OHSU HEALTH IDS ETHICS AND COMPLIANCE PLAN

Purpose

The OHSU Health IDS (IDS) Board of Directors has adopted this Compliance Program ("Program") to articulate OHSU Health IDS's longstanding commitment to support the provision of comprehensive health services to its Oregon Health Plan Members through its subcontractors and providers in compliance with all federal, state and local laws and regulations; to prevent and detect fraud, waste and abuse by its workforce, subcontractors, providers, members, and other third parties; and to set forth an annual fraud, waste and abuse prevention plan ("FWA Plan") for implementing, analyzing, and reporting on the effectiveness of the policies and procedures set forth in the OHSU Health IDS' FWA Prevention Handbook. In addition, it supports the promotion of an organizational culture that encourages ethical conduct and places the highest value on integrity in the achievement of its mission.

This Program has been designed to address the elements identified by the United States Sentencing Commission Guidelines Chapter 8, 42 CFR 438.608 and 42 CFR 455 Medicaid Program Integrity as well as the Office of Inspector General of the U.S. Department of Health and Human Services that are required for the implementation of an effective compliance and ethics program and IDS contractual obligations under the Integrated Delivery System (IDS) Contract with Health Share of Oregon and the Health Plan Services Contract ("Contract") with the Oregon Health Authority.

Program Oversight

The OHSU Health IDS Board of Directors is responsible for the reasonable oversight of the Program with respect to its implementation and effectiveness and shall be knowledgeable about its content and operation. The Board will act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. The existence of a corporate reporting system not only keeps the board informed of the activities of the organization, but also enables the organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

The OHSU Health IDS Board of Directors has appointed a compliance officer who has operational responsibility for the development and effective implementation of an ethics and compliance program and fraud, waste and abuse (FWA) prevention plan that meets the requirements articulated in the Health Plan Services Contract with the Oregon Health Authority. OHSU Health IDS is committed to the prevention of FWA and will comply with all applicable laws, including without limitation the State's False

Claims Act and the Federal False Claims Act.

The compliance officer is responsible for ensuring OHSU Health IDS is committed to complying with the terms and conditions in sections 11, Exhibit B, Part 9 of the contract and all other applicable State and Federal laws. OHSU Health IDS has created a Special Investigations Unit (SIU) that is dedicated to, and responsible for, the implementation of the Annual FWA Prevention Plan and related FWA activities. Additionally, the SIU:

- Includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor.
- Demonstrates continuous work towards increasing the qualifications of its employees.
- OHSU Health IDS SIU investigators must meet mandatory core and specialized training program requirements for such employees.
- The team will employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care providers.
- The team may employ or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases.

The termination authority for the position of OHSU Health IDS Compliance Officer is the Board of Directors.

OHSU Health IDS Regulatory Compliance Committee

OHSU Health IDS has established a regulatory compliance committee at the board and senior management level that includes the Chief Compliance Officer and senior level management employee and is responsible for the operational oversight of IDS's compliance program and its compliance with the OHA Health Plan Services CCO Contract.

The regulatory compliance committee reports directly to the board. The board has appointed a chief compliance officer who reports directly to the Chief Executive Officer (CEO) and Board of Directors.

The compliance office consists of the chief compliance officer and at least one individual who reports directly to the Chief Compliance Officer.

The Moda Compliance Officer serves as the IDS' named Chief Compliance Officer. Due to the company's unique structure, the Moda Compliance Officer and OHSU Health IDS Compliance Officer serve as co-chair of the committee. Additionally, both Compliance Officers report to the Chief Executive Officer (or designee) and are accountable to the OHSU Health IDS Board of Directors.

The Compliance Officer(s) are responsible for developing and implementing compliance related policies, procedures, practices, and the Annual Fraud, Waste, and Abuse Prevention Plan. The Chief Compliance

Officer is delegated sufficient authority and adequate resources to undertake and comply with these responsibilities.

The Compliance Officer(s) also co-chair a bi-weekly IDS compliance workgroup. This group includes representation from compliance, operations and care management. The purpose of this group is to provide oversight and guidance of the day to day compliance tasks related to OHSU Health IDS.

Members of the OHSU Health IDS Regulatory Compliance Committee include Moda's Compliance Officer, OHSU Health IDS Compliance Officer, OHSU Health IDS Chief Executive Officer, Moda Chief Executive Officer OHSU Health IDS Chief Administrative Officer, OHSU Health IDS Chief Medical Officer, OHSU Health IDS Director of Operations, OHSU Health IDS Director of Network and Provider Relations, Manager Medicaid Services (all senior level management employees) and members of the Board of Directors.

Standards of Conduct and Policies and Procedures

OHSU Health IDS's standards of conduct contained in the Code of Conduct (the "Code") describe the ethical principles and standards of business practice for the IDS's workforce and subcontractors and demonstrate compliance with applicable requirements under the Contract. Those standards describe the behavior that is expected when interacting with other members of the IDS workforce in the performance of one's duties and provides guidance to ensure that their work is done in an ethical and legal manner.

In addition to the Code, OHSU Health IDS has implemented policies, procedures and internal controls that ensures compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, and OAR 410-120-1510 and that describe the mechanism by which management exercises due diligence in seeking not only to reduce the likelihood of misconduct, but to facilitate compliance with all applicable federal and State laws and prevent and detect any behavior contrary to those principles. The objectives of those policies and procedures, along with the Code are to: 1) provide comprehensive guidelines and standards for the provision of its services; 2) monitor the implementation of those guidelines and standards as a routine daily practice; 3) enhance a corporate culture which supports compliance with federal and state statutes and regulations, and 4) build community trust in OHSU Health IDS.

