing for health care services/goods provided
3. Accepting kickbacks for referring patients
4. Conducting improper dis-enrollment practices
5. Attracting healthy patients or refusing sicker patients
6. Persuading sicker patients to dis-enroll
7. Falsifying medical exemptions
8. Use of telemarketing/selling as marketing tools
9. Falsifying encounter data
10. Misrepresenting services to meet quality of care standards
11. Billing for "phantom patients" who did not receive services
12. Billing for services/supplies not provided
13. Upcoding charges and unbundling services
14. Excluding distinct groups of beneficiaries [e.g. patients with chronic conditions]
15. Engaging in under-utilization
16. Regularly denying treatment requests and specialist referrals without regard to proper medical evaluation
17. Concealing ownership in a related company.

Pharmacy - Examples

1. Inappropriate billing practices
2. Prescription Drug Shorting
3. Bait and switch pricing
4. Prescription forging or altering
5. Dispensing expired or adulterated prescription drugs
6. Prescription refill errors
7. True-Out-Of-Pocket (TrOOP) manipulation
8. Failure to offer negotiated prices

Other:

1. An individual or organization pretends to represent Medicare and/or Social Security, and asks a member for his/her Medicare or Social Security number, bank account number, credit card number, money, etc.
2. Someone who asks a member to (i) sell his/her Medicare prescription drug card or (ii) get drugs for him/her using a member's Medicare prescription drug card
3. A member feels that a managed care organization has discriminated against him/her, such as by prohibiting a member from signing up for the plan because of a member's age, health, race, religion, income
4. A member is encouraged to dis-enroll from his/her managed care organization (e.g. health plan)
5. A member is offered cash to (i) sign up for a Medicare prescription drug plan or (ii) a gift worth more than $15 to sign up for a Medicare prescription drug plan
6. A member's pharmacy does not give him/her all of the drugs to which the member is entitled

How to Report A Compliance Event

You may refer a compliance event to Health Choice through any of the following options:

1. Health Choice Personnel

To speak with someone from Health Choice, please contact:

- ✓ Any senior management staff at Health Choice, including our Company's Executive Officers (CEO - Mike Uchrin, CMO – Richard Sanchez, CFO – Jeff Butcher or COO – Troy Smith or the CCO - Chief Compliance Officer - Phil Nieri);
- ✓ Ilissa Lazar (AZ Medicaid – HCA);
- ✓ Jessica Meade (AZ Medicare - HCG);
- ✓ Nicole Larson (AZ Integrated Behavioral - HCIC);
- ✓ Diane Loram (AZ ACO - Preferred, BPCI Program and runout of AZ marketplace - HCE);
- ✓ Andrew Arnott (UT Medicaid – HCU and UT ACO - Preferred; and
- ✓ Any other representative from the Health Choice Compliance Department.

You may also reach anyone from above at one of these toll-free numbers:

- ❖ 800-322-8670 (HCA)
- ❖ 800-656-8991 (HCG)
- ❖ 877-358-8797 (HCU)
- ❖ 800-640-2123 (HCIC)
- ❖ TTY 711 (for hearing impaired)

2. Reporting Hotlines

If you are uncomfortable reporting a compliance event to someone at Health Choice and/or wish to remain anonymous, please call any of these hotlines:

Hotlines Operated by a 3rd Party on behalf of Health Choice:

- o **1-877-898-6080** (IASIS AlertLine – anonymous option for any event across all products and locations)
- o **1-888-677-3720** (IASIS/Health Choice Generations FWA Hotline)

Hotlines Operated Federal or State Regulators:

- o **1-877-772-3379** (Medicare Prescription Fraud Hotline/MEDIC)
- o **1-800-447-8477** (Medicare Fraud Hotline/HHS-OIG)
- o **1-855-403-7283** (AZ Office of Program Integrity Hotline for Medicaid Fraud)
- o **1-855-403-7283** (UT OIG for Medicaid Fraud)
- o **602-417-4193** (AZ Office of Program Integrity Hotline for Medicaid Fraud)

These hotlines are available 24 hours a day, 365 days a year, to all Health Choice employees and Partners.