To the extent that OHSU Health IDS subcontracts to any third parties any responsibility for providing services to Members or processing and paying for claims, IDS will require its subcontractors, pursuant to its subcontracts, to comply with the terms and conditions set forth in Sections 11- 18 of Exhibit B, Part 9 of the Contract.

The Code and relevant policies and procedures are developed with consideration for the rich and varied backgrounds of OHSU Health IDS's workforce, and will be made available to all workers. These policies and procedures will be reviewed annually and periodically updated to address new or modified statutes and/or regulations which apply to the services OHSU Health IDS provides. They will also be submitted annually to Health Share of Oregon and other

appropriate bodies charged with responsibility for operating and monitoring the Program.

Excluded Individuals and Organizations and Prohibited Affiliations

OHSU Health IDS will not employ, contract with or have a relationship with any individual or organization who/that has been excluded from: (1) Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States, and (2) federal procurement and non-procurement programs. The relationships described above are as follows:

- A director, officer, or partner of OHSU Health IDS
- A subcontractor of OHSU Health IDS
- A person with beneficial ownership of 5 percent or more of OHSU Health IDS's equity
- A network provider or person with an employment, consulting or other arrangement with IDS for the provision of items and services that are significant and material to IDS' obligations under its contract with the State.

OHSU Health IDS will immediately report to the Federal Department of Health and Human Services ("DHHS"), Office of the Inspector General ("OIG"), any providers, identified during the credentialing process, who are include on the List of Excluded Individuals ("LEIE") or on the Excluded Parties List System ("EPLS") also known as System for Award Management ("SAM"). Reporting requirements can be met by providing such information to OHA's provider Services via Administrative Notice. OHSU Health IDS provides notification to OHA and Health Share of Oregon within 30 days when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement.

Effective Communication, Training and Education

Systems are in place that are designed to maintain effective lines of communication between the OHSU Health IDS compliance office, its workforce and subcontractors. Reasonable steps are also taken to effectively communicate, periodically and in a practical manner the Code of Conduct, policies and procedures contained in this Program to the Board of Directors, high-level personnel, substantial authority personnel, OHSU Health IDS workforce members, and, as appropriate, subcontractors of OHSU Health IDS.

Communications with workers and subcontractors will emphasize: (1) OHSU Health IDS's commitment to ethical conduct; (2) the importance of statutory and regulatory compliance; (3) the identification of laws and regulations as they relate to an individual's job; and (4) the obligation of each worker to behave in a manner consistent with those statutes and regulations and the principles articulated in the Code.

Communication examples are: email, employee meetings, one-to-one meetings with workforce members, newsletters, PowerPoint presentations to affected departments/personnel and via numerous various committees.

This will be supported by conducting effective training and education for the federal and State standards and requirements under the Contract and otherwise disseminating information appropriate to such individuals' respective roles and responsibilities.

OHSU Health IDS provides and requires new employee education within 90 days of hire and annual attendance at training and education for the compliance officer, senior management, other members of the IDS workforce and Subcontractors regarding its fraud, waste, and abuse policies and procedures. Such training and education includes, without limitation, the right to be protected as a whistleblower for reporting any fraud, waste, or abuse as well as annual education and training to members of OHSU Health IDS's workforce who are responsible for credentialing providers and subcontracting with third parties. Such annual education and training includes material relating: (1) the credentialing and enrollment of Providers and Subcontractors, (2) the prohibition of employing, subcontracting, or otherwise being affiliated with (or any combination or all of the foregoing) sanctioned individuals and (3) OHSU Health IDS system for training and education must provide all information necessary for its employees, subcontractors and participating providers to fully comply with the FWA requirements of the Contract and (4) All such training and education must be specific and applicable to FWA in the Medicaid program. All training must include Medicaid-specific referral and reporting information and training regarding OHSU Health IDS's Medicaid FWA policies and procedures, including any time parameters required for compliance with Ex B, Part 9 of the Contract.

Training will be provided in a variety of ways: in-person or online education, email reminders, video conferencing and other modalities.

Monitoring and Auditing

OHSU Health IDS will develop and implement an annual plan to audit providers and subcontractors that will enable OHSU Health IDS to validate the accuracy of encounter data against provider charts and identify fraud, waste, and abuse risks and other related compliance risks. The results of these auditing and monitoring activities will be reported periodically to the OHSU Health IDS Chief Executive Officer and the Board of Directors.

OHSU Health IDS will routinely verify whether services that have been represented to be delivered by network providers were received by members to investigate incidents where services were not delivered or where the member paid out of pocket for services, and collect any associated overpayments. Such verification will be made by mailing monthly service verification letters to members, sampling, hotline reports or other methods.

Internal Reporting of Suspected Non-Compliance

OHSU Health IDS is committed to providing an environment that encourages and allows workers to report or to seek and receive prompt guidance before engaging in conduct that is believed to be inconsistent with federal or State statutes or regulations, the OHSU Health IDS ethics and compliance program or its Code of Conduct.

While OHSU Health IDS encourages members of the OHSU Health IDS workforce or subcontractors to report suspected misconduct to their supervisor, manager or the compliance officer, OHSU Health IDS provides a toll-free hotline (1-877-733-8313 or www.ohsu.edu/hotline) that allows OHSU Health IDS employee and others to report or seek guidance anonymously or confidentially regarding potential or actual non-compliance without fear of retaliation. OHSU Health IDS will maintain the privacy and anonymity of reporting parties except where legally proscribed. The ability of OHSU Health IDS to ensure total confidentiality may be limited by legal obligations relating to self-disclosure, law enforcement subpoenas, and civil discovery requests. Each report will be documented and a response provided, if possible, to the reporter.

Responding to a Suspected Violation

When potential fraud, waste, and abuse and other related compliance problems are reported or identified in the course of self-evaluation, hotline reports and audits, the allegations will be promptly investigated. In the event that an investigation reveals misconduct, corrective action will be immediately initiated.

Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of fraud, waste, and abuse and other related compliance problems will be taken in a manner that is designed to reduce the potential for recurrence, including the identification of any systemic shortcomings that compromise the deterrent effect of its Program. If necessary, appropriate modifications will be made to the Program.

External Reporting of Fraud, Waste or Abuse

Using the Quarterly and Annual FWA Report Template, OHSU Health IDS will provide to Health Share a quarterly and annual summary report of referrals, and cases investigated. The Quarterly FWA Report will be provided to Health Share no later the 30 days after the close of each quarter. ("Annual FWA Referrals and Investigations Report"). The annual FWA Referrals and Investigations Report will be provided to Health Share promptly after January I of each contract year following the reporting year but in no event later than January 31st. Additionally, OHSU Health IDS will report all opened, in-process and closed Program Integrity (PI) audits with both the quarterly and annual reports for the reporting period.

OHSU Health IDS will report all suspected cases of fraud, waste, and abuse, including suspected fraud committed by its employee, providers, subcontractors, members, or any other third parties to the Department of Justice (DOJ's) Medicaid Fraud Control Unit ("MFCU"), the Office of Program Integrity (OPI) and to Health Share. Reporting shall be made promptly but in no event more than seven (7) days after OHSU Health IDS is initially made aware of the suspicious case. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

Health Share of Oregon
2121 SW Broadway Suite 200
Portland, OR 97201
hearingsandappeals@Healthshareoregon.org

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

OHA Office of Program Integrity (OPI)
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD0l (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

OHSU Health IDS will cooperate with the MFCU and allow them to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse as follows:

- OHSU Health IDS will provide copies of reports or other documentation requested by MFCU, OPI, or their respective designees, or any or all of them. All reports and documents required will be provided without cost to MFCU, OPI, or their designees;
- OHSU Health IDS will permit MFCU, OPI, or their respective designees, or any combination or all of them, to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of OHSU Health IDS as such parties may determine is necessary to investigate any incident of fraud, waste, or abuse;
- OHSU Health IDS will cooperate in good faith with the MFCU, OPI, as well as their respective designees, or any or all of them, during any investigation of fraud, waste, or abuse; and
- In the event that OHSU Health IDS reports suspected fraud, waste, or abuse by OHSU Health IDS's subcontractors, providers, members, or other third parties, or learns of an MFCU, or OPI investigation, or any other fraud, waste, and abuse investigation undertaken by any other governmental entity, IDS is strictly prohibited from notifying, or otherwise communicating with, such parties about such report(s) or investigation(s) so as not to compromise the investigation.

If OHSU Health IDS is made aware of a credible allegation of fraud by the MFCU, or of a pending investigation against a provider, OHSU Health IDS will, upon notification of an investigation by MFCU, suspend payments to the provider unless the MFCU determines there is good cause not to suspend payments or to suspend payments in part.

OHSU Health IDS will include the above contact information for MFCU and OPI in its FWA Prevention Handbook and refer to the Health Share of Oregon Member Handbook.

External Reporting of Overpayments

Using the FWA Report Template (found on the Contract Reports website), and in accordance with OHSU Health IDS's FWA Prevention Handbook and Annual FWA Prevention Plan, OHSU Health IDS will provide Health Share with quarterly and annual reports of all audits performed ("Annual FWA Audit Report"). The Annual FWA Audit Report will include information on any provider overpayments that were recovered, the source of the provider overpayment recovery, and any sanctions or corrective actions imposed by IDS on its Subcontractors or Providers. The quarterly FWA Report is due thirty days following the end of each quarter and will be provided to Health Share.

OHSU Health IDS will self-report to Health Share any overpayment it received from Health Share under the Contract or any other contract, agreement, or Memorandum of Understanding (MOU) entered into by OHSU Health IDS and Health Share. This includes the obligation to report, as required under 42 CFR §401.305 such overpayment to OHA within sixty (60) days of its identification.

If the overpayment was identified by OHSU Health IDS as a result of an audit or investigation, it must be reported to Health Share promptly, but in no event more than seven (7) days after identifying such Overpayment.

OHSU Health IDS will return the overpayment within 60 calendar days after the date on which the overpayment was identified and notify Health Share in writing of the reason for the overpayment.

Reporting a Case of Fraud or Abuse by a Member

If OHSU Health IDS, is made aware of suspected fraud or abuse by a member (e.g. a Provider reporting Member fraud, waste and abuse) will promptly report the incident to the DHS/OHA fraud Investigation Unit and Health Share. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS/OHA Fraud Investigation
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01
(1-888-372-8301)
Fax: 503-373-1525 Attn: Hotline); or
Reports may also be made via on-line portal at:
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Health Share of Oregon
2121 SW Broadway Suite 200
Portland, OR 97201

OHSU Health IDS will include the above contact information for DHS/OHA fraud investigation in its FWA Prevention Handbook.

Network Providers will report an overpayment to OHSU Health IDS and to return the overpayment within 60 calendar days after the date on which the overpayment was identified, and to notify IDS in writing, the reason for the overpayment.

Enforcement and Disciplinary Action

Each member of the OHSU Health IDS workforce is responsible for supporting an environment that encourages ethical and compliant conduct and fosters reporting behavior inconsistent with such conduct. Disciplinary action will be initiated against: (1) individuals who have failed to comply with OHSU Health IDS's Code, compliance policies, applicable statutes, regulations or federal Health care program requirements; (2) responsible individuals who unreasonably fail to detect or report an offense; or (3) those who have otherwise engaged in wrongdoing that has the potential of impairing OHSU Health IDS's status as a reliable, honest, provider of Health care services. OHSU Health IDS disciplinary guidelines provide a progression of steps designed to:

- Eliminate surprise.
- Emphasize the seriousness of the problem.
- Clarify the problem and corrective action required.
- Determine if the individual has the willingness and ability to correct the problem.

Annual Fraud, Waste and Abuse Prevention Plan

In addition to creating the written FWA Prevention Handbook, the OHSU Health IDS compliance officer, with the assistance of OHSU Health IDS's compliance team, will annually draft the Annual FWA Prevention Plan. OHSU Health IDS's written plan must address what measures, criteria, or method(s) OHSU Health IDS will use to evaluate effectiveness.

- Routine internal monitoring, reporting, and PI Auditing of FWA risks. OHSU Health IDS will provide a work plan which lists all Program Integrity (PI) Audits planned for the Contract Year, identifies individual(s) or department resources used to conduct the reviews, data or information sources, whether each review is conducted in person/on-site, and when each review is scheduled to begin.
- Routine internal Monitoring, reporting, and auditing of other related compliance risks.
    - OHSU Health IDS will provide a copy of its criteria or checklist developed and implemented to perform routine internal monitoring and routine evaluation of subcontractors and participating providers for other related compliance risks.
    - OHSU Health IDS will must provide a work plan which lists all compliance reviews planned for the Contract Year, identifies individual(s) or department resources used to conduct the

reviews, data or information sources, whether each review is conducted in person/on-site, and when each review is scheduled to begin.

- Prompt response to FWA as they are reported or otherwise discovered. OHSU Health IDS will identify its methods used to: receive allegations; track, triage, and refer (i) to MFCU/OPI for fraud or abuse or (ii) to internal quality or compliance department(s); and investigate, resolve, and refer final case internally for further compliance, Corrective Action, or open a PI Audit to recover. Overpayments. OHSU Health IDS is prohibited from referring allegations to a subcontractor who is also a party to the allegation.
- Prompt response to other related compliance issues as they are reported or otherwise discovered. OHSU Health IDS will identify its methods used to: receive allegations; track, triage, and refer (i) to MFCU/OPI for fraud or abuse or (ii) to internal quality or compliance department(s); and investigate, resolve, and refer final case internally for further compliance, Corrective Action, or open a PI Audit to recover Overpayments.
- Investigation of potential FWA as identified in the course of self-evaluation and PI Audits.
- Investigation of other related compliance problems as identified in the course of self-evaluation and PI Audits.
- Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of FWA in a manner that is designed to reduce the potential for recurrence.
- Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of other related compliance problems in a manner that is designed to reduce the potential for recurrence.
- Activities that support ongoing compliance with the FWA prevention under the Contract.
- Activities that support ongoing compliance with other related compliance requirements under the Contract.
- Risk evaluation procedures to enable compliance in identified problem areas such as claims, prior authorization, service verification, utilization management and quality review. OHSU Health IDS's annual risk evaluation/assessment will identify a methodology for assessing risk of fraud and the likelihood and impact of potential fraud. The fraud risk assessment may be integrated into OHSU Health IDS's overall compliance risk assessment or be performed separately from OHSU Health IDS's overall compliance risk assessment.
- The development and implementation of an annual plan to perform PI Audits of Providers and subcontractors that will enable OHSU Health IDS to validate the accuracy of encounter data against provider charts.

Annual Assessment of FWA Activities

OHSU Health IDS will submit an annual assessment report of the quality and effectiveness of its annual FWA Prevention Plan and the related policies and procedures included in its FWA Prevention Handbook ("Annual FWA Assessment Report"). The Annual FWA Assessment Report will include:

- Identify the number of preliminary investigations and the final number of referrals to OPI or MFCU or both;
- Identify the number of subcontractor and provider audits PI Audits conducted by

OHSU Health IDS and whether they were performed on-site or based on a review of documentation;

- Identify the number of subcontractor and participating provider reviews conducted by OHSU Health IDS and whether they were performed on-site or based on a review of documentation.

- Identify the training and education provided to and attended by OHSU Health IDS's Chief Compliance Officer, its employee, and, if applicable, its providers and subcontractors;
- Compliance and fraud, waste, and abuse prevention activities that were performed during the reporting year. The work and activities reported in the Annual FWA Assessment Report must align with the Annual FWA Prevention Plan. The work and activities must be clearly described and be specific to the reporting year. OHSU Health IDs will provide such information for each program integrity activity or work conducted in the prior Contract Year. OHSU Health IDs will include in its report :
  - A review of the provider PI Audit activity OHSU Health IDS performed and whether such PI Audit activity was in accordance with OHSU Health IDS's FWA Prevention Plan.
  - A description of the methodology used to identify high-risk providers and services.
  - Compliance reviews of subcontractors, participating providers, and any other third parties, including a description of the data analytics relied upon.
  - Any applicable request for technical assistance from OHA, DOJ's MFCU, or CMS on improving the compliance activities performed by OHSU Health IDS;
  - A sample of the Service Verification Letters mailed to members.
  - A summary report on:
    - The number of Service Verification letters sent;
    - How members were selected to receive such letters;
    - Member response rates;
    - The frequency of mailings, including all dates on which such letters were mailed;
    - The results of the efforts, and
    - Other methodologies used to ensure the accuracy of data.
  - A narrative and other information that advises OHA of:
    - The outcomes of all of the fraud, waste, and abuse prevention activities undertaken by OHSU Health IDS;
    - Proposed or future process, policies, and procedure improvements to address deficiencies identified and;
    - OHSU Health IDS will identify where work or activities identified in its FWA Prevention Plan were not implemented or were implemented differently than initially described by OHSU Health IDS in its Annual FWA Prevention Plan and explain how and why the FWA prevention activities changed.
  - A copy of each final report resulting from compliance reviews of subcontractors and participating providers completed during the prior Contract Year as well as any Corrective Action Plans resulting from such compliance reviews.

IDS's Annual FWA Assessment Report will be provided to Health Share no later than January 31 of each contract years two, three, and four. Health Share will advise OHSU Health IDS of its reporting requirements for contract year five at least one-hundred and twenty (120) days prior to the contract termination date.

Compliance Risk Assessment

OHSU Health IDS will periodically assess the risk of the occurrence of fraud, waste or abuse and other misconduct to enable compliance in identified problem areas such as claims, prior authorization, service verification, utilization management and quality review. Specifically, OHSU Health IDS will evaluate the nature and seriousness of the misconduct, the likelihood that certain criminal conduct may occur because of the nature of OHSU Health IDS' business, and the prior history of the organization. OHSU Health IDS's compliance and ethics resources will be prioritized to target those potential activities that pose the greatest threat in light of the risks identified.

Review and Approval of Fraud, Waste, and Abuse Handbooks

OHSU Health IDS will provide to Health Share its FWA Prevention Handbook and Annual Plan for review and approval by no later than January 31 of each Contract Year. OHSU Health IDS' Annual FWA Prevention Handbook will not be implemented or distributed prior to approval by Health Share. Review and approval shall be provided to OHSU Health IDS by Health Share within thirty (30) days of receipt. In the event Health Share disapproves either the FWA Prevention Handbook and or the Prevention Plan for failing to meet the terms and conditions of this Contract and any other applicable State and federal laws, OHSU Health IDS will, in order to remedy the deficiencies in the Annual FWA Prevention Plan and FWA Prevention Handbook, follow the process set forth in Sec. 5, Ex. D of the Contract.

OHSU Health IDS will review and update its Annual FWA Prevention Plan and FWA Prevention Handbook annually and provide copies of such documents for Health Share's review and approval. In the event OHSU Health IDS has not made any changes to its FWA Prevention Handbook since it was last approved by Health Share, OHSU Health IDS will include an attestation that no changes have been made since it was last approved. After Health Share's initial approval of OHSU Health IDS' Annual FWA Prevention Plan and FWA Prevention Handbook, OHSU Health IDS will submit such Plan and Handbook for subsequent review and approval as follows:

- To Health Share upon any significant revisions, regardless of whether such changes are made prior or subsequent to annual approval by Health Share, or prior to OHSU Health IDS' final adoption of such Plan or Handbook after initial approval by Health Share. The revised Annual FWA Prevention Plan or FWA Prevention Handbook, or both. In the event the revised Annual FWA Prevention Plan or FWA Prevention Handbook fails to meet the terms and conditions of the Contract or applicable law, OHSU Health IDS shall follow the process set forth in Sec. 5, Ex. D of the Contract.
- To Health Share anytime upon request. OHSU Health IDS will provide Health Share with the requested Annual FWA Prevention Plan or FWA Prevention Handbook, or both, in the manner requested by Health Share.

OHSU Health IDS and Health Share Audits of Network Providers

If OHA, Health Share or other regulatory body conducts an audit of OHSU Health IDS's Providers or the Providers' encounter data that results in a finding of overpayment, OHA, Health Share or other regulatory body will calculate the final overpayment amount for the audited claims using the applicable fee-for-service fee schedule and recover the overpayment from OHSU Health IDS. OHSU Health IDS has the right, at its discretion, to pursue recovery of the overpayments made by OHSU Health IDS to the applicable Providers.

If OHA, Health Share or other regulatory body conducts an audit of OHSU Health IDS' Providers or the Providers' encounter data that results in an administrative or other non-financial finding, OHSU Health IDS agrees to use the information included in their final audit report to rectify any identified billing issues with its Providers and pursue financial recoveries for improperly billed claims if applicable.

If OHSU Health IDS or its subcontractors conduct an audit of OHSU Health IDS' Providers or Providers' encounter data that results in a finding of overpayment, OHSU Health IDS will return to OHA, Health Share or other regulatory body any and all applicable federally matched funds but is permitted to keep any sums recovered in excess of the federally matched funds as calculated by OHA. Recoveries that are retained by OHSU Health IDS will be reported as set forth in Sub. Paragraph (17) Section. 11, and Sec. 15, Paragraph b. of the Contract.

Documenting and Processing Recovery of Overpayments Made to Third Parties

OHSU Health IDS will also comply with all of the procedures for managing and otherwise processing the recovery of such overpayments as follows:

- OHSU Health IDS will adjust, void or replace, as appropriate, each encounter claim to reflect the Valid Encounter claim once OHSU Health IDS has recovered Overpayment within thirty (30) days of identifying such Overpayment.
- OHSU Health IDS will maintain records of OHSU Health IDS's actions and Subcontractors' actions related to the recovery of overpayments made to providers, subcontractors, or other third parties. Such records maintenance will be made in accordance with and made available to OHA and other parties in accordance with Ex. D, Sec.14 of the Contract.
- In the event OHSU Health IDS investigates or audits its providers, subcontractor, or any other third-party and overpayments made to such parties are identified as the result of fraud, waste, or abuse, OHSU Health IDS may collect and retain such overpayments.
- Examples of overpayment types that might be made to providers, subcontractors, or other third parties include, but are not limited to, the following:
    - Payments for non-covered services,
    - Payments in excess of the allowable amount for an identified covered service,
    - Errors and non-reimbursable expenditures in cost reports,
    - Duplicate payments, and
    - Receipt of Medicaid payment when another payer had the primary

responsibility for payment, and is not included in an automated third party liability retroactive recovery process.

OHSU Health IDS does not have the right to retain any overpayments made to any provider or any subcontractor that are recovered as a result of (1) claims brought under the State or federal False Claims Acts (2) a judgment or settlement arising out of or related to litigation involving claims of fraud, or (3) through government investigations, such as amounts recovered by OPI or MFCU or any other State or federal governmental entity, regardless of whether OHSU Health IDS referred the matter to such parties.

Reporting Changes in Eligibility

OHSU Health IDS will notify OHA and Health Share within 30 days when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the OHSU Health IDS, including the termination of the provider agreement. When the termination of a participating provider is for-cause, notice must be provided to Health Share within fifteen (15) days of termination, with a statement of the cause. Reporting requirements can be met by providing such information to OHA's provider Services via Administrative Notice.

OHSU Health IDS will also promptly notify Health Share when OHSU Health IDS receives information about changes in a member's circumstances that might impact eligibility, including changes in a member's residence, and death of a member. OHSU Health IDS will ensure that all network providers are enrolled with the State of Oregon as Medicaid Providers consistent with provider disclosure, screening and enrollment requirements of part 455, subparts B and E.

Member Grievance and Appeal Resolution Processes

OHSU Health IDS has a process in place to resolve member grievances and appeals that protect the anonymity of complaints and to protect callers from retaliation.

References

Attachment 1 COMP-100 Federal and State Statutes and Regulations

Revision Activity

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
		1/1/2020	1/1/2020
Revisions made to align with CCO contract changes	OHSU Health IDS Regulatory Compliance Committee	3/14/2022	1/1/2022
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	5/16/2022	3/14/2022

Attachment COMP 100 #1

FEDERAL AND STATE STATUTES AND REGULATIONS

Applicable Federal Laws

As a participant in federal Medicaid program IDS, its employee, agents, and contractors are required to comply with the following federal laws.

A. False Claims Act - The federal civil False Claims Act ("FCA") is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid. Under the statute the terms "knowing" and "knowingly" mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, and upcoding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions will be brought within six years of a violation, or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed. The Act allows for inflationary adjustments, and in 2019 FCA violations will result in a civil penalty per false claim, of not less than $11,181 and not more than $22,363, plus treble the Government's actual damages.

Qui Tam and Whistleblower Protection Provisions - The False Claims Act contains *qui tam*, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A *qui tam* action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has sixty days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim. However, if the government initially decides not to join, the whistleblower may pursue the action alone, with the government maintaining the ability to join the action at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent) plus attorneys' fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employee who are discharged, demoted, harassed, or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistleblowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest, and compensation for any special damages including attorneys' fees and costs of litigation.

B. Federal Program fraud Civil Remedies - The Program fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents, or submits, or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

C. Anti-kickback Statute - Under the federal Anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (*i.e. "*remuneration"), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a federal care program. The statute prohibits the offering or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal Health care program. Individuals found guilty of violating the anti-kickback statute may be subject to fines, imprisonment, and exclusion from participation in federal Health care programs.

There are certain statutory exceptions to the Anti-kickback statute. Under one exception, "remuneration" does not include a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under a federal care program.
In addition to the statutory exceptions, the OIG has identified several "safe harbors" for common business arrangements, under which the anti-kickback provision would not be violated. The list of safe harbors is not exhaustive, and legitimate business arrangements exist that that do not comply with a safe harbor.

D. Stark Laws - The Stark laws prohibit certain physician referrals for designated services that may be paid for by Medicaid or other state care plans. The Stark law provides that if a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated services for which payment may be made under Medicaid. A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician or immediate family member and the entity.

The Stark law includes a large number of exceptions, which may apply to ownership interests, compensation arrangements, or both. Unlike the Anti-Kickback laws which recognize that arrangements falling outside of the safe harbors may still be permitted, the Stark law is a strict prohibition against self-referrals. Accordingly, if a referral arrangement does not meet one of the exceptions, it will be considered unlawful.

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000, and in certain cases not to exceed $100,000, per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute or investment interest in any entity providing the designated Health care service." A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

E. Civil Monetary Penalties Law - The Office of the Inspector General of the Department of and Human Services (OIG) is authorized to impose civil penalties on any person, including an organization or other entity that knowingly presents or causes to be presented to a federal or state employee or agent false or fraudulent claims. Examples of actions that would give rise to penalties include submitting a claim for services that were not rendered or providing services that were known to be not medically necessary. In addition to specified monetary penalties, treble damages may also be assessed against any person who submits a false or fraudulent claim.

F. Section 1128B of the Social Security Act – This section of the Social Security Act provides for criminal penalties involving federal Health care programs. Under this section, certain false statements and representations, made knowingly and willfully, are criminal offenses. For example, it is unlawful to make or cause to be made false statements or representations in either applying for benefits or payments, or determining rights to benefits or payments under a federal Health care program. In addition, persons who conceal any event affecting an individual's right to receive a benefit or payment with the intent to either fraudulently receive the benefit or payment (in an amount or quantity greater than that which is due), or convert a benefit or payment to use other than for the use or benefit of the person for which it was intended may be criminally liable. Individuals who violate this statute may be guilty of a felony, punishable by a fine of up to $25,000, up to five years' imprisonment, or both. Other persons involved in connection with the provision of false information to a federal Health care program may be guilty of a misdemeanor and may be fined up to $10,000 and imprisoned for up to one year.

The Social Security Act also provides the OIG with the authority to exclude individuals and entities from participation in federal programs. Exclusions from federal programs are mandatory under certain circumstances, and "permissive" in others (*i.e.*, OIG has discretion in whether to exclude an entity or individual).

Examples of fraud, waste and abuse include, without limitation, any one combination of, or all of the following:

- Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.
- Providers, other CCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.
- Providers, other CCOs, or Subcontractors intentionally or recklessly billed IDS or OHA more than the usual charge to non-Medicaid recipients or other insurance programs.
- Providers, other CCOs, or Subcontractors altered, falsified, or destroyed clinical records for any purpose, including, without limitation, for the purpose of artificially inflating or obscuring such provider's own compliance rating or collecting Medicaid payments otherwise not due. This includes any intentional misrepresentation or omission of fact(s) that are material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or provider.
- Providers, other CCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.
- Providers, other CCOs, or Subcontractors that intentionally or recklessly misrepresent medical information to justify Referrals to other networks or out-of-network Providers when such parties are obligated to provide the care themselves.
- Providers, other CCOs, Subcontractors that intentionally fail to render medically appropriate covered services that they are obligated to provide to Members under this Contract, any subcontract with the IDS, or applicable law.
- Providers, other CCOs, or Subcontractors that knowingly charge Members for services that are covered services or intentionally or recklessly balance-bill a Member the difference between the total fee-for-service charge and IDS's payment to the provider, in violation of applicable law.
- Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment when such party knew the claim: (1) had already been paid by OHA or IDS, (2) had already been paid by another source.
- Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
- Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (1) results in unnecessary costs, (2) results in

reimbursement for services that are not medically necessary, or (3) fails to meet professionally recognized standards for Health care.

- Evidence of corruption in the enrollment and disenrollment process, including efforts of IDS employee, State employees, other CCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from IDS or any other CCO.

Attempts by any individual, including IDS's employee, Providers, Subcontractors, other CCOs, IDS, or State employees or elected officials, to solicit kickbacks or bribes. For illustrative purposes, the offer of a bribe or kickback in connection with placing a Member into a carved out program, or for performing any service that such persons are required to provide under the terms of such persons' employment, this Contract, or applicable law.

Applicable State Laws

A. ORS 411.675 - Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment which has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment which is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided to or for the benefit of a public assistance or medical assistance recipient. Violation of this law is a Class C Felony.

B. ORS 411.690 – Any who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) The amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

   Any person who after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

C. Oregon False Claims Act and False Claims for Health Care Payments Act – The Oregon False Claims Act ("OFCA") is a civil statute designed to help the state government combat fraud and recover losses resulting from fraud against public agencies. (Or. Rev. Stat. Ann. § § 180.765 to 180.785). Also, Oregon has a False Claims for Health Care Payments Act ("OFCHCP") (O.R.S.

§§165.690 to 165.698) which works to fight false claims for Health care payments.

Violations of the OFCA include: (1) presenting or causing to be presented for payment or approval a claim that the person knows is false; (2) in the course of presenting a claim for payment or approval, making or using a false record or statement that the person knows to contain, or to be based on, false or fraudulent information; (3) agreeing or conspiring with other persons to present for payment or approval a claim that the person knows is a false claim; (4) delivering, or causing to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt; (5) making or delivering a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information; (6) buying property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property; (7) receiving property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property; (8) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent; or (9) failing to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

The OFCA does not contain provisions that allow individuals (or qui tam plaintiffs) with original information concerning fraud to file a lawsuit on behalf of the state. Actions may be brought by the Oregon Attorney General on behalf of the state. All damages assessed for violations of the OFCA are awarded to the state. Similarly, violations of the OFCHCP may be prosecuted only by the district attorney or the Attorney General.

A claim for violating the OFCA will be brought within three years after the date that the officer or employee of the public agency charged with responsibility for the claim discovers the violation. Courts are instructed to award to the state all damages arising from a violation of the OFCA, as well as a penalty equal to the greater of $10,000 for each violation or an amount equal to twice the amount of damages incurred for each violation. Courts may also award attorney's fees and costs of investigation, preparation and litigation to the state if the state prevails. Damages are calculated using the market value of the property, services or benefits obtained by the person who made the claim at the time and place of receipt or delivery. If the market value cannot be established, damages may be calculated using the replacement value or through another measure that reasonably estimate damages incurred.

The penalty portion of the award may be mitigated if the defendant is also subject to fines or penalties for substantially the same acts and omissions under the Federal False Claims Act or the Federal Civil Monetary Penalties Law. In addition, the penalty may not be imposed if the defendant (1) provided the Attorney General with all the information known to the defendant about the violation within 30 days of acquiring the information, (2) fully cooperated with the Attorney General in the investigation, and (3) at the time the defendant provided the Attorney General with information about the violation, a court proceeding or administrative action related

to the violation had not commenced. If a court finds that an act or omission of an individual on behalf of a corporation constituted a violation of OFCA, the court may impose a separate penalty against both the individual and the legal entity.

Although the OFCHCP does not have its own set of penalties, the statute requires that the prosecuting attorney will notify the Oregon Health Authority and any appropriate licensing boards of a person convicted under the OFCHCP.

The Act generally requires that the contractor have knowledge of the false or fraudulent information. The knowledge of the contractor can be established if the contractor has actual knowledge, acts in deliberate ignorance of the false or fraudulent nature, or acts in reckless disregard of the false and fraudulent nature of the claim.
If the contractor violates the Act, the Attorney General of the State of Oregon can seek damages arising from a violation of the Act, plus the Court is required to award a penalty against the contractor for $10,000 per violation or an amount equal to twice the amount of damages incurred for each violation. IDS can reduce their liability for fully cooperating with the Attorney General. The Attorney General can also be awarded reasonable attorneys' fees. Attorneys' fees can only be awarded against the Attorney General if the Attorney General had no "objectively reasonable basis" for bringing the action.

The Act also provides the Attorney General's office with the broad powers of performing an investigation of whether a violation of the Act has occurred before a lawsuit is filed. The AG's can initiate an investigation, require individuals to appear and testify under oath, issue written discovery requests, and require production of documents requested by the Attorney General's office.

D. OAR 410-120-1380(1)(c)(B) – Any provider entity that receives or makes annual payments under the Title XIX State Plan of at least $5,000,000, as a condition of receiving such payments, shall: (i) Establish written policies for all employee of the entity (including management), and of any contractor, subcontractor, or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblowing protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal care programs (as defined in section 1128B(f)); (ii) Include as part of written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and (iii) Include in any employee handbook for the entity, a specific discussion of the laws described in (i), the rights of the employee to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

E. ORS 165.080 (falsification of business records) - A person commits the crime of falsifying business records if, with intent to defraud, the person (a) Makes or causes a false entry in the business records of an enterprise; or (b) Alters, erases, obliterates, deletes, removes or destroys a true entry in the business records of an enterprise; or (c) Fails to make a true

entry in the business records of an enterprise in violation of a known duty imposed upon the person by law or by the nature of the position of the person; or (d) Prevents the making of a true entry or causes the omission thereof in the business records of an enterprise.

ORS 659A.200 to 659A.224 protect public employee who disclosing fraud in good faith. More specifically, they prohibit a public employer from preventing an employee from discussing with the legislature the activities of a public agency or those authorized to act on behalf of a public agency. Employers may also not take or threaten to take action against an employee who discloses any information the employee reasonably believes is a violation of law or evidence of mismanagement, gross waste of funds or abuse of authority.

Employers may not require an employee to give notice prior to making any disclosure except that an employer may require the employee to give advanced notice of any testimony given as part of a legislative request to the agency.

G. OAR 410-120-1395 to 410-120-1510.

1. OAR 410-120-1395 identifies the approaches taken by the Department of Human Services to promote program integrity.
2. OAR 410-120-1397 describes the basis for denying claims payment and the process for recouping payments or obtaining refunds of payments to Providers.
3. OAR 410-120-1400 and 410-120-1460 describe the basis for imposing sanctions and the types and conditions of sanctions for violations of Federal and State statutes and regulations related to fraud and abuse.
4. 410-120-1505 describes the right to and the process for auditing provider payments.
5. 410-120-1510 sets forth requirements for detecting and investigating fraud and abuse.

Definitions

The terms below shall have the following meanings and shall apply when used:

- with a possessive case (such as "'s" or "s'"),
- in noun form when defined as a verb or vice versa,
- used in a phrase or with a hyphen to create a compound adjective or noun,
- with a participle (such as "-ed" or "-ing"),
- with a different tense than the defined term,
- in plural form when defined as singular and vice versa.

References to "they" when used in the singular or plural tense shall refer to all genders.

Terms not capitalized, whether or not listed below, shall have their commonly understood meaning and usage, including as applicable, the meaning as understood within the Health care field and community.

Abuse means has the meaning provided for in 42 CFR §455.2

Encounter data means certain information required to be submitted to OHA under OAR 410-141-3430 and related to services that were provided to Members regardless of whether the services provided: (i) were Covered Services, non-covered services, or other Health-Related services, (ii) were not paid for, (iii) paid for on a Fee-For-Service or capitated basis, (iii) were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor, and (iv) were performed pursuant to Subcontractor agreement, special arrangement with a facility or program; or other arrangement.

Fraud means the intentional deception or misrepresentation that Person knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result in some unauthorized benefit to themselves or some other Person(s).

Member means a client who is enrolled with Contractor under the Contract.

Participating Provider has the meaning as provided in OAR 410-141-3000.

Provider has the meaning as provided in OAR 410-120-000

Subcontractor means any individual, entity, facility, or organization, other than a Participating Provider, that has entered into a Subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.

Waste means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.

REVISION ACTIVITY

New P&P/Change/Revision and Rationale	Final Review/Approval	Approval Date	Effective Date of Policy/Change
		1/1/2020	1/1/2020
New approval	OHSU IDS Board of Directors	6/23/2020	6/23/2020
	IDS Regulatory Compliance Committee	9/13/2021	1/1/2021
Reviewed no revisions	IDS Regulatory Compliance Committee	3/14/2022	1/1/2021
Board Oversight, Consent Agenda	OHSU Health IDS Board of Directors	4/26/2022	3/14/2022